phn MURRAY

An Australian Government Initiative

MURRAY HEALTH REPORT

PRIMARY HEALTHCARE WORKFORCE | NOVEMBER 2022

Acknowledgement of Country

Murray PHN acknowledges its catchment crosses over many unceded First Nations Countries following the Dhelkunya Yaluk (Healing River).

We pay our respects and give thanks to the Ancestors, Elders and Young People for their nurturing, protection and caregiving of these sacred lands and waterways, acknowledging their continuation of cultural, spiritual and educational practices.

We are grateful for the sharing of Country and the renewal that Country gives us. We acknowledge and express our sorrow that this sharing has come at a personal, spiritual and cultural cost to the wellbeing of First Nations Peoples.

We commit to addressing the injustices of colonisation across our catchment, and to listen to the wisdom of First Nations communities who hold the knowledge to enable healing.

We extend that respect to all Aboriginal and Torres Strait Islander Peoples.

OUR COMMITMENT TO BEING AN ANTI-RACIST COMPANY

We aspire to be an anti-racist organisation, embedding cultural humility as a daily practice, to improve health outcomes and health equity in our communities. We recognise cultural humility as a life-long commitment to self-reflection, personal growth and redressing power imbalances in our society.

Message from our Executive Team

The primary care system has been shown, no more than during the COVID-19 pandemic, to be a critical part of a strong health system.

In our region, we have significant reasons for building a strong primary care system, including to promote healthy ageing, First Nations self-determination and to maximise people's capacity to participate in life, regardless of their socio-economic status or pre-existing health conditions.

To deliver on strong primary care, we need strong rural health teams, consisting of a range of health workers.

While rural communities have ageing health workforces and the next generation of health workers is more likely to seek metropolitan roles where they can manage working hours and scope of practice, there are many practitioners who consistently form the backbone of our rural healthcare system. Many have provided years of service and have an excellent knowledge base and capacity to inform local problem solving.

Local workers were never shown to be more important than during COVID, when the traditional migration of health workers to Australia was halted and we had to be self-reliant.

The Medicare system is now almost 50 years old – it is geared around illness and injury, but our community's needs have changed. People are now living with diabetes, heart and lung disease for much longer than they were half a century ago. The new Strengthening Medicare Taskforce is exploring ways to improve the Medicare system to ensure it meets universal healthcare goals. This includes allowing rural communities - who contribute tax to support Medicare - to have the same rights to access specialty care that are normally confined to the city. This is made possible by using face-to-face, telehealth and outreach service models as modes of delivery.

The reality is that patients who cannot obtain appropriate care in the primary healthcare system will present to emergency departments and hospitals, often with more advanced illness and disease complications. A more cost-effective model is to invest in prevention and early intervention and primary care system development, which is where Murray PHN's new strategic plan is focused.

At Murray PHN, we believe that now is the time to partner with community to explore new primary healthcare models that build scale and capacity across multiple communities; models where primary care providers are working in a combination of fee-for-service and bulk billing, but with the inclusion of allied health practitioners and services.

We need our models to be more flexible and make it more attractive for people to come and work in regional areas, like ours. And we need funding flexibility so we can make those types of models work well.

We recognise the value that can be gained when practitioners and communities contribute to solutions, and in doing so, we envisage our rural catchment will increasingly be able to access quality primary healthcare and enjoy health services closer to the scope of those available to people in major cities.

Matt Jones
Chief Executive Officer

Dr Belinda O'Sullivan
Chief of Strategy & Performance

MURRAY HEALTH REPORT

PHNs assess the health needs of their communities, then commission services to meet these needs, so that people can get the help they need, where and when they need it. This includes working closely with health services to build workforce capacity and capability, advocating for more resources and encouraging better use of existing resources.

While PHNs are already developing some locally relevant models of care and workforce solutions, there is considerable opportunity for PHNs to be further empowered to expand this work, to further improve access and health outcomes.

The Murray Health Report is published twice a year, to provide information to our communities on what we know to be the health priorities that matter most. Our May 2022 edition focused on healthy ageing in our region; while our second Murray Health Report for 2022 looks at the vital subject of workforce – the greatest healthcare challenge facing communities in regional and rural areas.

We always welcome suggestions and feedback from our communities, so please click here if you would like to make any comment.

INSIDE:

We encourage interested people in our region to sign up to our regular newsletters and register to join our consumer health panel Health Voices

The primary healthcare system in Australia

Australia has a complex public–private health system, with funding primarily from the federal and state or territory governments, as well as non-government funders such as private health insurers and individual patients.

Private businesses – both for-profit and not-for-profit – also play an important role in filling gaps in healthcare. The traditional model of general practice and much of allied health is that they are businesses needing sustainable billing models to stay financially viable, so they can continue to provide high-quality care to the community.

It is clear however that the rural primary healthcare model is not set up to be as responsive and sustainable as it could be, and some of this relates to attracting and retaining health workforce in rural and regional areas.

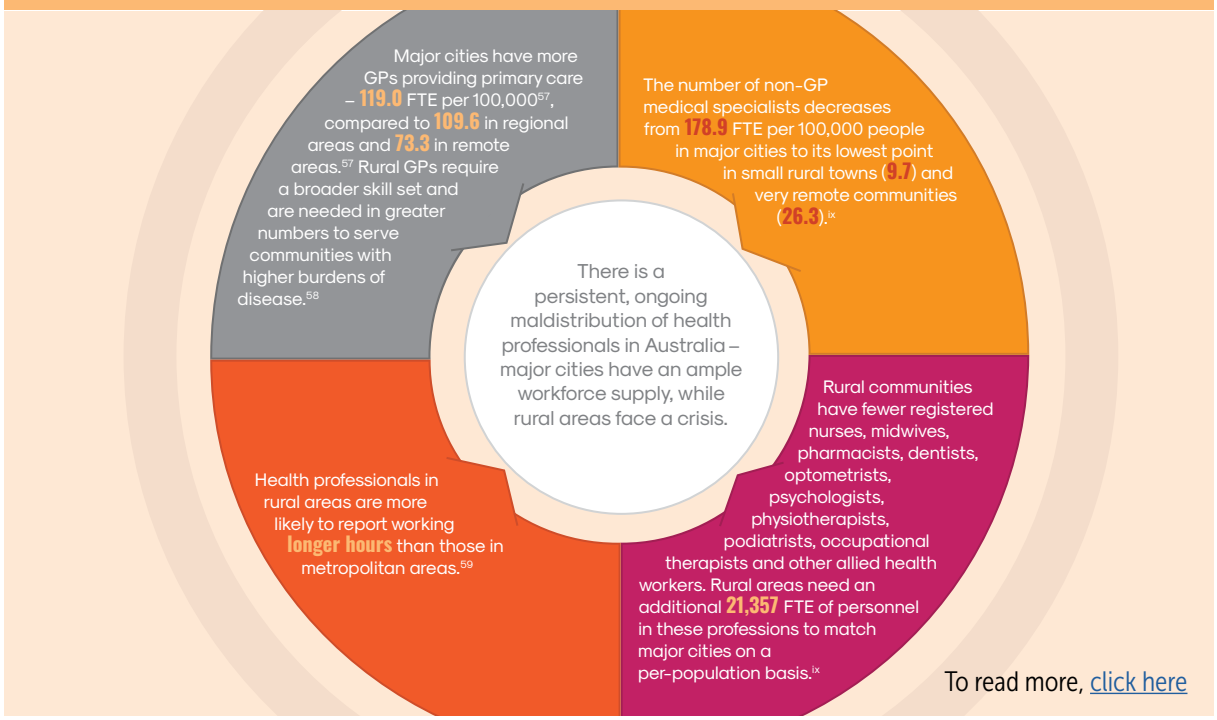
The Medicare rebate payable by the Commonwealth Government has not kept up with inflation, and means that GPs earn more per minute for shorter appointments. GPs receive less advantage from longer appointments, although these appointments are commonly the type needed for rural and regional patients that have more complex needs and come to the GP less often, but sometimes with a longer list of things they need advice about.

