medicare local TASMANIA

Connecting health to meet local needs

George Town Region Health, Community, Support and Wellbeing Survey Report

December 2014

Tasmania Medicare Local Limited
ABN 47 082 572 629

Contents

Executive Summary 1
Recommendations 2
Introduction 3
Goal of Survey 4
Methods 4
Survey Results and Discussion 5
Data collection 5
Demographics (Q: 1 – 3, 6 – 9, and 11 – 13) 5
Sense of community in George Town (Q: 4, 5, 10 and 14) 6
Perceptions of health and wellbeing (Q: 15 - 20) 6
Perceptions of Services in George Town (Q: 21 – 29 and 31) 7
Community Perceptions of Gaps in Services 8
Suggestions for improvements 8
Perception of key issues 9
Limitations 9
Recommendations 10
Conclusion 11
Tables 12
Table 1. Selected Demographics 12
Table 2. Respondents' sense of community 12
Table 3. Self-assessment of health 13
Table 4. Self-assessment of wellbeing 13
Table 5. Utilisation and satisfaction: health services 13
Table 6. Utilisation and satisfaction: community support services 14
Table 7. Utilisation and satisfaction: Wellbeing services 14
Table 8. Referral methods 15
Table 9. Access to services 15
Table 10. Barriers to accessing services. 15
References 16

Author	Audrey van Wyk, Tracey Tasker
Authorised by	Susan Powell
Date	
Internal/external dissemination	

Tasmania Medicare Local Limited
ABN 47 082 572 629
T 1300 365 169
E info@tasmedicarelocal.com.au
www.tasmedicarelocal.com.au
Tasmania Medicare Local acknowledges the financial and other support of the Australian Government Department of Health

Executive Summary

Tasmanian Medicare local (TML) commenced working with the Living Well and Happy in George Town Group (LWHGT) in July 2013 to collect information from the George Town community on their service needs and health concerns. There is much interest in understanding community needs at a local level to support better mobilisation of community resources to respond to areas for action. TML used the Collaborative Health Planning (CHP) model, which involves a process of working with communities to address this information gap using a population health planning approach, with the aim of improving the health and wellbeing of whole populations and reducing inequities between specific population groups. The scope of TML's role in this work was to support LWHGT and to facilitate the survey process but did not include the facilitation of action against recommendations / findings from the George Town needs assessment. The purpose of this report is to present an analysis of the results of the survey, and make recommendations for actions as suggested by the participants and recommendations for future community-based research.

A paper mail survey with 34 questions collecting both quantitative and qualitative data was designed collaboratively with LWHGT. The goal of the survey was to establish access to and utilisation of health, community, support and wellbeing services by the people of George Town.

The total number of survey respondents was 415, representing a response rate of 15%. Analysis of the results indicates the most common characteristics of the sample were female, older than 51 years, born in Australia and resided in George Town. Respondents mostly enjoy living in the town, identifying positive features such as community spirit and availability of services and community support, but expressed dissatisfaction with unemployment, antisocial behaviour such as vandalism, drug use and lack of vision for the community, which they believe could be led by the local council.

The greatest health concerns relate to the cost of living and ageing. The services most commonly utilised are health services, especially general practitioners and pharmacies. Satisfaction with these services is generally high. Access to services is good, the majority of respondents waiting a week or less for an appointment.

Some respondents access services in other towns, mostly Launceston. This appears to be by choice, and not necessarily due to a lack of services in George Town. The services most frequently requested by the participants include optical and dental services for people without private health insurance, additional specialised radiology services, medical specialists and treatments such as oncology and ophthalmology. Suggestions for other service improvements included an enclosed swimming pool, activities to increase community spirit, after hours GP service and more services that bulk bill.

Over the course of undertaking this research, collaboration and partnerships between George Town and stakeholders were strengthened, and some steps were taken to enhance community engagement. LWHGT recognises the importance of understanding their community, and needs to build on the momentum of this research to further embed the principles of collaboration and participation in health service delivery in George Town.

Recommendations

Community recommendations

1. Consider ways to action the suggestions made by respondents such as:

    a. Increased access to fitness classes such as Pilates and Yoga
    b. Community wellness events – e.g. cooking classes for healthy lifestyle
    c. Better use of the community vegetable garden and improved access to fresh produce
    d. Increase community spirit – e.g. community BBQ, family days, music festivals, create social spaces, promote volunteering especially amongst younger people
    e. Promote George Town in a positive way to undo the harm done by television programs such as *Bogan Hunters* – e.g. tourism
    f. Enclosed swimming Pool.

