Health Needs Assessment

2025-2028

phn MURRUMBIDGEE
An Australian Government Initiative

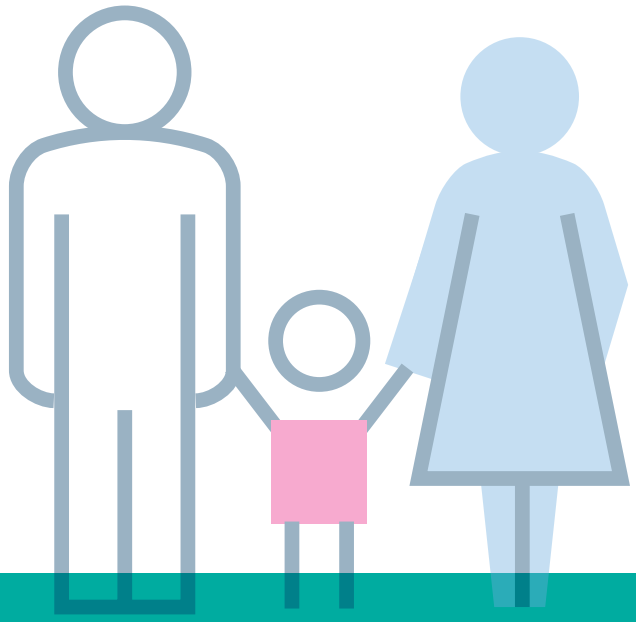
firstHealth LIMITED

Murrumbidgee Primary Health Network (MPHN) acknowledge and pay our respect to the traditional owners of the lands on which MPHN operates: the Wiradjuri, Nari Nari, Wemba Wemba, Perepa Perepa, Yorta Yorta, Ngunnawal, Nagrigo, Bangerang and Yitha Yitha Nations. We recognise our communities are made up of many Aboriginal and Torres Strait Islander peoples descended from additional mobs and clans who also call the Murrumbidgee region home. We pay our respects to elders past, present and future and recognise these lands have always been places of traditional healing and medicine, and this plays a role in shaping future health services.

Executive summary

Murrumbidgee Primary Health Network (MPHN) conducts regular Health Needs Assessments (HNA) to identify and understand the evolving health priorities of our region. Needs assessments are vital to evidence-based healthcare planning to identify changing and emerging gaps in services, health risks, disparities among population subgroups, and health workforce challenges. All Australian Primary Health Networks are required to undertake and submit a comprehensive needs assessment to the Department of Health and Aged Care (the Department) every three years.

This document outlines MPHN's HNA 2025–2028, submitted on 15 November 2024 and formally approved by the Department on 14 January 2025. The assessment draws on the latest population demographics, health data, and qualitative insights from community consultations and stakeholder engagement. Led by MPHN's population health and data team, the assessment integrates contributions from the executive, senior managers, and MPHN's Board to ensure broad strategic alignment.



Why we do the needs assessment

HNAs are fundamental to MPHN's commissioning approach. It identifies our communities' most pressing health and service needs, allowing us to prioritise resources, plan, and design services that improve health outcomes, particularly for people at risk of poor health.

How we do the needs assessment

Our methodology combines detailed national and local health datasets analysis with insights gathered through community consultations and stakeholder engagement. Weuse data triangulation techniques to verify findings and ensure they reflect the lived experiences of people across our region. This inclusive and evidence-based process helps ensure that commissioning decisions are responsive, targeted, and equitable.

Key findings

A review of the available data showed that while many issues remain consistent with the previous assessment, the 2025–2028 HNA highlights persistent and emerging health and service challenges.

Health needs	Service needs
Compared to NSW and Australia, the MPHN region experiences: • A higher proportion of very young (0–4 years) and older (≥65 years) populations • Greater socioeconomic disadvantage • Higher rates of domestic violence and sexual assault • Higher prevalence of risky alcohol consumption, smoking, insufficient physical activity, and obesity • Higher rates of avoidable and premature mortality from coronary heart disease, COPD, suicide, and all-cancers • Higher rates of youth mortality among those aged 16 to 24 years • Higher incidence of prostate, breast, and pancreatic cancer • Higher rates of people living with multi-morbidity • Significant mental health burden, along with high prevalence of arthritis, asthma, and COPD.	There are significant opportunities to improve system performance through: • Reduction in low-urgency presentations to emergency departments • Reduction in hospitalisations for conditions that could be prevented or managed in primary care • Increased availability and access to general practitioners, specialists, and alliedhealth professionals • Increased general practitioner, specialist practitioner and allied health attendance rates • Increase cervical screening participation rates.

What's changed

The 2025–2028 HNA identified several emerging or intensifying needs not as prominent in previous assessments, including:

✓	A growing need to support individuals (including children) living with multimorbidity (e.g. living with two or more long-term health conditions)
✓	Increasing need to reduce obesity rates among adults and children
✓	Increasing need to reduce the prevalence of asthma among adults and children
✓	Increasing need to reduce arthritis prevalence
✓	The need to address persistently high youth mortality (16–24 years)
✓	Increasing need to support people at risk of experiencing homelessness
✓	Address developmental vulnerability among children entering their first year of school

Contents

Section 1: Overview of MPHN and health needs assessment process

1.1 Murrumbidgee Primary Health Network

MPHN, operated by firsthealth Limited, is a not-for-profit organisation funded by the Australian Government to deliver the Primary Health Network (PHN) Program across the Murrumbidgee region. MPHN is one of 31 local and independent PHNs established nationally to strengthen the primary healthcare sector and improve health outcomes, particularly for people at greater risk of poor health.

Guided by our vision, *Well People, Resilient Communities across the Murrumbidgee*, MPHN operates across approximately 126,000 square kilometres, serving over 250,000 people across 508 communities. With individuals at the centre of care, we use a data-driven, place-based approach to understand the unique health needs of our region and shape the way services are delivered.

MPHN works in partnership with our communities and stakeholders to:

- Coordinate local services and systems to improve coordination of care
- Commission primary health services to meet population health needs with a focus on access and equity
- Support capacity-building to ensure a sustainable healthcare workforce through quality improvement, professional development, and other innovative measures

Our work and engagement with our communities and stakeholders are underpinned by our values of working together, being honest, valuing everyone, and aiming to inspire and learn from others.

For more information regarding Primary Health Networks, visit the Department of Health website.

1.2 Underlying principles and governance

MPHN has underpinning principles for commissioning, social inclusion , and planning that guide our needs assessment. These include ensuring an approach that includes equality and equity for communities across the Murrumbidgee region.

The MPHN Health Needs Assessment and Planning Guide supports MPHN in identifying indicative priority health needs and facilitating annual planning throughout the Murrumbidgee region via service commissioning, integration, and collaborative initiatives. This guide undergoes regular updates to reflect the latest methodologies, as evidence of the thorough processes involved. While needs assessment remains a continuous activity for MPHN, the extensive data analysis carried out at the start of the needs assessment cycle is elaborated upon in the planning guide.

View the guide here.

Collaboration is central to our approach. We work closely with partner service providers, including Murrumbidgee Local Health District (MLHD), Aboriginal Medical Services (AMS), and other local healthcare providers, to implement and deliver integrated and coordinated care models. This includes the development of Murrumbidgee HealthPathways, which supports consistent, evidence-based care across the region.

To strengthen primary healthcare and ensure community voices inform our work, we have established Clinical Councils and a Community Advisory Committee (CAC). Governance structures play a vital role in shaping best-practice healthcare delivery. The Clinical Councils and CAC provide strategic input regarding population health planning and service commissioning, and make formal recommendations to MPHN's Board for consideration and approval.

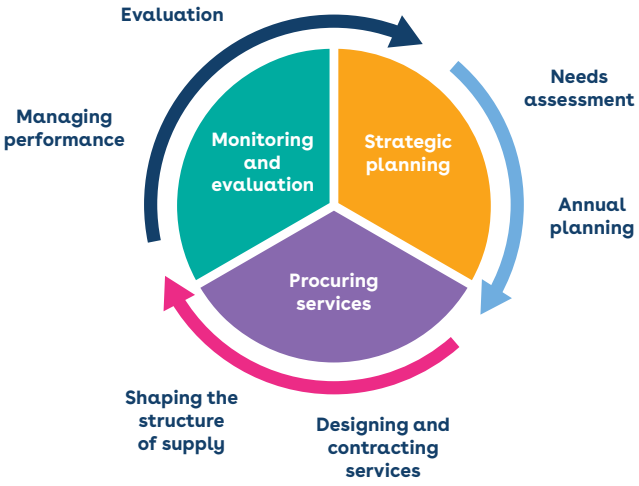
1.3 Health needs assessment process

The development of the HNA is led by MPHN's Chief Data Officer. To develop a better understanding of health status and service delivery across the region, all MPHN staff receive regular updates and opportunities to contribute.

MPHN employs a supply-and-demand approach to identifying service gaps, which leads to identifying, prioritising, and planning strategies or programs to address those gaps. Planned commissioned services and programs that respond to identified health needs generate service utilisation data, which informs the effectiveness and efficiency of services and programs and contributes to the ongoing review of health needs and gaps in service provision.

Understanding the quantity of the gap is one element measured by supply and demand. Understanding the reason for the gap is another. MPHN takes a consultative approach with community members, key stakeholders, and health service providers to understand why gaps exist and co-design, where applicable, solutions that address the root causes. As shown in Figure 1, the needs assessment forms the first and critical step in the PHN commissioning framework.

Figure 1: PHN Commissioning Framework

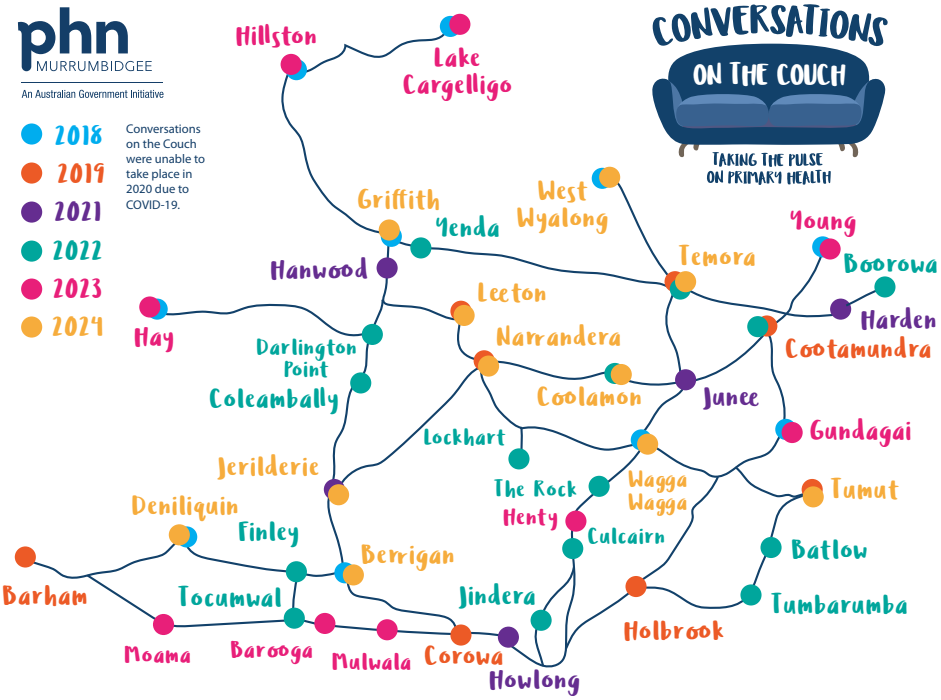


MPHN's HNA is developed through a thorough multi-step approach that gathers insights from various critical data sources regarding our community's health and the challenges of accessing quality primary healthcare. In essence, two main processes of data analysis and collection support the creation of our HNA: (i) Population health data; and (ii) Community Consultation. Each of these data sources will now be described.

1.3.1 Population health data

Population health data are used to identify the health issues of our community. This includes reviewing, analysing, and synthesising data from principal national health and demographic agencies, including the Australian Institute of Health and Welfare (AIHW), Australian Bureau of Statistics (ABS), Public Health Information Development Unit (PHIDU), and New South Wales Health. MPHN maintains an internal Population Health Analytics (PHA) tool, comprising approximately 1,300 health-related indicators relevant to our region. Data are ingested from the above agencies, and each indicator is ranked nationally across the 31 PHNs. Rankings are based on whether a higher or lower score indicates poorer performance, allowing MPHN to benchmark its results against national and NSW averages. As in previous assessments, we prioritise indicators where MPHN falls in the lowest-performing third of PHNs (i.e., ranked ≥20 of 31), flagging these as areas requiring urgent attention.

Figure 2: Overview of data collection points during Conversations on the Couch 2018-2024



1.3.2 Community consultation

A limitation of the population health data is the significant time lag that often occurs when it is collected and made publicly available. To address this, MPHN complements its analysis with real-time input from community consultations, helping to validate observed trends and identify emerging issues. Our primary methods include:

- Conversations on the Couch – conducted in towns across the region to gather perspectives from the general community.
- Yarns on the Couch – dedicated consultations with Aboriginal and Torres Strait Islander communities to capture culturally specific insights.

These conversations are conducted as qualitative interviews, where participants discuss their personal and community health experiences and barriers and enablers to primary healthcare access. Thematic analysis is applied to identify key emerging issues, which form a critical input into the 'identified needs' section of the HNA submission.

In addition, MPHN uses two online tools to gather community feedback:

- MPHN Community Feedback Survey
- MPHN Mini Feedback Survey

These surveys promote survey participation through social media (Facebook, LinkedIn, and Instagram) and media appearances, seeking insights on:

- Community perceptions and concerns
- Priority health issues
- Access to health services
- General wellbeing

In this HNA cycle, we have received over 1,200 responses, including 92 responses from Aboriginal and Torres Strait Islander participants.

1.3.3 Data triangulation

To ensure a robust evidence base, MPHN analyses these data sources to triangulate insights. Where possible, an identified need is supported by two or more data sources. For example, to support the identified 'need for specific age-related services' (page 10), we present data from the ABS, AIHW, and Conversations and Yarns on the Couch.

1.3.4 Key Stakeholder Feedback

The final phase of our HNA involves seeking input from our Clinical Councils, Community Advisory Committees, Local Health Advisory Committees, and Board. We provide a series of presentations to our key stakeholders for feedback. These stakeholders provide strategic guidance and help identify priority areas to inform commissioning decisions and future service planning.

1.4 Data and information issues and opportunities

Despite a strong methodological approach, several data limitations affect the accuracy and timeliness of the HNA.

1. Border and geographic challenges

MPHN's proximity to the NSW-Victoria and NSW-ACT borders, presents inherent issues with data accuracy. For example, residents may cross state lines for services such as cancer screening or to visit general practitioners, which can skew MPHN-specific health data. Similarly, parts of the Lachlan Local Government Area are shared with Western PHN, complicating population attribution. Given each of these border-related issues, we urge caution in interpreting the accuracy of some of the data presented in this HNA.

2. Data timeliness

National datasets often have significant lag times between data collection and release. For instance, cancer incidence data from the Australian Cancer Database are from 2014–2018, and mortality data extend only to 2021. These outdated data hinder timely understanding of emerging health trends and the ability to assess the effectiveness of recent health interventions.

3. Service mapping gaps

Accurate service mapping remains a challenge. Although several public sources exist, validation has highlighted concerns regarding the reliability of some workforce data. Furthermore, most PHN-level datasets are aggregated, limiting our capacity to identify and target the most affected subgroups (e.g., by age, income, ethnicity, or location). For example, while MPHN has the lowest cervical screening rates nationally, the absence of unit-level data makes it difficult to design interventions for those with the lowest participation.

While privacy concerns around identifiable data are acknowledged, access to de-identified unit-level data would significantly enhance the ability of PHNs to design targeted, effective interventions. In the future, we aim to leverage linked datasets such as the NSW Ministry of Health Lumos dataset to obtain a more granular and accurate understanding of the primary healthcare landscape in the Murrumbidgee region.

Section 2: Outcomes of the Health Needs Analysis

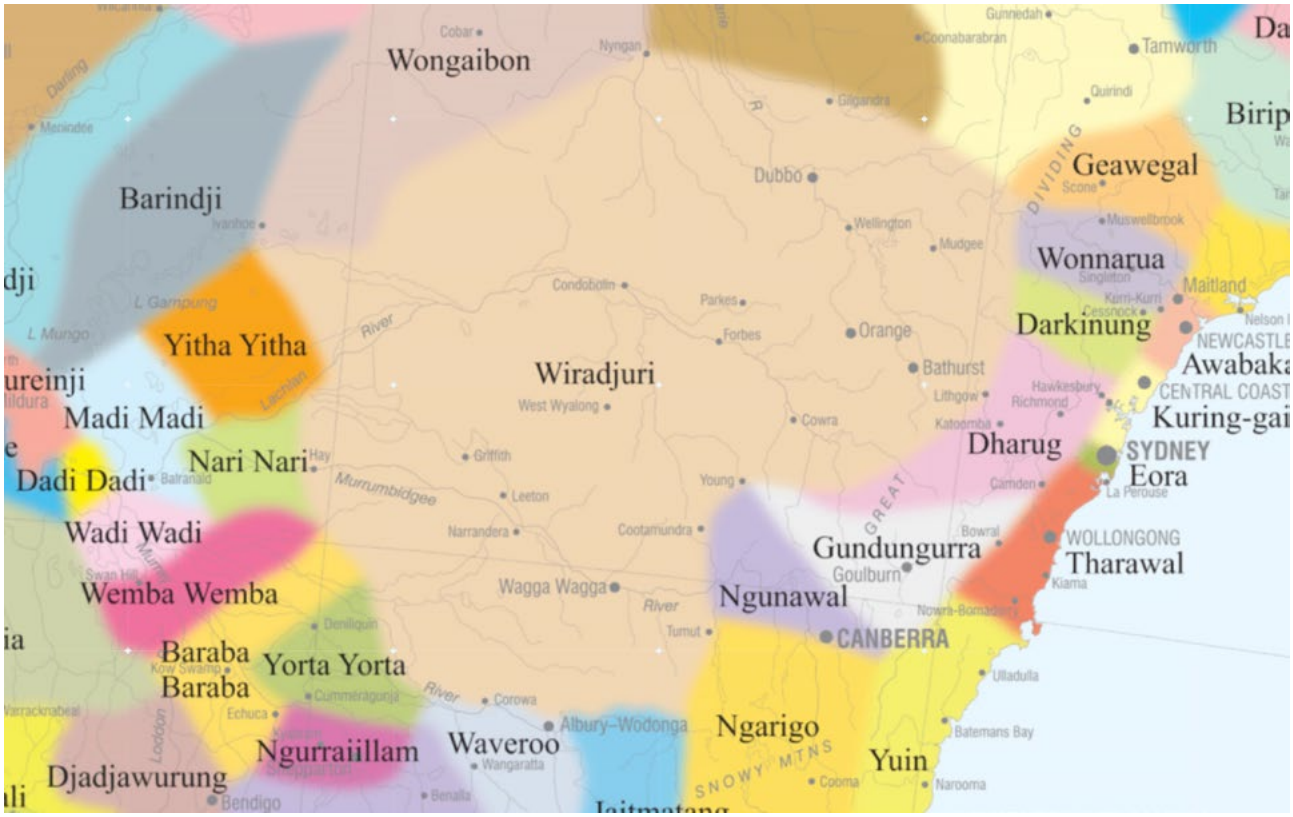
2.1 Overview of the MPHN region

MPHN is situated in southern New South Wales, bordered by communities in Victoria to the south, Lake Cargelligo in the north, Young and the Snowy Valleys in the east, and Barham in the west. Historically, the Murrumbidgee district comprised the land between the Murrumbidgee River and the Murray River, primarily used for pastoral and grazing activities; it is most known as the Riverina region.