Almost half of all Australians live with a chronic disease, with the most common being heart disease, diabetes, asthma and depression. For GPs and allied health professionals to support the community and effectively manage these conditions, it is vital that they are able to maintain ongoing relationships with patients, in a financially viable practice.

GPs and allied health professionals also need a team supporting them to provide routine care, outreach, education and advice, so they can spend more time with complex patients. But the current methods of funding for primary care do not support this easily (note that there are various government incentives around primary care teams and PHN programs to support team-based care).

The additional recruitment and retention challenges in rural areas can also affect the access and sustainability of care and in response, many communities like Swan Hill are shifting to "grow your own" strategies. (See page 18)

HEALTH WORKFORCE DISTRIBUTION



To read more, click here

Primary healthcare teams

When we talk about primary healthcare, most of us think of our local general practice. But with the changing health needs of our communities, primary healthcare is less about cuts and broken bones and more about maintaining good health throughout our lives, through engagement with a range of healthcare professionals.

Our primary healthcare workforce includes health professionals like physiotherapists, practice nurses, mental health workers, dieticians, radiologists and occupational therapists, who can all work with your GP to support your care needs throughout life.

The Royal Australian College of General Practice (RACGP) describes general practice as "the most efficient part of the healthcare system." We know that people who have a regular GP generally have more positive attitudes to healthcare and are more likely to be able to navigate to the best source of primary healthcare, when it is needed.

The Australian Institute of Health and Welfare (AIHW) notes the importance of health literacy in our communities – how people access, understand and use health information in ways that benefit their health. AIHW says that people with low health literacy are at higher risk of worse health outcomes and poorer health behaviours.

With health information able to be accessed (with permission) via the confidential My Health Record, patients are able to keep new health professionals updated on previous health issues, recent test results or medications prescribed. It also helps people to understand their own health journey, improving their health literacy and ability to manage their own care where appropriate.

Much of Murray PHN's work focuses on opportunities for effective integration of primary healthcare services to meet the needs of communities and regions, working within the wider health system, which includes acute hospitals, medical specialists, Aboriginal Community Controlled Health Organisations (ACCHOs), community health services, allied health and even self-help groups and services.

The make-up of rural healthcare teams

While the training of health professionals generally requires nationally accredited standards, there are additional, advanced qualifications available to practitioners who wish to provide high-quality care to people in rural and regional areas.

Aboriginal health workers/practitioners
An Aboriginal health worker/practitioner is an Aboriginal and Torres Strait Islander person who has or is undertaking primary care training to provide flexible, holistic and culturally sensitive health services to First Nations Peoples and the Community to achieve better health outcomes and access to health services.
To learn more, click here.

Rural generalist doctors
Rural generalists are general practitioners who provide primary care services and emergency medicine, and have training in additional skills like obstetrics or anaesthetics. They play a vital role in servicing rural and regional communities by broadening the range of medical services that are available locally. To learn more about the Rural Generalist Program in Victoria, click here and in NSW, click here.

Nurse practitioners
Nurse practitioners are some of the most senior clinical nurses who have advanced qualifications. They can help to support GPs by diagnosing and managing illnesses, prescribing certain medicines, requesting tests, such as blood tests and x-rays, and referring patients to other health professionals.

Allied health rural generalists
Allied health professionals can pursue additional training to increase their skills and scope through a formal education program, creating workforce policy and employment structures and service models that help care to be tailored to the needs of each community.
To learn more, click here.

Peer support workers
Peer workers are people with a lived experience of issues, such as mental illness, who draw on their own experiences to help and support others in similar circumstances. The lived experience of such support workers enables them to connect in a meaningful way.

Community paramedics
Community paramedics are highly skilled and trained healthcare professionals who focus on prevention and rehabilitation, helping people before they reach an emergency situation to stay in their homes for longer.

Q&A

with Julia Bridge, General Practitioner, Beechworth

Q: Where did you do your medical training – a mix of city and regional?

A: I trained at Monash University and had both city and regional placements. The city placements were mainly at the Alfred Hospital and Monash Medical Centre. As part of my training, I did a surgical rotation in Bendigo, an emergency rotation in Rosebud and then another emergency elective in Alice Springs. I also spent two weeks every year for my final three years of study at Beechworth Surgery.

Q: What initially drew you to general practice?

A: I was mainly drawn to the variety of general practice. During my training, I enjoyed each specialty so I was keen to find a career where I could incorporate all of them. As a student, I watched GPs and thought it was so amazing that they could jump from doing a skin excision to treating a patient's eczema, to educating a patient about COPD, to removing a foreign body from an eye. General practice really seemed to have it all.

Q: Did you start out thinking that you would work in a regional location?

A: Initially, I was open to wherever medicine might take me but the more years I spent studying and then working in the city, the more I realised that I wanted to work rurally.

Q: As an early career GP, what do you see as the advantages and benefits of practicing in the regions (as opposed to the city)?

A: The medicine we see rurally is so interesting! We do not always have ready access to specialists, and some of our patients are not keen to see them for a variety of reasons, so as rural GPs you really do manage nearly everything.

In the town where I work, we have a local hospital. This means that when our patients are unwell, and if it is appropriate, we can manage them in the town ourselves. This is such a wonderful thing to offer the community, and as a GP, exposes me to quite different medicine than I see in the rooms. There is also a palliative care room with space for family to stay, so when our patients are dying, they can stay in their own town and family can visit easily. This model is quite different to city medicine.

Q: What is it about general practice that keeps you working in primary healthcare? Can you share the three things you enjoy most about being a GP in a regional town?

A: Interesting medicine, flexible work hours, connection to the community.

Q: Every job has its downsides – what are the main challenges that you have to manage?

A: We just don't have enough GPs rurally, so we are very stretched. Patients are waiting weeks to see a GP and naturally they find this difficult. The lack of access to specialities is also difficult, and finding ones that bulk bill rurally is incredibly challenging, so at times we are managing conditions out of our comfort zone and with limited support.

Q: Do you think you have had professional development opportunities that you may not have been able to access in an urban location? (Or missed out on other opportunities because you were NOT in a city location?)

A: Given I work in a rural location, I am eligible for grants through the Rural Workforce Agency Victoria (RWAV) that I would not be eligible for if I worked in an urban location. In the past two years, I have successfully applied for grants to cover the cost of skin cancer medicine courses, dermoscopy courses and mental health courses.

Q: Are you part of any regionally-based professional networks (formal, informal or one-on-one mentoring) that support your career development?

A: I am part of a mentoring program called Mentorloop and am both a mentor and a mentee. My practice also has a strong focus on professional development and we have regular teaching and guest speakers.

Q: What are some of the non-professional or lifestyle upsides of living and working where you do?

A: My partner and I are keen bushwalkers, cross country skiers and rock climbers and we live in the ideal location for all of those activities. I also really value living in a close-knit, supportive community. Finally, I have a beautiful drive to work each day with no traffic!

First Nations' health and culturally safe care

The Murray PHN region is home to almost one-third of all First Nations Peoples living in Victoria. If we are to make better progress towards improving the health and life outcomes for First Nations Peoples, high-quality, culturally safe healthcare is vital.

While significant holistic primary care services are delivered very effectively by Aboriginal Community Controlled Health Organisation (ACCHOs), many First Nations people access primary healthcare through the wider health system. For this reason, it is important that all health services are able to offer culturally safe healthcare.

Clinicians raised in Western concepts and models of healthcare do not always recognise the impacts of intergenerational trauma, government history or policies, and socioeconomic structures on the health of First Nations individuals.

Murray PHN has a commitment to self-determination and working in partnership with ACCHOs in our region, while working to increase awareness of the importance of culture, connection, community and Country to Aboriginal and Torres Strait Islander communities.