2. More emphasis should be placed on the social determinants of health in this community. This will also involve finding innovative approaches to the use of current services in order to tailor service delivery to the needs of individuals. For example – the use of community transport for social needs is restricted by the policies of the funding organisation and is usually limited to transport associated with health care needs. If reviewing the funding model for community transport services is not feasible, alternative funds should be sought to ensure members of the community are able to access non-health care related transport as well.

Future community-based research recommendations

1. Consider health literacy levels of the population and select alternative data collection strategies such as short questionnaires, with simple questions or focus group and interviews.

2. Consider sampling methods that ensure that the health needs and health service utilisation patterns over the life course of a representative sample of the community are captured.

3. Additional exploration is required of the themes identified by this survey. Planning for additional data collection to build on the community profile over time should carefully consider what data are required to inform service delivery planning.

4. Future collaboration could extend to opportunities to link and share data sets between services providers to avoid duplication of efforts, and to use resources most efficiently.

Collaborative Health Planning process recommendations

1. More work needs to be done by the stakeholders to identify and prioritise actions, take action and evaluate the outcomes in order to complete the final steps in the CHP process.

2. Purposeful reflection by TML and LWHGT on how the CHP process can be improved will provide valuable insights for future projects.

Introduction

Tasmanian Medicare local (TML) commenced working with the Living Well and Happy in George Town Group (LWHGT) in July 2013 to collect information from the George Town community on their service needs and health concerns. George Town was identified as an area of priority as the community is interested in knowing more about coordination of health and community services in the municipality. There is also historical anecdotal evidence of a fragmented approach to community consultation and service planning. Hence, when approached by the local service providers, TML agreed to provide support to undertake a health and wellbeing service assessment in the region.

There is a significant incidence of inadequate healthcare in some non-urban settings in Australia, including inadequate primary health care services to improve outcomes for numerous chronic conditions[1]. This report describes amongst other issues the utilisation of and satisfaction with health care, community support and wellbeing services available to the community of George Town. Identifying the factors that influence the decision around when and where to seek health care is essential to the planning of primary health care services. Surveys of consumer satisfaction with health services are also important because they identify priorities for quality improvement, and satisfied patients are more likely to seek health care and complete treatment[2]. The main predictors of satisfaction with health care services are:

- Patient experience (autonomy, choice, communication, confidentiality, dignity, prompt attention and quality of amenities)
- Patient expectations (determined by socio-economic status, level of education and age)
- Type of care (public health, private health care or non-governmental organisations)
- Personality
- Self-reported health status

Community needs assessment is a useful tool to build understanding and community capacity because the process actively engages community members to assess their particular needs and wants. Other advantages of undertaking needs assessment to support service planning include:

- Increasing the awareness of issues affecting the community
- Contributing to the evidence base for services
- Mapping existing services and determines if community needs are being met
- Prioritising and making the best use of limited resources[3]

There is much interest in understanding community needs at a local level to support better mobilisation of community resources to respond to areas for action, but at times detailed information on local government areas (LGA) is not always available from these existing data collection activities.

The importance of consumer involvement in service planning and delivery cannot be overemphasised. At least one third of the burden of chronic disease can be attributed to modifiable lifestyle factors such as diet, alcohol and drug use, lack of exercise and smoking. When the client and service provider form successful partnerships, and strategies are tailored to meet specific needs, the likelihood of successful intervention increases. Client engagement increases satisfaction through having 'ownership' over their health care, decreases pressure on health resources and improves health outcomes due to increased patient commitment to achieving their health goals[4] .

The purpose of this report is to evaluate the results of the recent health and wellbeing needs assessment conducted in George Town by the LWHGT, with the assistance of TML. The report aims to present an analysis of the results and make recommendations for actions as suggested

by the participants, and recommendations for future community-based research.

Goal of Survey

The goal of the survey was to establish access to and utilisation of health, community, support and wellbeing services by the people of George Town.

The objectives of the survey for LWHGT were:

- To gain a clearer understanding of the community's perception of service gaps and priority health needs
- To strengthen collaboration and partnerships between George Town and stakeholders to improve health and wellbeing outcomes for the George Town community
- To strengthen community engagement

The scope of TML's role in this work was to support LWHGT and to facilitate the survey process but did not include the facilitation of action against recommendations / findings from the George Town service gap analysis.

Methods

The purpose, content and format of a self-administered paper based mail survey were developed and revised by LWHGT through a process of brainstorming, consultation and piloting. The final version of data collection tool was 15 pages in length and comprised 34 open and closed ended questions, collecting both quantitative and qualitative data.

