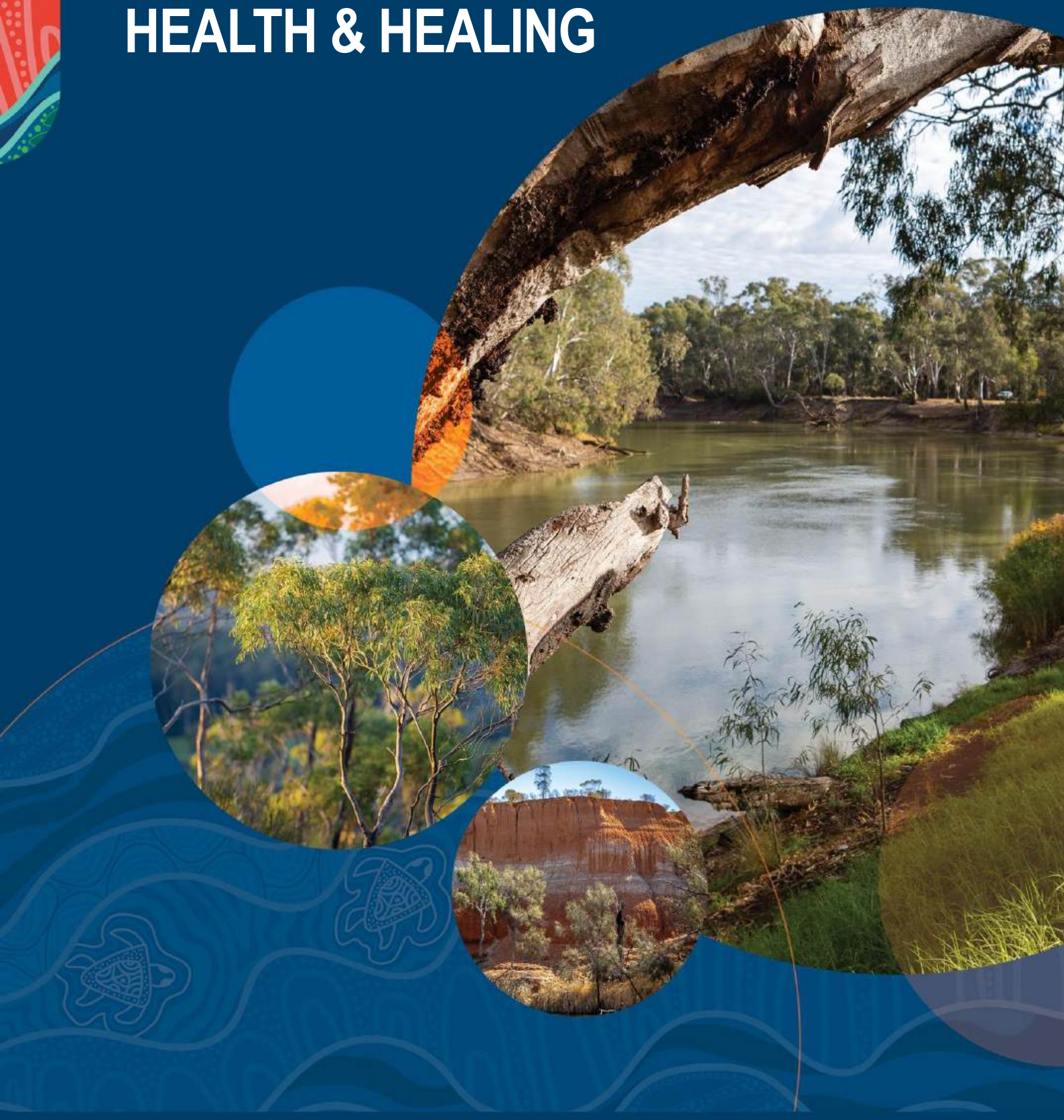
phn MURRAY

An Australian Government Initiative

POPULATION HEALTH SERIES REPORT

FIRST NATIONS HEALTH & HEALING



Leadership Collaboration Respect Accountability Innovation

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 listening 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.

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.

Recognition of lived experience

We recognise the individual and collective contributions of people with a lived and/or living experience of health issues, and their families, loved ones and supporters.

It is through listening to and acting on the voices of people with lived experience, those who provide services, those who fund services, and most importantly, those who use services that we will find the expertise we need to move towards the health system that Australia needs.

Every person's story we hear, and every experience shared, helps to develop our understanding of the system that is required to best meet the needs of people who live with or care for someone with health concerns.

Contributors and attribution

Murray PHN would like to extend sincere thanks to the many contributors to this population health series report including the members of the Community and Clinical Advisory Councils, Medical Advisors, and to local healthcare consumers, professionals, Community members and other stakeholders. We also acknowledge the contributions of Murray PHN staff who were involved in the planning, data collection, analysis and reporting, as well as consultants Impact Co and First Nations Co.

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Executive summary

Aboriginal and Torres Strait Islander Peoples, the First Nations Peoples of this land, possess a holistic view of health, which includes social, emotional and spiritual wellbeing developed over many thousands of years of healthcare science, research and practices. The disparities in health outcomes experienced by First Nations Peoples are caused by historical and ongoing colonisation and racism in the health system.

There are 21,841 Aboriginal and/or Torres Strait Islander Peoples living in the Murray PHN catchment, which represents 28 per cent of the total Aboriginal and Torres Strait Islander population in Victoria (78,696 people) (by PHN Catchment; ABS, 2022). Similar to the national and state population demographics, the First Nations population in the Murray PHN region has a young age structure, with 77 per cent aged 44 years or younger (by IARE; PHIDU, 2021), which is different to the total population that has a higher than average number of people aged 65 years and over (by LGA; ABS, 2021).

This Population Health Series report provides an overview of the current state of First Nations health in the Murray PHN (Primary Health Network) catchment, recognising both health needs and the inherent strengths of First Nations Peoples. The report is structured by 11 domains of health and healing based on current policy and research, developed by First Nations Health and Healing Strategic Lead Pauline Nolan (Yorta Yorta). The report contains insights and recommendations to inform Culturally Safe and anti-racist commissioning, coordination and capacity-building activities of Murray PHN and a range of health and community services and groups.

The insights presented in this report are the outcomes of health and service needs analysis, including quantitative data analysis and stakeholder consultations involving Aboriginal Community Controlled Health Organisations (ACCHOs), First Nations and mainstream service providers, and Community members. The quantitative data included in this report is mainly from years 2018 to 2022 which is limited and does not capture the latest advancements and achievements in the ACCHO sector. In recognition of the limitations of publicly available quantitative data sources, this methodology prioritises the voices of First Nations Peoples provided through consultations and literature review.

The key themes include:

- ACCHOs play a vital role in their communities. They are integral in providing best practice holistic primary healthcare that centres First Nations cultures, Communities and social and emotional wellbeing.
- The most significant barrier to accessing healthcare for First Nations Peoples is the experience of racism and culturally unsafe environments in mainstream services. These experiences contribute to adverse health outcomes and discourage First Nations People from seeking care.
- There's a need for outreach models that provide healthcare on Country, strengthening connections to family and Community. While ACCHOs have been doing this across the region, there is a need to further expand and sustain these programs.
- There are many examples of successful First Nations-led partnerships and collaborations between community-controlled and mainstream services. These examples demonstrate the positive, mutually beneficial impact that collaboration can have on health outcomes.

- There is a strong need for ACCHOs and Community to be involved in decision-making processes for place-based healthcare planning enabling self-determination and which overcomes the data gaps and limitations.
- Service provider feedback identifies the unmet need for early intervention focused care, to address preventable acute and chronic health issues.
- Initiatives that enable culturally-strong and place-based health literacy may enable First Nations Peoples and Communities to navigate complexities and barriers in the system and engage with health promotion and preventative care.
- Culturally Safe mental health and social and emotional wellbeing support are crucial across all stages of life, with particular emphasis on young people and older people.
- Mainstream services need to be accountable for improving Cultural Safety, which starts by employing First Nations staff and developing processes for identifying and addressing racism.
- There is a resounding need for a larger, well-supported First Nations workforce across ACCHOs and mainstream services. Traineeships are acknowledged as a positive step in building this workforce and highlights the need for additional support to ensure their continued success.
- Financial limitations, transportation issues, long wait times for allied health services and limited availability of after-hours care are all significant barriers to care, which disproportionately impact rural communities.
- Service providers face challenges with output and target-based funding models that restrict the provision of holistic care.
- Workforce shortages in both mainstream and ACCHO services are adding pressure on the system. Support to attract and retain local First Nations health workforce is needed.
- Alleviating the burden of administrative tasks on ACCHOs by streamlining reporting requirements can also help to address workforce and provider challenges.