Culturally safe healthcare, which looks at the range of factors that influence health and wellness, is also vital to support our region's growing refugee and migrant populations, who may also face health impacts due to varied experiences before and after their arrival in Australia.

First Nations healthy ageing through self-determination

Murray PHN is committed to the commissioning of services that strengthen First Nations self-determination, underpinned by First Nations world views on health and healing. Through this work, we aim to enable strong, healthy and vibrant First Nations communities accessing best models of practice care, in culturally safe environments, free of racism and respectful of First Nations Peoples, wisdom and knowledge.

We continue to work with Aboriginal Community Controlled Health Organisations (ACCHOs), which deliver interconnected whole-of-life services to First Nations communities, addressing issues of equity and access, including racism, experienced by First Nations Peoples accessing mainstream services.

ACCHOs offer culturally strong and safe health services, based on a social and cultural determinants model of healthcare. The recent report from the Lowitja Institute highlights the importance of culture as a driver of Aboriginal health policy.

Murray PHN's First Nations Health and Healing team is working with ACCHOs to ensure that commissioned First Nations services are co-designed and include early intervention activities and models of care that incorporate First Nations values and cultures.

Supported by the Strategy and Performance Unit, innovative work is underway to co-design a model of care aimed at supporting ACCHOs to deliver healthy ageing for First Nations Peoples – care that is suited to their unique wellness approach, matched to community needs and strengths, and with progress and program outcomes that are able to be monitored and evaluated.

Through this project, we hope to help older Aboriginal and Torres Strait Islander people to age well in their local communities - spiritually, physically and mentally - understanding their enduring connection to person, place and culture.

Initiatives for change

In recent times, a number of initiatives have been introduced to try to address some of the pressing issues impacting primary healthcare. Initiatives have looked at encouraging more health professionals to come to work in rural and regional areas, and how to make businesses such as general practice more financially sustainable.

Three key initiatives include:

Strengthening Medicare Taskforce

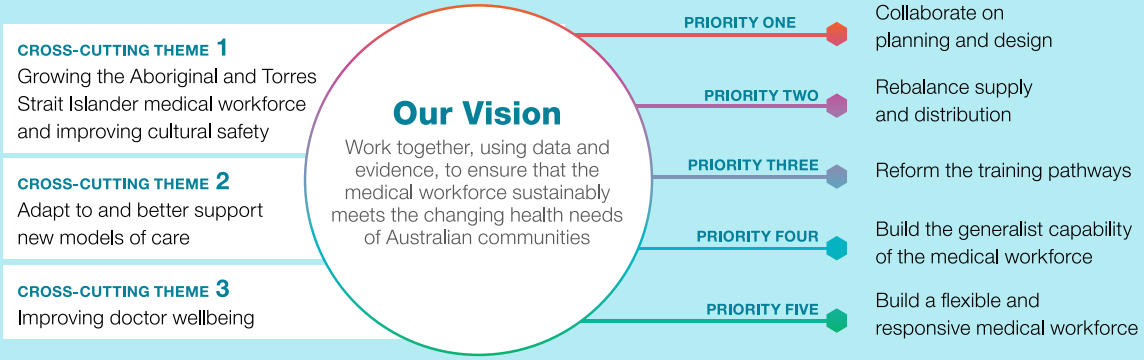
The Australian Government appointed a Strengthening Medicare Taskforce in July 2022, to provide recommendations focused on:

- improving patient access to general practice, including after hours
- improving patient access to GP-led multidisciplinary team care, including nursing and allied health
- making primary care more affordable for patients
- improving prevention and management of ongoing and chronic conditions
- reducing pressure on hospitals.

The taskforce builds on Australia's Primary Health Care 10 Year Plan 2022-32.

National Medical Workforce Strategy

The National Medical Workforce Strategy 2021-2031 was released in January 2022 and aims to address medical workforce issues by exploring actions under key priority areas.



Click here to read more. A Nurse Practitioner 10 Year Plan is also expected to be released by the end of 2022 - click here for more information. For more information on the work of the National Rural Health Commissioner in allied health, Indigenous health and nursing and midwifery, click here.

In the Murray PHN region

In our region, the most promising approaches are the "grow your own" rural health clinician strategies, such as those offering end-to-end medical school training under the Murray Darling Medical Schools Network, which is part of the Commonwealth's Stronger Rural Health Strategy; the Mallee Clinical School at Swan Hill with Charles Sturt University (see case study page 18), and the University of Melbourne and La Trobe University's rural medicine pathway.

Other university departments are investing in similar nursing and allied health strategies, while the Victorian Rural Generalist Training Program in Victoria's rural regions hosts 20 new interns each year. Interns do general practice rotations and continue their training across a wide scope of care in smaller communities.

An evaluation of this program demonstrated that between 2012 and 2020, it attracted 39 per cent of students with a rural background and 48 per cent who did undergraduate medical training in the region, with higher numbers than average becoming GPs. At the time of the evaluation, 40 per cent of the trainees continued to work in the same location as their internship, servicing primary, emergency and other specialist healthcare areas.

Our growing challenge

A research article published by the RACGP in 2016 looked at the changing face of Australian general practice across the decades.

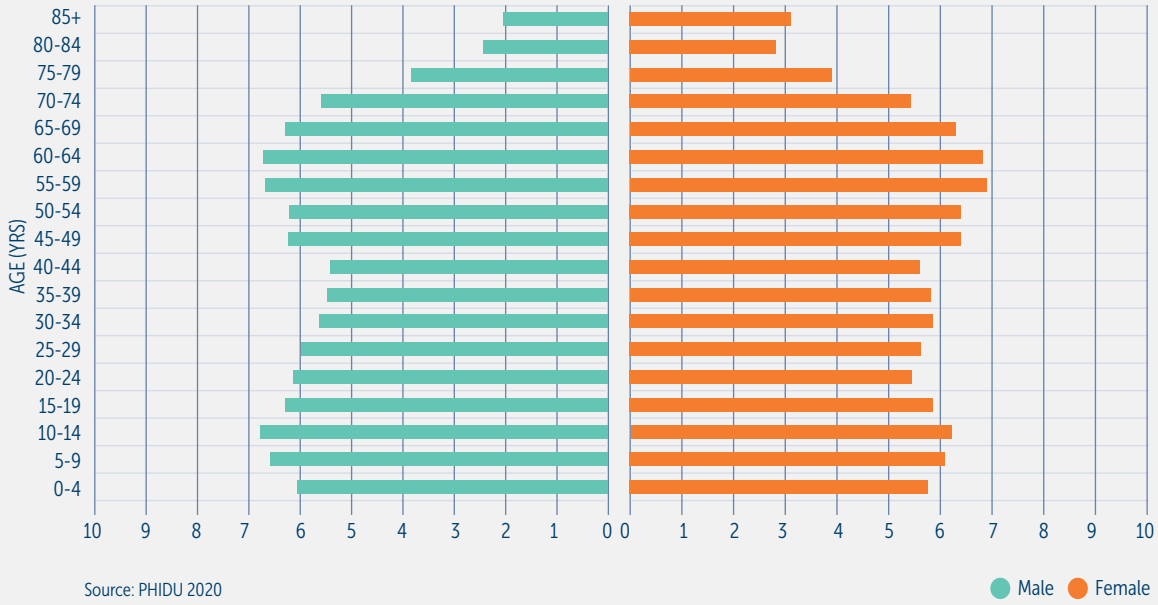
It found that between 1990–2015, Australia's population increased by 38 per cent (17.1 million to 23.5 million), with the proportion of the population aged 65 years and older rising from 11 per cent in 1990 to 15 per cent in 2015.

Other key research found there are fewer Medicare services per patient in regional and rural areas and they are less likely to be bulk billed.

O'Sullivan BG, Kippen R, Hickson H, Wallace G. Mandatory bulk billing policies may have differential rural effects: an exploration of Australian data. Rural and Remote Health 2022; 22: 7138.

