HAZELWOOD MINE FIRE INQUIRY REPORT 2015/2016
VOLUME III – HEALTH IMPROVEMENT

Hazelwood
Mine Fire
Inquiry

HAZELWOOD MINE FIRE INQUIRY REPORT 2015/2016 VOLUME III – HEALTH IMPROVEMENT

THE HON. BERNARD TEAGUE AO – CHAIRPERSON

PROF. JOHN CATFORD – BOARD MEMBER

MRS ANITA ROPER – BOARD MEMBER

ORDERED TO BE PUBLISHED

Hazelwood
Mine Fire
Inquiry

LETTER OF TRANSMISSION

The Honourable Linda Dessau AM
Governor of Victoria
Government House
Melbourne VIC 3004

29 January 2016

Your Excellency

In accordance with the Terms of Reference dated 26 May 2015 and subsequently updated
on 5 November 2015, we have the honour of presenting to you the third volume of the report
of the 2015/2016 Hazelwood Mine Fire Inquiry.

This volume addresses paragraph 7 of the Terms of Reference relating to short, medium and long-term
measures to improve the health of the Latrobe Valley communities, having regard to any health impacts
identified by the Board as being associated with the Hazelwood Coal Mine Fire. Through the process of
inquiring with the community, industry and stakeholders, the Board identified five main areas relevant to
progressing health improvements in the Latrobe Valley. These are discussed in the report and comprise:
strengthening health services, promoting healthy living, reducing health inequities, building pride of place,
and strengthening leadership and sustainability.

The report presents the Board's considerations for transforming the future health of the Latrobe Valley,
including a set of commendations, affirmations and recommendations, and identifies matters for
further consideration.

Undertaking this work has been a privilege and we thank the people of the Latrobe Valley for their
hospitality and generosity. We are also very grateful for the contribution made by a large number
of individuals from the community, health services and government agencies who assisted the
Board in formulating its recommendations.

Yours sincerely

The Hon. Justice Bernard Teague AO   Prof. John Catford   Mrs Anita Roper

Victoria Government Gazette

Inquiries Act 2014

APPOINTMENT OF A BOARD OF INQUIRY INTO THE
HAZELWOOD COAL MINE FIRE

Order in Council

The Governor in Council, on the recommendation of the Premier under section 53(1) of the **Inquiries Act 2014**, appoints:

- the Honourable Bernard George Teague AO;
- Professor John Charles Catford; and
- Mrs Anita Michele Roper

to constitute a Board of Inquiry to inquire into and report on the terms of reference specified in paragraphs 6 to 11 of this Order.

The Honourable Bernard George Teague AO is appointed as Chairperson of the Inquiry.

This Order comes into effect on the date it is published in the Government Gazette.

BACKGROUND

1. In early February 2014 a fire ignited which, on or about 9 February 2014, took hold in the Hazelwood Coal Mine.

2. The Hazelwood Coal Mine Fire impacted the Latrobe Valley communities.

3. In March 2014, a Board of Inquiry was established to inquire into and report on the following specified matters:

    1. *The origin and circumstances of the fire, including how it spread into the Hazelwood Coal Mine.*

    2. *The adequacy and effectiveness of the measures taken by or on behalf of the owner, operator and licensee of the Hazelwood Coal Mine to prevent the outbreak of a fire, and to be prepared to respond to an outbreak of a fire including mitigating its spread and severity, in the Hazelwood Coal Mine, including whether the owner, operator and licensee of the Hazelwood Coal Mine, or any person or entity acting on behalf of any of them:*

        i.   *implemented the recommendations arising from reviews of previous events; and*

        ii. *in the opinion of the Board, breached or did not comply with the requirements of (or under) any relevant statute or regulation, including any notification or directive given under such statute or regulation and any code of practice, management plan or similar scheme, developed and/or implemented due to such requirements.*

    3. *The adequacy and effectiveness of the application and administration of relevant regulatory regimes in relation to the risk of, and response to, fire at the Hazelwood Coal Mine.*

    4. *The adequacy and effectiveness of the response to the Hazelwood Coal Mine Fire by:*

        i.   *the owner, operator and licensee of the Hazelwood Coal Mine;*

        ii. *the emergency services; and*

        iii. *other relevant government agencies, including environmental and public health officials,*

        and in particular, the measures taken in respect of the health and well-being of the affected communities by:

SPECIAL

   iv. *informing the affected communities of the Hazelwood Coal Mine Fire and about its known effects and risks; and*

   v. *responding to those effects on, and risks to, the affected communities.*

  5. *Any other matter reasonably incidental to the matters specified in paragraphs 1 to 4.*

4. That Inquiry's report was tabled in the Victorian Parliament on 2 September 2014.

5. Since that report was tabled, further concerns have been raised about the potential health impacts of the fire on the Latrobe Valley communities and future options for rehabilitating Victorian mines in the Latrobe Valley.

TERMS OF REFERENCE

 You are required to inquire into and report on the following terms of reference:

6. Whether the Hazelwood Coal Mine Fire contributed to an increase in deaths, having regard to any relevant evidence for the period 2009 to 2014;

7. Short, medium and long term measures to improve the health of the Latrobe Valley communities having regard to any health impacts identified by the Board as being associated with the Hazelwood Coal Mine Fire;

8. Short, medium and long term options to rehabilitate:

 (a) land on which work has been, is being or may lawfully be done in accordance with a Work Plan approved for the Hazelwood Mine, the Yallourn Mine, and the Loy Yang Mine; and

 (b) land in relation to which an application for variation of the Work Plan is under consideration for the Hazelwood Mine, the Yallourn Mine, or the Loy Yang Mine;

9. For each rehabilitation option identified under paragraph 8:

 (a) whether, and to what extent, the option would decrease the risk of a fire that could impact the mine and if so, the cost of the option relative to the cost of other fire prevention measures;

 (b) whether, and to what extent, the option would affect the stability of the mine;

 (c) whether, and to what extent, the option would create a stable landform and minimise long term environmental degradation;

 (d) whether, and to what extent, the option would ensure that progressive rehabilitation is carried out as required under the **Mineral Resources (Sustainable Development) Act 1990**;

 (e) the estimated timeframe for implementing the option;

 (f) the option's viability, any associated limitations and its estimated cost;

 (g) the impact of the option on any current rehabilitation plans for each mine;

 (h) whether, and to what extent, the option would impact the future beneficial use of land areas impacted by the mines; and

 (i) whether the option is otherwise sustainable, practicable and effective;

10. Having regard to the rehabilitation liability assessments that have been or will be reported in 2015 by the operators of each of the Hazelwood Mine, the Yallourn Mine, and the Loy Yang Mine, as required by the **Mineral Resources (Sustainable Development) Act 1990**, and to the outcome of the Rehabilitation Bond Review Project:

 (a) whether the rehabilitation liability assessments referred to above are adequate;

 (b) whether the current rehabilitation bond system, being one of the measures to provide for progressive rehabilitation by end of mine life as required under the **Mineral Resources (Sustainable Development) Act 1990**, is, or is likely to be, effective for the Hazelwood Mine, the Yallourn Mine, and the Loy Yang Mine; and

(c)　　any practical, sustainable, efficient and effective alternative mechanisms to ensure rehabilitation of the mines as required by the **Mineral Resources (Sustainable Development) Act 1990**;

11.　Sustainable, practical and effective options that could be undertaken by the mine operator to decrease the risk of fire arising from or impacting the Anglesea Mine for the 2015/2016 summer season, noting the impending closure of the mine on 31 August 2015; and

12.　Any other matter that is reasonably incidental to those set out in paragraphs 6 to 10.

REPORTING DATES

You must report your findings and any recommendations to the Governor as soon as possible, and not later than:

(a)　31 August 2015, in respect of the Anglesea mine Term of Reference in paragraph 11 of this Order, and any reasonably incidental matters;

(b)　2 December 2015, in respect of the Health Terms of Reference, and any reasonably incidental matters; and

(c)　15 March 2016, in respect of the Mine Terms of Reference, and any reasonably incidental matters.

CONDUCTING THE INQUIRY

13.　You may:

(a)　conduct your inquiry as you consider appropriate, subject to the requirements of procedural fairness, including by adopting any informal and flexible procedures to: engage with the relevant local communities; ascertain the relevant facts as directly and effectively as possible; and avoid unnecessary cost or delay;

(b)　have regard to any research, past inquiries, reports and evaluations that may inform your inquiry and avoid unnecessary duplication;

(c)　have regard to any documents, things or evidence received by, and any matters submitted to, the Board of Inquiry referred to in paragraph 3 as if those documents, things or evidence had been received by you, or those matters had been submitted to you, as the case may be, for the purposes of your inquiry and any report or reports under this Order;

(d)　consult with the relevant local communities; and

(e)　consult with and engage experts (including Australian legal practitioners) as necessary to provide relevant advice and assistance.

14.　You must conduct your inquiry in accordance with this Order, the **Inquiries Act 2014**, and all other relevant laws.

15.　It is anticipated that in conducting your inquiry you will, to the extent you think it appropriate, work co-operatively with, and seek not to prejudice, any ongoing response or recovery activities or investigations into the Hazelwood Coal Mine Fire.

16.　The powers of the Board of Inquiry, at the discretion of the Chairperson may, at any time, be exercised by one or more Inquiry members.

BUDGET

17.　You may incur expenses and financial obligations to be met from the Consolidated Fund up to $3.378 million in conducting this Inquiry.

DEFINITIONS

18.　In this Order:

Anglesea Mine means the land the subject of the Mines Aluminium Agreement (Agreement 6829) as in force from time to time, which was ratified by the **Mines (Aluminium Agreement) Act 1961**;

Hazelwood Coal Mine Fire means the fire that took hold in the Hazelwood Mine on or about 9 February 2014;

Hazelwood Mine means the land the subject of Mining Licence Number 5004, as in force from time to time;

Health Terms of Reference means the terms of reference in paragraphs 6 and 7 of this Order;

Loy Yang Mine means the land the subject of Mining Licence Number 5189, as in force from time to time;

Mine Terms of Reference means the terms of reference in paragraphs 8, 9 and 10 of this Order;

Rehabilitation Bond Review Project means the current review into rehabilitation bonds and the methodology by which they are calculated, as referred to at page 1612, lines 7–8 of the transcript of the Hazelwood Mine Fire Inquiry dated 10 June 2014;

Work Plan means a work plan approved under the **Mineral Resources (Sustainable Development) Act 1990** or endorsed pursuant to clause 21A of the Agreement set out in Schedule 1 to the **Mines (Aluminium Agreement) Act 1961**, as amended by the Amendment Agreement set out in Schedule 2 to that Act, as the case may be;

Yallourn Mine means the land the subject of Mining Licence Number 5003, as in force from time to time.

Dated 26 May 2015

Responsible Minister:
THE HON DANIEL ANDREWS MP
Premier

YVETTE CARISBROOKE
Clerk of the Executive Council

Victoria Government Gazette

No. G44 Thursday 5 November 2015
By Authority of Victorian Government Printer

Inquiries Act 2014
AMENDMENT TO THE TERMS OF REFERENCE FOR
THE BOARD OF INQUIRY INTO THE HAZELWOOD COAL MINE FIRE
Order in Council

The Governor in Council under section 53 of the **Inquiries Act 2014**, amends the Order in Council dated 26 May 2015 establishing the Board of Inquiry into the Hazelwood Coal Mine Fire by:

1. For paragraphs (b) and (c) under the heading 'Reporting Dates' **substitute** –

    "(b) 2 December 2015, in respect of the Term of Reference in paragraph 6 of this Order, and any reasonably incidental matters; and

      (c) 29 January 2016, in respect of the Term of Reference in paragraph 7 of this Order, and any reasonably incidental matters; and"

2. After paragraph (c) under the heading 'Reporting Dates' **insert** –

    "(d) 15 March 2016, in respect of the Mine Terms of Reference, and any reasonably incidental matters."

Dated 4 November 2015

Responsible Minister
THE HON. DANIEL ANDREWS MP
Premier

MATTHEW McBEATH
Clerk of the Executive Council

CONTENTS

GUIDE TO READING THIS REPORT

This report constitutes the Board of Inquiry's response to the Hazelwood Mine Fire Inquiry's Term of Reference 7. Term of Reference 7 requires the Board to inquire into, report on, and make any recommendations that it considers appropriate in relation to short, medium and long-term measures to improve the health of the Latrobe Valley communities, having regard to any health impacts identified by the Board as being associated with the Hazelwood Coal Mine Fire.

This report takes into account information provided through community consultations, public submissions, expert reports, public hearings, and at Health Improvement Forums held in Traralgon on 28–30 September 2015, 13 October 2015 and 19 October 2015.

This report may be the first time that an overview of health improvements, considered across the continuum from primary prevention and screening through to treatment and care, has been compiled at the one time for a Victorian community. Uniquely, the report has also been approached from the perspective of a community, rather than a health service agency or government department.

A large number of possibilities for improving health in the Latrobe Valley, representing many different perspectives, were presented to the Board during this Inquiry. The Board has considered the best available advice and evidence for progressing health improvements.

The principles of community engagement and equity are embedded across this report. This reflects the Board's view that the purpose of any health improvements is threefold: to improve the health of the Latrobe Valley community; to reduce inequity within the Latrobe Valley; and to develop actions towards improving health that are community-centred and community-informed.

KEY TERMS

Throughout the report, the term 'State' is used broadly to encompass the Victorian Government and the Victorian public service.

The term 'statutory authorities' refers to public entities such as the Environment Protection Authority (EPA), VicHealth and WorkSafe.

The term 'state-level non-government health agencies' refers to non-government agencies that have a specific focus on promoting health and/or preventing or addressing ill health across Victoria, such as beyondblue, Cancer Council Victoria, Diabetes Victoria, Heart Foundation Victoria, the Victorian Branch of the Public Health Association Australia, Quit Victoria, and the Victorian Healthcare Association.

The term 'four principal health agencies' refers to Latrobe Regional Hospital, Latrobe Community Health Service, Latrobe City Council, and the Gippsland Primary Health Network. These are the key organisations responsible for health and wellbeing in the Latrobe Valley.

The term 'short-term' should be taken to be up to two years; 'medium-term' between two and five years; and 'long-term' more than five years.

Part 1 of this report, INTRODUCTION TO THE INQUIRY, outlines the new approach taken to addressing Term of Reference 7. This new approach involved collaborative discussion amongst a diverse range of experts from across the community at Health Improvement Forums.

Part 2 of this report, BACKGROUND TO HEALTH IMPROVEMENTS, provides an overview of health improvement themes, and considers the health of communities in the Latrobe Valley and the health impacts associated with the Hazelwood mine fire. This Part also provides an overview of matters the Board recommended for further consideration in the 2014 Hazelwood Mine Fire Inquiry Report, in particular the Hazelwood Mine Fire Health Study, the designation of the Latrobe Valley as a health zone and the appointment of a Health Advocate for the Latrobe Valley.

Part 3 of this report, HAZELWOOD MINE FIRE HEALTH STUDY, gives further consideration to the ongoing health surveillance of the Latrobe Valley community, which was the subject of much discussion and several recommendations in the 2014 Hazelwood Mine Fire Inquiry Report.

Part 4 of this report, STRENGTHENING HEALTH SERVICES, considers how health services in the Latrobe Valley could be strengthened in order to improve health outcomes. This Part discusses the need to re-design health services, and to innovate and coordinate healthcare so that the burden of chronic and complex health conditions can be more effectively managed. This Part also considers consumer-led care, screening and early detection of chronic disease, the health workforce in the Latrobe Valley, and the infrastructure required to support health service delivery.

Part 5 of this report, PROMOTING HEALTHY LIVING, considers a broad remit of measures—including reducing smoking, improving nutrition, increasing physical activity, and improving mental health— that will enable people in the Latrobe Valley to enjoy better health. This Part includes a particular focus on local and state-wide actions to support healthy living and explores settings for action, such as sports clubs, schools, workplaces and the environment. Priority populations in need of health support within the Latrobe Valley are also identified.

Part 6 of this report, REDUCING HEALTH INEQUITIES, considers the health inequities experienced both within the Latrobe Valley and between the Latrobe Valley and other parts of Victoria. It considers possible measures to address the social determinants of health inequity. Particular focus is given to the health of Aboriginal people in the Latrobe Valley, and potential measures to reduce health inequities by responding to the needs of Aboriginal communities as they relate to health services, health and wellbeing.

Part 7 of this report, BUILDING PRIDE OF PLACE, discusses the need for more effective engagement by the State and key health agencies with Latrobe Valley communities, and the need to acknowledge the assets of the community. This Part also considers the particular role that industry has had in forming the Latrobe Valley's sense of pride, and the importance of engaging the community in planning for the transition of industry in order to restore pride of place.

Part 8 of this report, STRENGTHENING LEADERSHIP AND SUSTAINABILITY, discusses how to achieve improvements to health in the Latrobe Valley through effective leadership and collective impact. This Part also explores the concepts of, and resourcing for, a designated health zone and a health advocate, initiatives recommended by the Board for further consideration in the 2014 Hazelwood Mine Fire Inquiry Report.

Part 9 of this report, TRANSFORMING THE FUTURE HEALTH OF THE LATROBE VALLEY, presents the Board's overarching considerations together with a set of Recommendations, Commendations and Affirmations. This Part notes that proposals made by various stakeholders throughout this Inquiry provide a rich source of advice in guiding future action towards better health in the Latrobe Valley.

Do you need
to see a
doctor?

GP Clinic
available

PART ONE
INTRODUCTION TO THE INQUIRY

PART 1 INTRODUCTION TO THE INQUIRY

The 2014 Hazelwood Mine Fire Inquiry was held from February to September 2014. On 26 May 2015, The Honourable Lily D'Ambrosio MP, Minister for Energy and Resources, and The Honourable Jill Hennessy MP, Minister for Health, announced the re-opening of the Inquiry. The purpose of the re-opened Inquiry is to investigate and report on whether the 2014 Hazelwood mine fire contributed to an increase in deaths; measures to improve the health of the Latrobe Valley; rehabilitation options for Latrobe Valley coal mines; and minimising fire risks at the Anglesea coal mine for the 2015/2016 summer season.

TERMS OF REFERENCE

This report addresses paragraph 7 of the Hazelwood Mine Fire Board of Inquiry's Terms of Reference (Term of Reference 7). Under Term of Reference 7, the Board is to inquire into, and report on, and make any recommendations that it considers appropriate in relation to short, medium and long-term measures to improve the health of the Latrobe Valley communities, having regard to any health impacts identified by the Board as being associated with the Hazelwood Coal Mine Fire.

The Board of the 2014 Inquiry determined that the health effects of the Hazelwood mine fire on Latrobe Valley communities were significant and diverse.[1] People with pre-existing illness or poor health generally, and people from socially disadvantaged backgrounds, were particularly susceptible to adverse health effects from the fire. The 2014 Board of Inquiry considered that it was important to have an understanding of the overall health of the Latrobe Valley in order to fully appreciate adverse health effects caused by the fire.[2] The 2014 Board concluded that the 'fire added further insult to an already vulnerable community.'[3]

The Board considers that the purpose and intent of its 2015 Inquiry into Term of Reference 7 is to examine both the health effects that are likely to be attributable to the Hazelwood mine fire, and the health of the Latrobe Valley region more generally—these matters are inextricably linked. The Board has also inquired into measures to improve the health of particularly vulnerable groups within the Latrobe Valley community. The Board is of the view that had the health of Latrobe Valley communities been more robust at the time the mine fire started, there would have been less adverse impacts on the community's health as a result of the fire.

'Short, medium and long-term measures' are not further specified in Term of Reference 7. The Board has determined that, for the purposes of this report, short-term means up to two years; medium-term means between two and five years; and long-term means more than five years.

ESTABLISHMENT OF THE INQUIRY

THE BOARD

On 26 May 2015, the Governor in Council established the Hazelwood Mine Fire Board of Inquiry and appointed the following Board members:

BERNARD TEAGUE, CHAIRPERSON

Justice Bernard Teague AO was a Supreme Court Judge from 1987 to 2008. During this period he also chaired the Adult Parole Board and the Victorian Forensic Leave Panel, and was a Council member at the Institute of Forensic Mental Health. Prior to his appointment to the Supreme Court, Justice Teague was a solicitor specialising in defamation and other civil law.

Justice Teague was Chair of the 2009 Victorian Bushfires Royal Commission and Chair of the 2014 Hazelwood Mine Fire Inquiry.

JOHN CATFORD, BOARD MEMBER

Professor Emeritus John Catford is a registered medical practitioner and the Executive Director, Academic and Medical, of the Epworth HealthCare Group.

Professor Catford has been a Professor of public health for 30 years and has held senior academic and health service management positions in Australia and the United Kingdom, and with the World Health Organization. In 2008, Professor Catford led the establishment of the School of Medicine at Deakin University in Geelong. He was appointed Vice President and Deputy Vice Chancellor of Deakin University in 2011.

Professor Catford was a Board member of the 2014 Hazelwood Mine Fire Inquiry.

ANITA ROPER, BOARD MEMBER

Mrs Anita Roper is an experienced Director with a strong background in sustainability. Her career spans the public and private sectors. She has over 30 years' experience in senior management roles working with business, government, communities and multi-lateral agencies in Australia and internationally. She is currently a Director of Yarra Valley Water, a Board member of the Fitzroy Football Club and a member of the Victorian Public Sector Commission Advisory Board.

Mrs Roper's previous roles include Chief Executive Officer at Sustainability Victoria and Global Director of Sustainability with Alcoa (New York). She has also previously served as a non-executive Director of Pacific-Hydro and as Chair of the Board's Health, Safety, Sustainability and People Committee; as a member of AngloGold Ashanti's Global Panel on Sustainability; and as a Board member of the Women's Network for a Sustainable Future (New York).

HAZELWOOD MINE FIRE INQUIRY SECRETARIAT

The Hazelwood Mine Fire Inquiry Secretariat was established to support the Board of Inquiry. Ms Genelle Ryan headed the Secretariat. Members of the Secretariat are listed in Appendix A. The Board thanks them for their dedication and commitment to this Inquiry. The Board also thanks K&L Gates for contributing their legal expertise.

COUNSEL ASSISTING

Counsel Assisting, Mr Peter Rozen and Ms Ruth Shann, provided the Board with legal advice and guidance throughout the Inquiry. The Board thanks Mr Rozen and Ms Shann for their assistance.

THE BOARD'S APPROACH

The Board recognised that, in order to effectively conduct this Inquiry, genuine engagement with the Latrobe Valley community was required. The Board emphasised transparency and accessibility throughout the Inquiry and endeavoured to hear and understand the concerns of the Latrobe Valley community relevant to Term of Reference 7.

Given the forward-looking nature of Term of Reference 7, the Board took a new approach by convening Health Improvement Forums, rather than conducting formal public hearings.[4]

The Board's overall approach to its inquiry in relation to Term of Reference 7 was:

- Communicating with the public through its website and other media.
- Obtaining expert opinions on health improvement measures for the Latrobe Valley.
- Holding informal discussions with key health agencies and bodies.
- Holding informal discussions with community members.
- Undertaking public community consultations in the Latrobe Valley.
- Commissioning research and conducting other investigations.
- Holding Health Improvement Forums in the Latrobe Valley.
- Inviting public submissions both before and after conducting Health Improvement Forums.

COMMUNICATIONS

A website (http://hazelwoodinquiry.vic.gov.au/) was established for the 2014 Hazelwood Mine Fire Inquiry. This website was updated when the Inquiry was re-opened, and has since been continuously updated to provide information to the Latrobe Valley and broader Victorian community about the Board, Terms of Reference, public submissions, community consultations, public hearings and documents relevant to public forums, including expert reports.

To generate community attendance at consultations, hearings and Health Improvement Forums, and to maximise the number of written submissions received, the Inquiry was promoted through local newspaper and radio advertisements, brochures, posters, mail drops and broader media.

Members of the public were able to contact the Inquiry by phone (1300 556 034) and by email (info@hazelwoodinquiry.vic.gov.au) for the duration of the Inquiry.

PUBLIC SUBMISSIONS

The Board invited the public to make submissions on the matters relevant to Term of Reference 7 until 10 August 2015. The Board received 61 written submissions from individuals and organisations. Board members read and considered all written submissions.

After the Health Improvement Forums were held, the Board invited the public to make additional submissions relevant to the matters discussed in each of the forums. The Board received eight additional submissions, all of which were read and considered by the Board.

The organisations and individuals who made submissions are listed at Appendix B. The Board thanks all who made written submissions.

INDEPENDENT EXPERTS

Taking into account the complexity of the issues to be considered under Term of Reference 7, the Board engaged a number of independent experts to provide information and advice regarding health improvements in the Latrobe Valley.

Professor Donald Campbell and Professor David Clarke prepared a report for the Board titled *Improving the health of the people of the Latrobe Valley*. Professor Campbell is Professor of Medicine, School of Clinical Sciences at Monash University and Program Director, General Medicine, Monash Health. Professor Clarke is Professor of Psychological Medicine, Department of Psychiatry, Monash University, and Medical Director of the Mental Health Program at Monash Health.

Professor Evelyne de Leeuw and Associate Professor Marilyn Wise prepared a report for the Board titled *Population health development in the Latrobe Valley*. Professor de Leeuw is the Director of Glocal Health Consultants, Editor-in-Chief of *Health Promotion International*, and the Director, Centre for Health Equity Training, Research and Evaluation, University of New South Wales. Associate Professor Wise is Associate Professor, Centre for Primary Health Care and Equity, University of New South Wales.

The Board thanks the experts for their reports.

COMMUNITY CONSULTATIONS

On 17 and 18 August 2015, the Board held four community consultation sessions in Morwell, Moe and Traralgon. Sixty-four people attended the consultations, including representatives from the local community, local industry and the State. Professor Campbell, Professor Clarke and Professor de Leeuw also attended the community consultations.

At the consultations, the Board provided an overview of the Inquiry and invited participants to discuss the challenges to achieving good health in the Latrobe Valley. Questions posed to participants included:

Question 1: The 2014 Hazelwood Mine Fire Inquiry Report identified that the effects of the mine fire were more significant in the Latrobe Valley because of underlying poor health in the Valley. What are the health challenges in the Latrobe Valley?

Question 2:   With regard to health services in the Latrobe Valley: What's working well? What's not working so well?

Question 3:   What are the potential solutions to the health issues in the Latrobe Valley? What would help to strengthen health services in the Latrobe Valley? What more could be done to improve the health of the whole population of the Latrobe Valley?

Question 4:   What do you think about the Latrobe Valley being designated a special area for health improvement, perhaps to be called a 'Health Conservation Zone'? What do you think about the idea of the Latrobe Valley having a special 'Health Advocate' who can be a champion—a voice—for the needs of local people?

The consultations enabled many voices to be heard and a broad range of issues to be raised. The Board considered the comments and ideas contributed by participants.[5] Many of the issues raised in the consultations informed the development of themes that were subsequently explored in the Health Improvement Forums.

The Board thanks the community members who attended the community consultations and provided the Board with invaluable insights and information.

HEALTH IMPROVEMENT FORUMS

The Board held a series of public Health Improvement Forums over five days in Traralgon—on 28–30 September 2015, 13 October 2015 and 19 October 2015. The aim of the Health Improvement Forums was to bring together diverse experts from across the community to discuss the best ways to improve the health and wellbeing of people in the Latrobe Valley, and to build consensus, where possible, about how best to move forward.

The Board heard from 70 panellists to discuss the possible short, medium and long-term measures required to improve particular health issues. The Board selected panellists based on their expertise and experience relevant to different areas of health. Panel members included representatives from the Latrobe Valley community, industry, state and local governments, state and local health agencies, and medical practitioners. Professor Campbell, Professor Clarke, Professor de Leeuw and Associate Professor Wise also participated in the Health Improvement Forums.

These forums considered themes commonly raised in public submissions and in community consultations. The Health Improvement Forums comprised 13 expert panels:

- **Chronic Disease Management:** helping people with serious ongoing health conditions to manage their illness well and prevent further complications—focusing on cardiovascular ailments, cancers, diabetes, and respiratory disease.

- **Health Behaviours:** enabling healthy lifestyles through education, sport, health policies and encouraging healthy choices—focusing on smoking, nutrition, and physical activity.

- **Mental Health:** responding to mental health issues such as anxiety and depression, drug and alcohol use, and by promoting mental wellbeing.

- **Early Detection and High Risk Screening:** detecting signs of chronic disease early to prevent further progression—focusing on raised blood pressure, sugar and cholesterol, and lung conditions.

- **Health Workforce:** recruiting and retaining suitable professionals to work locally—focusing on doctors, nurses, allied health, and other health professionals.

- **Children and Youth:** giving children and young people the best chance in life through health services, schools, and early childhood and youth services.

- **Healthy Workplaces:** strengthening work environments and cultures to create healthy and productive places to work.

- **Healthy Environments:** creating physical and built environments that protect and promote health (for example, air and water quality; public and private spaces).

- **Social Disadvantage:** reducing the impact of social disadvantage on health—focusing on access to health services, and health promotion opportunities.

- **Aboriginal Health:** responding to the needs of Aboriginal communities as they relate to health services, and health and wellbeing.

- **Community Engagement and Communication:** engaging and empowering the broader community to create and promote positive health futures for the Latrobe Valley.

- **Health Conservation Zone and Health Advocate:** investing in and implementing innovative action in the health sector.

- **Governance, Leadership and Sustainability:** considering the best ways to move forward in the short, medium and long-term.

The Board provided questions to each panel in advance of their Health Improvement Forum. Expert panels on the first 11 themes were asked to consider the following questions as they related specifically to their panel topic:

1. What are the strategies for action that should be taken within the next two years having regard to:
   a. Whether there is evidence to suggest the improvement is effective
   b. What the likely costs and benefits of the improvement are
   c. What enablers and barriers to successfully implementing the improvements presently exist
   d. How can any barriers be overcome?

2. What are the future areas for health improvement over the medium and longer-term having regard to:
   a. Whether there is evidence to suggest the improvement is effective
   b. What the likely costs and benefits of the improvement are
   c. What enablers and barriers to successfully implementing the improvements presently exist
   d. How can any barriers can be overcome?

3. What are the promising areas for health improvement that require further investigation and/or testing having regard to:
   a. Whether there is evidence to suggest the further investigation and/or testing is likely to be effective
   b. What the likely costs and benefits of the further investigation and/or testing are
   c. What enablers and barriers to successfully implementing the improvements currently exist
   d. How can any barriers be overcome?

4. How would you rank or prioritise the actions that should be taken:
   a. Within the next two years
   b. In the medium and longer-term?

The Health Conservation Zone and Health Advocate panel was asked to consider the following questions:

1. How can leadership and action for health in the Latrobe Valley be improved having regard to:
   a. Whether the Latrobe Valley should be designated a special area for action and investments to improve health (perhaps called a 'Health Conservation Zone')
   b. Whether the Latrobe Valley should have a special 'Health Advocate' who acts as a champion for the needs of local communities?

2. How should any such measures be implemented and maintained having regard to the need to ensure the sustainability and effectiveness of the measure?

The Governance, Leadership and Sustainability panel was asked to consider the following question:

1. Having regard to panel feedback sessions on 28–30 September 2015 and 13 October 2015, what is the best way forward to ensure that the health of people in the Latrobe Valley improves in the short, medium and long-term?

These questions were then considered in roundtable discussions with panellists and community members. Community members were invited to listen, ask questions and provide feedback to panel members. The panel then presented their views to the Board in an expert panel feedback session. Panel presentations and discussions were transcribed and are available on the Inquiry's website.[6]

The use of Health Improvement Forums departs from the Inquiry's usual approach of holding public hearings. The Board considered that Term of Reference 7 did not lend itself to public hearings, as there was no evidence that required testing using a formal inquisitorial hearing process. The Board considers that the Health Improvement Forums yielded a richer source of information and resulted in a greater degree of consensus because they provided an opportunity for discussion. The Board heard from many panellists and community members that the Health Improvement Forums were a positive step in modelling community engagement and inclusion. A number of panels made commitments to progress health improvement initiatives irrespective of the Board's findings and recommendations in this report. The Board affirms those commitments.

The Board thanks the panellists and the community members who attended the Health Improvement Forums for their insights and opinions, and for their valuable contribution and commitment to health improvements in the Latrobe Valley.

PART 2 BACKGROUND TO HEALTH IMPROVEMENTS

Under Term of Reference 7, the Board is tasked with considering short, medium and long-term measures to improve the health of Latrobe Valley communities, having regard to any health impacts identified by the Board as being associated with the Hazelwood mine fire. Term of Reference 12 requires the Board to consider any matters that are reasonably incidental to the Terms of Reference of this Inquiry, including Term of Reference 7.

During the 2014 Hazelwood Mine Fire Inquiry, the Board recognised a need to understand the general health of people in the Latrobe Valley prior to the Hazelwood mine fire, in order to appreciate the health effects of the mine fire.[1] In the 2014 Hazelwood Mine Fire Inquiry, the Board stated that:

> There is a strong case for the health of the population of the Latrobe Valley to be substantially improved. Based on current health status information, this was justified before the Hazelwood mine fire and is even more necessary after it.[2]

This Part provides a general overview of the health of Latrobe Valley communities and canvasses the broad areas relevant to health improvements that will be considered in detail in this report.

2.1 THE HEALTH OF COMMUNITIES IN THE LATROBE VALLEY

The 2014 Hazelwood Mine Fire Inquiry found that the Latrobe Valley, and in particular Morwell, has a poorer health profile compared to other local government areas in Victoria and the average for the State.[3] This means that amongst communities of the Latrobe Valley, more years of life will be lost on average than in other Victorian communities as a direct result of conditions such as cancer, diabetes, mental disorders, cardiovascular disease, asthma and injuries.[4] In the 2014 Hazelwood Mine Fire Inquiry Report, the Board states:

> …the population of the Latrobe Valley already has significant health challenges and does not enjoy the levels of health and social wellbeing of most other Victorians. Latrobe Valley is also socially and economically disadvantaged relative to the rest of Victoria, which further exacerbates health conditions.[5]

The 2014 Hazelwood Mine Fire Inquiry considered the results of investigations into the burden of disease in Victoria.[6]

Figure 1. Disability adjusted life year, males, Gippsland region, 1996[7]
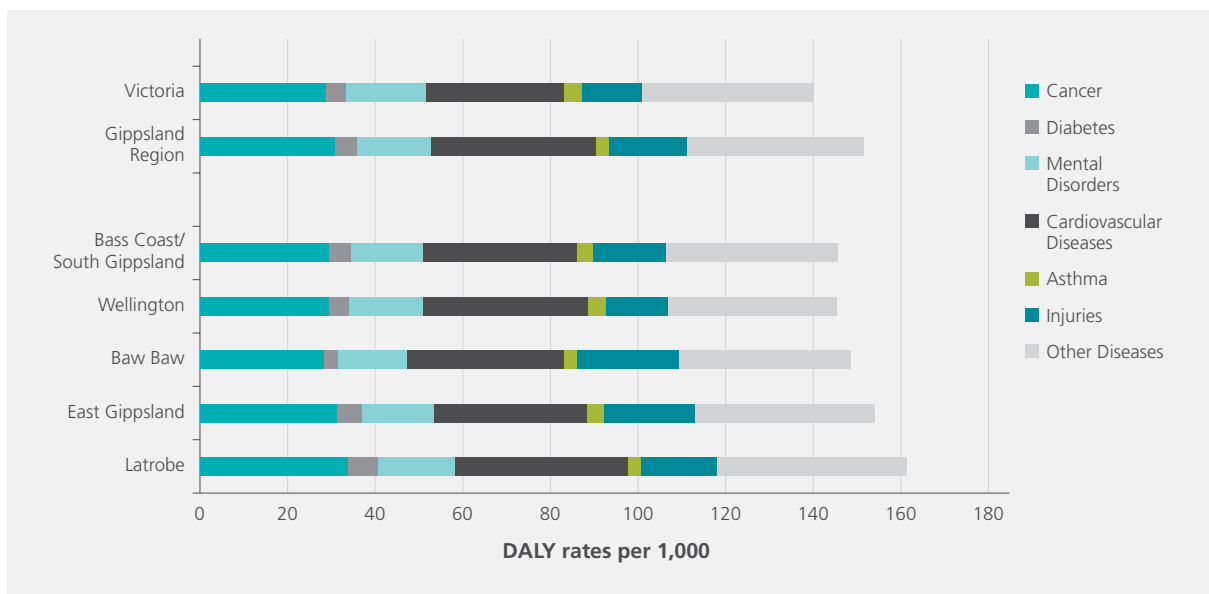
Figure 1 above shows the years of healthy life lost for males in the Gippsland region (referred to as disability adjusted life year or DALY) for six key health conditions: cancer, diabetes, mental disorders, cardiovascular diseases, asthma, injuries, and other diseases. Figure 2 below shows the years of healthy life lost for females. These figures demonstrate that men and women in the Gippsland region lose more years to disease than the average Victorian. Men and women in the Latrobe Valley also have the greatest number of years lost to disease of any area in Gippsland.

Figure 2. Disability adjusted life year, females, Gippsland region, 1996[8]
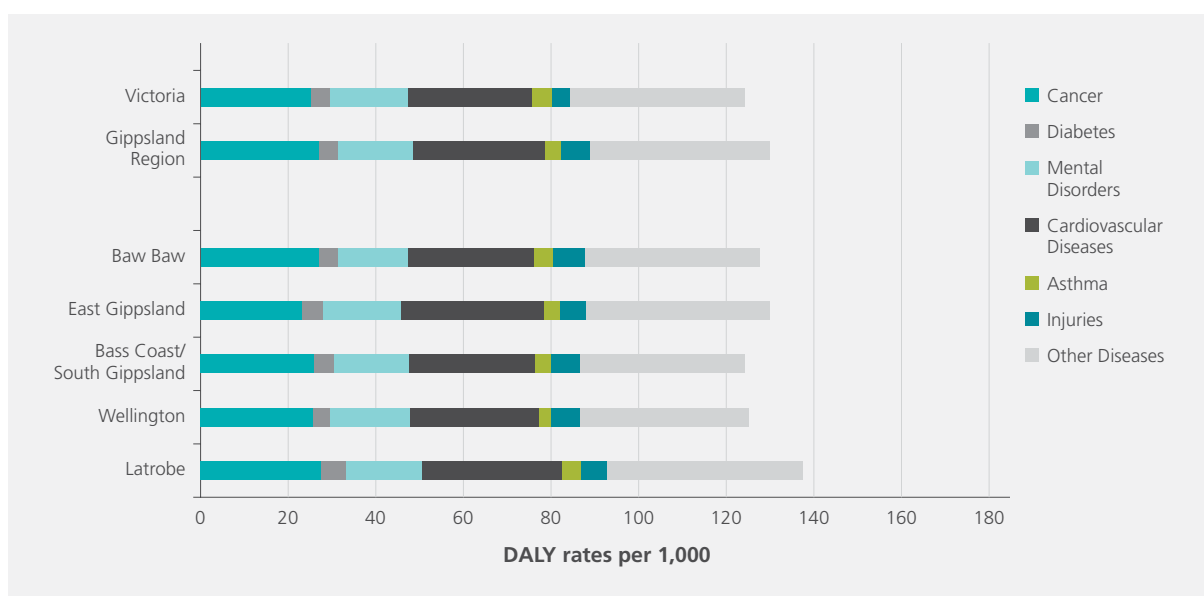
More recent data further demonstrates the stark differences in health that exist between populations of the Latrobe Valley and the rest of Victoria. In its submission to the Board during the re-opened Inquiry, VicHealth includes collated health-related information that compares health indicators in the Latrobe Valley to the Victorian average.[9] This information is presented in Table 1 below.

Table 1. Selected indicators of health – Latrobe Valley compared to the Victorian average[10]

Indicator	Latrobe	Victoria
Proportion of population that reports high or very high psychological distress (2011)	13.7%	11.1%
Proportion of population with depression and/or anxiety (2011)	24.1%	19.9%
Family violence incident reports per 1,000 population (2013–2014)	27.7	11.3
Percentage of adults over 18 years who are overweight or obese (2011–2012)	60.6%	49.8%
Percentage of smokers (2011–2012)	19.8%	15.7%
Proportion of population at short-term risk of alcohol-related harm: risky or high risk (2011–2012)	52.6%	45.3%
Proportion of population at long term risk of alcohol-related harm: risky or high risk (2011–2012)	4.8%	3.3%
Clients of drug and alcohol services per 1,000 population (2011–2012)	12.2	5.8

* Note that the most recent estimate of daily smoking rates in Victoria is 12.6%, reflecting the continuing decrease in the smoking rates at the population level. Daily smoking rates are likely to have also decreased in the Latrobe Valley, although a significant gap in smoking rates is likely to persist.

In its submission to the re-opened Inquiry, the Victorian branch of the Heart Foundation draws attention to the high levels of heart disease in the Latrobe Valley compared to the Victorian average. This information (presented in Table 2) is based on hospital admissions and out-of-hospital cardiac arrest for the period 2007–2008 to 2012–2013.[11]

Table 2. Hospital admissions and out-of-hospital cardiac arrest for the City of Latrobe (2007–2008 to 2012–2013) compared to the Victorian average[12]

Indicator	Latrobe	Victoria
Heart attack per 10,000 population	27.5	23
Unstable angina per 10,000 population	18.0	13
Heart failure per 10,000 population	28.6	24
Cardiac arrest per 10,000 population	9.9	7

In addition, Diabetes Victoria in its submission to the re-opened Inquiry, noted that the Latrobe Valley overall has high diabetes prevalence, with 6.6 per cent of the population affected (the average national rate is 5.3 per cent). Morwell is classified as a 'very high' diabetes prevalence area, with 7.8 per cent of the population of Morwell directly affected by diabetes.[13]

Given this significant disease burden, it is not surprising that men and women in the Latrobe Valley have, on average, a lower life expectancy than their counterparts in neighbouring Gippsland shires (as demonstrated by Figure 3 and 4) and in the rest of Victoria.

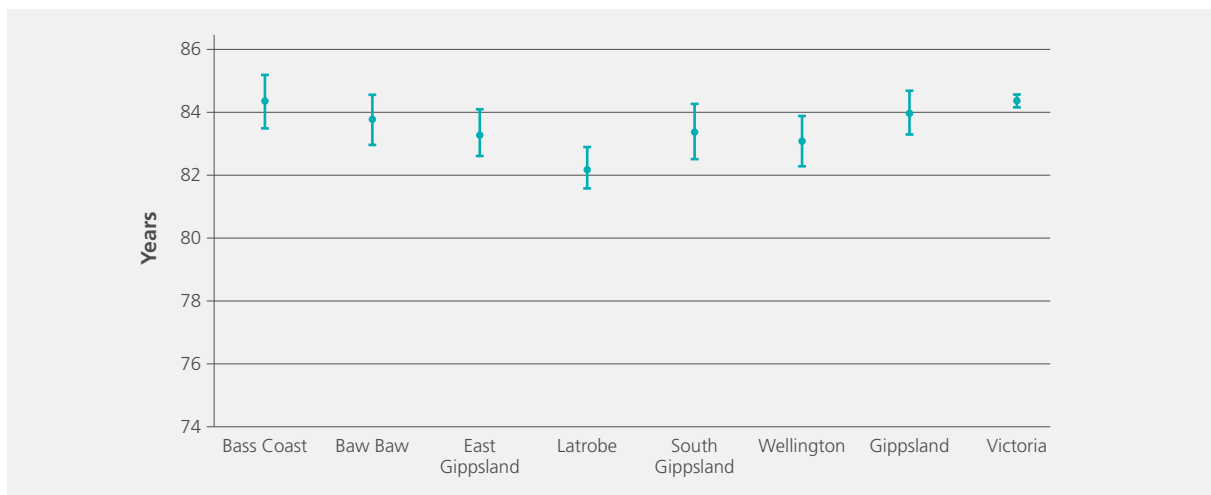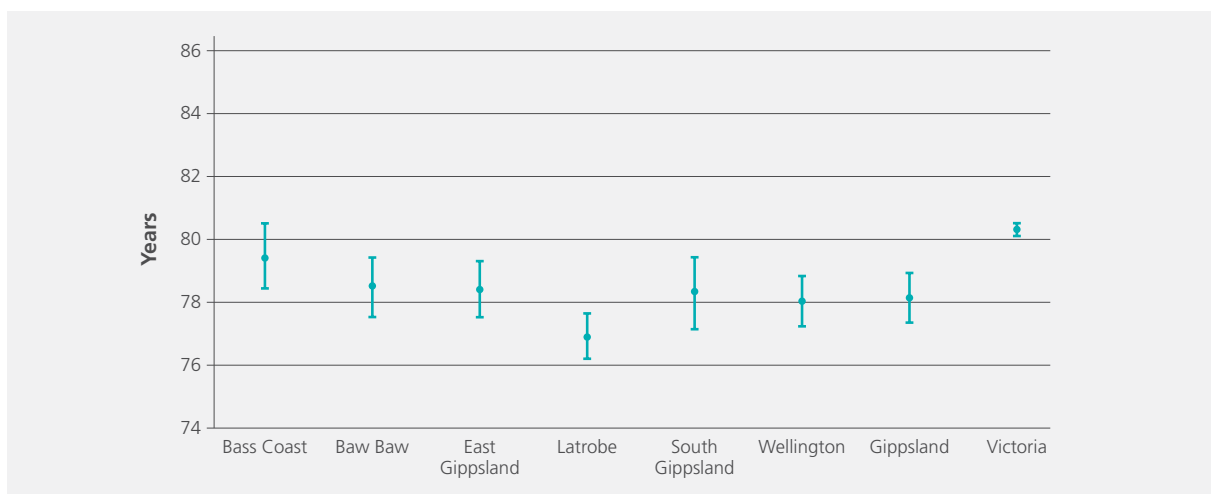**Figure 3. Life expectancy, females, Gippsland 2007**[14]

Figure 4. Life expectancy, males, Gippsland 2007[15]

The table below shows that, on average, males in the Latrobe Valley die 3.4 years earlier than men in Victoria overall. On average, females in the Latrobe Valley die 2.2 years earlier than women in Victoria overall. These differences in health status are significant.

Table 3. Life expectancy, Latrobe Valley compared to the Victorian average[16]

Indicator	Latrobe	Victoria
Life expectancy – Female	82.2 years	84.4 years
Life expectancy – Male	76.9 years	80.3 years

Recent research also shows that the socioeconomic disadvantage that exacerbates health problems in the Latrobe Valley is getting worse. Morwell is now amongst the most disadvantaged local government areas in Australia, with Moe and Churchill also disadvantaged relative to many other communities in Australia.[17] Further information about health inequities confronting the Latrobe Valley is provided in Part 6 of this report.

2.2 HEALTH IMPACTS ASSOCIATED WITH THE HAZELWOOD MINE FIRE

The 2014 Hazelwood Mine Fire Inquiry considered in detail the health impacts experienced by Latrobe Valley communities during, and in the immediate aftermath of, the Hazelwood mine fire. During the 2014 Inquiry, members of the Latrobe Valley community, and in particular residents of Morwell, reported suffering distressing adverse health effects from the mine fire, including sore and stinging eyes, headaches and blood noses. The majority of these symptoms resolved when smoke and ash from the mine fire dissipated, however some residents reported continuing symptoms. In addition to these symptoms, a small number of residents reported developing new health conditions.[18]

Professor Donald Campbell, Professor of Medicine, School of Clinical Sciences at Monash University and Program Director, General Medicine, Monash Health, advised the Board during the 2014 Inquiry that the probable cause of these adverse health impacts was the smoke and ash produced by the mine fire.[19]

Professor Campbell identified specific components of smoke and ash from the mine fire and indicated the potential short and long-term effects of exposure to those components. In particular, he noted the presence of carbon monoxide, ozone and particulate matter (PM) in the smoke and ash.[20] $PM_{2.5}$ is fine particulate matter that is found in smoke and haze and has the potential to cause adverse health effects.[21]

Professor Campbell advised that there are a number of vulnerable groups in the community who are particularly susceptible to adverse health effects from smoke and ash, namely those with pre-existing cardiovascular and respiratory conditions, pregnant women and unborn children, children and the elderly.[22] People with pre-existing health conditions, including asthma, chronic obstructive pulmonary disease, ischaemic heart disease and congestive heart failure, are at increased risk of adverse health impacts from exposure to $PM_{2.5}$, carbon monoxide and ozone.[23] Also at increased risk are smokers, who generally have compromised lung function, and people undertaking vigorous activity.[24] Research has shown that individuals with chronic obstructive pulmonary disease have an increased risk of requiring emergency care after exposure to elevated levels of $PM_{2.5}$.[25] Unborn children are particularly susceptible to high doses of carbon monoxide, which can lead to low birth weight, premature birth and foetal death.[26]

During the 2014 Inquiry, Professor Campbell also advised the Board that potential adverse health effects for people with pre-existing cardiovascular and respiratory disease range from exacerbation of their condition, hospital admission, stroke, heart attack, and in severe cases, death.[27] People with pre-existing cardiovascular and respiratory conditions are particularly susceptible to potential adverse long-term health effects when exposed to ozone, $PM_{2.5}$ and larger particles. In particular, they are susceptible to an aggravation or progression of their underlying condition, an increased risk of lung cancer, and potential effects on coagulation, which could result in an increased risk of arrhythmias, morbidity, hospital admissions, psychosocial effects, and death.[28]

Professor Campbell further advised the Board that there is a risk that the general population could develop health problems in the medium to long-term from exposure to $PM_{2.5}$ and ozone, including but not limited to the development of respiratory conditions, effects on cardiac conduction, increased risk of heart attack, stroke and lung cancer, long-term cognitive decline, psychosocial effects and death.[29]

In a submission to the Board, Doctors for the Environment Australia refer to findings of the United States Environmental Protection Agency on particulate matter and health.[30] The Agency's website states:

Numerous scientific studies have linked particle pollution exposure to a variety of problems, including:

- premature death in people with heart or lung disease
- nonfatal heart attacks
- irregular heartbeat
- aggravated asthma
- decreased lung function
- increased respiratory symptoms, such as irritation of the airways, coughing or difficulty breathing.[31]

During the re-opened Inquiry, the Board received submissions from a number of Latrobe Valley residents and service providers that describe ongoing health issues since the Hazelwood mine fire.[32]

In her submission to the Board, Dr Joanna McCubbin, a paediatrician and environmental medicine teacher based in Sale, states that health is a major concern for Latrobe Valley residents following the mine fire. Dr McCubbin has heard from parents in the Latrobe Valley that they are concerned that their children are not as healthy as they were prior to the mine fire. In particular, parents are reporting an increase in asthma, stomach aches and behavioural concerns amongst their children. She states in her submission that '[t]heir concerns are not unreasonable, since the evidence suggests that fine particulates are implicated in inflammation, which may cause both lung irritation but also brain inflammation leading to cognitive and behavioural effects as well as mental health issues.'[33]

In its submission to the Board, the Victorian Council of Social Service (VCOSS) indicates that it has consulted with members of the Latrobe Valley community and community sector organisations since the mine fire, and has heard a number of concerns about the potential long-term impacts on health, the availability of healthcare and whether the health impacts of the mine fire are being adequately monitored.[34] The VCOSS submission also notes that mental health organisations have advised VCOSS that 'there were significant ongoing, emerging and new mental health issues as a result of the mine fire.'[35]

Voices of the Valley undertook a 'door knock survey' in the Latrobe Valley at the commencement of the Hazelwood mine fire, during the mine fire, and in July 2015. Results of this survey were provided to the Board, and a summary of the health concerns identified is presented in Figure 5.

Figure 5. Summary of door knock survey undertaken by Voices of the Valley, July 2015 [36]

	Chest pain	Asthma	Sinus infection	Weight change	Heart attack	Breathing difficulties	Chest infection	Sore throat	Stress	Anxiety	Depression	Aneurysm /stroke	Renal problems	Miscarriage
Before	16.9%	3.2%	4.6%	0.9%	4.6%	8.7%	2.7%	3.2%	4.1%	4.1%	5.9%	1.8%	3.2%	0.5%
During	32.0%	21.5%	24.2%	8.6%	2.3%	57.5%	18.7%	37.9%	30.6%	27.4%	13.2%	0.9%	5.9%	0.0%
Since	32.4%	17.4%	27.4%	15.9%	1.4%	47.0%	21.9%	31.1%	24.7%	21.0%	15.5%	0.9%	7.3%	0.0%
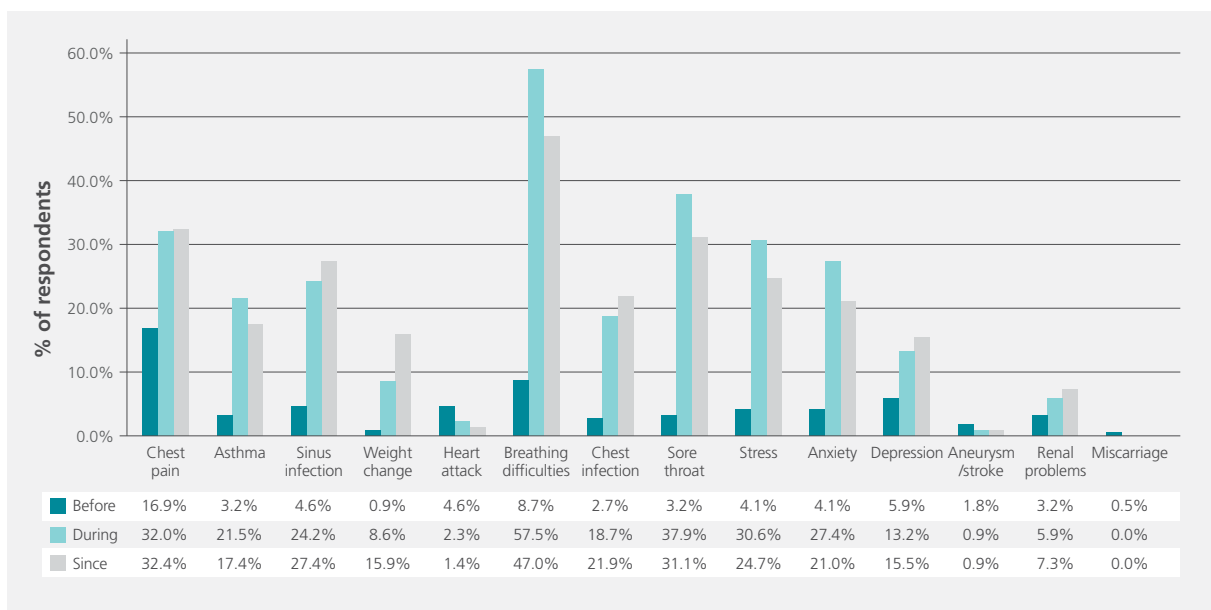
Voices of the Valley submits that whilst this information is not based on a representative sample, the responses are nonetheless 'indicative of the concerns that people are expressing' in the Latrobe Valley community.[37]

DID THE MINE FIRE CONTRIBUTE TO AN INCREASE IN DEATHS?