A process to access the target groups and support the collection of information was developed. The target groups identified by TML and LWHGT were:

- Young people
- Aboriginal and/or Torres Strait Islander people
- Older Tasmanians
- People from culturally and linguistically diverse backgrounds
- Families
- Young parents
- Adults

Approximately 3300 surveys were distributed to households of the George Town municipality. Surveys were returned to TML either via reply paid envelopes or to drop boxes placed throughout the community. Data were analysed by TML using Microsoft Excel.

This project gave TML an opportunity to trial the collaborative health planning (CHP)approach[5]. After the conclusion of the project, TML undertook process evaluation by conducting structured interviews with a representative sample of LWHGT. The goal of the evaluation was to assess their experience of being involved in CHP. Key reflections included:

- The structure, function and governance of the Leadership Group worked well.
- Community engagement and participation is vital and needs to be representative.
- Community driven process can be very challenging and requires perseverance, persistence and leadership to be successful.
- Establishing buy-in for all stages of the process in the beginning is essential.
- Additional use of the approach/model is required in varied communities to contest these learnings.

Survey Results and Discussion

Data collection

The total number of survey respondents was 415, representing a response rate of 15%. While this is generally considered low [6], the LWHGT reported that it was above average participation compared to previous surveys.

Questions were distributed as follows:

- Demographics: 10 questions (29%)
- Attitude to the community: 4 questions (12%)
- Perceptions about health: 4 questions (12%)
- Perceptions about wellbeing: 3 questions (8%)
- Services: 10 questions (29%)
- Gaps: 1 question (2%)
- Key Issues: 1 question (2%)
- Suggestions for improvements: 2 questions (6%)

Demographics (Q: 1 – 3, 6 – 9, and 11 – 13)

The respondents are mainly Australian born, and should therefore be proficient in English, but the Australian Bureau of Statistics reports that 68% of George Town residents have less than Year 10 school education. Readability assessment of the data collection tool returned a Flesh reading ease of 52.4% and a Flesh Kincaid grade level of 8.2. The readability of the tool may have impacted on the quality of the data collected as respondents required a minimum of grade 8 level education to understand the tool. The proportion of Tasmanian adults who do not have functional literacy skills is high [7] thus the data should be interpreted with caution as it is likely that this may have impacted the quality of responses. The length of the survey and the complexity of the questions may have contributed to the significant frequency of item non-responses [8].

There were a high number of female respondents in this survey (Table 1). According to the ABS census information for 2011 the ratio of women to men in George Town is nearly equal at 52% and 48% respectively[9], however the LWHGT survey results show that there were almost twice the number of female respondents (n=268) compared to males (n = 143). The majority of respondents (73%) have access to the internet, and 54% are regular users of the internet.

Women are the primary coordinators of health care for their families, and therefore more likely to have contact with a variety of health care providers. Many women carry the main responsibility for selecting their children's doctor, taking them to doctor's appointments, and arranging for their children's follow-up care[10]. In addition to their regular childrearing responsibilities, women are also more likely to be caregivers for a chronically sick or disabled family member. People older than 51 years were over represented in the sample (more than 56%), and younger people were under represented (1.46%). People have different health needs and health service utilisation patterns over their life course [11-13], and this information has not been captured for all residents of George Town.

Sense of community in George Town (Q: 4, 5, 10 and 14)

A strong sense of community has significant positive impacts on health and well-being outcomes of individuals and groups. Sense of community is characterised by community connections, a sense of belonging, networks, cohesion and social capital[14]. The respondents articulated many examples of commitment to their community, of which the most common are listed in Table 2. However, it is unlikely that the same sense of community is found in all residents as there is reported evidence of antisocial behaviour such as vandalism and drug abuse in the town. Sampling error and low response rate biases the results towards the people who have a well-developed sense of community, but excludes the people who do not. In spite of this bias, only 35% of the respondents stated that they volunteer, and some of the examples of "volunteering" were references to informal activities such as "keeping an eye on the neighbourhood" or being compelled to undertake activities by Centrelink.

Many community support and wellbeing activities assessed by this survey are possible because of volunteering, and require the development of sense of community to sustain these services. Participation in community events and projects, and the intention to stay in George Town is significantly related to sense of community, therefore more effort should be directed at growing sense of community and social engagement in all residents of George Town. Staying socially engaged is known to improve health and wellbeing, particularly in older people, and as the population of George Town ages, this will become increasingly important[15]. Fundamental to this process is that service frameworks are realigned towards the social determinants of health before the population becomes isolated and disengaged.