Many communities within the Murray PHN catchment are ageing. With ageing populations, there is increasing need for complex care coordination and management, and the availability of timely and accessible care.

Murray PHN estimated resident population



Source: PHIDU 2020

Unique rural factors

As a side-effect of COVID-19, many people in cities began looking to swap city for country life. In our catchment, the local government areas that have experienced the highest annual growth are Mitchell (3.4%), Mansfield (3.3%) and Strathbogie (2%) shires, to Melbourne's north and north east. (SOURCE: 2020)

The move from the city to the regions places additional stress on areas that already have challenges in meeting the healthcare needs of their communities – many people who move to these areas arrive with the expectation that healthcare availability will match that of their former city residences.

However, living in rural and regional areas can come with challenges. General practice is often the first health professional you see for physical and mental health concerns, but practices are increasingly under pressure, with long appointment wait times. Some have had to close their books to new patients.

Often people need to travel greater distances to get the care they need, particularly specialist care. In the Murray PHN region, we have an unequal distribution of primary healthcare providers across our catchment, including GPs, dentists, physiotherapists and dieticians, to name a few.

Since 2019, Australia's National Rural Health Commissioner has provided a voice to policymakers about the needs of rural communities for medical, allied health and nursing care teams. This work has led to strong developments in rural-based training models, and how to build sustainable service models. Innovative models of care based around rural health teams have been at the heart of Murray PHN's ongoing work in projects such as the Buloke Loddon Gannawarra Sustainable Rural Health Project.

The health of rural Australians is also impacted by disparities in availability and access to healthcare, and a range of behavioural risk factors. 2021 Census data revealed that Murray PHN was the fifth highest PHN area nationally for people having one or more long-term self-reported health conditions.

Daily smoking rates increase with remoteness

9.8%	13.4%	15.9%	19.6%
Major cities	Inner regional	Outer regional	Remote areas

SOURCE: AIHW 2019

Rates of lifetime risky drinking increase with remoteness

15.6%	18.2%	21.7%	25.5%
Major cities	Inner regional	Outer regional	Remote areas

SOURCE: AIHW 2019

Overweight or obese 18 years and over

65%	71%	70%
Major cities	Inner regional	Outer regional and remote

SOURCE: AIHW 2017-18

To keep people well and living in their own homes for as long as possible, healthcare models must meet both current and future needs and be cost effective to ensure they can be sustained over the long term. Murray PHN works with stakeholders at the community level to help us invest to make a difference to health outcomes.

What our communities have told us

Over the past six years, Murray PHN has had consistent feedback from its communities, which has helped us understand the need for more workforce in various areas - both health and geographical.

Aged care
More GPs who are willing to take on new residents and conduct onsite services, with better communication and documentation between staff and health professionals.

Alcohol and other drugs, including prescribed medicines
Improved deprescribing (stopping medication) practices especially for elderly patients, and more consultations and assessments to help reduce ambulance call-outs and police responses.

Cancer
More specialists to enable access to local treatment options and improved coordination of care between services, particularly for palliative care patients.

Child health
Increased access to appropriate supports for children who have special service needs, to reduce the cost and time burdens of having to travel to seek specialist paediatric care.

Chronic disease
Additional health services including psychology, podiatry, dietetics and exercise physiologists in regional areas and more integrated, including education and rehabilitation.

Digital health
Higher uptake of digital records and video-conferencing facilities, staff and patient training, to enable multidisciplinary service delivery including for specialist care.

Disability
Specialised workforce who are equipped to work with several community groups and members, and better data sharing arrangements between agencies.

Emergency planning
Better integration of primary healthcare into emergency preparedness and response, and continuation of services during major events such as access to asthma puffers.

First Nations
Improved culturally safe and appropriate care and comprehensive, collective data about local First Nations workforce.

LGBTIQA+
Increase access to workforce, capacity building and education opportunities on the diverse needs of LGBTIQA+ communities.

Mental health
More appropriately trained staff including psychiatrists, psychologists and mental health nurses, and accessible access to affordable and confidential services for young people.

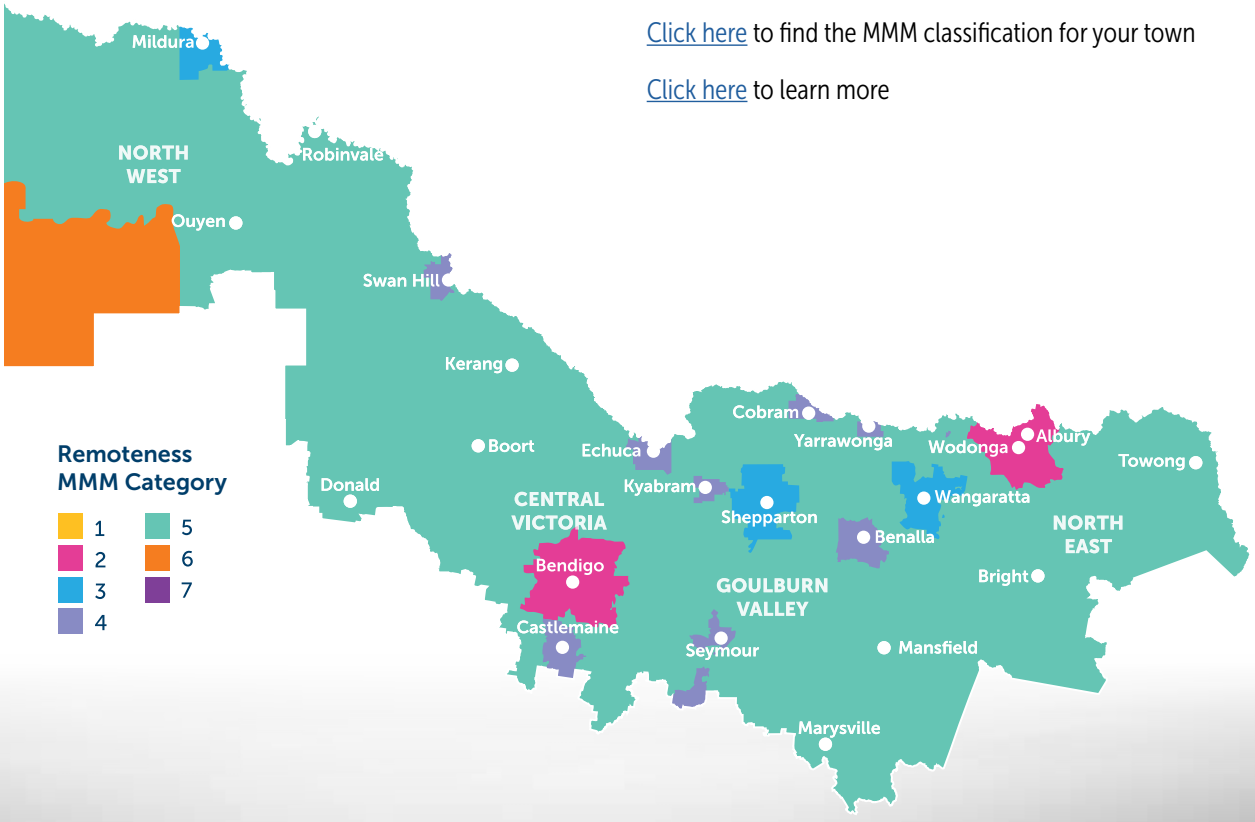
Refugee health
Increased specialised workforce that is educated on the needs of refugees, including access to care and the use of translators.

Consumer engagement conducted for Murray PHN's 2022-25 Health Needs Assessment

Identifying rural and regional areas

What we mean by rural and regional areas

The Modified Monash Model (MMM) is a measure used by the Australian Government to define whether a location is a city, rural, remote or very remote. The model measures remoteness and population size based on the 2016 Census data, on a scale of Modified Monash (MM) category MM 1 (major city) to MM 7. People living in MM 2-7 areas can find it harder to access doctors or other health workers and it may cost more. The MMM classifications are the basis for rural health investment strategies and are used to help distribute the health workforce better in rural and remote areas. Doctors are also eligible for various programs and incentives depending on the MM area in which they choose to work.