Pursuant to this Inquiry's Term of Reference 6, the Board considered whether the Hazelwood mine fire contributed to an increase in deaths in the Latrobe Valley. On 2 December 2015, the Board delivered its report relevant to this term of reference to the Governor of Victoria. The Board's key findings were:

- It is likely that there was an increase in deaths in the Latrobe Valley between February and June 2014 when compared with the same period during 2009–2013.

- It is likely that the Hazelwood mine fire contributed to some of the increase in deaths in the Latrobe Valley in 2014.[38]

During its inquiry relevant to Term of Reference 6, the Board heard from Professor Bruce Armstrong, medical practitioner, public health physician and epidemiologist from the School of Public Health, University of Sydney, and Associate Professor Adrian Barnett, a statistician from the Institute of Health and Biomedical Innovation and School of Public Health, Queensland University of Technology. These experts told the Board that the dominant health impacts of the mine fire were likely to be respiratory and cardiovascular disease.

Professor Armstrong informed the Board that 'any emission from the fire is potentially inhalable and can cause illness and death.'[39] In relation to particulate matter, Professor Armstrong noted that smaller particulate matter such as $PM_{2.5}$ is able to persist in the lung longer than larger particulate matter, and can have effects on the functional level of the lung and on the heart.[40] Professor Armstrong further stated that the dominant effect of air pollution on health is cardiovascular rather than respiratory.[41]

Associate Professor Barnett referred to reports published by the American Heart Association and World Health Organization, which describe the relationship between particulate matter pollution and death and morbidity, and demonstrate that there is very strong evidence that the short and long-term effects of air pollution include stroke, increased risk of death, and increased risk of emergency hospital admissions for cardiovascular and respiratory disease.[42]

2.3 2014 INQUIRY HEALTH IMPROVEMENT RECOMMENDATIONS

Discussing the impacts of the mine fire on community health in the 2014 Hazelwood Mine Fire Inquiry, the Board noted:

> these impacts have further compromised the poorer health and wellbeing of communities such that some residents feel more distrustful of government agencies and services than they previously did. Special attention and targeted action is required to change this and provide hope for current and future generations.[43]

The Board further stated:

> [s]ystem-wide improvements are also needed, such as strengthening community capacity and resilience, tackling the social determinants of health, and providing hope and optimism for the community.[44]

The Board made three suggestions in relation to addressing the potential health impacts of the Hazelwood mine fire — implementing a long-term health study; creating a designated health zone; and appointing a Health Advocate for the Latrobe Valley.

HAZELWOOD MINE FIRE HEALTH STUDY

There is some uncertainty about the long-term physical and mental health impacts of a coal mine fire that burnt for 45 days, particularly on a community with an already poorer health status. Given this context, in the 2014 Hazelwood Mine Fire Inquiry, the Board affirmed the decision of the Department of Health (as it was then known) to establish a long-term health study to consider the continued impact of the mine fire on the Latrobe Valley community. The Board also recommended that the study cover a period of at least 20 years in order to ensure that it captures the long legacy of some potential pollutants and their health impacts on young children as they grow.[45] The Board emphasised that taking action towards health improvements for the Latrobe Valley community should not be contingent on the findings of this study:

> studies are all very well, but they must be linked to sustained efforts to improve health outcomes for the region… Action protocols should be developed to ensure that any findings from the study are quickly implemented to minimise the health consequences for both individuals and communities.[46]

The Hazelwood Mine Fire Health Study was commissioned on 30 October 2014. The study is being undertaken by a number of researchers working collaboratively, including researchers from Monash University, Federation University Australia, the University of Tasmania and the CSIRO.[47] The Health Study is considered further in Part 3 of this report.

DESIGNATED HEALTH ZONE

The purpose of a designated health zone would be to significantly improve the health of the Latrobe Valley community by coordinating and integrating health services with health responses that address the broader social and economic determinants of health. In the 2014 Hazelwood Mine Fire Inquiry Report, the Board stated:

> [o]ne way of providing a focal point for the coordination and integration of health services is to nominate the Latrobe Valley as a priority area for action across the health continuum…The Victorian Government could require and encourage all relevant agencies and organisations to collaborate to protect and improve the health of the people of the Latrobe Valley…The Victorian Government could provide additional funding and other resources to enable this, together with legislative and regulatory measures where necessary.[48]

The Board indicated that the development of an integrated health plan for the Latrobe Valley could focus on the prevention and management of chronic diseases and the creation of supportive environments for health. In order for this plan to work, the following should be considered:

- health promotion/prevention (e.g. *Healthy Together* program)
- acute and subacute hospital care (public and private)
- rehabilitation, hospital in the home, aged care
- Aboriginal health, women's and men's health, health of minorities
- mental health
- alcohol and drug services
- general practice, community health services, community agencies
- tertiary universities, the regional medical school
- local government health services.[49]

HEALTH ADVOCATE

In the 2014 Hazelwood Mine Fire Inquiry Report, the Board stated:

[a] noticeable feature of the Hazelwood mine fire was a lack of health leadership at the local level. The Board found no examples of health professionals who took on the role of enabler, mediator and advocate for the health of the community. Rather this was left to local community members or officers of Melbourne-based government agencies, who inevitably were at some disadvantage.

This was a significant deficiency, as many community members expressed a lack of trust in Melbourne-based government officials, based on prior experience over several decades.[50]

The Board of the 2014 Inquiry proposed that a Health Advocate be appointed for the Latrobe Valley in order to provide 'advice, mediation and advocacy on health-related matters' for the community.[51] The Board noted that the Health Advocate role would not replace or compete with the roles of the Chief Health Officer or Health Services Commissioner.[52] The role of the Health Advocate would need to include:

- leadership
- monitoring and assessing the health of the public
- policy, planning and program development
- communication, collaboration and partnering
- foundational clinical competencies
- professional practice.[53]

Further consideration is given to the concepts of a designated health zone and a Health Advocate in Part 8 of this report.

2.4 FRAMEWORK FOR CONSIDERING HEALTH IMPROVEMENTS

As discussed in Part 1 of this report, the Board adopted a different approach to investigating the short, medium and long-term measures that could be implemented to improve the health of the Latrobe Valley. This approach included obtaining information and opinions from community members, representatives of key peak health bodies, medical practitioners, health professionals, academics in the area of public health, and government representatives. A variety of methods were used, including calling for public submissions, holding formal and informal consultations, commissioning research, and convening Health Improvement Forums.

As noted in Part 1, the Board has considered 13 health areas:

- chronic disease management
- health behaviours
- mental health
- early detection and high risk screening
- health workforce
- children and youth
- healthy workplaces
- healthy environments
- social disadvantage
- Aboriginal health
- community engagement and communication
- Health Conservation Zone and Health Advocate
- governance, leadership and sustainability.

The Board considers that the ideas and comments contributed by those who participated in one or more of the Inquiry's processes can be grouped into five main themes:

1. Health improvements that could be achieved by **strengthening health services** in the Latrobe Valley.

2. Health improvements that could be achieved by **promoting healthy living** more broadly in everyday settings.

3. The need to **reduce health inequities**, that is, to reduce measurable differences in the Latrobe Valley's health status that '…are considered to be unfair, unjust, and avoidable'.[54]

4. The need to strengthen community engagement and communicate the assets of the Latrobe Valley, by **building pride of place** and creating a positive health future in the Latrobe Valley.

5. Issues relating to **strengthening leadership and sustainability** in the Latrobe Valley, including consideration of a designated health zone and a health advocate.

These five themes are discussed in Parts 4 through 8 of this report.

PART THREE
HAZELWOOD MINE FIRE HEALTH STUDY

PART 3 HAZELWOOD MINE FIRE HEALTH STUDY

In 2014, prior to the conclusion of the 2014 Hazelwood Mine Fire Inquiry, the Department of Health (as it was then known) committed to undertake a long-term health study into the potential long-term effects of exposure to smoke and ash from the Hazelwood mine fire. Community consultations about the proposed study were held on 6 and 7 May 2014.

In his report to the Board for the 2014 Hazelwood Mine Fire Inquiry, Professor Donald Campbell, Professor of Medicine, School of Clinical Sciences at Monash University and Program Director, General Medicine, Monash Health, outlined a number of essential features of the proposed study. These included that it 'be conducted under the governance of an independent Steering Committee', which 'should have an independent chair and include community representatives.'[1] Professor Campbell gave evidence in the 2014 Inquiry about the importance of ensuring that the Latrobe Valley community is involved in the proposed study as they are 'very switched on and have a very good understanding of what are the important questions, and they need to be satisfied that those questions have been addressed and it hasn't been captured by the researchers for their own purpose.'[2]

The Board of the 2014 Hazelwood Mine Fire Inquiry affirmed the proposed long-term health study and made Recommendation 10, namely that:

The State should continue the long-term health study, and:

- extend the study to at least 20 years;

- appoint an independent board, which includes Latrobe Valley community representatives, to govern the study; and

- direct that the independent board publish regular progress reports.[3]

During the re-opened Inquiry, the Board received submissions and correspondence, and also heard evidence during its public hearings into Term of Reference 6 in September 2015, regarding the scope and progress of the now established Health Study, and raising concerns about its transparency and the level of community engagement undertaken.

Each of these matters is discussed in this Part.

3.1 STRUCTURE AND GOVERNANCE OF THE HEALTH STUDY

The State's *Implementation and Monitoring Plan* published in October 2014, articulates its responses to the recommendations and other matters set out in the 2014 Hazelwood Mine Fire Inquiry Report.[4] In relation to Recommendation 10, the plan records that '[c]ommunity members have concerns about the potential for long-term impacts on their health as a result of the fire' and that the 'government is committed to monitoring health impacts and supporting the community's health and wellbeing.'[5]

The *Implementation and Monitoring Plan* states that the Health Study will be informed by matters raised at community consultation sessions held in Morwell on 6 and 7 May 2014, and that it will be designed by the contractor and the Department of Health.[6] The plan further states:

- In undertaking the study, the contractor will be required to report regularly and engage with the community.

- Periodic reports from the study will be made available through the website, and sent to a mailing list that members of the public will be able to subscribe to.

- The final decision about when to conclude the study will be made on the basis of periodic reviews of the progress and findings, which will be completed as part of the study.[7]

On 30 October 2014, the Department of Health commissioned Monash University to undertake the Health Study.[8] The principal investigators for the Health Study are Professor Michael Abramson, Head of Clinical Epidemiology and Deputy Head of the Department of Epidemiology and Preventative Medicine, School of Public Health and Preventive Medicine at Monash University; and Professor Judi Walker, Head of the Monash School of Rural Health.[9] The Health Study will be undertaken in collaboration with the Monash School of Public Health and Preventive Medicine, Monash School of Rural Health, Federation University Australia, University of Tasmania, University of Adelaide and CSIRO.[10]

The Health Study is a long-term consideration of any health effects that may be caused by the Hazelwood mine fire, including cardiovascular and respiratory disease, low birth weight, psychological impacts, and the development of cancer.[11]

It is intended that the Health Study will answer the following questions:

- Is there evidence that people who were heavily exposed to smoke from the mine fire are more likely to have developed heart and lung conditions or to develop them in the future, when compared with another similar community with less exposure to the mine fire?

- Is there evidence of any impact of smoke exposure during pregnancy or infancy on the health and development of children in the Latrobe Valley compared to otherwise similar infants and children with less exposure to the mine fire?

- Is there evidence that people who were heavily exposed to smoke from the mine fire have a higher level of psychological distress than otherwise similar people with less exposure to the mine fire and is this associated with particular vulnerable groups?

- Is there evidence that people who were heavily exposed to smoke from the mine fire are more likely to develop cancers over a long period of time than otherwise similar people with less exposure to the mine fire?[12]

The Health Study contract between the Department of Health and Monash University includes the following terms:

- Within four months of the contract commencing, Monash University must establish a Community Advisory Committee and reference groups and finalise the terms of reference (the structure of which is to be approved by the Department) for each, and the membership of each (with the Department consulted regarding the composition of the committee).[13]

- The contract is for three years with further options to extend for three periods of two years and one further period of one year. The options to extend are exercisable by the Department.[14]

The Board has been informed that the budget allocated by the Department to Monash University for the first ten years of the study is $26.5 million. The budget for the first three years is $9.2 million.[15]

The Health Study has established a Community Advisory Committee, to work in partnership with the community and to disseminate information, as well as a Clinical Reference Group, a Scientific Reference Group, and a Project Steering Committee (comprising each of the leaders of the research stream areas).[16]

The Community Advisory Committee, which meets quarterly, is described on the Health Study's website as the 'study's peak advisory body'.[17] Its role is to ensure that the community informs the Health Study, and that those undertaking the study work in partnership with the community.[18] In a letter to the Board dated 27 October 2015, the State describes the Community Advisory Committee as 'a forum for the community to raise any concerns, suggestions and ideas in relation to scope.'[19] Monash University established the Community Advisory Committee in response to the Department of Health's requirement that a mechanism exist in the Health Study to provide information to the community.[20] There are three members of the local community on the Community Advisory Committee, along with representatives from the Department of Health and Human Services (DHHS), Federation University Australia, Latrobe City Council, Latrobe Community Health Service, Latrobe Regional Hospital, and the Victorian Chief Health Officer.[21]

In a written submission from Monash University to the Board, Professor Abramson advises that as the Health Study is necessarily an independent scientific study, the Community Advisory Committee could not be the primary governing body as recommended in the 2014 Hazelwood Mine Fire Inquiry Report. There is however, scope to restructure the Committee as a Community Advisory Board and appoint an independent Chairperson, in line with Recommendation 10.[22]

The Health Study's Scientific Reference Group is comprised of experts in various scientific disciplines. The Clinical Reference Group includes local clinicians who will be asked to provide input and advice on the clinical operations of the project.[23] Local residents, doctors and health professionals are involved in the Clinical Reference Group and the Scientific Reference Group.[24]

By virtue of these three committees or groups, the Health Study aims to provide a 'two way communication process through regular and ongoing connections to the local community' and to ensure that information arising from the study is 'distributed broadly and taken up in the operations of local health and community service agencies.'[25] Minutes of the meetings of the Scientific Reference Group held in 2015 have been published on the Health Study's website.[26]

The Project Steering Committee is comprised of the leaders of each of the research streams.

In addition to the above committees and groups, DHHS has also established a Contract Steering Committee. Monthly meetings of this committee are generally chaired by the Acting Chief Health Officer from DHHS, with representatives from Monash University and DHHS in attendance.[27] Minutes of the Contract Steering Committee, dated 28 July 2015, record that the committee received an email from a local community group voicing concerns about the independence of the Health Study, by reason of the requirement that the content and format of annual progress reports be considered and agreed to by the Chief Health Officer. In answer to that concern, the minutes record that the independence of the study is not compromised, as the contract entitles Monash University to publish its research to the public, without notifying or obtaining the consent of DHHS.[28]

At the public hearings in respect of Term of Reference 6,[29] Professor Abramson stated to the Board that the Health Study had conducted community briefings, which he described as being reasonably attended and generating lively discussion. There are plans for further briefings to be held in the future. Direct contact has also been made with local community groups, and the plan is for those contacts to continue.[30]

In his submission to the Board after that hearing, Professor Abramson states that a presentation he made at these community briefings has been published on the Health Study's website. Professor Abramson also states that he is prepared to publish full interim and annual reports on the Health Study's website, subject to agreement from DHHS, and to publish minutes of all advisory committee meetings, subject to agreement of the members of each committee.[31] The Board notes that the Health Study's Annual Report, dated 13 November 2015, has been published on the website.[32]

3.2 SCOPE OF THE HEALTH STUDY

The Health Study is divided into multiple streams:[33]

- Community Wellbeing Study—to commence in mid-2015. The area to be studied includes the whole Latrobe Valley.[34]

- Latrobe Early Life Follow up Study—to commence in mid-2015. The area to be studied includes the whole Latrobe Valley. This study will assess mothers and babies (particularly those who were in the womb at the time of the fire) up to two years of age, to consider whether there is any difference in their health and development when compared to children who were not exposed to the mine fire.[35]

- Older People Study—to commence in May 2015.[36]

- Schools Study—to commence July 2015. The group to be studied includes children in schools throughout the Latrobe Valley. The study will address whether the smoke exposure and disruption that was associated with the Hazelwood mine fire has had an effect on children's ultimate educational endpoint.[37]

- Adult Study—anticipated to commence in late-2015. All adults who were living in Morwell during the Hazelwood mine fire will be invited to participate in the Adult Survey, which aims to survey 7,500 people. The comparison community for the Adult Survey is Sale, where is it hoped 4,000 people will participate. Sale was selected as a comparison community after modelling conducted by CSIRO demonstrated that Sale was not likely to have been subject to the smoke effects of the mine fire.[38]

- Follow-up health and psychological assessment—anticipated to commence in 2017.[39]

- Linkage to health records including hospital, ambulance and cancer—to commence in 2016.[40]

SCOPE OF THE ADULT SURVEY

The 'Adult Survey' is the largest study stream and will include an assessment of the impact of the Hazelwood mine fire on respiratory and cardiovascular functions of adults residing in Morwell during the mine fire.[41] The Adult Survey will not include any persons who worked in Morwell during the fire (including emergency responders) who reside outside Morwell.[42]

Professor Abramson told the Board that he had received correspondence indicating that some emergency responders who are not residents of Morwell are interested in participating in the Health Study.[43] The Board is aware of the following:

- In May 2014, the Acting Chief Officer of the Metropolitan Fire and Emergency Services Board (MFB) emailed the then Chief Health Officer, DHHS, about the possibility of either linking the health monitoring of firefighters by the MFB to the scope of the Health Study or including the firefighters as a subset of Health Study.[44]

- On 5 June 2015, the details of 115 Environment Protection Authority (EPA) staff were provided to Monash University for potential inclusion in the Health Study.[45] None of the EPA staff were residents of Morwell during the fire.[46]

- By letter dated 16 June 2015 to Monash University, Victoria Police specifically requested involvement in the Health Study and indicated that 'it would not be viable for Victoria Police to do a comparative internal investigation.'[47]

- With respect to these emergency responders, an internal DHHS email dated 25 June 2015 notes that MFB and Country Fire Authority (CFA) employees are part of a voluntary monitoring program, and that the EPA and Victoria Police should be referring members who are not residents of Morwell to their internal occupational health and safety areas. The email confirms that the Health Study does not include funding for these emergency responders to be incorporated.[48]

The Board received correspondence from the Victorian Government Solicitor's Office (VGSO), on behalf of the State, that suggests that the majority of emergency responders to the mine fire are not residents of Morwell and are, therefore, not able to be included in the Adult Survey. Approximately 10 of the 2209 firefighters who attended the mine fire live in Morwell. Approximately 40 per cent of police stationed in Morwell during the mine fire are not residents of Morwell.[49]

At the Term of Reference 6 public hearings, in answer to questions about involving emergency responders in the Health Study, Ms Linda Cristine, Director, Inquiry Response Team, DHHS, gave evidence that firefighters and other emergency responders have their own programs and studies that are monitoring the health impacts of the fire.[50] Ms Cristine also stated that DHHS considers there to be significant methodological issues in including non-resident emergency responders in the study.[51] Ms Cristine did not know if there had been any discussions with Monash University about whether any such difficulties could be overcome.[52]

A letter dated 28 August 2015 from the VGSO to the Board, states that DHHS has carefully considered the scope of the Health Study, which was informed by community consultations undertaken in May 2014.[53] However, in a letter to the Board dated 15 October 2015, the VGSO, on behalf of the State, indicates that Monash University is best placed to consider the methodological limitations of the study.[54] The letter further states that MFB and CFA employees have access to voluntary health monitoring programs, however these programs are not long-term studies and are not comparable to the Health Study.[55]

Professor Abramson gave evidence that it would be possible to include emergency responders who were not residents of Morwell during the fire in the Health Study.[56] In his submission to the Board, Professor Abramson states that expanding the study to include emergency responders would be feasible but it would need to be separately funded. He indicates that there would be 'considerable scientific value' in including emergency responders in the Health Study.[57]

The Board was also advised of concerns that residents in other parts of the Latrobe Valley are not included in the Adult Survey, despite working in Morwell or otherwise being exposed to the mine fire.[58] The Board heard evidence during the Term of Reference 6 public hearings that there were comparable $PM_{2.5}$ levels in Traralgon and Morwell East during the mine fire.[59] Non-emergency responders who were working, but not resident, in Morwell at the time of the mine fire, including over 200 Latrobe City Council employees, are not included in the Health Study.[60] The Latrobe City Council estimates that only 25 per cent of its employees are residents of Morwell.[61]

During the Health Improvement Forums hosted by the Board in September 2015, Councillor Dale Harriman, Mayor of Latrobe City Council (at the time of this forum), stated that this issue 'continually comes up and is something that is of major concern to the whole community'.[62]

In its submission to the Board, the Construction, Forestry, Mining and Energy Union (CFMEU) states that many people exposed to the Hazelwood mine fire, both its members and others who continued to work in businesses located near the Hazelwood mine, do not reside in Morwell and therefore fall outside the scope of the Adult Study. The CFMEU states that of 351 members who worked at the Hazelwood mine site during the mine fire, 283 are not residents of Morwell.[63] The CFMEU suggests that the study be broadened to include these people.[64]

In its written submission, Doctors for the Environment Australia advocates that the Health Study should track the health outcomes of everyone in the vicinity of the mine fire for a period of at least 20 years. The submission also suggests that monitoring the health of firefighters should be a particular focus of the Health Study, given their direct exposure to smoke.[65]

The scope of the Health Study was a topic of discussion in meetings of the Contract Steering Committee on 24 June and 25 August 2015, when results from community briefing sessions were also discussed.[66] In a submission from Monash University, Professor Abramson states that the scope of the study will be listed as a discussion issue for the next meeting of the Community Advisory Committee.[67] However, Professor Abramson maintains there will be feasibility issues associated with including residents of other parts of the Latrobe Valley in the Adult Study:

> It is simply not feasible to include all Latrobe Valley residents in the Adult Study. The potential number of participants in Morwell is already about 11,000, and 4,500 in Sale. Data collection will already take at least a year. However, this does not mean that the study cannot say anything about the health of residents who were living in other parts of the Latrobe Valley. With the CSIRO air quality modelling, we are able to estimate exposures in other parts of the Valley and use the results from Morwell to extrapolate any health effects to other parts of the Valley. Our best chance of finding a signal is to look at those most exposed to smoke from the fire. From the CSIRO modelling presented to the Inquiry, this was clearly the population of Morwell.[68]

The documents considered by the Board in relation to the Health Study are listed in Appendix D.

3.3 BOARD'S CONSIDERATION AND PROPOSALS

Recommendation 10 of the 2014 Hazelwood Mine Fire Inquiry recommends that the Health Study should:

- be conducted for at least 20 years

- have a governing independent board that includes Latrobe Valley community representatives

- publish regular progress reports.

The Board notes that the State has gone some way to implementing this recommendation, but that there are more steps that could be taken to ensure that the Health Study provides the appropriate level of community access without foregoing scientific rigour.

The Board notes that the contract with Monash University is for three years with options to extend it for a maximum of 10 years. The Board reiterates its recommendation that the Health Study be run for a minimum of 20 years.

The Board accepts the evidence of Professor Abramson that the Health Study is an independent scientific study. The Board further recognises the expertise of Professor Abramson and Professor Walker, and the associated universities conducting the Health Study. The Board notes that, in line with Recommendation 10, there is community involvement in some of the committees and reference groups of the Health Study. However, the Board also notes that the Contract Steering Committee has no community participants. The Board reiterates that the Health Study should be governed, so far as it can be, independently from the State and with appropriate levels of community representation to provide guidance on the issues that matter to the local community.

The Board notes that the Annual Report dated 13 November 2015, together with minutes of meetings of the Scientific Advisory Group and the Community Advisory Committee, are now available on the Health Study website. However, there are currently no reports or other information available to the public with respect to the progress of the Health Study from the Clinical Reference Group, the Project Steering Committee or the DHHS Contract Steering Committee. The Board considers that community members should have access, to the extent possible, to interim reports and monthly progress reports of the Health Study produced by those committees.

Further, the Board considers that the Health Study should provide the community with information about the health status of the population and the health effects of the mine fire on an ongoing basis, so that action can be taken by individuals relating to their own health. As stated by Professor Abramson, the research into health effects suffered by Morwell residents can be extrapolated to the wider community, and the Board considers that such information should be made regularly available and accessible to the study participants, the community and to local health practitioners. Reports and information should be provided in a variety of forms and not just on websites, to ensure accessibility for the community.

The Board also considers that there should be further discussions between those funding the study (DHHS) and those with expertise in designing it (Monash University), about expanding the scope of the Adult Survey in light of the concerns of the community and at least some emergency responders.

The Board's recommendations with respect to the Hazelwood Mine Fire Health Study are below.

PROCEDURAL FAIRNESS

The Board is entitled to acquire information in accordance with the Inquiry's Term of Reference 13(a), which empowers the Board to:

> conduct [its] inquiry as [it] considers appropriate, subject to the requirements of procedural fairness, including by adopting any informal and flexible procedures to: engage with the relevant local communities; ascertain the relevant facts as directly and effectively as possible; and avoid unnecessary cost or delay

In this Inquiry, the Board received public submissions relating to both Terms of Reference 6 and 7, which raised concerns about the scope and governance of the Health Study. Those matters were similarly raised in community consultations and the Health Improvement Forums held by the Board.

The Board conducted public hearings in relation to Term of Reference 6 in September and October 2015. That term of reference required the Board to consider whether the Hazelwood mine fire contributed to an increase in deaths in the Latrobe Valley. Some of the evidence in those hearings related to whether or not the Health Study would consider if the mine fire had contributed to an increase in deaths in the Latrobe Valley. Professor Abramson was called to give evidence in relation to the Health Study's scope and governance. During his evidence, it became apparent to the Board that the scope of the Health Study required further consideration.

In order to further inform itself about issues relating to the scope of the Health Study, the Board sought information from Monash University, CFA, MFB, United Firefighters Union, Victoria Police, CFMEU, DHHS, Latrobe City Council and the Hazelwood Mine Fire Implementation Monitor. Following receipt of information and documents from these organisations, Counsel Assisting prepared and circulated submissions relevant to the Health Study, dated 23 October 2015, to the parties who were represented at the Term of Reference 6 public hearings, and invited responses by way of further submissions. Counsel Assisting's submissions were also provided to Monash University and to the Implementation Monitor, with an invitation to each to provide any comments or submissions.

In response to Counsel Assisting's submissions about the Health Study, Dr Rosemary Lester (a party to the Inquiry's Term of Reference 6 public hearings) submitted that if the Board intended to provide an opinion or recommendation about the limitations of the scope of the Health Study, then procedural fairness was not accorded to her because:

- Dr Lester was not asked questions during the Inquiry's public hearings in relation to Term of Reference 6, or subsequently about the decision to limit the scope of the Health Study.

- Dr Lester did not give permission for Counsel Assisting to refer to her views on the Health Study, or to refer to email correspondence sent and received by her which related to the Health Study, in closing submissions for Term of Reference 6.

- The matters relied upon by Counsel Assisting in their closing submissions relating to the Health Study were not in evidence.[69]

The Board considers that the process that has been adopted has been in accordance with the Inquiry's Term of Reference 13(a) and that procedural fairness has been accorded to each party, including Dr Lester. The additional information provided after the Term of Reference 6 public hearings has been of assistance to the Board in ascertaining the relevant facts. The Board considers that the scope of the Health Study is of significant relevance to Term of Reference 7 and that the manner in which it obtained the relevant information was procedurally fair.

The Board recommends that the State review the scope and structure of the Hazelwood Mine Fire Health Study.

The State should:

- Review the scope of the Hazelwood Mine Fire Health Study to consider whether the Adult Survey can include additional cohorts who do not reside in Morwell, including emergency responders to the Hazelwood mine fire.

- Reaffirm its commitment to a 20 year study and the importance of having a strong governance structure which ensures that the interests of the Latrobe Valley community are foremost in the short, medium and longer-term.

- Establish a process whereby key health information obtained through the Health Study about the health status of the population and the effects from the Hazelwood mine fire is provided to the study participants, the community, local health practitioners and the Latrobe Valley Health Assembly.

- Establish a process whereby policy-relevant health information obtained through the Health Study is considered by the State for action to improve the health of the Latrobe Valley and other populations in Victoria.

PART FOUR
STRENGTHENING HEALTH SERVICES

PART 4 STRENGTHENING HEALTH SERVICES

Part 4 considers how health services in the Latrobe Valley could be strengthened in order to improve health outcomes.

This Part is informed by public submissions, community consultations, and the discussion and feedback of four of the expert panels that contributed to the Health Improvement Forums.

These expert panels provided advice to the Board about the need to re-design health services, and to innovate and coordinate healthcare to manage the burden of chronic and complex conditions more effectively. The panellists considered areas including consumer-led care, screening and early detection of chronic disease, the health workforce in the Latrobe Valley, and the infrastructure required to support health service delivery.

The expert panels that considered how health services could be strengthened were:

- Chronic disease management: Dr Stephen Ah-Kion from Latrobe Regional Hospital; Professor Donald Campbell, Professor of Medicine, School of Clinical Sciences at Monash University and Program Director, General Medicine, Monash Health; Ms Marg Bogart from the Gippsland Primary Health Network; Associate Professor John Rasa from Networking Health Victoria; Ms Petra Bovery-Spencer from Latrobe Community Health Service; and Ms Sylvia Barry from the Department of Health and Human Services (DHHS).

- Mental health: Ms Robyn Humphries from DHHS; Dr Cayte Hoppner from Latrobe Regional Hospital; Professor David Clarke Professor of Psychological Medicine, Department of Psychiatry, Monash University, and Medical Director of the Mental Health Program at Monash Health; Ms Irene Verins from the Victorian Health Promotion Foundation (VicHealth); Mr Steve Tong from Latrobe City Council; Ms Jo Huggins from Relationships Australia; and Ms Kerry Scanlon from Latrobe Community Health Service.

- Early detection and high risk screening: Professor Clarke; Professor Andrew Tonkin, a cardiologist from Monash University; Ms Heather Scott, a registered nurse from Latrobe Community Health Service, Dr Alistair Wright, a general physician from Latrobe Regional Hospital; and Dr Daniel Steinfort, a respiratory physician from Royal Melbourne Hospital.

- Health workforce: Ms Pip Carew from the Australian Nursing and Midwifery Federation; Professor Campbell; Ms Marianne Shearer from the Gippsland Primary Health Network; Dr Simon Fraser from Latrobe Regional Hospital; Ms Amanda Cameron from Latrobe Regional Hospital; Mr Dean Raven from DHHS; Ms Katherine Walsh from the Australian Medical Association, Victoria; and Ms Anne Coxall from Latrobe Community Health Service

The expert panel on children and youth also raised issues relevant to strengthening health services in the Latrobe Valley. The views of this panel are discussed in more detail in Part 5 of this report.

4.1 CHRONIC DISEASE AND MENTAL HEALTH CONDITIONS

CHRONIC DISEASE

The World Health Organization describes 'chronic' diseases as those that 'are of long duration and generally slow progression.'[1] Chronic disease generally refers to one of four conditions: cardiovascular diseases (such as heart attacks and stroke), cancer, chronic respiratory diseases (including asthma and chronic obstructive pulmonary disease), and diabetes.[2]

Associate Professor John Rasa from Networking Health Victoria, and a member of the expert panel on chronic disease management, advised the Board that it is typical for Australians to have up to seven co-morbidities relating to chronic disease by the time they are 80 years old.[3] He noted that this presents a challenge for the current health service system, in particular in relation to the care coordination of clients with multiple health conditions.[4] He told the Board that general practitioners are increasingly having to refer clients to multiple specialists, however each specialist service tends to work in a silo, which can create difficulties for the coordination of care.[5]

Chronic disease and its impact on the health system have particular relevance for the Latrobe Valley. As outlined in Part 2 of this report, the Latrobe Valley experiences higher rates of chronic disease compared to most other parts of Victoria. The 2014 Hazelwood Mine Fire Inquiry heard that people with pre-existing health conditions, including asthma, chronic obstructive pulmonary disease, ischaemic heart disease and congestive heart failure, were at increased risk from exposure to smoke and ash from the Hazelwood mine fire.[6]

During the re-opened Inquiry, the community voiced ongoing concerns about the health status of the Latrobe Valley and increased demands on health services.

The Victorian branch of the Australian Nursing and Midwifery Federation notes in its submission to the Board that:

> the population [of the Latrobe Valley] includes an ageing population, people suffering lung cancer and chronic disease, [A]boriginal people who generally suffer poorer health outcomes, people with a high incidence of asbestos related disease and people requiring disability assistance.[7]

Diabetes Victoria states in its submission that '[t]he postcode of Morwell is classified as [a] "very high" diabetes prevalence area.'[8]

Quit Victoria advises in its submission to the Board that the Latrobe Valley community potentially has an imminent and existing large-scale respiratory health problem, due to the combination of exposure to environmental air pollution together with a high prevalence of smoking.[9] In her written submission to the Board, Latrobe Valley resident Ms Wendy Farmer states: 'We know that [the] Latrobe Valley suffers some of the highest rates of cancers and respiratory diseases yet we don't have specialists in these areas, and if we do have a medical specialist there is an extremely long wait.'[10]

MENTAL HEALTH

The Board heard from organisations that work across the 'spectrum' of action to improve mental health and wellbeing, namely, treatment, rehabilitation, early intervention or early identification of mental illness, as well as action that aims to prevent mental illness from occurring in the first place and promote mental wellbeing. While these efforts are interrelated, for clarity this report uses the term 'mental health' when referring to treatment, identification or intervention in mental illness, and the term 'mental wellbeing' when referring to prevention and promotion efforts.

The Board heard that the poor mental health of the Latrobe Valley community is a growing concern.[11] The panel on mental health highlighted that external factors, such as employment and social connection with family and peers, are underlying determinants of mental health and wellbeing.[12] These issues are considered further in Part 5 of this report. The Board was also advised that, whilst there are differences between mental health conditions and chronic disease, self-management is a goal for improving health outcomes in both of these areas.[13]

Dr Cayte Hoppner of Latrobe Regional Hospital and a member of the mental health expert panel, advised that people in the Latrobe Valley experience higher rates of suicide and greater barriers to accessing mental healthcare. She noted that 'there's no health without mental health'; that is, there are strong links between mental health and physical health.[14]

In their expert report to the Board, Professor Donald Campbell Professor of Medicine, School of Clinical Sciences at Monash University and Program Director, General Medicine, Monash Health and Professor David Clarke Professor of Psychological Medicine, Department of Psychiatry, Monash University, and Medical Director of the Mental Health Program at Monash Health, advise that mental health issues occur on a continuum, from those of short duration in the context of life stress, through to long-term, persistent and disabling conditions. They note that long-term mental health conditions are complex and often complicated by work, family and relationship difficulties, along with drug use and physical health problems.[15]

In her submission to the Board, Ms Christine Hamilton of Dromana raises concerns that the mine fire has had an adverse impact on the mental health of members of the Latrobe Valley community.[16] The Victorian Council of Social Service (VCOSS) also states in its submission that:

> Participants from mental health organisations advised that there were significant ongoing, emerging and new mental health issues as a result of the mine fire. During and after the fire, people with pre-existing mental health issues experienced stress and trauma, in some cases exacerbating their condition significantly. Other people with no history of mental health issues presented as new clients.[17]

During the 2014 Hazelwood Mine Fire Inquiry, the Board heard similar evidence that increased 'levels of anxiety and depression' could be attributed to the mine fire.[18]

The expert panel on mental health advised that, in order to improve future mental health outcomes in the Latrobe Valley, there is a need to first acknowledge the trauma that has been experienced by the community as a consequence of the mine fire.[19] In comparison, in its written submission to the Board following the Health Improvement Forums, GDF Suez Australian Energy (GDF Suez) stated that:

> such a suggestion runs counter to the extensive evidence that members of the community are looking to move on from the Mine Fire and focus on "good news" rather than continually being confronted with the past (and in particular an event that occurred 18 months ago)…[20]

GDF Suez suggests that a number of events, such as this Inquiry, the 2014 Hazelwood Mine Fire Inquiry, and GDF Suez's *Revive Morwell* program, have already given the community opportunity to engage with GDF Suez representatives and have their concerns about the impacts of the mine fire acknowledged.[21]

Organisations including Healthy Futures and Voices of the Valley submitted to the Board that additional resources should be dedicated to improving mental health in the Latrobe Valley.[22] Professor Campbell and Professor Clarke note in their expert report that the coordination and integration of health services is particularly important for people with mental illness, who find negotiating and engaging with services especially difficult.[23]

The principles of self-management and the current and potential capacity of chronic disease and mental health services in the Latrobe Valley are considered in section 4.2 below.

4.2 RE-DESIGNING HEALTH SERVICES

The Board was told that one of the objectives of health services is to support people with chronic disease to become better at self-managing their health.[24] The expert panel on chronic disease discussed how the design and resourcing of health services can therefore be informed by the different levels of support required by different groups of clients, and their capacity to self-manage health issues.

Expert panel member Ms Petra Bovery-Spencer from Latrobe Community Health Service described four categories of primary health service users for the Board:

- Self-managers, who are able to independently manage their chronic disease and access specific services when and where they are needed.

- Collaborative self-managers, who need some help navigating health services, but once they have better understood their disease and established a routine, they are able to work towards self-management.

- Supported self-managers, who will often have co-morbidities and complex social situations, however when linked to services they can work towards self-managing some aspects of their disease over time.

- Super users, who have complex health and related issues—such as mental health issues, experience of family violence or carer responsibilities—that hinder their ability to engage with self-management strategies.[25]

Ms Bovery-Spencer informed the Board that super users are often not assisted by chronic disease services, but are instead referred to other specialist agencies better equipped to support people with such complex issues.[26]

Professor Campbell endorsed the idea of re-thinking approaches to health service design in order to better assist people with multiple co-morbidities.[27] He provided an example to the Board of a situation where health agencies have pooled resources in New Zealand (called 'alliance contracting') to deliver specific projects. As no one health service provider is paid until an initiative is delivered, significant cooperation and trust is fostered amongst the providers involved.[28]

Associate Professor Rasa noted that the commissioning role of the new Primary Health Networks could fit in well with this type of approach, and that other reforms being considered by the Commonwealth, such as blended payment systems for people with chronic disease, may also be options to consider.[29] Ms Sylvia Barry of DHHS noted that the *Hospital Admission Risk Program* works with super users, and that the State is developing the *HealthLinks* program to encourage hospitals to use existing funding more flexibly to achieve better outcomes for this group.[30]

The expert panel on chronic disease management considered whether partnerships that currently exist within the Latrobe Valley could better support people with chronic disease in the short, medium and long-term. Ms Marg Bogart of the Gippsland Primary Health Network, provided an example that she believes demonstrates that the requisite capacity does exist within the Latrobe Valley.[31]

This example was the *Dementia Gippsland* project, which is led by the Gippsland regional office of DHHS and involves relevant health and related organisations. The *Gippsland Dementia Plan 2011–2014* was developed to facilitate the provision of services to meet the needs of people living with dementia, together with their families and carers. The specific objectives of the plan are recorded as providing 'direction to dementia policy and practice in Gippsland', improving 'coordination and access to services for people living with dementia and their carers', and creating 'client-focused services that go beyond program boundaries.'[32] The *Dementia Gippsland* website provides information about:

- understanding memory loss and dementia
- dementia support services
- reducing risk factors for dementia.[33]

Ms Bogart suggested that lessons learned from the approach used to develop *Dementia Gippsland* could be applied to any number of health conditions, such as diabetes, and that a significant amount of work has already been undertaken around referral and diagnostic pathways for diabetes in Gippsland. Ms Barry noted that this approach is most effective when trusted relationships already exist between service providers.[34]

The need for more and better-resourced health services was a common theme in written submissions to the Board.[35] Professor Campbell and Professor Clarke state in their expert report to the Board that 'Australia's healthcare arrangements [are] not working very well for those with complex care needs, we are currently poorly equipped to meet anticipated increases in demand.'[36]

The Victorian Healthcare Association states in its written submission that the health service system in the Latrobe Valley is less equipped when compared to other regions in Victoria.[37] In particular, the region has:

- fewer general practitioners (GPs) per 1,000 population;
- fewer GP attendances per 1,000 population;
- fewer specialist medical practitioners, pharmacists and physiotherapists per 1,000 population;
- lower percentage of persons with private health insurance;
- fewer aged care places per 12,000 population;
- higher emergency department presentations per 1,000 population, including more primary care type ED presentations.[38]

The Victorian Healthcare Association submits that these indicators are indicative of the community's difficulty accessing healthcare and are aligned with poorer health outcomes in the Latrobe Valley. It suggests that a 'system-wide approach' to health service design is required.[39] In their expert report, Professor Campbell and Professor Clarke also advise the Board that 'innovation and change in healthcare delivery models will be required, with a focus on support for the patient and their informal caregivers.'[40]

In its submission, the Victorian branch of the Heart Foundation states that increased access to cardiac rehabilitation services should be available post-hospital discharge:

> The Victorian Government should boost access to cardiac rehabilitation in the Latrobe Valley to help patients recover from heart attack…Better access to cardiac rehabilitation is needed because recovery from heart attack is compromised because not enough people are referred to cardiac rehabilitation when they are discharged from hospital.[41]

The Asbestos Council of Victoria recommends that a respiratory unit, staffed by doctors who specialise in lung and respiratory issues, be established in the Latrobe Valley.[42]

The expert panel on mental health advised the Board that there is also a need to transform the mental health services system in order to improve health in the Latrobe Valley.[43]

Professor Campbell cited a Scottish study that shows that 'people with three or more co-morbidities have a 60 per cent chance of having an extra mental health co-morbidity, be it anxiety, depression or other, by virtue of having multiple co-morbidities'.[44] Professor Campbell told the Board that the interplay between chronic disease and mental health means that eligibility for chronic disease management services should not be determined according to factors such as age.[45]

In its submission to the Board, beyondblue recommends a 'stepped-care' approach that integrates mental and physical healthcare and matches support services to need.[46]

Mechanisms to support the redesign of health services within the Latrobe Valley are considered in Part 8 of this report.

CONSUMER-LED CARE

The Health 2040 Summit has produced the following principle in relation to consumer-led care:

> We need to move to person-centred and person-directed care, valuing and respecting patients and their preferences, taking into account the whole person and what is important to the individual. We also need to address disparities in access and outcomes for individuals and communities across the state.[47]

The expert panel on chronic disease management noted that consumers should be at the centre of all health service improvement efforts.[48] Consumer-led care was also raised by the expert panel on mental health. Dr Hoppner described the *Optimal Health* program, which is a consumer-led, person-centred and recovery-focused program that supports people to self-manage their mental health. The program has been developed from work in chronic disease self-management and has been implemented over a number of years in the broader mental health system, including at Latrobe Regional Hospital. It focuses on a number of factors that impact on mental wellbeing, including partnerships and connectedness, health promotion, and stress management. It aims to help participants reduce health crises and acute hospital presentations and improve their long-term wellbeing. Dr Hoppner recommended building on the program to improve the community's capacity to manage its recovery (following the mine fire).[49]

Consistent with a number of other expert panels, the expert panel on mental health discussed the need for community engagement when designing health services and programs. The panel told the Board that whilst many programs to support mental health are implemented, they do not necessarily align with what the community and consumers say they need.[50]

Mr Steve Tong, from Latrobe City Council and a member of the expert panel on mental health, referred to the community engagement process recently undertaken by Latrobe City Council (outlined by Ms Sara Rhodes-Ward in Part 5 of this report) as a successful example of how community engagement in health service re-design might be implemented.[51]

Mr Tong also recounted work he has undertaken with disadvantaged young people in the Latrobe Valley and reinforced the principle: 'don't do it to me, do it with me'.[52] He submitted that including the community in the process of designing health initiatives creates the level of community ownership required for people to take responsibility for their own mental health, and is preferable to imposing a system upon them.[53]

Engaging consumers in the design of health initiatives and services is discussed further in Part 7 of this report.

INTEGRATED CARE COORDINATION

In its submission to the Board, the Royal Australasian College of Physicians makes the following suggestion for alleviating pressures on the current health system:

> The responsiveness of the health system in the Latrobe Valley can be further strengthened by improving links between the regional hospital and community health facilities, primarily GPs. A highly able GP liaison officer would be instrumental in directing patients to the appropriate medical specialist in a timely manner, which would avoid unnecessary Emergency Department presentations. Likewise, a GP liaison officer would be able to facilitate communication and services to patients with complex medical issues being transitioned home.[54]

The Board was referred to recent work that raises a similar point—better health outcomes are achieved when patient healthcare is coordinated.[55] In their expert report, Professor Campbell and Professor Clarke explain that the Primary Health Networks have recently been established out of the previous Medicare Locals structure to ensure that those at risk of poor health outcomes have access to effective services. Primary Health Networks also aim to improve coordination of patient care. These objectives will be achieved by working with healthcare providers, including general practitioners, secondary care providers and hospitals.[56]

Panel member Ms Marianne Shearer, of the Gippsland Primary Health Network, outlined for the Board how the Gippsland Primary Health Network is in the process of developing 'care pathways' with and for local doctors in relation to assessment, management, referral and treatment for a broad range of health issues.[57]

Panellist Ms Petra Bovery-Spencer from the Latrobe Community Health Service, told the Board that a good example of current care coordination in the Latrobe Valley is the podiatry-led high-risk foot clinic.[58] This initiative was introduced after it was identified that some clients who had been referred to Monash Health in Dandenong, had not attended follow up appointments. The initiative involves moving to a multi-disciplinary clinic model and establishing tele-medicine support from the Dandenong specialist clinic as required. These changes mean that clients do not have to travel long distances to receive specialist healthcare.[59]

The expert panel on children and youth discussed a program the *Pathways to Good Health* program. *Pathways to Good Health* focuses on children in out-of-home care and involves a multi-disciplinary assessment that provides a snapshot of the child's current health and enables planning for ongoing care.[60] Under the program, a child can be seen by multiple people in one location, rather than having to wait between referrals to different practitioners.[61]

The expert panel on children and youth also suggested that the development of a health manual could be useful in ensuring that medical practitioners coming into the Latrobe Valley are aware of the particular health issues for children in the region, such as respiratory conditions and heightened anxiety following the mine fire.[62]

Professor Clarke suggested to the Board that it consider recommending the full integration of community mental health services with general community health services. He provided an example of how this might work in practice, describing how a community nurse attending to a person with a chronic condition, such as diabetes, may also be able to screen for a mental health condition, such as depression.[63]

The expert panel on health workforce also discussed the opportunity for nurse practitioners with enhanced scope of practice to 'fill the gaps' in client care and work with doctors to provide ongoing support to people within the community environment.[64] There was much discussion of the Buurtzorg model,[65] which Professor Campbell and Professor Clarke describe in their expert report to the Board.[66] The model is a new approach to care coordination that uses self-governing teams of nurses in a flat organisational structure. Nurses are allocated to specific neighbourhoods, with between 10 and 12 nurses responsible for 50–60 patients, and work to maximise patients' self-management of chronic conditions. Under the model, nurses are supported by coaches and technology, rather than reporting up to managers.[67] An evaluation of the model found that:

Buurtzorg's patients required care for less time, regained autonomy quicker, had fewer emergency hospital admissions, and shorter lengths-of-stay after admission than those cared for by other home-care providers. In addition, the company had lower overhead costs and less than half the average incidence of sick leave and employee turnover.[68]

By allocating a group of patients to a nursing team, the Buurtzorg model also allows staff members of the team to share care responsibilities, which results in greater continuity of care for patients if staff come and go from the team.[69] The expert panel on health workforce advised the Board that adopting a Buurtzorg-type model could be a health improvement initiative to be developed in the medium-term. The expert panel suggested that in the short-term, nurse practitioners could be utilised in general medical practices as respiratory nurses, diabetes educators and care coordinators.[70]

Professor Campbell also noted that the concept of 'health coaching' was emerging as a 'promising area for innovation'.[71] He explained that coaching is a broad concept that can include medical practitioners coaching a patient or their family, or coaching a healthcare team to perform better in delivering health services.[72]

In relation to coordination of mental healthcare, the Board heard that whilst good services are available, there is scope for these services to be better integrated, particularly across service providers.[73] The expert panel on mental health suggested that the way forward starts with mapping services across the mental health system to see what funding streams and networks already exist, and to bring together leaders in the sector. The panel advised that this work should involve community leaders, and that there should be a focus on early-intervention.[74]

4.3 SCREENING AND EARLY DETECTION OF CHRONIC CONDITIONS

Screening refers to a variety of processes and tools aimed at identifying early signs of chronic disease (such as raised blood pressure, high cholesterol and decreased lung function) to prevent further disease progression. Professor Andrew Tonkin, a cardiologist from Monash University, and a member of the expert panel on early detection and high risk screening, advised the Board that when considering the usefulness of screening, the burden of disease within a community must first be taken into account. He advised that screening is most beneficial where there is a high burden of chronic disease in a population, as there is in the Latrobe Valley.[75] Screening enables the detection of risk factors, ideally without invasive testing, such as an angiogram.[76]

A significant number of written submissions received by the Board highlight the importance of early detection of chronic disease. Two themes were prominent across many of the submissions—the need for specialist screening processes to assist in the early identification of chronic disease, and the need for community education on the symptoms of chronic disease to increase uptake of screening.[77]

The expert panel on early detection and high risk screening discussed screening in the Latrobe Valley for risk factors of common chronic diseases such as cardiovascular disease, diabetes, pulmonary disease, and chronic depression and anxiety.[78] Professor Clarke submitted that screening for mental health should be incorporated into screening for chronic disease.[79] Professor Clarke submitted that there is a strong case to screen for anxiety and depression where people present with an acute cardiovascular event, such as a heart attack, or chronic physical health conditions like diabetes and arthritis.[80] He suggested that the case could be made to screen young people for mental health issues given the high rates of youth suicide in the Latrobe Valley.[81]

Professor Tonkin emphasised that for early detection to make a difference to health outcomes, effective, low cost interventions need to be available to change the trajectory of the disease: 'If you can't intervene after you have detected, there is really little to be said for screening.'[82] Consistent with this, Dr Daniel Steinfort, a respiratory physician from the Royal Melbourne Hospital, advised the Board that that there is a limited role for screening for chronic obstructive pulmonary disease, such as emphysema, as there is currently limited effective treatment for this condition.[83]

Professor Tonkin explained that screening usually occurs within a general medical practice,[84] although he noted that people may prefer to be screened in a community setting 'outside the usual medical framework.'[85] He told the Board that there is an opportunity for the Latrobe Valley to provide learnings about screening and disease prevention that might be of benefit across Australia.[86]

The Victorian Chronic Disease Prevention Alliance (VCDPA) states in its submission that '[m]any high risk individuals are unaware of their risk status and are therefore unlikely to undergo comprehensive, absolute risk assessment in an unprompted manner in primary care.'[87]

The VCDPA submitted that a consistent approach should be introduced for assessment and management of people at high risk of vascular disease. It recommends:

- Establishing risk awareness and promotion programs in community settings (including in pharmacies and the workplace), to increase the number of people over 45 years of age who attend their GP for a health assessment.

- Encouraging programs and policies that facilitate the use of an integrated health check (for cardiovascular disease, chronic kidney disease and diabetes) in the primary care setting.