These key themes are reflected in the 22 insights and their accompanying implications in the table below, followed by the proposed recommendations for future commissioning, collaboration and capacity building activities.

Overview of key insights

Insights	Implications
Domain: Autonomy, empowerment and recognition	
Insight 1: ACCHOs are effectively providing self-determined and Culturally Safe healthcare for First Nations People.	ACCHOs need continued and increased autonomy and funding to support First Nations People to live happy, healthy lives.
Insight 2: First Nations staff in mainstream services have an important role in supporting First Nations Peoples, particularly when access to ACCHOs is difficult due to travel distance.	First Nations staff in mainstream services are needed to support the provision of high-quality and Culturally Safe care across the health system and healthcare continuum.
Insight 3: First Nations Community and service providers believe that the publicly available quantitative data does not accurately represent community needs, highlighting the implications of solely relying on quantitative data to make decisions.	Community consultation is needed for decision-making, particularly relating to funding allocation and service design. Mainstream service providers would also value access to data for service planning that could be shared in ways that respect data sovereignty.
Insight 4: PHN reporting requirements are a significant and ongoing burden for First Nations services and are a deterrent in applying for small grants.	Simplified, streamlined reporting requirements would support ACCHOs and other First Nations organisations in delivering effective health and wellbeing outcomes for Community members.
Domain: Work, roles and responsibilities	
Insight 5: First Nations individuals in designated roles face challenges due to changing job boundaries, cultural duties, and in mainstream services, the expectation to take on colonial load.	Additional support and resourcing are required for First Nations individuals in identified roles (Aboriginal Health Practitioners [AHP], Aboriginal Health Workers [AHW] and Aboriginal Liaison Officers [ALO]) across health services, including increasing role clarity to recognise cultural load and to redistribute colonial load to non-First Nations staff.
Domain: Education	
Insight 6: Consultations emphasised the need for improved health literacy among First Nations Community members to support health promotion, early intervention and prevention through informed health choices relative to context and opportunity.	Additional resources and education are required to enhance health literacy in First Nations communities. This includes increased information on the service options available, how to access different services and ways to access low/no-cost services where available.

Domain: Physical health	
Insight 7: First Nations Peoples in the Murray PHN catchment were more likely to have three or more long-term health conditions compared to the state and national rate.	The increased likelihood of multimorbidities in the catchment demonstrates the need for holistic, wraparound care.
Domain: Social and emotional wellbeing	
Insight 8: There continues to be a notable surge in mental health needs across the region, post-referendum and for young people.	Additional funding is required for holistic, Culturally Safe social and emotional wellbeing support, with a significant focus on youth.
Insight 9: There are limited support options available for First Nations People experiencing alcohol and other drug (AOD) and mental health concerns, particularly those who are Culturally Safe.	There is a critical need for comprehensive dual diagnosis approaches for First Nations Community, addressing AOD issues and mental health concerns along the continuum of care. Local withdrawal and rehabilitation services are essential for recovery.
Domain: Access to services	
Insight 10: First Nations Peoples present with acute and chronic health issues, which may have been avoided with preventative or early intervention support.	Funding is needed to support health prevention and early intervention activities.
Insight 11: Transport issues are impacting the ability of First Nations People to be able to access the services they need.	There is a need to ensure that First Nations People have access to affordable and Culturally Safe transport options and, where possible, support for people to travel in ways that reflect family and kinship structures.
Insight 12: Service costs are a barrier for First Nations People accessing healthcare.	There is a need for increased access to low/no cost services for First Nations People.
Insight 13: There are opportunities to further support First Nations People in ways that encourage them to engage by meeting them where they are.	Innovative outreach models are effective at providing Culturally Safe care that reduces barriers to access for First Nations Peoples.
Insight 14: There are extensive wait times across the region for allied health services, which is impacting First Nations Peoples' ability to receive holistic, wraparound care.	Supporting ACCHOs with infrastructure and to enable equity of access and fair competition in the allied health market will help in reducing wait times and improve access to multidisciplinary teams.

Insight 15: First Nations Elders and older people provide an integral contribution to the wellness and health of their communities. However, there is a misalignment with the support provided and available to them.	Elders and older people should have opportunities to access local Culturally Safe aged care, including residential, palliative and end-of-life care.
Insight 16: There is currently a gap in Culturally Safe services in the after hours period which is impacting First Nations Peoples' ability to receive timely and effective care.	First Nations People need to feel supported and safe when accessing services in the after hours period, including having Aboriginal staff available.
Insight 17: First Nations People experience racism and are not receiving Culturally Safe healthcare in mainstream health services.	Mainstream services must offer Culturally Safe and accessible services by: • identifying and addressing racism • deepening their cultural capabilities • embracing flexibility • strengthening collaboration. Services should be held to account for this by commissioning bodies.
Insight 18: Collaboration and service integration are important ways of ensuring that First Nations People receive appropriate care for a wide range of needs.	ACCHO and mainstream services should be encouraged and supported to collaborate, instead of competing against one another for funding.
Insight 19: The current funding is focused on outputs and targets, not providing flexible funding opportunities to allow service providers to deliver holistic care.	More long-term and flexible funding, focused on achieving positive outcomes, will enable service providers to provide more holistic care.
Insight 20: Place-based care should be prioritised to ensure connection to Community, culture and family.	There should be support for initiatives that are place-based and allow First Nations People to access care locally.
Domain: Workforce	
Insight 21: The catchment's rural nature, and the challenges of recruiting and retaining First Nations identified staff, are leading to an insufficient workforce to meet demand adequately. Alongside First Nations identified staff, GPs were highlighted as a particular need.	Increased recruitment and retention of GPs is needed to meet the demand across the catchment. Service providers also need additional support to attract and retain a First Nations local health workforce.
Insight 22: Traineeships in ACCHOs and the health system are effectively increasing the First Nations-identified health workforce.	ACCHOs and the health sector require support to sustain and expand traineeships, which includes actively promoting health career pathways to young members of the Community.

Summary of key recommendations

No.	Description	Relevant insights
1	**Ensure Community input in decision-making for commissioning, coordination and capacity building.** In recognition of the limitations of quantitative data in this area, qualitative data and community consultation need to be considered and included in decision-making processes.	3
2	**Pool PHN funding to enable place-based and collaborative responses.** Consider pooling funding from various PHN programs rather than commissioning smaller, program-specific services to allow ACCHOs the flexibility to address their community's needs. Ensure funding does not create provider competition by supporting collaboration or partnership between multiple service providers. Once commissioned, contract obligations could include simplified, outcomes-focused reporting requirements.	1, 4, 7, 13, 18, 20 and 22
3	**Address the rising demand for social and emotional wellbeing (SEWB) services.** Increase investment in services focused on holistic, integrated SEWB for First Nations Peoples, specifically youth.	8
4	**Increase access to services that respond to First Nations People with dual diagnosis through commissioning, coordination and capacity building activities.** Increase in Culturally Safe dual diagnosis service models to meet Community need.	9
5	**Build on existing national and state reform to co-design and implement localised First Nations workforce strategies.** A localised strategy will address the challenges of attracting and retaining an adequate and effective workforce. Co-design should involve multiple stakeholders and seek to define ways to: • attract GPs and allied health professionals • provide traineeship pathways for ALOs, AHPs and AHWs • define clear scope of designated First Nations roles.	2, 5, 17 and 21
6	**Invest in innovative outreach and community-based models.** Strengthen existing solutions and co-design models that provide preventative and early intervention focused primary care for First Nations communities with limited access or transport.	6, 7, 10, 11, 13, 14 and 20

No.	Description	Relevant insights
7	**Address service gaps through commissioning, coordination and capacity building activities.** Community and service provider feedback identified gaps in after hours primary healthcare services and aged care, particularly residential, palliative and end-of-life care.	8, 9, 15, 16 and 18
8	**Increase accountability, coordination and capacity building for mainstream services providing Culturally Safe services.** The lack of Cultural Safety and experiences of racism were highlighted as key barriers to First Nations Peoples accessing mainstream healthcare. Addressing these will require holding services accountable to anti-racism and Culturally Safe practice that goes beyond training and exercises that 'tick the box'.	17
9	**Ensure two-way data sharing with ACCHOs and relevant service providers for local and regional service planning.** Data sharing agreements based on principles of First Nations data sovereignty will help to overcome data gaps and limitations and provide greater understandings of health need and service gaps to inform collaborative planning. This will also reduce duplication and ease reporting burdens for ACCHOs.	3, 4 and 19