Click here to find the MMM classification for your town

Click here to learn more

Sustainable rural health project/Integrated health networks

Murray PHN coordinates the Sustainable Rural Health Project, which is a local system-strengthening project focused on identifying and piloting a series of integrated, multi-site projects to strengthen health systems and services.

The project is based on co-planning with health services and the community, and informed by research and relevant policies and evidence. Using the principles of "grow your own" workforce, it aims to provide better access to prevention and early intervention services that help make the rural health system more sustainable.

The Sustainable Rural Health Project is currently being implemented across the Buloke, Loddon and Gannawarra local government areas, through the Integrated Health Network Alliance (IHN).

The alliance is a collaboration between Murray PHN and four rural health services (Northern District Community Health, Inglewood & Districts Health Service, Boort District Health and East Wimmera Health Service), acting as a representative working group of the broader health and wellbeing services network of the Buloke, Loddon and Gannawarra regions (BLG Health and Wellbeing Executive Network).

The alliance was successful in obtaining a $50,000 partnership grant awarded by the Violet Vines Marshman Centre for Rural Health Research at La Trobe University in July 2022. The grant provides matched funding to increase the value of Murray PHN's $130,000 investment in the first IHN pilot to be co-designed and trialled in the BLG - the Nurse Practitioner Rural Outreach Model.

Buloke, Loddon, Gannawarra (BLG) Health and Wellbeing Executive Network, Kerang, August 2022

Loddon, Buloke and Gannawarra alliance health priorities

Three priority areas have been identified by health and medical professionals that will become the focus of the pilot strategies and services for the Sustainable Rural Health Project.

1

Healthcare accessibility and affordability "Healthcare close to home"

- Assistance with patient transport
- Improving access to GPs, allied health services and specialists
- Increasing healthcare affordability
- Assistance with complex care navigation

2

Health priority areas "Our young and our old"

- Mental health
- Early childhood intervention
- Aged care
- Chronic conditions

3

Other determinants of health

- Housing
- Health literacy
- Socioeconomic status
- Childcare, early childhood education and schools
- Declining populations
- Social and cultural participation

Regional health system strengths and challenges

Health and medical professionals identified regional health system strengths and challenges that provide important insights for designing solutions.

Strengths

1. Enjoy working with rural people and communities
2. Rural practice is innovative, interesting and engaging
3. Supportive workplaces

Challenges

1. Travel costs
2. Workforce shortages
3. Professional and social isolation
4. Poor access to specialists and allied health, and fewer healthcare providers
5. Community expectations
6. Community isolation and self-reliance

Barriers and enablers to sustainability

Healthcare professionals described the following enablers and barriers to sustaining healthcare in the Buloke, Loddon and Gannawarra region, which need to be targeted through the Sustainable Rural Health Project.

BARRIERS		ENABLERS
• Competition, not collaboration • Exclusion from key partnerships	**Leadership and governance**	• Local leadership • Regional workforce strategy • Translational research
• Market failure and inadequate funding models, and unreasonable administrative burdens and targets	**Service planning and funding**	• Collaborative planning • Block funding • Public/private partnerships
• Pressure and strain on rural GPs • Workforce shortages	**Workforce**	• Access to schools and childcare • Support for families and partners • Community inclusion and belonging • Affordable housing • Attractive employment package • Accessible and high-quality postgraduate education • Professional networks • "Grow your own" workforce development and training pathways
• Difficulties using telehealth • Over-reliance on telehealth	**Data sharing and health information technologies**	• Business management and accreditation supports for GPs • Shared/regional healthcare policies and standards • Telehealth infrastructure • Shared/regional data and information sharing systems
• Travel costs and long travel distances	**Service delivery**	• Co-located services • Innovative models • Advanced/full scope roles – Rural generalist GP, Nurse Practitioner, RIPERN nurse, Allied Health Generalist, Allied Health Assistants, Key Worker model • Patient transport

Q&A

with Donna Doyle, CEO, Boort District Health

Q: Where did you do your training?

A: I did part of my Bachelor of Nursing at Ballarat University, had a nine-year break before completing the rest through the University of South Australia.

Q: What initially drew you to healthcare?

A: I think I just fell into it really and I am so glad I did. Apart from a few random hospitality jobs, I have worked my entire career in some area of healthcare. Including as a personal care attendant; in-home carer; aged care tutor; registered nurse in aged and acute care sectors; for Ambulance Victoria; as a practice nurse; care manager; quality manager; director of clinical services and now CEO. I have truly enjoyed every healthcare job that I have ever had.

Q: What do you see as the professional advantages and benefits of working in a rural location (as opposed to the city)?

A: Building your confidence and career in a rural health service gives you a truly holistic experience. The roles are much broader and multifaceted. Much more lateral thinking is required and really enhances your scope and ability. In my experience, the culture in a rural location is quite different to urban environments: there is a closeness and familiarity that's rewarding, comforting and embracing all at once.

Q: Can you share the three things you enjoy the most about working/living in a rural location?

A: 1. Making a visible difference to the health outcomes of my community.

2. The 'village' that you have around you both internally in your immediate workforce but also externally in your regional networks.

3. Being connected.

Q: In your opinion what needs to be done to address regional/rural workforce issues?

A: It's time to start thinking outside our normal train of thoughts about recruitment and retention.

We need collaboration to have more power and ability to be able to really sell the work style, work-life balance, culture, and the benefits of living and working in a rural area.

We also need funding to support relocation, housing, childcare.

Q: What would you say to other health professionals considering a move to a regional/rural area?

A: WHY WOULDN'T YOU????

Our work in alternate models of rural workforce

Recent royal commissions and government inquiries have shown that Australia is facing issues with out-of-pocket costs, availability and equitable access to person-centred, integrated care, in particular in rural and remote areas, for First Nations communities and other cultural groups, and access for the ageing population and those with chronic and complex conditions.

To improve the provision of primary healthcare across our diverse communities, flexible, innovative and place-based solutions must be funded appropriately. It is increasingly unlikely that we can continue to provide care by working within existing structures and silos.

Success depends on being able to establish mixed funding models and collaboration between primary, secondary and tertiary health services and governments.

To improve health outcomes and the sustainability of our health workforce, we must consider the redesign of roles and services, plus employment and training needs. Models need to provide continuity of care in a team-based environment that suits both patient and practitioner.

They must also reflect the changing needs of people who are choosing part-time and casual workforce options, to reflect lifestyle needs, caring responsibilities and career balance.

"Grow your own" approaches to recruiting medical professionals, and working with existing workforce are both critical, while professional isolation for workers can be minimised through networked professional support.

In concert with this thinking, Murray PHN believes that local people have first-hand experience of the issues and should be consulted on their ideas for improvements.

A co-design process brings together a variety of stakeholders with direct experience of the issues – consumers, carers, health services, local government etc. to develop informed and broadly acceptable solutions.

While some regard this research as time-consuming and resource-intensive, it enables improved relationships, fosters innovative ideas and increases the level of support for change.

CASE STUDY: "Grow your own" medical training

In June 2022, Charles Sturt University (CSU) and Swan Hill District Health created the Mallee Clinical School. Located in Swan Hill on the Murray River, this innovative approach will try to "grow" a rural medical workforce of general practitioners.

The clinical school hosts CSU medical students for five years of clinical training, where the students receive one-on-one mentorship in an environment that offers a strong and engaging learning experience.

Swan Hill District Health (SHDH) is a 143-bed fully integrated public health service, including a medical centre and aged care facilities. The 630 staff service a catchment of an estimated 35,000 people, living within 100 km of SHDH.