- Establishing and implementing integrated community-based risk reduction for people at risk of vascular disease.[88]

The Victorian branch of the Heart Foundation recommends a number of measures to improve cardiac health in the Latrobe Valley, including educating people on the warning signs of a heart attack.[89]

The Victorian branch of the Australian Nursing and Midwifery Federation suggests that programs 'should be implemented across all points of contact in the community including schools, health services, community services, community groups.'[90]

Dr Steinfort reported that there is emerging international evidence that screening individuals at high risk of lung cancer may lead to improved survival rates.[91] He advised that Australian pilot projects about early detection of lung cancer are currently underway, and that in the short-term a project could be developed to identify the risk profile of the Latrobe Valley community.[92] Dr Steinfort and Dr Alistair Wright, a general physician from Latrobe Regional Hospital, advised the Board that they have already commenced discussions about working together to understand the risk profile for lung cancer in the Latrobe Valley.[93]

Professor Campbell and Professor Clarke also state in their expert report to the Board that 'screening high-risk individuals for lung cancer with low dose CT scans (LDCT) can save lives,' and that such screening is particularly relevant for the Latrobe Valley community, given the community's exposure to asbestos and the high rate of smoking. Whilst acknowledging the gap in international evidence about the optimal frequency and duration of screening for lung cancer, Professors Campbell and Clarke also suggest that the Latrobe Valley be included in a study on early detection of lung cancer.[94]

Ms Heather Scott, from the Latrobe Community Health Service, and Professor Tonkin both commented that one-off health assessments for people aged 45–49 years are under-utilised.[95] Ms Scott noted that these assessments can be an important mechanism for assessing and identifying risk factors for disease.[96] Professor Tonkin also noted an additional existing risk assessment guideline—the *National Vascular Disease Prevention Alliance* tool—for assessing the risk of coronary heart disease, including stroke.[97]

Professor Tonkin referred the Board to international evidence, also relevant to the Australian context, which shows that the application of risk assessment guidelines is a highly cost-effective approach—cost effectiveness modelling showed that risk assessment costs approximately $6,000 for every disability adjusted life year it saves. As a comparator, Professor Tonkin advised that the 'cost-effectiveness bar' for new drugs being considered for listing under the Pharmaceutical Benefits Scheme is about $30,000.[98]

The expert panel on early detection and high risk screening submitted that there was a potentially valuable role for the nursing workforce in supporting screening. Ms Scott outlined her experience of how nurses currently support general practitioners in delivering screening services. The panel suggested that community liaison officers, who can promote screening to particularly disadvantaged members of the community, would be an invaluable resource.[99] The panel also suggested that a liaison officer who could facilitate communication between general practitioners and hospitals would be of value.[100]

The expert panel recommended a community screening day as a way forward in highlighting the importance of screening, and also as a way of regaining trust and giving back to the community in the short-term.[101] A community screening day in the Latrobe Valley would involve a broad range of stakeholders, including health professionals, community groups and non-government organisations.[102]

Professor Clarke noted that a screening day needs to be more than a one-off event,[103] and Professor Tonkin noted that a screening day cannot occur in isolation, but that thinking needs to go into what happens to people who, once screened, are identified as being at high risk of chronic disease.[104] Dr Wright cautioned that screening days may only reach those who are already likely to be screened and may miss those who need it most.[105] Ms Kellie O'Callaghan, chair of the Board of Latrobe Regional Hospital, committee member of Regional Development Australia Gippsland, and Councillor of Latrobe City Council, committed to progress the idea of a screening day in the Latrobe Valley.[106]

The expert panel suggested that the most cost-effective intervention for improving respiratory health in the Latrobe Valley is smoking cessation programs.[107] Professor Campbell and Professor Clarke also recommend this in their expert report.[108] Smoking cessation programs are considered in Part 5 of this report.

4.4 HEALTH WORKFORCE CHALLENGES

The Board heard of the need to increase the number and availability of health professionals (such as doctors and nurses) in the Latrobe Valley in order to achieve health improvements.

The Royal Australasian College of Physicians states in its submission that:

> there has been a lack of strong local public health leadership and systems including public health physicians permanently positioned in regional Victorian public health units. Victoria lags behind other states in employing public health physicians and trainees within local public health units.[109]

In its written submission to the Board, the Australian Nursing and Midwifery Federation (Victorian branch) states that its '[m]embers report the [Latrobe Valley] community is disadvantaged by the limited access to medical services in particular the availability of medical specialists, and as a result of the regular turnover of general practitioners in the community.'[110]

In its submission, the Victorian Healthcare Association notes that the Latrobe Valley has fewer general practitioners, specialist medical practitioners, pharmacists and physiotherapists per 1,000 population than the Victorian average, and that projections indicate 'significant shortages of nurses and moderate shortages of doctors in the coming years.'[111]

The Commonwealth Government's white paper on roles and responsibilities in health notes that, among other factors, the growing burden of chronic disease is increasing the demand for health services. Further, that both state and Commonwealth governments are facing workforce pressures, particularly in rural and regional areas.[112]

The expert panel on the health workforce provided an overview to the Board of nursing recruitment in the Latrobe Valley. Latrobe Regional Hospital is currently able to fill available nursing positions, largely due to its proximity to a tertiary provider of nursing training located in Churchill.[113] Ms Amanda Cameron from Latrobe Regional Hospital advised the Board that there is likely to be an under-supply of qualified nurses in the future, as health workforce modelling shows that the population is ageing and nursing shortages are projected.[114] Ms Cameron indicated that shortages will be exacerbated in the Latrobe Valley, particularly in midwifery, as the Churchill training provider has advised that they will cease training in midwifery in the foreseeable future.[115] Ms Cameron also noted that it would be beneficial to have mental health training for nurses delivered locally.[116]

Ms Cameron advised that Latrobe Regional Hospital also has difficulty recruiting allied health professionals due to the lack of undergraduate allied health training available in the Latrobe Valley, with significant consequences for health service delivery.[117] For example, a shortage of sonographers in the Latrobe Valley who provide a 24-hour diagnostic ultrasound service, means that patients requiring this service may need to wait in the emergency department of the hospital overnight, with flow-on pressures for the hospital staff.[118]

Ms Pip Carew of the Australian Nursing and Midwifery Federation (Victorian branch) advised that there is a current shortfall in mental health and drug and alcohol trained nurses in the Latrobe Valley, and further opportunities for postgraduate training to enable nurses to work in these areas should be locally available.[119]

Dr Simon Fraser, also from Latrobe Regional Hospital and a member of the health workforce expert panel, confirmed that recruitment of senior doctors at Latrobe Regional Hospital has been easier in the previous few years, though areas of speciality remain under represented, such as mental health, and to a lesser degree obstetrics, anaesthetics and emergency department doctors.[120] However, the *Gippsland Rural Intern Training* program, which supplies doctors to the hospital, is growing, and the *Rural Generalist Pathway* program is encouraging general practitioners to diversify and expand their training into anaesthetics and obstetrics.[121]

Dr Fraser advised that the greater issue now is retaining senior doctors at the hospital, and attracting and retaining general practitioners.[122] The expert panel on health workforce referred to key challenges relevant to recruiting and retaining doctors:

- Ensuring appropriate employment for doctors' partners and schooling for their children.[123]

- Providing networks with metropolitan centres to allow opportunities for progression into specialty training pathways.[124]

- Recruiting the next generation of doctors from rural areas.[125]

Professor Campbell also noted that retaining doctors and their families does not just increase service delivery resources, but also contributes social capital through doctors investing in and building their understanding of the local community.[126]

In its written submission to the Board, the Victorian Healthcare Association recommends that measures should be taken to 'promote pathways for students to enter the nursing, medical and allied health professions and work in the Gippsland region.'[127] The Association also suggests that the State has a continuing role to play in attracting and retaining a skilled health workforce in the Latrobe Valley.[128]

The health workforce expert panel also discussed the need to expand vocational training within Gippsland. The panel suggested to the Board that this might include expanding the *Gippsland Rural Intern Training* model into other specialties that are particularly in demand.[129] Ms Cameron described the *Maternity Connect* program as an example of the effectiveness of a local training approach to ensuring a robust health workforce in the Latrobe Valley.[130] The *Maternity Connect* program enables midwives from smaller health services to undertake placements in larger facilities, such as Latrobe Regional Hospital, to gain experience in managing higher risk patients. Staff are also sent to tertiary centres in Melbourne to gain experience in a tertiary environment. This program enables staff to be based in a rural area, such as Gippsland, for the bulk of their training, while still gaining higher level clinical experience.[131]

Professor Campbell suggested that another short-term option is to progress collaboration between Monash Health and Latrobe Regional Hospital on a regional advanced trainee program for general physicians, and he indicated he would progress this initiative.[132]

Another central theme discussed by the expert panel was the need for the local health workforce to be aware of and suitably trained to address the particular health needs of the Latrobe Valley community. A number of written submissions to the Board note that community members perceive a lack of expertise amongst health service providers in the region, particularly in relation to health problems associated with the Hazelwood mine fire.[133]

The expert panel on children and youth also discussed this issue in response to a question from the Board about strengthening general practice in the Latrobe Valley as it related to child-friendly attitudes and practices. The panel suggested identifying local general practitioners with an interest in child health, and providing access to the support and training already available to hospital medical staff working in paediatrics.[134] Panellists also recommended extending the services of paediatric general practitioners after hours, when access is most required. A further point of discussion for the panel was the value of co-locating services—having general practitioners and maternal and child health services operating alongside kindergarten programs and early intervention programs.[135]

The expert panel observed that the 'care pathways' to be developed by the Gippsland Primary Health Network will go some way towards providing information and expertise on appropriate treatment regimes.[136] The Board was advised that improvements in tele-medicine (discussed below) might assist in ensuring that doctors in the region are appropriately skilled.

TELE-MEDICINE

During community consultations and in written submissions, community members frequently told the Board about the imposition of travelling to Melbourne to see medical specialists.[137]

Tele-medicine, also referred to as tele-health, was discussed by a number of expert panels as an option for increasing community access to medical specialists and enabling medical tests to be carried out in the home.

The World Health Organization defines tele-medicine as:

> the delivery of health care services, where distance is a critical factor, by all health care professionals using information and communications technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities.[138]

In short, tele-medicine is the use of technology to assist in medical care. This assistance may be by way of supporting further education for health professionals or seeking second opinions from specialists in other locations; and it may extend to the use of machines to monitor patients in their own home where the results can be accessed by general practitioners or hospitals.[139]

Professor Campbell noted that the foot clinic example (discussed under the integrated care coordination section above) demonstrates the benefits of empowering local practitioners with the tools to treat clients and providing support through tele-medicine.[140]

Associate Professor Rasa endorsed tele-medicine as a model that can facilitate local care, particularly when clients have good support from their general practitioner. He noted that one of the challenges with tele-medicine is enabling payment for specialists, but that the current Commonwealth review of the Medicare Benefits Schedule offers an opportunity to ensure they are appropriately remunerated. Associate Professor Rasa also noted that further discussions with the Commonwealth may provide options for trials of new models of service using tele-medicine, in regional centres such as the Latrobe Valley.[141]

The health workforce expert panel and the children and youth expert panel also reported that tele-medicine can play a role in assisting with workforce training and retention.[142] It was noted that some equipment already exists at Latrobe Regional Hospital to allow for this, but that assistance is required to coordinate meetings and facilitate the technical aspects of the tools, so that the systems are more reliable.[143] The panel submitted that tele-medicine could be used to connect local practitioners with specialists who are not located locally, and also to connect specialists to clients in their own homes.[144]

INFRASTRUCTURE TO SUPPORT HEALTH SERVICE DELIVERY

Infrastructure to support health service delivery was identified by the community and expert panels as an issue for consideration.

In her written submission to the Board, Ms Grace FitzGerald, a Monash University medical student, expresses concern about the existing health infrastructure within the Latrobe Valley, and how this affects the community's access to healthcare.[145] In her submission, Latrobe Valley resident Ms Wendy Farmer mentions the need for specialist scanning equipment.[146] The Asbestos Council of Victoria recommends a specialist respiratory unit.[147]

The expert panel on chronic disease management brought the Board's attention to the forthcoming re-development of Latrobe Regional Hospital, which is part of a longer-term master plan for the hospital. The Board was advised that $73 million has been earmarked for this re-development—significantly less than the more than $600 million available for the new Bendigo Hospital.[148] The expert panel on health workforce emphasised the 'need to see a commitment to the further development of Latrobe Regional Hospital as a regional hospital for the people of the Latrobe Valley and the wider Gippsland area, and a commitment for that to continue.'[149]

The expert panel on children and youth discussed a number of issues relating to the forthcoming re-development of Latrobe Regional Hospital. Of immediate concern were the high levels of aggressive behaviour that children currently encounter in the mixed waiting room in the existing Emergency Department.[150] The panel recommended that this be addressed in the context of the re-development, where children should be separated from the general adult population in the triage, waiting and treatment areas.[151] A further option brought to the Board's attention was that of a general practitioner-led clinic, staffed by paediatric nurses, which could provide a quicker and more appropriate emergency department alternative to families and children.[152]

The expert panel on children and youth reported to the Board that the number of special care nursery beds in West Gippsland (including the Latrobe Valley region)—10 beds for the approximate 2,000 births per year—is below that of other regional areas. The panel advised that this has a significant impact on families, as they are away from home for lengthy periods.[153]

Health service facilities specific to the Latrobe Valley Aboriginal community are discussed in Part 6 of this report.

4.5 BOARD'S CONSIDERATION AND PROPOSALS

RE-DESIGNING HEALTH SERVICES

The Board considers that acknowledgment—by both Latrobe Valley residents and expert panel members—that the healthcare system needs to change shows a readiness for change in the Latrobe Valley. The poorer physical and mental health status of Latrobe Valley residents makes improvements to the health system for this community a priority.

The Board accepts that one of the overwhelming themes through the public submissions, community consultations and Health Improvement Forums was that the current health system needs to be re-designed and tailored for the particular requirements of the Latrobe Valley community. One of the key issues discussed in this respect was ensuring that the health system is accessible, understandable and easy to navigate. Other key themes included the desire for people to be able to self-manage where possible so as to take the strain off the health system, and for health practitioners to work more in partnership or otherwise adopt a coordinated approach.

The Board received support for the concept of the Latrobe Valley being designated as a special health zone to bring about improvements to health. The Board's considerations and recommendations with respect to the concept of a health zone are discussed in Part 8 this report.

The Board proposes that funds be prioritised for innovative health initiatives and trials of new approaches to health system design. The Board is of the view that this will lead to improved health outcomes for clients with chronic disease and mental ill health in the Latrobe Valley in the short, medium and long-term.

MENTAL HEALTH

The Board recognises that ensuring all members of the community understand mental health and know how to support people at risk of or experiencing mental health problems, is essential to supporting good mental health in the Latrobe Valley.

The Board accepts the evidence of Professor Campbell and Professor Clarke that mental illness is complex and can lead to persistent and disabling conditions. The Board notes that mental illness is often associated with other illnesses and linked to social and economic factors. The Board accepts that the Latrobe Valley experiences a higher rate of mental illness than other parts of Victoria. The Board also accepts that it is possible that the rates of mental illness in the Latrobe Valley have increased since the Hazelwood mine fire, although the evidence to demonstrate this is anecdotal. The Board considers that mental illness is an important issue that must be addressed, in the short to medium-term.

The Board strongly suggests that the issue of improving access to mental health support be considered in the short-term and that it be a priority of health initiatives to be implemented by or through the State. The Board proposes that future initiatives relating to mental health be considered in association with healthcare initiatives for other chronic disease management, to ensure that those affected can clearly navigate a coordinated health system.

Other programs to support the health of children and promote mental wellbeing are considered in Part 5 of this report.

CONSUMER-LED CARE

The Board has heard through public submissions, community consultations and the Health Improvement Forums that the community wants to be involved in generating solutions for the improvement of the health of the Latrobe Valley. The Board considers that engaging with the community affected by the issues will likely lead to a better health outcome for the Latrobe Valley. The Board endorses suggestions and recommendations by the mental health expert panel and the chronic disease management panel that involving the community will also likely lead to the community taking more responsibility for their own and their community's health.

The Board affirms the State's proposal to move towards a 'person-centred' healthcare system with equitable access, as documented in the Health 2040 Summit discussion paper.[154] The Board considers this proposal has great merit and ought to be implemented.

The Board also notes that there are existing programs, such as the *Optimal Health* program run by the Latrobe Regional Hospital for mental health, that demonstrate the success of initiatives for those accessing health services to self-manage their care.

As discussed later in this report, the importance of community engagement in the design and implementation of initiatives relating to the community was repeated in relation to most aspects of the health system. The Board acknowledges that community engagement is a critical step in ensuring that the community feels listened to, and it is likely to lead to better outcomes for all.

INTEGRATED CARE COORDINATION

The Board notes that both the expert panel on chronic disease management and the expert panel on mental health emphasised the importance of coordination and integration of care. The Board considers that this is a crucial aspect of improving health and that integration of care should be a key part of the underlying framework for developing health initiatives in the Latrobe Valley.

The Board proposes that consideration be given, in the medium-term, to nurses and nurse practitioners taking on a case management role in the care of people with chronic conditions, particularly those at high risk, to ensure a 'one system' approach from primary care through to tertiary care. The Board considers that the coordinated approach already taken in relation to some programs in the Latrobe Valley, such as the community health high-risk foot clinic and the State's *Children & Youth Pathways to Good Health*, demonstrate that care coordination is possible and can be highly successful.

In developing such an approach, the Board suggests drawing on the experience of the Buurtzorg model. Care coordinators should also be considered for medical services provided to Aboriginal people, although the Board notes that Aboriginal Health Workers, rather than nurses, may be better placed to undertake this role, and that effective case management should be determined in consultation with the Latrobe Valley Aboriginal community. Aboriginal health is discussed further in Part 6 of this report.

The Board affirms the commitment of the Gippsland Primary Health Network to develop 'care pathways' to assist general practitioners in the management of complex conditions. The Board suggests that these be developed in partnership with the other principal stakeholder organisations for health in the Latrobe Valley, particularly in relation to chronic cardiovascular and respiratory conditions, diabetes, anxiety and depression.

> The Board recommends that an initial health improvement program is focused on innovative ways to deliver integrated care for people with chronic diseases, especially those with related mental health conditions.

SCREENING AND EARLY DETECTION

The Board endorses the view of the Victorian Chronic Disease Prevention Alliance in relation to screening and early detection, and considers that there are health benefits to be gained by developing a consistent approach to the use of an integrated screening tool across the Latrobe Valley, in combination with risk awareness programs. In particular, the Board notes the cost benefits of screening. The Board considers that screening will be an important complement to the work of promoting healthy living (discussed in Part 5 of this report).

The Board suggests that consideration be given in the medium-term to establishing a purposeful outreach screening program for chronic disease, utilising a common screening tool that involves general practitioners, community health nurses and Aboriginal medical services, to proactively screen for risk of diabetes, cardiovascular disease, pulmonary disease, anxiety and depression.

In the short-term, the Board proposes that agencies reconsider the use of current centre-based community nursing resources and consider re-directing these towards a community outreach model as a first step.

The Board affirms the commitment of Ms Kellie O'Callaghan, chair of the Board of Latrobe Regional Hospital, committee member of Regional Development Australia Gippsland, and Councillor of Latrobe City Council to progress a community screening day, in partnership with the community and other major health services. This day could be approached as the 'launch' of a new outreach screening program to support chronic disease prevention.

The Board considers that the development of 'care pathways' should be directed, as a priority, towards screening for common risk factors of chronic disease, and that a screening program launch should not occur until these pathways are in place and understood across the healthcare system, to ensure that follow-up care is provided for those identified as at high risk.

The Board proposes that in the medium-term, a Latrobe Valley screening protocol should be developed that covers clinical pathways from assessment to management, referral and treatment for cardiovascular disease, diabetes, pulmonary disease, and chronic depression and anxiety. The Board considers that in the development of a screening protocol as proposed, consideration should be given to the merits of the Latrobe Valley participating in the national lung cancer screening trial.

The Board affirms the intention of Dr Alistair Wright, general physician from Latrobe Regional Hospital and Dr Daniel Steinfort, respiratory physician from the Royal Melbourne Hospital, to work together to understand the risk profile in the Latrobe Valley relevant to lung cancer, and the implications of this for a possible lung cancer screening program.

HEALTH WORKFORCE

The Board is concerned about existing difficulties recruiting health practitioners in some health workforce areas, and the projected significant shortages in the future, in particular in the nursing and medical workforces. The Board recognises that such shortages have the potential to be of detriment to the health of the people of the Latrobe Valley. The Board agrees that it is important to plan carefully to ensure that there is a sufficiently trained workforce in place over the coming years to improve the health of the Latrobe Valley community.

The Board accepts that effective long-term recruitment and retention will most likely be achieved through strategies that promote the development of young people from the Latrobe Valley, combined with training opportunities for people located in the Latrobe Valley. The Board also notes, from information presented in Part 5 of this report, 'growing your own' is an important part of creating local jobs into the future.

With regards to nursing and allied health training, the Board proposes that a strong university presence be maintained in the Latrobe Valley so that the future health workforce can be sourced from the local community.

With regards to medical training, the Board commends the work of the *Gippsland Rural Intern Training Program* and affirms the intention of Monash Health and Latrobe Regional Hospital to consider the development of an advanced physician trainee program for general physicians in the short-term.

In the long-term, the Board considers that the State should support Latrobe Regional Hospital to have a more self-sufficient medical workforce. This involves considering the establishment of private facilities in future hospital re-developments to attract specialists, and co-locating a clinical medical school on the hospital campus.

The Board also notes the health improvements recommended in Part 7 of this report, the objectives of which are to restore pride in the Latrobe Valley and to enhance the region's ability to attract and retain a strong health workforce.

TELE-MEDICINE

The Board recognises the valuable role that tele-medicine could play in improving access to health specialists and in providing a greater range of opportunities for workforce development to assist in the retention of medical staff in the Latrobe Valley. Given the broad ranging ways in which tele-medicine can support patients, and health services and staff, the Board considers it should be prioritised as an area for action when implementing health initiatives in the Latrobe Valley.

The Board proposes that a tele-medicine suite, with experienced tele-medicine providers, be established in the Latrobe Valley with priority given:

- In the short-term, to enabling tele-medicine consultations between medical staff in the Latrobe Valley and specialists in Melbourne.

- In the medium-term, to establishing the capacity for patient home monitoring to assist in supporting self-management of chronic conditions.

- In the long-term, to consider further expanding the Latrobe Valley tele-medicine capacity to involve general practitioners in hospital consultations.

The Board notes that making better use of technology is one of the principles for the future of the health system proposed by the State.

> The Board recommends that an initial health improvement program is focused on innovative ways to deliver tele-medicine services to reduce the barriers of access to medical specialists and other health practitioners.

INFRASTRUCTURE TO SUPPORT HEALTH SERVICE DELIVERY

The Board considers that infrastructure to support health service delivery is an important area for further consideration in the medium and long-term. The Board affirms the commitment of Latrobe Regional Hospital to continue to develop as a regional hospital for the people of the Latrobe Valley and the wider Gippsland area. The Board considers that the State should give serious consideration to ensuring that future investment in this facility is at least equitable with other regional areas in Victoria.

The Board was concerned to hear of the high levels of aggressive behaviour from adults in the presence of children in the Emergency Department waiting room at Latrobe Regional Hospital. The Board proposes that Latrobe Regional Hospital Board give immediate consideration to separating children from the general adult population in the current hospital Emergency Department, and that separation of children from the general adult population in triage, waiting and treatment areas be a priority for the forthcoming re-development of the hospital.

PART FIVE
PROMOTING
HEALTHY LIVING

PART 5 PROMOTING HEALTHY LIVING

Part 5 considers a broad spectrum of health initiatives aimed at improving the health and wellbeing of Latrobe Valley communities.

Particular attention is given in this Part to reducing smoking, improving nutrition, increasing physical activity, reducing harm from alcohol and drugs, and improving mental health by preventing family violence. Given that these are all contributors to chronic disease, improvements in these areas will make a considerable difference to the overall health of people in the Latrobe Valley.

Local and state-wide actions that can support healthy living are discussed in this Part, as are the possible settings for such actions, including sports clubs, schools, and workplaces. This Part also considers populations within the Latrobe Valley that should be prioritised when implementing health initiatives.

Four expert panels were convened as part of the Health Improvement Forums to consider health initiatives. These expert panels were:

- Health behaviours: Ms Kellie-Ann Jolly from Heart Foundation Victoria; Ms Sara Rhodes-Ward from Latrobe City Council; Dr Bruce Bolam from the Victorian Health Promotion Foundation (VicHealth); Ms Alison Skeldon from Latrobe Community Health Service; Mr Luke Atkin from Quit Victoria; Ms Jane Martin from the Obesity Policy Coalition; Mr Barry Switzer from Gippsport; and Ms Holly Piontek-Walker from the Department of Health and Human Services (DHHS).

- Healthy workplaces: Mr Alistair Edgar from Latrobe City Council; Mr Steve Rieniets from AGL Loy Yang; Ms Angie Deegan from WorkSafe Victoria (WorkSafe); Mr John Guy from Advance Morwell; Ms Irene Verins from VicHealth; and Mr Colin Sindall from DHHS.

- Healthy environments: Mr Ron Mether from EnergyAustralia Yallourn; Ms Carmel Flynn from DHHS; Dr Nick Aberle from Environment Victoria; Ms Carolyne Boothman from the Morwell & Districts Community Recovery Committee; Dr Peter Tait from the Ecology and Environment Special Interest Group for the Public Health Association of Australia; Ms Helen Taylor from Latrobe City Council; and Mr Chris Webb from the Environment Protection Authority (EPA).

- Children and youth: Ms Claire Watts from Latrobe Community Health Service; Dr Cathy Coates from Latrobe Regional Hospital; Ms Kate Kerslake from Latrobe City Council; Dr Cathy McAdam from Monash Health; and Ms Sally Richmond from DHHS.

5.1 REDUCING HEALTH RISKS

The Board received numerous written submissions that identify particular behaviours, prevalent in the Latrobe Valley community, which increase the risk of physical and mental ill health. Many of these submissions advocate the importance of reducing these risk factors to improve overall health outcomes in the Latrobe Valley.

SMOKING

In its submission to the Board, VicHealth advises that the Latrobe Valley has one of the highest rates of smoking in Victoria, with the proportion of female smokers in Gippsland being particularly high. The proportion of people who smoke in the Latrobe Valley is 19.8 per cent, compared with the Victorian average of 15.7 per cent.[1] In their submissions to the Board, Latrobe City Council, the Victorian branch of the Heart Foundation, and Quit Victoria also note the high rate of smoking in the Latrobe Valley.[2]

In its submission to the Board, Quit Victoria states that:

There is a clear need and a compelling argument to resource and prioritise smoking cessation treatment within health and community services and to develop and implement a community led direct marketing campaign to combat smoking and improve health and wellbeing status in the Latrobe Valley community.[3]

VicHealth similarly recommends that the Board consider increasing smoking cessation programs within the Latrobe Valley, and suggests that the region could become a leader in trialling innovative cessation strategies.[4]

PHYSICAL ACTIVITY

There is a direct link between physical activity levels and the risk of chronic disease.[5] In its submission VicHealth states that:

> Regular physical activity can provide significant gains in health and wellbeing by preventing chronic disease. It can improve mental wellbeing, build social connection, increase productivity and create positive change in the places where we live, learn, work and play… Action to address the social, economic and environmental conditions that result in low levels of physical activity can help improve health and wellbeing across the lifespan.[6]

According to VicHealth, 25 per cent of people in the Latrobe Valley do not meet physical activity guidelines for health.[7]

The Cancer Council Victoria (Cancer Council) notes in its submission to the Board that the 'availability of safe, accessible and affordable physical activity options for residents is likely to increase physical activity levels.'[8] The expert panel on health behaviours advised the Board that encouraging participation in physical activity has the dual benefit of fostering community members' sense of connection and engagement; as well as promoting the health benefits of exercise.[9]

The Board heard about a number of initiatives that encourage participation in physical activity, such as VicHealth's *Regional Sport Program*, which aims to engage physically inactive community members in sport.[10] However, the expert panel acknowledged that further work is required to increase community participation in sport and other physical activity.[11]

NUTRITION

VicHealth advises that nutrition is a key part of any health promotion in the Latrobe Valley: 'Diet-related illness is one of the greatest contributors to ill health in Australia…action to promote healthy eating has the potential to greatly benefit the Latrobe Valley.'[12]

In its submission to the Board, VicHealth cites key nutritional indicators and compares the prevalence of these indicators in the Latrobe Valley population relative to the broader Victorian population. These indicators are reproduced in Table 4, below.

Table 4. Key nutritional indicators: Latrobe Valley compared to the Victorian average[13]

Indicator	Latrobe	Victoria
Percentage of people not meeting fruit and vegetable guidelines (2011/12)	52.9%	51.1%
Daily soft drink consumption (2011/12)	22.5%	15.9%
Percentage of adults 18+ overweight or obese (2011/12)	60.6%	49.8%
Percentage obese	*23.8%*	*17.3%*
Percentage overweight	*36.8%*	*32.5%*

The Cancer Council submits that there is a direct link between the availability of unhealthy food and the rate of its consumption within the community. The Cancer Council also notes that the link between the consumption of unhealthy food is stronger 'when the unhealthy food is cheaper, healthy food is limited and when the unhealthy food outlets are in disadvantaged areas.'[14]

In its submission to the Board, the Cancer Council suggests that:

> Healthy systems planning should promote access to healthy affordable food and reduce availability of unhealthy foods and beverages particularly near education facilities, leisure centres and community venues. Local government should become a leader in this area extending the policies to council facilities and events.[15]

In her written submission to the Board, Latrobe Valley resident Ms Evelyn Scott, recommends an increase in nutrition and dietetic services in the Latrobe Valley.[16]

ALCOHOL AND DRUGS

In its written submission VicHealth advises that people in the Latrobe Valley are at greater risk of short term alcohol-related harm than other areas of Victoria. VicHealth emphasises that alcohol misuse disproportionately harms young people and people from low socioeconomic backgrounds, although alcohol misuse is not necessarily associated with socioeconomic disadvantage.[17]

The expert panel on mental health highlighted the link between poor mental health and alcohol and drug use,[18] and the expert panel on social disadvantage advised that many disengaged young people have problems with drug and alcohol use.[19]

MENTAL HEALTH AND FAMILY VIOLENCE

The expert panel on mental health advised the Board that the Latrobe Valley community has greater contact with mental health services than other areas of Victoria, and higher rates of suicide.[20] Dr Cayte Hoppner, from Latrobe Regional Hospital, highlighted the link between mental health and issues such as child welfare, drugs and alcohol use, and family violence.[21]

The connection between mental health and family violence was also highlighted during the 2014 Hazelwood Mine Fire Inquiry. The Board was advised that the whole community, and in particular young children, are at risk of psychosocial impacts from the Hazelwood mine fire, including an increased risk of family violence.[22] The Board also heard reports during the 2014 Inquiry of an increase in family violence due to stress,[23] and this was further raised with the Board during the community consultations in the current Inquiry.

The Latrobe Valley has a higher incidence of family violence than the Victorian average. In 2013–2014, there were 27.7 reports of family violence per 1,000 people in the Latrobe Valley, compared to the Victorian average in the same period of 11.3 reports per 1,000 people.[24] Members of the expert panel on mental health advised the Board that family violence services in the Latrobe Valley are at capacity, in a context of high ongoing demand. This is creating a 'service gap' for people at risk of or experiencing family violence in the Latrobe Valley.[25]

The vast majority of incidences of family violence are perpetrated by men against their female partners, with this form of violence generally having more severe impacts on women than male victims.[26] This includes fatalities, physical and mental health impacts, and economic and social costs. In terms of health impacts, it is estimated that eight per cent of the total disease burden for women aged 15 to 44 years is due to violence from a male intimate partner.[27] VicHealth particularly highlights the impact of family violence on women's mental health, with over half of the disease burden relating to mental health conditions such as stress, depression and anxiety.[28]

In its written submission VicHealth advises that, in addition to long-term efforts that prevent family violence, action taken to address stress and family violence in the short-term will have a significant impact on health improvements in the Latrobe Valley.[29] The Board understands that VicHealth developed a framework to guide policy and planning to prevent violence against women in 2007. The framework aims to promote primary prevention of violence against women. It is designed to assist Victorian and other Australian governments to pursue policies and actions that seek to address gender inequities, the key determinant of violence against women.[30]

This framework led VicHealth to develop the *Generating Equality and Respect* program in partnership with Monash City Council and MonashLink.[31] In its written submission to the Board, VicHealth discusses the *Generating Equality and Respect* model as a potential basis for developing a program to address family violence in the Latrobe Valley. The model focuses on primary prevention of violence, and aims 'to reach people where they live, work, study and play.'[32]

In addition, the Board is aware of the VicHealth *Mental Wellbeing Strategy 2015–2019,* which was released in December 2015. This strategy acknowledges that violence against women is a key contributor to mental ill health. The strategy also discusses ways to promote resilience, particularly among young people, as an important step in improving mental wellbeing.[33]

5.2 LOCAL AND STATE-WIDE ACTION TO SUPPORT HEALTHY LIVING

The expert panel on health behaviours noted that a discussion about individual behaviours relevant to health cannot occur in a vacuum: it needs to consider the services and systems that exist around a community to support healthy behaviours, and how these services and systems engage with communities and invest in health initiatives.[34]

COMMUNITY ENGAGEMENT

Consistent with a number of other expert panels, the expert panel considering healthy environments discussed the central importance of consulting with families and the community to better understand health needs and address health problems. Dr Peter Tait, from the Public Health Association of Australia, and a member of the healthy environments panel, provided examples of work undertaken in Windale, New South Wales and in the City of Melbourne, that involved the community designing its own solutions to problems. This work included consulting citizens when developing budgets to resource initiatives.[35] Panel member Dr Nick Aberle from Environment Victoria, told the Board that whilst he was initially sceptical about such processes, he has witnessed success in involving communities in this way. He told the Board that the approach needs to be: 'We are genuinely going to listen to what you have to say and we are really going to use that to inform the direction that we go [in].'[36] Effective community engagement is discussed further in Part 7 of this report.

The experience of the Myrtleford community in Victoria, which transitioned out of the tobacco industry and built a new economy based around the natural beauty of the Ovens Valley, was recounted for the Board.[37] The Board heard that involving the community in rebuilding pride in the Latrobe Valley, and progressing a vision for the economic future of the Latrobe Valley, is an important part of improving the health and wellbeing of the population.[38] This approach is considered further in Part 7 of this report.

Ms Sara Rhodes-Ward from Latrobe City Council, and a member of the health behaviours expert panel, outlined for the Board the work the Council is doing to better engage the community in improving their own health.[39] She recounted the work undertaken by Latrobe City Council as part of the recovery process after the Hazelwood mine fire. Council staff directly engaged community members living closest to the mine by going door to door and asking residents about their health concerns and possibilities for improving health. This initiative reached approximately 70 residents, in an area of 230 households. Following the door knock, about 35 residents attended a community workshop to develop an action plan around issues that emerged during the Council's survey.[40] Ms Rhodes-Ward advised that when asked 'are you comfortable asking your neighbours for help?' 93 per cent of residents surveyed said 'yes'. She noted that this statistic demonstrated how well this particular community was connected.[41]

The Council's approach to community engagement has already seen some benefits, with two residents coming together to remove undergrowth from a walking track they once used, and to establish a walking group connected to the rose garden in Morwell. This walking group was launched during the week of the Health Improvement Forums.[42] Ms Kellie-Ann Jolly from the Heart Foundation Victoria noted that these community engagement initiatives might contribute to the development of the Council's *Municipal Public Health and Wellbeing Plan* which will operate under the broader framework of the State's *Public Health and Wellbeing Plan*.[43]

HEALTHY TOGETHER LATROBE

In the 2014 Hazelwood Mine Fire Inquiry Report, the Board commends the State for prioritising the Latrobe Valley for funding under the *Healthy Together Victoria* program.[44] *Healthy Together Victoria* is a jointly funded program by the Commonwealth and State Governments under the *National Partnership Agreement for Preventive Health*.[45] *Healthy Together Victoria* is a state-wide initiative that was implemented in the Latrobe Valley under the title *Healthy Together Latrobe*. It fostered the development of initiatives to address causes of poor health in community settings, including children's settings, schools and workplaces.[46] *Healthy Together Latrobe* targeted health issues including obesity rates, consumption of alcohol and tobacco, low physical activity, and unhealthy eating.[47]

The Board was advised during the re-opened Inquiry that Commonwealth funding for *Healthy Together Victoria* has ceased.[48] The Board heard about the success of this program and received numerous submissions from local and state-wide organisations that identify *Healthy Together Latrobe* as a catalyst for change within the Latrobe Valley community.[49] In its written submission to the Board, Latrobe City Council states that the *Healthy Together* approach 'made a significant contribution in transforming health outcomes' in the Latrobe Valley.[50]

Members of the health behaviours expert panel emphasised the importance of ensuring that the legacy of *Healthy Together Latrobe*, described as a 'fantastic piece of architecture', is captured.[51] The panel also noted that changing health behaviours is complex and will require many actions that are mutually reinforcing, rather than expecting a single program to be a panacea for the health problems confronting the Latrobe Valley community.[52]

The expert panel on healthy workplaces advised the Board that one of the main learnings from the *Healthy Together Latrobe* approach has been the importance of leadership from managers and CEOs, as well as 'worker-led leadership.'[53] It was noted that businesses are well-placed to model good health leadership for the community and to support other workplaces to make health improvements.[54] The panel also advised the Board that creating healthy workplaces requires a long-term commitment, and that each workplace needs to map their own pathways towards this goal.[55]

The workplace as a key setting for implementing health initiatives is discussed further in section 5.3 below.

GENERAL PRINCIPLES FOR LOCAL ACTION TO SUPPORT HEALTHY LIVING

After reflecting on the *Healthy Together* program and other local health initiatives, three of the expert panels considering how healthy living can be promoted identified principles relevant to effective local action to achieve better health:

- Sustain action over time.[56]
- Invest resources for the long-term.[57]
- Build on good work that is already underway, including taking a systems approach (as occurred through the *Healthy Together Latrobe* program).[58]
- Learn from what other communities with similar challenges have done.[59]
- Engage the community in decision-making through processes such as participatory and deliberative democracy.[60]
- Recognise the significant assets that exist in the Latrobe Valley, in particular the natural environment.[61]

STATE-WIDE ACTION TO SUPPORT HEALTHY LIVING

Ms Jolly explained to the Board that a key to health improvement in the Latrobe Valley is to link local action more effectively with state-wide action.[62] She also explained 'touch points' to the Board—the notion that wherever people interact with a health service, they receive similar, reinforcing messages, for example, about quitting smoking or increasing physical activity.[63] This means that health service providers can capitalise on all opportunities where families make contact. She stated that such an approach requires agencies to work well together, as well as upskilling health providers.[64]

The expert panel on health behaviours also highlighted the *Healthy Together Achievement Program* as an example of local and state action, and noted that this action needs to be sustained.[65] *Healthy Together Achievement Program* was previously part of the *Healthy Together Victoria* initiative, and continues to be delivered by the Cancer Council.[66] *Healthy Together Achievement Program* provides frameworks to support health and wellbeing promotion in schools, early childhood services and workplaces. The frameworks are based on the World Health Organization's models for health promotion in schools and workplaces.[67]

Ms Alison Skeldon from Latrobe Community Health Service, and a member of the health behaviours expert panel, outlined the Latrobe Valley *Health Champions* program for the Board, developed as part of *Healthy Together Latrobe*. This program involves approximately 156 trained and registered 'health champions' who act as ambassadors for change in their everyday work and community environments.[68] The panel noted that in the future this work could be strengthened by developing peer support components.[69]

Ms Skeldon also described the *Foodcents* program run by the Latrobe Community Health Service. This program involves delivering three sessions to parents at primary schools. The sessions cover budgeting, shopping and a cooking session. Ms Skeldon told the Board that there is evidence to indicate that this program leads to an increase in the amount of fruit and vegetables consumed by participants and their families. Ms Skeldon told the Board that there is potential to extend access to this program extended across the community through, for example, delivering it at the neighbourhood house. It was noted, however, that the program requires participants to have a minimum level of numeracy and literacy.[70]

Ms Jane Martin from the Obesity Policy Coalition discussed how state-wide campaigns can be used by local health practitioners to promote physical exercise and healthy eating. The *LiveLighter* state-wide campaign encourages people to improve their nutrition, be physically active and maintain a healthy weight. This includes a focus on reducing sugary drink consumption. Although this is a television campaign, information and supporting materials about the campaign are circulated to local general practitioners to encourage them to have a discussion with their patients about diet. These messages are then reinforced when people are exposed to the campaign in other community spaces.[71]

The Board also heard about opportunities for future collaboration between state and local governments. Dr Bruce Bolam from VicHealth, noted that the Inquiry itself had already prompted VicHealth to think about how it can better support health improvements in the Latrobe Valley.[72]

MENTAL HEALTH

The expert panel on mental health discussed the need to build mental health literacy and capacity in the Latrobe Valley community in the short, medium and long-term.[73] The panel suggested that this should occur across the community and with industry, schools, health services, community organisations and spiritual organisations.[74] The panel directed the Board to a number of evidence-based programs, such as *Mental health first aid*, *Teen mental health first aid*, and other applied suicide intervention skills training. The panel also recommended school-based programs such as *KidsMatter*.[75] In its written submission to the Board, beyondblue also recommends *KidsMatter* and *MindMatters* and advises that it has already delivered these programs in a number of schools in the Latrobe Valley.[76]

KidsMatter was developed by beyondblue, the Australian Psychological Society, Early Childhood Australia and Principals Australia, with funding from the Commonwealth Government Department of Health and beyondblue.[77] It is a mental health promotion, prevention and early intervention initiative targeted to primary schools and early childhood education and care services. It seeks to build partnerships within the health and community sector to further support these institutions. *KidsMatter* provides a framework for educators, carers and parents to work together to support the social and emotional wellbeing of children. There are four focus areas of the program: to create positive school and early childhood communities; teaching children skills for good social and emotional development; working together with families; and recognising mental health issues in children and accessing the necessary help.[78] The foundation for the *KidsMatter* framework is described as recognising the 'troubling rates of mental health difficulties among children' and acknowledging that nearly half of all mental illness begins before the age of 14. The program also seeks to increase access to mental health services for primary-school aged children suffering from mental health conditions.[79]

MindMatters is based on a similar framework, and is aimed at secondary school students. It was commissioned by the Commonwealth Government Department of Health and beyondblue with support from Principals Australia.[80] The latest research and evidence-based strategies are available on the *MindMatters* website and are free for schools to utilise.[81] The program enables schools to build their capacity to meet the unique needs of the school community, including staff, students and families, around mental health and wellbeing. The *MindMatters* website notes that a successful whole school mental health strategy leads to improved academic results; fewer behavioural issues; greater student, staff and family engagement in school activities; better student and staff retention; and a positive school culture.[82]

SMOKING CESSATION

In its submission to the Board, Quit Victoria recommends the following strategies to reduce smoking within a population:

- Mobilise the local health and community sector

- Engage and involve multiple components of the community

- Build capacity in existing health and community services

- Enhance access to existing evidence-based interventions.[83]

In a feedback session with the Board, Mr Luke Atkin, from Quit Victoria and a member of the health behaviours panel, explained that research demonstrates that people want to quit smoking, however they need support to achieve that goal. He described a number of ways this support can be offered, including:

- leveraging existing local health services

- having people, such as health champions, as advocates for quitting

- utilising state-wide supports, such as Quitline, to provide co-managed care

- providing complementary state-wide messaging encouraging smoking cessation.[84]

Mr Atkin suggested that approaching smokers and proactively offering to provide support to quit smoking, both through *Quitline* telephone support services as well as local community health services, could be an effective model for co-managed care.[85]

Mr Atkin acknowledged Latrobe Regional Hospital as a good role model for reducing smoking in the broader community, as it was one of the first health services in Victoria to go smoke-free. He submitted that efforts to promote quitting also need to be reinforced by ensuring smoke-free environments in places such as sporting clubs. Mr Atkin also reinforced the concept of 'touch points', to ensure that all services raise the possibility of quitting with any smoker that they come into contact with.[86]

5.3 SETTINGS FOR ACTION

In their expert report to the Board, Professor Evelyne de Leeuw, Director of Glocal Health Consultants, Editor-in-Chief of *Health Promotion International*, and the Director, Centre for Health Equity Training, Research and Evaluation, University of New South Wales and Associate Professor Marilyn Wise, Associate Professor, Centre for Primary Health Care and Equity, University of New South Wales cite the *Ottawa Charter for Health Promotion*, which states that 'health is created and lived by people within the settings of their everyday life; where they learn, work, play and love.'[87] Taking action for better health in the places where people live is therefore a foundational principle of health promotion work.

ACTION IN SPORTS CLUBS

The expert panel on health behaviours advised the Board that sporting clubs are important settings for promoting overall health messages.[88] Mr Barry Switzer of Gippsport, and a member of the expert panel, described the changing nature of sport, whereby people are less interested in being part of a formal sporting club.[89] The panel brought the Board's attention to a new initiative by VicHealth, which is attempting to engage inactive people in sport. In this context, work is being done to re-orient traditional models of sporting clubs to encourage inactive members of the community to participate in sport into the future.[90]

Panel members also noted that sports clubs rely heavily on volunteers, however volunteer numbers are declining. The panel raised the possibility of sporting clubs engaging in a more diverse range of activities, such as providing community gardens, so that their role is more diverse and goes beyond providing sport for the community.[91]

The health behaviours expert panel described some of the initiatives in sports clubs that aim to create welcoming and inclusive environments and promote healthy behaviours, including providing a smoke-free environment, preventing violence against women, and advocating reduced consumption of alcohol and drug use.[92]

ACTION IN SCHOOLS

Ms Sally Richmond from DHHS, and a member of the expert panel on social disadvantage, advised the Board that the State has committed additional resources for helping children, with a new primary school to be built in Morwell, and additional funding to assist children requiring help at school and to strengthen the child and family services system.[93]

Board member Professor Catford asked the expert panel on health behaviours about possibilities for health action in schools, such as making fruit freely available to kids.[94] The expert panel was of the view that this type of approach will only work if it is part of a broader strategy for improving health through schools.[95]

The healthy environments expert panel also suggested building on the work of *Healthy Together Latrobe* by expanding kitchen garden programs to all schools and inviting parents to be involved,[96] and potentially connecting with other organisations such as senior citizen centres.[97] It was noted that expanding the program could have the benefit of supporting families to grow and eat healthy food, as well as providing a site for social connection.[98]

ACTION IN WORKPLACES

Concern was expressed in a number of written submissions to the Board about the health effects that the Hazelwood mine fire has had on people working in the Latrobe Valley at the time of the fire. Part 4.5 of the 2014 Hazelwood Mine Fire Inquiry Report provides a detailed overview of the immediate health effects of the mine fire.[99]

The Board received submissions advocating for the inclusion of workers who attended Morwell during the mine fire, including firefighters, in the Hazelwood Mine Fire Health Study.[100] The Board discusses this issue further in Part 3 of this report.

The Board was informed of the value of strengthening the health of the community through workplace-based health promotion initiatives. Many submissions noted that the workplace is a key setting for effecting change in the broader community.[101]

The expert panel on healthy workplaces advised the Board that making workplaces healthy is good for business and good for the community.[102] Mr Steve Rieniets of AGL Loy Yang, told the Board that workers' health 'doesn't start and finish at the gate.'[103] Workers take the benefits of a healthy workplace into their home life, which influences family members and the broader community. In this way, the workplace is 'a community resource, much broader than just the place of work.'[104]

The expert panel on healthy workplaces considered how a healthy workplace might be defined. They described a healthy workplace as one where both the physical environment and working conditions improve the health of workers.[105]

Panel member Mr Colin Sindall from DHHS, emphasised the significant role that managers play in creating a positive organisational culture, which can influence the health of workers. He advised that the National Institute for Health and Care Excellence in England has recently released guidelines on workplace policy and management practices, as workplace culture is known to fundamentally influence the health of employees.[106] Four of the 11 recommendations included in the guidelines focus on the role of managers and senior leadership in supporting healthy work environments and cultures.[107]

A strong theme emerging from the forums on healthy workplaces was that there has been much work already undertaken to improve worker health in the Latrobe Valley, and that this work provides a solid foundation to build upon.[108] Mr Sindall drew the Board's attention to the *Victorian Public Health and Wellbeing Plan 2015–2019*, which highlights the importance of improving the health of workers and identifies the need to build on experience from existing programs such as *WorkHealth* and the *Healthy Together Achievement Program*.[109]

Panel members provided feedback to the Board that *Healthy Together Achievement Program* is a valuable framework for making health improvements, as it considers culture and policies within workplaces, the physical environment, education, information and resources for workers, as well as connection with the broader community.[110] Panel members noted that workplaces need support to implement health and wellbeing programs, and therefore ongoing resourcing is required.[111]

Ms Angie Deegan from WorkSafe, and a member of the healthy workplaces expert panel, outlined WorkSafe's role in regulating occupational health under the *Occupational Health and Safety Act 2004* (Vic). She noted that it is a requirement under the Act that employers consult with workers if particular workplace issues impacting on workers' health are identified.[112] Ms Deegan provided an overview for the Board of *WorkHealth*, run by WorkSafe between 2008 and 2013.[113] Under this program, biomedical health checks were conducted for around 800,000 workers at workplaces across Victoria. The program also included the *WorkHealth Coach* initiative, where workers were supported to reduce their risk of chronic disease. *WorkHealth* grants were also made available to particular workplaces under the program, to support workplace health initiatives.[114]

Mr Sindall noted that a Ministerial WorkHealth Advisory Group has been established by the State, and is tasked with developing a strategy to improve the health of workers in Victoria.[115] The Advisory Group will build on the work of the former *WorkHealth* program.[116]

Some of the key findings of an evaluation of *WorkHealth* include:

- *WorkHealth* provided a first opportunity for many participants to take part in a comprehensive on-site health program.

- Workplaces that accessed *WorkHealth* grants were at least three times more likely to report changes to their workplace that improved healthy behaviours, workplace culture, morale and safety.

- 43 per cent of program participants were at medium risk of developing type 2 diabetes, 24 per cent at high risk of developing type 2 diabetes and 16 per cent at medium or high risk of developing cardiovascular disease.

- Modelling of the health outcomes of this initiative indicate a likely 10 per cent reduction in absenteeism and a 5 per cent reduction in injury rates that are compensable.[117]

A number of suggestions were made to the Board regarding short-term measures to improve health using workplace settings. The Victorian Chronic Disease Prevention Alliance suggests in its submission to the Board that risk awareness and health promotion programs that encourage people over 45 to visit their general practitioner for a comprehensive health assessment, be established in community settings, including in workplaces.[118] Organisations such as the Cancer Council have previously run successful workplace initiatives in the Latrobe Valley. The Cancer Council notes in its submission that in its *Healthy Together Achievement Program*, all six workplaces in the Latrobe Valley 'have shown progression on benchmarks that have included physical activity as a health priority, and are working towards making changes in this priority area.'[119]

A further idea that the expert panel on health behaviours put forward as a short-term option towards improving health is to establish the Latrobe Valley as a model of health promotion using publicly funded organisations as a setting to champion healthy eating, physical activity, and smoking cessation for their staff and visitors.[120] Dr Bolam suggested that while positive health behaviours can be promoted in workplaces, these initiatives need to be supported from the top down to ensure that employees are encouraged to engage in healthy practices throughout the work day and at home.[121]

Ms Martin provided a current example of this approach. Ms Martin described how the Alfred Hospital has changed the products available through its vending machines to discourage sugary drink consumption amongst its staff and visitors.[122] Ms Rhodes-Ward provided a further example, whereby the Latrobe City Council has created a catering framework so that council functions and events serve a greater proportion of healthy foods. This approach has been extended to Council-run children's services. Ms Rhodes-Ward advised that despite some resistance, these changes have made a difference. For example, children using these services are learning to grow vegetables and are very proud of their vegetable gardens.[123]

Ms Holly Piontek-Walker from DHHS, cited the state-wide *Healthy Choices* guidelines for hospitals and health services, and similar school canteen guidelines, as successful initiatives for supporting health improvements in a variety of settings. She also noted that local leadership is an important aspect of facilitating and sustaining such initiatives.[124]

AGL Loy Yang advised the Board that it regularly surveys the health of its employees and provides a range of programs to promote physical and mental health, such as free health assessments, flu vaccinations, exercise sessions and health awareness sessions, in addition to providing an onsite gymnasium.[125]

Another suggestion made was developing a wellbeing calendar with a focus on particular health information sessions available to businesses across the Latrobe Valley.[126] Initiatives such as these could reach a larger audience by prompting conversations that people then continue at home, recognising that 'what happens at home influences work and vice-versa.'[127]

The expert panel on healthy workplaces noted that the biggest challenge for promoting health through workplaces in the Latrobe Valley is that 75 per cent of workplaces are small businesses that have limited resources to engage with health and wellbeing initiatives. The panel noted that existing leadership forums conducted in the Latrobe Valley may provide an avenue for smaller business to learn about adopting positive health practices.[128]

Mr Alistair Edgar from Latrobe City Council, provided the Board with an overview of part of the work of *Healthy Together Latrobe* and in particular, efforts to improve fruit and vegetable consumption within workplaces. This involves workplaces assessing the food available in canteens, developing healthy catering policies, working with local cafés to make healthy catering easier, and looking at providing fruit and vegetable boxes for workers, amongst other activities.[129]

A further health initiative that was suggested for adoption by appropriate workplaces in the Latrobe Valley is *Think on your Feet*. This is a social marketing campaign that has been designed to motivate workers who sit for long periods to stand more often.[130] It has been trialled in some workplaces in the Latrobe Valley and is currently being developed for use in other workplaces in the future.[131]

5.4 SAFE AND SUPPORTIVE ENVIRONMENTS

The Board received submissions concerning the impact of physical and built environments on the health of the Latrobe Valley community. Submissions related to three main areas or themes: the physical characteristics of the built environment, such as public and private buildings and open spaces in Latrobe Valley towns; air quality and the community's proximity to Latrobe Valley mines; and ash residue from the Hazelwood mine fire remaining in the roof cavities of houses.