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Abbreviations

ABS	Australian Bureau of Statistics
ACCHO	Aboriginal Community Controlled Health Organisation
AHP	Aboriginal Health Practitioner
AHW	Aboriginal Health Worker
AIHW	Australian Institute of Health and Welfare
ALO	Aboriginal Liaison Officer
AOD	Alcohol and Other Drugs
ASR	Age-standardised rate
COPD	Chronic Obstructive Pulmonary Disease
CV	Central Victoria sub-region
ED	Emergency Department
ERP	Estimated Resident Population
FTE	Full time equivalent
GP	General Practitioner
GV	Goulburn Valley sub-region
IARE	Indigenous Area
LGA	Local Government Area
LMARG	Loddon Mallee Aboriginal Reference Group
MBS	Medicare Benefits Schedule
MMM	Monash Modified Model
NACCHO	National Aboriginal Community Controlled Health Organisation
NDIS	National Disability Insurance Scheme
NE	North East sub-region
NHSD	National Health Service Directory
NW	North West sub-region
PHIDU	Public Health Information Department Unit
PHN	Primary Health Network
PPH	Potentially Preventable Hospitalisations
RACH	Residential aged care home
RAP	Reconciliation Action Plan
RWAV	Rural Workforce Agency Victoria
SA	Statistical Area (for example, SA2)
SEIFA	Socio-economic Indexes for Areas
SEIFA IRSD	Socio-economic Indexes for Areas Index of Relative Socio-Disadvantage
SEWB	Social and Emotional Wellbeing
UCC	Rural Urgent Care Centre
VACCHO	Victorian Aboriginal Community Controlled Health Organisation Inc

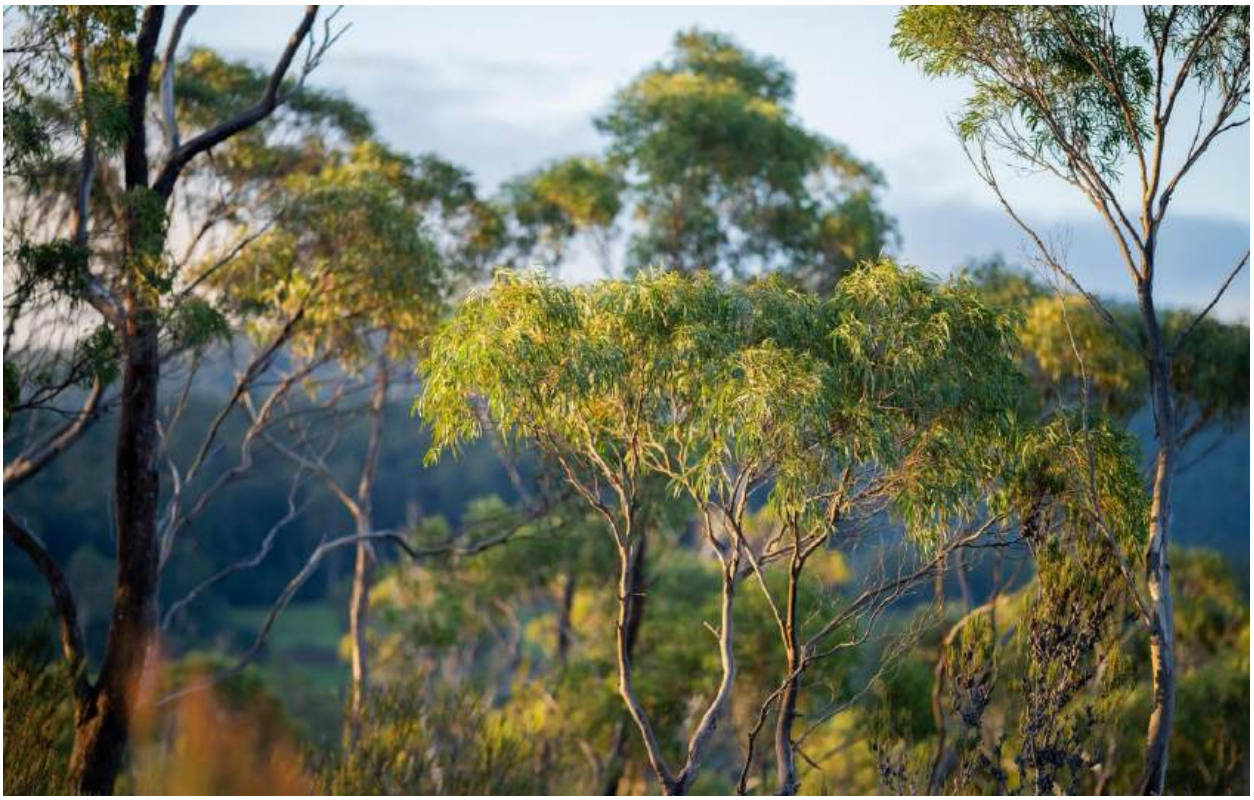
Section 1: Narrative

Background

Aboriginal and Torres Strait Islander Peoples, the First Nations Peoples in Australia, have culture and resilience grounded in millennia-old traditions, languages, and relationships to Land and Country. The First Nations holistic view of health encompasses physical, social, emotional and spiritual wellbeing, drawing from knowledge systems promoting harmony with nature and strong kinship bonds. However, historical and ongoing impacts of colonisation, dispossession and systemic racism have led to significant health disparities.

Interpersonal and systemic racism in the health sector has significant negative impacts on the health and wellbeing of First Nations Peoples. Published research provides clear evidence of these inequities through poorer access to community and hospital-based services. Racism is a major barrier for First Nations People to access health services and obtain equitable outcomes, and there are many instances of mortality that were directly caused by preventable discrimination, racism and institutional violence. The rejection of the Voice to Parliament referendum in 2023 further underscores the ongoing challenges in securing community and systemic support to address the holistic health needs of First Nations Peoples through self-determination.

Recognising these challenges, this report acknowledges the health needs of First Nations Peoples in the Murray PHN catchment while highlighting the inherent strengths and best practice exemplars. By understanding these needs and strengths, Culturally Safe healthcare approaches can be developed with Communities to achieve holistic health and wellbeing.



Murray PHN population overview

The Murray PHN catchment encompasses 100,406 square kilometres and 22 local government areas (LGAs) across northern Victoria and is home to 644,577 people (by PHN Catchment; ABS, 2022). The catchment crosses over many unceded First Nations Countries following the Murray River in the north and extending into Kulin Nation in the south. The catchment includes regional cities of Mildura (Latji Latji Country), Albury-Wodonga (Wiradjuri Country) and Bendigo (Dja Dja Wurrung Country). Given this scale, Murray PHN has divided the catchment into four sub-regions: North West (NW), Central Victoria (CV), Goulburn Valley (GV) and North East (NE).

Communities in this catchment are diverse, ranging from rural agricultural communities to rapidly growing rural centres, small rural communities, and major tourism destinations including the Alpine region and snowfields. The region is susceptible to severe weather and disaster events relating to climate change, including recent floods and bushfires.

In 2023, the population participated in the national referendum to establish a First Nations Voice to Parliament. Murray PHN supported the initiative, recognising the important role it could play in improving health outcomes for First Nations Peoples. However, the referendum did not pass. In the four electoral regions covered by the Murray PHN catchment, the majority of votes were against the proposal, with 29.7 per cent of the overall votes in the catchment in favour and 69.4 per cent opposed. This provides further context to Murray PHN's continued responsibility to listen deeply and to conduct anti-racism and Cultural Safety focused work with healthcare providers and systems with respect and reciprocity.

Role of Murray PHN in addressing First Nations health needs

Murray PHN plays a critical role in addressing the unique primary healthcare needs of First Nations Peoples in their catchment. Recognising the historical injustices and ongoing disparities faced by First Nations Communities, Murray PHN is dedicated to being an anti-racist organisation and actively confronting historical and ongoing colonisation.

Central to this approach is acknowledging the wisdom held by First Nations communities and respecting them as essential partners in shaping healthcare strategies that prioritise healing and empowerment. This commitment extends to influencing decisions across the healthcare system, including general practice, allied health, mental health and community health services.

Understanding First Nations' health and wellbeing is critical for Murray PHN and health stakeholders to address, heal and improve outcomes. The health of First Nations communities is often reported with a deficit discourse that privileges Western concepts and models of health. It narrowly situates responsibility for ill health and poor outcomes to the individual without recognising the impact of socioeconomic structures, policies and history. This results in homogenising First Nations communities across Australia and then comparing them to non-First Nations Peoples leading to inaccurate interpretations. To address this and present a strengths-based, culturally strong health and service needs analysis, this report uses 11 domains created by Pauline Nolan, First Nations Health and Healing Strategic Lead (Yorta Yorta) as an evidence-based framework.

First Nations focused health and service needs analysis

The First Nations health and service needs analysis was completed recognising the unique rights and experiences of First Nations Peoples, and the Culturally Safe and anti-racist approaches needed to improve primary healthcare access and outcomes, including self-determination approaches and models of care focused on social and emotional wellbeing, and a holistic definition of health and healing.