Perceptions of health and wellbeing (Q: 15 - 20)

Self-rated health status assessments are used extensively in public health research: partly because it is an easy and cost effective way to assess a community's health status; and partly because in the past it was believed that this method was a reliable predictor of mortality[16]. More recently, the factors that influence self-perception of health have been investigated, and some of these factors are relevant to the respondents of this survey[17]. While nearly two thirds of the respondents reported their health as good or excellent (Table 3 and 4), subjective health assessment does not necessarily correspond with objective health status[18]. For example, one of the factors that influences subjective health status assessment is socioeconomic status (SES)[19]. Low SES is associated with increased health risk factors, and lower health literacy. As a result health status is impaired, but due to over-estimation of health status, people from lower SES can be over-optimistic about their health. Other factors result in a more pessimistic view of health: older age, unemployment, lack of recreational activity and smoking status[18].

It is interesting to note that the respondents have a holistic understanding of the term "health and wellbeing" as two of the top five health concerns are related to social health (cost of living and lack of finances). The observation is further supported when the health and wellbeing concerns rated most important by the respondents are ordered by frequency; other social issues are raised including job security, gambling and drug use. This finding suggests that more emphasis should be placed on the social determinants of health in this community. It also raises questions about the capacity of the respondents to recognise health risks and effectively assess their own health needs as most of the common modifiable lifestyle factors offered in survey Q 19, were not reported as important. For example, smoking and alcohol use were only considered to be health concerns by 27% of the respondents. The top three barriers to good health as identified by the respondents were cost, time and motivation. TML would like to emphasise here though, that interpretation of the results to questions relating to health status are complicated by the probability that the respondents were not always reporting on the health of an individual (themselves), but rather on behalf of an undetermined number of people in a range of age groups that constitute their household.

Perceptions of Services in George Town (Q: 21 – 29 and 31)

Health care utilisation is considered an indicator of 'chronicity'. The combination of particular factors, for example people who attend GPs frequently and / or who use multiple medications and / or have frequent admissions to hospital, indicate that these people are likely to have chronic conditions, and it is therefore likely that their health status is impacted negatively. While the respondents have indicated that they consider their health and wellbeing to be good to excellent, and they have not reported many health risk factors, they appear to be utilising health care services consistently as shown in the list below.

1. General Practitioner / Doctor (80.96%)
2. Pharmacy (77.11%)
3. Dental (20.48%)
4. Optometry (19.76%)
5. Hospital (15.90%)

The utilisation of community support and wellbeing services is significantly lower than health services. The top five community services used are detailed in Table 6:

1. Seniors groups (15.18%)
2. LINC and digital hub (11.57%)
3. Transport assistance (10.84%)
4. Centrelink (8.92%)
5. Community Houses (5.06%)

Wellbeing services are not as well supported by the respondents of George Town either. The top five wellbeing services used are detailed in Table 7.

1. Gym (10.60%)
2. Religious groups (9.88%)
3. Sports clubs (9.64%)
4. Craft groups (8.19%)
5. Water exercise classes (5.30%)

Considering the age group of the majority of the respondents, these results are not unusual. It is important to note that older people are often reluctant to use formal social support services in the interest of maintaining privacy and avoiding the stigma of being seen as "unable to cope", fearing loss of independence. Approaches to offering services should be subtle and focussed on avoiding triggering resistance by not threatening residents' perceptions of self-efficacy and independence or suggesting intrusion into their lives[15]. Consideration should be given in future data collection projects to collecting health service utilisation information differently: meaningful information includes utilisation in a specific time frame (e.g. every month) and a frequency of use in the time frame. For instance, this would allow for quantification of services and correlation between service utilisation and other variables which could inform service delivery.

Generally the respondents report being satisfied with the services they access. Overall accessibility to services in George Town is good with two thirds of respondents waiting for a week or less for appointments (Table 9). Only 2.4% of respondents report waiting for longer than six weeks to be seen. However, approximately 30% of the respondents did not answer this question. A small number of people mentioned that they fear lack of privacy in George Town and therefore seek medical services elsewhere. This appears to be by choice and not related to access issue in George Town, with the exception of some specific specialist medical services such as oncology and eye surgery.

Referral to the services is detailed in Table 8. Generally all three categories of services have similar referral mechanisms, most commonly: General Practitioner, What When Where Booklet, George Town Service Directory and the pharmacy. This suggests that the existing communication structures are working well, and should be maintained.

Community Perceptions of Gaps in Services

Several services are accessed regularly outside of George Town. The respondents identified several barriers to accessing these services locally such as: service not available (13.5%), long waiting lists (13.0%), lack of information (8.9%) and lack of transport (6.3%) (Table 10). Gaps in current service provision are optical and dental services that cater to people without private health insurance, specialised radiology services, and specialised medical services such as oncology and ophthalmology. Given George Town's close proximity to a large regional centre, any service gaps identified could be addressed through innovative and creative use of existing resources such as community transport or telehealth services.