THE BUILT AND NATURAL ENVIRONMENT

The expert panel on health behaviours provided the Board with an overview of considerations relevant to improving natural and built environments in the longer-term. These included the need to consider changing physical infrastructure through urban planning, and creating places that enable and encourage people to be physically active.[132]

The panel on healthy environments considered strategies that could help Latrobe Valley residents to make the most of the natural environment in a way that would also improve their health. Panel members noted that whilst the Latrobe Valley does have natural assets, and other assets such as sporting facilities, these are not as well utilised as they could be.[133] The Board heard that one way to change this might be to strengthen the relationship between kids in schools and local sporting clubs—in particular, supporting

local clubs to address known barriers, such as the costs of participating in sport and having a means of transport to sporting venues, so that Latrobe Valley residents could better utilise these assets.[134]

The need to ensure that infrastructure such as walking paths and cycling tracks is built to support daily activity was also emphasised.[135] It was noted that encouraging older people to exercise more also requires having sufficient park benches and public toilets in and around walking tracks.[136] The panel advised that the current work of Latrobe City Council in developing a tracks, trails and paths strategy should be further supported.[137]

AIR QUALITY AND PROXIMITY TO MINES

Part 4.1 of the 2014 Hazelwood Mine Fire Inquiry Report provides an overview of the different environmental impacts that the Hazelwood mine fire had on the Latrobe Valley. The 2014 Hazelwood Mine Fire Inquiry Report provides a description of smoke, coal combustion, ash, and air quality standards.

In its submission to the re-opened Inquiry, the Latrobe City Council observes that:

> mining and power generation – particularly mining in close proximity to an urban area – can be seen to have negative impacts on lifestyle and amenity. While residents can learn to co-exist with such operations, the more that those operations intrude on the lives of those residents, the more resentful residents become. This in turn can lead to a diminishing of a community's ability to feel empowered and resilient.[138]

During community consultations and through written submissions, the Board heard concerns about the proximity of the coal mines and power stations to the community, and how this may have an adverse effect on health and wellbeing.[139] In its written submission to the Board, the Australian Medical Association Victoria states: 'Government needs to ensure that the environments within which we live are as healthy as possible.'[140]

The Victorian branch of the Australian Nursing and Midwifery Federation expresses concern that air pollution has adverse health effects on the community, even in the absence of fire:

> The risks withstood are not just those related to the exposure to harmful environmental factors arising from the 45 day fire causing a state of emergency, but also because of the ever present risks from harmful levels of air pollution due to proximity to the mining operations of the coal industry.[141]

The Climate and Health Alliance states in its submission that '[t]he risk of exposure to air pollution for people in the Latrobe Valley is both long and short term.'[142]

The Asbestos Council of Victoria expresses similar concerns regarding proximity, and suggests that there needs to be a long-term planning strategy implemented in the Latrobe Valley which includes:

- 'proper buffer zones' between residents and the coal mines being created
- restrictions placed on the development of areas (for residential or workplaces) with identified high pollution levels.[143]

Environment Victoria submits that regulations and standards must first be tightened for air quality to improve,[144] whilst Doctors for the Environment Australia suggest that any air monitoring systems established in the area should have the permanent capability of measuring $PM_{2.5}$ fine particulate matter and should be situated so as to enable measurement of the exposure of the population nearest the mine. It also suggests that the data from air monitoring systems be made available to the public and healthcare professionals in a timely and accessible format.[145]

Many of the submissions before the Board call for a shift away from the coal industry to other forms of renewable energy as a way of eliminating any detrimental environmental effects from coal-generated power on health.[146] The expert panel on healthy environments also noted that:

> …the Valley is going to need to go through an economic transition and I think now is the time to be planning for the economic transition, away from electricity generation into new sorts of energy generation…into other economic activities that people in the Valley can get involved with and that needs to be planned.[147]

These concerns are addressed in Part 7 of this report.

The Board heard mixed opinions with regards to air quality from the healthy environment expert panel. Dr Aberle stated that 'the four power stations in the Latrobe Valley are four of the five biggest emitters of $PM_{2.5}$ in the country' and that they 'are the sources of the air pollution that are potentially contributing to adverse health outcomes in the Latrobe Valley.'[148] He recommended that the Board consider options for reducing the levels of $PM_{2.5}$ in the Latrobe Valley based on the best available technology and consider undertaking an audit of measures already implemented.[149] He also asked the Board to consider the EPA approvals process for new sources of pollution, so that the total air quality when adding the new source is considered, given the cumulative effects.[150] Dr Aberle noted that work currently being undertaken to consider tightening standards at the national level should be continued, although action in Victoria should not be dependent upon national agreement.[151] Finally, he indicated that the lack of consequences for breaches of air pollution standards is a problem.[152]

In contrast, Mr Chris Webb from the EPA, assured the Board that air quality in the Latrobe Valley, (on average and not including the period of the mine fire) is good or very good 85 to 90 per cent of the time.[153] He noted that the EPA's approval process for new industries already considers the overall impact on air quality, but indicated that the issue of pushing industry to use improved technologies was a continual and long-term process.[154] Mr Webb also noted that although air quality is generally good in the Latrobe Valley, this is not the perception of people living there. There has been recognition of the need for greater community engagement in monitoring air quality, rather than simply communicating air quality data back to them.[155]

In order to provide the Board with advice about air quality in the Latrobe Valley, the EPA submitted further information to the Board following the Health Improvement Forums, including information regarding the emission contribution of various sources (see Figure 6). This information shows that, historically, air quality in the Latrobe Valley has generally been similar to air quality in Melbourne.[156]

Figure 6. Emission contribution to the Latrobe Valley air shed from industry and diffuse sources such as vehicles, wood-fires, windblown dust and bushfires.[157]
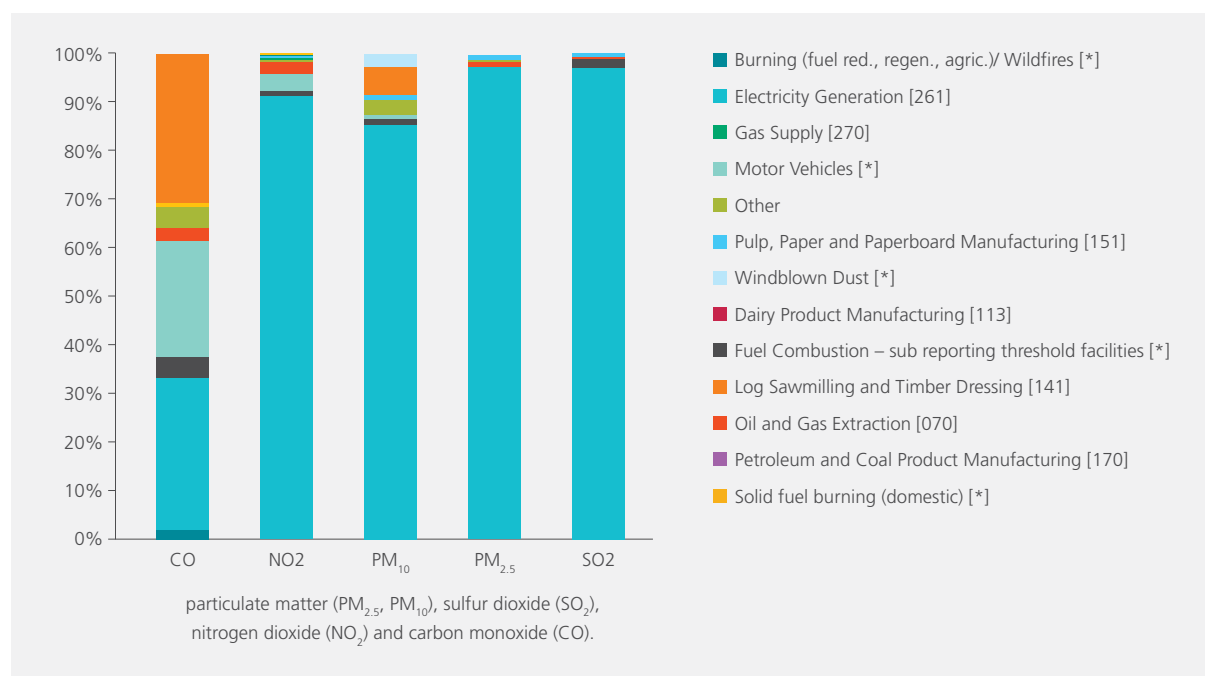
In relation to the question of engaging citizens on air quality issues, Ms Carolyne Boothman, from the Morwell & Districts Community Recovery Committee, gave a brief overview to the Board of the *Citizens' Science* program, which involves citizens in water sampling and air quality testing to try and build people's confidence and trust in the data and in the EPA.[158] The panel proposed the possibility of reporting on air quality data in the local paper,[159] noting that providing information on a website alone was insufficient to inform the community.[160] Further consideration of community engagement measures is explored in Part 7 of this report.

The expert panel also considered the role that Council Environmental Health Officers (EHOs) could play in supporting or connecting people to the *Citizens' Science* program, although they usually deal with domestic rather than industrial environmental matters.[161] Ms Helen Taylor from Latrobe City Council, and a member of the healthy environments expert panel, noted that it may be beneficial to upgrade the undergraduate training that EHOs have to include more content on air pollution monitoring, given that their involvement in this space is likely to increase.[162]

The panel discussed the State's new smoke health protocol, developed in response to the 2014 Hazelwood Mine Fire Inquiry.[163] The Board has been provided with a copy of the unsigned *Community Smoke, Air Quality and Health Protocol* dated 29 July 2015 which 'provides direction for the protection of community health in response to smoke events resulting in significant levels of fine particles in the outdoor environment' for the purpose of protecting community members rather than emergency responders. The protocol records that it is an updated version which combines the *Hazelwood Coal Mine Fire PM$_{2.5}$ Health Protection Protocol* (Department of Health 2014) and the *Bushfire Smoth, Air Quality and Health Protocol* (Department of Health & EPA, 2014).[164] The panel noted that, with regard to fires or planned burns, the biggest issue was not just having a policy in place, but communicating this policy effectively to the community.[165] Effective communication with the community is discussed further in Part 7 of this report.

ASH RESIDUE IN ROOF CAVITIES OF HOUSES

During community consultations and throughout submissions provided to the Board, a large number of people and organisations expressed concern about ash residue from the Hazelwood mine fire remaining in the houses of Morwell residences. Ms Anne Horrigan-Dixon and Ms Marilyn Dawson from Melbourne, local Latrobe Valley residents Ms Julia Browell and Ms Wendy Farmer, and Ms Grace FitzGerald, a Monash University medical student, all made calls for the residue to be removed as a priority.[166]

In her written submission, Ms Deearne Nicholson, a resident of the Latrobe Valley, cites data about ash samples that were tested by the EPA during the mine fire.[167] This data appears to show levels of aluminium, barium, iron, titanium and other trace minerals, with no clear guidance as to whether these are hazardous. Ms Nicholson suggests that this data goes some way to explaining the concern regarding the ash that remains in roof cavities.[168]

In its submission to the Board, Quit Coal states that:

> many residents we spoke with still have coal ash in the cavity of their roof, meaning they remain exposed to the risk of contact and breathing in this pollutant. Given the toxic metals contained in coal ash, we put it to the Inquiry that all residents should be assisted in having this ash removed.[169]

The Board notes that the Centre for Air Quality and Health Research and Evaluation has provided a seed grant to Dr Fay Johnston, Menzies Institute for Medical Research, University of Tasmania, to undertake a study about exposure for polycyclic aromatic hydrocarbons and metals in residential dust and soil resulting from the Hazelwood mine fire smoke plume. The study will analyse vacuum dust and soil samples from homes at increasing distances from the Hazelwood mine.[170]

The matter of ash residue remaining in roof cavities, in addition to being the subject of many submissions, was also a matter of discussion for the healthy environments expert panel. The panel advised the Board that many of the houses in Morwell, particularly those south of Commercial Road, have ash residue in their roof cavities, and that this is a cause of concern for the community. More recent reports indicate that when this ash residue becomes wet, it grows mould, potentially creating further structural and health issues.[171]

There was some agreement amongst the expert panel that the best approach to ash residue is to undertake an audit of the extent of the issue, along with further analysis of the residue.[172]

5.5 PRIORITY POPULATIONS FOR ACTION

The Board was presented with information about priority populations that should be targeted for promotion of healthy living and health initiatives.

CHILDREN AND YOUNG PEOPLE

In the 2014 Hazelwood Mine Fire Inquiry Report, the Board notes:

> The Australian Early Development Index, a measure of how young children are developing in communities, demonstrates that prior to the Hazelwood mine fire, the children of Morwell were functioning below the state average in five key areas: physical health and wellbeing, social competence, emotional maturity, language and cognition skills, and communication skills and general knowledge. As a result, the children of Morwell were particularly vulnerable to the potential adverse effects of smoke and ash from the mine fire.[173]

In the re-opened Inquiry, the Board again heard that the trends in health and wellbeing of children are of concern to the wider community.

A large number of organisations highlight the health of children in their submissions. The Victorian Healthcare Association notes that the Gippsland region has a 'higher percentage of children vulnerable in one or more domains'.[174] In its submission, the Cancer Council notes the importance of promoting nutrition and physical activity when considering improvements to children's health and wellbeing.[175]

The Victorian branch of the Australian Nursing and Midwifery Federation recommends that an emphasis be placed on targeting the health and wellbeing of newborns and children.[176] The Public Health Association of Australia submitted that 'the provision of additional learning programs, and educational opportunities to minimise potential degradation in scholastic achievement' is needed.[177]

Dr Joanna McCubbin, a paediatrician and environmental medicine teacher based in Sale, notes in her submission that the short-term deployment of paediatricians from Melbourne is not a long-term solution to children's health needs, and that a permanent presence is required to monitor ongoing health concerns. She further submits that a range of other service providers are needed to address issues with children and youth including 'public health specialists, statisticians, toxicologists, paediatricians, [M]aternal and Child Health nurses, psychologists, teachers.'[178]

From the outset, the expert panel on children and youth considered some of the significant demand pressures on the care system in the Latrobe Valley. These include:

- increasing child protection and family violence reports

- an over representation of Aboriginal children in out-of-home care

- late referrals to specialists, resulting in missed opportunities for early intervention in relation to more significant health issues.[179]

There is a need for families with particular vulnerabilities to be identified early and provided with support.[180] The expert panel outlined some of the barriers to the sharing of information across organisations that provide services to children, which lead to families having to repeat their story several times.[181] Two models have been trialled in Victoria which can assist in addressing these issues—*Services Connect*, which uses a key worker model to assist people dealing with complex issues;[182] and *Patchwork*, which is an electronic system that attempts to make information on services available to parents in one place.[183]

The issue of service access has also been considered by a number of expert panels, with some issues—such as the need to travel long distances to specialist appointments—common across discussions.[184] Of particular consideration for children is the need to work through trusted service providers who have contact with the family. Enhanced maternal and child health services were noted as having close relationships with families that can enable nurses to link the family to additional health services. The enhanced maternal and child health services are well placed to link vulnerable children and families to other service providers, such as *Child FIRST*, which are specifically designed to provide longer-term support for families.[185] The panel noted that there was additional funding announced in the 2015–2016 state budget to extend services provided under *Child FIRST* to the Latrobe Valley.[186]

Ms Sally Richmond from DHHS, also mentioned the State's reform agenda for the child and family service system called *The Roadmap for Reform: Strong Families, Safe Children*. This is a long-term reform agenda that seeks to improve the service system, including child protection, out-of-home care and early intervention services.[187]

The expert panel on children and youth reiterated that long-term change requires sustained effort and funding, along with evaluation, as addressing the underlying social determinants of children's health takes time.[188]

The Board was advised that school health and wellbeing committees, established through the *Healthy Together Achievement Program,* can enable students to take control of their own health by working through the program with students.[189] Ms Claire Watts from the Latrobe Valley Community Health Service, and a member of the expert panel on children and youth, recommended that school nurses be better utilised to undertake health screening for children, which could potentially assist in reducing waiting list times for accessing specialists.[190]

The panel noted that if children can be supported to engage with their health, they can take this knowledge back to their families and community.[191] Dr Cathy McAdam from Monash Health supported the notion of engaging children in tasks on the proposed screening day discussed in Part 4 of this report, as it will encourage parents to come along as well.[192]

The expert panel discussed a number of other matters relating to health services that are considered in Part 4 of this report. With regards to the discussion on general practices and service delivery, Dr McAdam advised the Board that the expert panel is supportive of co-locating general practitioner services with other services, for example placing general practitioners and maternal and child health services alongside kindergarten programs and early intervention programs.[193]

WORKERS

The expert panel on healthy workplaces discussed medium and long-term considerations relating to workers, and recognised that these needed to focus on the changing requirements industry will have of workers over the next 10–20 years. Recent reports cited by the panel identify that major trends, such as the automation of industries, technological advancements and globalisation, mean that workers of the future will be undertaking less manual work.[194]

Given this, the expert panel discussed the need for the next generation of workers to be trained in new skills, including social and emotional learning skills.[195] It was suggested that revitalising the Latrobe Valley Transition Group might be a way to progress this.[196] The panel noted that with the changing nature of work, those with lower levels of education from low socioeconomic areas will be most at risk of missing out in the future, and that these groups need to be considered as a priority.[197] It was suggested that further analysis of future employment needs and skill gaps in the Latrobe Valley may assist.[198]

The panel noted that consideration of employment transition and economic development in the Latrobe Valley also presents new opportunities around achieving health and wellbeing benefits: if health outcomes are prioritised in these discussions, economic development might facilitate healthy, productive workplaces in the Latrobe Valley.[199] These issues are discussed further in Parts 6 and 7 of this report.

5.6 BOARD'S CONSIDERATION AND PROPOSALS

ACTION TO SUPPORT HEALTHY LIVING

The Board strongly supports the principles devised by the expert panels relevant to promoting healthy living. These include: learning from others; building on the assets of the Latrobe Valley; and engaging leadership at all levels. The Board considers that these principles will assist in achieving health improvements for the Latrobe Valley.

The Board considers that sustained action and the investment of additional resources are required to embed a culture of healthy living in the Latrobe Valley. The Board notes that the *Healthy Together Latrobe* program sparked action at the community level and that the community can see this action starting to make a positive difference.

The Board considers that targeted action to support healthy living, consistent with the action that was initiated through *Healthy Together Latrobe*, needs to continue for the full benefits of the work already undertaken through that program to be realised. The Board proposes that this work be strengthened by incorporating a focus on reducing health inequities.

The Board considers that, in order to continue this health promotion effort commenced under *Healthy Together Latrobe*, a well-resourced local health promotion team is fundamental. The Board considers that at least the same amount of funding that was in place under the *Healthy Together Latrobe* program should be provided for local health promotion action. This should focus on the initiatives that are described in this Part and supported by the Board, in partnership with the community.

Programs such as *Healthy Together Achievement Program* and those undertaken by workplaces such as AGL Loy Yang, may be a starting point for improvement in the health of a workplace and the wider community.

The Board suggests that the local health promotion team continue to support local action on nutrition and physical activity in settings such as early childhood services, schools and workplaces. This would include action to:

- implement the *Healthy Together Achievement Program*
- strengthen the *Health Champions* program
- reduce sedentary behaviour
- reduce sugary drink consumption
- strengthen kitchen garden programs in schools
- extend kitchen garden programs into the broader community.

In addition, the local health promotion team should expand prevention activities into drug and alcohol misuse.

The Board agrees that local action of this nature is strengthened when supported by complementary state-wide efforts. The Board affirms the commitment of the State, VicHealth, WorkSafe and relevant state-wide organisations to continue support for local action through policies, plans, infrastructure, programs, campaigns, training, research and evaluation – recognising that for action to be effective it needs to be community-led as much as possible. The Board considers that VicHealth, given its remit as a state-wide health promotion foundation, should consider funding staff positions or secondments to support the Office of the Health Advocate (see Part 8).

The Board's recommendations regarding funding for health initiatives in the Latrobe Valley, and the mechanisms for ensuring local control, community engagement, and sustainable funding, are also discussed in Part 8.

MENTAL HEALTH AND FAMILY VIOLENCE

The Board is very concerned about the prevalence of mental health issues in the Latrobe Valley and also the high rates of family violence in the community.

The Board notes that support services for family violence victims are at capacity and that there are currently a lack of resources available to meet the needs of the community in the Latrobe Valley. The Board therefore supports measures to increase mental health and family violence services to ensure adequate support for those experiencing family violence.

The Board supports VicHealth's *Generating Equality and Respect* program and suggests that this model be used to develop a program to address the prevention of family violence in the Latrobe Valley. The Board also commends the *VicHealth Mental Wellbeing Strategy 2015–2019.* The Board considers that this strategy could also be a useful basis for developing a local program in the Latrobe Valley.

The Board commends beyondblue for developing its programs *MindMatters* and *KidsMatter* and for undertaking training in mental health in the Latrobe Valley. The Board encourages beyondblue to work in partnership with the Latrobe Valley to further develop its programs. The Board also encourages the State to give consideration to ensuring that mental health literacy programs are implemented in all Latrobe Valley schools.

The Board is aware that the Victorian Royal Commission into Family Violence has considered issues relevant to family violence in detail, and will hand down its report and recommendations shortly. The Board is of the view that any program and funding to address family violence in the Latrobe Valley should take into consideration the report and recommendations made by the Royal Commission.

> The Board recommends that an initial health improvement program is focused on innovative ways to deliver services for the promotion of mental wellbeing, including the prevention of family violence.

SMOKING CESSATION

The Board notes the strong and consistent recommendations through submissions and the Health Improvement Forums for further action to be taken to support people in the Latrobe Valley to quit smoking. The Board also notes the advice from the expert panel on early detection and high risk screening, outlined in Part 4 of this report, that the most cost-effective intervention for improving respiratory health (and for health generally at a broader level) in the Latrobe Valley is smoking cessation programs.[200]

The Board accepts that the community's health would be significantly improved with a reduction in smoking rates. The Board considers that this is an area for priority action in delivering health initiatives in the Latrobe Valley. The measure should:

- Engage the community and local health professionals in developing an innovative and comprehensive initiative.

- Mobilise the local health and community sectors to encourage people—particularly those in disadvantaged groups—to quit and direct them to state and local supports.

- Build in local support for people's quit attempts through a range of strategies, such as peer support for people wanting to quit, and easy access to general practitioners and pharmacists for nicotine replacement therapy.

- Involve a local media campaign, consistent with state-wide media, relating to the specific need for Latrobe Valley residents to quit smoking.

- Engage settings in continuing to expand smoke free venues and events.

> The Board recommends that an initial health improvement program is focused on innovative ways to deliver smoking cessation programs which are effective for priority groups.

SAFE AND SUPPORTIVE ENVIRONMENTS

The Board affirms the Latrobe City Council's intention to develop a tracks, trails and paths strategy to create supportive environments for physical activity and community engagement. The Board suggests that this strategy be consistent with the health initiatives to be implemented by a local health promotion team, as noted above.

The Board notes the mismatch between community experience and understanding of air quality in the Latrobe Valley, and statements from the EPA that air quality in the Latrobe Valley is usually good.

The Board encourages the EPA and mine operators to engage with the community more actively and effectively to ensure that the Latrobe Valley community understands and trusts the monitoring of air quality in the Latrobe Valley.

Consideration should be given to enhancing the *Citizens' Science* program and to reconsidering the role of Environmental Health Officers, to support and increase community understanding of air quality monitoring.

The Board further considers that, in line with the designation of the Latrobe Valley as a Health Innovation Zone (see Part 8), Latrobe Valley mine operators should lead the way in implementing the best available technology to reduce emissions.

The Board acknowledges the significant distress that ash residue remaining in the roof cavities of houses in Morwell is continuing to cause for many members of the Latrobe Valley community. The Board acknowledges that whilst some testing of ash occurred during the Hazelwood mine fire, the content and toxicity of the ash residue in roof cavities is not known at the time of writing. The Board notes that while the University of Tasmania is undertaking analyses of dust and soil samples, it is not clear whether (and if so, when) the results of the analyses will be published. The Board considers that the issue about potential ongoing exposure to pollutants from the mine fire should be addressed by the State now.

> **The Board recommends that the State ensure that ash contained in roof cavities in Morwell is analysed and acted on.**
>
> The State should:
>
> - Commission an analysis of the ash contained in roof cavities of houses in Morwell and publish the results of that analysis to the community and Latrobe Valley Health Assembly, together with clear advice about the potential known, or unknown health effects.
>
> - If the analysis of the ash residue in roof cavities reveals any content that is potentially hazardous to health or of unknown impact on health, conduct an audit of the extent of the exposure to ash and develop an action plan to remove the ash from all affected houses.

CHILDREN AND YOUNG PEOPLE

The Board considers that the future improvement of the health of the Latrobe Valley depends on the wellbeing of Latrobe Valley children. In many of the Health Improvement Forums, the sentiment expressed was that improvement in the health of children would lead to an improvement in the health of the rest of the community.

The Board considers that particular attention should be given to children and young people when developing a roadmap for health improvements.

The Board notes that funding has been allocated for a new school in Morwell. The Board considers that the building of this school presents an opportunity for the State to consider carefully some of the suggestions in this report, such as incorporating space for a kitchen garden that can also be used by the community, and co-location of children's health services. For example, the new school could include facilities for paediatricians and maternal and child health nurses, making this a central service and community hub for families.

The Board notes that there are a significant number of children in the Latrobe Valley who are subjected or witnesses to family violence. The Board has heard that family violence is associated with poorer mental health, and that there are higher incidences of family violence and mental health issues in the Latrobe Valley. Accordingly, the Board considers that improvements in family violence will likely bring about an improvement to the mental wellbeing of children and youth in the Latrobe Valley.

PART SIX
REDUCING HEALTH INEQUITIES

PART 6 REDUCING HEALTH INEQUITIES

This Part considers how social disadvantage impacts on the health of Latrobe Valley communities, and the potential measures to improve health equity and therefore health outcomes in the Latrobe Valley. Given that Aboriginal people experience significant overall health inequities and a life expectancy of some 10 years less than non-Aboriginal people,[1] this Part has a particular focus on the health and wellbeing of Aboriginal people in the Latrobe Valley.

This Part was informed by the community through consultations and written submissions, and by two Health Improvement Forums convened to consider social disadvantage and Aboriginal health.

The members of the expert panel on social disadvantage were Ms Sally Richmond from the Department of Health and Human Services (DHHS); Ms Kellie Horton from the Victorian Health Promotion Foundation (VicHealth); Ms Mary Sayers from the Victorian Council of Social Service (VCOSS); Mr Steve Tong from the Latrobe City Council; Professor Evelyne de Leeuw, Director of Glocal Health Consultants, Editor-in-Chief of *Health Promotion International,* and the Director, Centre for Health Equity Training, Research and Evaluation, University of New South Wales; and Ms Jayne Gallo from the EW Tipping Foundation.

An informal consultation with Latrobe Valley Aboriginal community members was held at Ramahyuck Aboriginal Health Service in Morwell on 18 August 2015. Subsequently, a Health Improvement Forum on Aboriginal health was held in Morwell. This forum was conducted less formally than other Health Improvement Forums. Rather than being led by an expert panel, community members were invited to share their views directly with the Board. In adopting a more informal approach, the Board aimed to promote open and frank discussion amongst community members.

In attendance at the Health Improvement Forum on Aboriginal health were representatives from Ramahyuck District Aboriginal Corporation; the Victorian Aboriginal Community Controlled Health Organisation (VACCHO); the Victorian Aboriginal Legal Service; and DHHS. A representative of VACCHO made an oral presentation to the Board that was subsequently provided to the Board as a written submission on behalf of VACCHO. Other members of the Latrobe Valley Aboriginal community participated in the Aboriginal health panel and the informal consultation on the basis that their contributions were anonymous. For this reason, these community members have not been named.

6.1 SOCIAL DISADVANTAGE AND HEALTH

The social conditions that impact on health are often referred to as the 'social determinants of health'.[2] The World Health Organization defines social determinants of health as:

> The conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries.[3]

The Board heard that social disadvantage is an underlying determinant of health and health inequity, and is closely linked to an individual's health outcomes.[4] In their expert report to the Board, Professor Evelyne de Leeuw, Director of Glocal Health Consultants, Editor-in-Chief of *Health Promotion International,* and the Director, Centre for Health Equity Training, Research and Evaluation, University of New South Wales, and Associate Professor Marilyn Wise, Centre for Primary Health Care and Equity at the University of New South Wales, discuss the relationship between social determinants and health inequities, and the way in which health equity can be achieved by addressing social disadvantage.[5]

The Board was advised that health inequities exist within the Latrobe Valley and between the Latrobe Valley and other parts of Victoria, and that these inequities contribute to the poor health of the Latrobe Valley.[6]

UNDERSTANDING SOCIAL DISADVANTAGE IN THE LATROBE VALLEY

The 2014 Hazelwood Mine Fire Inquiry Report outlines the greater social and economic challenges confronting the Latrobe Valley relative to other areas of Victoria.[7] During the re-opened Inquiry, a number of submissions commented on the socioeconomic circumstances of the Latrobe Valley and the connection of these circumstances with poorer health outcomes.[8]

In its submission to the Board, VicHealth states that:

> the Latrobe Valley area has higher levels of socioeconomic disadvantage compared to the Victorian average. Morwell has recently been identified as one of the most socioeconomically disadvantaged postcodes in Victoria, and has been consistently reported among the most disadvantaged populations in previous research.[9]

The expert panel on social disadvantage told the Board that the 'pathways to poverty and disadvantage are very complex and solutions are not simple' and that Morwell in particular, 'has a pattern of deep and entrenched and persistent disadvantage.'[10] The panel also noted that disadvantage in the Latrobe Valley community can be inter-generational (experienced across generations).[11]

In its written submission, VicHealth identifies some of the key indicators of disadvantage within the Latrobe Valley region (see below Table 5).[12] VicHealth notes that these indicators may have worsened since the mine fire.[13]

Table 5. Key indicators of disadvantage[14]

Indicator	Latrobe	Victoria
Unemployment rate (2015)	6.9% (12.5% in Morwell)	6%
Medium weekly household income (2011)	$942	$1,216
Percentage of population who did not complete year 12 (2011)	62.4%	43.7%
Percentage of population with higher education qualification (2011)	24.8%	45.7%
Food insecurity (2011)	7.2%	4.6%
Total criminal offences per 1,000 population (2013/14)	138.5	74.9

In its submission to the Board, Victorian Council of Social Service states that:

> [s]ignificant service gaps in public housing, drug and alcohol services, dental services, accommodation for people with mental health issues, youth services, child protection, and other areas prevent [the Latrobe Valley] from addressing the causes and impacts of disadvantage.[15]

In their expert report to the Board, Professor de Leeuw and Associate Professor Wise state that '[t]he social and economic disadvantages experienced by the residents of the Latrobe Valley are strongly, positively associated with poor health and premature death.'[16] Figure 7 demonstrates that the lower a person's household income, the higher the likelihood that they will have a chronic disease.

Figure 7. Social gradient for four disease groups presented by Rebecca Vassarotti (2013)[17]
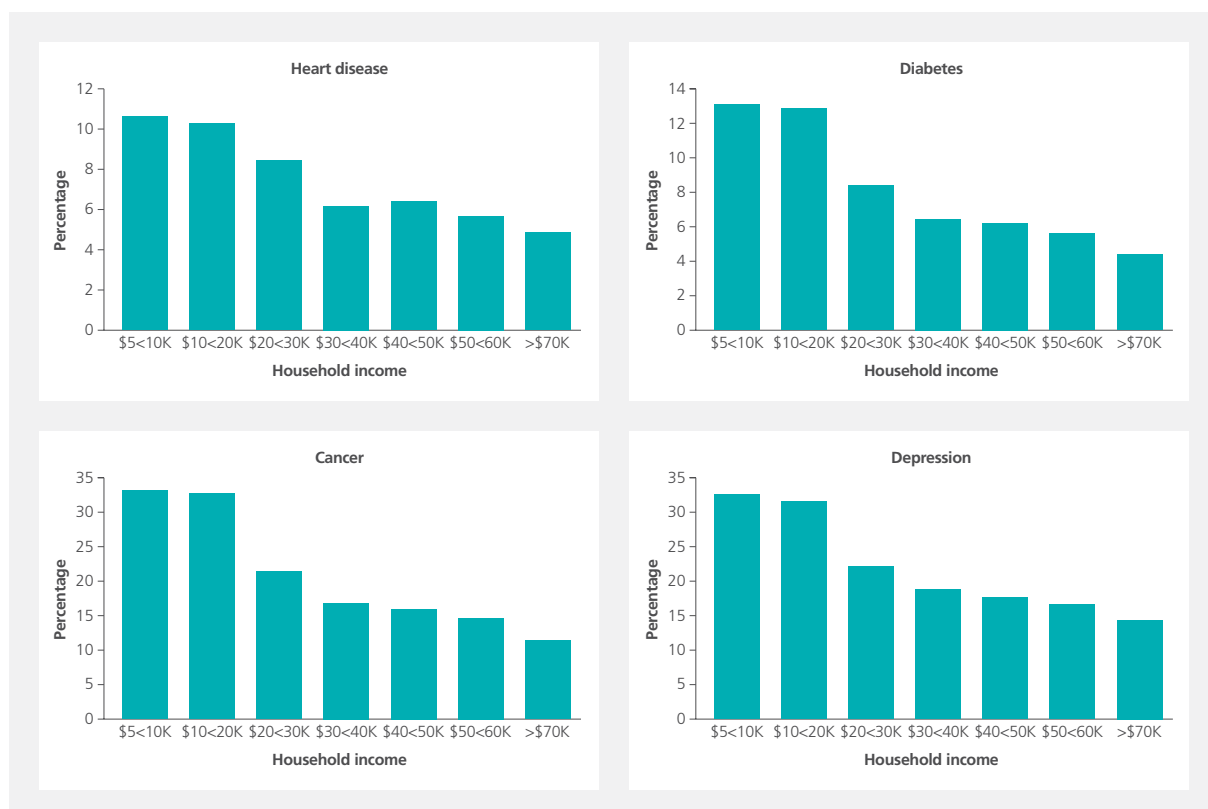
CHANGING SOCIAL DISADVANTAGE

In their report, Professor de Leeuw and Associate Professor Wise state that the social determinants of health are amenable to change, and they point to research demonstrating the interrelation between policies that strive to:

- Give every child the best start in life
- Enable all children, young people and adults, to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention[18]

In its submission, VicHealth refers to a framework it has developed, titled *Fair Foundations: The VicHealth framework for health equity,* to guide policy and practice to promote health equity (see Figure 8). The framework promotes understanding of the social determinants of health and offers 'entry points for action'.[19] The framework recognises four levels of influence that impact on health outcomes, such as life-expectancy, and mortality and morbidity rates.[20] These are:

- Socioeconomic, political and cultural contexts: the influence of governance and policy, and the dominant societal norms and values that can influence daily living conditions.
- Social position: key markers of social position include education, occupational status, income, gender, race/ethnicity, Aboriginality and disability.
- Daily living conditions: these impact on an individual's material circumstances, psychosocial control and social connections, and either protect or damage their health.
- Individual health-related factors: people's health-related knowledge, attitudes and behaviours.[21]

Figure 8 below illustrates the influence of these factors on health and wellbeing outcomes.

Figure 8. Fair Foundations: The VicHealth framework for health equity adapted from Fair Foundations [22]

DIFFERENCES IN HEALTH AND WELLBEING OUTCOMES

• **Life expectancy** • **Mortality rates** • **Morbidity rates** • **Self-rated health status**

Differential health and wellbeing outcomes are seen in life expectancy, mortality rates, morbidity rates and self-rated health. These differences are socially produced, systematic in their distribution across the population, avoidable and unfair.

SOCIAL POSITION

INDIVIDUAL HEALTH-RELATED FACTORS

• **Knowledge** • **Attitudes** • **Behaviours**

Examples of action

• Smoking cessation programs that are tailored to particular consumer needs and supported by other strategies such as restrictions on tobacco advertising, availability and smoke-free area policies

Prompts for planning

• What are the social variations in knowledge, attitudes and behaviours of interest? What additional individual level supports are needed?

SOCIAL POSITION

DAILY LIVING CONDITIONS

• **Early child development** • **Education** • **Work and employment**
• **Physical environment** • **Social participation** • **Health care services**

Examples of action

• Primary health care – socially appropriate, universally accessible, evidence-based first level care that gives priority to those most in need; maximises community and individual participation and control; and involves collaboration and partnership with other sectors to promote public health

Prompts for planning

• How could you improve the quality of people's daily living conditions?

SOCIAL POSITION

• **Education** • **Occupation** • **Income** • **Race/ethnicity**
• **Gender** • **Aboriginality** • **Disability** • **Sexuality**

The socioeconomic, political and cultural context creates a process of social stratification, or ranking, which assigns individuals to different social positions. The process of stratification results in the unequal distribution of power, economic resources and prestige.

Examples of action

• Constitutional recognition of Indigenous Australians

Prompts for planning

• Which cultural and societal norms and values generate or perpetuate social hierarchies by favouring, advantaging, excluding or degrading some people or groups? Where do these norms and values come from? How could they be challenged or changed?

• How could you meaningfully engage affected groups, to build capacity and advocate for change?

SOCIOECONOMIC, POLITICAL AND CULTURAL CONTEXT

• **Governance** • **Policy** • **Dominant cultural and societal norms and values**

JOINT RESPONSIBILITIES AND RESOURCING

In their expert report to the Board, Professor de Leeuw and Associate Professor Wise also point to evidence indicating that, in addition to the benefits to people's health and wellbeing, taking action to improve the social determinants of health equity can have significant financial benefits.[23] At a national level, the projected cost savings include:

- 170,000 extra Australians could enter the workforce, generating $8 billion in extra earnings
- annual savings of $4 billion in welfare support payments
- 60,000 fewer admissions to hospital annually, resulting in annual savings of $2.3 billion
- 5.5 million fewer Medicare services annually, resulting in annual savings of $273 million
- 5.3 million fewer Pharmaceutical Benefits Scheme (PBS) scripts being filled annually, resulting in annual savings of $184.5 million.[24]

International evidence also demonstrates the significant cost of health inequities, and therefore the potential savings if health inequities are addressed. A review of 25 European countries found that health inequity accounted for up to 20 per cent of total healthcare costs.[25]

The expert panel on social disadvantage noted that there have been recent funding cuts in relation to emergency relief, financial counselling, child and family services, and the *Youth Connections* program, which provided intensive case management to disengaged young people to assist them to get back to education or work.[26] This program had a 93 per cent success rate.[27] The Board heard that the loss of funding is felt acutely, as reduced resourcing for services puts additional pressures on disadvantaged community members who utilise these services.[28]

The factors that impact on health equity are often outside the immediate control of the local community, and mitigating social disadvantage is an endeavour shared by Commonwealth, state and local governments.[29] Further discussion about health funding and governance structures, and the interplay between stakeholders, can be found in Part 8.

6.2 ADDRESSING THE SOCIAL DETERMINANTS OF HEALTH EQUITY

A consistent message that the Board heard was that measures to improve social disadvantage need consistent and long-term effort, and increased resourcing.[30] The Board also heard that focusing only on the disadvantage confronting the Latrobe Valley is disempowering, and that measures to improve health must also be positive and build on the assets of the Latrobe Valley.[31]

EDUCATION

The Board heard that access to education was a significant issue for the Latrobe Valley community. The expert panel on social disadvantage described several factors that are currently limiting the community's access to education, including: reductions in funding for education; changes to the vocational education and training sector; and challenges with getting transport to and from education centres.[32] The expert panel on children and youth also advised that children in the Latrobe Valley often start school developmentally behind their peers, when measured according to the Australian Early Development Index.[33]

Ms Sally Richmond from DHHS, highlighted a number of recent State announcements about additional investment in schools, including opening a new primary school in Morwell.[34] The Department of Education has also published its vision for Victoria as the 'Education State', with funding announced to support the education of children in out-of-home-care and to re-engage students who drop out of school and training.[35]

Ms Richmond told the Board that the *Roadmap for Reform: Strong Families, Safe Children* policy presents an opportunity to influence the way family and childrens services are delivered and to improve outcomes for those most disadvantaged.[36] The Roadmap will set out 'how the Victorian child and family service system can be improved to help prevent neglect and abuse, intervene early, keep more families together through crises, and secure better futures for children who cannot live at home.' The first stage of the *Roadmap for Reform* is due to be implemented in December 2015.[37]

The panel also reflected on the *Children and Youth Area Partnership*, which runs in Gippsland.[38] The Partnership looks at new ways of working at the local level, in particular by joining up local and state-wide services to more effectively support vulnerable children, young people and their families. It adopts a collaborative model of governance and involves representatives from the State, Commonwealth and local governments, the community sector and the broader community.[39] The Partnership's initial priority was to focus on assisting children living in out-of-home care, however it now also focuses on early intervention.[40]

In the short-term, the panel suggested that the additional funding made available in the current State budget can assist children who need additional help at school.[41] The Board also heard that future programs to strengthen the health of children in the Latrobe Valley could build on the work of the existing *Children and Youth Area Partnership*.[42]

EMPLOYMENT

Mr Steve Tong from Latrobe City Council and a member of the expert panel on social disadvantage told the Board that significant job losses occurred in the Latrobe Valley following privatisation of the Latrobe Valley mines. Participants at the Health Improvement Forums told the Board that before the Latrobe Valley mines were privatised, there were significant job and apprenticeship opportunities for all members of the community, including those with disabilities and vulnerabilities.[43]

The Board heard that lack of job security is a concern for many in the Latrobe Valley.[44] The expert panel on healthy environments also advised that economic transition is anticipated in the coming decades, and that there is a need to plan for transition of industry and skills.[45] Mr Tong described employment as part of the 'building blocks of a good life' and indicated that unless more jobs are created in the Latrobe Valley, social disadvantage will continue.[46]

The expert panel noted that processes for accessing training have changed over time and become less acessible.[47] Mr Tong told the Board that many training courses and opportunities have become 'extremely fragmented and difficult, almost nigh-on impossible for people from disadvantaged backgrounds to access.'[48]

Members of the expert panel on healthy workplaces suggested that consideration should be given to how new industries and employment opportunities can be generated in the Latrobe Valley using existing assets. The panel suggested that initial additional resourcing is needed to promote new industry and employment in the short-term, alongside longer-term planning for the Latrobe Valley's future.[49]

Ms Mary Sayers from the Victorian Council of Social Service (VCOSS) suggested that supporting social enterprise could provide pathways to the attainment of new skills for Latrobe Valley residents, in turn leading to greater employment opportunities.[50]

ACCESS TO HEALTH SERVICES

The expert panel on social disadvantage advised that vulnerable people in the community can have difficulty accessing health services, and that current methods for engagement with vulnerable communities may be ineffective.[51] One example provided was the Hazelwood Mine Fire Health Study, with the panel raising concerns that it may not be reaching those most vulnerable in the community.[52] The Health Study is discussed in Part 3 of this report.

In the medium to long-term, the expert panel on social disadvantage considered the need for a 'universal service guarantee' – 'everyone in the Latrobe Valley gets a minimum level of service' – that is monitored to ensure it is being achieved.[53] It was noted that access to a minimum standard of service would assist to achieve 'proportionate universalism', whereby additional services are available to those with greater need.[54] In their report, Professor de Leeuw and Associate Professor Wise describe the concept of 'proportionate universalism' by reference to the work of Professor Sir Michael Marmot who states 'we need not only to deal with poverty but to examine the whole distribution. Hence the need for universalist policies with effort proportionate to need, what we have called proportionate universalism.'[55] They further cite 'inverse care law', namely that those that need healthcare the most, get it the least, as an issue that applies to high risk social groups.[56]

Ms Sayers advised the Board that 'there is very solid evidence around that …if you scale up off a universal service system you are more likely to get the support for the most vulnerable.'[57] She emphasised that vulnerable members of the community should not have to worry about 'all the business that happens behind all the silos that we face… All they should see is good service.'[58]

The Board heard that, aligned with the issue of equal access to healthcare is the capacity of vulnerable members of the community to take measures to protect their health from the consequences of the mine fire. An example of this is removing ash residue from the mine fire that remains in the roof cavities of many houses, with the panel noting that community members living in social housing or rental properties are most likely to require assistance.[59] This issue is considered in Part 5 of this report.

COMMUNITY ENGAGEMENT

In their expert report to the Board, Professor de Leeuw and Associate Professor Wise emphasise the importance of basing any future health strategy for the Latrobe Valley on the principles of procedural, substantive and distributive justice.[60] Professor de Leeuw and Associate Professor Wise define these principles as follows:

- Procedural justice means ensuring that decision-making bodies are more representative of the community (in terms of culture, gender, socioeconomic demographics) and ensuring that a broad cross section of the community has an opportunity to influence the agenda.

- Substantive justice means 'putting items on the agenda, influencing discussion and debate on all agenda items, and influencing the outcome of decisions.'

- Distributive justice means ensuring that social resources are accessible to everyone. This could include ensuring the distribution of health services, prevention programs, and education, employment and transport. [61]

Professor de Leeuw and Associate Professor Wise also state that 'in the absence of the people who are most affected by the decisions being made…implementation of new initiatives [is] unlikely to address the causes of inequities and unlikely to succeed.'[62]

The expert panel on social disadvantage reaffirmed the need to strongly engage with the community, and supported the principle that community members who are affected by decisions should be involved in the decision-making process.[63] Professor de Leeuw told the Board that 'there is a place for communication, there is a place for sharing information, but only in the right mix between communication, facilities, regulation and consultation.'[64]

The panel cautioned about labelling a community as 'disadvantaged', and that future work needs to 'build on the assets of this community and really try to be part of re-establishing community pride.'[65] There was much discussion about the success of placed-based initiatives such as *Go Goldfields*. This initiative was cited as an example of how things could be turned around for a community with similar disadvantage.[66] The *Go Goldfields* initiative and other community engagement practices are considered further in Part 7 of this report. Place-based approaches are considered further below.

COMMUNITY SERVICES SECTOR

During the expert panel on social disadvantage, three key themes were discussed regarding the role of the community services sector in reducing health inequities:

- Bringing agencies together to work on the underlying causes of ill health, in a manner similar to the expert panels constituted for this Inquiry.

- Engaging with the community and allowing community members who are affected by decisions to be involved in actually making those decisions.

- Building on the assets of the community rather than emphasising or labelling the community as disadvantaged.[67]

There was agreement amongst the panel that, to see a reduction in social disadvantage, agencies need to work together with the community.[68] The panel explained to the Board that the Hazelwood mine fire, and subsequent forums about the mine fire, brought agencies together, which led to discussions about the underlying causes of common social and health issues. The panel suggested that this level of communication should occur more often.[69]

The expert panel explained to the Board that community sector organisations have direct relationships with the most disadvantaged members of a community through the direct services they provide. Those organisations can therefore play a significant role in informing the community about support services and health initiatives, particularly in an emergency, provided they have adequate resources to undertake this role.[70] The panel further noted that there is an opportunity to make improvements to community engagement by building on existing networks.[71] Ms Sayers commented that: 'vulnerable people aren't hard to reach; the system finds it hard to access them.'[72]

In its submission to the Board, VicHealth recommends an approach to community engagement that builds on and incorporates existing community services and service providers.[73] This recommendation is endorsed by VCOSS in its submission to the Board. VCOSS further states that decision-makers must '[a]cknowledge and support the unique role that community sector organisations play in the region through filling service gaps.'[74]

PLACE-BASED APPROACHES

In their expert report, Professor de Leeuw and Associate Professor Wise discuss place-based approaches, where the focus of action is on a particular geographic location that experiences disadvantage. They note that place-based approaches have previously been used to address health inequity.[75] In particular, the report discusses international evidence on *Healthy Cities*. The *Healthy Cities* approach was developed by the World Health Organization in 1986 and continues to be utilised today. The approach discusses a number of qualities that a local government should strive to achieve, in order to improve the health of its population.[76]

In their report, Professor de Leeuw and Associate Professor Wise discuss the success of *Healthy Cities* throughout Europe and note that this approach to designing, expanding and resourcing cities has 'resonated' with other place-based initiatives in the world, including in the Americas.[77] The *Healthy Cities* approach has also been implemented in Onkapringa, South Australia and Illawarra, New South Wales.[78]

A *Healthy City* strives to attain a number of attributes, including the following:

- A clean, safe, high quality physical environment (including housing quality).
- Meeting basic needs (such as food, water, shelter, income, safety, work) for everyone.
- Encouraging connectedness with the past, with the cultural and biological heritage of the city and with other groups and individuals.
- An ecosystem that is stable and sustainable now and in the long-term.
- Access for the population to a wide variety of experiences and resources, with the opportunity to have a range of contacts, interactions and communications.
- An optimum level of appropriate and universally accessible public health and care services.
- A high degree of public involvement in and control over the decisions affecting health and wellbeing.
- High health status (meaning both low disease status and high positive health status).[79]

The expert panel endorsed the idea of new approaches to health initiatives:

If we are going to transform this community—if we are going to do the same things and think we are going to get a different outcome then we are totally going to get the same outcome. So we actually need to think about doing things quite differently.[80]

The panel emphasised the importance of monitoring new approaches, in particular monitoring the impacts of new approaches on the most vulnerable members of the community.[81]

6.3 ABORIGINAL HEALTH

A number of public submissions specifically addressed health issues relating to Aboriginal communities.[82] A community consultation regarding Aboriginal health was held on 18 August 2015, and the Health Improvement Forum on Aboriginal health was held on 13 October 2015.[83]

VCOSS notes in its submission to the Board that '[a]ccording to the 2011 Census, there are approximately 500 Aboriginal people living in Morwell, making up about 2.2 per cent of the local population.'[84] VCOSS submits that '[t]he Aboriginal population in the Morwell region experiences significantly poorer health, education and employment outcomes than the non-Aboriginal population.' VCOSS further submits that the Latrobe Valley Aboriginal community is less likely to access mainstream community and health services, and is at particular risk of detrimental impacts on health in times of emergency.[85]

Four broad themes directly relevant to Aboriginal health were apparent in written submissions, at the community consultation and at the Health Improvement Forum on Aboriginal health. These were:

- access to health services
- the need for community control of health services
- underlying determinants of health
- the future is in young people.

ACCESS TO HEALTH SERVICES

During both the community consultation and at the Health Improvement Forum on Aboriginal health, Latrobe Valley Aboriginal community members recounted for the Board the health issues they experienced during the Hazelwood mine fire.[86] They indicated to the Board that they were not aware of the potential dangers from inhalation of smoke and ash from the mine fire, and that health warnings came too late. A number of community members reported that they are still experiencing adverse health effects as a consequence of the mine fire.

Community members expressed concern that many members of the Latrobe Valley Aboriginal community do not understand the potential short and long-term health consequences of the mine fire. Health information provided to the broader community does not always reach, nor is it always understood, by Aboriginal members of the community, because of literacy issues and the relatively low use by the community of mainstream health services.

Latrobe Valley Aboriginal community members told the Board that during and after the Hazelwood mine fire they noticed a significant increase in alcohol and other drug use, particularly methamphetamine use (ICE), as well as an increase in episodes of family violence amongst members of their community. In its written submission to the Board, VCOSS noted similar reports from members of the Latrobe Valley Aboriginal community.[87]

The Board heard that 'being stuck indoors' for several weeks during the mine fire was like 'being in prison' which exacerbated alcohol and drug use. The Board heard that an increase in alcohol and drug use, and episodes of family violence during the mine fire, also put additional pressure on support services. Participants told the Board that there is a lack of dedicated rehabilitation support for Aboriginal parents affected by drugs in the Latrobe Valley, which in turn adversely impacts their children.

It was suggested that the Latrobe Community Health Service's mine fire clinic could provide an outreach service to the Aboriginal medical service operated by the health organisation Ramahyuck in Morwell, in order to explain potential health consequences to Latrobe Valley Aboriginal community members in a culturally safe place.

It was also suggested that a register of health checks for Aboriginal people most exposed to the mine fire, including children, might be warranted. The Aboriginal medical service in Morwell currently has a good system for following up community members with chronic medical conditions. It was suggested that this system could be expanded to address health issues relating to the mine fire, although it was noted that further resources are required to support Aboriginal Health Workers or nurses to act as case managers for those with complex needs.

The issue of resourcing health services for the Latrobe Valley Aboriginal community was raised at the forum. Participants told the Board that more Aboriginal health services and Aboriginal Health Workers are required as services are already stretched. Insufficient transport options was also identified as an obstacle to accessing health services for Aboriginal people, especially those with chronic health conditions.