MPHN is located on the lands of the Wiradjuri, Wemba Wemba, Baraba Baraba, Nari Nari, Perepa Perepa, Ngunnawal, Ngario, Bangerarg, Yitha Yitha, and Yorta Yorta people. MPHN acknowledges the Traditional Custodians of all the lands on which we work, and we pay our respects to Elders past, present and emerging. We are committed to walking alongside Aboriginal and Torres Strait Islander peoples to support culturally safe, equitable, and responsive health care.

The AIATSIS Indigenous Australia map, depicted below in Figure 1 (not accurate and lacking fixed boundaries), aims to represent the language, social, or nation groups of Aboriginal Australia by using broader groupings of nations that may encompass clans, dialects, or individual languages. The nations mentioned here are within, but not limited to, the MPHN footprint.

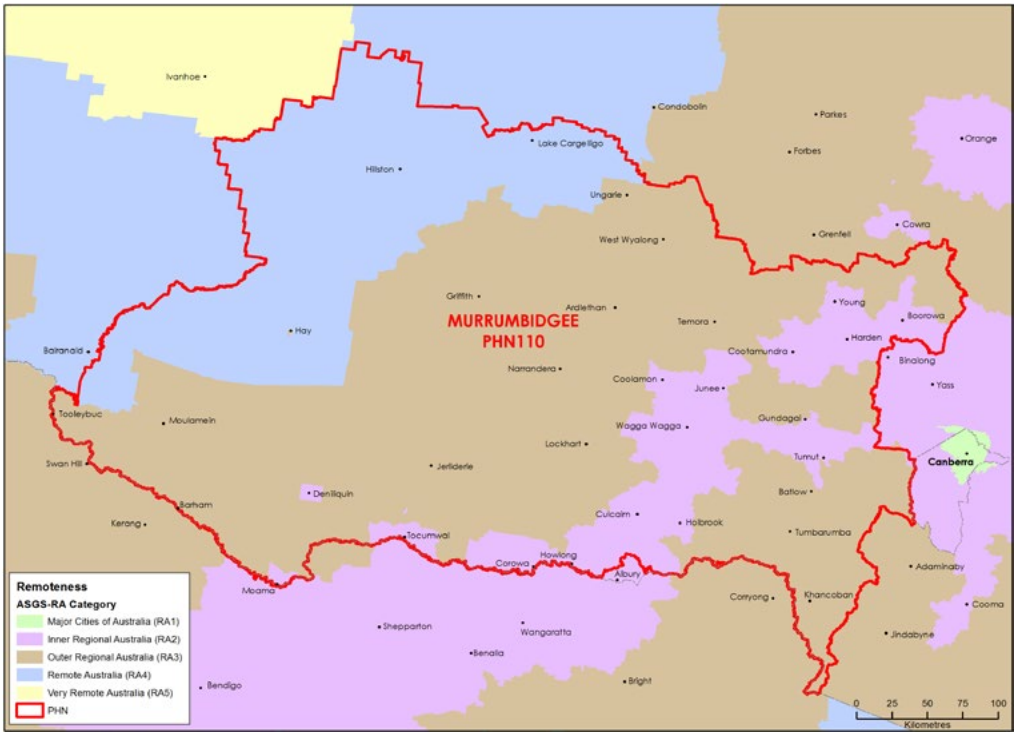
Figure 3: Map of Indigenous Australia, focusing on MPHN region



The people of Wiradjuri country are known as the 'people of three rivers', referring to the Macquarie River (Wambool), Lachlan River (Kalari), and Murrumbidgee River (Murrumbidjeri), which border their lands.

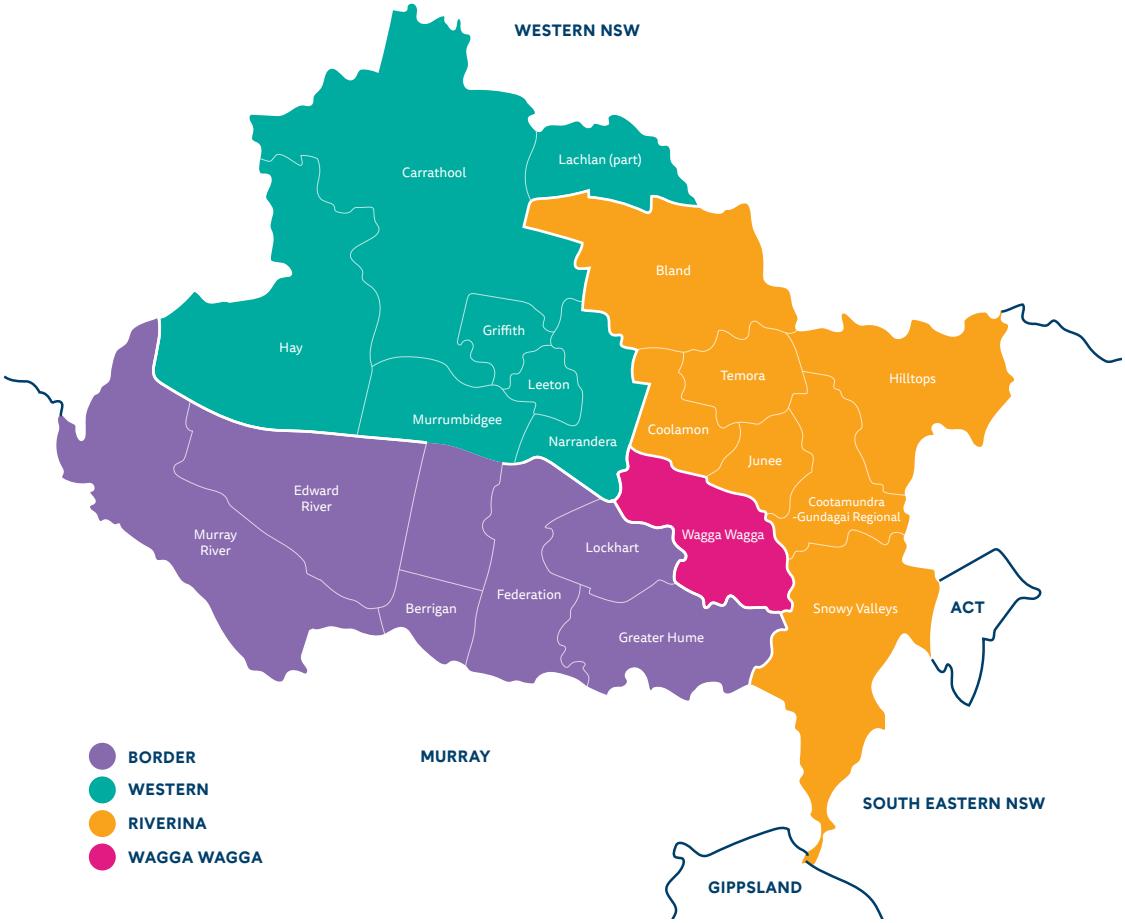
Most of the region is classified as outer regional Australia (RA3), along with remote areas (RA4) and inner regional areas (RA2). The region's major city is Wagga Wagga, as shown in Figure 4.

Figure 4: Australian Standard Geographical Classification (ASGC) map of the MPHN region



MPHN includes four sectors, developed for the purpose of planning, engagement, and where relevant, service delivery. the Border sector to the south, the Western sector to the northwest, the Riverina sector to the east, and Wagga Wagga, which is centrally situated in the largest city. There are 21 Local Government Areas located within the MPHN Region.

Figure 5: Sector map of the MPHN region



2.2 Demographic analysis

MPHN has a population of 250,744 people (2023 Estimated Resident Population [ERP]). The three most populated LGAs are Wagga Wagga (68,716), Griffith (27,132), and Hilltops (19,255).[1] Across the Murrumbidgee, the population is anticipated to increase by 3.5% from 2025 to 2030, with the largest growth projected in the Lockhart (14.6%), Coolamon (12.9%), and Greater Hume Shire (9.2%) LGAs.[1]

Population density across the Murrumbidgee is 3.3 persons/km^2, with Griffith (16.6 persons/km^2) and Wagga Wagga (14.2 persons/km^2) being the most densely populated LGAs. In contrast, the least densely populated LGAs are Carrathool (0.1 persons/km^2), Hay (0.2 persons/km^2), and Lachlan–part b (0.4 persons/km^2).[1]

A total of 17,859 Aboriginal and Torres Strait Islander people reside in the Murrumbidgee, according to the 2021 ERP. The Murrumbidgee has a higher proportion of individuals identifying as Aboriginal and Torres Strait Islander (7.2%) compared to NSW (4.2%) and Australia (3.8%). The LGAs with the largest number of Aboriginal and Torres Strait Islander individuals are Wagga Wagga (5,433), Griffith (1,788), and Hilltops (1,142). The LGAs with the highest proportion of their populations identifying as Aboriginal and Torres Strait Islander are Lachlan–part b (23.8%), Narrandera (16.1%), and Carrathool (11.4%).[1]

Population health and community consultation data analysis for the 2025-2028 MPHN HNA highlighted several unique demographic factors that guide our primary health care planning. The next section provides an overview of these. Appendix Table 1 (located on pages 64-68) provides a complete description of the demographic health needs assessment outcomes.

2.2.1 Need for specific age-related services

Population data:

- MPHN's median age (44.3 years) is older than that of NSW (39.0 years) and Australia (38.0 years).[1]
- MPHN has a higher prevalence of people aged 65 years and over (21.6%) compared to NSW (17.1%) and Australia (17.5%).[1]
- Among persons aged 65 years and over living in households, MPHN has a higher prevalence of those living with a 'moderate or mild core activity limitation' (30.9 age-standardised rate [ASR] per 100) than in NSW (28.3 ASR per 100) and Australia (28.6 ASR per 100).[13]

Community consultation:

Our analysis of MPHN's Community Feedback Survey showed that among a sample of 1,214 people in our region, 57.0% reported it was '*difficult*' to '*very difficult*' to access 'aged care services'. A sub-sample of our survey participants indicated that 'high cost' and 'wait times' were key factors impacting access to age-related services.

2.2.2 Improve health literacy due to less education

Population data:

- MPHN has a higher prevalence of individuals 'who left school at year 10 or below, or did not attend school' (36.9%) compared to NSW (27.8%) and Australia (25.4%).[13]
    - The prevalence is higher among our Aboriginal and Torres Strait Islander people (MPHN 49.0; NSW 45.5; Aust 42.7%).[14]
- Compared to NSW (25.1%) and Australia (29.1%), MPHN (11.4%) has a lower prevalence of 'school-leaver participation in higher education'.
- MPHN has a higher prevalence of 'children in families where the mother has low educational attainment' (21.8%) compared to NSW (15.8%) and Australia (14.1%).[13]

Community consultation:

A thematic analysis of qualitative interviews conducted during 'Conversations on the Couch' and 'Yarns on the Couch' indicated that the absence of 'health education and information' emerged as a leading theme among both general community members and Aboriginal and Torres Strait Islander community members.

2.2.3 Increase access to services

Population data:

- MPHN has a lower SEIFA Index of Relative Socio-economic Disadvantage (974), than NSW (1001) and Australia (1000); and for Indigenous Relative Socioeconomic Outcomes Index' (MPHN: 44; NSW 35; Aus: 41).[13]
- MPHN has a higher prevalence of 'low income, welfare-dependent families' (5.3%) than NSW (4.2%) and Australia (4.4%).[13]
- MPHN has a higher prevalence of 'households where weekly income is between $1-$799' (33.4%), when compared to NSW (30.0%) and Australia (30.6%).[1]

Community consultation:

Online Community Feeback Survey

- Percentage who listed 'cost of living' as one of the top five most serious health and wellbeing concerns for your community as a whole:
  - Non-Aboriginal and Torres Strait Islander sample = 47.9%
  - Aboriginal and Torres Strait Islander sample = 55.4%
- Percentage *'strongly disagreed'* or *'disagreed'* with the statement 'living costs are affordable here, e.g. food, petrol, housing':
  - Non-Aboriginal and Torres Strait Islander sample = 52.1%
  - Aboriginal and Torres Strait Islander sample = 49.4%

Conversations on the Couch and Yarns on the Couch

- Increased 'cost of living' and 'lack of affordability of primary health care' were among the top five themes emerging from qualitative interviews with Murrumbidgee community members.

2.2.4 Support people at risk of or experiencing homelessness

Population data:

- The rate of people accessing 'specialist homelessness services' across the MPHN is 42.9% above the national average.[2]
- Across the Murrumbidgee, the number of people who are 'experiencing homelessness or marginally housed' increased from 2016 (230.2 per 100,000) to 2021 (355.5 per 100,000).[3]

Community consultation:

Increased cost of living was one of the top five themes emerging from qualitative interviews with community members conducted as part of 'Conversations on the Couch' and 'Yarns on the Couch'.

Table 1: Priority areas for action for population groups from demography

	Aboriginal and Torres Strait Islander people	Maternal, child and youth	Older persons	Population
Need for specific age related services			✓	
Increase access to services due to limitations for fee based healthcare services	✓	✓		✓
Improve health literacy due to less education or lack of internet access	✓	✓		
Support people at risk of or experiencing homelessness				✓

2.3 Health determinants analysis

Health determinants include a range of elements, such as biological, environmental, and social factors. Describing and understanding these determinants within the Murrumbidgee is crucial for providing meaningful and impactful primary health care. The following section provides an overview of the most recent health determinants data. Appendix Table 2 (located on pages 69-70) provides a complete description of the outcomes of the health needs assessment for health determinants.

2.3.1 Increase life expectancy due to lower life expectancy experienced

Population data:

The most recent mortality data show that people in the Murrumbidgee have a lower life expectancy (81.0 years) than those in NSW (82.0 years). In addition, compared to females from the rest of the nation (85 years), life expectancy in the MPHN (84 years).[7]

2.3.2 Decrease youth mortality among those aged 16 to 24 years

Population data:

- MPHN has a higher rate of death among people aged 15 to 24 years (81.0 ASR per 100,000), compared to NSW (27.6 ASR per 100,000) and Australia (26.5 ASR per 100,000).[7]
- Among the Aboriginal and Torres Strait Islander people in the Murrumbidgee aged 15 to 24 years, the rate of death is higher in NSW and Australia (MPHN: 47.2; NSW 24.6; Aus: 26.8; ASR per 100,000).[14]

2.3.3 Increase support for people living with multi-morbidity

Population data:

- MPHN has a higher proportion of people aged ≥15 years who reported having three or more long-term health conditions (4.4%), compared to NSW and Australia (3.6 and 3.7%, respectively).[1,2]
- MPHN has a higher proportion of people aged 0 to 14 who reported having two long-term health conditions (0.8%), compared to NSW and Australia (0.5 and 0.5%, respectively).[1,2]

2.3.4 Address development vulnerability among 1st-year school children

Population data:

- MPHN has a higher proportion of children aged ~5 years who are 'developmentally vulnerable on two or more domains' (12.2%), compared to NSW and Australia (10.5 and 11.4%, respectively).[13]

2.3.5 Increased ante-natal support

Population data:

- MPHN has a higher prevalence of people aged 0-4 years (11.7%) compared to NSW and Australia (11.1 and 10.8%, respectively).[1,2]
- MPHN has a total fertility rate (2.0) compared to NSW and Australia (1.7 and 1.6, respectively).[13]

Community consultation:

MPHN's Community Feedback Survey showed that 56.7% reported finding it *'difficult'* to *'very difficult'* to access Childcare services. Almost 70% of respondents reported that 'wait times' and 'high cost' are key factors impacting access to childcare services.

2.3.6 Domestic violence-related assault and sexual assault

Population data:

- MPHN has a higher prevalence of 'domestic assault incidents' (429.2 per 100,000) compared to NSW (382.1 per 100,000).[11]
- MPHN has a higher prevalence of 'sexual assault incidents' (100.8 per 100,000) compared to NSW (81.8 per 100,000).[11]

Community consultation:

MPHN's Community Feedback Survey showed that 36.1% of the non-Aboriginal and Torres Strait Islander sample and 50.1% of the Aboriginal and Torres Strait Islander sample reported 'family violence' as one of the top five most serious health and wellbeing concerns for the community.

Table 2: Priority areas for action for population groups from health determinates

	Aboriginal and Torres Strait Islander people	Maternal, child and youth	Older persons	Population
Need to increase life expectancy due to lower life expectancy experienced			✓	✓
Need to decrease youth mortality among those aged 16 to 24 years	✓	✓		✓
Need to increase support for people living with multi-morbidity among adults and children		✓		✓
Need to address development vulnerability among 1st-year school children		✓		
Increased need for ante-natal support due to higher teenage mother birth rate		✓		
Need for support related to domestic violence-related assault	✓			✓

2.4 Risk factor analysis

Risk factors are attributes and characteristics that increase the likelihood of a person developing a disease or injury. In our needs analysis, we focused on modifiable risk factors, which can be altered through primary healthcare interventions.

In the section below, we provide an overview of the key risk factors that affect our region. Appendix Table 3 (located on pages 71-72) provides an overview of our risk factors analysis.

2.4.1 Reduce levels of risky alcohol consumption

Population data:

- MPHN has a higher prevalence of people 'drinking more than two standard drinks on a day when usually drinking' (36.5%), compared to NSW (33.5%).[12]

Community consultation:

MPHN's Community Feedback Survey showed that 49.8% of the non-Aboriginal and Torres Strait Islander sample and 65.2% of the Aboriginal and Torres Strait Islander sample reported 'drug and alcohol misuse' as one of the top five most serious health and wellbeing concerns for the community.