Population health data were retrieved from a range of sources for the quantitative descriptive and prioritisation analyses. A detailed list of the data indicators, definitions and sources that were analysed and presented in this report is in Section 6. Data sources were preferred if they had been released in the last five years, however most are from years 2018 to 2022 which is limited and does not capture the latest advancements and achievements in the ACCHO sector, which is a data gap addressed through qualitative data collection. The geographic filters used were PHN catchment, LGA and state (Victoria) as they are the most relevant to Murray PHN's planning and partnership work, and provide accurate representations of local and regional diversity.

This stakeholder consultation was conducted by First Nations identified consultants (First Nations Co.), and the analysis and reporting were guided by a strengths-based framework with 11 domains.

Stakeholder consultations with First Nations and non-First Nations Community members and service providers included:

Overall, 90 participants participated in the consultation process, with 64 (or 71%) identifying as Aboriginal and/or Torres Strait Islander Peoples. This group reflected the geographic spread of six organisations in the NW, nine in the CV, seven in the GV and eight in the NE.

See Section 6 for a detailed overview of the needs analysis process and a list of data sources

Section 2: Outcomes of health and service needs analysis

The outcomes of the health and service needs analysis are presented for each domain and with reference to relevant evidence. Strengths and best practice exemplars are included throughout presented as “Strong Solutions” (Pauline Nolan, Yorta Yorta). Gaps and limitations of the report are described in Section 6. For example, there were some domains with no outcomes that need further explanation and note that the domains are overlapping and interconnected, therefore some findings could relate equally to multiple domains.

The insights presented in this section have been generated primarily from the stakeholder consultations to prioritise the voices of First Nations Peoples, and to address data limitations (see **Insight 3**).

Domain: Autonomy, empowerment and recognition

Self-determination

No.	Insight	Implication	Heard from
1	ACCHOs are effectively providing self-determined and Culturally Safe healthcare for First Nations People.	ACCHOs need continued and increased autonomy and funding to support First Nations People to live happy, healthy lives.	First Nations voices

The consultations highlighted how ACCHOs are integral for delivering holistic healthcare for and with Communities aligned with First Nations ways of being and doing. Discussions provided examples of ACCHOs providing tailored, person-centred and Culturally Safe care, with participants noting that while the current healthcare system is ill-equipped to address the unique complexities of First Nations health, ACCHOs find ways to do this. This includes viewing individuals holistically, acknowledging and respecting First Nations ways of living and being in the world, and respecting individuals’ autonomy in determining their own needs, as aptly articulated by one First Nations participant from the Central Victoria sub-region.

"We trust that every family and person knows their own needs, and we encourage and support that.”

First Nations participant,
Central Victoria sub-region

One ACCHO provided an illustration of their approach, highlighting that GPs in mainstream services try to get patients in and out as quickly as possible. Whereas ACCHOs will take the time to understand the whole picture, even if that takes an hour, or a full day, and includes care coordination and referrals to additional services. Examples like this exemplify how the existing structure of the Medicare Benefits Schedule (MBS) does not support care for First Nations Peoples as in this particular instance, a full day of care could only be counted as one item.

Strong Solution. Loddon Mallee Aboriginal Reference Group

Following a rise in preventable hospital admissions for young First Nations People experiencing toothaches, Bendigo & District Aboriginal Co-operative sought a relationship with a dental hygiene company. They worked with the company to set up toothbrushing stations at a number of ACCHOs across the Murray PHN catchment and also worked with the AHP to be able to use fluoride varnish - a dental treatment that helps prevent tooth decay, slow it down, or stop it from getting worse.

This emphasises the ability of ACCHOs to make linkages between presentations and larger holistic issues, seeking to address them instead of solely treating the presenting issue.

A case study **(Case study 1)** illustrates the holistic nature of care for First Nations individuals. The example of an older client (over 50 years of age) highlights the extensive support required to address an individual's diverse needs, from obtaining identification documents to accessing medical specialists and psychosocial support services. Without this comprehensive and holistic assistance delivered by the service provider, the client faced significant challenges, particularly in accessing essential resources like food and housing.

Case study 1: Older First Nations individual

Support provided by one support worker:

- *Identification*: Assisted in obtaining ID documents
- *Medical visits*: Supported more than 30 medical visits including for dental, vision, mental health and general health support
- *Medical specialists*: Transported to rural centre multiple times for specialist care and treatment and to Melbourne for surgery
- *Regular and social support:* Supervision of daily medication, regular transport to food bank and weekly activity group, and emotional support
- *Financial assistance:* Provided financial support for general expenses, provided items of clothing, footwear and household goods and assisted with utility discounts and payments
- *Housing support:* Liaised with housing provider for housing issues, repairs and cleanup
- *Legal support:* Provided court support for family violence cases and assisted with a police report
- *Counselling and rehabilitation:* Offered drug and alcohol counselling, and arranged rehabilitation and withdrawal admissions.

While ACCHOs play a crucial role in providing holistic, self-determined healthcare, they experience many barriers in doing so. Instances was noted where ACCHOs are funded to provide outreach services to cover areas without a local service, but struggle to provide comprehensive services due to insufficient funding.

No.	Insight	Implication	Heard from
2	First Nations staff in mainstream services have an important role in supporting First Nations Peoples, particularly when access to ACCHOs is challenging.	First Nations staff in mainstream services are needed to support the provision of high-quality and Culturally Safe care across the health system and healthcare continuum.	First Nations voices Non-First Nations voices

Consultation participants highlighted that First Nations staff are required in all levels of mainstream health services (leadership, health practitioners, reception, cleaners) to ensure the provision of high-quality options across the system. First Nations staff in mainstream services were also key in enabling self-determined healthcare by providing choice and options across the continuum of care.

"The more First Nations staff you have, the more safe we will feel."

First Nations participant, Central Victoria sub-region

"Every Aboriginal person deserves the highest quality of care, and they should get it from no matter who they go to and who they access."

First Nations participant, North East sub-region

Consultations highlighted potential practical factors for which First Nations Peoples need to or choose to access mainstream services including:

- where there is no local ACCHO and the required service is not provided by the ACCHO
- where First Nations People have the means to travel and choose to access a service in another location, acknowledging that this comes with cost and Cultural Safety concerns
- where the waitlist at an ACCHO and it is more efficient to go elsewhere
- when privacy is a perceived concern.

Some ACCHOs also require evidence of Aboriginal and/or Torres Strait Islander identity for access to care, and some First Nations Peoples are unable or unwilling to provide this evidence because of historical and ongoing effects of colonisation, trauma and the experiences and outcomes of the Stolen Generations, and dispossession and dislocation.

There are many examples of First Nations identified professionals facilitating exemplary models in mainstream services. One hospital staff member exemplified the critical role of ALOs in emergency departments, which reduces the high percentage of First Nations individuals who were leaving the emergency department without care. ALOs explained the triage categories being used and supported First Nations People to wait. The presence of the ALO also helped to identify service and systemic issues that led patients to feel culturally unsafe, including when patients who reported complaints were encouraged to go home.

	Insight	Implications	Heard from
3	First Nations Community and service providers believe that the publicly available quantitative data doesn't accurately represent actual community needs, highlighting the implications of solely relying on quantitative data to make decisions.	Involvement and consultation is needed in decision-making, particularly those related to funding allocation and service design. Mainstream service providers would also value access to any data and information the PHN collects, which should be shared in ways that respect data sovereignty.	First Nations voices Non-First Nations voices

Relying solely on quantitative data overlooks the complexities of First Nations Peoples' health needs. There was a call to move beyond numbers and to integrate the voices of Community members and ACCHOs into decision-making and service-planning processes. The consultations highlighted the importance of qualitative information and First Nations Peoples voices to capture the rich tapestry of Community experiences and needs.

"The voice of the community needs to be included... This is probably the piece that isn't happening. The story behind the data is what we need to have, not just the data."

Non-First Nations participant, Goulburn Valley sub-region

The quality of the quantitative data for First Nations service provision can be inaccurate, thereby limiting its use in evidence-based decision-making. Consultations raised the failure of the data to account for factors such as boundary towns and transient populations. The data also doesn't account for some First Nations Peoples' ability or willingness to disclose their cultural identity, or situations where First Nations People may request a service and are refused or decline. For instance, emergency department (ED) presentation data, often used as a metric, provides incomplete data by excluding individuals who avoid hospitals due to safety concerns or leave after learning about extended wait times.

To mitigate this, mainstream service providers underscored the potential benefits of supplementing quantitative data with qualitative insights. They also suggested that it could be beneficial if local services or funding/governing bodies (e.g. the PHN) shared any additional data or information they collect to build greater understanding of the mix of services the community needs. For instance, a service provider suggested that accurate data from local public health units on vaccination coverage could facilitate them to do targeted promotions and address gaps in communities.