It was noted that the low retention rates of doctors in the Aboriginal medical service has impacts for continuity of patient care. Local medical staff training and retention is further addressed in Part 4 of this report.

COMMUNITY CONTROLLED HEALTH SERVICES

Mr Jimi Peters, manager of the Public Health Research Unit at the Victorian Aboriginal Community Controlled Health Organisation (VACCHO), attended the Health Improvement Forum on Aboriginal health and submitted a written statement to the Board on behalf of VACCHO (which he also read aloud at the Health Improvement Forum on Aboriginal health).

Mr Peters highlighted the significance of community controlled health organisations to self-determination for Aboriginal people. The Board heard that the benefits of community controlled health organisations are:

- service provision—Latrobe Valley Aboriginal community controlled organisations make a strong contribution to improving health outcomes by making accessible, appropriate and cost-effective primary healthcare available to Aboriginal people

- functioning as a gathering place

- promoting Aboriginal culture and self-determination

- giving voice to communities on issues beyond the scope of their service provision role

- providing employment for Aboriginal people.[88]

In its written submission to the Board, VACCHO states that:

> Available evidence indicates that [Aboriginal Community Controlled Health Organisations] have been key contributors to closing the health gap for Aboriginal Peoples and that there is strong evidence of the link between access to appropriate primary health care and improved health outcomes for Aboriginal and Torres Strait Islander people.[89]

In written submissions, a number of organisations note that local Aboriginal community controlled organisations can provide an avenue for health services to engage with the Latrobe Valley Aboriginal community to improve health outcomes.[90] VicHealth also notes that there are also a number of 'health brokers' working in Aboriginal and Torres Strait Islander communities across Australia, who provide support to individuals and families to access appropriate health services.[91]

The Board heard that, although there are health services provided to the Latrobe Valley Aboriginal community in Morwell, those services are not controlled by the local Latrobe Valley Aboriginal community. The Board was advised that a community controlled health service called the Central Gippsland Aboriginal Health and Housing Co-operative Ltd (in liquidation) previously existed in Morwell. Following the demise of the Co-operative, Ramahyuck, the community controlled health service for the Aboriginal community of Sale, expanded to provide health services for the Latrobe Valley Aboriginal community.[92]

The Board notes that, because the health service in Morwell is not controlled by the local Aboriginal community, the service does not meet the conditions of community-control as outlined by VACCHO:

> Aboriginal Community Controlled Health Organisations (ACCHOs) are the embodiment of self-determination. Each ACCHO has been initiated by a local Aboriginal community and [is] based in that local Aboriginal community. ACCHO boards of management are drawn directly from the communities they serve, and are democratically elected.[93]

A community member explained that the facilities currently used by Ramahyuck to provide health services to the Latrobe Valley Aboriginal community are inadequate. The Aboriginal medical service is housed in a building that is 25 years old with no disability access for the upstairs community room, and limited outdoor space as the surrounding land has been sold off. This community member told the Board that the state of the building means that it is not an appropriate gathering place for the community, and also has consequences for access to the medical service. It was noted that the building compares poorly with other health, Council and government facilities in the Latrobe Valley, many of which have undergone significant renovation in recent years. The absence of a community controlled health organisation affects health service delivery for a number of reasons, including that:

- Many in the community do not access the service because it is not locally controlled.

- Insecurity of the tenure on the building used to house the current Aboriginal medical services means that decisions about expansion or alternate premises are difficult.

- People with physical disabilities cannot use the limited facilities that are available because of access difficulties.

The lack of a community gathering space was also identified as an obstacle to improving health for Aboriginal members of the community.

THE FUTURE IS IN YOUNG PEOPLE

The Board was advised that the Aboriginal community in the Latrobe Valley has a greater proportion of young people compared with the rest of the local population.[94] Many Aboriginal community members told the Board that there has been an increase in the number of disaffected Aboriginal young people in the Latrobe Valley. They highlighted the high incidence of young people involved with the justice system; high rates of homelessness and unemployment; barriers for Aboriginal children participating in positive activities like sport, such as the costs associated with registration and uniforms, and transport issues; and threats of violence and vandalism by young people in schools.

Community members had a number of suggestions for the Board about how to improve this situation. These suggestions included:

- Having a community-gathering place as a site for alternative activities for young people. It was noted that when events or sports carnivals have been held, young people have attended in large numbers, however further resources are required to do this more regularly.

- Art projects. Community members described a successful art project on the walking track alongside Waterhole Creek. This project required only a small amount of funding and it allowed young people to develop their artistic skills and learn about the cultural heritage of the area. It was noted that this area has not been sprayed with graffiti. Community members told the Board that more opportunities to undertake such projects and engage young people in their cultural heritage would be helpful.

The Board heard that sport has been used as a motivator for health improvement amongst Aboriginal young people in other Victorian communities. In particular, the Board is aware of the work of the Rumbalara football and netball club, based in Shepparton, which provides local Aboriginal young people with an avenue to engage in community sports in a positive environment.[95] Similarly the Clontarf Academies, which aim to promote school-engagement by linking education to sport, could provide another model of improving health outcomes for Aboriginal people through sport.[96] The Board heard that both of these initiatives have enjoyed considerable success.

Following the Health Improvement Forum on Aboriginal health, the Board visited Waterhole Creek walking track and the adjacent art project. The Board noticed that the art work was in excellent condition, indicating the high level of positive support for the project shown by both Aboriginal and non-Aboriginal community members.

6.4 BOARD'S CONSIDERATION AND PROPOSALS

The Board considers that actions to reduce health inequities in the Latrobe Valley are relevant to, and need to be reflected in, all of the areas considered in this report.

The Board recognises that many organisations, individuals and experts have advised that improvements to health in the Latrobe Valley will require action to change the social determinants of health.

The Board accepts that there is a link between social disadvantage and health, and that social disadvantage contributes to the poorer health outcomes observed in the Latrobe Valley. The Board accepts that the social disadvantage experienced in the Latrobe Valley is worsening, rather than improving.

CHANGING SOCIAL DISADVANTAGE

The Board acknowledges that understanding social disadvantage and health inequities is complex, as is finding practical solutions. However, the Board also accepts that it is possible to change social conditions and reduce health inequities. The expert panel on social disadvantage noted that education and employment, in particular, can be pathways out of disadvantage. The Board accepts that in order to bring about an improvement to the health status of the Latrobe Valley community, and in particular, Morwell, action is needed to address the social determinants of health inequities.

The Board notes evidence that children in the Latrobe Valley often start school developmentally behind their peers, when measured according to the Australian Early Development Index. The Board considers that education is critical for bringing change to social disadvantage. The Board affirms the commitment by the Gippsland *Children and Youth Area Partnership* to include an early intervention focus to not only protect vulnerable children but also to support access to education of children in out-of-home-care.

The Board accepts that employment is another key issue that must be considered in the Latrobe Valley. The State and local industry should consider both short and long-term planning for creating jobs and new industries.

The Board has concerns regarding the impact of funding cuts on education and training opportunities in the Latrobe Valley. The Board heard evidence from the expert panel on social disadvantage that these funding cuts have had a significant impact on the community, and particularly on young people as a result of the closure of the *Youth Connection* program. The Board proposes that further consideration be given to the resources allocated to education programs in the Latrobe Valley, recognising that supporting education initiatives is a crucial means of reducing social inequality and consequently, improving health outcomes.

The Board acknowledges that given the nature and complexity of health inequities, such changes will require sustained commitment, funding and action over the long-term before results will be evident.

The Board considers that the success of short, medium and long-term healthcare initiatives will be dependent upon State, Commonwealth and local agencies developing a coordinated approach to funding and sustaining support for those initiatives. The Board considers that there will be potential cost savings to both levels of government by improving social disadvantage in the Latrobe Valley.

Further discussion about health funding is discussed in Part 8.

COMMUNITY ENGAGEMENT AND COMMUNITY SECTOR INVOLVEMENT

Whilst acknowledging that the way resources are distributed can influence equity, the Board also notes that achieving equity depends on more than money – '[it] also reflects culture, history and heritage, and context.'[97] Community, local government and local community organisations can and should play a part in reducing health inequities by influencing daily living conditions and individual health-related behaviours.

The Board notes the evidence of the expert panel on social disadvantage regarding the importance of strengthening the role of existing community sector organisations. The Board agrees that building on the strengths of existing organisations should be further considered. There is merit in the suggestion that agencies should collaborate to strengthen the existing networks and relationships between community sector agencies and the more vulnerable.

The Board considers that the VicHealth *Fair Foundations Framework* is an excellent tool and commends VicHealth on its development. The Board considers that it should be used by other community agencies to inform action and future work concerning social disadvantage. The Board considers that this framework should influence all decisions relating to health improvements in the Latrobe Valley so that more equitable outcomes are achieved.

The Board recognises the significance of ensuring that the community, and more particularly those more vulnerable to social disadvantage, are involved in determining change.

The Board was encouraged by the discussion in submissions and during the Health Improvement Forums that there were opportunities to learn from existing place-based approaches that have been used to reduce health inequity across the world and in Australia. The Board considers that approaches such as *Healthy Cities* and *Go Goldfields* offer an opportunity for similar models to be implemented in the Latrobe Valley. The Board considers there is real merit in such an approach in terms of working towards better health and reducing inequity. Given the sustained history of the *Healthy Cities* approach and the promising results obtained across the world, the Board suggests that the model provides a source of examples for the Latrobe Valley, and that Latrobe City Council consider adopting a similar approach in the longer-term.

The Board is of the view that all health improvement strategies should:

- be informed by a strong community engagement process
- focus on reducing health inequities
- draw on the capacity, goodwill and opportunities present
- integrate actions across relevant providers
- be evaluated for their wider applicability across Victoria.

> **The Board recommends that funding for new and existing health improvement programs is allocated to reduce health inequities through strengthening health services, promoting healthy living and building pride of place.**

CLOSING THE GAP IN ABORIGINAL HEALTH

There is no doubt that the health of Aboriginal people in all communities warrants particular attention. Both the state and Commonwealth Governments have already acknowledged this through their commitment to the *National Indigenous Reform Agreement*.[98] The Board acknowledges that Aboriginal '[s]elf determination and cultural expression are human rights' and that lack of control over life circumstances is a contributor to the health gap between Aboriginal and non-Aboriginal Australians.[99]

The Board notes the significantly poorer health of Aboriginal people in the Latrobe Valley compared with non-Aboriginal people, as highlighted in the submissions received. Given the level of disadvantage experienced by the Latrobe Valley community as a whole, this suggests that Aboriginal people in the Latrobe Valley are amongst the most disadvantaged people anywhere in Victoria.

The Board considers that a significant change could be made to Aboriginal health in the Latrobe Valley with the provision of a community controlled Aboriginal health service in Morwell. The Board notes the concerns raised by Latrobe Valley Aboriginal community members regarding the unresolved matter of the liquidation of the previous community controlled health service (Central Gippsland Aboriginal Health and Housing Co-operative Ltd (in liquidation)). The Board is concerned that the liquidation of the Co-operative has led to inadequate facilities for provision of healthcare services to local Aboriginal people, and has created uncertainty around the long-term availability of a dedicated premises to provide healthcare services to local Aboriginal people living in Morwell and surrounds.

ABORIGINAL YOUNG PEOPLE

The Board notes the differing age profile of the Aboriginal community in the Latrobe Valley, which has a greater proportion of young people compared with the rest of the local population.

The Board heard promising stories of how young community members have successfully engaged with local health services and with the broader community. Particularly, the Board commends the Latrobe Valley Aboriginal community, in particular the leadership and enterprise shown in the Waterhole Creek art project.

However, the Board notes that there are many barriers that prevent young people in the Latrobe Valley Aboriginal community achieving good health. The cost of participating in sport and arranging transport are obstacles to Aboriginal young people's participation in physical activity and education. The Board suggests that further consideration be given to other options to enable Aboriginal young people to access sport and education as a pathway out of disadvantage and towards better health outcomes.

The Board also notes the link between the absence of an Aboriginal community controlled health service in Morwell and poor health outcomes for Aboriginal young people. The Board considers that the availability of a community controlled Aboriginal health service would increase the uptake of health services accessed by young Aboriginal people. The Board considers that, when establishing a community controlled Aboriginal health service, the State should support the building of a culturally appropriate health and community facility with outdoor space that is suitable to engage young people.

> The Board recommends that the State assist in establishing an independent community controlled health organisation for the Latrobe Valley Aboriginal community and co-fund a culturally appropriate health and community facility which will help with the engagement of Aboriginal young people.

PART SEVEN
BUILDING PRIDE OF PLACE

PART 7 BUILDING PRIDE OF PLACE

One of strongest themes that emerged during this Inquiry is the need for more effective engagement by the State with Latrobe Valley communities. Better engagement by the State with the community was also a recommendation of the 2014 Hazelwood Mine Fire Inquiry[1] and an issue considered in the Board's recent investigation into whether the mine fire contributed to an increase in deaths (see the 2015/2016 Hazelwood Mine Fire Inquiry Report Volume 2).

Another common theme throughout this Inquiry has been the need to acknowledge the assets of the Latrobe Valley community and to restore the sense of pride and optimism that has been present in the community's history.[2]

This Part outlines the significance of community engagement to health improvements. It also considers the role that industry has played in the community's sense of esteem, and the need to engage the community in planning for the transition of industry. This Part considers how the State can more effectively engage with the community on a range of issues relevant to improving health, but particularly in relation to re-establishing a sense of pride and optimism in the Latrobe Valley so that a positive health future for Latrobe Valley communities can be co-created.

An expert panel on community engagement and communication was convened as part of the Health Improvement Forums to consider effective community engagement and building pride of place. The expert panel members were Ms Sara Rhodes-Ward from Latrobe City Council; Associate Professor Marilyn Wise from the Centre for Primary Health Care and Equity at the University of New South Wales; Ms Lisa Sinha from Gippsland Multicultural Service; Ms Stephanie Charalambous from the Latrobe Valley Express; Ms Jerril Rechter from Victorian Health Promotion Foundation (VicHealth); Ms Tracie Lund from the Morwell Neighbourhood House; Ms Wendy Farmer from Voices of the Valley; Mr Simon Klapish from GDF Suez Australian Energy; Ms Jayne Gallo from the EW Tipping Foundation; Mr Steve Cameron from Emergency Management Victoria; and Ms Carolyne Boothman from the Morwell & Districts Community Recovery Committee.[3]

The expert panels on healthy workplaces and social disadvantage also discussed the connection between pride of place and positive health outcomes. The constitution of these panels is listed at Parts 5 and 6.

7.1 COMMUNITY ENGAGEMENT AND COMMUNICATION

During the 2014 Hazelwood Mine Fire Inquiry, the Board heard considerable feedback from the Latrobe Valley community about the significant shortcomings of government authorities and GDF Suez in engaging and communicating with the community during the mine fire.[4]

A number of written submissions received by the Board during the re-opened Inquiry express concern about an ongoing shortfall in the information exchange between government agencies, industry and the Latrobe Valley community.[5]

The Board heard about the community's concerns in relation to various State decisions and decision-making processes that have had significant consequences for the Latrobe Valley. In particular, community members expressed concern about the State's historical decision to privatise coal mines in the Latrobe Valley, resulting in significant job losses, and more recent decisions to cut funding to programs considered successful by the community.[6]

In relation to decisions made by the State during and after the Hazelwood mine fire, Ms Anne Horrigan-Dixon and Ms Marilyn Dawson submitted to the Board that there is 'a common thread of fear and anger in the community' that the State has been 'keeping a lid on health concerns.'[7]

Latrobe City Council states in its submission to the Board that there is a possibility that the community's sense of mistrust in the State may be due, in part, to the health impacts of the power generation industry in general, not just during the mine fire, and in particular the effect of mesothelioma on the community.[8] Its submission highlights the trauma associated with this 'silent killer…which has been unleashed into their lives by the very industry from which they derived their livelihood and pride.'[9]

Submissions to the Board note that a renewed commitment to community engagement is essential for the process of repairing relationships between the Latrobe Valley community, government agencies, and industry.[10] Latrobe Valley resident Ms Julia Browell states in her submission that '[it] will take much dedicated effort and many years to repair the damage done. And it will need to encompass ALL of the community, not just one or two tiny unrepresentative selections. Not just one side of the railway line.'[11] Ms Kiery-Anne Clissold of Morwell states in her submission that 'to try and rebuild that trust we need honesty, accountability and transparency.'[12]

Submissions from the Royal Australasian College of Physicians and the Victorian branch of the Public Health Association of Australia identified local engagement and partnership as key components of improving relationships between the community and the State, and for planning for the future of the Latrobe Valley.[13]

GENERAL PRINCIPLES OF COMMUNITY ENGAGEMENT

In their report to the Board, Professor Evelyne de Leeuw, Director of Glocal Health Consultants, Editor-in-Chief of *Health Promotion International,* and the Director, Centre for Health Equity Training, Research and Evaluation, University of New South Wales and Associate Professor Marilyn Wise from the Centre for Primary Health Care and Equity at the University of New South Wales, state that 'status (the respect we receive from others), control (influence over the things that affect our lives) and affiliation (sense of belonging) are universal determinants of wellbeing.'[14] In written submissions, a number of agencies state that community engagement in health planning and service delivery is essential if health improvements are to be achieved.[15]

Community engagement at its simplest is 'a generic, inclusive term to describe the broad range of interactions between people.'[16] It can include consultation, communication, education, public participation, participatory democracy and working together with the community.[17] The expert panel on community engagement and communication touched on three general principles of effective community engagement:

1. Working with the community.
2. Reaching out and going to the places where the community already gathers.
3. Inclusivity—ensuring that particular groups in the community are not overlooked.[18]

The panel told the Board that at its core, effective community engagement requires 'that engagement should be undertaken with communities, not done to communities.'[19]

Associate Professor Wise advised the Board that community involvement in making decisions that affect them is a social determinant of health: 'The communities that have been excluded from decision-making are always less healthy than those that are [included], and it's consistent everywhere.'[20] Ms Lisa Sinha from the Gippsland Multicultural Service also noted the connection between including communities in decision-making processes and their sense of investment and belonging in their community. She stated that this inclusion is 'the difference between being marginalised or feeling like you're part of the conversation.'[21]

The panel also emphasised that decision-makers need to go to where communities gather to seek their involvement, rather than expecting people to come to them, or making token efforts to involve disconnected groups.[22] The expert panel advised the Board that it is often not the community's preference to go to unfamiliar places to engage with government agencies and other organisations, because they perceive they will be talked at rather than listened to:[23] 'you do need to meet them where they are, and if that's at Coles or anywhere else, that's where you need to go.'[24] The panel noted that it is also important that communication be two-way, involving both speaking and listening, and that decision-makers are genuinely open to feedback.[25]

In relation to inclusive practice, Ms Sinha stated that this requires cultural competence. Ms Sinha told the Board that cultural competence should be 'part of the core business of our authorities and services and our agencies so that we're able to work in a partnership with all of our communities, and we're able to work effectively with them.'[26] She advised the Board that agencies need to take into account that some members of the community may come from different backgrounds that do not distinguish between the State and statutory authorities, and may be apprehensive about engaging with these authorities.[27]

EFFECTIVE COMMUNICATION IN PRACTICE

The expert panel on community engagement and communication noted that effective communication requires the use of various media, as different people access information in different ways—some through social media, others through the Latrobe Valley Express and others again through television or radio news.[28] Panellists noted that people in Morwell are less likely to be connected to social media.[29]

A number of written submissions received by the Board emphasised the need for communication and education about measures that can be adopted to reduce health risks (such as quitting smoking) or enhance health (such as promoting fruit and vegetable intake and the reduction of sugary drink consumption).[30]

Panel members stressed the importance of conveying positive stories about the Latrobe Valley,[31] and noted that community wellbeing is enhanced when the good stories, not just the bad, are communicated.[32] The panel suggested that creating connections and partnerships between the community and the local media is one way to enhance positive representations of the community:[33]

> there are lots of opportunities and certainly a willingness from local media to partner with, whether it be government organisations, the community or local government, because there is a common goal of improving the health of the Latrobe Valley and that's something that local media wants to be part of.[34]

Partnerships could be informal, or more structured partnerships working towards common goals.[35] The suggestion was also made that profiling local people in the local media could help to generate connection between organisations, industry and the community.[36]

On the suggestion of Board member Professor Catford, the community considered whether a campaign to promote the Latrobe Valley might be worth recommending. The expert panel discussed the potential merits of a social marketing campaign, which could encompass a broad range of media platforms, and recognised that it could be a valuable tool for re-building a sense of unity and pride.[37] Ms Stephanie Charalambous from the Latrobe Valley Express was of the view that 'absolutely there should be' a campaign and emphasised that a campaign should be community-led.[38] Panel members noted that the capacity and resources to develop and deliver a campaign already exist within the community and that a campaign should proceed regardless of the recommendations made by the Board in relation to Term of Reference 7.[39]

In its written submission to the Board after the Health Improvement Forums, VicHealth cautions that such a campaign will only be valuable if it is 'anchored to a long term, shared vision for the Latrobe Valley, and is one of a complementary suite of strategies aimed at creating new/additional social and economic opportunities.'[40] The submission notes that 'relying on campaign activity alone to make significant impact and sustainable change within communities is a recipe for failure.'[41]

FACILITATING COMMUNITY ENGAGEMENT

The expert panel on community engagement and communication emphasised the importance of a place-based approach to community engagement, noting that there can be significant differences between neighbourhoods in the Latrobe Valley.[42] The panel suggested that working through trusted community leaders is an effective way to engage communities.[43] The point was made that much can be asked of community leaders, particularly in times of crisis, however there is also a need to take a systematic approach to ensuring that the consultative functions of agencies and the not-for-profit sector are in place and applied well in times of emergency.[44]

In its written submission to the Board, Monash University advises that a Community Wellbeing Study will be undertaken as part of the Hazelwood Mine Fire Health Study.[45] The aim of the Community Wellbeing Study is to understand community perceptions of the impact of the mine fire on their wellbeing, the effectiveness of community rebuilding activities after the fire, and the effectiveness of community engagement during and after the fire. This study builds on a study undertaken by Federation University Australia into the initial impact of the mine fire.[46]

Ms Wendy Farmer, a Latrobe Valley resident and a member of the expert panel on community engagement and communication, suggested that an important part of community engagement is asking community members how they want to be involved in the decisions that affect them. She noted that views on community engagement will vary between individuals and some people may not want to be engaged much at all.[47] The panel recognised that more traditional face-to-face methods of communicating, such as the door knock undertaken by Latrobe City Council during the mine fire, work well in the Latrobe Valley.[48] Ms Tracey Lund of the Morwell Neighbourhood House, shared her experience of the *Valley to Valley* project conducted after the mine fire, during which she visited many of the smaller communities in the Latrobe Valley to ask people what message they would want to share about their community with another community:

> We got words like, in Boolarra it was about local heroes, and those were the people on the ground that were making sandwiches all night for people when there were fires…In Morwell the words were around respect; this community wants to be respected…it was about, we are one, it was about being included. In Yallourn North…their messages were about mateship and power and what that looks like for them…there is a shared vision here for the Latrobe Valley; we all want the same thing.[49]

The expert panel also discussed the strengths and capacity of the Latrobe Valley community. The panel noted the need to build and strengthen community cohesiveness, and in particular the importance of supporting community groups so that they remain strong.[50]

CO-DESIGNING HEALTH INITIATIVES

There was 'absolute agreement' amongst the panel about co-designing health initiatives with the community.[51] The importance of allowing the community to lead the development of a vision for the Latrobe Valley was emphasised, with the role of 'experts' being to support the community in achieving its vision. Community ownership of health initiatives was also identified as a pathway to re-building trust and strengthening the capacity of the community.[52]

The panel noted that community involvement in designing initiatives should not be limited to health, but could also consider the operation of the mines and power stations in the region, and a vision for mine rehabilitation.[53] Mine rehabilitation will be considered further in the 2015/2016 Hazelwood Mine Fire Report Volume 4.

In its written submission to the Board, VicHealth suggests a 'Citizens' Jury' to facilitate engagement with the community throughout decision-making and planning processes relevant to health. VicHealth's Citizens' Jury was described as follows:

> The jury will be a representative sample of the Victorian public, selected at random. They will be from as many communities, professions, lifestyle groups and demographics as possible. This means that everyday Victorians are truly tackling the issue on behalf of all Victorians. Just like a traditional jury, they will hear evidence submitted by all interested parties regarding different approaches to this issue which they will consider, question and discuss. This is a pioneering approach in the way government makes decisions and manages difficult community issues. This is because it presents a result that is uncontrolled, unedited, transparent and non-aligned.[54]

The Board notes that a variety of community engagement mechanisms are outlined in a series of documents produced by the State titled *Effective Engagement: building stakeholder relationships with community and other stakeholders*, and in particular *Book 3: the engagement toolkit*.[55] The *engagement toolkit* records that each of the various tools can perform different purposes, such as to inform, consult, involve, collaborate or empower.[56]

> Choosing a tool or combination of tools for engaging your community is a critical step in the engagement planning process. It is important that you know what you are asking from the stakeholders when you decide to use a specific engagement tool.[57]

PLANNING FOR THE FUTURE

In its submission to the Board, the Australian Nursing and Midwifery Federation (Victorian Branch) notes that there is pressure on the State and the coal industry to transition to cleaner energy sources. That transition must consider the necessary support for the local community with respect to employment opportunities. The Federation suggests 'the development of a plan, in consultation with all stakeholders, to create employment and give hope to a the declining prosperity of the community.' Further, it recommends that the plan develop 'economic and employment opportunities associated with transitioning the community from a coal based economy, including expanding the renewables economy.'[58]

The Board heard that uncertainty associated with the future of the coal mining industry has contributed to diminishing community pride in the Latrobe Valley, as have negative portrayals of the community and the mine fire.[59] Examples of this include publications in the Ballarat Courier below (Figure 9) and more recently in the Herald Sun article of 10 December 2015 titled 'Valley of Death'.

Figure 9. Morwell cartoon published 4 March 2014 in the *Ballarat Courier*

(Source: Inkcinct Cartoons Australia)

Many of the expert panels that contributed to this Inquiry described the natural assets of the Latrobe Valley. They highlighted examples of other communities (such as the Ovens Valley) that have successfully transitioned from a particular industry (in the case of the Ovens Valley, the tobacco industry) and created a new identity and economy based on the natural beauty of the area.[60]

The expert panel on community engagement and communication expressed great optimism about the ability of the Latrobe Valley community to solve its own problems and create a brighter future,[61] and that there is a need to 'unleash that potential that exists within the community.'[62]

The need to establish a common long-term vision was recommended by the panel and supported in a number of submissions:[63]

The Morwell community has a strong appetite to re-establish a sense of place and pride, including among its residents, businesses, community organisations, schools, local government and industry.

The aftermath of the mine fire presents a unique and significant opportunity to take a new approach that acknowledges Morwell's past contributions to the state of Victoria, recognises its strengths and challenges, and provides an innovative and collaborative way forward.[64]

In considering what was needed to create a 'stronger sense of hope and optimism for the future', the panel identified the following:[65]

- A sense of unity amongst the towns of the Latrobe Valley, rather than competition: 'We need to start looking at Latrobe Valley as one place, one united place where we're working together to improve the whole of the Latrobe Valley rather than just one town';[66] 'we need to start connecting; instead of fighting, the three towns [Traralgon, Morwell and Moe], we really need to connect'[67]

- Economic resilience: The panel noted the inevitability of a transition away from coal-fired power generation—'by mid-century, it's highly unlikely there'll be any coal fire generation in Australia'—but that the industries of the future are uncertain.[68] The panel recommended that 'the economic future for the Valley should be created with the community in partnership, that that's a co-created plan with bipartisan support that envisages a future post coal from a strengths-based approach.'[69]

In order to rebuild pride of place, the expert panel emphasised that, by and large, the community does not want 'handouts'—rather, they want to be a part of determining what the future is and to be a part of creating a better future for the next generation.[70] The panel acknowledged that the community might need a 'kick-start' in terms of a long-term vision and a clear path of action to achieving it, as well as support along the way.[71]

The panel also acknowledged that power generation and coal mining were built 'on the backs of our culturally diverse community' and that planning for the future should include as broad a cross section of the community as possible.[72]

As discussed in Part 5 of this report, the expert panel on healthy workplaces advised the Board that with the changing nature of work, those with the poorest educational outcomes from low socioeconomic areas will be most at risk of missing out in the future. There is thus a need to consider this group as a priority in any transition arrangements. It was suggested that further analysis of current employment rates and opportunities both inside and outside the Latrobe Valley may assist in the identifying the needs and gaps for future skills.[73]

The healthy workplaces panel also advised the Board that planning for employment transition and economic development in the Latrobe Valley presents new opportunities for how health and wellbeing outcomes are achieved. If health outcomes are prioritised in planning discussions, healthy and productive workplaces can assist in achieving better economic outcomes.[74]

The expert panel on social disadvantage cautioned about labelling a community as disadvantaged, and that future work needs to 'build on the assets of this community and really try to be part of re-establishing community pride.'[75] There was much discussion about the success of placed based initiatives, including *Go Goldfields*.[76]

Go Goldfields is a strategy that has been implemented by the Central Goldfields Shire Council. It is described as 'our community aspiring, achieving and living a full life'.[77] The initiative focuses on:

- Working together to challenge and change the existing systems to build socially and economically independent citizens;

- Helping people think deeply and differently to improve the lives of children, youth and families;

- Maximising the benefits of working together;

- Being a part of our community for the long-term;

- Challenging ourselves and learning dynamically from our work;

- Being accountable to each other and our community;

- Involving our community in creating solutions.[78]

The governance of *Go Goldfields* is led by the Go Goldfields Alliance (comprising the Mayor of Central Goldfields Shire Council and key community and service agency leaders) and the Steering Committee (comprising Council leaders and regional government representatives, including representatives from Regional Development Victoria, the Commonwealth Department of Employment, and Victoria Police). *Go Goldfields* also includes a number of action groups who progress specific areas, including early years, family violence, youth engagement and workforce development.[79] The *Go Goldfields* website notes that there will be a change in the governance of this work to include business and community leaders and people who have day-to-day experience of the issues that are being addressed.[80]

A report evaluating the progress of *Go Goldfields* shows that there have been many successes and as many challenges.[81] As discussed by the expert panel on social disadvantage, the Latrobe Valley could consider the processes adopted in *Go Goldfields* and implement a program that follows similar processes.[82]

7.2 BOARD'S CONSIDERATION AND PROPOSALS

IMPORTANCE OF COMMUNITY ENGAGEMENT

Throughout public consultations and forums, and in the written submissions received by the Board, the Latrobe Valley community has indicated that they want a greater degree of involvement in decisions that impact on their health and lives.

A lack of effective communication and engagement with the Latrobe Valley community during the Hazelwood mine fire has already been well documented by the Board in the 2014 Hazelwood Mine Fire Inquiry Report. The need for the State to engage more effectively with the Latrobe Valley community on all matters relating to health was a strong theme that emerged from community consultations, public submissions and across the majority of Health Improvement Forums conducted as part of the re-opened Inquiry. More effective community engagement was also discussed in the 2015–2016 Hazelwood Mine Fire Inquiry Report Volume 2. The Board accepts that a history of ineffective community engagement in decision-making processes has contributed not only to the community's mistrust of the State, but also to a loss of pride in their community. The Board acknowledges that the Latrobe Valley community had and still has a strong sense of identity as a coal mining community and as the 'power generators' for much of Victoria.

The Board considers that three issues are critical to restoring a sense of community pride in the Latrobe Valley—more effective community engagement in relation to health; more effective communication relevant to the transition of industry in the Latrobe Valley; and community involvement in re-establishing a sense of community pride in the Latrobe Valley.

The Board agrees with the proposition put to it by the expert panel on community engagement and communication that inclusion in decision-making is a social determinant of health, and consequently is a crucial aspect of developing and implementing effective health improvements in the Latrobe Valley.

CONNECTING WITH THE COMMUNITY

The Board heard many suggestions about how best to engage and communicate with the community. These suggestions drew from practical examples in the Latrobe Valley, such as conducting door knocks, as was undertaken by Voices of the Valley and Latrobe City Council; and involving consumers in the re-design of health services as has occurred with the *Optimal Health* program at Latrobe Regional Hospital (see Part 4). The Board commends the efforts of Latrobe City Council, Latrobe Community Health Service, Latrobe Regional Hospital, the Morwell Neighbourhood House and Voices of the Valley for demonstrating effective ways to engage, consult and connect with the community.

The Board recognises that there is not just one way, but many, to effectively engage with a community. As the Board heard, members of the Latrobe Valley community will want to be engaged in different ways and to differing degrees. The value and methods of community engagement were considered at some length in the 2014 Hazelwood Mine Fire Inquiry Report.

The Board acknowledges that choosing an appropriate method or methods to communicate and engage depends on the purpose of engagement, the size, scale and timeline of the project or initiative you hope to engage the community about, and the community context. The purpose of engagement may vary from wanting to inform or empower the community, through to active consultation, involvement, and collaboration.

Methods such as door knocking and shop fronts can be used to inform and consult, and can also develop into more collaborative methods, such as has occurred with Morwell & Districts Community Recovery Committee (supported by the Latrobe City Council) in developing neighbourhood plans informed by consultations during door knocks. Methods such as a Citizens' Jury, described by VicHealth, allow for consultation, involvement and a degree of collaboration.

The Board encourages the use of resources such as *Book 3: the engagement toolkit*, and other similar resources, to determine appropriate community engagement methods.

The Board recommends that the State and each of the four principal stakeholder organisations for health in the Latrobe Valley—Latrobe Regional Hospital, Latrobe Community Health Service, Latrobe City Council, and Gippsland Primary Health Network—strengthen community engagement processes in the development of new health improvement strategies and in the delivery of existing services.

Whilst the Board recommends strengthening engagement with the Latrobe Valley community, the Board also acknowledges that the community has been very clear about wanting accountable and transparent action. Community engagement should not be used as a means to delay decisions, but rather to guide action.

The Board affirms work being undertaken by the Community Wellbeing Study (part of the Hazelwood Mine Fire Health Study) to enhance agencies' ability to effectively engage with the Latrobe Valley community.

The Board heard of the unique role that community sector organisations can play in connecting with diverse parts of the community, particularly those that are most disadvantaged. The Board agrees that establishing more effective engagement processes as part of the usual business of governments and agencies will assist in ensuring there are systems in place to aid communication during emergencies.

The Board suggests that further consideration be given to the role of existing community sector organisations and existing community leaders who have particular reach into disadvantaged communities in establishing a systematic approach to communication.

INDUSTRY TRANSITION

The Board considers that health improvements in the Latrobe Valley are in part dependent upon a thriving economy and the availability of job opportunities, as employment is an important determinant of health and can provide a pathway out of disadvantage. This is also discussed in Part 6 of this report.

The Board acknowledges that the coal industry provides an important source of jobs in the Latrobe Valley community and that secure, meaningful employment has a marked effect on the health of a community. The Board acknowledges that the uncertainty associated with the coal industry is having a detrimental impact on the health and wellbeing of the Latrobe Valley community.

The Board understands that the community wants to be involved in planning the transition of industry, and to be assured that there will be viable industries in the Latrobe Valley that can provide a more certain future. The Board recognises that without a clear plan for transition, the prospect of further job losses with the closure of mines would have a very real detrimental impact on the health and wellbeing of the community.

The Board considers that as an important contribution to improving the health of the Latrobe Valley, the State, in collaboration with the Commonwealth Government and relevant agencies, and in partnership with the community:

- Develop a long-term plan around the transition of industry away from coal mining and coal-fired power generation.
- Consider rehabilitation of the mines as an integral part of such a plan.

The Board is of the view that given the strong, proud history of this community in generating power for the State, and the infrastructure already present, that further consideration be given to the role that the Latrobe Valley community could play in continuing to generate power for the State.

RECOGNISING COMMUNITY STRENGTHS

In addition to sharing their stories of concern with the Board, the community also demonstrated considerable passion and commitment to creating a positive future for the Latrobe Valley. The Board agrees with the expert panel on community engagement and communication that the Latrobe Valley community has the ability to help solve its own problems and create a brighter future.

The Board recognises that energy and momentum exists within the community to create this new vision for their future. This was clearly demonstrated by the commitment of a number of locally based organisations participating in the panel session, who advised of their intention to get a campaign off the ground regardless of the recommendations and action resulting from this Inquiry. The Board agrees with the panel that such a campaign would need to be a community-led approach built on a solid foundation of action. This would support efforts to promote healthy living as discussed in Part 5 of this report.

The Board affirms the intention of members of the expert panel on community engagement and communication to work together to develop a community-led, shared vision for the health, wellbeing and prosperity of the Latrobe Valley.

> The Board recommends that the State provide funding for the development and implementation of a Latrobe Valley social marketing campaign, co-designed by the expert panel members and the community, which recognises the natural assets of the Latrobe Valley, builds a sense of hope and optimism, and assists in the re-establishment of community pride (discussed further in Part 8).

Developing partnerships with the media was also recommended by the expert panel, with strong interest expressed in working in this way.

The Board supports and encourages strong partnerships between organisations of the Latrobe Valley, VicHealth and the media to build pride of place. The development of a co-designed social marketing campaign, as recommended above, is an opportunity to commence this partnership.

The Board agrees with the views expressed by VicHealth—that the introduction of a campaign needs to be accompanied by strategies for implementing new social and economic opportunities in the Latrobe Valley, to ensure that the campaign is successful in promoting positive outcomes.

> The Board recommends that an initial health improvement program is focused on innovative ways to deliver social marketing programs which build pride of place.

PART EIGHT
STRENGTHENING LEADERSHIP AND SUSTAINABILITY

PART 8 STRENGTHENING LEADERSHIP AND SUSTAINABILITY

Parts 4–7 of this report have considered the health issues affecting Latrobe Valley communities; the health responses that currently exist and how these might be leveraged and improved; and the gaps in health responses and how these might be addressed. In light of the many issues that have been discussed in these Parts, Part 8 considers the leadership, governance and resourcing requirements that will support the design, implementation and sustainability of health improvement strategies in the Latrobe Valley.

The importance of community participation and engagement for improving health in the Latrobe Valley is discussed in detail in Part 7 of this report. This Part considers how the four principal health organisations in the Latrobe Valley—namely, Latrobe Regional Hospital, Latrobe Community Health Service, Gippsland Primary Health Network and Latrobe City Council—can work more effectively together in leading better health outcomes for the community. These organisations carry significant responsibility for future advances in health in the Latrobe Valley.

This Part also explores:

- The designation of the Latrobe Valley as a health zone, as proposed in the 2014 Hazelwood Mine Fire Inquiry Report, to support the governance, implementation and coordination of health improvement strategies.

- The role of a Health Advocate, as proposed in the 2014 Hazelwood Mine Fire Inquiry Report, in providing leadership and advocacy for the health of the Latrobe Valley community.

- Funding and sustaining health improvements in the Latrobe Valley in ways which will ensure they result in measurable, long-term improvements to health.

Two expert panels were convened during the Health Improvement Forums to consider governance, leadership and sustainability:

- Health conservation zone and health advocate panel: Mr Gary Van Driel CEO, of Latrobe City Council; Mr Ben Leigh, CEO of Latrobe Community Health Service; Mr Peter Craighead, CEO of Latrobe Regional Hospital; Ms Marianne Shearer, CEO of the Gippsland Primary Health Network; Mr Colin Sindall, Director of Population Health and Prevention Strategy at the Department of Health and Human Services (DHHS); Mr Greg Blakely, Regional Director for Health in Gippsland at DHHS; Professor Donald Campbell, Professor of Medicine, School of Clinical Sciences at Monash University and Program Director, General Medicine, Monash Health; and Professor Evelyne de Leeuw, Director of Glocal Health Consultants, Editor-in-Chief of *Health Promotion International,* and the Director, Centre for Health Equity Training, Research and Evaluation, University of New South Wales.

- Governance, leadership and sustainability panel: Mr John Guy, Chair of the Board of Latrobe Community Health Service; Ms Kellie O'Callaghan, Chair of the Board of Latrobe Regional Hospital; Dr Nola Maxfield, Chair of the Board of the Gippsland Primary Health Network; Councillor Dale Harriman, Mayor of Latrobe City Council (at the time of this forum); Ms Kym Peake, Acting Secretary of DHHS; and Mr Terry Symonds, Deputy Secretary, Portfolio Strategy and Reform at DHHS.

In the Board's opening remarks to the panel on governance, leadership and sustainability, Professor John Catford highlighted the need to consider 'joined up leadership – agencies engaged and co-designing with the community'. He asked expert panel members to provide advice on how to build and strengthen health in the Latrobe Valley going forward, in light of the many issues that had been considered in greater depth during the previous Health Improvement Forums.[1]

8.1 STRENGTHENING LEADERSHIP AND COLLECTIVE ACTION

GOVERNANCE AND LEADERSHIP

The Victorian healthcare system is administered by the State and operates as part of a national system of healthcare financing and delivery.[2] The State is responsible for ensuring a wide range of health services are delivered to the Victorian community. DHHS plans, develops policy directions and policies, and funds and regulates health service providers and activities.[3] Through DHHS, the State funds more than 500 organisations to provide various health services to Victorians, including:

- acute and subacute healthcare delivered by public hospitals and in community settings
- mental health and alcohol and drugs services delivered by public hospitals and community services organisations
- residential and community care for older people, support and assistance to enable people to function independently in their own homes, positive ageing programs, and healthy and active living
- primary health services delivered by a wide community of health services and others
- health promotion and protection through emergency management, public health and related preventative services, education and regulation
- emergency transport and ambulance services through Ambulance Victoria.[4]

The Commonwealth Department of Health also has key governance and funding roles in the Latrobe Valley, for example through the Medicare system, the Gippsland Primary Health Network, and directly funded state-level non-government health agencies. The Department's wide range of functions includes:

- public health, including health protection
- health promotion and disease prevention
- primary healthcare
- hospitals funding and policy, including relationships and linkages within the continuum of healthcare
- health research
- pharmaceutical benefits
- health benefits schemes
- sport and recreation
- national drug strategy
- regulation of therapeutic goods
- private health insurance
- health workforce capacity
- mental health policy and primary mental healthcare.[5]

Figure 10 below illustrates the complex arrangements between State, Commonwealth and private providers.

Figure 10. Health services funding and responsibility[6]
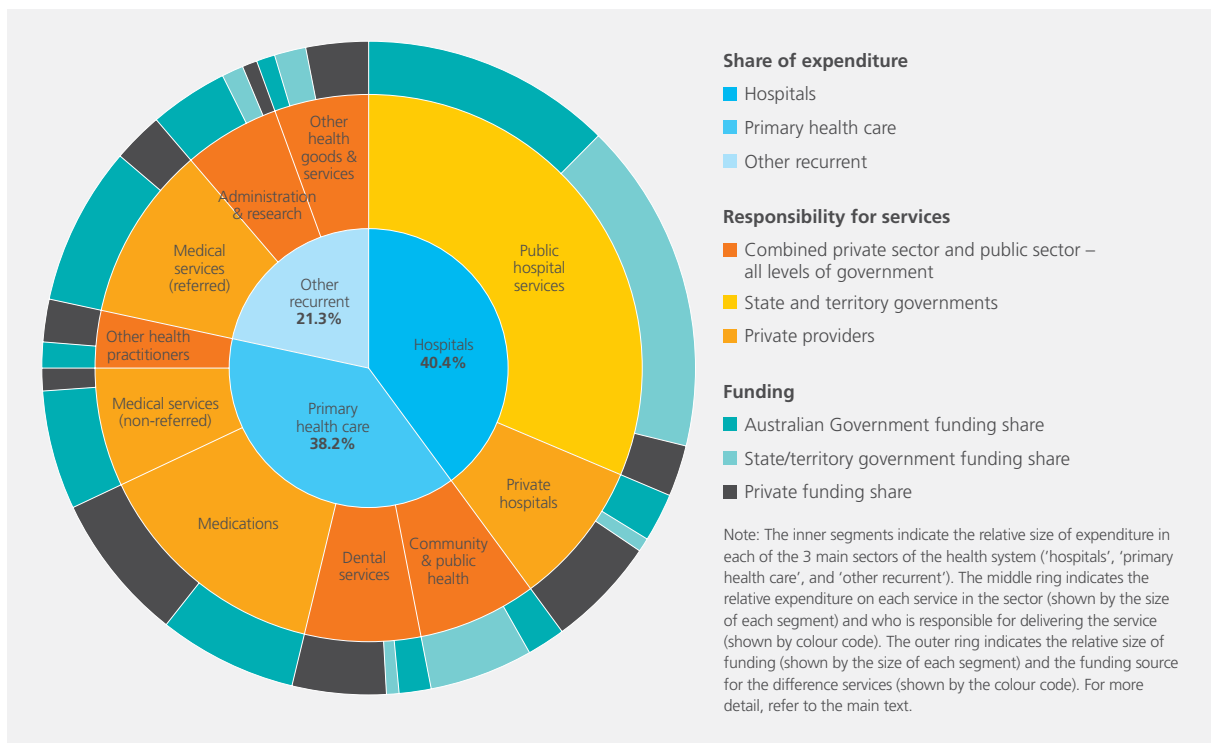
Victoria has a long-established system of devolved governance for healthcare delivery. Devolved governance allows health services 'to make local decisions to meet local needs, recognising that a solution in one place—with a unique combination of patients and service demand, culture or workforce—may not be the most effective solution in another environment.' For example, Victorian hospitals are organised into local network entities that are governed by a board, the members of which are appointed by the Governor-in-Council, generally on the recommendation of the Minister for Health. The entities are incorporated public statutory authorities established under the *Health Services Act 1998* (Vic) (Health Services Act).[7]

In her presentation to the board, Ms Kym Peake, then Acting Secretary of DHHS, noted that DHHS had been actively listening to the issues raised by the Latrobe Valley community in the Health Improvement Forums—in particular, the importance of a more coordinated person-centred approach to healthcare; the need for new initiatives to be co-designed with the community; the desire for long-term sustainable solutions; and the need to build on the strengths of the community. Ms Peake acknowledges that social determinants, higher levels of chronic disease and barriers to healthcare access are critical issues that need to be addressed in any future planning.[8]

> [W]e've heard really strong feedback that a long-term whole-of-community approach is required to improve health and wellbeing, based on governments and communities working together to improve economic opportunities, social supports and to address the drivers of both good and ill-health.[9]

Ms Peake noted that Victoria's healthcare system does perform well but that there are areas which can be improved. For example, Ms Peake acknowledged that the current system does not work well for people with chronic or complex needs:

> care is often not well coordinated to meet people's needs; we don't have a strong enough focus on prevention, early intervention and self-management; patients in communities are not always treated as partners in care, and there are variations in health outcomes across different parts of our community.[10]

Ms Peake advised the Board that a regional review conducted by DHHS in early 2015 indicates that current approaches to regional health planning would benefit from DHHS having deeper local engagement and better feedback loops to 'inform and influence State Government policy and investment decisions.'[11] Ms Peake further noted that using local leadership that leverages off networks that already exist should be incorporated into future approaches.[12]

Ms Peake noted the current *State Public Health and Wellbeing Plan* and the State's regional planning processes as providing for more sustainable healthcare solutions. She indicated that strategic plans have continued to exist beyond electoral cycles where those plans have originated from a planning process that is embedded in the community. Further, initiatives that are measured with success are more likely to receive ongoing funding from a new government.[13]

Mr Terry Symonds, Deputy Secretary, Portfolio Strategy and Reform at DHHS, brought the Board's attention to the Victorian Auditor-General's guide, released earlier this year, which calls for agencies to better include communities in health service governance. In response, DHHS has established an engagement branch that will develop an approach to 'public participation in policy making to ensure that our policies and programs are well directed to the needs of communities.'[14]

Mr Symonds provided a number of examples of successful community governance of health strategies. *Koolin Balit* is a DHHS-initiated Aboriginal health strategy where over half the budget is managed by local committees. In Gippsland, the Aboriginal community controlled health services determine the local priorities and how funding under this strategy will be allocated.[15] The DHHS *Healthlinks* program also provides an opportunity for hospitals to determine how they can best use their funding to meet the needs of the communities they serve.[16]

With respect to the Commonwealth's role in local healthcare, Mr Symonds explained to the Board that there are six Primary Health Networks in Victoria (the Gippsland Primary Health Network being one of them), and that the purpose of these networks is to understand local health needs and to commission primary care services according to these needs. He noted the Commonwealth Government's establishment of a Primary Healthcare Advisory Group that will advise the Commonwealth Government later this year of options for primary healthcare reform. He suggested to the Board that the Gippsland Primary Health Network may have a leadership role in setting the agenda for local, state and Commonwealth-funded primary healthcare services, and in governing funding models for local general practitioners.[17]

Mr Martin Bowles, Secretary of the Commonwealth Department of Health, states in his written submission to the Inquiry:

> From 1 July 2015 the Medicare Local ceased, and the Gippsland Primary Health Network (GPHN) commenced operations, with the aim of increasing the efficiency and effectiveness of medical services for patients and improving coordination of care [in the Latrobe Valley]... This work will be informed by the involvement of GP-led Clinical Councils and Community Advisory Committees... The GPHN will use these consultation mechanisms to identify innovative local arrangements for the effective delivery of services under their flexible funding allocations. This could include activities in the Latrobe Valley with regard to the ongoing health impacts associated with the Hazelwood Coal Mine Fire.[18]

Dr Nola Maxfield, Chair of the Board of the Gippsland Primary Health Network, told the Board that the Gippsland Primary Health Network has 'a mandate and an opportunity to contribute to a collaborative governance system and leadership that's going to create a sustainable response and support to grow the health of the Valley community.'[19] She confirmed the commitment of the Gippsland Primary Health Network to work collaboratively to achieve these outcomes.[20] Dr Maxfield suggested to the Board that in the short-term, a collaborative network of community and health leaders could be created to establish a strong commitment to action in the Latrobe Valley.[21]

The importance of community development approaches to effective health governance was reiterated by a number of panellists. Dr Maxfield emphasised that sustainable health improvements come from 'an enduring intuition of shared commitment' with the community to improve health.[22]

In its submission to the Board, VCOSS state that good governance and 'strong trusted leadership' is required to address long-term disadvantage and improve health outcomes in the Latrobe Valley.[23] Professor Evelyne de Leeuw, Director of Glocal Health Consultants, Editor-in-Chief of *Health Promotion International,* and the Director, Centre for Health Equity Training, Research and Evaluation, University of New South Wales, advised the Board that the Latrobe Valley community does not believe the current leadership of health and wellbeing organisations is serving them well, and that what they want is more 'concrete action'[24] and that the action needs to be taken now.[25]

Professor de Leeuw told the Board of the importance of people 'taking charge of their own fate, and their fate not just in health or wealth or wellbeing, it really is active improvements in their direct living environment.'[26]

Mr Ben Leigh, CEO of the Latrobe Community Health Service, Councillor Dale Harriman, Mayor of Latrobe City Council (at the time of this forum), and Ms Kellie O'Callaghan, Chair of the Board of Latrobe Regional Hospital, also acknowledged the need for community involvement in the oversight of health strategies.[27]

Councillor Harriman also noted the importance of harnessing local community leaders when the Council considers new structures or initiatives relevant to community health and wellbeing. He acknowledged three local groups who have played a key role in providing leadership around health for the Latrobe Valley community to date—the Morwell & Districts Community Recovery Committee, the Morwell Neighbourhood House, and Voices of the Valley.[28]

Mr Colin Sindall, Director of Population Health and Prevention Strategy at DHHS, also emphasised to the Board that one of the most important components of sustaining positive health outcomes in communities is to ensure that actions towards improving health are 'designed with, owned by, local communities and local agencies.'[29]

Mr Sindall informed the Board of a recent report entitled *What's next for place based initiatives to tackle disadvantage?* which reviews a number of place-based models, including the *Go Goldfields* model discussed in Part 7 of this report. Mr Sindall explained that the report provides examples of communities who are exercising appropriate governance over health initiatives, including tracking and monitoring progress and reporting back to the broader community.[30]

COLLECTIVE ACTION

The Board heard that there is a need to integrate the work of the four principal stakeholder organisations that have responsibility for the health of the Latrobe Valley community.

'Collective action', also known as 'collective impact', is an emerging model of collaboration based on the notion that no one organisation on its own can bring about the change required to improve health. This approach goes beyond traditional collaborative models, whereby organisations share information and networks. Collective impact refers to a core group of community leaders abandoning their individual agendas in favour of adopting a common agenda, such as health improvement. Collective impact has five principles:

- Common agenda—all participants have a common understanding of the problem they are facing, a shared vision for the change they want to see, and a joint approach to change through agreed actions.

- Shared measurement systems—built on agreement between the organisations of the ways in which success will be measured and reported.

- Mutually reinforcing activities—all participants work together, not necessarily doing the same thing, but encouraging and supporting each other to undertake the specific activities they are best placed to progress.

- Continuous communication—this involves senior leaders meeting regularly and not delegating attendance to lower level delegates. It also includes communicating informally through various mediums.

- Core support—requires an office or secretariat with dedicated staff, separate from participating organisations, to support the entire initiative.[31]

Mr Symonds highlighted some examples of this approach, including *Carepoint*, a partnership between private health insurers and the State, and Primary Care Partnerships, which have a strong history of cross-sector collaboration.[32] Primary Care Partnerships exist across Victoria. They are long-standing collaborations between Community Health, Councils, health service providers and Medicare Locals (recently replaced by Primary Health Networks).