2.4.2 Reduce smoking among the general population and during pregnancy

Population data:

- MPHN has a higher prevalence of adult daily smokers (11.6%), compared to NSW (8.2%).[12]
- MPHN has a higher prevalence of smoking in the first 20 weeks of pregnancy for all women giving birth (14.7%), compared to NSW and Australia (9.4 and 8.3%, respectively).[13]
    - Smoking in the first 20 weeks of pregnancy is higher among our Aboriginal and Torres Strait Islander women (48.2%), compared to NSW and Australia (40.2 and 41.5%, respectively).

2.4.3 Reduce blood pressure among adults

Population data:

- MPHN has a higher prevalence of adults with 'high blood pressure' (24.4 ASR per 100), compared to NSW and Australia (23.3 and 23.5 ASR per 100, respectively).[13]

Community consultation:

MPHN's Community Feedback Survey showed that 22.6% of the non-Aboriginal and Torres Strait Islander sample and 22.8% of the Aboriginal and Torres Strait Islander sample reported 'high blood pressure' as one of the key health challenges that they are currently experiencing.

2.4.4 Reduction in the use of cannabis and amphetamines

Population data:

- MPHN has a higher arrest rate for 'possession and use of cannabis' (256.8 per 100,000), compared to NSW (178.1 per 100,000).[11]
- MPHN has a higher arrest rate for 'possession and use of amphetamines' (120.8 per 100,000), compared to NSW (92.5 per 100,000).[11]

Community consultation:

MPHN's Community Feedback Survey showed that 49.8% of the non-Aboriginal and Torres Strait Islander sample and 65.2% of the Aboriginal and Torres Strait Islander sample reported 'drug and alcohol misuse' as one of the top five most serious health and wellbeing concerns for the community.

Table 3: Priority areas for action for population groups from risk factor analysis

	Aboriginal and Torres Strait Islander people	Maternal, child and youth	Older persons	Population
Reduce levels of risky alcohol consumption	✓			✓
Reduce smoking		✓		✓
Increase physical activity due to low level reporting insufficient physical activity				✓
Reduction in obesity among adults and children		✓		✓
Reduce blood pressure among adults				✓
Increased support to address smoking in pregnancy		✓		✓
Reduction of use of cannabis	✓			✓
Reduction of use of amphetamines	✓			✓

2.5 Health conditions analysis

Health conditions are areas where a person's health and wellbeing are compromised. These can include mild illnesses to chronic, severe diseases and disorders. Understanding health conditions in the MPHN context is essential for developing strategies for early detection, targeted intervention planning, and improving the quality of life among those in our region.

The section below provides an overview of the most recent data on the health conditions in the MPHN. Appendix Table 4 (located on pages 73-77) provides an overview of our health conditions analysis.

2.5.1 Reduce all-cause and disease-specific mortality.

Premature deaths among all persons (aged 0-74 years)

- MPHN has a higher rate of 'premature deaths among those aged 0-74 years' (285.3 per 100,000), compared to NSW and Australia (236.5, 246.7 per 100,00, respectively).[7]

Potential years of life lost

- MPHN has a higher rate of 'potential years of life lost deaths before 75 years of age' (46.8 per 100,000), compared to NSW (36.8 per 100,000) and Australia (38.1 per 100,000).[7]

Chronic disease-related mortality

Coronary heart disease

- Leading cause of death in the MPHN (+6.5% Aus rate).[7]

Chronic obstructive pulmonary disease

- 4th leading cause of death in the MPHN (+37% Aus rate).[7]

Diabetes

- 5th lead cause of death in the MPHN (+21% Aus rate).[7]

Heart failure and complications

- 8th leading cause of death in the MPHN (+27% Aus rate).[7]

Hypertensive disease

- 10th leading cause of mortality (+73% Aus rate).[7]

Kidney disease

- 17th leading cause of mortality (+15% Aus rate).[7]

Cancer-related mortality

- **Lung cancer:** 5th leading cause of mortality (+8% Aus rate).[7]
- **Colorectal cancer:** 6th leading cause of mortality (+26% Aus rate).[7]
- **Prostate cancer:** 9th leading cause of mortality (+20% Aus rate).[7]
- **Pancreatic cancer:** 12th leading cause of mortality (+12% Aus rate).[7]
- **Breast cancer:** 16th leading cause of mortality (+9% Aus rate).[7]

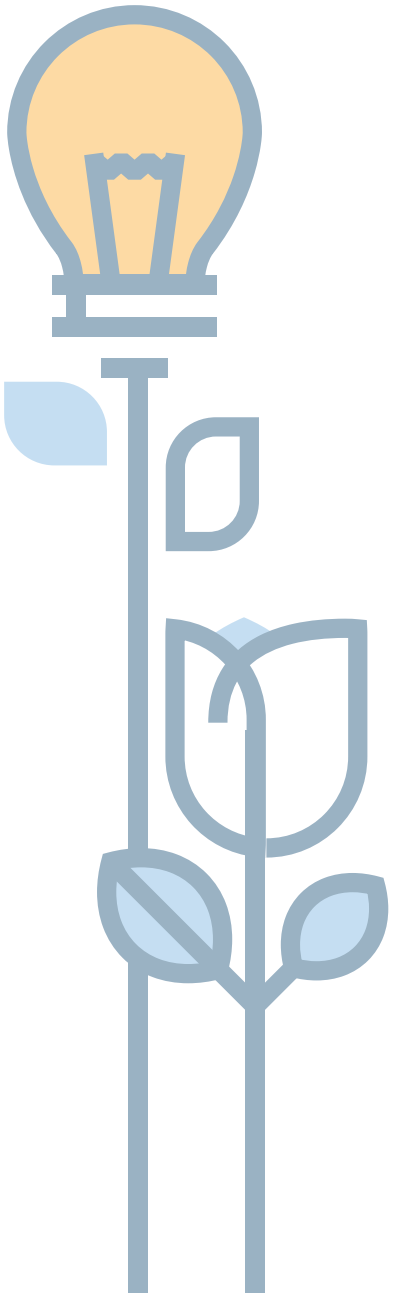
Risk factor-related mortality

Alcohol-attributable

- MPHN has a higher rate of 'alcohol-attributable deaths' (23.7 per 100,000), compared to NSW (18.8 per 100,000).[12]

Smoking-attributable

- MPHN has a higher rate of 'smoking-attributable deaths' (76.7 per 100,000), compared to NSW (59.3 per 100,000).[12]



2.5.2 Reduce suicide-related mortality

Suicide-related mortality

- 13th leading cause of mortality (+41% Aus rate).[7]

Premature deaths from suicide and self-inflicted injuries

- MPHN rate (9.0 per 100,000) is higher than NSW and Australia (3.4 and 4.1 per 100,000, respectively).[13]

Potential years lost from suicide and self-inflicted injuries

- MPHN rate (5.8 per 100,000) is higher than NSW and Australia (3.6 and 5.1 per 100,000, respectively).[13]

2.5.3 Reduce the incidence of specific cancers

Population data

Prostate cancer

- MPHN rate (193.1 per 100,000) is higher than NSW and Australia (167.7 and 167.7 per 100,000, respectively).[13]

Pancreatic cancer

- MPHN rate (17.1 per 100,000) is higher than NSW and Australia (15.5 and 167.7 per 100,000, respectively).[13]

Breast cancer

- MPHN rate (147.5 per 100,000) is higher than NSW and Australia (143.5 and 144.0 per 100,000, respectively).[13]

2.5.4 Reduce mental health conditions among the total population and younger adults

Population data:

- MPHN has a higher rate of Community Mental Health Care Service contacts for a depressive episode (30.8 ASR per 100) than NSW and Australia (18.8 and 20.2 ASR per 100, respectively).[4]
- MPHN has a higher rate of prevalence of 'females aged 16-24 years with a severe mental health disorder' (14.2%) than NSW and Australia (13.5 and 13.5%, respectively).[4]

Community consultation:

MPHN Community Feedback Survey

- Percentage who listed 'mental health issues' as one of the top five most serious health and wellbeing concerns for your community as a whole:
  - Non-Aboriginal and Torres Strait Islander sample = 56.1%
  - Aboriginal and Torres Strait Islander sample = 72.8%

Conversations on the Couch and Yarns on the Couch

- 'Poor mental health' was one of the top five themes emerging from qualitative interviews with both general MPHN community members and Aboriginal and Torres Strait Islander community members.

2.5.5 Reduce the prevalence of chronic obstructive pulmonary and emphysema

Population data:

- MPHN has a higher prevalence of people who 'report a long-term lung condition' (12.6 ASR per 100) than NSW and Australia (10.1 and 10.3 ASR per 100, respectively).[1]

Community consultation:

MPHN's Community Feedback Survey showed that 11.6% of the non-Aboriginal and Torres Strait Islander sample and 23.9% of the Aboriginal and Torres Strait Islander sample reported 'lung disease (asthma, COPD)' as one of the top five most serious health and wellbeing concerns for the community.

2.5.6 Reduce the prevalence of arthritis

Population data:

- MPHN has a higher prevalence of people who 'report having arthritis' (11.7 ASR per 100) than NSW and Australia (10.1 and 10.3 ASR per 100, respectively).[1]

Community consultation:

MPHN's Community Feedback Survey showed that 32.1% of the sample reported 'arthritis/osteoporosis' as one of the key health challenges that they are currently experiencing.

2.5.7 Reduce the prevalence of asthma

Population data:

- MPHN has a higher prevalence of people 'aged 15 years and over who report having asthma' (10.9 ASR per 100) than NSW and Australia (8.0 and 8.5 ASR per 100, respectively).[1,2]
- MPHN has a higher prevalence of people 'aged 0 to 14 years who report having asthma' (9.0 ASR per 100) than NSW and Australia (6.6 and 6.3 ASR per 100, respectively).[1,2]

Table 4: Priority areas for action for population groups from health conditions analysis

	Aboriginal and Torres Strait Islander people	Maternal, child and youth	Older persons	Population
Reduce all-cause and disease-specific mortality		✓	✓	✓
Reduce suicide-related mortality		✓		✓
Reduce the incidence of specific cancers				✓
Reduce mental health conditions among the total population and younger adults		✓		✓
Reduce the prevalence of chronic obstructive pulmonary and emphysema				✓
Reduce the prevalence of arthritis			✓	✓
Reduce the prevalence of asthma	✓			✓

2.6 Community consultation analysis

In addition to the insights from the community consultation described above, our analysis provided the following insights linked to identified community needs. Appendix Table 5 (located on page 78) provides an overview of the community consultation analysis.

2.6.1 Increase respect and reduce racism and discrimination, and increase support for those experiencing racism

Community consultation:

MPHN Community Feedback Survey

- Percentage who *'strongly agreed'* or *'agreed'* to the statement 'racism is a problem in our community'
- Aboriginal and Torres Strait Islander sample = 71.3%
- Non-Aboriginal and Torres Strait Islander sample = 40.7%
- Percentage *'strongly agreed'* or *'agreed'* to the statement 'I have experienced racism or discrimination in this town'
- Aboriginal and Torres Strait Islander sample = 75.6%
- Non-Aboriginal and Torres Strait Islander sample = 29.7%.

2.6.2 Increase Aboriginal and Torres Strait Islander workers settings

Community consultation:

Issues surrounding 'lack of presence of Aboriginal and Torres Strait Islander in primary health settings' were the most common theme emerging from 'Yarns on the Couch'.

2.6.3 Reduce issues related to travel/distance for primary healthcare.

Issues surrounding 'travel and distance to access primary health care' was the 2nd most common theme among Aboriginal and Torres Strait Islander community members, and general community members.

Section 3 – Outcomes of the service needs analysis

We conducted a service needs analysis across the Murrumbidgee to provide a comprehensive understanding of the existing services and primary health infrastructure in our region. This analysis particularly examined the distribution of workforce and services across the Murrumbidgee and specific areas and types of services in our region.

The section below provides an overview of the most recent data on the health conditions in the Murrumbidgee. Appendix Table 5 (located on pages 79-84) provides an overview of our service needs analysis.

3.1 Increase the number of general medical practitioners

Population data:

- MPHN has a lower rate of 'general medical practitioners' (90.1 per 100,000) than NSW and Australia (122.6 and 125.5 per 100,000, respectively).[8]

3.2 Increase general practice attendance

Population data:

- MPHN has a lower rate of 'general practice medical attendance' (612.1 services per 100) than Australia (639.2 services per 100).[8]

Community consultation:

MPHN Community Feedback Survey showed that 81.1% reported it was *'difficult'* to *'very difficult'* to access 'a GP.' A sub-sample of our survey participants indicated that 'wait times' and 'high cost' were key factors impacting GP access.

3.3 Increase GP attendances after-hours

Population data:

- MPHN has a lower rate of 'GP attendances after-hours' (11.8 rate per 100) than NSW and Australia (26.7 and 30.7 rate per 100, respectively).[8]

3.4 Increase the number of Specialist Practitioners

Population data:

- MPHN has a lower rate of 'specialist practitioners working in our region' (67.7 rate per 100,000) than NSW and Australia (156.6 and 160.2 rate per 100,000, respectively).[1]

Community consultation:

MPHN Community Feedback Survey showed that 81.0% of the non-Aboriginal and Torres Strait Islander sample, and 94.4% of the Aboriginal and Torres Strait Islander sample reported it was *'difficult'* to *'very difficult'* to access a 'specialist doctor.' A sub-sample of our survey participants indicated that 'wait times' and 'high cost' were key factors impacting access to a specialist doctor.

3.5 Increase specialist practitioner attendances

Population data:

- MPHN has a lower rate of 'specialist practitioner attendance' (93.5 rate per 100 people) than Australia (97.3 rate per 100 people).[8]

3.6 Increase allied health attendances

Population data:

- Lower rate of 'allied health attendance' (MPHN: 80.0 vs. Aus: 98.7 services per 100).[8]
- Lower rate of 'occupational therapy services' (MPHN: 0.2 vs. Aus: 0.3 services per 100).[8]
- Lower rate of 'physiotherapy services' (MPHN: 5.5 vs Aus: 11.6 services per 100).[8]
- Lower rate of 'speech pathology services' (MPHN: 0.1 vs Aus: 0.4 services per 100.[8]

Community consultation:

The MPHN Community Feedback Survey showed that 80.7% of the non-Aboriginal and Torres Strait Islander sample and 88.2% of the Aboriginal and Torres Strait Islander sample reported finding it *'difficult'* to *'very difficult'* to access an allied health service (psychologist, speech therapist)'.

3.7 Increase MBS mental health services

Population data:

- Lower 'psychiatry services' rate (MPHN: 3.6 vs. Aus: 7.77 services per 100).[8]
- Lower 'clinical psychology services' rate (MPHN: 3.9 vs. Aus: 13.3 services per 100).[8]
- Lower 'other psychologist services rate' (MPHN: 8.1 vs Aus: 13.3 services per 100).[8]

3.8 Reduce low urgency emergency department presentations

Population data:

- Higher use of 'low-urgency presentation all hours' (MPHN: 261.6 vs Aus: 120.1 per 1,000).[13]
- Higher use of 'low-urgency presentation in-hours' (MPHN 153.6 vs Aus: 66.6 per 1,000).[13]
- Higher use of 'low-urgency presentation after-hours' (MPHN: 108.0 vs Aus: 53.5 per 1,000).[13]

3.9 Reduce total admissions to hospital

Population data:

MPHN has a higher rate of

- 'Total hospital admissions' (MPHN: 41,554 vs NSW: 40,992.7 vs Aus: 40,927.2 per 100,000).[13]
- 'Hospital admissions to public hospitals' (MPHN: 26,158.8 vs NSW: 20,978.8; Aus: 24,038.7 per 100,000).[13]
- Hospital admissions of 'all potentially preventable conditions' (MPHN: 2,462.6; vs NSW: 1,958.8 vs Aus: 2,132.9 per 100,000).[13]

3.10 Increase cervical screening participation

Population data:

- MPHN has a lower percentage of 'cervical screening participation' (MPHN: 40.8 vs NSW 45.9 vs AUS: 47.5%).[13]

3.11 Increase antenatal visits

Population data:

- MPHN has a lower percentage of 'women who did not attend antenatal care within the first 10 weeks' (MPHN: 30.9 vs NSW 35.7 vs AUS: 40.1).[13]

Table 5: Priority areas for action for population groups from the service needs analysis

	Aboriginal and Torres Strait Islander people	Maternal, child and youth	Older persons	Population
Increase the number of general medical practitioners				✓
Lower general practice attendance				✓
Lower rate of GP attendances after-hours				✓
Increase the number of specialist practitioners	✓			✓
Lower specialist practitioner attendances	✓			✓
Lower MBS mental health services	✓			✓
Higher use of emergency department for low urgency presentations				✓
Higher total admissions to hospital				✓
Lower rate of cervical screening participation				✓
Lower proportion of antenatal visits				✓

Section 4 –Opportunities and priorities

Summary of evidence for all domains

	Demography	Health determinants	Risk factor	Health condition	Community consultation	Service need	# times a priority
Aboriginal and Torres Strait Islander Health							
Increase respect and reduce racism and discrimination					✓		1
Reduce admissions for Aboriginal and Torres Strait Islander people for chronic PPH including genitourinary, acute UTIs, kidney disease, digestive disease, chronic iron deficiency anaemia, acute convulsions and epilepsy, intentional self-harm and respiratory disease (asthma, COPD).				✓			1
Aged Care							
Increase specific age-related services increasing life expectancy	✓				✓		2
Reduce Influenza admissions over 65 years						✓	1
Increase GP attendance to RACF						✓	1
Alcohol and Other Drugs							
Reduction of alcohol at harmful levels and drug use specifically amphetamines and cannabis			✓		✓		2
Digital Health							
Increase access to services impacted by limitations for fee-based healthcare services	✓				✓	✓	3
Health Workforce							
Increase health workforce					✓	✓	2
Increase care delivery in general practice, specialists in community and allied health, improve number of dentists available					✓	✓	2
Mental Health							
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital and identified by community consultations for; mental health conditions including social isolation				✓	✓	✓	3

	Demography	Health determinants	Risk factor	Health condition	Community consultation	Service need	# times a priority
Population Health							
Improve poor health literacy due to less education	✓				✓	✓	3
Respond to issues relating to housing affordability, transport and cost of living	✓				✓		2
Develop general practice capacity to use evidence and data driven quality improvement to improve patient outcomes					✓	✓	2
Reduce ED presentations and admissions for PPH					✓	✓	2
Increase GP attendances after hours					✓	✓	2
Increase support related to domestic violence related assault and victims of sexual or indecent assault		✓					1
Reduction of risk factors including low exercise, high blood pressure, obesity, and smoking			✓		✓		1
Reduction of prevalence, incidence, mortality and or morbidity for; Alzheimer's disease or dementia, cerebrovascular disease, road traffic injuries or transport accidents				✓		✓	2
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for; coronary heart disease and CHD including congestive cardiac failure				✓		✓	2
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for genitourinary system disease including chronic kidney disease or kidney failure				✓		✓	2
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for infectious and parasitic disease, including influenza				✓		✓	2
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for digestive disease, specifically liver disease				✓		✓	2
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital and identified by community consultations for diabetes				✓		✓	2