No.	Insight	Implication	Heard from
4	PHN reporting requirements are a significant and ongoing burden for First Nations services and programs, and are a deterrent in applying for additional, smaller funding opportunities.	Simplified and streamlined reporting requirements would support ACCHOs and other First Nations organisations in delivering effective health and wellbeing outcomes for Community members.	First Nations voices

ACCHOs across the catchment area are contending with the heavy burden of reporting requirements associated with PHN funding. They noted that the current funding allocation does not reflect or consider the necessary administrative staff to fulfil reporting requirements. There's a prevailing frustration among ACCHOs that while reporting requirements have increased, funding allocations have not kept pace.

One specific source of frustration is the uniformity of reporting requirements across grants, irrespective of funding amount. ACCHOs noted the unreasonable expectation for the same level of reporting across small grants (e.g. $10,000) to those much larger in size, ranging from $1-2 million. Consequently, some ACCHOs mentioned opting to forgo pursuing grants provided by the PHN of less than $50,000 due to the burdensome reporting.

In contrast, ACCHOs noted that funding sourced through other channels is simpler and more manageable. One ACCHO suggested that the PHN adopt a similar model to NACCHO funding requirements, which are perceived to be more reasonable and conducive to effective service delivery. Another spoke to a recent, more positive example where Murray PHN approached them to ask what the community needed for a particular health concern. The ACCHO was then able to design the service and provide verbal reporting and quarterly acquittals.

“Sometimes the funding is that poor, I don't even want it.”

First Nations participant
(region redacted)

Domain: Family and Community

Estimated population

In the 2021 Census, there were approximately 19,000 residents[1] in the Murray PHN catchment who identified as being of Aboriginal and/or Torres Strait Islander descent. Of the First Nations population living in the catchment, the majority (5,353 or 29%) resided in the Goulburn Valley sub-region. For LGAs, Greater Bendigo (C) had the highest population (15%) for the Murray PHN catchment, followed by Greater Shepparton (14%) and Mildura (14%).

Mildura (RC) and Swan Hill (RC) had the highest proportion of Aboriginal and Torres Strait Islander Peoples of the total LGA population, with 4.6 per cent and 4.5 per cent, respectively.

Table 1: Aboriginal and/or Torres Strait Islander Peoples population, by LGA with the highest proportion of the total population (%) (PHIDU, 2021)

LGA	No. of First Nations Peoples	% of First Nations population as a proportion of total population
Mildura (RC)	2621	4.6
Swan Hill (RC)	967	4.5
Greater Shepparton (C)	2686	3.9
Albury (C)	2126	3.8
Wodonga (C)	1479	3.4
Campaspe (S)	1169	3.0
Gannawarra (S)	268	2.5
Greater Bendigo (C)	2743	2.3
Loddon (S)	170	2.2
Mitchell (S)	1073	2.2
Moira (S)	647	2.1
Benalla (RC)	284	2.0
Wangaratta (RC)	559	1.9
Strathbogie (S)	207	1.8
Towong (S)	112	1.8
Murrindindi (S)	259	1.7
Indigo (S)	278	1.6
Buloke (S)	92	1.5
Mount Alexander (S)	267	1.3
Mansfield (S)	111	1.1
Alpine (S)	137	1.0
Macedon Ranges (S)	481	0.9
Catchment	**18736**	**2.3**
State	**78696**	**1.2**
National	**812728**	**3.2**

[1] The estimated First Nations population in the Murray PHN catchment has been calculated based on the total residing across the 22 LGAs reported in the ABS 2021 Census.

Age distribution

Similar to the national and state rate[2], the First Nations population in Murray PHN has a young age structure, with 77 per cent aged 44 years or less. This is illustrated in **Table 2** below.

Table 2: First Nations population by age group in Murray PHN (PHIDU, 2021)[3]

Age group	Murray PHN		State		National	
	No. of First Nations Peoples	% of total First Nations Peoples	No. of First Nations Peoples	% of total First Nations Peoples	No. of First Nations Peoples	% of total First Nations Peoples
0-4 years	2228	11.9	8819	11.2	85941	10.6
5-14 years	4542	24.3	17408	22.1	179610	22.1
15-24 years	3354	17.9	14554	18.5	150056	18.5
25-44 years	4297	22.9	20449	26.0	205886	25.3
45-64 years	3138	16.8	13153	16.7	143566	17.7
65+ years	1167	6.2	4313	5.5	47677	5.9

Table 3: First Nations population by age group by region (PHIDU, 2021)

Region	No. of First Nations Peoples	% of First Nations Peoples aged					
		0-4 years	5-14 years	15-24 years	25-44 years	45-64 years	65+ years
Central Victoria	4617	10.7	24.0	17.5	23.4	17.2	7.1
Goulburn Valley	5353	12.6	22.9	16.9	23.1	17.3	6.8
North East	5086	12.3	24.8	19.5	22.0	16.1	5.8
North West	3680	11.8	25.8	17.7	23.4	16.2	5.0
Catchment	**18736**	**11.9**	**24.2**	**17.9**	**22.9**	**16.8**	**6.2**
State	**78966**	**11.2**	**22.1**	**18.5**	**26.0**	**16.7**	**5.5**
National	**812728**	**10.6**	**22.1**	**18.5**	**25.3**	**17.7**	**5.9**

[2] AIHW. (2024). *Profile of First Nations people*. Retrieved from 19 April 2024 from: http://www.aihw.gov.au

[3] There are discrepancies in the data extracted in the total First Nations population overall (i.e. Table 1), and according to each age group (i.e. Table 2) for Murray PHN catchment and nationally.

Table 4: Aboriginal and/or Torres Strait Islander Peoples population (aged 45 - 64 years), by LGA with the highest proportion per population (%) (PHIDU, 2021)

LGA	No. of First Nations population (aged 45 -64 years)	% of First Nations population (aged 45 - 64 years)
Wodonga (C)	27	29.3
Buloke (S)	32	28.6
Towong (S)	31	27.9
Mansfield (S)	36	26.3
Alpine (S)	69	25.8
Mount Alexander (S)	63	24.3
Murrindindi (S)	45	21.7
Strathbogie (S)	134	20.7
Moira (S)	56	20.1
Indigo (S)	33	19.4
Loddon (S)	93	19.3
Macedon Ranges (S)	49	18.3
Gannawarra (S)	213	18.2
Campaspe (S)	100	17.9
Wangaratta (RC)	167	17.3
Swan Hill (RC)	47	16.5
Benalla (RC)	438	16.3
Greater Shepparton (C)	432	15.7
Greater Bendigo (C)	402	15.3
Mildura (RC)	310	14.6
Albury (C)	153	14.3
Mitchell (S)	208	14.1
Catchment	**3138**	**16.8**
State	**13153**	**16.7**
National	**143566**	**17.7**

Domain: Basic needs

Socio-economic status

The quantitative data on socio-economic status was explored. The key findings were:

- The IAREs of Swan Hill, Mildura, Albury, Castlemaine-Kerang, Campaspe - Shepparton - Moira, Wodonga and Bendigo have higher socioeconomic disadvantage than the state and other areas (see **Table 5**)
- The areas with the lowest IRSEO score (or highest socioeconomic status) were LGAs in the Upper Goulburn Valley including Benalla, Mansfield, Murrindindi, Strathbogie, and in Mitchell and the Macedon Ranges (PHIDU, 2021).

A key determinant of health is the social conditions in which people are born, live and work. A main component of this is the socioeconomic gradient in health status, which implies that people with higher incomes live longer and have better health in comparison to those with lower incomes. The socioeconomic gradient or position is also influenced by other characteristics such as level of education attained, employment status and occupation.

One method of assessing socioeconomic disadvantage across First Nations communities is via the Indigenous Relative Socioeconomic Outcomes Index (IRSEO). Using Census data, the IRSEO scores IAREs from 1 (most advantaged area) to 100 (most disadvantaged area).

On average, IAREs, collectively, across the Murray PHN had a IRSEO score that was higher the Victorian rate (36 vs 25). This may infer that First Nations communities in the Murray PHN catchment were more socioeconomic disadvantaged compared to the state. However, there was variation across the catchment.

Table 5: IRSEO ranked according to the IARE with the highest socioeconomic disadvantage (PHIDU, 2021)

IARE	LGAs	IRSEO Index
Swan Hill	Swan Hill (RC)	62
Mildura	Mildura (RC)	56
Albury	Albury (C)	54
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	47
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	43
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	32
Bendigo	Greater Bendigo (C)	28
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	22
Wallan - Seymour	Mitchell (S)	16
Macedon Ranges - Moorabool	Macedon Ranges (S)	5
Catchment		**36**
National		**41**
State		**25**

**Red shading indicates equal or higher than state benchmark*

Housing

The quantitative data on housing living conditions was explored to identify areas with people who might be at higher risk of homelessness. The key findings were:

- The Mildura IARE had the lowest proportion of Aboriginal and/or Torres Strait Islander Peoples living in appropriate sized housing at 83.3 per cent, which was higher than the state (inverse of crowded dwellings; PHIDU, 2021) (see **Table 6**). High rates were also observed in the Castlemaine - Kerang IARE (Buloke (S), Gannawarra (S), Loddon (S) and Mount Alexander (S)).