Mr Sindall advised the Board that the *Central West Gippsland Primary Care Partnership* and the *Children and Youth Area Partnership* aim to coordinate work across health agencies in the Latrobe Valley.[33] The *Central West Gippsland Primary Care Partnership* is a partnership between health and community support agencies which strives to strengthen relationships of primary care providers in order to improve service coordination and integration. The partnership has a number of strategies to achieve its aims, including promoting early intervention and health prevention programs.[34] The *Children and Youth Area Partnership* is discussed in Part 6 of this report.

Members of the expert panel on governance, leadership and sustainability also noted that many examples of collective action were raised throughout the Health Improvement Forums. This included the work of the Primary Health Networks in developing 'care pathways' discussed in Part 4 of this report.[35]

8.2 DESIGNATED HEALTH ZONE FOR THE LATROBE VALLEY

Ms O'Callaghan, stressed the importance of adopting a new approach to health services in the Latrobe Valley as 'doing more of the same is not going to work.' [36] Ms Wendy Farmer, a Latrobe Valley resident, expressed her concern to the Board that it is some 18 months after the Hazelwood mine fire and still nothing has changed. She urged the Board to take action.[37]

Health innovation and reform has been identified at both State and Commonwealth levels as a key priority for policy change. 'Innovation' in the design and delivery of health services was a key principle identified at the recent Victorian Health 2040 Summit: '[t]here is strong support for a new systemic approach to innovation, to ensure that we make the best use of the great ideas developed by individuals working across our health system.'[38] The Travis Review, which examined increasing the capacity of the Victorian public hospital system, also had recommendations for system innovation in particular new models of service delivery.[39] Innovation is also a function of the new Primary Health Networks, with special innovation funding being made available by the Commonwealth Government.[40]

In the 2014 Hazelwood Mine Fire Inquiry, the Board proposed that further consideration be given to the concept of a designated health zone. This is referred to in the 2014 Hazelwood Mine Fire Report as a 'health conservation zone' and is described as follows:

> One way of providing a focal point for the coordination and integration of health services is to nominate the Latrobe Valley as a priority area for action across the health continuum… The Victorian Government could require and encourage all relevant agencies and organisations to collaborate to protect and improve the health of the people of the Latrobe Valley…The Victorian Government could provide additional funding and other resources to enable this, together with legislative and regulatory measures where necessary.[41]

During the re-opened Inquiry, the community expressed support for the concept of a specially designated health zone. In its written submission to the Board, Voices of the Valley is explicit in its support of a health zone designation for the Latrobe Valley.[42]

The Latrobe Community Health Service, Gippsland Primary Health Network, Victorian Healthcare Association, Victorian Branch of the Public Health Association Australia, and Cancer Council Victoria also support the designation of the Latrobe Valley as a health zone, noting that the Latrobe Valley could be a test case for such a designation, allowing other areas and regions to draw on the experience and potential success.[43] In its submission, the Royal Australasian College of Physicians states that the development of a health zone could enhance knowledge and increase capacity to respond to industrial disasters.[44]

Ms Marianne Shearer of Gippsland Primary Health Network, stated that the health zone would need to focus on integration of care.[45]

DESIGNING A HEALTH ZONE

Many written submissions received by the Board outline key areas for consideration when designing a health zone. These include:

- Having clear geographical margins[46]

- Considering how the zone would interact and overlay with existing services[47]

- Adopting programs and procedures that have proven effectiveness for the region[48]

- Establishing specific goals and objectives from inception, with a clear plan on how to achieve them[49]

- Ensuring 'collaborative management'[50]

- Resourcing the zone with a full time public health physician, working with the regional public health manager, health promotion officers and the regional environmental health officer[51]

- Ensuring any new positions or services are located within the Latrobe Valley.[52]

Professor Donald Campbell, Professor of Medicine, School of Clinical Sciences at Monash University and Program Director, General Medicine, Monash Health and Professor David Clarke, Professor of Psychological Medicine, Department of Psychiatry, Monash University, and Medical Director of the Mental Health Program at Monash Health, provided the Board with an extensive report that reviews the literature and research relevant to health zones. In their report, Professor Campbell and Professor Clarke discuss the health action zones implemented in the United Kingdom in the late 1990s. Health action zones were multi-agency partnerships located in 26 areas of England. The three broad objectives of these zones were to: identify and address the public health needs of the local area; increase the effectiveness, efficiency and responsiveness of services; and develop service partnerships for improving people's health. The majority of the initial programs sought to improve health by promoting healthy lifestyles, improving employment, housing, education and tackling substance abuse.[53]

However, the United Kingdom health action zones were abandoned in 2003 for reasons linked to poor conception and implementation, such as insufficient community buy-in and the setting of unclear directions.[54] Professor Campbell and Professor Clarke refer to an evaluation of the zones by Professor Ken Judge stating:

> the [health action zone] experience clearly demonstrated that there was a need to think more carefully about the focus of such initiatives, their objections, their timescales, the support that they need both locally and nationally and the space, trust and time that is required to make any kind of sustainable change possible. The testable but unstated thesis is that a well-conceived, well supported [health action zone] which was immune to political disruption and established for a longer period, could be effective. [55]

In their report Professor Campbell and Professor Clarke discuss the work of Elinor Ostrom, Nobel Prize winner for economics, in relation to 'common pool resources'. The work of Ostrom debunks the theory that only strong government or private ownership can successfully manage a shared resource pool.

Professor Campbell and Professor Clarke also refer to work undertaken by Michael McGinnis, who argues that the community benefits from access to the shared resources of health and healthcare services, such as physical facilities (for example, hospitals), financial resources, human capital (that is, health professionals) and social capital (trust amongst health professionals and community members).[56] McGinnis argues that collaborative stewardship of common resources will enable the stakeholders who are most directly concerned with the long-term sustainability of these resources, to take ownership, and coordinate ways to use the resources and make decisions based on long-term perspectives. McGinnis concludes that collaborative stewardship of shared resources will lead to better health outcomes and higher quality of care delivered at a lower-cost to a wider segment of the community.[57]

In their report, Professor Campbell and Professor Clarke set out ten directions that McGinnis, referencing the work of Ostrom, suggests for managing the healthcare resources pool:

1. Find a trusted convener—Identify a widely respected individual, group, or organisation to convene and sponsor general meetings on public health and healthcare.

2. Think systematically—Identify leaders who share a deep understanding of the overall dynamics of their regional system, and who respect the defining values of the local community.

3. Build momentum—Establish a forum for regular meetings of officials from key stakeholder groups to discuss plans and concerns, and focus discussions on meaningful and interdependent tasks.

4. Establish shared priorities—Collectively assign the highest priority to those locally-based programs that can best contribute towards effective improvements in health or healthcare for the community as a whole, and arrange secure funding for these high-priority programs.

5. Align programs to community values—Encourage local stakeholders to consider community-wide effects when setting their own corporate missions and policies.

6. Gather and share information—Systematically collect data for high-priority programs and comparative performance measures, and share this information widely.

7. Hold each other accountable—Establish common expectations about how violations of agreements will be sanctioned, and adjust the levels of sanctions so that stakeholders who act protectively are warned but not excluded from subsequent discussions.

8. Recognise inequities—Pay careful attention to any concerns that the benefits and costs of these high priority programs are distributed in an unbalanced or unfair way.

9. Remain practical—Resolve disputes locally, if possible, and in ways that respect the vital interests of all stakeholders, avoid partisan entanglements and leave minimal recriminations.

10. Nurture innovation—Endeavour to make sure that all individual and joint actions contribute to the sustainability of a multi-level eco-system of effective innovations and continuous learning.[58]

Based on the above, and notwithstanding the United Kingdom experience, Professor Campbell and Professor Clarke state that there is an opportunity for the Latrobe Valley to reorganise health services in a very different way and that the Latrobe Valley community needs to be involved in healthcare decision-making via a genuine process of co-design.[59] They state that a health conservation zone should be declared in the Latrobe Valley to provide for 'responsibility at a local level for financing and policy settings to foster effective local governance of improvement activities in the Latrobe Valley.'[60]

Professor Campbell and Professor Clarke advise that the zone should be maintained for a period of at least five years and be supported by a mechanism to ensure that it survives a change in government.[61]

Professor Campbell told the Board that the suite of initiatives and programs that should be considered for a health zone approach include employment pathways for people experiencing disadvantage, ensuring the right healthcare workforce is in place, and developing a financial plan to ensure sustainability of the model in the long-term.[62] He advised the Board that the establishment of a zone would require 'some seed funding'.[63]

Ms O'Callaghan, Chair of the Latrobe Regional Hospital, advised the Board that a designated health zone could facilitate:

> …immediate focus on decision-making, resourcing and planning that focuses on the health and wellbeing of our local community; developing models and practices that are reflective of community expectation, working alongside community organisations and service agencies to identify current gaps, barriers and inhibitors to good outcomes for individuals and groups; and then implement pathways, processes and models in partnership with all stakeholders to ensure a strengthening of outcome for a local community.[64]

In their expert report to the Board, Professor Evelyne de Leeuw Director of Glocal Health Consultants, Editor-in-Chief of *Health Promotion International*, and the Director, Centre for Health Equity Training, Research and Evaluation, University of New South Wales and Associate Professor Marilyn Wise Associate Professor, Centre for Primary Health Care and Equity, University of New South Wales, explain that place-based initiatives are a way of thinking about the concept of a health conservation zone, and in part underpin the concept.[65] Place-based initiatives are targeted to a particular geographic location that experiences concentrated disadvantage. They have been used to address health inequity and are discussed in Part 6 of this report.[66] Mr Sindall noted that the recently released *State Public Health and Wellbeing Plan* emphasises a commitment to place-based initiatives and that the convergence of place-based initiatives and a designated health zone provides a real opportunity for the healthy future of the Latrobe Valley.[67]

The concept of 'systematic listening' particularly resonated in discussions about what was needed to support the success of a designated health zone. Systematic listening refers to listening directly to the experiences and concerns of consumers coping with ill health. It assumes that the personal experiences of consumers are legitimate, and that consumers are a valuable source of input for planning health initiatives and responses.[68]

Councillor Harriman, a member of the expert panel on governance, leadership and sustainability, told the Board that a specially designated zone would also provide an opportunity to incorporate community-led approaches to improving health outcomes, with the community co-creating the direction, functions and reporting arrangements.[69] Councillor Harriman recommended that 'the Health Conservation Zone should be established for a period of at least 10 years to coincide with the work being undertaken through the Monash Health study.'[70]

There was general agreement between the expert panels that the designation of the Latrobe Valley as a health zone should build on existing health service coordination and planning efforts.[71] In its submission, the Victorian Branch of the Public Health Association Australia (PHAA) notes the importance of a health zone building on existing partnerships and activities, such as those initiated under the Latrobe Valley *Healthy Together Victoria* program.[72]

ESTABLISHING A HEALTH ZONE

The Board heard from Mr Sindall that a mechanism to govern and lead the establishment of a health zone 'could be a consultative council created for Latrobe Valley' under the *Public Health and Wellbeing Act 2008* (Vic) (Public Health Act), which 'empowers the Minister of the day to establish a consultative council.'[73] It was suggested that the Chair of such a council could also hold the role of the proposed Health Advocate for the Latrobe Valley.[74] The Health Advocate is discussed in more detail below.

The Board notes that Part 4 of the Public Health Act includes a series of provisions relating to the establishment of Consultative Councils. Section 33(1) of the Act provides that the Minister may establish by Order a Consultative Council as the Minister considers appropriate 'in respect of matters and functions that the Minister determines and specifies in the Order'. Section 33(3) enables the Minister to appoint members of such a Council of whom one must be the Chairperson. The majority of appointees must be 'persons with special knowledge in the matters specified for that Consultative Council'.[75]

Under s 36 of the Act, a Consultative Council may, subject to the approval of the Minister, appoint a sub-committee for the purpose of carrying out any of its functions. Under s 37(2)(a), the Minister or the Secretary may give a direction in writing to a Consultative Council 'to consider and report on a matter relevant to the functions of the Council specified in the direction'.

An example of a Consultative Council established under the Public Health Act is the Consultative Council on Obstetric and Paediatric Mortality and Morbidity.[76] The functions of this Consultative Council are set out in s 46. Its role is to conduct research into the incidence and causes of maternal deaths, stillbirths and the deaths of children, provide information to health service providers, and report to the Minister or Secretary on any matter referred by either of them to it.[77] Its budget is controlled by the Secretary.[78]

In their report to the Board, Professor Campbell and Professor Clarke suggest that the zone should be managed collaboratively as a health commons by a 'commission' with a 'health commissioner' as its chair. They note that the commission could be an 'exemplary manifestation' of the work to be undertaken by the local Primary Health Network.[79] Other suggestions made by Professor Campbell and Professor Clarke in relation to the structure and governance of a 'commission' include:

- The 'commission' will have the responsibility of engaging with the community to co-design a healthcare system that will meet its needs, incorporating best practice approaches.[80]

- The 'commission' should be responsible for maintaining the scale and scope of activities in relation to the health strategy and operational plan for the Latrobe Valley. The health activities and health service partnerships must be recognised and managed as 'inextricably inter-related sets of activities'.[81]

- The 'commission' should have a steering committee, including representatives from the Council, community health centres, regional health service, DHHS, Primary Health Network, public and

private health insurers, local medial practitioner groups, the aboriginal community, local business (including power generation companies and mining companies), and representatives from the social sector including housing and justice.[82]

- The 'commission' will need an external advisory body to assist and guide its development, comprising members with a broad range of expertise including business, finance, healthcare and policy.[83]

- The 'commission' should ensure that the activities it undertakes are measured and reported to the community.

- The 'commissioner' should report annually to the community.[84]

Professor Campbell and Professor Clarke also suggest that the appointment of a 'commissioner' (or Health Advocate) would need to be a person who can engender trust broadly across the community, provide 'selfless leadership' and take responsibility for the implementation of change.[85]

In its submission to the Board, VCOSS states that:

> [a]ny independent Chair or Commissioner of a Health Conservation Zone would need a unique set of skills, ability, profile, respect, networks and standing to influence key decision and mobilise the community. Importantly any initiatives must involve community groups that not only represent disadvantaged and vulnerable people, but that have expertise at a grass roots level. There is also a need to regularly report to the community against a dashboard of community health indicators.[86]

Mr Sindall told the Board that preliminary work has been undertaken by DHHS to explore a special zone designation for the Latrobe Valley. This work has involved convening two roundtable discussions with a range of people from all levels of government as well as non-government agencies in the Latrobe Valley.[87]

8.3 HEALTH ADVOCATE FOR THE LATROBE VALLEY

In the 2014 Hazelwood Mine Fire Inquiry, the Board proposed that 'the Latrobe Valley needs a local health voice that can win the trust of the community and be a sound source of advice, mediation and advocacy on health-related matters.'[88] The Board also suggested that a Health Advocate could provide leadership and assist in communicating and engaging directly with the community about health matters.[89]

Health advocacy is key to achieving health improvements. In their expert report, Professor de Leeuw and Associate Professor Wise refer the Board to the *Ottawa Charter for Health Promotion* (Ottawa Charter) as a foundational international document for enabling people to 'increase control over and improve their health.'[90] The Ottawa Charter states that:

> Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.[91]

During the re-opened Inquiry, the Board heard consistent support for the concept of a Health Advocate, referred to as a 'commissioner' by Professor Campbell and Professor Clarke, particularly in community consultations. The health conservation zone and health advocate expert panel also supported the concept of a Health Advocate in principle. The panel considered that ultimately, the success of the Advocate would depend on their capacity to effectively engage with the community.[92]

In its submission to the Board, the Victorian Branch of the PHAA strongly endorses the concept of a Latrobe Valley Health Advocate. It suggests:

> that a local medical and/or public health professional with requisite specialist knowledge and skills in prevention and community engagement would be the most appropriate person for the Health Advocate position. Such a person would be both known and respected as a health and/or medical authority in the Latrobe Valley, and be seen as truly independent of government and thereby able to garner community trust and offer the frank and fearless advice to government that would be critical to success in the role.[93]

Ms O'Callaghan described the role of a Health Advocate as:

> our champion for change, the individual who would drive the innovation, breaking down the barriers and building up the relationships. The Health Advocate needs to be underpinned by a strong values base, with a focus on leadership, accountability and the capacity to report back to the community, integration and collaboration across a broad range of stakeholders, and flexibility with the capacity to change and adapt approaches to ensure responsiveness.[94]

Some organisations told the Board that a Health Advocate should not necessarily have a background in health, while others were of the view that a Health Advocate should be a well-respected and well-known leader within the health sector.[95] Professor de Leeuw told the Board that whilst it might be important to have a well-known figure as an advocate, the role could really be considered 'a function rather than a person.'[96]

In a number of submissions before the Board, the essential characteristics of a Health Advocate are identified as being independent,[97] respected by the community,[98] and well resourced.[99] Councillor Harriman suggested that the Health Advocate could be several people, not just one, and that the role should be located in the Latrobe Valley. Ms O'Callaghan and Mr John Guy, Chair of the Board of Latrobe Community Health Service, described the Health Advocate as a person or persons who could work independently from a shopfront in Morwell.[100]

In its submission, VicHealth suggests that the following competencies are required of a Health Advocate:

- Knowledge of health promotion.
- Ability to lead effective consultation processes with community members, industry, agriculture, health services, community organisations and all levels of government.
- Connections with the Latrobe Valley community, including local knowledge and relationships with key local partners.[101]

In its submission to the Board, the Victorian Branch of the PHAA reiterate the possible competencies of a Health Advocate as described in the 2014 Inquiry as 'leadership, monitoring and assessing the health of the public, policy, planning and program development, communication, collaboration and partnering, foundational clinical competencies and professional practice.'[102]

There was some concern that the role may duplicate services already in operation. In its submission, the Victorian Healthcare Association states:

> under existing arrangements local governments are required to deliver a Municipal Public Health and Wellbeing Plan, public health services are required to form a Population Health Advisory Committee, Primary Health Networks will undertake population health needs analyses, registered community health services undertake similar studies of local health needs; all of which would have a degree of interaction with the population residing within the proposed Zone and under the remit of the proposed Advocate.[103]

8.4 ADDITIONAL HEALTH FUNDING FOR THE LATROBE VALLEY

A white paper released by the Commonwealth Department of Prime Minister and Cabinet in December 2014 discusses the history and complexities of the funding arrangements for health services between the Commonwealth and States.[104] The white paper refers to the number of pressures on Australian healthcare arrangements, including the increasing demand on services leading to rising health expenditure —in particular, the ageing population; the higher incidence of chronic disease; and shortages of health professionals, particularly in rural and regional areas. Health expenditure is expected to be the main source of pressure on both State and Commonwealth budgets in the future.[105]

The white paper also notes:

- there is no single overarching 'health system'—rather, healthcare is a 'complex web of services, providers and structures. All levels of government (Commonwealth and State) share responsibility for health with different roles (as funders, policy developers, regulators and service deliverers) although in some cases, those roles are sometimes shared

- the Commonwealth is predominantly responsible for primary care—general practitioners and some medical specialists; medical and pharmaceutical benefits

- the States are predominantly responsible for public hospitals, ambulances, community and mental health services, and health infrastructure

- the Commonwealth and States share roles relating to community health, mental health, public health arrangements and the health workforce

- the not-for-profit sector and private sector also have significant roles in healthcare and its funding.[106]

The funding flows in Australia's healthcare arrangements as they existed in 2012–2013 are demonstrated in Figure 11 below. This figure illustrates the proportional split between the Commonwealth, States and private sector in funding for healthcare, noting that the private sector provides a significant amount to healthcare.

Figure 11. Funding flows in Australia's healthcare arrangements 2012–13[107]
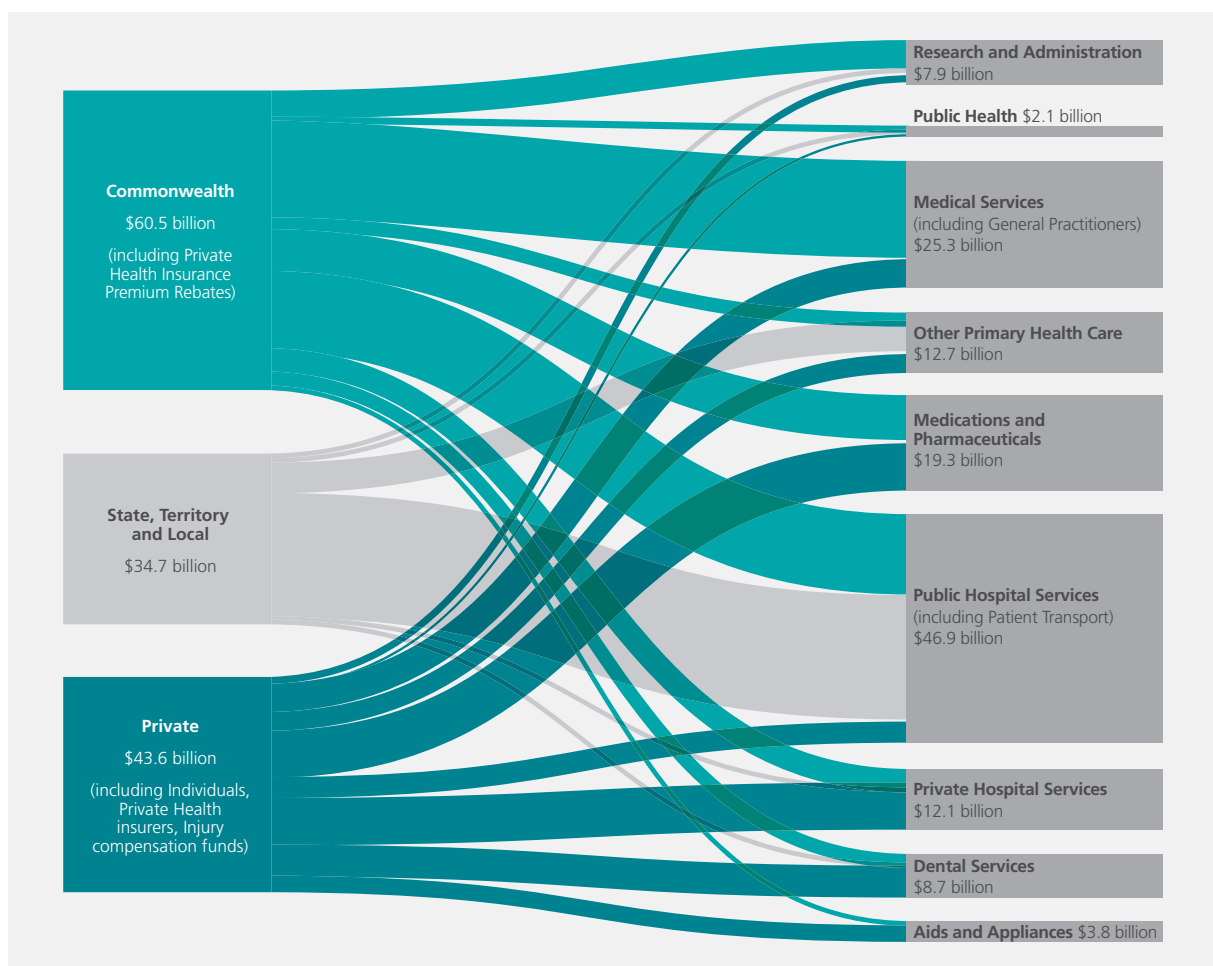
Ms Sylvia Barry from DHHS referred the Board to the Health 2040 Summit, and the focus on health reform at a State level.[108] The Health 2040 Summit discussion paper states that 'it is vital for the Commonwealth and state and territory governments to work cooperatively to get the right policy settings and funding arrangements in place to allow the system to work in a unified way.' Following the Summit, the State Minister for Health and the State Minister for Mental Health announced that one of the key principles identified at the Summit was 'strong support for a new systemic approach to innovation, to ensure that we make best use of the great ideas developed by individuals working across our health system.'[109]

According to *DHHS Policy and Funding Guidelines 2015*, DHHS 2015–2106 budget totals over $20 billion, representing a 6.2 per cent increase in overall funding from 2014–2105.[110] Of this amount, the 2015–2106 State Budget provides $15.852 billion recurrent funding for health, mental health and aged care services.[111] The Guidelines record that some of the budgeted initiatives include:

- $1.38 billion in additional funding for health, mental health and aged care sectors, with $561.3 million for new investment in hospital infrastructure

- $717 million in funding over five years for programs and services targeting Victorian communities, families, children and young people

- $327.7 million in additional funding for acute health and ambulance services output initiatives

- $29.1 million for mental health output initiatives

- $6.8 million in additional funding for the Home and Community Care (HACC) program, providing indexation of funding

- $17.6 million in additional funding for public health

- $28.7 million for the primary, community and dental output program to deliver the government's election commitment to establish 20 super pharmacies across metropolitan and rural Victoria

- $206 million 'budget boost' for people with disability, their families and carers, as well as people who are either homeless or facing homelessness, including $7.5 million for housing assistance support services for people who experience, or at risk of experiencing family violence

- $117.8 million in extra funding for mental health, including $88.2 million to provide 80—adults and up to 500 older people with intensive, specialist support they need and funding to help manage critical demand pressures in the mental health systems

- $70 million to replace clinical services hardware, engineering infrastructure and medical equipment

- $99 million for ambulance services, including $20 million for capital upgrades and $20 million for equipment

- $15 million of initial funding to progress planning to build Australia's first specialist heart hospital

- $226 million to support community sports clubs and upgrade stadiums and venues across the state so they can host more events and hold more spectators.[112]

Funding for public health is a combined Commonwealth and State responsibility.[113] In the 2014–15 Commonwealth budget, the Commonwealth announced significant changes to health funding arrangements between the State and Commonwealth governments, particularly with respect to the allocation of funding under the *National Health Reform Agreement*.[114] *DHHS Policy and Funding Guidelines 2015* record that the 2015–16 Commonwealth Budget reported $4.1 billion in national health reform payments to Victoria in 2015–16.[115] The Commonwealth continues to play an important role in healthcare funding, and in establishing priorities in healthcare spending and reform.[116]

FUTURE FUNDING NEEDS

The Board heard repeatedly of the need for additional resources over the long-term to support new approaches to improving health, such as a designated health zone.

Councillor Harriman proposed that '[to] ensure that the Inquiry's recommendations are able to make a meaningful difference, adequate funding will need to be provided to facilitate opportunities for innovation, transformation and dynamic co-creation.'[117]

Professor Campbell and Professor Clarke note in their report that substantial funding is necessary to implement the zone, with recurrent funding being provided for ongoing expenditure, and that the State and Commonwealth should have a role in funding the zone and the 'commission' overseeing it. They also note that a long-term strategy needs to be implemented to ensure that funding is resistant to political inference.[118]

In relation to the role of a Health Advocate, the Victorian Branch of the PHAA states that 'remuneration for this role would be crucial, as would appropriate infrastructure and resources to enable delivery of this function.'[119]

The Board was also informed that the Hazelwood Mine Fire Health Study has been allocated an average of approximately $2.7 million per annum (see Part 3 of this report).[120]

The Board was advised that the Latrobe Valley region contributes significantly to State revenue by way of mining royalties, rent and levies. Revenue of approximately $37 million per annum is received by the State from the Latrobe Valley mines.[121]

8.5 BOARD'S CONSIDERATION AND PROPOSALS

The Board accepts that there is a need to integrate the work of the four principal organisations that have responsibility for the health of the Latrobe Valley community, these being Latrobe Regional Hospital, Latrobe Community Health Service, the Gippsland Primary Health Network and Latrobe City Council. The Board considers that in order for the health improvements described throughout this report to be enacted, a mechanism for coordinated governance and collective action across agencies needs to be established and resourced.

The Board accepts that a coordinated approach (as discussed by Professor Campbell and Professor Clarke in their report) is likely to result in better health outcomes and higher quality of care delivered at a lower-cost to a wider segment of the community. The Board is cognisant of the strained and competing health needs of the community. Further, the Board accepts that to change the health system and healthcare services in the Latrobe Valley, a more coordinated and strategic approach, with a sustained, long-term view of priorities, is required. The Board accordingly considers that, rather than a wholesale change to the current system, building on elements of the existing system is necessary. It considers that the proposals outlined below will bring about that necessary and important change to the health of the Latrobe Valley.

The Board commends the Latrobe City Council, Latrobe Community Health Service, Latrobe Regional Hospital, and the health professionals and non-government organisations that work with them, for the broad range of quality and well-managed health services that have contributed to the health and wellbeing of the broader community to date. The Board recognises that the major challenges going forward are not ones of competence but rather capacity and coordination. There are significant opportunities for greater integration of services, including funds pooling, particularly with the recently formed Gippsland Primary Health Network.

The Board recognises that the State has significant responsibility for health. However, for integration to be effective, commitment and active engagement with the Commonwealth Government, the private sector and the not-for-profit and community sectors, is also required.

PRIORITY AREAS

The Board acknowledges that a broad range of important health issues in need of new approaches were canvassed throughout the Health Improvement Forums and in this report. The Board considers the following areas should be prioritised: improving integration of care for chronic disease suffers (see Part 4); advancing tele-medicine services (see Part 4); promoting mental wellbeing and preventing family violence (see Parts 4 and 5); and supporting smoking cessation programs (see Part 5); and social marketing to improve pride of place (see Part 7).

The Board has identified these priority areas as they:

- were raised with a high degree of frequency during the community consultations, submissions and Health Improvement Forums

- relate to the health issues associated with the Hazelwood mine fire

- are directly relevant to the most vulnerable groups in the Latrobe Valley, hence addressing it would lead to significant gains in reducing health inequities

- have a broad reach and thus potential to have a significant positive effect on the health of the Latrobe Valley community.

DESIGNATED HEALTH ZONE FOR THE LATROBE VALLEY

The Board has heard wide-ranging evidence relevant to the concept of a designated health zone. The Board notes that there is significant support from the community and from local and state-level non-government health agencies for such a designation, to focus on health improvements for the Latrobe Valley community.

In light of the need for innovative approaches to health in the Latrobe Valley, the Board considers that 'Latrobe Valley Health Innovation Zone' could be an appropriate term for the State to use in designating the Latrobe Valley as a special zone for investment and evaluation of new approaches to health improvement. The Board considers that the title that is ultimately selected should avoid further stigmatising the Latrobe Valley community and be one that creates a sense of purpose and direction for the Latrobe Valley. The Board considers that the designation of the Latrobe Valley as a 'Health Innovation Zone' will facilitate an integrated approach to addressing health issues in the Latrobe Valley.

The purpose of the Latrobe Valley Health Innovation Zone is to ensure that there is a continuing focus on addressing the poor health of the Latrobe Valley community, and applying the principles of collective impact to the development and implementation of new health initiatives. The Board envisages that the designation of the Latrobe Valley Health Innovation Zone will ensure that the need to improve the health of the Latrobe Valley is recognised and prioritised at commonwealth, state and local levels. Sustainability of the zone over electoral cycles is important.

The Board acknowledges that this report canvasses a broad range of proposals regarding the need for sustainable funding of health programs, increased community engagement, and a reconsideration of the way in which health programs should be governed, developed and delivered.

Having regard to the matters discussed so far in this report, the Board strongly suggests that the Latrobe Valley Health Innovation Zone be used as a mechanism to ensure that there is a focus on implementing these proposals, particularly with respect to:

- Strategy: ensuring that innovative and integrated health improvement strategies are developed, implemented and evaluated.

- Funding: increasing funding for new and existing health improvement programs that reduce health inequities by:

  a. strengthening health services (including chronic disease management, mental health services, early detection and high risk screening, health workforce development)

  b. promoting healthy living (including health behaviours, healthy workplaces, healthy environments, children and young people, mental wellbeing and prevention of family violence)

  c. building pride of place (including communication, community engagement and social marketing).

- Governance: creating new mechanisms which enable participation of all relevant stakeholders at a local level in the control of any additional funding for health improvement strategies.

- Sustainability: ensuring that health improvement strategies are implemented for a sufficient length of time so that their impact can be optimised and evaluations undertaken.

The Board envisages that the benefits of the Latrobe Valley Health Innovation Zone will be seen through:

- Measurable health improvements in the Latrobe Valley through the use of innovative strategies.

- Reduced health inequity within the Latrobe Valley, and between the Latrobe Valley and other parts of Victoria.

- Establishment of effective community engagement processes as the core driver of health improvements in the Latrobe Valley.

The Board notes that the Latrobe Valley Health Innovation Zone may be used as a model for the establishment of other place-based Health Innovation Zones in future.

> The Board recommends that the State designate the Latrobe Valley as a special
> geographical zone for health improvement (Latrobe Valley Health Innovation Zone)
> for a minimum of eight years (two electoral cycles), with a focus on innovation,
> integration and community engagement.

LATROBE VALLEY HEALTH ASSEMBLY AND BOARD

The Board notes that there are existing legislative mechanisms to facilitate health governance in the Latrobe Valley, such as the requirement for the Latrobe City Council to develop a *Municipal Public Health and Wellbeing Plan* under the Public Health Act and for Latrobe Regional Hospital to establish a primary care and population health committee under the *Health Services Act 1988* (Vic). The Latrobe Valley Health Innovation Zone should not duplicate these existing structures, rather, it should complement them by facilitating a more coordinated approach to planning and governance of health services delivery in the Latrobe Valley.

During the course of the Health Improvement Forums, the Board was advised that DHHS has considered using a mechanism under the Public Health Act to establish a Consultative Council as a way of utilising existing legislation in order to designate the Latrobe Valley as a zone for health improvement.[122]

A Consultative Council under the Act is primarily a research and monitoring body providing advice to government, the budget of which is controlled by government. The Board notes that having a chief executive officer of a Consultative Council appears to be inconsistent with the model under the Public Health Act. For these reasons, the Board does not consider a Consultative Council to be a suitable mechanism for governance of a Health Innovation Zone.

The Board instead recommends that a Latrobe Valley Health Assembly be established to oversee the Health Innovation Zone. The manner in which the Assembly is established and members are appointed is a matter for the State but the Board considers the following issues should be addressed.

To ensure that the Latrobe Valley Health Assembly is a transparent and accountable body, the Board considers that a Constitution be created for the Assembly, incorporating accountability and governance mechanisms, and facilitating the creation of an executive Board. The executive Board of the Latrobe Valley Health Assembly should be responsible for overseeing the implementation of the Latrobe Valley Health Assembly functions, including:

- Commissioning health improvement programs.
- Raising, receiving and distributing funding for the Latrobe Valley Health Innovation Zone.
- Securing the employment of the Latrobe Valley Health Advocate.

The State should conduct a public process, whereby individuals and organisations who are interested in joining the Assembly can submit an expression of interest for consideration by the Minister of Health. The Board considers that the membership of the Assembly should be greater than that of its executive Board to provide opportunities for key stakeholders to participate in the governance of the Health Innovation Zone and to have a sense of ownership over it. Membership of the Assembly should comprise a broad cross-section of stakeholders who have a direct interest in improving the health of the Latrobe Valley, including:

- Independent Chair appointed by the Minister of Health
- Gippsland Primary Health Network
- Gippsland Regional Office of DHHS
- Latrobe City Council
- Latrobe Community Health Service
- Latrobe Regional Hospital
- community organisations from the Latrobe Valley community
- employers and businesses from the Latrobe Valley
- individuals from the Latrobe Valley community

- state-level non-government health agencies
- Secretary of DHHS
- Chief Executive Officer of the EPA
- Chief Executive Officer of VicHealth
- Chief Executive Officer of WorkSafe.

The Latrobe Valley Health Assembly and Board should be independent of government with a high degree of autonomy and an earmarked budget.

The executive Board of the Latrobe Valley Health Assembly should be comprised of:

- The Chair of the Latrobe Valley Health Assembly.
- A nominee each of Latrobe Regional Hospital, Latrobe Community Health Service, Latrobe City Council, Gippsland Primary Health Network, and the Gippsland Regional Office of DHHS.
- Up to four others across non-government agencies, industry and the community.

The Latrobe Valley Health Assembly Board should appoint a Health Advocate (discussed further below).

The Assembly should focus on implementing innovative initiatives that address the key health challenges in the Latrobe Valley, listed as priority areas above and in Parts 4, 5 and 7.

The Board recommends that the State establish the 'Latrobe Valley Health Assembly' and the executive Board to promote, support and oversee the development of the Latrobe Valley Health Innovation Zone.

The Board recommends that the Latrobe Valley Health Assembly should ensure that:

- Health improvement strategies:
  - are informed by a strong community engagement process
  - focus on reducing health inequities
  - draw on the capacity, good will and opportunities present
  - integrate actions across relevant providers
  - are evaluated for their wider applicability across Victoria.
- Initial health improvement programs are focused on innovative ways to deliver:
  - social marketing programs which build pride of place
  - integrated care for people with chronic diseases, especially those with related mental health conditions
  - tele-medicine services to reduce the barriers of access to medical specialists and other health practitioners
  - promotion of mental wellbeing, including the prevention of family violence
  - smoking cessation programs which are effective for priority groups.
- In allocating funding for health improvement programs, serious consideration is given to the proposals supported by the Board in Parts 4–7 of this report.
- Funds are principally distributed to the organisations of the Latrobe Valley that may singly or in partnership deliver health improvement programs supported by the Latrobe Valley Health Assembly. The Board of the Latrobe Valley Health Assembly may also directly fund and manage programs through the Office of the Health Advocate.

The Board recommends that each of the four principal health agencies in the Latrobe Valley should commit to, support and promote the Latrobe Valley Health Innovation Zone. In particular they should support health innovations and service integration, including the pooling of resources.

The Board recommends that statutory authorities and state-level non-government health agencies commit to, support and promote the Latrobe Valley Health Innovation Zone. These bodies should prioritise the Latrobe Valley Health Innovation Zone for investments in program delivery and health innovation projects, recognising that the lessons learned will have broader application.

HEALTH ADVOCATE FOR THE LATROBE VALLEY

The Board considers that a Health Advocate is required for the Latrobe Valley. The Board envisages that the Health Advocate will provide a trusted and independent voice for the Latrobe Valley community, while also working in an integrated manner with the Latrobe Valley Health Assembly and its Board, to ensure the community is engaged with the development of the Latrobe Valley Health Innovation Zone.

The key functions of the Health Advocate should be to:

1. Provide community-wide leadership for the Latrobe Valley Health Innovation Zone by enabling, mediating and advocating for health improvements.

2. Be the principal officer of the Latrobe Valley Health Assembly and the Latrobe Valley Health Board.

3. Participate in policy, planning and program development with the Latrobe Valley Health Assembly and its Board, ensuring that the community is engaged in the design and implementation of health improvement measures.

4. Create and manage a process to evaluate the programs initiated through the Latrobe Valley Health Innovation Zone.

5. Monitor the health of the Latrobe Valley drawing on all available information, with a focus on outcomes achieved from health improvement measures.

6. Report regularly on the health of the Latrobe Valley and any improvements made to the Health Assembly, Latrobe Valley community and the State.

7. Be a member of the Hazelwood Mine Fire Health Study governance committee(s) and reference groups.

8. Appoint and manage staff of the Office of the Health Advocate.

9. Manage budgets allocated by the Board of the Latrobe Valley Health Assembly.

The Board has heard from a range of agencies and community groups on the competencies required of a Health Advocate. The Board agrees that a Health Advocate should:

- have relevant health training and experience

- be knowledgeable of health issues at an individual and population level within the Latrobe Valley

- be a capable researcher and evaluator

- be an effective communicator and negotiator

- be a competent planner and manager

- live in the Latrobe Valley.

The Board considers that the executive Board of the Latrobe Valley Health Assembly should prioritise the development of clear goals, objectives and measures for the appointment of a Health Advocate. The Board also considers that there should be an appropriate community engagement process used by the Latrobe Valley Health Assembly to determine the requirements of the role of the Health Advocate.

The Board suggests that the Health Advocate be supported by a small office with dedicated staff separate from participating organisations. The Board considers that the State should provide funding to establish the Office of the Health Advocate.

The Board recognises that the Health Advocate and the Office of the Health Advocate will work closely with the Latrobe Valley Health Assembly and executive Board, as well as relevant organisations in the Latrobe Valley region. The Board suggests that careful consideration should be given to the employment of the Health Advocate to ensure that the Health Advocate is primarily focused on the wellbeing of the community and can maintain an appropriate level of independence.

VicHealth is strategically well placed to support such an Office through funding the secondment of staff to assist with 'promoting healthy living', 'reducing health inequities' and 'building pride of place' (see Parts 5, 6, 7 of this report), as well as providing back of office services, if required. Part time appointments (comprising at least 1.5 full time equivalent staff) should be considered as a way of providing a broad range of skills to resource the Office.

> The Board recommends that a suitably qualified Health Advocate be appointed on the recommendation of the executive Board of the Latrobe Valley Health Assembly, and be supported by an Office.

ADDITIONAL HEALTH FUNDING FOR THE LATROBE VALLEY

The Board considers that health improvements are urgently needed in the Latrobe Valley and that it is imperative that additional funding be provided immediately to address the poor health of this community. The Board has heard repeatedly of the need for additional resources, over the long-term, to support health improvements in the Latrobe Valley.

The Board notes that the State prioritised the Latrobe Valley as a site for its *Healthy Together* program because the level of disadvantage in the community meant further investment in health initiatives was warranted. However, Commonwealth funding has now ceased for this program (see Part 5 of this report). The Board was also told of potential disparities in investment in the Latrobe Valley compared to other areas in Victoria, for example the investment in Latrobe Regional Hospital compared to Bendigo Hospital (see Part 4 of this report).

The Board considers that the Latrobe Valley's poorer health outcomes are linked to the industry of power generation. The State has benefited from that industry—revenue of approximately $37 million per annum is received by the State from the Latrobe Valley mines.[123] The Board considers that the State has an obligation to ensure that it allocates sufficient funding to health initiatives for the Latrobe Valley to seek to alleviate the effects of the industry.

The Board notes the State's investment in the Hazelwood Mine Fire Health Study of an average of $2.7m per annum for ten years (see Part 3 of this report). This is a considerable investment indicating the gravity that the State has placed on the potential long-term health impacts of the Hazelwood mine fire on an already vulnerable population.

The Board supports the continuation and strengthening of the Hazelwood Mine Fire Health Study as discussed in Part 3. However, the Board notes that the Health Study will not itself provide any health services and so it will not in itself prevent any deaths or improve health. The Health Study may in due course provide evidence for even greater investment and may help target interventions more effectively. Nevertheless, it will likely take at least five years before any actionable results emerge and probably much longer than this.

The Board does not consider that it would be appropriate to wait for the results of the Hazelwood Mine Fire Health Study before allocating funding to improve the health of the Latrobe Valley. In the 2015–2016 Hazelwood Mine Fire Inquiry Report (Volume 2) the Board considers that it is likely that the Hazelwood mine fire has already contributed to an increase in deaths, particularly from cardiovascular disease.

The Board notes that the loading normally applied to research and evaluation of health programs is usually in the order of 10 per cent or a 1:9 investment. Using that level of funding as a guide, the Board proposes that three times the average annual investment in the Hazelwood Mine Fire Study should be allocated to the Latrobe Valley Health Innovation Zone for an initial period of eight years. This funding would amount to $8.1 million per year (indexed to inflation). The Board considers that this additional allocation of funds is crucial to the success of the Latrobe Valley Health Innovation Zone, and to improving the health of the Latrobe Valley.

The Board considers that this funding should be utilised by the Latrobe Valley Health Assembly and executive Board, and the Office of the Health Advocate, to implement health initiatives in line with the objectives of the Health Innovation Zone.

With regards to sustainability of health improvements, the Board has heard evidence of the need for long-term investment that surpasses electoral cycles, particularly with regards to measures to be implemented to reduce social disadvantage and health inequities. At a minimum, the Board considers that investment in the Latrobe Health Innovation Zone is required over two electoral cycles (a period of eight years) to ensure sustainability of the health initiatives implemented by the Latrobe Valley Health Assembly and executive Board.

In allocating such resources to the Latrobe Valley Health Assembly, the State will need to be satisfied that the investment is well made and appropriately accounted for. To this end, the Board suggests that the priority areas for the Latrobe Valley Health Assembly recommended above should also act as overarching principles for the use of funding.

In public submissions to the Inquiry and in the Health Improvement Forums, a number of state-wide bodies offered to support and fund health improvements in the Latrobe Valley. The Board considers that formal commitment by these bodies is important to sustaining assistance over the duration of the Health Innovation Zone. The Board also considers that the Commonwealth should be called on to contribute resources to the Health Innovation Zone.

> The Board recommends that the State support and fund the development and delivery of additional health improvement strategies in the Latrobe Valley Health Innovation Zone. The State should:
>
> - Provide earmarked funding for the Health Innovation Zone and the establishment of the Office of the Health Advocate to the Board of the Latrobe Valley Health Assembly, which will be held accountable for the appropriate use of such funding.
>
> - Allocate funding that is at least three times that for the Hazelwood Mine Fire Health Study per annum, and not less than $8.1 million per year (indexed to inflation) for an initial period of eight years.
>
> - Require that the funding for new and existing health improvement programs is allocated to reduce health inequities by:
>   - strengthening health services (including chronic disease management, mental health services, early detection and high risk screening, health workforce development)
>   - promoting healthy living (including health behaviours, healthy workplaces, healthy environments, children and young people, mental wellbeing and prevention of family violence)
>   - building pride of place (including communication, community engagement and social marketing).

The Board recommends that the State engage with the Commonwealth Government at the highest ministerial level so that the Commonwealth Department of Health:

- Formally recognises the designation of the Latrobe Valley as a Health Innovation Zone.

- Pools funding with the State to provide integrated services for the management of chronic disease and mental health conditions in the Latrobe Valley.

- Provides health innovation funding to the Gippsland Primary Health Network, commensurate to innovation funds provided by the State for community health and health promotion in the Latrobe Valley.

LATROBE VALLEY HEALTH INNOVATION TASKFORCE

The Board is aware that the recommendations discussed above—the designation of the Latrobe Valley Health Innovation Zone; the creation of the Latrobe Valley Health Assembly and executive Board; and the appointment of a Health Advocate—are substantial measures. The Board acknowledges that it may take some time to implement these recommendations fully.

The Board suggests that the State establish a taskforce to initiate and guide the implementation of the Board's recommendations for a Health Innovation Zone and Health Assembly, and Health Advocate. The Board has been guided by the success of the Emergency Management Commissioner's taskforce implemented following the 2014 Hazelwood Mine Fire Inquiry to deal with certain recommendations of the Board.[124] The Board considers that this model could provide a valuable resource as a first step to initiating and guiding the implementation of the Board's measures through a 'Latrobe Valley Health Innovation Taskforce'.

The Board suggests that the composition of the Latrobe Valley Health Innovation Taskforce should be similar to the executive Board of the Health Assembly. This will ensure that the key stakeholders interested in the health of the Latrobe Valley are engaged with the process of designing and implementing the Board's recommendations from the outset, and are committed to ensuring their success.

The Board recommends that the State should create, as an interim measure for 12 months, a Latrobe Valley Health Innovation Taskforce to assist in progressing recommendations 1–4.

4 Sense of hope + optimism

+ Bipartisan

+ Co-create with community

+ Build on strengths + what people love about Lol

+ Community to drive it — all inclusive.

+ Publicise/amplify the optimism that's already here

+ Groups to network + share their good news stories

+ Business to have a local point of contact for the wider community interest.

+ Keep it realistic.

+ Understand the hazards

**TRANSFORMING THE
FUTURE HEALTH OF
THE LATROBE VALLEY**

PART 9 TRANSFORMING THE FUTURE HEALTH OF THE LATROBE VALLEY

As highlighted in the 2014 Hazelwood Mine Fire Inquiry Report, the Board considers there is a need to substantially improve the health of the Latrobe Valley community.

During the re-opened Inquiry, the Board heard strong affirmation of this sentiment through community consultations, written submissions and Health Improvement Forums. Ms Kellie O'Callaghan, Chair of the Board of Latrobe Regional Hospital remarked: 'doing more of the same isn't going to work. We're nearly two years down the track, at the rate we're going, if we don't make a change, there will be no change for this community.'[1]

Professor Evelyne de Leeuw, Director from the Centre for Health Equity Training, Research and Evaluation, University of New South Wales, said in reference to the consequences of the Hazelwood mine fire and the poor health status of the Latrobe Valley population:

> …what we want in a resilient community is to also have the capacity to bounce up, getting better; and not just a few people getting better, but everybody getting better.[2]

The Board places great emphasis on the need for the full engagement and participation of the Latrobe Valley in charting the way ahead. This includes the principal stakeholder organisations for health, together with other non-government organisations and representatives of the community. For this reason the Board does not wish to be too prescriptive in its recommendations in relation to specific health interventions and has focused instead on the mechanisms to ensure progressive, sustainable and effective momentum for change. It was evident from the Health Improvement Forums that there is considerable capacity, optimism and energy to improve the health of the Latrobe Valley if the right conditions, structures and resources are present.

Parts 3–8 of this report present a range of very promising proposals and suggestions for improving the health of the Latrobe Valley in the short, medium and long-term. These proposals and suggestions are significant and require serious consideration, although they may not be formally recommended by the Board. These proposals should be considered for future action in the light of the overarching recommendations outlined in this Part.

In making its recommendations, the Board has identified specific areas that should be prioritised for action in the Latrobe Valley, including: social marketing to improve pride of place; improving integration of care for chronic disease suffers; advancing tele-medicine services; promoting mental wellbeing and preventing family violence; and supporting smoking cessation programs. These areas have been identified based on the following considerations:

- The matters were raised with a high degree of frequency during the community consultations, submissions and Health Improvement Forums.
- The matters are directly linked to the Hazelwood mine fire.
- The matters are directly relevant to the most vulnerable groups in the Latrobe Valley, hence addressing it would lead to significant gains in reducing health inequities.
- The matters have a broad reach and thus potential to have a significant positive effect on the health of the Latrobe Valley community.

Through the process of this Inquiry, the Board has made key findings in relation to chronic disease management, mental health, early detection and high-risk screening, health behaviours, healthy workplaces, healthy environments, the health of children and young people, the effect of social disadvantage on health, and Aboriginal health in the Latrobe Valley.

Some of the Board's key findings are:

- The healthcare system in the Latrobe Valley needs to change. Innovation is needed to improve health outcomes and this requires significant support and additional funding from State and Commonwealth Governments.

- Improvements to the health of Latrobe Valley communities requires participation from all members of the community, local health practitioners, local and state agencies and authorities, and State and Commonwealth Governments.

- There is a strong causal relationship between social disadvantage and health; this needs to be addressed more overtly in future health improvements to reduce inequity.

- A concerted effort is needed to plan for and project a positive and healthy future for the Latrobe Valley, which builds pride in the local community and its natural environment.

- There are key health improvements that require immediate attention, such as integrating chronic disease management, addressing associated mental health conditions, promoting mental wellbeing (including the prevention of family violence), and promoting the cessation of smoking.

- Community access to health professionals needs to be improved for those requiring investigations, treatment and ongoing care, both locally and outside of the Latrobe Valley.

- Improvements in leadership and governance are required to enhance and integrate the variety of health responses undertaken by multiple agencies in the Latrobe Valley.

- New mechanisms are required to ensure that health initiatives are sustainable and longer lasting, and not so susceptible to changes in the political and financial landscape.

Based on the information and feedback provided through public submissions, community consultations, Health Improvement Forums and expert reports, the Board considers that the most effective catalyst for improving the health of the Latrobe Valley in the short, medium and long-term would be for the State to formally designate and resource the Latrobe Valley as a Health Innovation Zone and to establish a Latrobe Valley Health Assembly which would appoint a Health Advocate for the region.

These reforms will help facilitate innovation, coordination and integration in the provision of health services and health promotion, and foster the increased community engagement and empowerment necessary for health improvements in the Latrobe Valley. The Board considers that the designation of a Health Innovation Zone, and the creation of a Health Assembly and an Office of the Health Advocate, are crucial steps towards closing the health gaps of communities within the Latrobe Valley, and between the Latrobe Valley and the rest of Victoria.

The Board makes 12 broad recommendations, 12 affirmations and 12 commendations.

RECOMMENDATIONS

The Board's recommendations take into account the issues and proposals raised in Parts 3–8 of this report, and the feasibility and priority of implementation.

The term 'State' is used broadly to encompass the Victorian Government and the Victorian public service.

The term 'statutory authorities' refers to public entities such as the Environment Protection Authority, the Victorian Health Promotion Foundation (VicHealth) and WorkSafe.

The term 'state-level non-government health agencies' refers to non-government agencies that have a specific focus on improving health, health services, or the health professions across Victoria. Such agencies include the Australian Medical Association, Australian Nursing and Midwifery Federation, beyondblue, Cancer Council Victoria, Diabetes Victoria, Heart Foundation Victoria, the Victorian Branch of the Public Health Association Australia, Quit Victoria, the Royal Australasian College of Physicians, and the Victorian Healthcare Association.

The term 'four principal health agencies' refers to Latrobe Regional Hospital, Latrobe Community Health Service, Latrobe City Council, and the Gippsland Primary Health Network. These are the key local organisations responsible for advancing health and wellbeing in the Latrobe Valley.