Suggestions for improvements

Thematic analysis revealed the following common threads. Useful additional services should include:

1. Medical and dental services
    a. After hours service
    b. Bulk billing
    c. Retention of health care professionals
2. Improved advertising and marketing of services:
    a. Community notice board
    b. Better utilisation of local newspaper
    c. Improved coordination of services
3. Local Council:
    a. Maintenance of roads and footpaths
    b. Cleanliness of town, parks and beaches
    c. Increase seats in recreational areas
4. Health and wellbeing:
    a. Promote George Town in a positive way – e.g. tourism
    b. Enclosed swimming pool
    c. Increased access to fitness classes – e.g. Pilates and Yoga
    d. Community wellness events – e.g. cooking classes for healthy lifestyle
    e. Better use of the community vegetable garden and improved access to fresh produce
    f. Increase community spirit – e.g. community BBQ, family days, music festivals, create social spaces, promote volunteering especially amongst younger people

It should be noted that the survey was purposefully not designed to evaluate specific service providers, but was intended to capture information about service utilisation. However, some respondents took the opportunity to include information about what worked well, and where improvements could be made, and the most common and relevant of these suggestions have been included in this the list above.

Perception of key issues

The following list is a compilation of the most common themes expressed by the respondents. Comments were diverse, and often very specific to the individual responding to the questionnaire. The list below is a compilation of the most generic comments.

1. Employment / job security
2. Maintain medical services – i.e. keep the hospital, attract more general practitioners, etc.
3. Ageing population – i.e. housing needs, places at residential aged care facilities
4. Youth issues: activities / facilities to address boredom
5. Crime and vandalism control
6. George Town reputation – e.g negative aspects over-emphasised in media
7. Health and wellbeing – e.g. availability of fresh produce
8. Drug and alcohol issues
9. Public transport
10. Environmental issues e.g. lighting in public places, foot paths, etc.

Limitations

These results reflect the perspective of predominantly female respondents, who are Australian born and older than 51 years. The results are therefore biased towards their needs and experiences and exclude many issues, for example, those related to maternal, child and youth health.

The design of the questionnaire was ambitious, with the intention of collecting as much information as possible. Unfortunately, this may have made completing the form daunting and contributed to the low response rate. Several questions were complex, which may have caused confusion and made interpretation of the data difficult when the second part of the question was not answered. Additional consideration could be given to literacy levels and preferred data collection methods relevant for different target groups.

The option of answering the questionnaire on behalf of multiple people (a household), or on behalf of another person, also confounded the data, and may have encouraged social desirability bias. Several respondents may have answered the questions in a way that reflected well on them, without taking responsibility for uncomfortable truths about their own health behaviour or risk factors, instead attributing them to “my spouse” or “the household” instead.

The use of validated and standardised questions and definitions could have yielded more reliable data, however this does not necessarily align with the community-driven nature of CHP, and this project was intended to be a learning experience for the LWHGT and the broader community.

Recommendations

Community recommendations

1. Consider ways to action the suggestions made by respondents such as:

    a. Increased access to fitness classes such as Pilates and Yoga
    b. Community wellness events – e.g. cooking classes for healthy lifestyle
    c. Better use of the community vegetable garden and improved access to fresh produce
    d. Increase community spirit – e.g. community BBQ, family days, music festivals, create social spaces, promote volunteering especially amongst younger people
    e. Promote George Town in a positive way to undo the harm done by television programs such as *Bogan Hunters* – e.g. tourism
    f. Enclosed swimming Pool.

2. Direct more effort at growing the sense of community and supporting social engagement in all residents of George Town to ensure sustainability of volunteer-driven community support and wellbeing services.

3. More emphasis should be placed on the social determinants of health in this community. This will also involve finding innovative approaches to accountability processes in order to tailor service delivers to the needs of individuals. (For example – the use of community transport for social needs as well as health care needs)

Future community-based research recommendations

1. Consider health literacy levels of the population and select alternative data collection strategies such as short questionnaires, with simple questions or focus group and interviews

2. Consider sampling methods that ensure that the health needs and health service utilisation patterns over the life course of a representative sample of the community is captured.

3. Additional exploration is required of the issues identified by this survey. Planning for additional data collection to build on the community profile over time should carefully consider what data are required to inform service delivery planning.

4. Future collaboration could extend to opportunities to link and share data sets between services providers to avoid duplication of efforts, and use resources most efficiently.