Crowded dwellings are defined by housing where the number of occupants exceed the capacity of a dwelling space available[4], resulting in the need for more bedrooms or floor area. People living in overcrowded dwellings are considered a marginal housing group that may be at risk of homelessness.[5]

Table 6: Percentage of Aboriginal and/or Torres Strait Islander Peoples living in appropriately sized housing (By IARE; Inverse of crowded housing, PHIDU, 2021)

IARE	LGAs	% Appropriately sized housing
Macedon Ranges - Moorabool	Macedon Ranges (S)	91.6
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	91.2
Bendigo	Greater Bendigo (C)	88.7
Albury	Albury (C)	88.7
Wallan - Seymour	Mitchell (S)	88.7
Upper Goulburn Valley	Murrindindi (S), Strathbogie (S), Benalla (RC), Mansfield (S)	88.0
Swan Hill	Swan Hill (RC)	86.9
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	86.6
Castlemaine - Kerang	Gannawarra (S), Loddon (S), Mount Alexander (S), Buloke (S)	85.4
Mildura	Mildura (RC)	83.3
Catchment		**88.0**
National		**82.8**
State		**89.6**

**Red shading indicates equal or lower than state benchmark*

[4] World Health Organisation (WHO). (2018). *WHO Housing and Health Guidelines*. WHO: Geneva.

[5] AIHW. (2022). *Australia's children: Overcrowding.*

Financial stress from mortgage or rent

Financial stress provides an indication of the ability to access health services, particularly primary care services where an out-of-pocket expense may be incurred.

The inverse of the percentage of Aboriginal and Torres Strait Islander Peoples low-income households under financial stress is presented to determine the number of households without financial stress. The majority of areas in the Murray PHN catchment were above the state comparison. Only the IARE of Bendigo had a rate lower than the state, indicating a higher percentage of households with financial stress.

Table 7: % of Aboriginal and Torres Strait Islander Peoples households without financial stress from mortgage or rent (By IARE; Inverse of low-income households under financial stress from mortgage or rent PHIDU, 2021)

IARE	LGAs	% Households without financial stress from mortgage or rent
Castlemaine - Kerang	Buloke (S), Gannawarra (S) Loddon (S), Mount Alexander (S)	79.3
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	74.2
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	71.4
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	71.0
Swan Hill	Swan Hill (RC)	68.2
Wallan - Seymour	Mitchell (S)	67.5
Macedon Ranges - Moorabool	Macedon Ranges (S)	66.5
Mildura	Mildura (RC)	66.1
Albury	Albury (C)	66.0
Bendigo	Greater Bendigo (C)	62.6
Catchment		**71.9**
National		**63.5**
State		**63.6**

**Red shading indicates equal or lower than state benchmark*

Domain: Work, roles and responsibilities

Paid work

No.	Insight	Implication	Heard from
5	First Nations Peoples in designated roles face challenges due to changing job boundaries, cultural duties, and in mainstream services, the expectation to take on colonial load.	Additional support and resourcing are required for First Nations individuals in identified roles (ALOs, AHPs, AHWs) across health services, including increasing role clarity to recognise cultural load and to redistribute colonial load to non-First Nations staff.	First Nations voices Non-First Nations voices

Consultations revealed that roles designated for First Nations individuals (ALOs, AHPs and AHWs) across the catchment carry substantial responsibilities. This burden is influenced by various factors, including the scope of practice of the roles, the cultural load inherent in these positions, and the expectation to lead efforts in building Cultural Safety in mainstream services (colonial load).

First Nations workforce - Scope of practice

Scope of practice contributes to the strain individuals face in these roles. Clear delineation of responsibilities is essential for effective communication and inclusion in relevant aspects of a First Nations client's care journey. A clarified scope, and shared understanding of this scope, would also support employed First Nations individuals in developing and building confidence in their tasks. A defined scope of practice could build on the existing accreditation standards and professional capabilities defined for AHWs and AHPs by the Australian Health Practitioner Regulation Agency.

This might involve the expansion of existing initiatives, like the Hume Health Partnership Project in the Goulburn Valley sub-region, which was highlighted as an exemplar where ALOs participate in a community of practice and provide each other with valuable peer support and guidance.

First Nations workforce - Cultural responsibilities

Participants spoke about the experience of individuals in ALO, AHP and AHW roles who are often on call 24/7 as they cannot switch off from supporting their communities.

Comprehensive support structures, such as First Nations-led mentoring and cultural supervision, are essential to support wellbeing. One hospital provided an example of supporting its ALO team by facilitating sessions with a Traditional Healer to help First Nations staff process their work with the Community. Consultations also mentioned that services must recognise and accommodate cultural requirements, such as Sorry Business and kinship roles, to support individuals effectively.

"It's much harder for them (ALOs) to call out racism. We have to prioritise their safety."

First Nations participant,
Central Victoria sub-region

First Nations workforce - Colonial load

Stakeholders also spoke to the common expectation that people in designated roles in mainstream services are often involved in assessing and building Cultural Safety in their organisations. Assessing an organisation's cultural capability can pose challenges for Aboriginal and Torres Strait Islander staff, mainly when providing honest feedback on internal racism and Cultural Safety issues. This expectation, to take on the colonial load, can contribute to role overload.

Employment

The quantitative data on employment rates was explored. The key findings were:

- The employment rate of Aboriginal and Torres Strait Islander Peoples in the Murray PHN catchment was the same as the state rate and slightly higher than the national rate (PHIDU, 2021)
- The lowest rates of employment that were below the state rate were in IAREs Campaspe - Shepparton – Moira, Castlemaine – Kerang, Albury, Mildura, and Swan Hill (PHIDU, 2021).

Table 8: % of Aboriginal and Torres Strait Islander Peoples employment (By IARE; Inverse of unemployment; PHIDU, 2021)

IARE	LGA Name	% Employment
Macedon Ranges - Moorabool	Macedon Ranges (S)	93.9
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S) Strathbogie (S)	91.7
Wallan - Seymour	Mitchell (S)	91.1
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC) Wodonga (C)	90.9
Bendigo	Greater Bendigo (C)	90.3
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	89.9
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	88.0
Albury	Albury (C)	87.6
Mildura	Mildura (RC)	85.1
Swan Hill	Swan Hill (RC)	84.3
Catchment		**89.8**
National		**87.7**
State		**90.4**

**Red shading indicates equal or lower than state benchmark*

Domain: Education

No.	Insight	Implication	Heard from
6	Consultations emphasised the need for improved health literacy among First Nations Community members to support self-determination through informed health choices.	Additional resources and education are required to enhance health literacy in First Nations communities. This includes increased information on the service options available, how to access different services, and ways to access low/no-cost services.	First Nations voices Non-First Nations voices

Consultations highlighted the pressing need to improve health literacy with First Nations communities. Health literacy refers to the knowledge and skills to make informed decisions and take action for optimal health and wellbeing.

"Go back to basics and do the preventative stuff, make sure we are educating people - it's not happening as much as it did before."

First Nations participant,
North East sub-region

Service providers and Community members noted a specific need to provide health literacy for young First Nations People, noting a drop-off in engagement with the healthcare system following primary school. They highlighted the need for more funding during this developmental stage.

"We want to get in while these people are young kids… It's where we will make the biggest change. There isn't that much money in early intervention."

First Nations participant,
Central Victoria sub-region

Participants in the consultations emphasised that health literacy isn't just about understanding medical information; it also involves knowing how to navigate healthcare services effectively and safely. ACCHOs highlighted several existing initiatives to build health literacy in their local populations.

Strong Solution 2: *Mungabareena Aboriginal Corporation*

Mungabareena Aboriginal Corporation highlighted a successful example of promoting health literacy. The service organised a two-day event focused on women's health. The first day involved a visit from the breast screening van to screen local women. On the second day, the service organised a GP to talk about general health. The service made the experience engaging and enjoyable by incorporating games, such as 'bra pong', into the educational activities. This approach provided valuable health information and helped overcome access barriers by adopting a community-centred approach.

Domain: Health and chronic conditions

No.	Insight	Implication	Heard from
7	First Nations Peoples in the Murray PHN catchment were more likely to have three or more long-term health conditions compared to the state and national rates.	The increased likelihood of multi-morbidities in the catchment supports consultation feedback on the critical need for holistic, wraparound care for First Nations Peoples.	N/A

For First Nations Peoples, chronic conditions are the leading cause of illness, disability and death is estimated to be responsible for 70 per cent of the health gap[6], which disproportionately impacts the population due to colonisation, systemic barriers to equitable healthcare and racism.