	Demography	Health determinants	Risk factor	Health condition	Community consultation	Service need	# times a priority
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital and identified by community consultations for respiratory system disease, including asthma and chronic obstructive pulmonary disease				✓		✓	2
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital and identified by community consultations for musculoskeletal system and connective tissue including arthritis				✓		✓	2
Reduction of prevalence, incidence, mortality and or morbidity and identified by community consultations for; suicide and intentional self-harm				✓		✓	2
Reduction of prevalence, incidence, mortality and or morbidity and identified by community consultations for cancer				✓		✓	2
Responding to issues relating to chronic pain				✓	✓	✓	3
Increase cervical cancer screening participation					✓		1
Respond to emerging issues related to disasters (drought, bushfires, floods, pandemic)						✓	1
Improve coordination of care and to allow palliative patients to receive appropriate care and to pass away in their place of choice						✓	1

Opportunities and priorities

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Aboriginal and Torres Strait Islander				
Increase respect and reduce racism and discrimination. *Associated Identified Need:* *Increase support for those experiencing racism*	Aboriginal and Torres Strait Islander health	Appropriate care (including cultural safety)	**HSI 202 – Collaboration with the Aboriginal population** Improved coordination and collaboration between Aboriginal health services and other health providers that results in improved health and wellbeing for Aboriginal and Torres Strait Islander people. **AOD 201 – Aboriginal and Torres Strait Islander people's employment initiative** Improved education and employment rates for Aboriginal and Torres Strait islander people with alcohol and/or other drug issues.	MPHN Murrumbidgee Aboriginal Health Consortium
Reduce admissions for Aboriginal and Torres Strait Islander people for chronic PPH including genitourinary, acute UTIs, kidney disease, digestive disease, chronic iron deficiency anaemia, acute convulsions and epilepsy, intentional self-harm and respiratory disease (asthma, COPD) *Associated Identified Need:* *Higher total admissions to hospital*	Aboriginal and Torres Strait Islander health	Early intervention and prevention	**HSI 201/202 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement, immunisation support and health literacy activities. • Maintain childhood immunisation rates of 95% for all children under 5 years. • Increase in smoking status recorded by 20%. • Increase in BMI recorded (including height and weight) by 20%. • Increase in Alcohol consumption status recorded by 20%. • Increase in Cervical Screening tests recorded. **CF 301 – Activities relating to the Aboriginal population** Increased access to culturally appropriate services and improved outcomes that lead to a reduction for chronic disease.	MPHN MLHD Murrumbidgee Aboriginal Health Consortium

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Aboriginal and Torres Strait Islander cont.				
			ITC 101 – Care coordination and supplementary services ITC clients will have improved health literacy and capacity to manage their chronic health condition and will have received support to establish and engage with their care plan to set and meet their health goals. • Increased access to culturally appropriate services. • Improved access will lead to a positive engagement with local health services. • Improved health outcomes that leads to a reduction for chronic disease. **AOD 202 – Aboriginal and Torres Strait Islander outreach services** • Improved health outcomes. • Increased access to services and reduction in substance use for Aboriginal and Torres Strait islander people in outlying rural communities. **MH 201 – Aboriginal and Torres Strait Islander mental health services** • Increasing culturally appropriate mental health supports for Aboriginal and Torres Strait Islander people. • Increased Aboriginal and Torres Strait Islander mental health workforce.	
Maternal, child and youth				
Increased need for ante-natal support for all women, teenage mothers and including breastfeeding *Associated Identified Need:* *Increased need for ante-natal support due to higher teenage mother birth* *Need for newborn and infant-related services* *Lower proportion of antenatal visits*	Population health	Early intervention and prevention	**CF 302 – Activities relating to maternal and child health** Improved health outcomes for women (pre and postnatally) and for children resulting from improved linkage with existing and new services. **AOD 103 – Targeted services for pregnant women and new mothers** Improved health outcomes and reduction in substance use for pregnant women and/or women with children. **CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways)** Increased uptake of HealthPathways.	MPHN MLHD Murrumbidgee Aboriginal Health Consortium

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Maternal, child and youth cont.				
Increase smoking cessation during pregnancy *Associated Identified Need:* *Increased support to address smoking in pregnancy*	Population health	Early intervention and prevention	**CF 302 – Activities relating to maternal and child health** • The Maternal and Child Health Strategy and the programs that are implemented aim to improve outcomes for children (including the first 2000 days), families and expectant women. • Reduction in the number of pregnant women (and household members) smoking during pregnancy.	MPHN Murrumbidgee Aboriginal Health Consortium
Increase specific age-related services increasing life expectancy – youth *Associated Identified Need:* *Need to decrease youth mortality among those aged 16 to 24 years*	Mental health	Access	**MH 102 – Child and youth mental health services (Youth Enhanced)** Improved mental health outcomes for children and/or young people with, or at risk of, severe and complex mental health issues, especially for young people who experience considerable disadvantage when accessing or attempting to access services. **MH 103 – Child and youth mental health services (headspace)** Improved access to youth friendly mental health services and increased mental health and wellbeing for young people in the Murrumbidgee region. **AOD 102 – Drug and alcohol services in headspace** • Improved health outcomes and a reduction in substance use for young people measured by the outcome tool ATOP, as well as other provider specific outcome measurement tools. • Increased workforce capacity of headspace staff.	MPHN Murrumbidgee Mental Health and Drug and Alcohol Alliance
Older persons				
Increase life expectancy *Associated Identified Need:* *Need for specific age-related services* *Need to increase life expectancy due to lower life expectancy experienced*	Aged care	Access	**CF 306 – Activities relating to population health (Murrumbidgee Wellness and Resilience Program)** • Increased access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours. • Increased adoption of healthy diet and exercise to reduce overweight and obesity. • Increased access to the frailty program to halt progression of frailty in older people in Residential Aged Care Homes (RACHs).	MPHN Local general practices Murrumbidgee Aged Care Consortium

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Older persons cont.				
			AC-EI 103 – Early intervention initiatives to support healthy ageing in the community • Participation in healthy ageing programs by older people in the Murrumbidgee region. • Halt the progression of frailty in older people. • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community.	
			AC-VARACF 101 – Support RACHs to increase availability and use of telehealth • Increased capacity and capability for RACHs to support telehealth consultations for residents. • Improved technological interoperability between aged care services and the health care system.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Older persons cont.				
			AC-CF 104 – Care finder transitioned assistance with care and housing program Improved outcomes for people in the care finder target population including: • Existing ACH clients receive service continuity. • Improved coordination of support when seeking to access aged care. • Improved understanding of aged care services and how to access them. • Improved openness to engage with the aged care system. • Increased care finder workforce capability to meet client needs. • Increased rates of access to aged care services and connections with other relevant supports. • Increased rates of staying connected to the services they need post service commencement. • Improved integration between the health, aged care, and other systems at the local level within the context of the care finder program.	
			MH 109 – More choices for longer life • Improved quality of life for residents by addressing issues that may be impacting their overall wellbeing, such as managing chronic illnesses, pain, or disability. • Halt progression of frailty. • Residents better able to cope with the emotional challenges associated with ageing, acquiring better coping skills for dealing with the challenges of ageing. • Reduced risk of unplanned hospitalisations.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Older persons cont.				
			HSI 400 – Clinical referral pathways • Decreased clinical variation and improved health outcomes for patients in the Murrumbidgee. • Improved and increased local clinicians and health professional engagement in the development and utilisation of HealthPathways. • Improved provider and patient experience of the health system. • Improved linkages to health care and social support services for older people.	
			AC-EI 103 – Early intervention initiatives to support healthy ageing in the community **AC-CF 104 – Care finder** • Increased participation in healthy ageing programs by older people in the Murrumbidgee region. • Halt the progression of frailty in older people. • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community.	
			AC-VARACF 101 – Support RACHs to increase availability and use of telehealth • Increased capacity and capability for RACHs to support telehealth consultations for residents. • Improved technological interoperability between aged care services and the health care system.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Older persons cont.				
			AC-AHARACF 102 – Enhanced out of hours support for RACHs Improved RACH capacity to manage the health care needs of residents in the out-of-hours period, reducing the need for residents to be transferred to hospital in the out-of-hours period and have a planned approach for when transfer of care is required.	
			AC-CF 104 – Care finder transitioned assistance with care and housing program • Improved outcomes for people in the care finder target population, including: existing ACH clients receive service continuity. • Improved coordination of support when seeking access to aged care. • Improved understanding of aged care services and how to access them. • Improved openness to engage with the aged care system. • Increased care finder workforce capability to meet client needs. • Increased rates of access to aged care services and connections with other relevant supports. • Increased rates of staying connected to the services they need post service commencement. • Improved integration between the health, aged care, and other systems at the local level within the context of the care finder program.	
Reduce Influenza admissions over 65 years *Associated Identified Need:* *Higher total admissions to hospital*	Aged care	Potentially preventable hospitalisations	**CF 406 – Vulnerable peoples COVID-19 vaccination program** Vulnerable and isolated people have timely access to Covid vaccinations.	MPHN Local general practices MLHD

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Older persons cont.				
			AC-CF 104 – Care finder (operational) • Increased participation in healthy ageing programs by older people in the Murrumbidgee region. • Halt the progression of frailty in older people. • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community.	
			Partnership: Winter Strategy – Collaborative Commissioning partnership between MPHN and MLHD Increased access to proactive care in general practice for patients with chronic disease at risk of deterioration over the winter period, specifically Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), and diabetes.	
Increase GP attendances RACF *Associated Identified Need:* *Increase the number of general medical practitioners*	Aged care	After hours	**AH 105 – After hours (regional approach to after hours access)** Communities across the Murrumbidgee region have access to timely care and support for urgent but not better use of and improved access to after-hours services.	MPHN Wagga GP After Hours Service Local general practices MLHD
			GPACI-GPM 409 – GP in aged care Improve regular and routine access to primary health care.	
			AC-VARACF 101 – Support RACHs to increase availability and use of telehealthoperational • Increased capacity and capability for RACHs to support telehealth consultations for residents. • Improved technological interoperability between aged care services and the health care system.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population				
Reduction of alcohol at harmful levels and drug use specifically amphetamines and cannabis *Associated Identified Need:* *Reduce levels of risky alcohol consumption* *Reduction of use of cannabis* *Reduction of use of amphetamines* *Reduce alcohol-attributable deaths*	Alcohol and other drugs	Access	**AOD 101 – Community Managed Organisations (CMO) enhancement** Improved health outcomes and reduction in substance use for people before and after drug and alcohol rehabilitation services. **AOD 103 – Targeted services for pregnant women and new mothers** Improved health outcomes and reduction in substance use for pregnant women and/or women with young children. **AOD 202 – Aboriginal and Torres Strait Islander outreach services** Improves access to education and improved employment rates for Aboriginal and Torres Strait islander people with alcohol and/or other drug issues.	MPHN Murrumbidgee Mental Health and Drug and Alcohol Alliance
Increase access to services impacted by limitations for fee-based healthcare services *Associated Identified Need:* *Increase access to services due to limitations for fee-based healthcare services* *Reduce issues related to travel and distance to access primary healthcare* *Higher out-of-pocket costs*	Population health	HealthPathways	**CF 306 – Integrated system of primary healthcare – decision support tool (HealthPathways)** • Increased uptake of HealthPathways across the region. • Commissioning of services funded via relevant schedules to improve access to primary care clinical and coordinated care services for people impacted by the cost of accessing primary health care. • Integrated models of care codesigned and implemented to improve access and health outcomes, especially in priority populations.	MPHN MLHD Murrumbidgee Mental Health and Drug and Alcohol Alliance Murrumbidgee Aged Care Consortium Murrumbidgee Primary Care Collaborative Group

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Increase health workforce *Associated Identified Need:* *Increase the number of general medical practitioners* *Lower general practice attendance* *Lower rate of GP attendances after-hours* *Increase the number of specialist practitioners* *Lower specialist practitioner attendances* *Lower allied health attendances* *Lower MBS mental health services*	Health workforce	Workforce	**HSI 201-201 – General practice capacity development and support (workforce support)** People in the MPHN region are able to access a high quality, culturally safe and appropriately trained workforce. **AH 105 – Regional approach to after-hours access** Communities across the Murrumbidgee region have access to timely care and support for urgent but not better use of and improved access to after-hours services. **AH 107 – Wagga GP After Hours Service** Residents of and visitors to Wagga have access to after-hours primary care to reduce numbers of non-urgent attendances at the hospital emergency department. **WIP-PS 410 – Workforce incentive program** Increased WIP-PS incentives to implement effective models of multidisciplinary team care. **PP&TP-GP 103 – Strengthening Medicare (general practice grants program)** Increased take-up of contemporary digital health solutions including video telehealth, secure data storage and interoperable software that supports seamless, secure communication of patient data.	MPHN Murrumbidgee Health and Knowledge Precinct NSWRDN
Increase care delivery in general practice, specialists in community and allied health, improve number of dentists available *Associated Identified Need:* *Lower allied health attendances*	Health workforce	Workforce	**HSI C0201-202 – Primary care capacity development and workforce support and CPD** • People in the MPHN region have access to a high quality, culturally safe and appropriately trained workforce. • General practitioners, practice nurses, practice managers, pharmacists, allied health professionals have local access to relevant CPD activities. **HSI230.4 – General practice capacity development and support (digital health)** Primary care providers have access to digital support strategies to enable better coordinated care and informed treatment decisions.	MPHN NSWRDN Murrumbidgee Health and Knowledge Precinct

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Reduction of prevalence, incidence, mortality and/or morbidity and high use of services in ED or hospital and identified by community consultations for; mental health conditions including social isolation *Associated Identified Need:* *Reduce mental health conditions among the total population and younger adults* *Lower MBS mental health services* *Higher use of Emergency Department for low urgency presentations* *Need to increase support for adults living with multi-morbidity*	Mental health	Access	**MH 104 – Services for severe and complex mental illness** Access to clinical and psychosocial health services, improving outcomes for people with severe and complex mental illness. **MH 201 – Aboriginal and Torres Strait Islander mental health services** • Increasing culturally appropriate mental health support for Aboriginal and Torres Strait Islander people. • Increased the Aboriginal and Torres Strait Islander mental health workforce. **PSDCS 101 – Mental health psychosocial supports service delivery** Improved health and social outcomes for people living with severe mental illness who are not engaged in the NDIS or receiving psychosocial services through other state funded psychosocial programs. **CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways)** Increased uptake and utilisation of HealthPathways. **AC-CF 104 – Care finder (operational)** • Increased participation in healthy ageing programs by older people in the Murrumbidgee region. • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community. **MH-H2H 115 – H2H intake and assessment** Murrumbidgee residents are aware of, and connected to mental health supports through calling the Head to Health national phone line.	MPHN MLHD Murrumbidgee Primary Care Collaborative Group

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			MH 101 – MyStep to mental wellbeing People living across the Murrumbidgee have access to quality, affordable psychological therapies, connected within a system that facilitates stepping up and down the intensity of care as required by the client, providing the right care at the right time by the most appropriate clinician.	
			MH 102 – Child and youth mental health services – Youth Enhanced Improvement in the mental health of children and/or young people with, or at risk of, severe and complex mental health issues, especially for young people who experience considerable disadvantage when accessing or attempting to access services.	
			MH 103 – Child and youth mental health services – headspace Improved access to youth friendly mental health services and increased mental health and wellbeing for young people in the Murrumbidgee region.	
			NAB-H2H 103 – Adult mental health centre and satellite network (Head to Health) People in the Murrumbidgee region experiencing crisis or significant distress, requiring information, service navigation, assessment and evidence-based care can access appropriate, affordable, quality, and culturally appropriate services when and where they need it.	
			NAB-HE 102 – headspace enhancement (Griffith) **NAB-HE 102 – headspace enhancement (Wagga)** Increased access and reduce wait times for young people through a coordinated multidisciplinary approach.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			HSICO2 – Quality improvement and health literacy in general practice • Improved health outcomes for patients and population through effective quality improvement, immunisation support and health literacy activities. • Maintain childhood immunisation rates of 95% for all children under 5 years. • Increase in smoking status recorded by 20%. • Increase in BMI recorded (including height and weight) by 20%. • Increase in Alcohol consumption status recorded by 20%. • Increase in Cervical Screening tests recorded.	
			CF 303 – Activities relating to population health – integrated care coordination • Increased access to support for people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes. • Improved health literacy and improved capacity to manage their chronic health condition and will have received support to establish and engage with their care plan to set and meet their health goals.	
			CF 406 – Vulnerable peoples COVID-19 vaccination program Increased access COVID vaccinations.	
			ITC 102 – Care coordination and outreach services **ITC 101 – Supplementary services** • Reduction in barriers to accessing culturally appropriate primary health care for Aboriginal and Torres Strait Islander people. • Increased access to culturally appropriate services in mainstream general practice. • Improved health literacy and capacity for ITC clients to manage their chronic health condition and will have received support to establish and engage with their care plan to set and meet their health goals. • Improved health outcomes that lead to a reduction in chronic disease.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			CF 306 – Activities relating to Murrumbidgee wellness and resilience activity • Increased access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours. • Increased adoption of healthy diet and exercise to reduce overweight and obesity. • Increased access to the frailty program to halt progression of frailty in older people in Residential Aged Care Homes (RACHs).	
			HSI 202 – Collaboration with the Aboriginal population Improved coordination and collaboration between Aboriginal health services and other health providers that results in improved health and wellbeing for Aboriginal and Torres Strait Islander people.	
			NAB-H2H 103 – Adult mental health centre and satellite network (Head to Health) People in the Murrumbidgee region experiencing crisis or significant distress, requiring information, service navigation, assessment and evidence-based care can access appropriate, affordable, quality, and culturally appropriate services when and where they need it.	
			NAB-UAS 101 – Universal aftercare services People in the Murrumbidgee region have access to supports following a suicide attempt and/or suicidal crisis.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Develop general practice capacity to use evidence and data driven quality improvement to improve patient outcomes *Associated Identified Need:* *Higher use of Emergency Department for low urgency presentations* *Lower general practice attendance* *Increase the number of Specialist Practitioners* *Higher out of pocket costs*	Population health	Safety and quality of care	**AH-HAP 103 – MPHN homelessness (health access)** Improved access to primary care by people experiencing or at risk of homelessness to support funding applications aimed at improving support for people who are, or are at risk of homelessness, an important SDoH. **HSICO2 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement activity and support. **CF 302 – Activities relating to maternal and child health** Improved health outcomes for women (pre and postnatally) and for children by linking them with existing and new services. **CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways)** Increased uptake of HealthPathways across the region. **HSI 400 – Clinical referral pathways** Increased uptake and utilisation of HealthPathways across the region to improve compliance with best practice guidelines. **HSI 401 – Dementia consumer resources** Improved timely access to dementia information and supports for patients and carers and enhance the use of existing local dementia care support pathways within the region to better support people living with dementia to live well in the community for as long as possible. **HSI C0201-202 – Primary care capacity development and workforce support and CPD** • Digital health supports strategies to enable better coordinated care and informed treatment decisions. • People in the MPHN region have access to high quality, culturally safe and appropriately trained workforce. Outcome 2: general practitioners, practice nurses, practice managers, pharmacists, allied health professionals are provided with relevant CPD activities.	MPHN General practices MLHD