Collaborative Health Planning Process recommendations

1. More work needs to be done by the stakeholders to identify and prioritise actions, take action and evaluate the outcomes in order to complete the final steps in the CHP process.

2. Purposeful reflection by TML and LWHGT on how the CHP process can be improved will provide valuable insights for future projects.

Conclusion

George Town has a broad variety of health and wellbeing and community support services available to its residents. As it is located close to a major regional centre, additional specialist services and both public and private hospitals are also readily available, although admittedly there are some challenges around public transport and travel. In general, the results of this survey indicate that the respondents consider themselves fairly healthy and are satisfied with the services available to them.

The goal to establish an understanding of access to and utilisation of health, community, support and wellbeing services by the people of George Town was partially achieved providing consideration is given to the limitations of the sampling, data collection and CHP process. The provision of support for the community in undertaking the research, as provided through the CHP process, has been an important component of this work, with the role of facilitation by organisations such as TML an important one in order that communities are developing their skills in undertaking this type of work. Future work using this model should take into consideration that communities may require more technical support to build the capacity to undertake effective community-based research.

In George Town more work needs to be done by LWHGT to identify and prioritise actions, take action and evaluate the outcomes in order to complete the final steps in the CHP process. Over the course of undertaking this research, collaboration and partnerships between George Town and stakeholders were strengthened, and some steps were taken to enhance community engagement. LWHGT recognises the importance of understanding their community, and needs to build on the momentum of this research to further embed the principles of collaboration and participation in health service delivery in George Town.

Tables

Table 1. Selected Demographics

Variable	Responses		Census 2011 (%)
	(%)	(n)	
Gender			
• Male	34.5	143	48
• Female	64.6	268	52
Age			
• 51 – 70 years	49	203	27
• 18 – 25 years	1.46	6	9
• Older than 81 year	7.5	31	3
Relationship to respondent			
• Answered for self	49	203	
• Answered for household	48	198	
Living arrangements			
• Live in George Town	74.4	291	4305
• Live alone	32.5	134	28
• Live with spouse /partner	53	219	36.5
• Live with someone with disability	24.8	99	
• Are carers	12.6	51	
Cultural			
• Born in Australia	78	318	85
• Aboriginal / Torres Strait	2.2	9	5.5
• Non-English speaking country of origin	2.4	10	3
Internet			
• Access	73	302	61
• Regular users	54	222	

Table 2. Respondents' sense of community

Variable	Responses	
	(%)	(n)
Most Positive Aspects of living in George Town		
• Access to services (shops, hospital, GP, cafes, etc.)		
• Rivers and beaches		
• Friendly people		
• Community feel / spirit		
• Community support services (CWA, Lions, Community garden, Neighbourhood house, Wattle group)		
Least Positive Aspects of living in George Town		
• Unemployment / lack of job opportunities		
• Mismanagement / lack of vision at council level		
• Vandalism		
• Unsocial / negative people		
• Lack of access to shops, services and quality products (including opening hours)		
Residents who volunteer	35.5	148
Intention to stay in George Town	76	315

Table 3. Self-assessment of health

Variable	Responses	
	(%)	(n)
Respondent's health		
• Good	41.1	170
• Excellent	16.2	67
Household's health		
• Good	38.1	158
• Excellent	15.7	65
Greatest health / wellbeing concerns (rated 1 = most concerning)		
1. Cost of living	73.98	307
2. Ageing	71.08	295
3. Lack of Finance	53.49	222
4. Arthritis	51.81	215
5. Hearing	47.95	199
6. Vision	47.95	199

Table 4. Self-assessment of wellbeing

Variable	Responses	
	(%)	(n)
Respondent's wellbeing		
• Good	42.72	176
• Excellent	24.03	99
Household's wellbeing		
• Good	37.3	155
• Excellent	22.6	94
Barriers to good health		
Cost of living	30.1	125
Motivation	22.4	93
Time	14.7	61
Difficulty accessing what I want	13.9	58
Not a priority	12.8	53
Barrier rated least important		
Lack of information	12.7	24