STATE OF VICTORIA

The Board recommends that the State:

RECOMMENDATION 1

Empower the Hazelwood Mine Fire Implementation Monitor or another appropriate agency to:

- Oversee the implementation of these recommendations.
- Report publicly on progress every year for the next eight years.
- Identify in each report any additional actions the State should take to ensure the intent of this report is achieved.

RECOMMENDATION 2

Designate the Latrobe Valley as a special geographical zone for health improvement (Latrobe Valley Health Innovation Zone) for a minimum of eight years (two electoral cycles), with a focus on innovation, integration, and community engagement.

RECOMMENDATION 3

Establish the Latrobe Valley Health Assembly and executive Board to promote, support and oversee the development of the Latrobe Valley Health Innovation Zone.

The Latrobe Valley Health Assembly should ensure that:

- Health improvement strategies:

    - are informed by a strong community engagement process

    - focus on reducing health inequities

    - draw on the capacity, goodwill and opportunities present

    - integrate actions across relevant providers

    - are evaluated for their wider applicability across Victoria.

- Initial health improvement programs are focused on innovative ways to deliver:

    - social marketing programs which build pride of place

    - integrated care for people with chronic diseases, especially those with related mental health conditions

    - tele-medicine services to reduce the barriers of access to medical specialists and other health practitioners

    - promotion of mental wellbeing, including the prevention of family violence

    - smoking cessation programs which are effective for priority groups.

- In allocating funding for health improvement programs, serious consideration is given to the proposals supported by the Board in Parts 4–7 of this report.

- Funds are principally distributed to the organisations of the Latrobe Valley that may singly or in partnership deliver health improvement programs supported by the Latrobe Valley Health Assembly. The Board of the Latrobe Valley Health Assembly may also directly fund and manage programs through the Office of the Health Advocate.

RECOMMENDATION 4

Appoint a suitably qualified Health Advocate on the recommendation of the executive Board of the Latrobe Valley Health Assembly, to be supported by an Office.

RECOMMENDATION 5

Support and fund the development and delivery of health improvement strategies in the Latrobe Valley Health Innovation Zone.

The State should:

- Provide earmarked funding for the Health Innovation Zone and the establishment of the Office of the Health Advocate to the Board of the Latrobe Valley Health Assembly, which will be held accountable for the appropriate use of such funding.

- Allocate funding that is at least three times that for the Hazelwood Mine Fire Health Study per annum, and not less than $8.1 million per year (indexed to inflation) for an initial period of eight years.

- Require that the funding for the health improvement strategies is allocated to reduce health inequities by:

  - strengthening health services (including chronic disease management, mental health services, early detection and high risk screening, health workforce development)

  - promoting healthy living (including health behaviours, healthy workplaces, healthy environments, children and young people, mental wellbeing and prevention of family violence)

  - building pride of place (including communication, community engagement and social marketing).

RECOMMENDATION 6

Review the scope and structure of the Hazelwood Mine Fire Health Study.

The State should:

- Review the scope of the Hazelwood Mine Fire Health Study to consider whether the Adult Survey can include additional cohorts who do not reside in Morwell, including emergency responders to the Hazelwood mine fire.

- Reaffirm its commitment to a 20 year study and the importance of having a strong governance structure which ensures that the interests of the Latrobe Valley community are foremost in the short, medium and longer-term.

- Establish a process whereby key health information obtained through the Health Study about the health status of the population and the effects from the Hazelwood mine fire is provided to the study participants, the community, local health practitioners and the Latrobe Valley Health Assembly.

- Establish a process whereby policy-relevant health information obtained through the Health Study is considered by the State for action to improve the health of the Latrobe Valley and other populations in Victoria.

RECOMMENDATION 7

Assist in establishing an independent community controlled health organisation for the Latrobe Valley Aboriginal community and co-fund a new culturally appropriate health and community facility which will help with the engagement of Aboriginal young people.

RECOMMENDATION 8

Engage with the Commonwealth Government at the highest ministerial level so that the Commonwealth Department of Health:

- Formally recognises the designation of the Latrobe Valley as a Health Innovation Zone.

- Pools funding with the State to provide integrated services for the management of chronic disease and mental health conditions in the Latrobe Valley.

- Provides health innovation funding to the Gippsland Primary Health Network, commensurate to innovation funds provided by the State for community health and health promotion in the Latrobe Valley.

RECOMMENDATION 9

Ensure that ash contained in roof cavities in Morwell is analysed and acted on.

The State should:

- Commission an analysis of the ash contained in roof cavities of houses in Morwell and publish the results of that analysis to the community and Latrobe Valley Health Assembly, together with clear advice about the potential known, or unknown health effects.

- If the analysis of the ash residue in roof cavities reveals any content that is potentially hazardous to health or of unknown impact on health, conduct an audit of the extent of the exposure to ash and develop an action plan to remove the ash from all affected houses.

RECOMMENDATION 10

Create, as an interim measure for 12 months, a Latrobe Valley Health Innovation Taskforce to assist in progressing recommendations 1–4.

PRINCIPAL STAKEHOLDER ORGANISATIONS IN THE LATROBE VALLEY

The Board recommends that each of the four principal health agencies in the Latrobe Valley:

RECOMMENDATION 11

Commit to, support and promote the Latrobe Valley Health Innovation Zone. In particular they should support health innovations and service integration, including the pooling of resources.

STATUTORY AUTHORITIES AND STATE-LEVEL NON-GOVERNMENT HEALTH AGENCIES

The Board recommends that the statutory and state-level non-government health agencies:

RECOMMENDATION 12

Commit to, support and promote the Latrobe Valley Health Innovation Zone. These bodies should prioritise the Latrobe Valley Health Innovation Zone for investments in program delivery and health innovation projects, recognising that the lessons learned will have broader application.

AFFIRMATIONS

During this Inquiry, the State, statutory authorities, state-level non-government health agencies, the key principal stakeholder agencies and individual members of the expert panels, expressed commitments to numerous actions relevant to improving health in the Latrobe Valley in the short, medium and long-term. The Board affirms those commitments.

The Board affirms:

1. The commitment of the principal stakeholder organisations for health in the Latrobe Valley to making improvements in the way that they engage with the Latrobe Valley community.

2. The commitment of Latrobe Regional Hospital to continue to develop as a regional hospital for the people of the Latrobe Valley and the wider Gippsland area. The Board considers that the State should give serious consideration to ensuring that future investment in this facility is at least equitable with other regional areas in Victoria.

3. The commitment of Ms Kellie O'Callaghan, Chair of the Board of Latrobe Regional Hospital, to progress a community screening day, in partnership with the community and other major health services. This day could be approached as the 'launch' of a new outreach screening program to support chronic disease prevention.

4. The intention of Dr Alistair Wright, general physician from Latrobe Regional Hospital and Dr Daniel Steinfort, respiratory physician from the Royal Melbourne Hospital, to work together to understand the risk profile of the Latrobe Valley relevant to lung cancer, and the implications of this for a possible lung cancer screening program.

5. The proposal of the State to move towards a 'person-centred' healthcare system with equitable access, as documented in the Health 2040 Summit discussion paper.

6. The intention of Monash Health and Latrobe Regional Hospital to consider the development of an advanced physician training program for general physicians in the short term.

7. The commitment of the Gippsland Primary Health Network to develop 'care pathways' to assist general practitioners in the management of complex conditions.

8. The commitment of state-level statutory and non-government health agencies to assist Latrobe Valley organisations and the broader community to improve health through policies, plans, funding, infrastructure, programs, campaigns, training, research and evaluation, recognising that for action to be effective it needs to be community-led as much as possible.

9. The commitment by the Children and Youth Area Partnership to include an early intervention focus to protect vulnerable children and support access to education for children in out-of-home care, having regard to the fact that children in the Latrobe Valley often start school developmentally behind their peers when measured according to the Australian Early Development Index.

10. The commitment of the Latrobe City Council to develop a tracks, trails and paths strategy to create supportive environments for physical activity and community engagement.

11. The commitment of members of a Health improvement Forum expert panel on community engagement and communication to work together to develop a community-led shared vision for the health, wellbeing and prosperity of the Latrobe Valley. The panel comprised representatives from EW Tipping Foundation, Gippsland Multicultural Service, GDF Suez Australian Energy, Latrobe City Council, Latrobe Valley Express, Morwell Community Recovery Committee, Morwell Neighbourhood House, VicHealth and Voices of the Valley.

12. The Board affirms work being undertaken by the Community Wellbeing Study (part of the Hazelwood Mine Fire Health Study) to enhance agencies' ability to effectively engage with the Latrobe Valley community.

COMMENDATIONS

The Board commends:

1. The Latrobe Valley community and its organisations for their resilience during and after the Hazelwood mine fire and their commitment to improving the health of the population.

2. The State for re-opening the Inquiry to provide an opportunity for the future health needs of the Latrobe Valley community to be considered, so that recommendations for action can be presented.

3. Latrobe City Council, Latrobe Community Health Service, Latrobe Regional Hospital, and the health professionals and non-government organisations that work with them, for the broad range of quality and well managed health services that have contributed to the health and wellbeing of the broader community.

4. All those individuals and organisations from the Latrobe Valley, and further afield, who engaged enthusiastically and contributed constructively and optimistically to the development of this report and its recommendations, through submissions, consultations, and participation in public hearings and the Health Improvement Forums.

5. The Latrobe Valley Aboriginal community, in particular for the leadership and enterprise shown in developing the Waterhole Creek art project.

6. The Latrobe City Council, Latrobe Community Health Service, Latrobe Regional Hospital, the Morwell Neighbourhood House and Voices of the Valley for demonstrating effective ways to engage, consult and connect with the community.

7. VicHealth for developing a number of health resources which could be adapted for use in the Latrobe valley including: *Fair Foundations Framework to reduce health inequities; Preventing violence against women: A framework for action; Generating Equality and Respect Program; and the VicHealth Mental Wellbeing Strategy 2015–19.*

8. beyondblue for developing its programs *MindMatters* and *KidsMatter* and for undertaking training in mental health in the Latrobe Valley.

9. The State for having prioritised the *Latrobe Valley for the Healthy Together program,* whilst recognising that elements of this work need to be continued.

10. Latrobe City Council for developing its first *Municipal Public Health and Wellbeing Plan 2013–17* and contributing additional resources to the *Healthy Together Latrobe program.*

11. VicHealth for a new initiative in the Latrobe Valley aimed at engaging inactive people in sport, by re-orienting the traditional competitive model of sport towards broader sporting options based on community interest.

12. The *Gippsland Rural Intern Training Program* coordinated by the Post Graduate Medical Council of Victoria, which provides medical training in the Latrobe Valley.

APPENDICES

APPENDICES

APPENDIX A: INQUIRY PERSONNEL

NAME	ROLE
BLACKMAN, Joel	Paralegal Support
HORSFIELD, Sam	Editor
JACKSON, Candice	Business and Paralegal support
KELLY, Monica	Health Lead
MITTEN, Spencer	Communications Manager
NICHOLLS, Cassie	Senior Policy Officer
RADOJKOVIC, Andrew	Technical Officer – Mines
ROZEN, Peter	Counsel Assisting
RYAN, Genelle	Head of Secretariat
SHANN, Ruth	Counsel Assisting
STANSEN, Justine	Principal Legal Advisor
WELLINGTON, Bethany	Legal Advisor

APPENDIX B: ORGANISATIONS AND INDIVIDUALS WHO MADE PUBLIC SUBMISSIONS

ORGANISATIONS
AGL Loy Yang Pty Ltd
Australian Medical Association Victoria
Asbestos Council Victoria
Australian Medical Students Association
Australian Nursing and Midwifery Federation (Victorian Branch)
Baker IDI Heart and Diabetes Institute
beyondblue
Cancer Council Victoria
Construction, Forestry, Mining & Energy Union (CFMEU)
Climate and Health Alliance
Department of Health (Commonwealth)
Diabetes Victoria
Doctors for the Environment Australia
Environment Protection Authority
Environment Victoria
GDF Suez Australian Energy
Healthy Futures
Heart Foundation (Victoria)
Latrobe City Council
Latrobe Community Health Service

ORGANISATIONS
Monash University
Public Health Association Australia
Public Health Association Australia (Victorian Branch)
Quit Coal Collective
Quit Victoria
The Royal Australasian College of Physicians (Victorian Regional Committee)
United Firefighters Union of Australia (Victorian Branch)
Victorian Aboriginal Community Controlled Health Organisation
Victorian Health Promotion Foundation
Victorian Chronic Disease Prevention Alliance
Victorian Council of Social Service
Victorian Healthcare Association
Voices of the Valley

INDIVIDUALS
BANNISTER, Tracey
BROWELL, Julia
CHARLESWORTH, Elizabeth
CLISSOLD, Kiery-Anne
DAWSON, Marilyn
DOIG, Tom
ELLIS, Simon
FARMER, Wendy
FITZGERALD, Grace
HAMILTON, Christine
HOLLIS, David
HORRIGAN-DIXON, Anne
McCUBBIN, Joanna
NICHOLSON, Deearne
PATTISON, Lynette
PATTISON, Sandra
PINERO, Claudette
RAI, Rita
SCOTT, Evelyn
YACONO, Peter

APPENDIX C: EXPERT PANEL MEMBERS WHO PARTICIPATED IN THE HEALTH IMPROVEMENT FORUMS

TITLE	NAME	ORGANISATION	HEALTH IMPROVEMENT FORUM
Dr	ABERLE, Nicholas	Environment Victoria	Healthy Environments
Dr	AH-KION, Stephen	Latrobe Regional Hospital	Chronic Disease Management
Mr	ATKIN, Luke	Quit Victoria	Health Behaviours
Ms	BARRY, Sylvia	Department of Health and Human Services	Chronic Disease Management
Mr	BLAKELY, Greg	Department of Health and Human Services	Health Conservation Zone and Health Advocate
Ms	BOGART, Margaret	Gippsland Primary Health Network	Chronic Disease Management
Dr	BOLAM, Bruce	Victorian Health Promotion Foundation	Health Behaviours
Ms	BOOTHMAN, Carolyne	Morwell & Districts Community Recovery Committee	Healthy Environments
			Community Engagement and Communication
Ms	BOVERY-SPENCER, Petra	Latrobe Community Health Service	Chronic Disease Management
Ms	CAMERON, Amanda	Latrobe Regional Hospital	Health Workforce
Mr	CAMERON, Steve	Emergency Management Victoria	Community Engagement and Communication
Prof	CAMPBELL, Donald	Monash Health and Monash University	Chronic Disease Management
			Health Workforce
			Health Conservation Zone and Health Advocate
Ms	CAREW, Pip	Australian Nursery & Midwifery Federation	Health Workforce
Ms	CHARALAMBOUS, Stephanie	Latrobe Valley Express	Community Engagement and Communication
Prof	CLARKE, David	Monash Health and Monash University	Mental Health
			Early Detection and High Risk Screening
Dr	COATES, Cathy	Latrobe Regional Hospital	Children and Youth
Ms	COXALL, Anne	Latrobe Community Health Service	Health Workforce
Mr	CRAIGHEAD, Peter	Latrobe Regional Hospital	Health Conservation Zone and Health Advocate
Prof	de LEEUW, Evelyne	Glocal Health Consultants and University of New South Wales	Social Disadvantage
			Health Conservation Zone and Health Advocate
Ms	DEEGAN, Angie	WorkSafe Victoria	Healthy Workplaces
Mr	EDGAR, Alistair	Latrobe City Council	Healthy Workplaces
Ms	FARMER, Wendy	Voices of the Valley	Community Engagement and Communication
Ms	FLYNN, Carmel	Department of Health and Human Services	Healthy Environments

TITLE	NAME	ORGANISATION	HEALTH IMPROVEMENT FORUM
Dr	FRASER, Simon	Latrobe Regional Hospital	Health Workforce
Ms	GALLO, Jayne	E.W. Tipping Foundation	Social Disadvantage
			Community Engagement and Communication
Mr	GUY OAM, John	Advance Morwell and Latrobe Community Health Service	Healthy Workplaces
			Governance, Leadership and Sustainability
Cr	HARRIMAN, Dale	Latrobe City Council	Governance, Leadership and Sustainability
Dr	HOPPNER, Cayte	Latrobe Regional Hospital	Mental Health
Ms	HORTON, Kellie	Victorian Health Promotion Foundation	Social Disadvantage
Ms	HUGGINS, Jo	Relationships Australia	Mental Health
Ms	HUMPHRIES, Robyn	Department of Health and Human Services	Mental Health
Ms	JOLLY, Kellie-Ann	Heart Foundation Victoria	Health Behaviours
Ms	KERSLAKE, Kate	Latrobe City Council	Children and Youth
Mr	KLAPISH, Simon	GDF Suez Australian Energy	Community Engagement and Communication
Mr	LEIGH, Ben	Latrobe Community Health Service	Health Conservation Zone and Health Advocate
Ms	LUND, Tracie	Morwell Neighbourhood House	Community Engagement and Communication
Ms	MARTIN, Jane	Obesity Policy Coalition	Healthy Behaviours
Dr	MAXFIELD, Nola	Gippsland Primary Health Network	Governance, Leadership and Sustainability
Dr	McADAM, Cathy	Monash Health	Children and Youth
Mr	METHER, Ron	EnergyAustralia Yallourn	Healthy Environments
Ms	O'CALLAGHAN, Kellie	Latrobe Regional Hospital	Governance, Leadership and Sustainability
Ms	PEAKE, Kym	Department of Health and Human Services	Governance, Leadership and Sustainability
Ms	PIONTEK-WALKER, Holly	Department of Health and Human Services	Health Behaviours
Assoc Prof	RASA, John	Networking Health Victoria	Chronic Disease Management
Mr	RAVEN, Dean	Department of Health and Human Services	Health Workforce
Ms	RECHTER, Jerril	Victorian Health Promotion Foundation	Community Engagement and Communication
Ms	RHODES-WARD, Sara	Latrobe City Council	Health Behaviours
			Community Engagement and Communication

TITLE	NAME	ORGANISATION	HEALTH IMPROVEMENT FORUM
Ms	RICHMOND, Sally	Department of Health and Human Services	Children and Youth
			Social Disadvantage
Mr	RIENIETS, Steve	AGL Loy Yang	Healthy Workplaces
Ms	SAYERS, Mary	Victorian Council of Social Service	Social Disadvantage
Ms	SCANLON, Kerry	Latrobe Community Health Service	Mental Health
Ms	SCOTT, Heather	Latrobe Community Health Service	Early Detection and High Risk Screening
Ms	SHEARER, Marianne	Gippsland Primary Health Network	Health Workforce
			Health Conservation Zone and Health Advocate
Ms	SINHA, Lisa	Gippsland Multicultural Service	Community Engagement and Communication
Mr	SINDALL, Colin	Department of Health and Human Services	Healthy Workplaces
			Health Conservation Zone and Health Advocate
Ms	SKELDON, Alison	Latrobe Community Health Service	Health Behaviours
Dr	STEINFORT, Daniel	Melbourne Health	Early Detection and High Risk Screening
Mr	SWITZER, Barry	Gippsport	Health Behaviours
Mr	SYMONDS, Terry	Department of Health and Human Services	Governance, Leadership and Sustainability
Dr	TAIT, Peter	Public Health Association Australia	Healthy Environments
Ms	TAYLOR, Helen	Latrobe City Council	Healthy Environments
Mr	TONG, Steven	Latrobe City Council	Mental Health
			Social Disadvantage
Prof	TONKIN, Andrew	Monash University	Early Detection and High Risk Screening
Mr	VAN DRIEL, Gary	Latrobe City Council	Health Conservation Zone and Health Advocate
Ms	VERINS, Irene	Victorian Health Promotion Foundation	Mental Health
			Healthy Workplaces
Ms	WALSH, Katherine	Australian Medical Association Victoria	Health Workforce
Ms	WATTS, Claire	Latrobe Community Health Service	Children and Youth
Mr	WEBB, Chris	Environment Protection Authority	Healthy Environments
Assoc Prof	WISE, Marilyn	University of New South Wales	Community Engagement and Communication
Dr	WRIGHT, Alistair	Latrobe Regional Hospital	Early Detection and High Risk Screening

Note: The attendees of the Aboriginal Health Improvement Forum are not listed above (see Part 6).

APPENDIX D: DOCUMENTS PRODUCED – HAZELWOOD MINE FIRE HEALTH STUDY

CORRESPONDENCE AND SUBMISSIONS

13 May 2014 – 21 May 2014	Email chain between Rosemary Lester, Department of Health and Human Services, and Peter Rau, Metropolitan Fire and Emergency Services Board, re Health Monitoring
16 – 22 June 2015	Email chain between Victoria Police and Monash University re Hazelwood Health Study
16 June 2015	Letter from Victoria Police to Hazelwood Health Study – Project Management Group
28 August 2015	Letter from Victorian Government Solicitors Office to Hazelwood Mine Fire Inquiry
22 September 2015	Letter from Hazelwood Mine Fire Inquiry to Victorian Government Solicitors Office re Metropolitan Fire Service and Country Fire Authority
22 September 2015	Letter from Hazelwood Mine Fire Inquiry to Victorian Government Solicitors Office re Victoria Police
22 September 2015	Letter from Hazelwood Mine Fire Inquiry to Victorian Government Solicitors Office re the Department of Health and Human Services
22 September 2015	Letter from Hazelwood Mine Fire Inquiry to Victorian Government Solicitors Office re the Environment Protection Authority
22 September 2015	Letter from Hazelwood Mine Fire Inquiry to Monash University
22 September 2015	Letter from Hazelwood Mine Fire Inquiry to CFMEU M&E Victoria District
22 September 2015	Letter from Hazelwood Mine Fire Inquiry to United Fire Fighters Union
22 September 2015	Letter from Hazelwood Mine Fire Inquiry to Latrobe City Council
1 October 2015	Letter from CFMEU M&E Victoria District to Hazelwood Mine Fire Inquiry
6 October 2015	Letter from United Fire Fighters Union to Hazelwood Mine Fire Inquiry
8 October 2015	Letter from Monash University to Hazelwood Mine Fire Inquiry
15 October 2015	Letter from Victorian Government Solicitors Office to Hazelwood Mine Fire Inquiry
2 November 2015	Letter from Monash University to Hazelwood Mine Fire Inquiry
5 November 2015	Letter from Hazelwood Mine Fire Inquiry Implementation Monitor to Hazelwood Mine Fire Inquiry
5 November 2015	Email from Latrobe City Council to Hazelwood Mine Fire Inquiry
25 June 2015	Email from Sandra Falconer, Department of Health and Human Services, to Alexander McLeod, Department of Health and Human Services, re Advice to Monash re inclusion of agency responders in LTHS

HEALTH STUDY MINUTES

25 March 2015	Hazelwood Study Contract Steering Committee Minutes
28 April 2015	Hazelwood Study Contract Steering Committee Minutes
24 June 2015	Hazelwood Study Contract Steering Committee Minutes
28 July 2015	Hazelwood Study Contract Steering Committee Minutes
25 August 2015	Hazelwood Study Contract Steering Committee Minutes
1 April 2015	Hazelwood Mine Fire Healthy Study Community Advisory Committee Meeting Minutes
17 June 2015	Hazelwood Mine Fire Healthy Study Community Advisory Committee Meeting Minutes

OTHER

Monash University (n.d.), *Tender Response to Department of Health, State Government Victoria for a long term study into potential health effects from the Hazelwood Coal Mine Fire (Tender No Health C3478),* unpublished

Monash University 2014, *Final Report Australian Firefighters' Health Study Summary,* Monash University, Melbourne

Country Fire Authority and Metropolitan Fire Brigade 2014, *Hazelwood Mine Fire – Emergency Services post incident health check*

Department of Health – Agenda for Health Study public consultation at Morwell (session 1) dated 6 May 2014

Department of Health – Agenda for Health Study public consultation at Morwell (session 2) dated 6 May 2014

Department of Health – Agenda for Health Study public consultation at Morwell (Koorie) dated 7 May 2014

Department of Health – Agenda for Health Study public consultation at Morwell (CALD) dated 7 May 2014

Department of Health, Hazelwood open cut mine fire – health study, Community survey form, Summary, undated

Department of Health, Hazelwood open cut mine fire – health study, Community update, 9 May 2014

SHORTENED FORMS, GLOSSARY AND BIBLIOGRAPHY

SHORTENED FORMS

SHORTENED FORM	CONTRACTIONS
AHW	Aboriginal Health Worker
CGAHHS	Central Gippsland Aboriginal Health and Housing Service
CHETRE	Centre for Health Equity, Training, Research and Evaluation
CFA	Country Fire Authority
CFMEU	Construction, Forestry, Mining and Energy Union
CSIRO	Commonwealth Scientific and Industrial Research Organisation
DHHS	Department of Health and Human Services
EPA	Environment Protection Authority
GDF Suez	GDF Suez Australian Energy
GP	general practitioner
Health Study	Hazelwood Mine Fire Health Study
LCC	Latrobe City Council
LCHS	Latrobe Community Health Service
LRH	Latrobe Regional Hospital
MFB	Metropolitant Fire and Emergency Services Board
Ottawa Charter	Ottawa Charter for Health Promotion
PBS	Pharmaceutical Benefits Scheme
PHAA	Public Health Association Australia
PHN	Primary Health Network
PM$_{2.5}$	Particulate matter of 2.5 micrometres or less in diameter
Public Health Act	*Public Health and Wellbeing Act 2008 (Vic)*
the Board	Hazelwood Mine Fire Inquiry Board of Inquiry
the State	refers to both the Napthine Victorian Government and the Andrews Victorian Government, which came into power on 30 November 2014
VACCHO	Victorian Aboriginal Community Controlled Health Organisation
VCDPA	Victorian Chronic Disease Prevention Alliance
VCOSS	Victorian Council of Social Service
VGSO	Victorian Government Solicitor's Office
VHA	Victorian Healthcare Association
VicHealth	Victorian Health Promotion Foundation
WorkSafe	Victorian WorkCover Authority (also known as WorkSafe Victoria)

GLOSSARY

TERM	EXPLANATION
Commonwealth Government	Encompasses the Commonwealth and the Commonwealth public service
Co-morbidity or co-morbidities	The occurrence of two or more diseases at the same time.
Department of Health	State Department of Health under the Napthine State Government, which left office on 30 November 2014
Department of Health and Human Services	State Department of Health and Human Services under the Andrews State Government, which came into office on 30 November 2014
Four principal health agencies	Latrobe Regional Hospital, Latrobe Community Health Service, Latrobe City Council, and the Gippsland Primary Health Network
Long-term	More than five years
Medium-term	Between three and five years
Short-term	Up to two years
State Government	Encompasses the Victorian Government and the Victorian public service
State-level non-government health agencies	Non-government agencies that have a specific focus on promoting health and/or preventing or addressing ill health across Victoria, including beyondblue, Cancer Council Victoria, Diabetes Victoria, Heart Foundation Victoria, Public Health Association Australia (VIC), Quit Victoria, and the Victorian Healthcare Association
Statutory Authorities	Public entities, including the Environment Protection Authority, VicHealth and the Victorian WorkCover Authority

For more information on the health terms used in this report, see the Australian Institute of Health and Welfare: http://www.aihw.gov.au/australias-health/2014/glossary/

BIBLIOGRAPHY

LEGISLATION

Health Services Act 1988 (Vic)

Occupational Health and Safety Act 2004 (Vic)

Public Health and Wellbeing Act 2008 (Vic)

Public Health and Wellbeing Regulations 2009 (Vic)

WEBSITE REFERENCES

Australian Government Department of Health, *Primary Health Networks Grant Programme Guidelines,* viewed 3 January 2016, http://www.health.gov.au/internet/main/publishing.nsf/Content/00069147C384180DCA257F14008364CB/$File/guidelines.pdf

Campbell, D and Clarke, D, 2015, *Improving the health of the people of the Latrobe Valley,* Monash Health, Clayton, viewed 3 January 2016, http://hazelwoodinquiry.vic.gov.au/wp-content/uploads/2015/09/TOR-7-Health-Improvement-Report-of-D-Campbell-D-Clarke.pdf

Central Goldfields Shire Council (n.d.), *Go Goldfields,* Victoria, viewed 8 January 2016, http://www.centralgoldfields.com.au/?id=25510100AFF8685CA5710B9ACA257B6B0006291D

Central Victorian Primary Care Parnership on behalf of the Go Goldfields Evaluation Working Group 2015, *Go Goldfields Alliance Evaluation Report 2012-2014,* CVPCP, Victoria, viewed 2 January 2016, http://www.centralgoldfields.com.au/CA2573450006E09E/Lookup/GoGoldfieldsfinalevalreport/$file/Go%20Goldfields%2088pp%20FINAL-Low%20Res.pdf

Central West Gippsland Primary Care Partnership (n.d.), *Moe*, viewed 8 January 2016, http://www.centralwestgippslandpcp.com/about/

Centre for Air Quality & Health Research and Evaluation 2015, *Seed Grants Awarded* – 2015*,* CAR, Glebe, viewed 11 January 2016, http://www.car-cre.org.au/research/seed-grants/index.php

Clontarf Foundation 2015, *Clontarf Foundation*, Western Australia, viewed 7 January 2016, http://www.clontarf.org.au/academy/

Council of Australian Governments (n.d.), *Closing the Gap in Indigenous disadvantage,* COAG, Canberra, viewed 7 January 2016, https://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage

Council of Australian Governments 2008, *National Indigenous Reform Agreement,* COAG, Canberra, viewed 7 January 2016, http://www.dpc.vic.gov.au/images/documents/Aboriginal_Affairs/National_Indigenous_Reform_Agreement_.pdf

de Leeuw, E and Wise, M, 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, viewed 7 January 2016, http://hazelwoodinquiry.vic.gov.au/wp-content/uploads/2015/09/TOR-7-Health-Improvment-Report-of-E-de-Leeuw-M-Wise.pdf

Department of Education and Training 2015, *Education State: Schools,* viewed 30 November 2015, http://www.education.vic.gov.au/Documents/about/educationstate/launch.pdf

Department of Health 2011, *Life Expectancy – Females. Gippsland by LGA, 2006 and 2007,* viewed 10 December 2015, https://www2.health.vic.gov.au/getfile/?sc_itemid=%7bFA123E28-FA88-4B7D-8745-6726CF2F419D%7d&title=LGA%20Female%20Life%20Expectancy

Department of Health 2011, *Life Expectancy – Males, Gippsland by LGA, 2006 and 2007,* viewed 10 December 2015, https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b9E472F77-B7CB-4EDA-B32E-F8ABC1AFC6DC%7d&title=LGA%20Male%20Life%20Expectancy

Department of Health 2012, *The Victorian health services governance handbook,* viewed 10 January 2016, https://www2.health.vic.gov.au/hospitals-and-health-services/boards-and-governance/about-health-boards

Department of Health and Human Services 2014, *Local Government Area Profiles, Latrobe City,* viewed 4 January 2016, https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b94FA614B-E89A-42D4-A744-6BDB5823EC56%7d&title=Latrobe%20(C)%20

Department of Human Services 2015, *Roadmap for Reform: Strong Families, Safe Children,* viewed 30 November 2015, http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/roadmap-for-reform-strong-families,-safe-children

Department of Human Services 2015, *Children and Youth Area Partnerships,* viewed 30 November 2015, http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/children,-youth-and-family-services/children-and-youth-area-partnerships

Department of Health and Human Services 2015, *Funding, performance and accountability*, viewed 8 January 2016, https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability

Department of Health and Human Services 2015, *Message from the Minister for Health and Minister for Mental Health, Health 2040: The Victorian Health Reform Summit September 2015,* viewed 25 November 2015, http://www.vision6.com.au/em/mail/view.php?id=1234050&a=47492&k=518a7b4

Duckett, S 2015, *Federal health spending is forecast to slow, but states face rising bills,* Grattan Institute, viewed 9 January 2016, http://grattan.edu.au/news/federal-health-spending-is-forecast-to-slow-but-states-face-rising-bills/

Environment Protection Authority Victoria 2014, *Ash sampling data at Wallace Street,* viewed 25 November 2015, http://www.epa.vic.gov.au/hazelwood/hazelwood-mine-fire/testing-during-the-hazelwood-fire/ash-testing-data-during-the-fire/ash-data-wallace-st

Hazelwood Health Study 2015, *Community Advisory Committee,* Monash University, Victoria,viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/community-advisory-committee/

Hazelwood Health Study 2015, *Community Wellbeing,* Monash University, Victoria,viewed 4 January 2016, http://hazelwoodhealthstudy.org.au/research-areas/community-wellbeing/

Hazelwood Health Study 2015, *Governance,* Monash University, Victoria,viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/

Hazelwood Health Study 2015, *Project Management Group,* Monash University, Victoria,viewed 24 November 2015, http://hazelwoodhealthstudy.org.au/study-team/project-management-group/

Hazelwood Health Study 2015, *Reports,* Monash University, Victoria,viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/reports/

Hazelwood Health Study 2015, *Scientific Reference Group,* Monash University, Victoria, viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/scientific-reference-group/

Hazelwood Health Study 2015, *Study Team,* Monash University, Victoria,viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/study-team/

Healthy Illawarra 2016, viewed 4 January 2016, http://www.healthyillawarra.org.au/

Healthy Cities Onkaparinga, *Home,* viewed 4 January 2016, http://www.healthycitiesonkaparinga.org.au/

Healthy Together Achievement Program 2015, *About the Achievement Program,* viewed 6 January 2016, http://www.achievementprogram.healthytogether.vic.gov.au/about

Kania J and Kramer M Winter 2011, 'Collective Impact', *Stanford Social Innovation Review,* Winter 2011, pp 36-41, viewed 3 December 2015, http://ssir.org/articles/entry/collective_impact

KidsMatter (n.d.), *Which organisations are involved in KidsMatter?*, viewed 6 January 2016, https://www.kidsmatter.edu.au/faqs/which-organisations-are-involved-kidsmatter

KidsMatter (n.d.), *Why do we need a mental health initiative for children?,* viewed 6 January 2016, https://www.kidsmatter.edu.au/faqs/why-do-we-need-mental-health-initiative-children

Latrobe City Council 2012, *Healthy Together Latrobe,* viewed 18 December 2015, http://www.latrobe.vic.
gov.au/Our_Community/Healthy_Together_Latrobe

MindMatters 2015, *MindMatters in action,* viewed 6 January 2016, http://www.mindmatters.edu.au/
about-mindmatters/mindmatters-in-action/story/new-mindmatters-launched-by-i-beyondblue-i-

MindMatters (n.d.), *What's involved,* viewed 6 January 2016, http://www.mindmatters.edu.au/about-
mindmatters/whats-involved

MindMatters (n.d.), *Mental health and school success,* viewed 6 January 2016, http://www.mindmatters.
edu.au/about-mindmatters/what-is-mindmatters

Monash Centre for Occupational and Environmental Health, School of Public and & Preventative Medicine,
Baker IDI Heart & Diabetes Institute, Institute for Safety, Compensation and Recovery Research
2013, *WorkHealth Research Synthesis Report,* viewed 6 January 2016, http://www.worksafe.vic.
gov.au/__data/assets/pdf_file/0016/120850/WorkHealth-Research-Synthesis-Report.pdf

National Institute for Health and Care Excellence 2015, *Workplace health: management practices
NICE guidelines June 2015,* viewed 7 December 2015, http://www.nice.org.uk/guidance/NG13/
chapter/1-recommendations

Our Watch (n.d.), *Facts and figures,* viewed 9 January 2016, http://www.ourwatch.org.au/Understanding-
Violence/Facts-and-figures

Parliament of Australia (n.d.) *Health funding agreements,* viewed 11 January 2016, http://www.
aph.gov.au/about_parliament/parliamentary_departments/parliamentary_library/pubs/rp/
budgetreview201415/healthfunding

United States Environmental Protection Agency 2015, *Health,* viewed 10 December 2015, http://www.
epa.gov/pm/health.html

Ramahyuck District Aboriginal Corporation (n.d.), viewed 7 January 2016, http://www.ramahyuck.org/

Rumbalara Football and Netball Club 2014, viewed 7 January 2016, http://www.rfnc.com.au/

State Government of Victoria (n.d.), *Healthy Together Victoria,* viewed 11 January 2016,
https://www2.health.vic.gov.au/getfile/?sc_itemid=%7bD1CC4E43-81AE-4901-ABCC-
B3935B0374AF%7d&title=Healthy%20Together%20Victoria%3A%20Frequently%20asked%20
questions%20(FAQs)

Victorian Council of Social Service 2015, *One year on: Morwell and the 2014 Hazelwood Mine Fire,
June 2015,* viewed 8 January 2016, http://vcoss.org.au/documents/2015/06/2015-Hazelwood-
Report-FINAL.pdf

VicHealth 2011, *Preventing violence against women in Australia: Research summary,* Victorian Health
Promotion Foundation, Melbourne, viewed 2 January 2016, https://www.vichealth.vic.gov.au/
media-and-resources/publications/violence-against-women-in-australia-research-summary

VicHealth 2004, *The health costs of violence: Measuring the burden of disease caused by intimate partner
violence,* Victorian Health Promotion Foundation, Melbourne, viewed 11 January 2016, https://
www.vichealth.vic.gov.au/media-and-resources/publications/the-health-costs-of-violence

VicHealth 2007, *Preventing violence before it occurs: A framework and background paper to guide the
primary prevention of violence against women in Victoria,* Victorian Health Promotion Foundation,
Melbourne, viewed 9 January 2016, https://www.vichealth.vic.gov.au/media-and-resources/
publications/preventing-violence-before-it-occurs

VicHealth 2014, *Generating Equality and Respect*t, Victorian Health Promotion Foundation, Melbourne,
viewed 6 January 2016, https://www.vichealth.vic.gov.au/search/generating-equality-and-respect-2

VicHealth 2015, *VicHealth Mental Wellbeing Strategy 2015-2019,* Victorian Health Promotion
Foundation, Melbourne, viewed 2 January 2016, https://www.vichealth.vic.gov.au/search/mental-
wellbeing-strategy

VicHealth 2015, *Fair Foundations: The VicHealth framework for health equity,* Victorian Health Promotion
Foundation, Melbourne, viewed 11 January 2016, https://www.vichealth.vic.gov.au/media-and-
resources/publications/the-vichealth-framework-for-health-equity

Victorian Healthcare Association 2014, *2014-15 Commonwealth Budget Briefing,* VHA, Melbourne, viewed 9 January 2016, http://www.vha.org.au/docs/20140514_federal-budget.pdf

World Health Organization 2016, *The Ottawa Charter for Health Promotion 1986,* First International Conference on Health Promotion, Ottawa, Canada, 17–21 November 1986, viewed 9 January 2016, http://www.euro.who.int/en/publications/policy-documents/ottawa-charter-for-health-promotion,-1986

World Health Organization 2016, *What are the social determinants of health?,* WHO, viewed 11 January 2016, http://www.who.int/social_determinants/sdh_definition/en/

GOVERNMENT PUBLICATIONS

Commonwealth Government 2014, *Budget 2014-15: Health,* Commonwealth Government, Canberra

Commonwealth Government 2014, *Reform of the Federation White Paper,* Commonwealth Government, Canberra

Department of Health and Human Services & Environment Protection Authority 2015, *Community Smoke, Air Quality and Health Protocol,* Victorian Government, East Melbourne

Department of Sustainability and Environment 2005, *Effective Engagement: building relationships with community and other stakeholders, Book 1: an introduction to engagement,* Victorian Government, East Melbourne

Department of Sustainability and Environment 2005, *Effective Engagement: building relationships with community and other stakeholder, Book 3: the engagement toolkit,* Victorian Government, East Melbourne

Hazelwood Mine Fire Inquiry 2014, *Hazelwood Mine Fire Inquiry Report 2014,* Victorian Government Printer, Victoria

Hazelwood Mine Fire Inquiry 2015, *Hazelwood Mine Fire Inquiry report 2015/2016, Volume 2,* Victorian Government Printer, Victoria

Victorian Government 2015, *Victorian public health and wellbeing plan 2015-2019,* Victorian Government, Melbourne

Victorian Government 2014, *Hazelwood Mine Fire Inquiry Report Victorian Government Implementation and Monitoring Plan,* Victorian Government Printer, Victoria

Victorian Government 2015, *Health 2040: A discussion paper on the future of healthcare in Victoria,* Victorian Government, Melbourne

Victorian Government 2015, *Department of Health & Human Services Policy and funding guidelines 2015,* Victorian Government, Brunswick

OTHER

Vinson, T, Rawsthorne M, Beavis A and Ericson M, 2015 *Dropping off the Edge*, Jesuit Social Services, Victoria and Catholic Social Services Australia, Canberra

Wise, M, Hirono, K and Harris, E 2015 *Equity Focussed Health Impact Assessment of Healthy Together Victoria*, Centre for Primary Health Care and Equity, UNSW, Australia

World Health Organization 2010, *Telemedicine: opportunities and developments in Member States: report of the second global survey on eHealth 2009,* World Health Organization, Geneva

World Health Organization Regional Office for Europe 2014, *The Case for Investing In Public Health: A public health summary report for EPHO 8,* World Health Organization, Denmark

EXHIBITS FILED IN PUBLIC HEARINGS ON TERM OF REFERENCE 11

Exhibit 20 – Witness Statement of Craig Lapsley, 20 July 2015

EXHIBITS FILED IN PUBLIC HEARINGS ON TERM OF REFERENCE 6

Exhibit 5 – Letter from VGSO to Hazelwood Mine Fire Inquiry dated 28 August 2015

Exhibit 6 – Statement of Michael Abramson, undated

Exhibit 37 – Brook, R, Rajagopalan, S, Pope, A, Brook, J, Bhatnagar, A, Diez-Roux, et al 2010, *Particulate Matter Air Pollution and Cardiovascular Disease,* American Heart Association, viewed 2 January 2016, http://circ.ahajournals.org/content/121/21/2331.full.pdf; World Health Organization 2014, 'Ambient (outdoor) air quality and health', viewed 10 December 2015, http://www.who.int/mediacentre/factsheets/fs313/en/

ENDNOTES

PART 1

1   Hazelwood Mine Fire Inquiry Report 2014, p. 309

2   Hazelwood Mine Fire Inquiry Report 2014, p. 250

3   Hazelwood Mine Fire Inquiry Report 2014, pp. 23-24; see also, Hazelwood Mine Fire Inquiry Report 2014, pp. 310-312

4   See, for example, Catford T274:30-31

5   Hazelwood Mine Fire Inquiry 2015, *Health Community Briefings and Consultations: Summary of Discussions*, viewed 9 January 2016, http://hazelwoodinquiry.vic.gov.au/wp-content/uploads/2015/09/Summary-of-Health-Improvement-Community-Consultations.pdf

6   The Board considered that it was critical to create a forum which encouraged frank discussion and facilitated engagement with the local Aboriginal community. To that end, the discussions at the Health Improvement Forum on Aboriginal health and the community consultation at Ramahyuck Aboriginal Health Service were not transcribed and participation was on an anonymous basis.

PART 2

1   Hazelwood Mine Fire Inquiry Report 2014, p. 250

2   Hazelwood Mine Fire Inquiry Report 2014, p. 359

3   Hazelwood Mine Fire Inquiry Report 2014, pp. 250-254 & 352

4   Hazelwood Mine Fire Inquiry Report 2014, pp. 250-254

5   Hazelwood Mine Fire Inquiry Report 2014, p. 352

6   Hazelwood Mine Fire Inquiry Report 2014, pp. 250-252

7   Adapted from Hazelwood Mine Fire Inquiry 2014 Exhibit 56 – Statement of Alan Hall, attachment 29 (as cited in the Hazelwood Mine Fire Inquiry Report 2014, p. 251)

8   Adapted from Hazelwood Mine Fire Inquiry 2014 Exhibit 56 – Statement of Alan Hall, attachment 29 (as cited in the Hazelwood Mine Fire Inquiry Report 2014, p. 251)

9   Written submission of VicHealth, 10 August 2015, pp. 10, 14, 15 & 17

10   Adapted from written submission of VicHealth, 10 August 2015, pp. 10, 14, 15 & 17

11   Written submission of the Heart Foundation (Victoria), 10 August 2015, p. 1

12   Written submission of the Heart Foundation (Victoria), 10 August 2015, p. 1

13   Written submission of Diabetes Victoria, 3 August 2015, attachment 1

14   Department of Health 2011, 'Life Expectancy – Females. Gippsland by LGA, 2006 and 2007', viewed 10 December 2015, https://www2.health.vic.gov.au/getfile/?sc_itemid=%7bFA123E28-FA88-4B7D-8745-6726CF2F419D%7d&title=LGA%20Female%20Life%20Expectancy

15   Department of Health 2011, 'Life Expectancy – Males, Gippsland by LGA, 2006 and 2007', viewed 10 December 2015, https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b9E472F77-B7CB-4EDA-B32E-F8ABC1AFC6DC%7d&title=LGA%20Male%20Life%20Expectancy

16   Adapted from Department of Health and Human Services 2014, 'Local Government Area Profiles, Latrobe', viewed 4 January 2016, https://www2.health.vic.gov.au/getfile/?sc_itemid=%7b94FA614B-E89A-42D4-A744-6BDB5823EC56%7d&title=Latrobe%20(C)%20

17   Vinson T et al 2015, *Dropping off the Edge 2015,* Jesuit Social Services, Catholic Social Services Australia, viewed 10 December 2015, http://www.dote.org.au/

18   Hazelwood Mine Fire Inquiry Report 2014, p. 308

19   Hazelwood Mine Fire Inquiry Report 2014, p. 308

20   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Expert report of Donald Campbell, 28 May 2014, pp. 7-22

21   Hazelwood Mine Fire Inquiry Report 2014, p. 243

22   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Expert report of Donald Campbell, 28 May 2014, pp. 23-26

23   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Expert report of Donald Campbell, 28 May 2014, pp. 24 & 26

24   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Expert report of Donald Campbell, 28 May 2014, para 54

25   Hazelwood Mine Fire Inquiry 2014 Exhibit 37 – California Guide for Public Health Officials, pp. 9-10

26   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Expert report of Donald Campbell, 28 May 2014, p. 23

27   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Expert report of Donald Campbell, 28 May 2014, p. 24

28   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Expert report of Donald Campbell, 28 May 2014, p. 26

29   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Expert report of Donald Campbell, 28 May 2014, p. 26

30   Written submission of Doctors for the Environment Australia, 5 August 2015, p. 3

31   United States Environmental Protection Agency 2015, 'Health', viewed 10 December 2015, http://www.epa.gov/pm/health.html

32   See, for example, written submission of Evelyn Scott, 31 July 2015; written submission of Julia Browell, 10 August 2015; written submission of Simon Ellis, 1 August 2015

33   Written submission of Dr Joanna McCubbin, 4 August 2015

34   Written submission of Victorian Council of Social Service, August 2015, pp. 1 & 5

35   Written submission of Victorian Council of Social Service, August 2015, p. 6

36   Written submission of Voices of the Valley, 10 August 2015, figure 4

37   Written submission of Voices of the Valley, 10 August 2015, para 6

38   Hazelwood Mine Fire Inquiry Report 2015/2016, Volume 2, p. 90

39   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Armstrong T471:19-20

40   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Armstrong T473:20-474:6

41   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Armstrong T569:22-27

42   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 37 – Brook, R, Rajagopalan, S, Pope, A, Brook, J, Bhatnagar, A, Diez-Roux, et al 2010, *Particulate Matter Air Pollution and Cardiovascular Disease*, American Heart Association, viewed 2 January 2016, http://circ.ahajournals.org/content/121/21/2331.full.pdf; World Health Organization 2014, 'Ambient (outdoor) air quality and health', viewed 10 December 2015, http://www.who.int/mediacentre/factsheets/fs313/en/; Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Barnett T474:19-475:1; T525:3-21

43   Hazelwood Mine Fire Inquiry Report 2014, p. 352

44   Hazelwood Mine Fire Inquiry Report 2014, p. 359

45   Hazelwood Mine Fire Inquiry Report 2014, p. 357

46   Hazelwood Mine Fire Inquiry Report 2014, p. 357

47   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, para 2; Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Abramson T333:11-15, T334:2-16 & T338:30-31

48   Hazelwood Mine Fire Inquiry Report 2014, p. 359

49   Hazelwood Mine Fire Inquiry Report 2014, p. 360

50   Hazelwood Mine Fire Inquiry Report 2014, p. 360

51   Hazelwood Mine Fire Inquiry Report 2014, p. 38

52   Hazelwood Mine Fire Inquiry Report 2014, p. 361

53   Hazelwood Mine Fire Inquiry Report 2014, p. 361

54   Wise, M, Hirono, K and Harris, E May 2015, *Equity Focused Health Impact Assessment of Healthy Together Victoria*, Literature Review Centre for Primary Health Care and Equity, UNSW Australia, p. 16

PART 3

1   Hazelwood Mine Fire Inquiry 2014 Exhibit 48 – Report of Donald Campbell, 28 May 2014, p. 28

2   Hazelwood Mine Fire Inquiry Report 2014, p. 352

3   Hazelwood Mine Fire Inquiry Report 2014, p. 358

4   Victorian Government 2014, *Hazelwood Coal Mine Fire Inquiry: Implementation and Monitoring Plan*, Victorian Government, Melbourne, viewed 8 January 2016, http://www.dpc.vic.gov.au/images/141001_Hazelwood_Mine_Fire_Inquiry_Report_Web_%C6%92.pdf

5   Victorian Government 2014, *Hazelwood Coal Mine Fire Inquiry: Implementation and Monitoring Plan*, Victorian Government, Melbourne, viewed 8 January 2016, http://www.dpc.vic.gov.au/images/141001_Hazelwood_Mine_Fire_Inquiry_Report_Web_%C6%92.pdf, p. 21

6   Victorian Government 2014, *Hazelwood Coal Mine Fire Inquiry: Implementation and Monitoring Plan*, Victorian Government, Melbourne, viewed 8 January 2016, http://www.dpc.vic.gov.au/images/141001_Hazelwood_Mine_Fire_Inquiry_Report_Web_%C6%92.pdf, p. 21

7   Victorian Government 2014, *Hazelwood Coal Mine Fire Inquiry: Implementation and Monitoring Plan*, Victorian Government, Melbourne, viewed 8 January 2016, http://www.dpc.vic.gov.au/images/141001_Hazelwood_Mine_Fire_Inquiry_Report_Web_%C6%92.pdf, p. 21

8   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, para 2

9   Hazelwood Health Study 2015, 'Project Management Group', viewed 24 November 2015, http://hazelwoodhealthstudy.org.au/study-team/project-management-group/

10   Hazelwood Health Study 2015, 'Study Team', viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/study-team/

11   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, para 4

12   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, para 7

13   Contract between the State of Victoria and Monash University, 30 October 2014, p. 7

14   Contract between the State of Victoria and Monash University, 30 October 2014, p. 22; Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated

15   Contract between the State of Victoria and Monash University, 30 October 2014, p. 7

16   Hazelwood Health Study 2015, 'Governance', viewed, 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/; `http://hazelwoodhealthstudy.org.au/study-team/project-management-group/

17   Hazelwood Health Study 2015, 'Governance', viewed, 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/

18   Hazelwood Health Study 2015, 'Governance', viewed, 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/;

19   Letter from VGSO to the Hazelwood Mine Fire Inquiry, 27 October 2015, p. 2

20   Monash University (u.d.), *Tender Response to Department of Health, State Government Victoria for a long term study into potential health effects from the Hazelwood Coal Mine Fire (Tender No Health C3478)*, unpublished, pp. 38-39; Letter from VGSO to the Hazelwood Mine Fire Inquiry, 27 October 2015, p. 1

21   Hazelwood Health Study 2015, 'Community Advisory Committee', viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/community-advisory-committee/

22   Written submission of Monash University, 2 November 2015, para 5.1(b)

23   Hazelwood Health Study 2015, 'Governance', viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/

24   Written submission of Monash University, 2 November 2015, para 3.3

25   Hazelwood Health Study 2015, 'Governance', viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/

26   Hazelwood Health Study 2015, 'Scientific Reference Group', viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/about/governance/scientific-reference-group/

27   Minutes – Hazelwood Study Contract Steering Committee, 24 June 2015, 28 July 2015 & 25 August 2015

28   Minutes – Hazelwood Study Contract Steering Committee, 28 July 2015, p. 4

29   Term of Reference 6 required the Board to inquire into and report on whether the Hazelwood mine fire contributed to an increase in deaths, having regard to any relevant evidence for the period 2009 to 2014.

30   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Abramson, T336:6-21

31   Written submission of Monash University, 2 November 2015, para 5.1(d)

32   Hazelwood Health Study 2015, 'Reports', Monash University, viewed 8 January 2016, http://hazelwoodhealthstudy.org.au/reports/

33   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, paras 8, 11 & 12

34   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, paras 8 & 9

35   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, paras 8 & 9; Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Abramson T334:6-14

36   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, para 8

37   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, paras 8 & 9; Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Abramson T333:25-30; T343:2-8

38   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, paras 8, 11 & 12; Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Abramson T339:31-340:5

39   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, para 8

40   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, para 8

41   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 6 – Statement of Michael Abramson, undated, paras 8, 11 & 12

42   Written submission of Monash University, 8 October 2015, para 3(b)

43   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Abramson T341:2-13

44   Emails between Acting Chief Officer Metropolitan Fire and Emergency Services Board Peter Rau and Dr Rosemary Lester, 16 May 2015 & 21 May 2014

45   Letter from VGSO to the Hazelwood Mine Fire Inquiry, 15 October 2015

46   Letter from VGSO to the Hazelwood Mine Fire Inquiry, 15 October 2015

47   Letter of Victoria Police to Hazelwood Health Study – Project Management Group, 16 June 2015, pp. 1 & 2

48   Email of Sandra Falconer to Alexander McLeod, 25 June 2015

49   Letter from VGSO to the Hazelwood Mine Fire Inquiry, 15 October 2015

50   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Cristine T319:26-31. See also letter and submissions on behalf of Dr Lester dated 6 November 2015 in which it was stated that, if asked at the public hearing, Dr Lester 'would have given evidence about an important meeting she attended in 2014 with CFA management and its medical staff during which the CFA indicated their intention to follow up the workers' health itself' (para 5). No further details as to what follow up was to be undertaken were provided in the letter or submissions.