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			MH 114 – Initial assessment and referral project General practitioners and other relevant clinicians within the Murrumbidgee region are trained in use of the IAR tool and utilise the tool to link people to the appropriate level of care, supporting national consistency of assessments and referrals.	
			PP&TP-GP 103 – Strengthening Medicare (general practice grants program) • Increased take-up of contemporary digital health solutions including video telehealth, secure data storage and interoperable software that supports seamless, secure communication of patient data;. • Increased proportion of COVID positive and other respiratory patients treated in a general practice setting (by increasing practices' capacity to treat more of these patients. • Increased number of accredited general practices across the region.	
			PP&TP-GCPC 102 – Greater choice for at home palliative care • Increased capability in primary care to provide quality palliative care. • Generation of palliative care specific data for ongoing quality improvement purposes. • Increased number of sustainable palliative care multidisciplinary team meetings. • Generation of palliative care specific data for ongoing quality improvement purposes.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Reduce ED presentations and admissions for PPH *Associated Identified Need:* *Higher total admissions to hospital* *Lower specialist practitioner attendances*	Population health	After hours	**CF 303 – Activities relating to population health (integrated care coordination)** Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes resulting in reduced unplanned presentations to ED through: • Improved health literacy and improved capacity to manage their chronic health condition. • Received support to establish and engage with their care plan to set and meet their health goals. **AH 107 – Wagga GP After Hours Service** • Increased access to primary care services in the after-hours period, reducing presentations to ED for GP-type presentations. **CF 306 – Activities relating to Murrumbidgee wellness and resilience activity** Provide an integrated wellness and resilience activity enabling older people, those with or at risk of chronic disease, vulnerable or high risk group's timely access to appropriate primary care services resulting in: • Increased access to allied health professional support for early intervention and chronic disease management of community participants. • Increased access to the frailty program to halt progression of frailty in older people in RACHs. **AC-CF 104 – Care finder** Improved health and wellbeing of carers of older people in the community.	MPHN MLHD PCCG

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			PP&TP-GCPC 102 – Greater choice for at home palliative care • Increased capability in primary care to provide quality palliative care. • Generation of palliative care specific data for ongoing quality improvement purposes. • Increased number of sustainable palliative care multidisciplinary team meetings. • Generation of palliative care specific data for ongoing quality improvement purposes.	
			PMHC commissioned services Increased awareness of improved access to mental health services in-hours to reduce unplanned mental health related presentations to ED and improve health outcomes for patients.	
			Collaborative commissioning activity, governed and delivered in partnership with MLHD, and funded by NSW Health to increase access to CHF and COPD related healthcare services in communities with higher unplanned presentations to ED and limited-service access, resulting in earlier diagnosis and access to appropriate, coordinated and integrated care as close to home as possible.	
Increase GP attendances after hours *Associated Identified Need:* *Increase the number of General Medical Practitioners* *Lower rate of GP attendances after-hours*	Population health	Early intervention and prevention	**AH 105 – Regional approach to after-hours access** Communities across the Murrumbidgee region have access to timely care and support for urgent but not better use of and improved access to after-hours services.	MPHN
			AH 107 – Wagga GP After Hours Service Maintain access to after-hours primary care for the residents of Wagga Wagga and visitors, reducing numbers of non-urgent attendances at the hospital emergency department.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Increase support related to domestic violence related assault and victims of sexual or indecent assault *Associated Identified Need:* *Need for support related to domestic violence-related assault* *Need for support related to sexual-related assault*	Population health	Vulnerable population (non-First Nations specific)	**MH 101 – Family violence initiative** Women have access to appropriate mental health service crisis and follow-up support where and when it is needed.	Wagga Women's Health Service
Reduction of risk factors including low exercise, high blood pressure, obesity, and smoking *Associated Identified Need:* *Reduce smoking-attributable deaths* *Increase physical activity due to low level reporting insufficient physical activity;* *Reduce blood pressure among adults* *Reduction in obesity among adults and children* *Reduce smoking*	Population health	Early intervention and prevention	**CF 302 – Child and maternal health (WARATAH for Kids)** **CF 306 – Activities relating to Murrumbidgee wellness and resilience activity** An integrated wellness and resilience activity enables older people, those with or at risk of chronic disease, vulnerable or high-risk group's timely access to appropriate primary care services. • Increased access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours in children and adults. • Increased adoption of healthy diet and exercise to reduce overweight and obesity in children and adults. • Increased access to the frailty program to halt progression of frailty in older people in RACHs.	MPHN MLHD Murrumbidgee Aged Care Collaborative Murrumbidgee Aboriginal Health Collaborative

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			AC-EI 103 – Early intervention initiatives to support healthy ageing in the community Early intervention healthy ageing initiatives, to support the effective management of chronic conditions for older people living in the community resulting in: • Increased participation in healthy ageing programs by older people in the Murrumbidgee region. • Halt the progression of frailty in older people. • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community.	
			ITC 102 – Care coordination and outreach services Improved health outcomes to manage chronic disease including reduction in smoking.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Reduction of prevalence, incidence, mortality and or morbidity for; Alzheimer's disease or dementia, cerebrovascular disease, road traffic injuries or transport accidents. *Associated Identified Need:* *Reduce premature deaths among all persons (aged 0-74 years.* *Reduce mortality and morbidity due to external causes; premature mortality; avoidable deaths, external causes* *Reduce coronary heart disease and coronary heart disease-related mortality; (P 12);* *Need to increase support for adults living with multi-morbidity (P15).*	Population health	Access	**HSI 401 – Dementia consumer resources** Improved timely access to dementia information and supports for patients and carers and enhance the use of existing local dementia care support pathways within the region to better support people living with dementia to live well in the community for as long as possible. **HSICO2 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement activity and support. **AC-EI 103 – Early intervention initiatives to support healthy ageing in the community** Early intervention healthy ageing initiatives, to support the effective management of chronic conditions for older people living in the community resulting in: • Increased participation in healthy ageing programs by older people in the Murrumbidgee region. • Halt the progression of frailty in older people. • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community.	MPHN Murrumbidgee Aged Care Collaborative

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for; coronary heart disease and CHD including congestive cardiac failure *Associated Identified Need:* *Higher use of Emergency Department for low urgency presentations* *Higher total admissions to hospital* *Reduce coronary heart disease and coronary heart disease-related mortality* *Need to increase support for adults living with multi-morbidity*	Population health	Care coordination	**HSICO2 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement activity and support. **CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways)** Increased uptake of HealthPathways across the region. **CF 303 – Activities relating to population health (integrated care coordination)** Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes resulting in reduced unplanned presentations to ED through: • Improved health literacy and improved capacity to manage their chronic health condition. • Received support to establish and engage with their care plan to set and meet their health goals. **CF 306 – Activities relating to Murrumbidgee wellness and resilience activity** An integrated wellness and resilience activity enables older people, those with or at risk of chronic disease, vulnerable or high-risk group's timely access to appropriate primary care services. • Increase in access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours in children and adults. • Increase in adoption of healthy diet and exercise to reduce overweight and obesity in children and adults. • Increased access to the frailty program to halt progression of frailty in older people in Residential Aged Care Homes (RACHs). **Collaborative commissioning activity**, governed and delivered in partnership with MLHD, and funded by NSW Health to increase access to CHF and COPD related healthcare services in communities with higher unplanned presentations to ED and limited-service access, resulting in earlier diagnosis and access to appropriate, coordinated and integrated care as close to home as possible.	MPHN MLHD/PCCG

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for genitourinary system disease including chronic kidney disease or kidney failure *Associated Identified Need:* *Reduced mortality and morbidity due to kidney disease* *Higher use of Emergency Department for low urgency presentations* *Higher total admissions to hospital*	Population health	Care coordination	**CF 303 – Activities relating to population health (integrated care coordination)** Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes resulting in reduced unplanned presentations to ED through: • Improved health literacy and improved capacity to manage their chronic health condition. • Received support to establish and engage with their care plan to set and meet their health goals. **CF 306 – Activities relating to Murrumbidgee wellness and resilience activity** An integrated wellness and resilience activity enables older people, those with or at risk of chronic disease, vulnerable or high-risk group's timely access to appropriate primary care services. • Increased access to allied health professional support for early intervention and chronic disease management of community participants. • Increased access to the frailty program to halt progression of frailty in older people in Residential Aged Care Homes. **CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways)** Increased uptake of HealthPathways across the region.	MPHN RACHs

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			AC-EI 103 – Early intervention initiatives to support healthy ageing in the community Early intervention healthy ageing initiatives, to support the effective management of chronic conditions for older people living in the community resulting in: • Increased participation in healthy ageing programs by older people in the Murrumbidgee region. • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community.	
			AC-VARACF 101 – Support RACHs to increase availability and use of telehealth Operational • Increased capacity and capability for RACHs to support telehealth consultations for residents. • Improved technological interoperability between aged care services and the health care system.	
			AC-AHARACF 102 – Enhanced out of hours support for RACHs Improved RACH capacity to manage the health care needs of residents in the out-of-hours period, reducing the need for residents to be transferred to hospital in the out-of-hours period and have a planned approach for when transfer of care is required.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for infectious and parasitic disease, including influenza *Associated Identified Need:* *Higher use of Emergency Department for low urgency presentations* *Higher total admissions to hospital*	Population health	Care coordination	**HSICO2 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement activity and support. **CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways)** Increased uptake of HealthPathways across the region. **AC-VARACF 101 – Support RACHs to increase availability and use of telehealth operational** • Increased capacity and capability for RACHs to support telehealth consultations for residents. • Improved technological interoperability between aged care services and the health care system. **AC-AHARACF 102 – Enhanced out of hours support for RACHs** Improved RACH capacity to manage the health care needs of residents in the out-of-hours period, reducing the need for residents to be transferred to hospital in the out-of-hours period and have a planned approach for when transfer of care is required.	MPHN
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for digestive disease, specifically liver disease *Associated Identified Need:* *Reduce deaths related to liver disease* *Higher use of Emergency Department for low urgency presentations* *Higher total admissions to hospital*	Population health	Care coordination	**HSICO2 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement activity and support. **CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways)** Increased uptake of HealthPathways across the region.	MPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			CF 303 – Activities relating to population health (integrated care coordination) Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes resulting in reduced unplanned presentations to ED through: • Improved health literacy and improved capacity to manage their chronic health condition. • Received support to establish and engage with their care plan to set and meet their health goals. **CF 306 – Activities relating to Murrumbidgee wellness and resilience activity** An integrated wellness and resilience activity enables older people, those with or at risk of chronic disease, vulnerable or high-risk group's timely access to appropriate primary care services. • Increase in access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours.	
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital for Injury, poisoning and other external causes *Associated Identified Need:* *Higher use of Emergency Department for low urgency presentations* *Higher total admissions to hospital*	Population health	Care coordination	**CF 303 – Activities relating to population health (integrated care coordination)** Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes. CF306 Activities relating to Murrumbidgee Wellness and Resilience activity. Provide an integrated wellness and resilience activity enabling older people, those with or at risk of chronic disease, vulnerable or high risk group's timely access to appropriate primary care services. **CF 306 – Activities relating to Murrumbidgee wellness and resilience activity** Provide an integrated wellness and resilience activity enabling older people, those with or at risk of chronic disease, vulnerable or high risk group's timely access to appropriate primary care services.	MPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			AC-CF 104 – Care finder Improved outcomes for people in the care finder target population.	
			NAB-UAS 101 – Universal aftercare services People in the Murrumbidgee region have access to supports following a suicide attempt and/or suicidal crisis.	
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital and identified by community consultations for diabetes *Associated Identified Need:* *Reduce diabetes-related deaths;* *Department for low urgency presentations* *Higher total admissions to hospital*	Population health	Care coordination	**HSICO2 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement activity and support	MPHN MLHD/PCCG
			CF 303 – Activities relating to population health (integrated care coordination) Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes resulting in reduced unplanned presentations to ED through: • Improved health literacy and improved capacity to manage their chronic health condition. • Received support to establish and engage with their care plan to set and meet their health goals.	
			CF 306 – Activities relating to Murrumbidgee wellness and resilience activity An integrated wellness and resilience activity enables older people, those with or at risk of chronic disease, vulnerable or high-risk group's timely access to appropriate primary care services. • Increase in access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours.	
			CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways) Increased uptake of HealthPathways across the region.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			ITC 102 – Care coordination and outreach services • Reduction in barriers to accessing culturally appropriate primary health care for Aboriginal and Torres Strait Islander people. • Increased access to culturally appropriate services in mainstream general practice. • On exit of the program, an ITC client will have improved health literacy and capacity to manage their chronic health condition and will have received support to establish and engage with their care plan to set and meet their health goals. • Improved health outcomes that lead to a reduction in chronic disease.	
			ITC 101 – Supplementary services Improved client health literacy and capacity to manage chronic health condition and ability to establish and engage with their care plan to set and meet their health goals.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital and identified by community consultations for respiratory system disease, including asthma and chronic obstructive pulmonary disease *Associated Identified Need:* *Reduce chronic obstructive pulmonary disease-related mortality;* *Reduce the prevalence of chronic obstructive pulmonary and emphysema;* *Reduce the prevalence of asthma among adults and children;* *Department for low urgency presentations* *Higher total admissions to hospital*	Mental health	Care coordination	**HSICO2 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement activity and support. **CF 303 – Activities relating to population health (integrated care coordination)** Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes resulting in reduced unplanned presentations to ED through: • Improved health literacy and improved capacity to manage their chronic health condition. • Received support to establish and engage with their care plan to set and meet their health goals. **CF 306 – Activities relating to Murrumbidgee wellness and resilience activity** An integrated wellness and resilience activity enables older people, those with or at risk of chronic disease, vulnerable or high-risk group's timely access to appropriate primary care services. • Increase in access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours. **CF 406 – Vulnerable peoples COVID-19 vaccination program** Increase access to COVID vaccinations, especially by the priority population cohort. **CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways)** Increased uptake of HealthPathways across the region.	MPHN MLHD/PCCG

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			CF 306 – Activities relating to Murrumbidgee wellness and resilience activity An integrated wellness and resilience activity enables older people, those with or at risk of chronic disease, vulnerable or high-risk group's timely access to appropriate primary care services. • Increase in access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours.	
			CF 304 – Integrated system of primary healthcare – decision support tool (HealthPathways) Increased uptake of HealthPathways across the region.	
			ITC 102 – Care coordination and outreach services • Reduction in barriers to accessing culturally appropriate primary health care for Aboriginal and Torres Strait Islander people. • Increased access to culturally appropriate services in mainstream general practice. • On exit of the program, an ITC client will have improved health literacy and capacity to manage their chronic health condition and will have received support to establish and engage with their care plan to set and meet their health goals. • Improved health outcomes that lead to a reduction in chronic disease.	
			ITC 101 – Supplementary services Improved client health literacy and capacity to manage chronic health condition and ability to establish and engage with their care plan to set and meet their health goals.	
			AC-AHARACF 102 – Enhanced out of hours support for RACHs Improved RACH capacity to manage the health care needs of residents in the out-of-hours period, reducing the need for residents to be transferred to hospital in the out-of-hours period and have a planned approach for when transfer of care is required.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			PP&TP-GCPC 102 – Greater choice for at home palliative care Increased capability in primary care to provide quality palliative care and reduce avoidable presentations to ED.	
Reduction of prevalence, incidence, mortality and or morbidity and high use of services in ED or hospital and identified by community consultations for musculoskeletal system and connective tissue including arthritis *Associated Identified Need:* *Reduce the prevalence of arthritis;* *Department for low urgency presentations;* *Higher total admissions to hospital* *Need to increase support for adults living with multi-morbidity*	Population health	Care coordination	**CF 303 – Activities relating to population health (integrated care coordination)** Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes resulting in reduced unplanned presentations to ED through: • Improved health literacy and improved capacity to manage their chronic health condition. • Received support to establish and engage with their care plan to set and meet their health goals.	MPHN
			CF 306 – Activities relating to Murrumbidgee wellness and resilience activity An integrated wellness and resilience activity enables older people, those with or at risk of chronic disease, vulnerable or high-risk group's timely access to appropriate primary care services. • Increase in access to allied health professional support for early intervention and chronic disease management of community participants to facilitate an increase in adoption of healthy behaviours.	
Reduction of prevalence, incidence, mortality and or morbidity and identified by community consultations for; suicide and intentional self-harm *Associated Identified Need:* *Reduce suicide-related mortality* *Higher total admissions to hospital*	Mental health	Access	**MH 118 – Targeted regional initiatives (community based suicide prevention activity)** • Reduce the incidence and impact of suicidality within the Murrumbidgee region. • Improve coordination and integration of early intervention and suicide prevention activities across the Murrumbidgee region, following a multiagency regional plan. • Develop and implement activities to meet the needs of identified priority population groups or communities and prevent suicidal distress. • Improved connection to the National Aboriginal Community Controlled Health Organisation Culture Care Connect Program.	MPHN Murrumbidgee Mental Health Drug and Alcohol Alliance

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			MH-H2H 115 – H2H intake and assessment Murrumbidgee residents have a central point to receive information and advice about mental health and alcohol and other drug use, receive a holistic assessment of needs and are connected to local mental health and/or alcohol and other drugs supports.	
			MH 101 – MyStep to mental wellbeing People living across the Murrumbidgee have access to quality, affordable psychological therapies, connected within a system that facilitates stepping up and down the intensity of care as required by the client, providing the right care at the right time by the most appropriate clinician.	
			MH 102 – Child and youth mental health services (Youth Enhanced) Improvement in the mental health of children and/or young people with, or at risk of, severe and complex mental health issues, especially for young people who experience considerable disadvantage when accessing or attempting to access services.	
			MH 103 – Child and youth mental health services (headspace) Improved access to youth friendly mental health services and increased mental health and wellbeing for young people in the Murrumbidgee region.	
			MH 104 – Services for severe and complex mental illness Improved clinical and psychosocial outcomes for people with severe and complex mental illness.	
			MH 114 – Initial assessment and referral project General practitioners and other relevant clinicians within the Murrumbidgee region are trained in use of the IAR tool and utilise the tool to link people to the appropriate level of care, supporting national consistency of assessments and referrals.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			MH 118 – Targeted regional initiatives for suicide prevention (regional response coordinator) • Reduced incidence and impact of suicidality within the Murrumbidgee region. • Improved coordination and integration of early intervention and suicide prevention activities across the Murrumbidgee region. • Development and implementation of activities to meet the needs of identified priority population groups or communities and prevent suicidal distress. • Strong regional planning addressing gaps in services, building community capability to prevent and respond to suicidal distress.	
			NAB-H2H 103 – Adult mental health centre and satellite network (Head to Health) People in the Murrumbidgee region experiencing crisis or significant distress, requiring information, service navigation, assessment and evidence-based care can access appropriate, affordable, quality, and culturally appropriate services when and where they need it.	
			NAB-UAS 101 – Universal aftercare services People in the Murrumbidgee region have access to supports following a suicide attempt and/or suicidal crisis.	
			NAB-HE 102 – headspace enhancement (Griffith) **NAB-HE 102 – headspace enhancement (Wagga)** Increased access and reduce wait times for young people through a coordinated multidisciplinary approach.	