Table 5. Utilisation and satisfaction: health services

Service used	No	%	% Satisfied	Service used	No	%	% Satisfied
GP/Doctor	336	80.96	87.20	Child Heath	21	5.06	90.48
Chemist/ Pharmacy	320	77.11	92.50	Counselling	19	4.58	78.95
Dental	85	20.48	82.35	Osteopathy	13	3.13	69.23
Optometry/ Vision services	82	19.76	80.49	Dietician	12	2.89	83.33
Hospital Services (other than listed)	66	15.90	83.33	Psychologist	11	2.65	81.82
Physiotherapy	59	14.22	86.44	Continence	8	1.93	62.50
Podiatry/ Foot care	52	12.53	88.46	Aboriginal Health	6	1.45	50.00
Exercise classes	51	12.29	82.35	Speech Therapy	5	1.20	80.00
Hearing	43	10.36	83.72	Drug Services	3	0.72	66.67
Diabetes Educator	34	8.19	82.35	Palliative Care	3	0.72	66.67
Home help	31	7.47	83.87	Social Work	3	0.72	100.00
Community Nursing	28	6.75	85.71	Alcohol Services	2	0.48	100.00
Massage/ Alternative Therapies	26	6.27	73.08	Exercise Physiology	1	0.24	100.00
Aged Care	23	5.54	86.96				
not used any of these services	23	5.54		unsure of what services used	2		

Table 6. Utilisation and satisfaction: community support services

Service	Service users (n)	% users	Satisfied (n)	% satisfied
Seniors Groups (Wattle Group, Probus)	63	15.18	57	90.48
LINC and Digital Hub	48	11.57	40	83.33
Transport Assistance (i.e. community car)	45	10.84	37	82.22
Centrelink support services	37	8.92	21	56.76
Community Houses	21	5.06	19	90.48
Job Service provider	18	4.34	10	55.56
Home based services (i.e. Community Options, Family Based Care)	15	3.61	11	73.33
Housing and Accommodation	14	3.37	9	64.29
After School activities (i.e. play group, Neighbourhood House)	12	2.89	9	75.00
Financial services	10	2.41	8	80.00
Cancer support services	9	2.17	9	100.00
Crisis service (i.e. food assistance)	9	2.17	8	88.89
Food services (i.e. Meals on Wheels)	9	2.17	6	66.67
Child minding	6	1.45	4	66.67
Mental Health support	6	1.45	6	100.00
Community Shed	5	1.20	4	80.00
Family Support (i.e. Centacare)	5	1.20	5	100.00
Pregnancy and early childhood services	5	1.20	3	60.00
I have not used any of these services	184	44.34		
I am unsure of what services I have used	6			

Table 7. Utilisation and satisfaction: Wellbeing services

Service Used	No	%	No	%
Gyms	44	10.60%	37	84.09%
Religious groups	41	9.88%	34	82.93%
Sports clubs	40	9.64%	37	92.50%
Craft Groups	34	8.19%	33	97.06%
Water exercise classes	22	5.30%	17	77.27%
Walking groups	21	5.06%	18	85.71%
Alternative therapy	20	4.82%	19	95.00%
Parents/children's groups	12	2.89%	11	91.67%
Cultural groups	9	2.17%	7	77.78%
Kinder Gym	7	1.69%	6	85.71%
Workplace wellbeing programs	4	0.96%	2	50.00%
Mental health support groups	2	0.48%	2	100.00%
I have not used any of these services	191	46.02%		

Table 8. Referral methods

Referral Method	Health services		Community support services		Wellbeing services	
	No	%	No	%	No	%
General practitioner	**202**	48.67	65	15.66	42	10.12
What Where When booklet	161	38.80	**96**	23.13	68	16.39
Pharmacy	116	27.95	39	9.40	26	6.27
Friends/family	91	21.93	60	14.46	91	21.93
George Town service directory	83	20			27	6.51
Telephone directory			45	10.84		

Table 9. Access to services

Appointment waiting times	**Responses**	
	(%)	**(n)**
• 1 – 3 days	49.46	182
• 1 week	16.58	61
• 1 – 2 weeks	8.70	32
• 3 – 4 weeks	2.99	11
• 6+ weeks	2.45	9

Table 10. Barriers to accessing services.

Variable	**Responses**	
	(%)	**(n)**
Barriers to accessibility		
• Cost	23.1	96
• Service not available	13.5	56
• Long waiting list	13.0	54
• Lack of information	8.9	37
• Lack of transport	6.3	26
Services regularly accessed outside of George Town		
• Optical and dental services		
• X-ray services		
• Medical Specialists and Tertiary hospitals – LGH, RHH, Eye Institute		
• Allied health services		
• Indoor swimming pool		

References

1. Bywood P, Ketterl R, Lunnay B. Disparities in primary health care utilisatio: who are the disadvantaged groups? How are they disadvantaged? What interventions work? Brief summary of key messages. Primary Health Care Research & Information Service,; 2011. Available from: www.phcris.org.au.

2. Bleich SN, Özaltin E, Murray CJL. How does satisfaction with the health care system relate to patient experience? Bulletin of the World Health Organisation. 2009 [cited January 3, 2014]; 87:271-278. DOI:10.2471/BLT.07.050401.