The program promotes the sunny, outdoor lifestyle of the Swan Hill region, and the benefits of living three and a half hours north west of Melbourne, or five and a half hours from Adelaide.

The benefits for GP trainees and registrars include a dedicated exam coaching mentor and above-award GP training rates, leading to a high success rate in the first attempt of the GP Fellowship exam.

Click here to read more.




How do we get more workforce?

Choosing a generalist career

Research conducted in 2019 demonstrated that there were a range of drivers that led to medical graduates choosing to become a generalist or specialist doctor.

In interviews with a range of medical graduates, the researchers discovered there were eight main considerations for choosing a generalist or specialist career, falling into professional, non-professional and environmental categories.

Professionally, emerging and junior doctors were looking for a practice that fitted their personality and skills, suited their desired clinical practice, and provided both status and reward. Non-professionally, they looked at personal sustainability and work-life balance, along with their desired social and economic position. Environmentally, the emerging and junior doctors' exposure to specific clinical experiences in a diverse range of clinical areas and receiving validation and support from senior clinicians or other role models played a part in their choices. Generalists are therefore more likely to be produced if they are given generalist role models and recurrent rural and generalist experience which is positive.

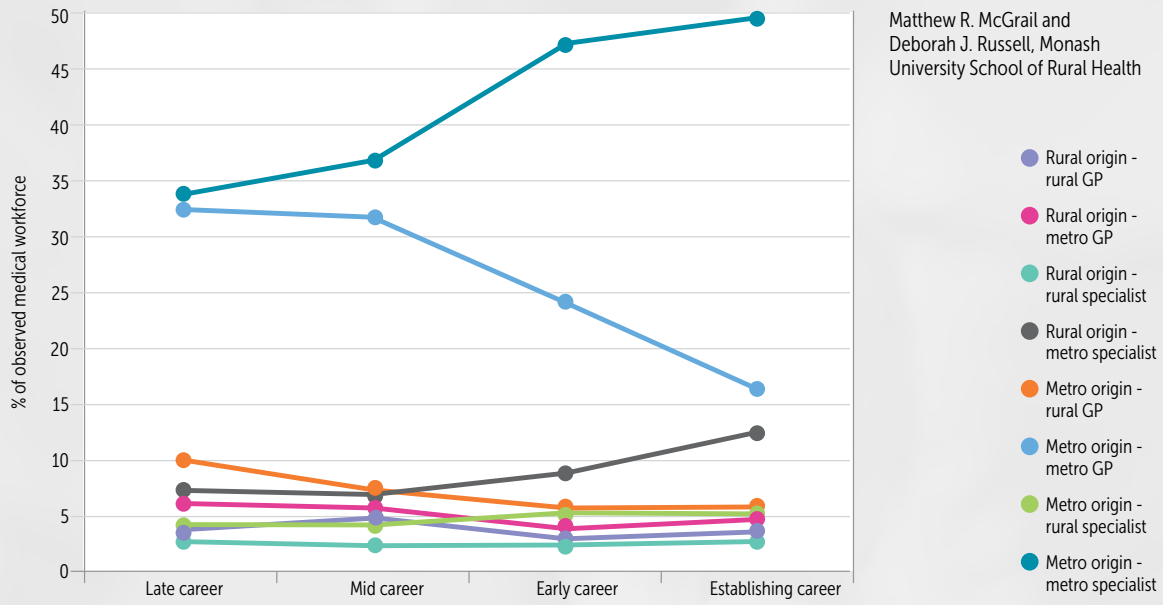
For generalists, that reward was more focused on the impact they could have on community and the recognition they got from the community, rather than within the medical profession (which was related to wanting to be a specialist).

While Australia trains more and more medical graduates each year, and an increasing proportion become specialists, the percentage of graduates choosing general practice or public health is decreasing.

The challenge for young doctors pursuing tightly focused specialities is that specialities where there are narrower pools of jobs can lead to professional "dead ends".

The study's findings suggested that more generalists may be achieved in medicine by enrolling more students with wider values and social interests based on family, culture and community.

Overall supply of Australia's medical workforce by career stage cohort and childhood-origin



Matthew R. McGrail and Deborah J. Russell, Monash University School of Rural Health

MURRAY PHN's FOCUS ON WORKFORCE

Sustainable rural healthcare relies on targeting a series of interconnected building blocks that together help maintain effective, accessible and equitable health systems. First among these is ensuring the availability of a professional clinical workforce, suited to the needs of the region.

There are many players involved in the development of health workforce, but the unique role of Murray PHN is to be a broker of local solutions. We provide support to ensure that local agencies are working well together and that communities are able to access relevant funding and policy initiatives that can support access to and sustainability of healthcare. The challenges for sustainable workforce include the availability of rural health professional training for rural people, funding (salaried positions versus fee-for-service, or blended models), career pathways (including peer support, networks, training and education); sustainable rosters, rather than provision of care after hours, and the different types of workforce needed to ensure responsive care, not cultural safety.

The World Health Organisation (WHO) has described the building blocks required for sustainable rural healthcare. We address these elements when we co-plan models with community.

Leadership and governance

- Networked and aligned rural health services to provide governance and leadership, based on geographical definitions, community factors and healthcare access pathways that reflect normal patterns of service use by those communities. Such as Rural Area Community-Controlled Health Organisations

Service planning and funding

- Co-planning with key stakeholders to achieve consensus on local and regional needs and priorities
- Pooling of resources to improve sustainability, including management and administrative capabilities
- Mixed funding models comprising of joint and pooled funding from existing streams and financing methods, and cross-sector revenue streams and co-investment where available
- Networked with other services in the health system, creating place-based care pathways that reduce fragmentation and duplication, and increase access and efficiency, spanning public-private boundaries
- Leveraging of cross-sector partnerships to ensure optimal use of local resources and create opportunities for innovation
- Attractive employment models to foster supportive team environments including professional education and supervision, and community and family supports needed for job satisfaction and wellbeing
- A 'grow your own' approach to rural workforce development with training pathways and opportunities for advanced scope training and employment

Service delivery

- High-quality clinical and responsive care targeting early intervention and prevention and complex care in the community
- Horizontal integration with alignment between primary care providers, and vertical integration showing alignment between primary care providers and rural and regional hospitals to provide as much cost-effective, quality care in the region as possible
- Involve multidisciplinary teams with medical leadership and co-leadership models, with professionals working at the top of their scope and in substantive, rather than fractional positions
- Outreach and transport services to enable equitable access

Health technologies

- Telehealth included where it can improve service access, continuity or escalation without imposing travel and to build sustainability of face-to-face services
- Integration of digital technologies and platforms that support shared care and secure sharing of patient information, and mechanisms for increasing consumer engagement and healthcare accessibility

Data and evaluation

- Mechanisms and agreements established for sharing real-time data for planning and embedding evaluation and ongoing refinement of any system developed

Rural student placements

- Many health professionals who work in rural and regional areas do so having grown up in the country and having established family and social connections nearby
- Several universities including the La Trobe University Department of Rural Health, Bendigo, recently completed a study to determine if completing rural placements could help to influence where health graduates work
- The study revealed that the more time young clinicians spent on placement in a rural and regional area, the more likely it was that they would continue working there. The authors concluded that end-to-end training in regional and rural areas was an effective approach to retaining workforce, and that priority for rural and regional student placements should be given to students from a regional or rural background.

  Click here to read the full study.

Rural Area Community-Controlled Health Organisations

A new model of health delivery aimed at addressing the key barriers to attracting a rural workforce has been developed.

Rural Area Community Controlled Health Organisations (RACCHOs) are organisations that are tailored to each community and employ a range of healthcare professionals including GPs, nurses, midwives and allied health professionals, such as physiotherapists, podiatrists and psychologists.

RACCHOs have close links with community pharmacies, infant health centres, dentists, paramedics, multipurpose services and local hospitals, and scope for visiting specialists.