51   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Cristine T320:19-30

52   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Cristine T321:10-12

53   Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings) Exhibit 5 – Letter from VGSO to Hazelwood Mine Fire Inquiry dated 28 August 2015

54   Letter from VGSO to the Hazelwood Mine Fire Inquiry, 15 October 2015

55   Letter from VGSO to the Hazelwood Mine Fire Inquiry, 15 October 2015

56   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Abramson T340:31-341:2, T341:18-342:5

57   Written submission of Monash University, 8 October 2015, para 2

58   See, for example, Minutes – Hazelwood Study Community Advisory Committee 1 April 2015; minutes – Hazelwood Study Contract Steering Committee, 25 August 2015

59   Evidence in Hazelwood Mine Fire Inquiry 2015/16 (Health Public Hearings), Gordon T522:2-11

60   Written submission of Monash University, 2 November 2015, para 4.12; written submission of Latrobe City Council, 5 November 2015

61   Written submission of Latrobe City Council, 5 November 2015

62   Harriman T850:12-14

63   Written submission of Construction, Forestry, Mining and Energy Union, 1 October 2015, p. 1

64   Written submission of Construction, Forestry, Mining and Energy Union, 1 October 2015, p. 2

65   Written submission of Doctors for the Environment Australia, 5 August 2015, p. 6

66   Minutes – Hazelwood Study Contract Steering Committee, 24 June 2015, pp. 4 & 5; Minutes – Hazelwood Study Contract Steering Committee, 25 August 2015, pp. 1 & 4

67   Written submission of Monash University, 2 November 2015, para 5.1(c)(iii)

68   Written submission of Monash University, 2 November 2015, para 4.12

69   Letter and submissions on behalf of Dr Rosemary Lester, 6 November 2015

PART 4

1   World Health Organization 2015, 'Noncommunicable diseases', viewed 25 November 2015, http://www.who.int/mediacentre/factsheets/fs355/en/

2   World Health Organization 2015, 'Noncommunicable diseases', viewed 25 November 2015, http://www.who.int/mediacentre/factsheets/fs355/en/

3   Rasa T3:23-25

4   Rasa T4:1-5

5   Rasa T3:26-4:2

6   Hazelwood Mine Fire Inquiry Report 2014, p. 310

7   Written submission of the Australian Nursing and Midwifery Federation (Victorian Branch), 3 August 2015, p. 4

8   Written submission of Diabetes Victoria, 3 August 2015, appendix 1

9   Written submission of Quit Victoria, 10 August 2015, p. 1

10   Written submission of Wendy Farmer, 11 August 2015

11   See, for example, Hoppner T66:25-67:1

12   Verins T76:9-18

13   See, for example, Hoppner T70:27-71:19; Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 6

14   Hoppner T66:25-67:7

15   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 161

16   Written submission of Christine Hamilton, 23 July 2015

17   Written submission of Victorian Council of Social Service, 4 August 2015, p. 6

18   Hazelwood Mine Fire Inquiry Report 2014, p. 318

19   Hoppner T67:29-68:1; Tong T74:24-28

20   Written submission of GDF Suez Australian Energy, 26 October 2015, pp. 3 & 4

21   Written submission of GDF Suez Australian Energy, 26 October 2015, p. 4

22   Written submission of Healthy Futures, 10 August 2015; written submission of Voices of the Valley, 10 August 2015

23   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 161

24   Bovery-Spencer T6:3-7

25   Bovery-Spencer T5:3-6:2

26   Bovery-Spencer T6:24-30

27   Campbell T19:9-15

28   Campbell T19:30-20:13

29   Rasa T20:19-21:6

30   Barry T21:13-15, T21:28-22:6

31   Bogart T22:18-23:13

32   Victorian Department of Health 2011, *Gippsland Dementia Plan 2011-2014*, Victorian Government, Traralgon, p. 1

33   Gippsland Dementia 2014, 'Dementia Gippsland', viewed 2 January 2016, http://dementiagippsland.com.au/default.aspx

34   Bogart T24:24-30, Barry T25:11-15

35   See, for example, written submissions of Grace FitzGerald, 9 August 2015; written submission of Wendy Farmer, 11 August 2015

36   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 4

37   Written submission of Victorian Healthcare Association, 3 August 2015, pp. 2 & 3

38   Written submission of Victorian Healthcare Association, 3 August 2015, pp. 2 & 3. The Board interprets 'primary care type' emergency department presentations to be those that could be more appropriately attended to in the primary care setting, such as general practice, rather than a hospital emergency department.

39   Written submission of Victorian Healthcare Association, 3 August 2015, p. 3

40   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 4

41   Written submission of Heart Foundation (Victoria), 10 August 2015, p. 3

42   Written submission of Asbestos Council of Victoria, 17 July 2015, p. 4

43   Hoppner T67:16-21

44   Campbell T7:10-13

45   Campbell T7:19-21

46   Written submission of beyondblue, 10 August 2015

47   Department of Health and Human Services 2015, *Message from the Minister for Health and Minister for Mental Health*, *Health 2040: The Victorian Health Reform Summit September 2015*, viewed 25 November 2015, http://www.vision6.com.au/em/mail/view.php?id=1234050&a=47492&k=518a7b4

48   Campbell T1:27-2:2

49   Hoppner T70:26-71:24

50   Tong T71:30-72:7

51   Tong T72:9-14

52   Tong T74:5-6

53   Tong T74:5-11

54   Written submission of the Royal Australasian College of Physicians, 13 August 2015, p. 3

55   Rasa T9:6-9

56   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 28

57   Shearer T125:21-31

58   Bovery-Spencer T14:20-22

59   Bovery-Spencer T14:29-15:7, T15:17-28

60   Coates T159:14-28

61   Coates T159:19-23, T160:4-6

62   McAdam T158:19-27

63   Clarke T78:25-79:7

64   Carew T134:5-11; Campbell T134:18-26

65   Campbell T135:21-136:2

66   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 146

67   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, pp. 146-149

68   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 146

69   Shearer T136:20-24

70   Shearer T136:27-137:6

71   Campbell T8:7-10

72   Campbell T7:25-27

73   See, for example, Huggins T68:11-14; Verins T84:29-30; Hoppner T85:8-14

74   Huggins T68:17-28

75   Tonkin T89:20-30

76   Tonkin T90:13-17

77   See, for example written submission of Grace FitzGerald, 9 August 2015; written submission of Healthy Futures, 10 August 2015

78   Tonkin T91:12-20

79   Clarke T95:30-96:3

80   Clarke T95:22-23, T95:30-96:3

81   Clarke T96:4-7

82   Tonkin T90:2-5

83   Steinfort T96:25-97:6

84   Tonkin T100:21

85   Tonkin T99:16-20

86   Tonkin T99:28-100:4

87   Written submission of Victorian Chronic Disease Prevention Alliance, 5 August 2015, p. 2

88   Written submission of Victorian Chronic Disease Prevention Alliance, 5 August 2015, p. 1

89   Written submission of Heart Foundation (Victoria), 10 August 2015, p. 2

90   Written submission of Australian Nursing and Midwifery Federation (Victorian Branch), 3 August 2015, p. 7

91   Steinfort T97:19-24

92   Steinfort T97:25-98:7

93   Steinfort T111:6-13, T111:30-112:1; Wright T112:4-9

94   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, pp. 152 & 153

95   Scott T102:14-15; Tonkin T93:28-94:2

96   Scott T102:18-19

97   Tonkin T92:17-28

98   Tonkin T94:3-22

99   Scott T101:12-18; Tonkin T102:22-27

100   Tonkin T103:6-9

101   Tonkin T104:21-105:2

102   Tonkin T104:24-26

103   Clarke T108:30-109:8

104   Tonkin T115:4-8

105   Wright T108:11-15

106   Tonkin T108:23-29. Whilst not a member of the panel, Ms O'Callaghan indicated to the Board during the feedback session for panel on early detection and high risk screening that she would progress a community screening day, in partnership with the community and other major health services.

107   Steinfort T98:15-18

108   Campbell, D and Clarke, D 2015, *Improving the health of the people of the Latrobe Valley*, Monash Health, Clayton, p. 55

109   Written submission of Royal Australasian College of Physicians, 13 August 2015, p. 2

110   Written submission of Australian Nursing and Midwifery Federation (Victorian Branch), 3 August 2015, p. 7

111   Written submission of Victorian Healthcare Association, 3 August 2015, pp. 2 & 3

112   Commonwealth Government 2014, *Reform of the Federation White Paper*, Commonwealth Government, Australia, pp. 1 & 2

113   Cameron T119:21-30, T120:14

114   Cameron T119:31-120:3

115   Cameron T120:7-16

116   Cameron T120:17-20

117   Cameron T120:21-23

118   Cameron T121:17-26

119   Carew T133:22-30

120   Fraser T121:30-122:8

121   Fraser T122:14-18

122   Fraser T122:19-123:3

123   Walsh T123:24-27

124   Walsh T124:3-6

125   Walsh T124:8-11

126   Campbell T124:23-28

127   Written submission of Victorian Healthcare Association, 3 August 2015, p. 1

128   Written submission of Victorian Healthcare Association, 3 August 2015, p. 3

129   Fraser T127:9-19

130   Cameron T127:26-128:9

131   Cameron T128:1-15

132   Campbell T138:10-12

133   Written submission of Julia Browell, 10 August 2015; written submission of Evelyn Scott, 31 July 2015

134   Coates T173:4-9

135   McAdam T174:1-14, Coates T173:22-25

136   Shearer T125:21-29, T126:4-23

137   Written submission of Julia Browell, 10 August 2015; written submission of Wendy Farmer, 11 August 2015

138   World Health Organization 2010*, Telemedicine: opportunities and developments in Member States: report of the second global survey on eHealth 2009*, World Health Organization, Geneva, p. 9

139   See, for example, Rasa T27:6-24; Fraser T146:29-147:1

140   Campbell T26:17-28

141   Rasa T27:6-30

142   Fraser T129:2-8; McAdam T161:1-2

143   Fraser T129:22-30

144   Fraser T146:29-147:4

145   Written submission of Grace FitzGerald, 9 August 2015

146   Written submission of Wendy Farmer, 11 August 2015

147   Written submission of Asbestos Council of Victoria, 17 July 2015, p. 4

148   Cameron T140:19-24

149   Cameron T140:4-8

150   Coates T162:28-163:10

151   Coates T163:15-18

152   Coates T163:18-28

153   Coates T164:9-22

154   Victorian Government 2015, *Health 2040: A discussion paper on the future of healthcare in Victoria*, Victorian Government, Melbourne, viewed 14 January 2016, https://www2.health.vic.gov.au/Api/downloadmedia/%7BEC6160F5-C58F-478F-9DC7-EE663D69A441%7D, pp. 14 & 15; Department of Health and Human Services 2015*, Message from the Minister for Health and Minister for Mental Health*, *Health 2040: The Victorian Health Reform Summit September 2015*, viewed 25 November 2015, http://www.vision6.com.au/em/mail/view.php?id=1234050&a=47492&k=518a7b4

PART 5

1   Written submission of VicHealth, 10 August 2015, p. 15. VicHealth notes 'the most recent estimate of daily smoking rates in Victoria is 12.6%, reflecting the continuing decrease in the smoking rates at the population level. Daily smoking rates are likely to have also decreased in the Latrobe Valley, although a significant gap in smoking rates is likely to persist' (p. 15)

2   Written submission of Latrobe City Council, 10 August 2015, p. 10; written submission of Heart Foundation (Victoria), 10 August 2015, p. 2; written submission of Quit Victoria, 10 August 2015, p. 1

3   Written submission of Quit Victoria, 10 August 2015, p. 2

4   Written submission of VicHealth, 10 August 2015, p. 16

5   Written submission of VicHealth, 10 August 2015, p. 12

6   Written submission of VicHealth, 10 August 2015, p. 12

7   Written submission of VicHealth, 10 August 2015 , p. 12

8   Written submission of Cancer Council Victoria, 31 July 2015, para 4

9   Jolly T53:11-18

10   Switzer T55:21-22

11   Switzer T56:23-25

12   Written submission of VicHealth, 10 August 2015, p. 14

13   Written submission of VicHealth, 10 August 2015, p. 14

14   Written submission of Cancer Council Victoria, 31 July 2015, para 6

15   Written submission of Cancer Council Victoria, 31 July 2015, para 6

16   Written submission of Evelyn Scott, 31 July 2015

17   Written submission of VicHealth, 10 August 2015, p. 17

18   Hoppner T67:2-5

19   Sayers T262:5-6

20   Hoppner T66:27-30

21   Hoppner T67:1-5

22   Hazelwood Mine Fire Inquiry Report 2014, p. 318

23   Hazelwood Mine Fire Inquiry Report 2014, p. 318

24   Written submission of VicHealth, 10 August 2015, p. 10

25   Huggins T84:13-19; Hoppner T85:10

26   Our Watch (n.d.), 'Facts and figures', viewed 9 January 2015, http://www.ourwatch.org.au/Understanding-Violence/Facts-and-figures

27   VicHealth 2011, *Preventing violence against women in Australia: Research summary,* Victorian Health Promotion Foundation, Melbourne, viewed 2 January 2015, https://www.vichealth.vic.gov.au/media-and-resources/publications/violence-against-women-in-australia-research-summary, p 6 & 7

28   VicHealth 2015, *VicHealth Mental Wellbeing Strategy 2015–2019*, Victorian Health Promotion Foundation, Melbourne, viewed 2 January 2015, https://www.vichealth.vic.gov.au/search/mental-wellbeing-strategy, p. 38; VicHealth 2011, *Preventing violence against women in Australia: Research summary,* Victorian Health Promotion Foundation, Melbourne, viewed 2 January 2015, https://www.vichealth.vic.gov.au/media-and-resources/publications/violence-against-women-in-australia-research-summary, p. 7

29   Written submission of VicHealth, 10 August 2015, p. 9

30   VicHealth 2007, *Preventing violence before it occurs: A framework and background paper to guide the primary prevention of violence against women in Victoria*, Victorian Health Promotion Foundation, Melbourne, viewed 9 January 2016, https://www.vichealth.vic.gov.au/media-and-resources/publications/preventing-violence-before-it-occurs

31   VicHealth 2014, 'Generating Equality and Respect', viewed 6 January 2016, https://www.vichealth.vic.gov.au/search/generating-equality-and-respect-2

32   Written submission of VicHealth, 10 August 2015, p. 27

33   VicHealth 2015, *VicHealth Mental Wellbeing Strategy 2015-2019*, Victorian Health Promotion Foundation, Melbourne, viewed 2 January 2016, https://www.vichealth.vic.gov.au/search/mental-wellbeing-strategy

34   See, for example, Jolly T34:19-20, T34:23-25, T35:8-18

35   Tait T180:8-31

36   Aberle T186:10-23

37   Webb T184:14-185:3

38   See, for example, Webb T184:29-3; Boothman T185:22-186:2; Horton:T251:19-23; Gallo T266:9-12

39   Rhodes-Ward T36:20-28

40   Rhodes-Ward T37:8-16

41   Rhodes-Ward T37:26-30

42   Rhodes-Ward T38:8-17, T38:22-23

43   Jolly T39:6-14

44   Hazelwood Mine Fire Inquiry Report 2014, p. 359

45   State Government of Victoria (n.d.), 'Healthy Together Victoria', viewed 11 January 2016, https://www2.health.vic.gov.au/getfile/?sc_itemid=%7bD1CC4E43-81AE-4901-ABCC-B3935B0374AF%7d&title=Healthy%20Together%20Victoria%3A%20Frequently%20asked%20questions%20(FAQs)

46   Latrobe City Council 2012, 'Healthy Together Latrobe', viewed 18 December 2015, http://www.latrobe.vic.gov.au/Our_Community/Healthy_Together_Latrobe

47   Latrobe City Council 2012, 'Healthy Together Latrobe', viewed 18 December 2015, http://www.latrobe.vic.gov.au/Our_Community/Healthy_Together_Latrobe

48   Written submission of Latrobe City Council, 10 August 2015, p. 12. See also written submission of the Victorian Healthcare Association, 3 August 2015, para 2.4; written submission of Latrobe Community Health Service, 24 August 2015; Bolam T60:5-6; Parliament of Australia (n.d.) 'Health funding agreements', viewed 11 January 2016, http://www.aph.gov.au/about_parliament/parliamentary_departments/parliamentary_library/pubs/rp/budgetreview201415/healthfunding

49   Written submission of Latrobe City Council, 10 August 2015, p. 11; written submission of the Victorian Healthcare Association, 3 August 2015, para 2.4; written submission of Cancer Council Victoria, 31 July 2015; written submission of Latrobe Community Health Service, 24 August 2015

50   Written submission of Latrobe City Council, 10 August 2015, p. 11

51   Bolam T59:31-60:9

52   Piontek-Walker T63:14-19

53   Edgar T223:8-18

54   Edgar T223:30-224:4

55   Edgar T224:12-13, T224:24-26

56   Jolly T34:14-15

57   Jolly T34:23-24

58   Jolly T35:10-12

59   Boothman T179:22-24

60   Tait T180:12-14

61   Webb T184:29-185:3

62   Jolly T39:7-16

63   Jolly T42:24-30

64   Jolly T43:17-20

65   Jolly T39:17-23

66   Written submission of Cancer Council Victoria, 31 July 2015, para 2. See also Healthy Together Achievement Program 2015, 'About the Achievement Program', viewed 6 January 2016, http://www.achievementprogram.healthytogether.vic.gov.au/about

67   Healthy Together Achievement Program 2015, 'About the Achievement Program', viewed 6 January 2016, http://www.achievementprogram.healthytogether.vic.gov.au/about

68   Skeldon T43:28-44:8

69   Jolly T50:23-29

70   Skeldon T44:20-45:9

71   Martin T41:2-16

72   Bolam T42:6-9

73   Hoppner T69:31-70:2

74   Hoppner T70:3-5

75   Hoppner T70:17-22

76   Written submission of beyondblue, 10 August 2015

77   KidsMatter (n.d.), 'Which organisations are involved in KidsMatter?', viewed 6 January 2016, https://www.kidsmatter.edu.au/faqs/which-organisations-are-involved-kidsmatter

78   KidsMatter (n.d.), 'Heath and community', viewed 6 January 2016, https://www.kidsmatter.edu.au/health-and-community

79   KidsMatter (n.d.), 'Why do we need a mental health initiative for children?', viewed 6 January 2016, https://www.kidsmatter.edu.au/faqs/why-do-we-need-mental-health-initiative-children

80   MindMatters, 4 May 2015, 'New MindMatters launched by beyondblue', viewed 6 January 2016, http://www.mindmatters.edu.au/about-mindmatters/mindmatters-in-action/story/new-mindmatters-launched-by-i-beyondblue-i –

81   MindMatters (n.d.), 'What's involved', viewed 6 January 2016, http://www.mindmatters.edu.au/about-mindmatters/whats-involved

82   MindMatters (n.d.), 'Mental health and school success', viewed 6 January 2016, http://www.mindmatters.edu.au/about-mindmatters/what-is-mindmatters

83   Written submission of Quit Victoria, 10 August 2015, p. 4

84   Atkin T51:8-52:9

85   Atkin T41:21-26

86   Atkin T51:28-30, T52:10-12, T52:24-27

87   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 25. See also, World Health Organization 2016, *The Ottawa Charter for Health Promotion 1986,* First International Conference on Health Promotion, Ottawa, Canada, 17–21 November 1986, viewed 9 January 2016, http://www.euro.who.int/en/publications/policy-documents/ottawa-charter-for-health-promotion,-1986

88   Switzer T54:30-55:4

89   Switzer T54:12-16

90   Switzer T55:21-23, T56:2-8

91   Switzer T56:15-18; Jolly T61:25-62:2

92   Switzer T55:5-19

93   Richmond T265:9-16

94   Jolly T56:27-28

95   Jolly T56:29-30

96   Boothman T203:11-17

97   Boothman T203:24-28

98   Boothman T203:7-9; Tait T204:6-12

99   Hazelwood Mine Fire Inquiry Report 2014, Part 4.5

100   Written submission of the Construction, Forestry, Mining and Energy Union, 25 August 2015; written submission of Latrobe City Council, 5 November 2015

101   Written submission of Quit Victoria, 10 August 2015, p. 3; written submission of beyondblue, 10 August 2015; written submission of Victorian Chronic Disease Prevention Alliance, 5 August 2015, p. 1

102   Rieniets T222:9-11

103   Rieniets T222:16-17

104   Verins T227:17-18. See also Rieniets T222:29-30

105   Verins T217:22-28

106   Sindall T218:25-219:30

107   National Institute for Health and Care Excellence 2015, *Workplace health: management practices NICE guidelines June 2015*, viewed 7 December 2015, http://www.nice.org.uk/guidance/NG13/chapter/1-recommendations

108   Edgar T232:11-13

109   Sindall T221:15-23. See also Victorian Government 2015, *Victorian public health and wellbeing plan 2015-2019*, Victorian Government, Melbourne, pp. 6 & 8

110   Edgar T232:27-233:16

111   Edgar T235:20-23

112   Deegan T218:1-9

113   Deegan T224:30-225:5

114   Deegan T225:1-14

115   Sindall T220:13-30

116   Sindall T220:25-26

117   Monash Centre for Occupational and Environmental Health, School of Public and & Preventative Medicine, Baker IDI Heart & Diabetes Institute, Institute for Safety, Compensation and Recovery Research 2013, *WorkHealth Research Synthesis Report*, viewed 6 January 2016, https://www.worksafe.vic.gov.au/__data/assets/pdf_file/0016/120850/WorkHealth-Research-Synthesis-Report.pdf, p. 5

118   Written submission of Victorian Chronic Disease Prevention Alliance, 5 August 2015, p. 1

119   Written submission of Cancer Council Victoria, 31 July 2015, para 4

120   Jolly T45:17-18, T45:28-31

121   Bolam T46:17-27

122   Martin T47:18-25

123   Rhodes-Ward T48:11-49:8

124   Piontek-Walker T49:18-27

125   Written submission of AGL Loy Yang, 10 August 2015, pp. 26 & 27

126   Rieniets T226:14-20

127   Verins T227:12-13

128   Verins T227:27-29; Guy T228:4-10; Edgar T230:5-8

129   Edgar T234:5-25

130   Edgar T234:26-30

131   Edgar T235:1-8

132   Jolly T60:24-61:4

133   Rozen T181:13-20

134   Boothman T183:17-26

135   Tait T186:31-187:6

136   Taylor T205:6-12

137   Taylor T204:28-205:2, T205:21-26

138   Written submission of Latrobe City Council, 10 August 2015, p. 3

139   See, for example, written submission of Climate and Health Alliance, 12 August 2015

140   Written submission of Australian Medical Association, Victoria, 3 August 2015, p. 2

141   Written submission of Australian Nursing and Midwifery Federation (Victorian branch), 3 August 2015, p. 4

142   Written submission of Climate Health Alliance, 12 August 2015

143   Written submission of Asbestos Council Victoria, 17 July 2015, pp. 3 & 4

144   Written submission of Environment Victoria, 10 August 2015

145   Written submission of Doctors for the Environment Australia, 5 August 2015, p. 7

146   Written submission of Climate and Health Alliance, 12 August 2015; written submission of Grace Fitzgerald, 9 August 2015; written submission of Doctors for the Environment Australia, 5 August 2015, p. 7; written submission of Australian Medical Students Association, 9 August 2015; written submission of Healthy Futures, 10 August 2015

147   Tait T207:23-30

148   Aberle T188:13-15, T188:2-5

149   Aberle T188:26-189:7, T211:7-11

150   Aberle T189:8-20

151   Aberle T189:21-190:9

152   Aberle T199:10-20

153   Webb T190:27-191:3

154   Webb T192:5-19, T192:23-193:1

155   Webb T193:16-29

156   Written response of the Environment Protection Authority to the Hazelwood Mine Fire Inquiry, 20 November 2015, annexure 2

157   Written response of the Environment Protection Authority to the Hazelwood Mine Fire Inquiry, 20 November 2015, annexure 1, p. 2

158   Boothman T195:7-22

159   Boothman T213:27-214:4

160   Taylor T213:7-9

161   Taylor T195:28-196:6

162   Taylor T196:13-16

163   Flynn T198:14-19

164   Department of Health and Human Services & Environment Protection Authority 2015, *Community Smoke, Air Quality and Health Protocol* Victorian Government, East Melbourne (VGSO.1017.001.0001)

165   Boothman T198:28-199:8

166   Written submission of Anne Horrigan-Dixon and Marilyn Dawson, 13 August 2015, p. 6; written submission of Julia Browell, 10 August 2015; written submission of Wendy Farmer, 10 August 2015; written submission of Grace FitzGerald, 9 August 2015

167   Written submission of Deearne Nicholson, 10 August 2015

168   Written submission of Deearne Nicholson, 10 August 2015. See also Environment Protection Authority Victoria 2014, 'Ash sampling data at Wallace Street', viewed 25 November 2015, http://www.epa.vic.gov.au/hazelwood/hazelwood-mine-fire/testing-during-the-hazelwood-fire/ash-testing-data-during-the-fire/ash-data-wallace-st

169   Written submission of Quit Coal, 10 August 2015

170   Centre for Air Quality & Health Research and Evaluation 2015, 'Seed Grants Awarded – 2015', viewed 11 January 2016, http://www.car-cre.org.au/research/seed-grants/index.php

171   Boothman T200:4-27

172   Aberle T211:12-14; Rozen T200:28-201:2; Mether T201:3-7

173   Hazelwood Mine Fire Inquiry Report 2014, p. 312

174   Written submission of Victorian Healthcare Association, 3 August 2015, p. 2

175   Written submission of Cancer Council Victoria, 31 July 2015

176   Written submission of Australian Nursing and Midwifery Federation (Victorian Branch), 3 August 2015

177   Written submission of Public Health Association of Australia, 3 August 2015, p. 5

178   Written submission of Dr Joanna McCubbin, 4 August 2015

179   Richmond T149:22-150:6

180   Coates T153:9-17

181   Kerslake T151:24-27

182   Richmond T152:6-13

183   Kerslake T152:14-19

184   See, for example, McAdam T161:14-18; Coates T153:1-6

185   Coates T153:18-154:8

186   Richmond T155:19-26

187   Richmond T155:27-156:8

188   Watts T165:1-15

189   Watts T167:2-17

190   Watts T155:1-7

191   McAdam T169:3-5

192   McAdam T169:21-28

193   McAdam T174:1-14

194   Verins T237:5-23

195   Verins T238:17-24

196   Verins T239:4-8

197   Verins T239:25-31

198   Verins T241:12-17

199   Edgar T241:22-30

200   Steinfort T98:15-18

PART 6

1   Written submission of Victorian Aboriginal Community Controlled Health Organisation, 13 October 2015, p. 2; see also written submission of Victorian Council of Social Service, 4 August 2015, p. 9

2   VicHealth 2015, *Fair Foundations: The VicHealth framework for health equity*, viewed 11 January 2016, https://www.vichealth.vic.gov.au/media-and-resources/publications/the-vichealth-framework-for-health-equity

3   World Health Organization 2016, 'What are the social determinants of health?', viewed 11 January 2016, http://www.who.int/social_determinants/sdh_definition/en/

4   See, for example, de Leeuw T254:23-24; Horton T249:11-13; written submission of VicHealth, 10 August 2015, p. 5. See also de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, appendix 1

5   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, pp. 19-23

6   See, for example, written submission of VicHealth, 10 August 2015, pp. 6 & 7; de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 5

7   Hazelwood Mine Fire Inquiry Report 2014, Part 4.1

8   See, for example, written submission of Quit Victoria, 10 August 2015, p. 1; written submission of Cancer Council Victoria, 31 July 2015; written submission of Latrobe City Council, 10 August 2015, p. 10; written submission of Victorian Council of Social Service, 4 August 2015, p. 13; written submission of VicHealth, 10 August 2015, pp. 6 & 7

9   Written submission of VicHealth, 10 August 2015, p. 6

10   Sayers T246:4-5, T246:17-18

11   Sayers T246:9-11

12   Written submission of VicHealth, 10 August 2015, p. 7

13   Written submission of VicHealth, 10 August 2015, p. 7

14   Written submission of VicHealth, 10 August 2015, p. 7

15   Written submission of Victorian Council of Social Service, 4 August 2015, p. 13

16   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 47

17   Vassarotti, R 2013, *Consumer Health Forum, Key Challenges and Current Issues in Public Health in Australia,* (http://slidehsare.net/informaoz/rebecca-vassarotti-29088236) as cited in de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 20

18   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 19 & 21

19   Written submission of VicHealth, 10 August 2015, p. 5

20   Written submission of VicHealth, 10 August 2015, p. 6

21   Written submission of VicHealth, 10 August 2015, p. 6. See also VicHealth 2015, *Fair Foundations: The VicHealth framework for health equity*, viewed 11 January 2016, https://www.vichealth.vic.gov.au/media-and-resources/publications/the-vichealth-framework-for-health-equity

22   VicHealth 2015, *Fair Foundations: The VicHealth framework for health equity*, viewed 11 January 2016, https://www.vichealth.vic.gov.au/media-and-resources/publications/the-vichealth-framework-for-health-equity

23   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, pp. 21 & 22

24   Community Affairs Committee 2013, *Australia's domestic response to the World Health Organization's (WHO) Commission on Social Determinants of Health report 'Closing the gap within a generation'*, The Senate, Commonwealth of Australia, Canberra as cited in de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, pp. 21 & 22

25   World Health Organization Regional Office for Europe 2014, *The Case for Investing In Public Health: A public health summary report for EPHO 8*, World Health Organization, Denmark, p. 8

26   Sayers T261:12-17

27   Sayers T262:3

28   Sayers T261:18-24

29   Sayers T261:7-10

30   See, for example, Watts T165:1-5; Tong T252:5-11

31   Horton T251:15-22

32   Tong T252:5-253:1

33   Richmond T150:12-19

34   Richmond T265:9-16

35   Department of Education and Training 2015, *Education State: Schools,* Department of Education and Training, Melbourne, viewed 30 November 2015, http://www.education.vic.gov.au/Documents/about/educationstate/launch.pdf, p. 9

36   Richmond T265:21-266:6

37   Department of Human Services 2015, 'Roadmap for Reform: Strong Families, Safe Children', viewed 30 November 2015, http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/roadmap-for-reform-strong-families,-safe-children

38   Richmond T260:3-13

39   Department of Human Services 2015, 'Children and Youth Area Partnerships', viewed 30 November 2015, http://www.dhs.vic.gov.au/about-the-department/plans,-programs-and-projects/projects-and-initiatives/children,-youth-and-family-services/children-and-youth-area-partnerships

40   Richmond T157:17-22

41   Richmond T265:9-13

42   Richmond T156:16-19

43   Tong T253:6-9. For example, discussion in the Health Improvement Forum workshop on Social Disadvantage, 30 September 2015

44   For example, discussion in the Health Improvement Forum roundtable discussion on Social Disadvatange and Healthy Workplaces, 30 September 2015

45   See, for example, Aberle T210:12-17; Tait T207:17-31

46   Tong T253:18-21. For example, discussion in the Health Improvement Forum workshop on Social Disadvantage, 30 September 2015

47   Tong T252:12-17

48   Tong T252:23-26

49   Verins T238:21-24, T239:10-18; Guy T:238:28-T239:3

50   Sayers T269:30-270:3

51   Gallo T264:7-16

52   Sayers T263:6-12

53   Sayers T268:8-20

54   de Leeuw T255:19-20; Sayers T268:24-27

55   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 23

56   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 23

57   Sayers T268:24-27

58   Sayers T274:12-16

59   Sayers T262:27-263:2

60   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 9

61   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 48

62   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 13

63   de Leeuw T254:2-3, T254:8-16; Tong T257:2-5

64   de Leeuw T256:8-11

65   Horton T251:15-22

66   Sayers T257:18-21

67   See, for example, Sayers T260:21-24; de Leeuw T254:3-5; Horton T251:15-22

68   Richmond T259:14-17

69   Sayers T260:25-27; Horton T271:11-13

70   See, for example, Sayers T247:2-19, T263:17-21

71   Sayers T248:2-5

72   Sayers T263:23-24

73   Written submission of VicHealth, 10 August 2015, p. 8

74   Written submission of Victorian Council of Social Service, 4 August 2015, p. 14

75   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, pp. 29-32

76   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, pp. 8, 26-29

77   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 26

78   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 26. See also, Healthy Illawarra 2016, 4 January 2016, http://www.healthyillawarra.org.au/; Healthy Cities Onkaparinga, 'Home', viewed 4 January 2016, http://www.healthycitiesonkaparinga.org.au/

79   Hancock and Duhl 1986, as cited by de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 27

80   Sayers T269:7-11

81   Horton T271:20-30

82   Written submission of VicHealth, 10 August 2015; written submission of Victorian Council of Social Service, 4 August 2015, pp. 9-12; written submission of Victorian Aboriginal Community Controlled Health Organisation, 13 October 2015

83   The Health Improvement Forum on Aboriginal health and the consultation at Ramahyuck Aboriginal Health Service were not transcribed

84   Written submission of Victorian Council of Social Service, 4 August 2015, p. 9

85   Written submission of Victorian Council of Social Service, 4 August 2015, p. 9

86   The Board considered that it was critical to create a forum which encouraged frank discussion and facilitated engagement with the local Aboriginal community. To that end, the discussions at the Health Improvement Forum on Aboriginal health and the consultation at Ramahyuck Aboriginal Health Service were not transcribed and participation was on an anonymous basis. For this reason, Part 6.3 refers to issues raised during these discussions without reference to specific individuals or publically available material. The Board notes that Mr Jimi Peters participated in the panel on behalf of the Victorian Aboriginal Community Controlled Health Organisation and subsequently provided a written submission on its behalf.

87   Written submission of Victorian Council of Social Service, 4 August 2015, p. 10

88   Written submission of Victorian Aboriginal Community Controlled Health Organisation, 13 October 2015, p. 1

89   Written submission of Victorian Aboriginal Community Controlled Health Organisation, 13 October 2015, p. 2

90   Written submission of VicHealth, 10 August 2015, p. 22; written submission Victorian Council of Social Service, 4 August 2015, p. 9

91   Written submission of VicHealth, 10 August 2015, p. 25

92   Ramahyuck District Aboriginal Corporation (n.d.), viewed 7 January 2016, http://www.ramahyuck.org/

93   Written submission of Victorian Aboriginal Community Controlled Health Organisation, 13 October 2015, p. 1

94   Written submission of Victorian Council of Social Service, 4 August 2015, p. 9

95   Rumbalara Football and Netball Club 2014, viewed 7 January 2016, http://www.rfnc.com.au/

96   Clontarf Foundation (n.d.), viewed 7 January 2016, http://www.clontarf.org.au/academy/

97   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 12

98   Council of Australian Governments (n.d.), 'Closing the Gap in Indigenous Disadvantage', viewed 7 January 2016, https://www.coag.gov.au/closing_the_gap_in_indigenous_disadvantage. See also Council of Australian Governments 2008, *National Indigenous Reform Agreement*, viewed 7 January 2016, http://www.dpc.vic.gov.au/images/documents/Aboriginal_Affairs/National_Indigenous_Reform_Agreement_.pdf

99   Written submission of Victorian Aboriginal Community Controlled Health Organisation, 13 October 2015, p. 1

PART 7

1   Hazelwood Mine Fire Inquiry Report 2014, Recommendation 12, p. 31

2   See, for example, Horton T251:20-22

3   Ms Gallo and Ms Boothman were not able to be present when the expert panel provided feedback to the Board.

4   Hazelwood Mine Fire Inquiry Report 2014, Part 5

5   See, for example, written submission of Latrobe Valley Council, 10 August 2015, p. 6; written submission of Voices of the Valley, 10 August 2015

6   Tong T253:6-9; written submission of Victorian Council of Social Service, 4 August 2015, p. 2

7   Written submission of Anne Horrigan-Dixon and Marilyn Dawson, 13 August 2015, p. 3

8   Written submission of Latrobe City Council, 10 August, 2015, p. 13

9   Written submission of Latrobe City Council, 10 August, 2015, p. 13

10   Written submission of Kiery-Anne Clissold, 3 September 2015; Written submission of Julia Browell, 10 August 2015

11   Written submission of Julia Browell, 10 August 2015

12   Written submission of Kiery-Anne Clissold, 3 September 2015

13   Written submission of the Royal Australasian College of Physicians, 13 August 2015, p. 3; written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015, p. 3

14   Friedli as cited by de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 36

15   See, for example, written submission of VicHealth, 10 August 2015, p. 1; written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015, p. 3

16   Department of Sustainability and Environment 2005, *Effective Engagement: building relationships with community and other stakeholders, Book 1: an introduction to engagement,* Victorian Government, East Melbourne, p. 10

17   Department of Sustainability and Environment 2005, *Effective Engagement: building relationships with community and other stakeholders, Book 1: an introduction to engagement,* Victorian Government, East Melbourne, p. 10

18   See, for example, Rhodes-Ward T771:10-16; Farmer T777:4-10; Sinha T770:25-T771:6

19   Rhodes-Ward T760:8-10

20   Wise T761:1-3

21   Sinha T761:13-16

22   Sinha T761:18-22, T761:29

23   Lund T763:15-18

24   Farmer T777:22-23

25   Rhodes-Ward T777:28-29; Cameron T778:1-3

26   Sinha T770:26-31

27   Sinha T773:28-31

28   Farmer T762:20-25

29   Lund T776:27-29

30   See, for example, written submission of VicHealth, 10 August 2015; written submission of Quit Victoria, 10 August 2015; written submission of Cancer Council Victoria, 31 July 2015

31   Klapish T765:23-26; Charalambous T766:9-11

32   Charalambous T766:16-26

33   Rhodes-Ward T767:2-4

34   Charalambous T775:26-31

35   Charalambous T776:1-4

36   Charalambous T785:5-14

37   Charalambous T780:2-13

38   Charalambous T780:2, T780:14-24

39   Charalambous T780:15-16, T781:1-4; Rhodes-Ward T781:16-17

40   Supplementary written submission of VicHealth, 16 October 2015

41   Supplementary written submission of VicHealth, 16 October 2015

42   Rhodes-Ward T762:6-9

43   Lund T763:9-10

44   Lund T764:26-30; Sinha T778:29-779:7

45   Written submission of Monash University, 11 August 2015

46   Written submission of Monash University, 11 August 2015; Hazelwood Health Study 2015, 'Community Wellbeing', viewed 4 January 2016, http://hazelwoodhealthstudy.org.au/research-areas/community-wellbeing/

47   Farmer T762:16-18

48   Rhodes-Ward T771:12-14

49   Lund T771:30-772:14

50   Rhodes-Ward T764:31-765:2, T765:14-15

51   Rechter T767:12-13

52   Rechter T767:15-26

53   Rhodes-Ward T767:29-768:13

54   Written submission of VicHealth, 10 August 2015, p. 23

55   Department of Sustainability and Environment 2005, *Effective Engagement: building relationships with community and other stakeholder, Book 3: the engagement toolkit,* Victorian Government, East Melbourne

56   Department of Sustainability and Environment 2005, *Effective Engagement: building relationships with community and other stakeholder, Book 3: the engagement toolkit,* Victorian Government, East Melbourne, p. 7

57   Department of Sustainability and Environment 2005, *Effective Engagement: building relationships with community and other stakeholder, Book 3: the engagement toolkit,* Victorian Government, East Melbourne, p. 7

58   Written submission of Australian Nursing and Midwifery Federation (Victoria), 3 August 2015, pp. 8 & 9. See also, written submission of the Australian Medical Students Association, 9 August 2015; written submission of Climate and Health Alliance, 12 August 2015

59   Klapish T782:19-21

60   Webb T184:14-185:3

61   Rhodes-Ward T775:2-4

62   Rhodes-Ward T775:8-10

63   Charalambous T786:27-787:5; supplementary written submission of VicHealth, 16 October 2015; supplementary written submission of Victorian Council of Social Service, 13 October 2015, p. 3

64   Supplementary written submission of Victorian Council of Social Service, 13 October 2015, p. 2

65   Rhodes-Ward T782:3-4

66   Farmer T769:8-11

67   Farmer T769:28-30

68   Klapish T782:16-22

69   Rhodes-Ward T783:3-7

70   Farmer T783:14-19

71   Charalambous T786:27-787:5; Farmer T783:23-24

72   Sinha T787:13-16

73   Verins T239:25-31, T241:6-17

74   Edgar T241:22-30

75   Horton T251:20-22

76   Sayers T257:18-258:5

77   Central Goldfields Shire Council, 'Go Goldfields', viewed 8 January 2016, http://www.centralgoldfields.com.au/?id=25510100AFF8685CA5710B9ACA257B6B0006291D

78   Central Goldfields Shire Council, 'Go Goldfields', viewed 8 January 2016, http://www.centralgoldfields.com.au/?id=25510100AFF8685CA5710B9ACA257B6B0006291D

79   Central Goldfields Shire Council, 'Go Goldfields', viewed 8 January 2016, http://www.centralgoldfields.com.au/?id=25510100AFF8685CA5710B9ACA257B6B0006291D

80   Central Goldfields Shire Council, 'Go Goldfields', viewed 8 January 2016, http://www.centralgoldfields.com.au/?id=25510100AFF8685CA5710B9ACA257B6B0006291D

81   Central Victorian Primary Care Parnership on behalf of the Go Goldfields Evaluation Working Group 2015, *Go Goldfields Alliance Evaluation Report 2012-2014*, viewed 2 January 2016, http://www.centralgoldfields.com.au/CA2573450006E09E/Lookup/GoGoldfieldsfinalevalreport/$file/Go%20Goldfields%2088pp%20FINAL-Low%20Res.pdf

82   Sayers T258:6-16

PART 8

1   Catford T794:3-8, T794:28-30

2   Department of Health, 2012, 'The Victorian health services governance handbook', viewed 10 January 2016, https://www2.health.vic.gov.au/hospitals-and-health-services/boards-and-governance/about-health-boards p. 51

3   Department of Health and Human Services 2015, 'Funding, performance and accountability', viewed 10 January 2016, https://www2.health.vic.gov.au/hospitals-and-health-services/funding-performance-accountability

4   Victorian Government 2015, *Department of Health & Human Services Policy and funding guidelines 2015*, Victorian Government, Brunswick, p. 12

5   Commonwealth Department of Health 2016, viewed 10 January 2016, http://www.health.gov.au/

6   Australian Institute of Health and Welfare (AIHW) 2015, 'Australia's health system', viewed 9 January 2016, HYPERLINK "http://www.aihw.gov.au/australias-health/2014/health-system/"http://www.aihw.gov.au/australias-health/2014/health-system/#figure_2_1

7   Department of Health 2012, 'The Victorian health services governance handbook', viewed 10 January 2016, https://www2.health.vic.gov.au/hospitals-and-health-services/boards-and-governance/about-health-boards, p. 3 & 4

8   Peake T798:11-799:17

9   Peake T801:4-9

10   Peake T804:31-805:6

11   Peake T807:17-24

12   Peake T812:15-20

13   Peake T821:27-823:10

14   Symonds T816:4-14

15   Symonds T816:17-23

16   Symonds T815:10-15

17   Symonds T817:3-25

18   Written submission of Commonwealth Department of Health, 8 July 2015

19   Maxfield T879:10-14

20   Maxfield T888:10-12

21   Maxfield T886:9-13

22   Maxfield T886:6-7

23   Written submission of Victorian Council of Social Service, 10 August 2015, p. 5

24   de Leeuw T736:23-26

25   de Leeuw T736:30-31

26   de Leeuw T737:9-13

27   Leigh T747:29-T748:1; Harriman T844:18-25; O'Callaghan T920:22-27

28   Harriman T841:20-T842:4

29   Sindall T727:14-18

30   Sindall T725:3-11

31   Kania J and Kramer M Winter 2011, 'Collective Impact', *Stanford Social Innovation Review,* viewed 3 December 2015, http://ssir.org/articles/entry/collective_impact

32   Symonds T815:5-9

33   Sindall T724:6-18

34   Central West Gippsland Primary Care Partnership (n.d.), 'About', viewed 8 January 2016, http://www.centralwestgippslandpcp.com/about/

35   Peake T828:2:6

36   O'Callaghan T861:9

37   Written submission of Wendy Farmer, 10 August 2015

38   Department of Health and Human Services 2015, 'Message from the Minister for Health and Minister for Mental Health, Health 2040: The Victorian Health Reform Summit', viewed 22 December 2015, http://www.vision6.com.au/em/mail/view.php?id=1234050&a=47492&k=518a7b4

39   Victorian Government 2015, *Department of Health and Human Services Policy and funding guidelines 2015*, Victorian Government, Brunswick, pp. 14 & 15

40   Australian Government Department of Health, *Primary Health Networks Grant Programme Guidelines*, p. 10, viewed 3 January 2016, http://www.health.gov.au/internet/main/publishing.nsf/Content/00069147C384180DCA257F14008364CB/$File/guidelines.pdf.

41   Hazelwood Mine Fire Inquiry Report 2014, p. 359

42   Written submission of Voices of the Valley, 10 August 2015

43   Written submission of Latrobe Community Health Service, 24 August 2015; Leigh T746:26-T747:2; written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015; written submission of Cancer Council Victoria, 31 July 2015; written submission of Victorian Healthcare Association, 3 August 2015

44   Written submission of The Royal Australasian College of Physicians, 13 August 2015, p. 2

45   Shearer T755:26-28

46   Written submission of VicHealth, 10 August 2015, p. 21

47   Written submission of Australian Medical Association, 4 August 2015, p. 2

48   Written submission of Cancer Council Victoria, 31 July 2015

49   Written submission of Australian Medical Association Victoria, 4 August 2015, p. 2

50   Campbell T733:20-22

51   Written submission of The Royal Australasian College of Physicians, 13 August 2015

52   Written submission of VicHealth, 10 August 2015

53   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 43

54   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 44

55   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 44

56   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 123

57   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 124

58   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, pp. 130-132

59   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 47

60   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 9

61   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 10

62   Campbell T735:19-30

63   Campbell T735:28

64   O'Callaghan T860:8-17

65   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, p. 32

66   de Leeuw, E and Wise, M 2015, *Population health development in the Latrobe Valley: A literature review of world best practice in building healthy communities and health systems*, Glocal Health Consultants, Drumcondra and University of New South Wales, Sydney, pp. 26-32

67   Sindall T727:25-728:4

68   Sindall T720:3-8

69   Harriman T845:11-26

70   Harriman T840:7-10

71   Sindall T722:3-10

72   Written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015, p. 3

73   Sindall T721:3-7

74   Sindall T721:9-11

75   Section 33(4)(c), *Public Health and Wellbeing Act 2008* (Vic)

76   Section 44, *Public Health and Wellbeing Act 2008* (Vic)

77   See sections 46(1)(1), 46(1)(d) and 46(1)(e) of the *Public Health and Wellbeing Act 2008* (Vic). Other examples of Consultative Councils established under the Act are the Surgical Consultative Committee, and the Consultative Committee on Anaesthetic Morbidity and Mortality.

78   Section 46(2), *Public Health and Wellbeing Act 2008* (Vic)

79   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 10

80   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 10

81   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 11

82   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 11

83   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 12

84   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, pp. 10-12

85   Campbell,D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 10

86   Written submission of Victorian Council of Social Service, 4 August 2015, p. 14

87   Sindall T719:22-T721:2, T721:12-20

88   Hazelwood Mine Fire Inquiry Report 2014, p. 360

89   Hazelwood Mine Fire Inquiry Report 2014, p. 360

90   World Health Organization 2016 'The Ottawa Charter for Health Promotion, 1986', viewed 25 November 2015, http://www.euro.who.int/en/publications/policy-documents/ottawa-charter-for-health-promotion,-1986

91   World Health Organization 2016 'The Ottawa Charter for Health Promotion, 1986', viewed 25 November 2015, http://www.euro.who.int/en/publications/policy-documents/ottawa-charter-for-health-promotion,-1986

92   Van Driel T754:26-30

93   Written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015, p. 4

94   O'Callaghan, T858:16-24

95   Written submission of Asbestos Council Victoria, 17 July 2015, p. 5; cf written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015, p. 4

96   de Leeuw T739:6-27

97   Written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015, p. 4

98   Written submission of Asbestos Council Victoria, 17 July 2015, p. 5

99   Written submission of Asbestos Council Victoria, 17 July 2015, p. 5

100   O'Callaghan T867:24-26; Guy T900:1-3

101   Written submission of VicHealth, 10 August 2015, p. 21

102   Written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015, p. 4

103   Written submission of Victorian Healthcare Association, 3 August 2015, p. 5

104   Commonwealth Government 2014, *Reform of the Federation White Paper: Roles and Responsibilities in Health, Issues Paper 3*, Commonwealth of Australia, p. 1

105   Commonwealth Government 2014, *Reform of the Federation White Paper: Roles and Responsibilities in Health, Issues Paper 3*, Commonwealth of Australia, pp. 12 & 13

106   Commonwealth Government 2014, *Reform of the Federation White Paper: Roles and Responsibilities in Health, Issues Paper 3*, Commonwealth of Australia, p. 1

107   Commonwealth Government 2014, *Reform of the Federation White Paper: Roles and Responsibilities in Health*, Issues Paper 3, Commonwealth of Australia,

108   Barry T12:25-27

109   Department of Health and Human Services 2015, Message from the Minister for Health and Minister for Mental Health, Health 2040: The Victorian Health Reform Summit September 2015, viewed 25 November 2015, http://www.vision6.com.au/em/mail/view.php?id=1234050&a=47492&k=518a7b4

110   Victorian Government 2015, *Department of Health & Human Services Policy and funding guidelines 2015*, Victorian Government, Brunswick, p. 3

111   Victorian Government 2015, *Department of Health & Human Services Policy and funding guidelines 2015*, Victorian Government, Brunswick, p. 19

112   Victorian Government 2015, *Department of Health & Human Services Policy and funding guidelines 2015*, Victorian Government, Brunswick, p. 3

113   Victorian Government 2015, *Department of Health & Human Services Policy and funding guidelines 2015*, Victorian Government, Brunswick, p. 40

114   See, for example, Victorian Healthcare Association 2014, '2014-15 Commonwealth Budget Briefing', viewed 9 January 2016, http://www.vha.org.au/docs/20140514_federal-budget.pdf, p. 1; Duckett, S 2015, 'Federal health spending is forecast to slow, but states face rising bills', Grattan Institute, viewed 9 January 2016, http://grattan.edu.au/news/federal-health-spending-is-forecast-to-slow-but-states-face-rising-bills/

115   Victorian Government 2015, *Department of Health & Human Services Policy and funding guidelines 2015*, Victorian Government, Brunswick, p. 40

116   See, for example, Victorian Healthcare Association 2014, '2014-15 Commonwealth Budget Briefing', viewed 9 January 2016, http://www.vha.org.au/docs/20140514_federal-budget.pdf; Commonwealth Government 2014, *Budget 2014-15: Health*, Commonwealth of Australia, viewed 9 January 2016, http://budget.gov.au/2014-15/content/glossy/health/download/Health.pdf; Commonwealth Government 2014, *Reform of the Federation White Paper: Roles and Responsibilities in Health, Issues Paper 3*, Commonwealth of Australia, pp. 10 & 11

117   Harriman T840:19-22

118   Campbell, D and Clarke, D 2015, *Improving the health of people of the Latrobe Valley*, Monash Health, Clayton, p. 15

119   Written submission of Public Health Association of Australia (Victorian Branch), 2 August 2015, p. 4

120   Hazelwood Mine Fire Inquiry Report 2014, Part 4; Hazelwood Mine Fire Inquiry Report 2015/2016, Volume 2

121   Hazelwood Mine Fire Inquiry 2015/2016 (Mine Rehabilitation Public Hearings) Exhibit 5C - Further Statement Luke Wilson, 7 December 2015, Annexure 4

122   Sindall T721:4-8

123   Evidence in Hazelwood Inquiry Mine Fire Inquiry 2015/2016 (Mine Rehabilitation Public Hearings), Rozen, T5:4-6

124   During Anglesea Public Hearings, Mr Craig Lapsley, Emergency Management Commissioner and chair of the Taskforce, explained that the Taskforce is 'a collaborative process to get priority, direction and hopefully discussion' at Lapsley T177:4-5. See also exhibit 20 – Witness Statement of Craig Lapsley, 20 July 2015

PART 9

1   O'Callaghan T861:9-12

2   de Leeuw T738:20-24

Hazelwood
Mine Fire
Inquiry