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
Reduction of prevalence, incidence, mortality and or morbidity and identified by community consultations for cancer *Associated Identified Need:* *Reduce cancer-related mortality* *Reduce the incidence of all cancers and specific cancers* *Need to increase support for adults living with multi-morbidity*	Population health	Multi-disciplinary care	**HSICO2 – Quality improvement and health literacy in general practice** Improved health outcomes for patients and population through effective quality improvement activity and support. **CF 303 – Activities relating to population health (integrated care coordination)** Support people with complex chronic disease and their families to navigate the health system and to achieve better health outcomes resulting in reduced unplanned presentations to ED through: • Improved health literacy and improved capacity to manage their chronic health condition. • Received support to establish and engage with their care plan to set and meet their health goals.	MPHN NSW Cancer Institute
Responding to issues relating to chronic pain *Associated Identified Need:* *Reduce the prevalence of arthritis*	Population health	After hours	**AC-EI 103 – Early intervention initiatives to support healthy ageing in the community** Early intervention healthy ageing initiatives, to support the effective management of chronic conditions for older people living in the community resulting in: • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community. **AH 107 – Wagga GP After Hours Service** Provides urgent non-life-threatening primary care in the after-hours period. **AC-CF 104 – Care finder** Improved outcomes for people in the care finder target population.	MPHN MLHD NSWRDN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			AC-AHARACF 102 – Enhanced out of hours support for RACHs Improved RACH capacity to manage the health care needs of residents in the out-of-hours period, reducing the need for residents to be transferred to hospital in the out-of-hours period and have a planned approach for when transfer of care is required. **PP&TP-GCPC 102 – Greater choice for at home palliative care** • Increased capability in primary care to provide quality palliative care. • Generation of palliative care specific data for ongoing quality improvement purposes. • Increased number of sustainable palliative care multidisciplinary team meetings. • Generation of palliative care specific data for ongoing quality improvement purposes. • Increased number of patients with access to best practice pain assessments. • Improved access to palliative medicines at end of life. **Local access to pain specialists and integrated chronic pain care** Local people experiencing chronic pain continue to have access to pain specialists and integrated allied health care through programs funded by NSW Health and NSWRDN.	
Increase cervical cancer screening participation *Associated Identified Need:* *Lower rate of cervical screening participation*	Population health	Early intervention and prevention	**HSICO2 – Quality improvement and health literacy in general practice** Improved screening rates and health outcomes for patients and population through effective quality improvement activity and support.	MPHN
Respond to emerging issues related to disasters (drought, bushfires, floods, pandemic)	Population health	Emergency response	**CF 407 – COVID primary care support** Increased effectiveness of primary care response to emerging disasters and recovery.	MPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			CF 406 – Vulnerable peoples COVID-19 vaccination program Increased access to COVID vaccinations by vulnerable population groups.	
			MH 101 – MyStep to mental wellbeing Increased access to mental health support by people impacted by incidents and disasters.	
Improve coordination of care and to allow palliative patients to receive appropriate care and to pass away in their place of choice	Population health	Palliative care / end of life care	**PI 102 – Greater choice for at home palliative care** • Increased carer knowledge of and linkage to dementia related supports and services. • Increased carer confidence and skills in preventing potentially avoidable presentations to emergency departments. • Improved community awareness that dementia is a life limiting illness. • Improved community capacity to support carers who care for someone with dementia. • Increased capability in primary care to provide quality palliative care. • Generation of palliative care specific data for ongoing quality improvement purposes. • Increased number of sustainable palliative care multidisciplinary team meetings. • Generation of palliative care specific data for ongoing quality improvement purposes. • Improve access to quality palliative care at home for Aboriginal people. • Increase the number of bereaved carers who receive a bereavement risk assessment and referrals to support. • Increased number of dementia patients with access to best practice pain assessments. • Improved access to palliative medicines at end of life.	MPHN

Priority	Priority area	Priority sub-category	Expected outcome	Potential lead agency and /or opportunities for collaboration and partnership
Population cont.				
			AC-EI 103 – Early intervention initiatives to support healthy ageing in the community Early intervention to support the effective management of chronic conditions for older people living in the community resulting in: • Improved linkages for older people living in the community to appropriate care. • Improved health outcomes for older people living in the community. • Increased awareness in primary healthcare regarding the needs of older people and supports available in the community. • Improved health and wellbeing of carers of older people in the community.	
			AC-CF 104 – Care finder Improved outcomes for people in the care finder target population.	
			AC-VARACF 101 – Support RACHs to increase availability and use of telehealth • Increased capacity and capability for RACHs to support telehealth consultations for residents. • Improved technological interoperability between aged care services and the health care system.	
			AC-AHARACF 102 – Enhanced out of hours support for RACHs Improved RACH capacity to manage the health care needs of residents in the out-of-hours period, reducing the need for residents to be transferred to hospital in the out-of-hours period and have a planned approach for when transfer of care is required.	

Data sources/references

1. Australian Bureau of Statistics (2021). 2021 Census of Population and Housing. 20 August 2024. URL: https://www.abs.gov.au/statistics/people/housing/housing-census/latest-release.

2. Australian Bureau of Statistics (2024). Table Builder. 20 August 2024. URL: https://www.abs.gov.au/statistics/microdata-tablebuilder/tablebuilder.

3. Australian Bureau of Statistics (2021). Estimating Homelessness: Census. 20 August 2024. URL: https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release.

4. Australian Bureau of Statistics (2023). 2021 National Study of Mental Health and Wellbeing. URL: https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/2020-2022.

5. Australian Institute of Health and Welfare (2024). National Core Maternity Indicators. 20 August 2024. URL: https://www.aihw.gov.au/reports/mothers-babies/national-core-maternity-indicators/contents/about.

6. Australian Institute of Health and Welfare (2024). National Perinatal data collection. 20 August 2024. URL: https://www.aihw.gov.au/about-our-data/our-data-collections/national-perinatal-data-collection.

7. Australian Institute of Health and Welfare (2024). Mortality Over Regions and Time (MORT) books. 20 August 2024. URL: https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/related-material.

8. Australian Institute of Health and Welfare (2024). Medicare-subsidised GP, allied health and specialist health care across local areas: 2022-23. 20 August 2024. URL: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/contents/allied-health-services.

9. Australian Institute of Health and Welfare (2024). Use of emergency departments for lower urgency care. 20 August 2024. URL: https://www.aihw.gov.au/reports/primary-health-care/use-of-emergency-departments-lower-urgency-care/contents/lower-urgency-care/summary.

10. Cancer Institute NSW. Reporting for Better Outcomes. Primary Health Care, 2023. Sydney: Cancer Institute NSW, 2024.

11. NSW Bureau of Crime Statistics and Research (2024). Local Government Area crime tables. 20 August 2024. URL: https://data.nsw.gov.au/data/dataset/nsw-local-government-area-crime-tables.

12. NSW Ministry of Health (2024). Centre for Epidemiology and Evidence, HealthStats. 20 August 2024. URL: https://www.healthstats.nsw.gov.au/topics.

13. Public Health Information Development Unit (PHIDU), Torrens University Australia. Social Health-Atlas of Australia Primary Health Networks; 2024. 20 August 2024. URL: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks.

14. Public Health Information Development Unit (PHIDU), Torrens University Australia. Aboriginal & Torres Strait Islander Social Health Atlas of Australia; 2024. 20 August 2024. URL: https://phidu.torrens.edu.au/social-health-atlases/indicators-and-notes-on-the-data/indigenous-social-health-atlas-of-australia-content.

Section 5 - Checklist

Requirement	✓
Provide a brief description of the PHN's Needs Assessment development process and the key issues discovered.	✓
Outline the process for utilising techniques for service mapping, triangulation and prioritisation.	✓
Provide specific details on stakeholder consultation processes.	✓
Provide an outline of the mechanisms used for evaluating the Needs Assessment process.	✓
Provide a summary of the PHN region's health needs.	✓
Provide a summary of the PHN region's service needs.	✓
Summarise the priorities arising from Needs Assessment analysis and opportunities for how they will be addressed.	✓
Appropriately cite all statistics and claims using the Australian Government Style Manual author-date system.	✓
Include a comprehensive reference list using the Australian Government Style Manual.	✓
Use terminology that is clearly defined and consistent with broader use.	✓
Ensure that development of the Needs Assessment aligns with information included in the PHN Needs Assessment Policy Guide.	✓

Appendix Tables

Appendix Table 1: Outcomes of demographic analysis

Identified Need	Key Issue	Description of Evidence
Need for specific age-related services	**POPULATION DATA** Higher prevalence of **'people aged ≥65 years and over'** (Murrumbidgee Primary Health Network [MPHN]: 21.6; New South Wales [NSW]: 17.1; Australia [Aus]: 17.5%; **+19.1% Aus**; PHN rank: 26/31).[1] Higher prevalence of **'persons aged ≥65 years, living in households, with moderate or mild core activity limitation'** (MPHN: 30.9; NSW 28.3; Aus: 28.6 age-standardised rate (ASR) per 100; **+9.2% Aus**; PHN rank: 26/27).[1] **COMMUNITY CONSULTATION** 57.0% reported it being *'difficult'* to *'very difficult'* to access **'aged care services'**.[2] **Factors impacting access to aged services**[2b] Wait times – 39.0% Cost – 34.1% Physical access – 9.8% Travel distance – 9.8% Transport – 7.3%	[1]PHIDU. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Findings from MPHN Community Feedback Survey (n=1,214). [2a]Data from items asking about the level of difficulty they encountered when accessing aged care services across the Murrumbidgee. [2b]Data drawn from an item assessing the factors impacting access to aged care services.
Need for newborn and infant-related services	**POPULATION DATA** Higher prevalence of **'people aged 0-4 years'** (MPHN: 11.7; NSW 11.1; Aus: 10.8%; **+7.0% Aus**; PHN rank: 22/31).[1] Higher **'total fertility rate'** (MPHN: 2.0; NSW 1.7; Aus: 1.6; **+20% Aus**; PHN rank: 29/31).[1] **COMMUNITY CONSULTATION** 56.7% reported it being *'difficult'* to *'very difficult'* to access **'childcare services'**.[2] **Factors impacting access to child services**[2b] Wait times – 38.9% Cost – 31.8% Physical access – 13.6% Travel distance – 9.1% Transport – 6.8%	[1]PHIDU. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Findings from MPHN Community Feedback Survey (n=1,214). Data from items asking about the level of difficulty they encountered when accessing medical services across the Murrumbidgee. [2]Findings from MPHN Community Feedback Survey (n=1,214). [2a]Data from items asking about the level of difficulty they encountered when accessing childcare services across the Murrumbidgee. [2b]Data drawn from an item assessing the factors impacting access to childcare services.

Identified Need	Key Issue	Description of Evidence
Improve health literacy due to less education	**POPULATION DATA** Higher prevalence of **'people who left school at year 10 or below or did not go to school'** (MPHN: 36.9; NSW 27.8; Aus: 25.4 ASR per 100; **+31.2% Aus**; PHN Rank: 29/31).[1] Higher prevalence of **'Aboriginal and Torres Strait Islander people who left school at Year 10 or below or did not go to school'** (MPHN: 49.0; NSW 45.5; AUS: 42.7 ASR per 100; **+12.9% Aus**; PHN Rank: 28/31).[1] Lower prevalence of **'school leaver participation in higher education'** (MPHN: 11.6; NSW 24.0; AUS: 29.1%; **-50.9% Aus**; PHN Rank: 27/31). Lower prevalence of **'Aboriginal and Torres Strait Islander school leaver participation in higher education'** (MPHN: 3.3; NSW 5.3; AUS: 6.6%; **-100% Aus**; PHN Rank: 27/31).[1] Higher prevalence of '**children in families where the mother has low educational attainment'** (MPHN: 21.8; NSW 15.8; Aus: 14.1%; **+35.3% Aus**; PHN Rank: 27/31).[1] Higher prevalence of **'Aboriginal and Torres Strait Islander children in families where the mother has low educational attainment**' (MPHN: 40.8; NSW 39.6; Aus: 35.0%; **+6.8% Aus**; PHN Rank: 27/31).[1] **COMMUNITY CONSULTATION** Percentage who reported it being '*difficult*' to '*very difficult*'; to **'education and training'**:[2] • Non-Aboriginal and Torres Strait Islander sample = 53.5% • Aboriginal and Torres Strait Islander sample = 65.4% Lack of **'health education and information'** was one of the top 5 themes emerging from qualitative interviews with both general MPHN community members and Aboriginal and Torres Strait Islander community members.[3]	[1]PHIDU. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data from items asking about the level of difficulty they encountered when accessing medical services across the Murrumbidgee. [3]Findings from 'Conversations on the Couch' and 'Yarns on the Couch'. Data were drawn from a thematic analysis of semi-structured interviews involving community members (n=108) conducted across nine MPHN towns, and Aboriginal and Torres Strait Islander (n=55) community members across five towns.

Identified Need	Key Issue	Description of Evidence
Increase access to services due to limitations for fee-based healthcare services	**POPULATION DATA** Higher prevalence of **'SEIFA Index of Relative Socio-economic Disadvantage'**. (MPHN: 974; NSW 1001; AUS: 1000; **-11% Aus**; PHN Rank: 20/31).[1] Higher prevalence of **'Indigenous Relative Socioeconomic Outcomes Index'**. (MPHN: 44; NSW 35; Aus: 41; **+6.8% Aus**; PHN Rank: 20/31).[1] Higher prevalence of '**low income, welfare-dependent families'** (MPHN: 5.3; NSW 4.2; AUS: 4.4%; **+20.5% Aus**; PHN Rank: 21/31).[1] Higher prevalence of **'households where weekly income is between $1-$799'** (MPHN: 33.4; NSW: 30.0; Aus: 30.6%; **+9.2% Aus**; PHN Rank 26/31).[2] **COMMUNITY CONSULTATION** Percentage who listed **'cost of living'** as one of the top five most serious health and wellbeing concerns for your community as a whole:[3b] • Non-Aboriginal and Torres Strait Islander sample = 47.9% • Aboriginal and Torres Strait Islander sample = 55.4% Percentage *'Strongly disagreed'* or *'disagreed'* with the statement: **'Living costs are affordable here, e.g. food, petrol, housing'**:[3b] • Non-Aboriginal and Torres Strait Islander sample = 52.1% • Aboriginal and Torres Strait Islander sample = 49.4% Increased **'cost of living'** and **'lack of affordability of primary health care'** were one of the top five themes emerging from qualitative interviews with both general MPHN community members and Aboriginal and Torres Strait Islander community members.[4]	[1]PHIDU. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]ABS 2024: Table Builder – based on the 2021 Australian Census data. [3]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). [3a]Data were drawn from items asking *'What do you think are the five (5) most serious health and wellbeing concerns for your community as a whole?'* [3b]Data were drawn from statements assessing the level of agreement regarding 15 aspects of the community where the respondents live. [4]Findings from 'Conversations on the Couch' and 'Yarns on the Couch'. Data were drawn from a thematic analysis of semi-structured interviews involving community members (n=108) conducted across nine MPHN towns, and Aboriginal and Torres Strait Islander (n=55) community members across five towns.

Identified Need	Key Issue	Description of Evidence
Support people at risk of or experiencing homelessness	**POPULATION DATA** Higher prevalence of **'people accessing specialist homelessness services'** (MPHN **+42.9% Aus**, PHN rank: Rank 19/31).[1] Increased number of **'people who are experiencing homelessness or marginally housed'** (2016: 230.2 vs 2021: 355.5 rate per 100,000)[2] **COMMUNITY CONSULTATION** Percentage who listed **'housing affordability'** as one of the top five most serious health and wellbeing concerns for your community as a whole:[3] • Non-Aboriginal and Torres Strait Islander sample = 36.1% • Aboriginal and Torres Strait Islander sample = 50.1% Increased **'Cost of living'** was one of the top five themes emerging from qualitative interviews with MPHN community members and Aboriginal and Torres Strait Islander community members.[4]	[1]AIHW 2024: Specialist Homelessness Services Collection data cubes 2011–12 to 2022–23. Available at: https://www.aihw.gov.au/reports/homelessness-services/shsc-data-cubes/contents/data-cubes. Accessed: 8/09/2024. [2]ABS. Estimating Homelessness: Census: Available at: https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release#data-downloads. Accessed: 21/05/2024. [3]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data drawn from items asking *'What do you think are the five (5) most serious health and wellbeing concerns for your community as a whole?'* [4]Findings from 'Conversations on the Couch' and 'Yarns on the Couch'. Data were drawn from a thematic analysis of semi-structured interviews involving community members (n=108) conducted across nine MPHN towns, and Aboriginal and Torres Strait Islander (n=55) community members across five towns.