They link to universities and colleges to facilitate rural placement and training opportunities, and enable health professionals to be part of a multidisciplinary team, receiving professional support and ongoing employment.

Click here to read more.

Consulting with local workforce

Our region has an estimated 1200 GPs, working full or part-time, who deliver more than 4.5 million services each year, supported by around 2000 practice nurses.

However, the capacity for general practice to surge up to address emerging issues is diminishing. Recent changes to the COVID Positive Pathways program require general practice to manage higher acuity (sicker) patients without additional resources, place significant demand on general practice and push back our practices' ability to manage core business.

After almost three years of COVID, practices have a growing need to focus on deferred care and to respond to emergency appointment requests. Changes to COVID-19 vaccination criteria and the drive to increase population vaccination rates also add to the burden that COVID has left on general practice.

However, many practices do make appointments available at the expense of planned appointments. They run additional clinics, with many GPs working excessive hours across the full seven-day week, with some bringing back retired GPs to support the increasing workload.

They do this to support their communities, but in many cases, this is not sustainable.

In the Murray PHN region

195* general practices

1229* individual GPs

745.5* GP full-time equivalents

2071* Nurses working in general practice

4,625,593* GP services

What local general practices have told us

A Murray PHN survey of general practice in July 2022 showed the extent of the stress and strain on the primary healthcare system in our region. With just over 190 general practices in our region, we were gratified to receive responses from 135 local practices – a more than two-thirds response rate.

90% workforce issues as their major concern

67% staff fatigue and burnout

57% staff illness

50% additional pressures of patient appointments and complex presentations

37% continuing patient aggression

When asked about the future

84% Workforce was still their biggest concern

58% Staff burnout

24% The financial burden of running a practice

The information provided by this survey is now helping the Murray PHN team to shape our general practice consultation and engagement plan. It will inform advocacy papers for change, and help structure new models of care focused on capacity, capability, strengthening systems and sustainability. We thank the practices involved for their time to help us understand issues more fully.

* Figures are approximate

Murray PHN region workforce consultation

Immediate concerns

WORKFORCE (shortage/appropriate skills/ageing/turnover)

93%	88%	91%	88%

PATIENTS (increasing numbers/more complex)

62%	26%	39%	68%

STAFF ILLNESS

100%	61%	36%	90%

PATIENT AGGRESSION

21%	24%	45%	44%

STAFF BURNOUT

64%	71%	64%	71%

GOVERNMENT DEMANDS

29%	34%	24%	37%

INFORMATION OVERLOAD/ LACK OF TIMELY INFORMATION

93%	53%	36%	59%

FINANCIAL BURDEN

50%	24%	5%	44%

COMPETING PRIORITIES

50%	26%	n/a	78%

ACCREDITATION

7%	26%	11%	27%

Current level of demand at practice

NOT TAKING ANY NEW PATIENTS

50%	26%	43%	13%

APPOINTMENTS AVAILABLE NEXT WEEK

57%	26%	61%	59%

TAKING NEW PATIENTS

21%	71%	57%	66%

APPOINTMENTS AVAILABLE IN 2+ WEEKS

21%	42%	34%	27%

North West Victoria Central Victoria Goulburn Valley North East Victoria

Support needed

- More support with attracting and upskilling workforce e.g. a local workforce pool of semi-retired and casual workers
- More workforce needed – GPs (including overseas doctors and locums), allied health, psychologists, psychiatrists, nurses
- More after hours support/models of care/urgent care ideas needed
- Timely access to specialists e.g. ears, nose and throat (ENT) specialists and local pathology services
- Support with recruitment and retention of GPs and GP registrars
- Training to support GPs/nurses transition from hospital to practice settings
- Opportunities for shared learning and support
- Look at ways to help reduce increasing patient numbers in general practice, while decreasing GP hours and emergency department presentations
- Practice managers need more connection with local public health units, teams and managers
- A greater focus on chronic disease management which has suffered during COVID
- Timely communication that highlights changes.

Q&A

with Simone O'Brien, Nurse Practitioner, Heathcote and Bendigo

Q: What initially drew you to healthcare?

A: It feels like a long time ago now (30 years!) but I was always drawn to nursing as I enjoy helping people.

Q: Where did you do your training?

A: My undergraduate years were at Deakin Burwood and the Melbourne hospitals. I grew up in Healesville which was a small country town in the 80s and 90s, and I was lucky enough to do my graduate year there. I loved every minute of working at Healesville Hospital. We never knew what was going to walk through the door. Back then, most small rurals had maternity services and looking back it was kind of a wild graduate year. One minute I was helping in the urgent care, the next I running to the labour ward to help.

I moved up to Bendigo in 1997 to do my midwifery training. I did not want to do it in the city, and I have a lot of family in Bendigo. In the mid-2000s, I also studied forensic nursing and completed my Nurse Practitioner Master's Degree via La Trobe University, Bundoora.

Q: What do you see as the professional advantages and benefits of working in a rural location (as opposed to the city)?

A: There are so many professional benefits. As a clinician, you really learn how to use your senses, and assessment/examination is crucial as we do not have the resources (imaging, pathology) at hand. This makes for a resourceful and skilled clinician. Innovation is often easier as there are not the levels of bureaucracy that can limit and constrain ideas. Rural communities are full of amazing, resilient people; they are different to city folk. It is also really nice walking out to your car across the paddock with the kangaroos, rather than a multi-story car park.

Q: Can you share the three things you enjoy the most about working/living in a rural location?

A: 1. The people. I'm a country girl and I love country people. They're real, genuine and for the most part have fewer hang ups about things like status and prestige. The land, community and environment are more important to them.

2. Being able to genuinely make a difference. Rural communities are often poorer, underserviced with far less resources (this also makes them very inventive and creative). Healthcare programs and workers can have a huge impact in a community. It facilitates great outcomes, expedites access to care and breaks down many health silos.

3. The variety. In a small rural health service, one day to the other is never the same. You cater for pretty much everything that walks in the door in some capacity, even if it is just to stabilise and ship them out somewhere. Alternatively, you might be visiting a farmer who is refusing all treatment and wanting to do their own palliation at home, standing in a paddock assessing his symptoms while he attends to the farm. We go to some isolated and beautiful properties.

Q: In your opinion what needs to be done to address regional/rural workforce issues?

A: I will try to keep this one simple! One, all health practitioners need to be able to work to full scope of practice and the bureaucracy around who accesses who needs to be removed. Two, Medicare needs to be expanded for ALL allied health practitioners. Then change will occur as the GP workload will be lightened and they will also be free to work at the top of their scope and do the things they want to do. We need more of everyone. Patients are older, more complex and public health is worsening.

Q: What would you say to other health professionals considering a move to a regional/rural area?

A: Rural communities need to grow rural clinicians who understand rural people. I can understand why the rural shortage of clinicians is yet to be solved. For most people who have not grown up in a country town, the difference can be very hard to adjust to and they do it for a couple of years then return to the city. I don't blame them, they have done a great job to stick it out for that long, it can be hard living. But, if you love variety, autonomy, community and fun, rural and regional is where that's at!

Responding to health workforce needs

The challenge in building a sustainable rural healthcare system is the need for ongoing investment in dynamic planning. It cannot be resolved with short-term funding or a single research project, no matter how insightful a project might be.

Sustainable rural healthcare is based on community priorities and aims to be integrated and multi-service, to cater for multiple community health needs.

As a primary health network, Murray PHN looks to evaluate its projects to expand them past "proof of concept" so that effective models can be replicated in other areas, to assist a wider number of communities.

Projects like our Sustainable Rural Health Project in Loddon, Buloke and Gannawarra will operate with a range of health and social partnerships, maintaining a strengthened clinical governance framework and building communities of practice for the health workers involved.

In recent years, Murray PHN has commissioned innovative, locally-based services, including health navigators and social prescribing services, along with additional funding for dedicated Aboriginal health workers, the training of highly-skilled RIPERN nurses, mental health services, and integrating pharmacy and general practice.