3. Hawtin M, Percy-Smith J. Community Profiling : A Practical Guide. Maidenhead: McGraw-Hill Education; 2007 [cited. Available from: http://CURTIN.eblib.com.au/patron/FullRecord.aspx?p=332664.

4. Hunt E, Moore J, Sherriff J. Community health-care planning in Western Australian Country Health Service-South West: An evaluation of patient views. 2012; Available from http://onlinelibrary.wiley.com.dbgw.lis.curtin.edu.au/doi/10.1111/j.1747-0080.2011.01571.x/abstract

5. Gudes O, Kendall E, Yigitcanlar T, Patak V, Baurm S. Rethinking health planning: a framework for organising information to underpin collaborative health planning. Health Information Management Journal. 2010; 39(2) Available from http://web.a.ebscohost.com.dbgw.lis.curtin.edu.au

6. Reis HT, Judd CM. Handbook of Research Methods in Social and Personality Psychology. Cambridge: Cambridge University Press; 2014.

7. Tasmanian Department of Education. Tasmanian Adult Literacy Action Plan. Hobart: Department of Education; 2010. Available from: https://www.education.tas.gov.au/documentcentre/Documents/Tasmanian-Adult-Literacy-Action-Plan.pdf.

8. Kays K, Gathercoal K, Buhrow W. Does survey format influence self-disclosure on sensitive question items? Computers in Human Behavior. 2012; 28(1):251-256. DOI:http://dx.doi.org/10.1016/j.chb.2011.09.007.

9. Australian Bureau of Statistics (ABS). 2011 Census Community Profiles George Town, Tasmania. Canberra: ABS; 2013. Available from: http://www.censusdata.abs.gov.au/census_services/getproduct/census/2011/communityprofile/SSC60125?opendocument&navpos=230.

10. Salganicoff A, Ranji UR, Wyn R. Women and health care: a national profile. Key findings from the Kaiser Women's Health Survey. Washington, DC: Kaiser Family Foundation; 2005. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/women-and-health-care-a-national-profile-key-findings-from-the-kaiser-women-s-health-survey.pdf.

11. Ben-Shlomo Y, Kuh D. A life course approach to chronic disease epidemiology: conceptual models, empirical challenges and interdisciplinary perspectives. International Journal of Epidemiology. 2002; 31(2):285-293. DOI:10.1093/ije/31.2.285.

12. Glass TA. Health Inequalities: Lifecourse Approaches. American Journal of Epidemiology. 2004; 160(5):503-504. DOI:10.1093/aje/kwh230.

13. Yu S. The Life-Course Approach to Health. American Journal of Public Health. 2006; 96(5):768-768. DOI:10.2105/AJPH.2006.088617.

14. Pretty G, Bishop B, Fisher A, Sonn C. Psychological sense of community and its relevance to well-being and everyday life in Australia. Melbourne: Australian Psychological Society Ltd; 2006. Available from: https://groups.psychology.org.au/Assets/Files/Community-Updated-Sept061.pdf.

15. Walker J, Orpin P, Baynes H, Stratford E, Boyer K, Mahjouri N, et al. Insights and principles for supporting social engagement in rural older people. Ageing and Society. 2013; 33(6):938-963. DOI:http://dx.doi.org/10.1017/S0144686X12000402.

16. Murata C, Kondo T, Tamakoshi K, Yatsuya H, Toyoshima H. Determinants of self-rated

health: Could health status explain the association between self-rated health and mortality? Archives of Gerontology and Geriatrics. 2006 [cited 2006/12//]; 43(3):369-380. DOI:http://dx.doi.org/10.1016/j.archger.2006.01.002.

17. Holm AL, Severinsson E. A Qualitative Systematic Review of Older Persons' Perceptions of Health, Ill Health, and Their Community Health Care Needs. 2013; 2013 DOI:10.1155/2013/672702.

18. Layes A, Asada Y, Kephart G. Whiners and deniers – What does self-rated health measure? Social Science & Medicine. 2012; 75(1):1-9. DOI:http://dx.doi.org/10.1016/j.socscimed.2011.10.030.

19. Kaleta D, Polańska K, Dziankowska-Zaborszczyk E, Hanke W, Drygas W. Factors influencing self-perception of health status. Central European journal of public health. 2009; 17(3):122-127. Available from: http://search.proquest.com/docview/733656229?accountid=10382

Tasmania Medicare Local Limited
ABN 47 082 572 629
T 1300 365 169
E info@tasmedicarelocal.com.au
www.tasmedicarelocal.com.au
Tasmania Medicare Local acknowledges the financial and other support of the Australian Government Department of Health