First 1000 days

An analysis of childhood immunisation data indicates that, on average across the Murray PHN catchment, Aboriginal and Torres Strait Islander children were fully immunised either above or at the same level as the state and national rates (PHIDU, 2021).

Self-assessed health

Table 9: ASR per 100 Aboriginal and/or Torres Strait Islander Peoples (aged 15 years and over) with fair or poor self-assessed health, by LGA with highest rate (PHIDU, 2018-19)

IARE	LGA Name	ASR per 100 Peoples (aged 15 years and over) with fair or poor self-assessed health
Mildura	Mildura (RC)	35.6
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	33.0
Bendigo	Greater Bendigo (C)	29.1
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	29.1
Macedon Ranges - Moorabool	Macedon Ranges (S)	29.1
Swan Hill	Swan Hill (RC)	29.1
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	29.1
Wallan - Seymour	Mitchell (S)	29.1
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC)	29.1

[6] AIHW. (2023). Aboriginal and Torres Strait Islander Health performance Framework. Tier 3 – Health System Performance. 3.05 Chronic disease management. Retrieved 4 January 2024 from http://www.aihw.gov.au

	Wodonga (C)	
Albury	Albury (C)	26.6
Catchment		**29.8**
National		**23.9**
State		**26.0**

*Red shading indicates equal or higher than state benchmark

Multimorbidity

People with a chronic condition are more likely to have multimorbidity where they experience or are managing two or more chronic conditions at the same time. According to AIHW, based on a 2017-18 self-report, one in five Australians had multimorbidity. It also increases with age, from 12 per cent for those aged 15-44 years old, to 51 per cent for those aged 65 years and over.[7] There is also evidence to suggest that there is higher prevalence of multimorbidity with Aboriginal and Torres Strait Islander Peoples compared to the total population.[8]

As **Insight 7** described, First Nations residents in the Murray PHN catchment were more likely to have three or more long-term health conditions compared to the national rate (5.5 vs. 4.0 per 100 people) (see **Table 10).** The rate of multimorbidity per 100 First Nations Peoples was highest within the Wodonga IARE at 6.6 per 100 people, followed by Mildura at 5.9. (see **Figure 1**). Similarly, First Nations children and youth (aged 0 - 14 years) were more likely to have multiple longer-term health conditions compared to the national rate (2.5 vs.1.3 per 100 people) (PHIDU, 2021) (see **Table 11**).

Table 11: ASR per 100 Aboriginal and/or Torres Strait Islander People (all ages) with three or more long term conditions (PHIDU, 2021)

IARE	LGA Name	ASR per 100 People that had three or more long-term health conditions
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	6.6
Mildura	Mildura (RC)	5.9
Bendigo	Greater Bendigo (C)	5.9
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	5.5
Albury	Albury (C)	5.3
Swan Hill	Swan Hill (RC)	5.3
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	5.1
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	5.0

[7] AIHW. (2021). *Chronic condition multimorbidity*. Retrieved 10 January 2024 from: http://www.aihw.gov.au

[8] Carman et al. (2022). Epidemiology of physical-mental multimorbidity and its impact among Aboriginal and Torres Strait Islander in Australia: a cross-sectional analysis of a nationally representative sample. BMJ Open, 12 (10)

Wallan - Seymour	Mitchell (S)	4.5
Macedon Ranges - Moorabool	Macedon Ranges (S)	3.6
Catchment		**5.5**
National		**4.0**
State		**4.8**

*Red shading indicates equal or higher than state benchmark

As illustrated in **Figure 1**, the rate of multi-morbidity (based on three or more long-term conditions) varied across the catchment from lowest (3.6 per 100 People) in Macedon Ranges to highest (6.6) for the LGAs within the Wodonga IARE.

Figure 1: ASR per 100 Aboriginal and/or Torres Strait Islander People that had three or more long-term health conditions across the Murray PHN by LGA (PHIDU, 2021)

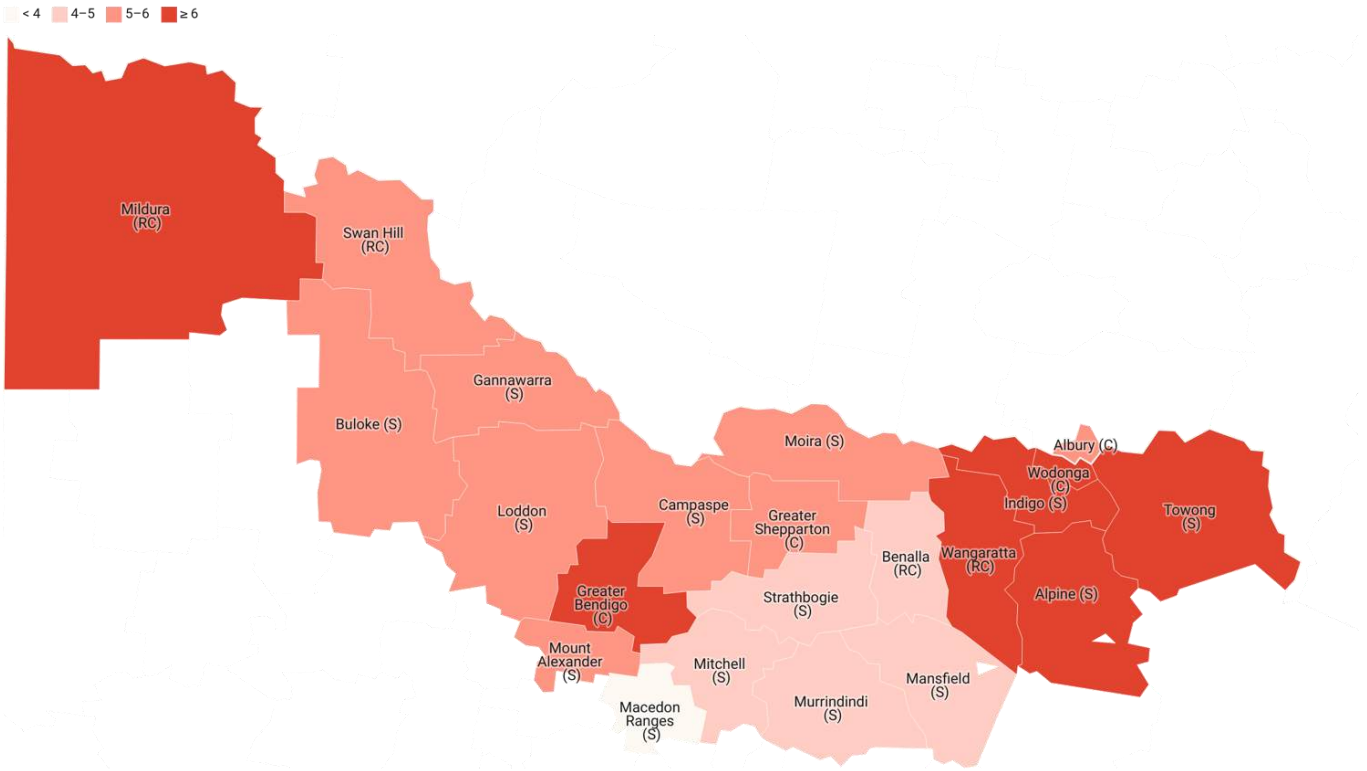


Table 11: ASR per 100 children and youth aged 0-14 years with two or more conditions (PHIDU, 2021)

IARE	LGAs	ASR per 100 Children aged 0-14 years with two long term health conditions
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	3.7
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	3.4
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	2.6
Bendigo	Greater Bendigo (C)	2.0
Mildura	Mildura (RC)	1.8
Swan Hill	Swan Hill (RC)	1.7
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	1.3
Macedon Ranges - Moorabool	Macedon Ranges (S)	1.1
Wallan - Seymour	Mitchell (S)	0.9
Albury	Albury (C)	0.7
Catchment		**2.5**
National		**1.3**
State		**1.8**

*Red shading indicates equal or higher than state benchmark

Chronic health conditions

The prevalence rate for the most common chronic health conditions is outlined in **Table 12.**

With the exception of cancer, dementia, kidney disease and stroke, the rate of chronic conditions reported by First Nations Peoples in the Murray PHN catchment was higher than the state rate. Specifically, arthritis and COPD had the highest difference from the state rate, with First Nations residents more likely to have the conditions.

Specifically, the LGAs within the Wodonga IARE (Alpine (S), Indigo (S), Towong (S), Wangaratta (RC) and Wodonga (C)) had the highest rates in the catchment for the greatest number of chronic conditions - asthma, cancer and COPD.