Posao 'Nido' Taveesupmai is a Humanitarian Community Guide at Bendigo Community Health Services, commonly referred to as a 'health navigator'

Health Navigators

Murray PHN has commissioned Health System Navigators in four regional health services. The Health System Navigators are Karen, Afghan and South Sudanese refugees who provide non-clinical care and help with literacy support and advocate for newly settled arrivals who face barriers in accessing the Western health system.

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RIPERN nurses

Rural and isolated practice endorsed registered nurses (RIPERN) work in rural communities and can help to provide immediate urgent and primary care to those who need it, without having to wait for a doctor.

Murray PHN has been providing RIPERN scholarships since 2017, with 75 registered nurses now RIPERN-trained across local rural and remote urgent care centres, with another 15 set to complete their training by the end of this year.

Matilda Henley-Johnstone, Community Wellbeing - Link Worker at City of Greater Bendigo

Social prescriptions

Murray PHN is funding a pilot that employs community wellbeing link workers who help people who live with a chronic or complex health condition to find social activities in their own communities, to increase participation and wellbeing.

Artwork: Dhelkunya Yaluk (Healing River)

Aboriginal health

Aboriginal health workers are health professionals who use their primary health skills, community knowledge and communication skills to ensure First Nations Peoples, their families and communities receive culturally appropriate and safe care. Murray PHN funds a number of positions at local Aboriginal Community Controlled Health Organisations to help people with care coordination.

Murray PHN is also committed to supporting all health care services to become culturally aware and competent through our work in cultural humility.

Supporting local solutions

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Telehealth Enhanced Aged Care project

Residents of residential aged care facilities can have complex care needs, which can be impacted by staff shortages and limited access to GP services.

Murray PHN's Telehealth Enhanced Aged Care (TEAC) project is looking at ways to improve access to care for some of our most vulnerable community members, while supporting both the nursing and general practice workforces.

To date, this work has involved building a greater understanding of the sector and its use of digital health systems to determine what workforce education and training needs are required. Next, we will be looking to co-design relevant telehealth service models in facilities that will include the use of electronic medical records and advance care plans.

HEAD TO HEALTH

Head to Health

In August 2020, the Commonwealth asked Victorian PHNs to come together to develop a new state-wide service with a single mental health intake function, in just four weeks. The result was the HeadtoHelp (now Head to Health) service, which supported Victorians who were struggling with the impact of COVID, job losses and lockdown.

The multidisciplinary teams in Head to Health hubs include psychologists, mental health nurses, social workers, occupational therapists and alcohol and drug workers. The hubs work closely with existing providers including GPs and hospitals, referring people to more intensive mental healthcare or social supports if needed.

The unique single central phone number meant that no one has to be aware of the 30 different services that a PHN might commission – they just receive the care they need, at the time they need it. Click here or more information.

Kim Ching, a consultant pharmacist and managing director of two Wangaratta general practices in partnership with her GP husband Dr Julian Fidge, the practice principal

Integrating pharmacy into general practice

As part of Murray PHN's General Practice Investment Strategy, four general practice clinics – Docker Street General Medical Centre in Wangaratta, Ontario Medical Clinic in Mildura, iHealth Albury and Yarrawonga Medical Clinic – have been funded to employ non-dispensing consultant pharmacists.

The co-location of pharmacists within general practice is recognised as a way to develop collaborative working relationships, reduce fragmentation of care and allow better patient-centred chronic disease and medication management services.

Business resilience program

Building business resilience is an ongoing challenge for general practices and other private primary health providers, often exacerbated in changing environments brought on by pandemics, regulatory changes and workforce availability.

In April 2021, Murray PHN established the Business Resilience Program; 'Insight, Learn, Develop' to support practices in our region as they build their business viability and develop into high-performing practices.

The three-part program assisted practices to focus on key areas, such as adaptability in the face of adverse events, using digital technology to enhance business and health outcomes, and attracting and retaining workforce.

For more information on this and the other tools and resources available to support general practices, click here.

Building skills and knowledge

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Transition to Practice Program

The Australian Primary Health Care Nurses Association (APNA) Transition to Practice Program supports nurses who work in general practice to drive efficiencies and strengthen team-based care.

In July this year, Murray PHN funded eight nurses who were new to general practice to complete the 12-month program, and receive clinical and professional mentoring to guide and support their induction.

The program develops foundational knowledge, skills, confidence and competencies, while also strengthens the use and capability of the nursing workforce and improves team-based approaches to primary healthcare service delivery.

General practice mentorships

As part of Murray PHN's General Practice Investment Strategy, several practices have been funded to implement new or enhanced models of care coordination for people living with chronic disease.

From April this year, some of these practices have shared their experiences with other practices through six-month mentorships, helping to strengthen networks, build capacity and streamline efficiencies across the region.

Murray Health Pathways

Murray HealthPathways

Murray PHN invests significantly in HealthPathways, an online tool that helps local clinicians to provide best practice care and navigate care pathways to other services. It includes information for assessing common conditions, identifying symptoms, treatment and referral options, and information to give to patients.

During the pandemic, pathways were often updated daily to reflect the constant changes in clinical and government advice, with many health professionals grateful to have access to information in a single place.

The main strength of pathways is having a list of services provided locally, which makes it much easier for newly trained doctors and nurses and for those who move to the Murray PHN region.

For more information, click here.

Stock photograph

Education and training

Each year, Murray PHN funds and works with partners to help deliver continuing professional development education, helping the local health workforce to update their skills, knowledge and accreditation.

Topics have included infection and prevention practices during COVID to keep staff and patients safe; how to best care for patients with cancer during treatment, including managing side effects and where to refer to locally, and how to work in teams to prioritise and deliver the best possible care for patients at the end-of-life.

Health professionals can access resources and see our events calendar here.

REFERENCES

- https://www.aihw.gov.au/reports-data/behaviours-risk-factors/overweight-obesity/overview
- https://www.aihw.gov.au/reports/australias-health/overweight-and-obesity#_Toc30499259
- https://www.aihw.gov.au/reports/alcohol/alcohol-tobacco-other-drugs-australia/contents/drug-types/tobacco#consumption
- https://population.gov.au/data-and-forecasts/dashboards/population-local-government-areas
- https://www.aihw.gov.au/reports-data/behaviours-risk-factors/illicit-use-of-drugs/overview
- www.hwd.health.gov.au/resources/data/gp-primarycare.html
- https://openresearch-repository.anu.edu.au/handle/1885/119241
- www.hwd.health.gov.au/resources/dashboards/nhwds-summary-metrics.html
- https://phidu.torrens.edu.au/current/tools/population-pyramid/current/datagraph_agepyramid.html
- https://population.gov.au/data-and-forecasts/dashboards/population-local-government-areas
- https://www.racgp.org.au/afp/2016/september/the-changing-face-of-australian-general-practice-a
- https://phidu.torrens.edu.au/current/maps/sha-aust/census/phn-pha-single-map/atlas.html
- https://onlinelibrary.wiley.com/doi/10.1111/ajr.12864
- https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/PrimaryHealthServices/Interim_Report
- https://www.health.gov.au/resources/publications/draft-recommendations-from-the-primary-health-reform-steering-group
- https://www.murrayphn.org.au/needsassessment/

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An Australian Government Initiative

murrayphn.org.au

Central Victoria
3-5 View Point, Bendigo VIC 3550
e: centralvic@murrayphn.org.au
p: 03 4408 5600

Goulburn Valley
3/148 Welsford Street,
Shepparton VIC 3632
e: goulburnvalley@murrayphn.org.au
p: 03 5831 5399

North East Victoria
594 Hovell Street, South Albury NSW 2640
e: northeast@murrayphn.org.au
p: 02 6041 0000

North West Victoria
Suite 1, 125 Pine Avenue, Mildura VIC 3500
e: northwest@murrayphn.org.au
p: 03 4040 4300