Appendix Table 2: Outcomes of health determinants analysis

Identified Need	Key Issue	Description of Evidence
Need to increase life expectancy due to lower life expectancy experienced	Lower **'life expectancy'** among: • All persons (MPHN: 81.0 yrs; NSW 82.0 yrs; Aus: 81.0 yrs; PHN Rank 18/31). • Males: (MPHN: 79.0 yrs; NSW 79.0 yrs; Aus: 79.0 yrs; PHN Rank 18/31). • Females: (MPHN: 84.0; NSW 84.0 yrs; Aus: 85.0; PHN Rank 19/31).	PHIDU 2024: Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 21/04/2024.
Need to decrease youth mortality among those aged 16 to 24 years	Higher rate of deaths among **'people aged 15 to 24 years'** (MPHN: 81.0; NSW 27.6; Aus: 26.2; ASR per 100,000; **+66.7 Aus**; PHN Rank 28/31). Higher rate of deaths among **'Aboriginal and Torres Strait Islander people aged 15 to 24 years'** (MPHN: 47.2; NSW 24.6.2; Aus: 26.8; ASR per 100,000; **+76.1 Aus**; PHN Rank 28/31).	PHIDU. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Need to increase support for people living with multi-morbidity among adults and children	Higher prevalence of **'people aged ≥15 years who reported they had three or more long-term health conditions'** (MPHN: 4.4%; NSW 3.6%; AUS: 3.7%; **+15.9% Aus**; PHN Rank: 25/31). Higher prevalence of **'people aged 0 to 14 years who reported they had two long-term health conditions'** (MPHN: 0.8%; NSW 0.5%; AUS: 0.5%; **+37.5% Aus**; PHN Rank: 29/31).	PHIDU. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Need to address development vulnerability among 1st-year school children	Higher prevalence of **children aged ~5 years** who are **'developmentally vulnerable on two or more domains'**. (MPHN: 12.2%; NSW 10.5%; Aus: 11.4%; **+7% Aus**; PHN Rank 17/31).	PHIDU: based on findings from the 2021 Australian Early Development Census. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024
Increased need for ante-natal support due to higher teenage mother birth rate	Higher **'teenage mother birth rate'** (MPHN: 11.0; NSW 7.8; AUS: 6.6 births per 1,000 women aged between 15 and 19 years; **+66.7 Aus**; PHN Rank: 22/31).	AIHW - Data tables: National Perinatal Data Collection annual update. Available at: https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/archived-content. Accessed: 30/09/2024.

Identified Need	Key Issue	Description of Evidence
Need for support related to domestic violence-related assault	**POPULATION DATA** Higher rate of **'Domestic assault incidents'** (MPHN: 429.2; NSW 382.1; rate per 100,000 **+11% NSW**). **COMMUNITY CONSULTATION** Percentage who listed **'family violence'** as one of the top five most serious health and wellbeing concerns for your community as a whole: • Non-Aboriginal and Torres Strait Islander sample = 36.1% • Aboriginal and Torres Strait Islander sample = 50.1%	NSW Local Government Area excel crime tables. Available at: https://www.bocsar.nsw.gov.au. Accessed: 17/08/2024. [2]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data drawn from items asking *'What do you think are the five (5) most serious health and wellbeing concerns for your community as a whole?'*
Need for support related to sexual-related assault	Higher rate of **'Sexual assault incidents'** (MPHN: 100.8; NSW 81.1; rate per 100,000 **+19.5% NSW**).	NSW Local Government Area excel crime tables. Available at: https://www.bocsar.nsw.gov.au. Accessed: 17/08/2024.

Appendix Table 3: Outcomes of risk factor analysis

Identified Need	Key Issue	Description of Evidence
Reduce levels of risky alcohol consumption	**POPULATION HEALTH DATA** Higher prevalence of people **'drinking more than 2 standard drinks on a day when usually drinking'** (MPHN: 36.5%; NSW 33.5%; **+9.3% NSW**).[1] Higher prevalence of **'people who consume alcohol at harmful levels'** for males and females: • Males: (MPHN: 29.7%; NSW: 22.7%; Aus: 23.7%; **+23.7% Aus**; PHN Rank 26/31). • Females: (MPHN: 11.1%; NSW: 8.5%; Aus: 8.5%; **+30.6% Aus**; PHN Rank 26/31). **COMMUNITY CONSULTATION** Percentage who listed **'drug and alcohol misuse'** as one of the top five most serious health and wellbeing concerns for your community as a whole:[3] • Non-Aboriginal and Torres Strait Islander sample = 49.8% • Aboriginal and Torres Strait Islander sample = 65.2%.	[1]Centre for Epidemiology and Evidence. 2024 HealthStats NSW. Sydney: NSW Ministry of Health. Available at: https://www.healthstats.nsw.gov.au/r/116057. Accessed: 30/09/2024. [2]PHIDU: Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [3]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data drawn from items asking *'What do you think are the five (5) most serious health and wellbeing concerns for your community as a whole?'*
Reduce smoking	Higher prevalence of adults who were **'daily smokers'** (MPHN: 11.6%; NSW 8.2%; **+29.3% NSW**).	Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116070. Accessed: 30/09/2024.
Increase physical activity due to low level reporting insufficient physical activity	Higher prevalence of **'people aged 15 years and over reporting insufficient physical activity'** (MPHN: 36.5%; NSW 33.5%; **+14.3% NSW**).	Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health. Available at: https://www.healthstats.nsw.gov.au/r/116063. Accessed: 30/09/2024.
Reduction in obesity among adults and children	**POPULATION HEALTH DATA** Higher prevalence of **'adults aged 16 years who are obese'** (MPHN: 31.1; NSW 24.6%; **+20.9% NSW**).[1] Higher prevalence of **'children aged 5-16 years who are obese'** (MPHN: 29.8%; NSW 22.3%; **+25.1% NSW**).[2] **COMMUNITY CONSULTATION** Percentage who listed **'weight/nutrition'** as one of the key health-related health challenges' currently experienced:[3] • Non-Aboriginal and Torres Strait Islander sample = 53.3% • Aboriginal and Torres Strait Islander sample = 36.6%	[1]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health. Available at: https://www.healthstats.nsw.gov.au/r/116064. Accessed: 30/09/2024. [2]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health. Available at: https://www.healthstats.nsw.gov.au/r/114573. Accessed: 30/09/2024. [3]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data drawn from items asking *'What do you think are the five (5) most serious health and wellbeing concerns for your community as a whole?'*

Identified Need	Key Issue	Description of Evidence
Reduce blood pressure among adults	**POPULATION HEALTH DATA** Higher prevalence of **'uncontrolled and total high blood pressure among adults'** (MPHN: 24.4; NSW: 23.3; AUS: 23.0%; **+9% Aus**; PHN Rank: 25/31).[1] **COMMUNITY CONSULTATION** Percentage listing **'high-blood pressure'** as one of the key health-related health challenges' currently experienced:[2] • Non-Aboriginal and Torres Strait Islander sample = 26.2% • Aboriginal and Torres Strait Islander sample = 22.8%	[1]PHIDU 2024: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data drawn from an item asking, *'What are the key health challenges that you are currently experiencing?'*
Increased support to address smoking in pregnancy	Higher rate of **'smoking in the first 20 weeks of pregnancy for all women giving birth'** (MPHN: 14.7; NSW 9.4; AUS: 8.3%; **+77.1% Aus**; PHN Rank: 27/31).[1] Higher rate of **'Aboriginal and Torres Strait Islander women who reported smoking during pregnancy'** (MPHN: 48.2; NSW 40.2; AUS: 41.5%; **+13.9% Aus**; PHN Rank: 30/31).[2]	[1]AIWH, 2023: National Core Maternity Indicators. Available at: https://www.aihw.gov.au/reports-data/population-groups/mothers-babies/data. Accessed: 30/09/2024. [2]PHIDU 2024: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Reduction of use of cannabis	Higher rate of **'possession and or use of cannabis'** (MPHN: 256.8; NSW 178.1 per 100,000; **+44.8% NSW**).	NSW Bureau of Crime Statistics and Research: Available at: https://bocsar.nsw.gov.au/statistics-dashboards/open-datasets/local-area-rankings.html. Accessed: 30/09/2024.
Reduction of use of amphetamines	Higher rate of **'possession and or use of amphetatmines'** (MPHN: 120.8; NSW 92.5; per 100,000; **+11.3% NSW**).	NSW Bureau of Crime Statistics and Research: Available at: https://bocsar.nsw.gov.au/statistics-dashboards/open-datasets/local-area-rankings.html. Accessed: 30/09/2024.

Appendix Table 4: Outcomes of health condition analysis

Identified Need	Key Issue	Description of Evidence
Reduce coronary heart disease and coronary heart disease-related mortality	Deaths from **'coronary heart disease'** are the leading cause of death in the MPHN. • Attributable to 11.6% of all deaths between 2017-2021 (**+6.5% Aus rate**). Deaths from **'heart failure and complications'** are the 8th leading cause of death in the MPHN • Attributable to 2.4% of all deaths between 2017-2021 (**+27% Aus rate**).	AIHW: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024.
Reduce chronic obstructive pulmonary disease-related mortality	Deaths from **'chronic obstructive pulmonary disease'** are the 4th leading cause of death in the MPHN • Attributable to 5.5% of all deaths between 2017-2021 (**+37% Aus rate**).	AIHW: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024.
Reduce premature deaths among all persons (aged 0-74 years)	Higher rate of **'premature deaths' (0-74 years)** for: • All persons (MPHN: 285.3; NSW 235.5; Aus: 236.5 ASR per 100,000; **+20.6 Aus**; PHN Rank: 27/31). • Males (MPHN: 364.5; NSW 293.6; Aus: 291.1 ASR per 100,000; **+ 20% Aus**; PHN Rank: 27/31). • Females (MPHN: 208.3; NSW 179.5; Aus: 182.1; ASR per 100,000; **+14.4% Aus**; PHN Rank: 22/31).	PHIDU: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Reduce potential years of life lost	Higher rate of **'potential years of life lost deaths before 75 years of age'** • All persons (MPHN: 46.8; NSW 36.8; Aus: 38.1 ASR per 1,000; **+22.8% Aus**; PHN Rank: 26/31). • Males (MPHN: 60.5; NSW 46.4; Aus: 47.8 ASR per 1,000; **+26.2% Aus**; PHN Rank: 26/31). • Females (MPHN: 32.7; NSW 27.2; Aus: 28.3; ASR per 1,000; **+15.5% Aus**; PHN Rank: 21/31).	PHIDU 2024: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Reduce alcohol-attributable deaths	Higher rate of **'alcohol-attributable deaths'** (MPHN: 23.7; NSW 18.8 per 100,000; **+20.4% NSW**).	Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health. Available at: https://www.healthstats.nsw.gov.au/r/116067. Accessed: 30/09/2024.
Reduce smoking-attributable deaths	Higher rate of **'smoking-attributable deaths'** (MPHN: 76.7; NSW 59.3 per 100,000; **+22.7% *NSW***).	Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health Available at: https://www.healthstats.nsw.gov.au/r/116068. Accessed: 30/09/2024.
Reduce diabetes-related deaths	Deaths from **'diabetes'** are the 5th lead cause of death in the MPHN • Attributable to 3.4% of all deaths between 2017-2021. • MPHN rate is **21% higher than the Australian rate**.	AIHW 2024: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024.

Identified Need	Key Issue	Description of Evidence
Reduce the prevalence of asthma among adults and children	Higher prevalence of **'people aged 15 years who reported they had asthma'** (MPHN: 10.9; NSW 8.0; AUS: 8.5 ASR per 100; **+28.2% Aus**; PHN Rank: 30/31). Higher prevalence of **'people aged 0 to 14 years who reported they had asthma'** (MPHN: 9.0; NSW 6.6; AUS: 6.3 ASR per 100; **+42.9% Aus**; PHN Rank: 31/31).	PHIDU: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Reduce the prevalence of arthritis	**POPULATION HEALTH DATA** Higher prevalence of 'people aged 15 years who reported they had arthritis' (MPHN: 11.7; NSW 10.1; AUS: 10.3 ASR per 100; **+13.6 Aus**; PHN Rank: 22/31).[1] **COMMUNITY CONSULTATION** Percentage listing **'arthritis/osteoporosis'** as one of the key health-related health challenges' currently experienced:[2] • Non-Aboriginal and Torres Strait Islander sample = 32.1% • Aboriginal and Torres Strait Islander sample = 28.3% Percentage listing **'chronic pain'** as one of the key health-related health challenges' currently experienced:[2] • Non-Aboriginal and Torres Strait Islander sample = 21.1% • Aboriginal and Torres Strait Islander sample = 32.6%	[1]PHIDU: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data drawn from an item asking, *'What are the key health challenges that you are currently experiencing?'*
Reduce the prevalence of chronic obstructive pulmonary and emphysema	**POPULATION HEALTH DATA** Higher prevalence of **'people aged 15 years who reported they who reported they had a lung condition (including COPD or emphysema)'** (MPHN: 2.6; NSW 2.0; AUS: 2.1 ASR per 100; **+23.8 Aus**; PHN Rank: 24/31).[1] **COMMUNITY CONSULTATION** Percentage listing **'lung disease (asthma, COPD)'** as one of the key health-related health challenges' currently experienced:[2] • Non-Aboriginal and Torres Strait Islander sample = 11.6% • Aboriginal and Torres Strait Islander sample = 23.9%	[1]PHIDU: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data drawn from an item asking, *'What are the key health challenges that you are currently experiencing?'*

Identified Need	Key Issue	Description of Evidence
Reduce mortality and morbidity due to external causes; premature mortality; avoidable deaths, external causes	Deaths from **'other ill-defined causes'** are the 15th leading cause of mortality (**+34% Aus rate**). Deaths from **'accidental falls'** are the 19th leading cause of mortality.[1] Higher rate of **'premature deaths from external causes'** (MPHN: 40.3; NSW 26.2; AUS: 30.4 ASR per 100,000; **+32.6% Aus**; PHN Rank: 25/31).[2] Higher rate of **'avoidable deaths from selected external causes of mortality'** (MPHN: 25.3; NSW 19.2; AUS: 21.6 ASR per 100,000; **+17.1% Aus**; PHN Rank: 21/31).[2] Higher rate of **'potential years of life lost from external causes'** (MPHN: 13.5; NSW 9.4; AUS: 8.2 ASR per 1,000; **+64.6% Aus**; PHN Rank: 25/31).[2]	[1]AIHW 2024: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024. [2]PHIDU: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Reduced mortality and morbidity due to kidney disease	Deaths from **'kidney disease'** are the 17th leading cause of mortality (**+15% Aus rate**).[1] Higher rate of **'same-day admissions for dialysis for kidney disease'** (MPHN: 5,753; NSW 5,421; AUS: 5,326 ASR per 100,000; **+8% Aus**; PHN Rank: 22/31).[2]	[1]AIHW: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024. [2]PHIDU 2024: Data drawn from the Australian Institute of Health and Welfare, supplied by State and Territory health departments. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.

Identified Need	Key Issue	Description of Evidence
Reduce mental health conditions among the total population and younger adults	**POPULATION HEALTH DATA** Higher rate of **'Community Mental Health Care Service contacts for a depressive episode'** (MPHN: 30.8; NSW 18.8; AUS: 20.2 ASR per 100; **+ 52.5% Aus**; PHN Rank: 23/27).[1] Higher rate of **'Community Mental Health Care Service contacts for an anxiety disorder'** (MPHN: 23.9; NSW 10.2; AUS: 13.0 ASR per 100; **+83.8% Aus**; PHN Rank: 26/27).[1] Higher prevalence of **'females aged 16-24 years with a severe mental health disorder'** (MPHN: 14.2; NSW 13.5; Aus: 13.5%; **+0.7 Aus**; PHN Rank: 21/31). Higher prevalence of **'females aged 16-24 years with an anxiety disorder'** (MPHN: 41.0; NSW 36.9; AUS: 37.3%; **+9.9% Aus**; PHN Rank: 26/31). **COMMUNITY CONSULTATION** Percentage who listed **'mental health issues'** as one of the top five most serious health and wellbeing concerns for your community as a whole:[3] • Non-Aboriginal and Torres Strait Islander sample = 56.1% • Aboriginal and Torres Strait Islander sample = 72.8% **Impacting access to mental health services**[2b] Wait times – 32.2% Cost – 21.6% Physical access – 17.9% Travel distance – 17.9% Transport – 12.3% Issues surrounding **'poor mental health'** were one of the top 5 themes emerging from qualitative interviews with Aboriginal and Torres Strait Islander community members.[4]	[1]PHIDU: Available at: https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]National Study of Mental Health and Wellbeing (NSMHW). Available at https://www.abs.gov.au/statistics/health/mental-health/national-study-mental-health-and-wellbeing/latest-release#data-downloads. Accessed: 30/09/2024. [3]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). [3a]Data drawn from an item asking, *'What are the key health challenges that you are currently experiencing?'* [4]Findings from 'Yarns on the Couch'. Data were drawn from a thematic analysis of semi-structured interviews conducted across five towns involving Aboriginal and Torres Strait Islander (n=55) community members.
Reduce suicide-related mortality	Deaths from **'suicide'** are the **13th leading cause** of mortality (**+41% Aus rate**).[1] Higher rate of premature deaths from **'suicide and self-inflicted injuries'** (MPHN: 9.0; NSW 3.4; AUS: 4.1 ASR per 100,000; **+119.1% Aus**; PHN Rank: 26/31).[2] Higher rate of avoidable deaths from **'suicide and self-inflicted injuries'** (MPHN: 7.6; NSW 5.3; AUS: 5.3 ASR per 100,000; **+43.4 Aus**; PHN Rank: 31/31).[2] Higher rate of potential years lost from **'suicide and self-inflicted injuries'** (MPHN: 5.8; NSW 3.6; AUS: 4.1 ASR per 1,000; **+41.5 Aus**; PHN Rank: 25/31).[2]	[1]AIHW: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024. [2]PHIDU 2024: Data drawn from the Australian Institute of Health and Welfare, supplied by State and Territory health departments. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.

Identified Need	Key Issue	Description of Evidence
Reduce the incidence of all cancers and specific cancers	Between 2021 and 2024, **total cancer incidence increased by 7.4%**.[1] Higher rate of **'total cancer incidence among males'** (MPHN: 667.6; NSW 624.3; AUS: 628.7 ASR per 100,000; **+6.2 Aus**; PHN Rank: 23/31).[2] Higher rate of **'prostate cancer incidence'** (MPHN: 193.1; NSW 167.7; AUS: 166.7 ASR per 100,000; **+15.8 Aus**; PHN Rank: 31/31).[2] Higher rate of **'pancreatic cancer incidence among males'** (MPHN: 17.1; AUS: 15.5 ASR per 100,000; **+10.3% Aus**; PHN Rank: 31/31).[2] Higher rate of **'breast cancer incidence'** (MPHN: 147.5; NSW: 143.5; AUS: 144.0 ASR per 100,000; **+2.4% Aus**; PHN Rank: 24/31).[2]	[1]Cancer Institute NSW. Reporting for Better Outcomes. Primary Health Care, 2023. Sydney: Cancer Institute NSW, 2024. [2]PHIDU 2024: Data drawn from the Australian Institute of Health and Welfare, supplied by State and Territory health departments. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Reduce cancer-related mortality	Between 2021 and 2024, **deaths from increased by 2.8%**.[1] Site-specific cancer deaths from:[2] • **Lung cancer** = the 5th leading cause of mortality (**+8% Aus rate**). • **Colorectal cancer** = the 6th leading cause of mortality (**+26% Aus rate**). • **Prostate cancer** = the 9th leading cause of mortality (**+20% Aus rate**). • **Cancer from unknown sites** = the 11th leading cause of mortality (**+22% Aus rate**). • **Pancreatic cancer** = the 12th leading cause of mortality (**+12% Aus rate**). • **Breast cancer** = the 16th leading cause of mortality (**+9% Aus rate**).[1]	[1]Cancer Institute NSW. Reporting for Better Outcomes. Primary Health Care, 2023. Sydney: Cancer Institute NSW, 2024 [2]AIHW: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024.
Reduce deaths related to hypertensive disease	Deaths from **'hypertensive disease'** are the 10th leading cause of mortality (**+73% Aus rate**).	AIHW 2024: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024.
Reduce deaths related to liver disease	Deaths from **'liver disease'** are the 20th leading cause of death in the MPHN. (**+24% Aus rate**)	AIHW 2024: Mortality Over Regions and Time (MORT) books. Available at https://www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/archived-content/2017-2021. Accessed: 30/09/2024.

Appendix Table 5: Outcomes of community consultation

Identified Need	Key Issue	Description of Evidence
Increase respect and reduce racism and discrimination	Percentage *'Strongly agreed'* or *'Agreed'* to the statement **'Racism is a problem in our community'** • Aboriginal and Torres Strait Islander sample = 71.3% • Non-Aboriginal and Torres Strait Islander sample = 40.7%	MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data were drawn from statements assessing the level of agreement regarding 15 aspects of the community where the respondents live.
Increase support for those experiencing racism	Percentage *'Strongly agreed'* or *'Agreed'* to the statement **'I have experienced racism or discrimination in this town'** • Aboriginal and Torres Strait Islander sample = 75.6% • Non-Aboriginal and Torres Strait Islander sample = 29.7%	MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data were drawn from statements assessing the level of agreement regarding 15 aspects of the community where the respondents live.
Increase Aboriginal and Torres Strait Islander workers in primary healthcare settings	Issues surrounding **'lack of presence of Aboriginal and Torres Strait Islander in primary health settings'** was the top theme emerging from qualitative interviews with Aboriginal and Torres Strait Islander community members.[4]	Findings from 'Yarns on the Couch'. Data were drawn from a thematic analysis of semi-structured interviews conducted across five towns involving Aboriginal and Torres Strait Islander (n=55) community members.
Reduce issues related to travel and distance to access primary healthcare	Issues surrounding **'travel and distance to access primary health care'** were the 2nd most common theme among Aboriginal and Torres Strait Islander community members, and general community members.	MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). Data were drawn from statements assessing the level of agreement regarding 15 aspects of the community where the respondents live.

Appendix Table 6: Outcomes of the service needs analysis

Identified Need	Key Issue	Description of Evidence
Increase the number of general medical practitioners	Lower rate of **'general medical practitioners'** (MPHN: 90.1; NSW 122.6; Aus: 125.5; rate per 100,000; **-28.2% Aus**; PHN Rank: 31/31).	PHIDU: Based on data from the National Health Workforce Dataset (NHWDS), 2022. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.
Lower general practice attendance	**SERVICE USAGE DATA** Lower rate of **'general practice attendance'** (MPHN: 612.1; Aus: 639.2 services per 100 people; **-4.2% Aus**; PHN Rank: 17/31).[1] **COMMUNITY CONSULTATION** Percentage who found it *'difficult'* to *'very difficult'* **'to access a GP'**[2] • Non-Aboriginal and Torres Strait Islander sample = 81.1% • Aboriginal and Torres Strait Islander sample = 75.6% **Factors impacting access to GP**[2b] Wait-times – 55.3% Cost – 21.1% Travel distance – 10.6% Transport – 8.2% Physical access – 4.7%	[1]AIHW 2024: Medicare-subsidised services, by Primary Health Network (PHN) area: 2022–23. Available at: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/data. Accessed: 30/09/2024 [2]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). [2a]Data were drawn from an item asking about the level of difficulty they encountered when accessing medical services across the Murrumbidgee. [2b]Data drawn from an item assessing the factors impacting access to various health services.
Lower rate of GP attendances after-hours	Lower rate of **'GP attendances after-hours'** (MPHN: 11.8; NSW: 27.6; Aus: 30.7 rate per 100; **-61.6% Aus**; PHN Rank: 29/31).	AIHW 2024: Medicare-subsidised services, by Primary Health Network (PHN) area: 2022–23. Available at: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/data. Accessed: 30/09/2024

Identified Need	Key Issue	Description of Evidence
Increase the number of specialist practitioners	**SERVICE USAGE DATA** Lower rate of **'specialist practitioners'** (MPHN: 67.7; NSW 156.6; Aus: 160.2; rate per 100,000; **-57.7% Aus**; PHN Rank: 28/31)1 **COMMUNITY CONSULTATION** Percentage who found it *'difficult'* to *'very difficult'* to **'access a specialist doctor'**[2a] • Non-Aboriginal and Torres Strait Islander sample = 81.0% • Aboriginal and Torres Strait Islander sample = 94.4% **Factors impacting access to specialist doctor**[2b] Wait-times – 30.5% Cost – 25.7% Physical access – 22.2% Travel distance – 12.6% Transport – 9.0%	[1]PHIDU 2024: based on data from the National Health Workforce Dataset (NHWDS), 2022. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Findings from MPHN Community Feedback Survey (Non-Aboriginal and Torres Strait Islander: sample n=1,123; Aboriginal and Torres Strait Islander sample: n= 92). [2a]Data were drawn from an item asking about the level of difficulty they encountered when accessing medical services across the Murrumbidgee. [2b]Data were drawn from an item assessing the factors impacting access to various health services.
Lower specialist practitioner attendances	Lower rate of **'specialist attendance'** (MPHN: 93.5; Aus: 97.3 services per 100 people; **-3.9% Aus**; PHN Rank: 16/31).[1]	[1]AIHW 2024: Medicare-subsidised services, by Primary Health Network (PHN) area: 2022–23. Available at: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/data. Accessed: 30/09/2024.

Identified Need	Key Issue	Description of Evidence
Lower allied health attendances	**SERVICE USAGE DATA** Lower rate of **'allied health attendance'** (MPHN: 80.0; Aus: 98.7 services per 100 people; **-18.9% Aus**; PHN Rank: 25/31).[1] Lower rate of **'occupational therapy services'** (MPHN: 0.2; Aus: 0.3 services per 100 people; **-33.3% Aus**; PHN Rank: 27/31).[1] Lower rate of **'physiotherapy services'** (MPHN: 5.5; Aus: 11.6 services per 100 people; **-52.6% Aus**; PHN Rank: 26/31).[1] Lower rate of **'speech pathology services'** (MPHN: 0.1; Aus: 0.4 services per 100 people; **-75.0% Aus**; PHN Rank: 26/31).[1] **COMMUNITY CONSULTATION** Difficulty accessing an allied health specialist: Percentage who found it *'difficult'* to *'very difficult'* to **'access an allied health service (psychologist, speech therapist)'**[2] • Non-Aboriginal and Torres Strait Islander people = 80.7% • Aboriginal and Torres Strait Islander people = 88.2% **Factors impacting allied health access**[2b] Wait times – 34.7% Cost – 22.9% Travel distance – 19.5% Physical access – 11.9% Transport – 11.0%	[1]AIHW 2024: Medicare-subsidised services, by Primary Health Network (PHN) area: 2022–23. Available at: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/data. Accessed: 30/09/2024.
Higher out of pocket costs	Higher rate of '**more patients with out-of-pocket costs for non-hospital Medicare services'** (**+27.0% Aus**; PHN Rank: 26/31).	AIHW 2024: Medicare-subsidised services, by Primary Health Network (PHN) area: 2022–23. Available at: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/data. Accessed: 30/09/2024.
Lower MBS mental health services	Lower rate of **'psychiatry services'** (MPHN: 3.6; Aus: 7.7 services per 100 people; **-46.7% Aus**; PHN Rank: 29/31). Lower rate of **'clinical psychology services'** (MPHN: 3.9; Aus: 11.2 services per 100 people; **-65.2% Aus**; PHN Rank: 30/31). Lower rate of **'other psychologist services'** (MPHN: 8.1; Aus: 13.3 services per 100 people; **-60.1% Aus**; PHN Rank: 30/31).	AIHW 2024: Medicare-subsidised services, by Primary Health Network (PHN) area: 2022–23. Available at: https://www.aihw.gov.au/reports/primary-health-care/medicare-subsidised-care-2022-23/data. Accessed: 30/09/2024.

Identified Need	Key Issue	Description of Evidence
Higher use of emergency department for low urgency presentations	Higher use of **'low-urgency presentation all hours'** (MPHN: 261.6; Aus: 120.1 per 1,000 people; **+117.1% Aus**; PHN Rank: 30/31).[1]* Higher use of **'low-urgency presentation in-hours'** (MPHN: 153.6; Aus: 66.6 per 1,000 people; **+130.6% Aus**; PHN Rank: 30/31).[1]* Higher use of **'low-urgency presentation after-hours'** (MPHN: 108.0; Aus: 53.5 per 1,000 people; **+95.3% Aus**; PHN Rank: 30/31).[1]* *Sensitivity analysis showed that higher rates in the MPHN were observed across sex (males vs females), and age groups. Higher use of ED for non-urgent disease for:[2]* • Diseases of the **'circulatory system'** (MPHN: 1,824.3; NSW: 1,456.4; Aus: 1,429.4 ASR per 100,000 people; **+27.6% Aus**; PHN Rank: 23/31). • Diseases of the **'digestive system'** (MPHN: 2,841.8; NSW: 2,084.4; Aus: 1,905.1 ASR per 100,000 people; **+45.7% Aus**; PHN Rank: 25/31). • **'Infectious and parasitic diseases'** (MPHN: 1,751.6; NSW: 1,373.84; Aus: 1,675.1 ASR per 100,000 people; **+4.5% Aus**; PHN Rank: 24/31). • **'Mental and behavioural disorders'** (MPHN: 1,595.8; NSW: 1,294.0; Aus: 1,304.8 ASR per 100,000 people; **+21.9% Aus**; PHN Rank: 26/31). • Diseases of the **'respiratory system'** (MPHN: 3,777.7; NSW: 2,595.3; Aus: 2,118.0 ASR per 100,000 people; **+78.1% Aus**; PHN Rank: 27/31). • Diseases of the **'musculoskeletal system and connective tissue'** (MPHN: 4,105.4; NSW: 2,638.7; Aus: 1,829.0 ASR per 100,000 people; **+124.2% Aus**; PHN Rank: 27/31). • Diseases of the **'genitourinary system'** (MPHN: 2,225.6; NSW: 1,649.1; Aus: 1,461.3 ASR per 100,000 people; **+52.3% Aus**; PHN Rank: 26/31). • **'Injury, poisoning and certain other consequences of external causes'** (MPHN: 13,521.4; NSW: 9,737.7; Aus: 8,848.7 ASR per 100,000 people; **+52.8% Aus**; PHN Rank: 27/31). *Sensitivity analysis showed that higher rates in the MPHN were generally observed across sex (males vs females), and among Aboriginal and Torres Strait Islander people.	[1]AIHW: Use of emergency departments for lower urgency care: 2021–22. Available at: https://www.aihw.gov.au/reports/primary-health-care/use-of-emergency-departments-lower-urgency-care/data. Accessed: 30/09/2024. [2]PHIDU 2024: Data drawn from the Australian Institute of Health and Welfare, supplied by State and Territory health departments. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.

Identified Need	Key Issue	Description of Evidence
Higher total admissions to hospital	Higher rate of **'total hospital admissions'** (MPHN: 41,554; NSW: 40,992.7; Aus: 40,927.2 per 100,000 people; **+1.5% Aus**; PHN Rank: 14/21).[1] Higher rate of **'hospital admissions to public hospitals'** (MPHN: 26,158.8; NSW: 20,978.8; Aus: 24,038.7 per 100,000 people; **+8.8% Aus**; PHN Rank: 19/31).[1] Higher admission rate for **'all potentially preventable conditions'** (MPHN: 2,462.6; NSW: 1,958.8; Aus: 2,132.9 per 100,000 people; **+9.0% Aus**; PHN Rank: 23/31).[1] Higher admission rate for **'potentially preventable conditions – all chronic conditions'** (MPHN: 1,3004; NSW: 932.4; Aus: 1,035.9 per 100,000 people; **+25.5% Aus**; PHN Rank: 23/31).[1] Higher admission rate for **'potentially preventable conditions – all acute conditions'** (MPHN: 1,092.7; NSW: 928.8; Aus: 996.1 per 100,000 people; **+7.0% Aus**; PHN Rank: 21/31).[1] The higher admission rate for potentially preventable: • **'Congestive cardiac failure'** (MPHN: 260.2; NSW:217.5; Aus: 210.3 per 100,000 people; **+19.6% Aus**; PHN Rank: 25/30).[1] • **'Diabetes complications failure'** (MPHN: 250.0; NSW:161.5; Aus: 195.0 per 100,000 people; **+28.2% Aus**; PHN Rank: 25/31).[1] • **'Type 1 diabetes'** (MPHN: 88.4; NSW:43.5 per 100,000 people; **+50.8% NSW**; PHN Rank: 9/10).[2] • **'Type 2 diabetes'** (MPHN: 128.9; NSW: 87.6 per 100,000 people; **+32.0% NSW**; PHN Rank: 9/10).[3] • **'Injury, poisoning and other external causes'** (MPHN: 2,936.5; Aus: 2,756.5 per 100,000 people; **+6.1% Aus**; PHN Rank: 19/31).[1] • **'Genitourinary system disease'** (MPHN: 1,464.4; NSW: 1,212.8; Aus: 1,294.5 per 100,000 people; **+11.6% Aus**; PHN Rank: 25/31).[1] • **'Aboriginal and Torres Strait Islander people with genitourinary system disease'** (MPHN: 1,678.6; NSW: 1,286.7; Aus: 1,609.0 per 100,000 people; **+4.1% Aus**; PHN Rank: 20/24).[1] • **'Aboriginal and Torres Strait Islander people with acute urinary tract infections'** (MPHN: 361.5; NSW: 364.8; Aus: 402.8 per 100,000 people; **-2.6% Aus**; PHN Rank: 19/24).[1] • **'Kidney disease'** (MPHN: 6,207.1; NSW: 5878.8; 100,000 people; **+5.3% NSW**; PHN Rank: 19/24).[4] • **'Infectious and parasitic diseases'** (MPHN: 622.9; NSW: 575.6; Aus: 581.5 per 100,000 people; **+11.6% Aus**; PHN Rank: 18/31).	[1]PHIDU 2024: Data drawn from the Australian Institute of Health and Welfare, supplied by State and Territory health departments. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116240. Accessed: 30/09/2024. [3]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116240. Accessed: 30/09/2024. [4]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116241. Accessed: 30/09/2024. [5]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116243. Accessed: 30/09/2024.

Identified Need	Key Issue	Description of Evidence
Higher total admissions to hospital (cont.)	• **'Aboriginal and Torres Strait Islander same-day admissions for dialysis for kidney disease'** (MPHN: 12,319.4; NSW: 8,749.2; Aus: 25,245.6 per 100,000 people; **-106.6% Aus**; PHN Rank: 16/24).[1] • **'Aboriginal and Torres Strait Islander respiratory system disease'** (MPHN: 2,698.3; NSW: 2,112.4; Aus: 2,858.0 per 100,000 people; **-5.9% Aus**; PHN Rank: 19/24).[1] • **'Chronic asthma'** (MPHN: 92.4; NSW: 86.0; Aus: 85.5 per 100,000 people; **+15.9% Aus**; PHN Rank: 23/31).[1] • **'Chronic obstructive pulmonary disease'** (MPHN: 337.5; NSW: 193.0; Aus: 199.7 per 100,000 people; **+69.0% Aus**; PHN Rank: 28/31).[1] • **'Influenza and pneumonia'** (MPHN: 316.7; NSW: 206.3; 100,000 people; **+34.9% NSW**; NSW PHN Rank: 10/10).[5] • **'Influenza and pneumonia aged ≥65 years'** (MPHN: 1,378.5; NSW: 895.5; 100,000 people; **+34.7% NSW**; NSW PHN Rank: 10/10).[5] • **'Digestive system disease'** (MPHN: 2,899.4; NSW: 2,361.2; Aus: 2,361.2 per 100,000 people; **+18.1% Aus**; PHN Rank: 21/31).[1] • **'Aboriginal and Torres Strait Islander digestive system disease'** (MPHN: 3,066.1; NSW: 2,588.6; Aus: 2,949.8 per 100,000 people; **+3.8% Aus**; PHN Rank: 18/24).[1] • **'Congenital malformations, deformations and chromosomal abnormalities'** (MPHN: 157.7; NSW: 117.8; Aus: 115.7 per 100,000 people; **+26.8% Aus**; PHN Rank: 31/31).[1] • **'Aboriginal and Torres Strait Islander iron deficiency anaemia'** (MPHN: 255.8; NSW: 171.0; Aus: 188.7 per 100,000 people; **+35.6% Aus**; PHN Rank: 25/31).[1] • **'Aboriginal and Torres Strait Islander acute convulsions and epilepsy'** (MPHN: 593.5; NSW: 374.4; Aus: 483.9 per 100,000 people; **+22.7% Aus**; PHN Rank: 26/31).[1]	[1]PHIDU 2024: Data drawn from the Australian Institute of Health and Welfare, supplied by State and Territory health departments. Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024. [2]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116240. Accessed: 30/09/2024. [3]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116240. Accessed: 30/09/2024. [4]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116241. Accessed: 30/09/2024. [5]Centre for Epidemiology and Evidence. HealthStats NSW. Sydney: NSW Ministry of Health: Available at: https://www.healthstats.nsw.gov.au/r/116243. Accessed: 30/09/2024.
Lower rate of cervical screening participation	Lower percentage of **'cervical screening participation'** (MPHN: 40.8; NSW 45.9; AUS: 47.5; **-14.1% Aus**; PHN Rank: 31/31).	PHIDU 2024: Available at https://phidu.torrens.edu.au/social-health-atlases/data#social-health-atlas-of-australia-primary-health-networks. Accessed: 30/09/2024.


phn
MURRUMBIDGEE
An Australian Government Initiative


firstHealth
LIMITED