Data on 0-14 year age group was only available for asthma and mental health conditions, which shows that First Nations Peoples (aged 0-14 years) are more likely to have asthma compared to the state rate, with the highest rates also found in the LGAs within the Wodonga IARE (see **Table 13**).

Table 12: ASR per 100 Aboriginal and/or Torres Strait Islander Peoples, self-report of chronic conditions by IARE (PHIDU, 2021)

IARE	LGAs	Arthritis	Asthma	Cancer	Dementia	Diabetes	Heart disease	Kidney disease	Lung condition	Mental health condition	Stroke
Albury	Albury (C)	7.3	15.5	1.4	0.3	5.1	3.6	1.0	2.8	18.7	0.3
Bendigo	Greater Bendigo (C)	8.5	19.1	1.9	0.1	5.8	3.8	1.3	2.4	21.6	0.7
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	7.6	15.0	1.7	0.4	5.5	4.3	1.3	2.5	16.9	1.1
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	8.7	16.6	1.9	0.4	5.6	3.4	1.3	2.4	20.9	0.6
Macedon Ranges - Moorabool	Macedon Ranges (S)	7.1	15.9	1.4	0.0	4.1	4.4	0.9	1.7	15.7	0.7
Mildura	Mildura (RC)	7.1	16.3	1.4	0.3	7.6	3.7	1.1	2.7	17.1	1.4
Swan Hill	Swan Hill (RC)	9.5	19.5	0.5	0.8	6.7	5.1	1.2	2.3	15.5	0.4
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	7.9	15.3	1.0	0.9	3.3	2.9	0.7	2.5	15.7	1.0
Wallan - Seymour	Mitchell (S)	6.9	15.0	2.0	0.0	5.3	2.8	1.2	3.3	16.6	1.0
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	9.3	20.3	2.2	0.2	4.7	4.5	0.9	3.5	21.9	1.4
Catchment		**8.3**	**17.1**	**1.6**	**0.4**	**5.0**	**3.8**	**1.1**	**2.7**	**18.7**	**1.0**
National		**6.3**	**13.2**	**1.6**	**0.4**	**5.9**	**3.7**	**1.2**	**2.2**	**13.3**	**0.9**
State		**7.2**	**16.1**	**1.9**	**0.4**	**4.8**	**3.6**	**1.2**	**2.4**	**18.2**	**1.1**

**Red shading indicates equal or higher than state benchmark*

Table 13: ASR per 100 Aboriginal and/or Torres Strait Islander Youth aged 0-14 years, self-report of conditions by IARE (PHIDU, 2021)

IARE	LGA Name	Asthma	Mental health condition
Albury	Albury (C)	11.9	3.2
Bendigo	Greater Bendigo (C)	14.7	6.9
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	11.5	4.0
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	12.2	6.8
Macedon Ranges - Moorabool	Macedon Ranges (S)	9.7	4.8
Mildura	Mildura (RC)	12.1	4.7
Swan Hill	Swan Hill (RC)	13.6	5.7
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	10.2	5.6
Wallan - Seymour	Mitchell (S)	10.4	3.9
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	17.1	8.2
Catchment		**12.8**	**6.0**
National		**10.4**	**4.0**
State		**12.0**	**5.4**

**Red shading indicates equal or higher than state benchmark*

Disability

There is a higher proportion per population of Aboriginal and Torres Strait Islander People with a profound or severe disability in the Murray PHN catchment (10.8%) compared to the state (10%) and national (8.2%) populations, with the highest proportion of People in the IAREs of Bendigo and Wodonga (12.1%) (see **Table 14**).

Table 14: Proportion of Aboriginal and/or Torres Strait Islander People with a profound or severe disability by IARE (%) (PHIDU, 2021)

IARE	LGAs	% People with a profound or severe disability
Bendigo	Greater Bendigo (C)	12.1
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	12.1
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	11.6
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	10.5
Mildura	Mildura (RC)	10.4
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	10.0
Wallan - Seymour	Mitchell (S)	9.9
Macedon Ranges - Moorabool	Macedon Ranges (S)	9.7
Albury	Albury (C)	8.8
Swan Hill	Swan Hill (RC)	8.1
Catchment		**10.8**
National		**8.2**
State		**10.0**

**Red shading indicates equal or higher than state benchmark*

Domain: Social and emotional wellbeing

No.	Insight	Implication	Heard from
8	There continues to be a notable surge in mental health needs across the region, particularly post-referendum, with a significant demand for youth support.	Additional funding is required for holistic, Culturally Safe social and emotional wellbeing support, with a significant focus on support for young First Nations People.	First Nations voices Non-First Nations voices

From March 2019 - February 2024, more than 1300 First Nations Peoples accessed mental health services commissioned by Murray PHN, resulting in more than 14,000 service contacts. Most clients come from the Greater Bendigo area, with areas like Macedon Ranges and Mitchell seeing the highest number of contacts per client.

However, despite this effort, the consultations and quantitative data revealed a pressing need for more mental health support and the limitations of existing services throughout the catchment.

For example, participants emphasised that there are long wait times for services and not enough mental health workers to meet the demand. They stressed the importance of having psychological support that's not only clinically effective, but culturally appropriate for First Nations Peoples.

Publicly available data supports this pressing need for mental health support. The rate of mental health conditions reported for First Nations Peoples in the catchment is higher than the national rate (18.7 vs. 13.3 per 100 people). The difference is slightly higher in First Nations children and youth (aged 0 - 14 years) in the catchment (6.0 vs. 4.0).

Services emphasised that the need for mental health support in First Nations communities has increased following the Voice to Parliament Referendum in 2023. Explaining that the misinformation and racism present in the referendum debate has ongoing effects. Community members also spoke to the cumulative impact of Sorry Business, highlighting a growing need to help communities cope with the emotional toll. This means providing more services and ensuring existing services apply holistic social and emotional wellbeing approaches.

People mentioned that First Nations individuals often only seek mental health support when they're in severe distress or have complex ill health. This shows the importance of focusing on early intervention efforts. Shame and stigma around mental health issues can prevent First Nations People from seeking help, especially in smaller towns where everyone knows each other, and individuals may be reluctant to be seen walking into a mental health service. Existing services occasionally fail to meet expectations, as evidenced by instances where individuals in crisis are required to wait in ED or when limited opportunities exist for individuals to reconnect with their Country or Culture after discharge from acute mental healthcare. This is also seen when First Nations People are discharged from acute services with the expectation or assumption that their families will be able to provide ongoing support in the community, even when they are unequipped to do so. Consultations highlighted the need to support First Nations Peoples in accessing women's or men's healing retreats.

"Tribal and spiritual ways of doing and being, and awareness of mental health is different than the 'white' or westernised way, and this needs to be recognised. If there is a lack of spiritual or cultural awareness, it can lead to misdiagnosis of schizophrenia."

First Nations participant,
North West sub-region

Many service providers and Community members stressed the need for consistent and increased funding for youth mental health support. They've seen cases where funding is provided after a series of youth suicides, only to be taken away later. Mental health support for young First Nations People is another area where participants spoke to the fact that mainstream services aren't providing culturally appropriate care for First Nations Peoples (linked to **Insight 17**).

"No Aboriginal kids are going to headspace."

First Nations participant,
Central Victoria sub-region

No.	Insight	Implication	Heard from
9	There are limited support options available to support First Nations Peoples experiencing alcohol and other drug (AOD) and mental health concerns, particularly those that are culturally appropriate.	There is a critical need for comprehensive dual diagnosis approaches for First Nations Community members, addressing AOD issues and mental health concerns at all levels of care. Additionally, establishing local rehabilitation and detox clinics is essential to ensure adequate support for individuals in their recovery journey.	First Nations voices Non-First Nations voices

During the community consultations, in addition to the concerns about mental health services waitlists, there was a clear call for more comprehensive support for individuals using alcohol and other drugs.

Participants noted that many First Nations People facing these challenges also have mental health problems, stressing the importance of a holistic dual diagnosis approach to support First Nations Peoples.

For instance, they mentioned that policies, like the "three strikes and you're out" approach used in mainstream services, don't effectively support First Nations individuals and fail to acknowledge the co-occurrence of mental ill-health and AOD. Several consultations raised the scarcity of local rehabilitation and detox centres across the catchment.

One example shared by a stakeholder was the difference between a mainstream approach to supporting a First Nations individual to attend an AOD withdrawal program and an Aboriginal-supported model. In the mainstream model, individuals are given a train ticket for a clinic more than 100km away and told to arrive by 10am, causing significant stress and fear in the person

trying to access care. Conversely, in an Aboriginal-supported model, individuals might be picked up from home, given support, provided clothing and guided through the process, highlighting the importance of culturally sensitive care.

"We need rehabs that are culturally appropriate - out bush on Country…[where] *people can have access to cultural practices, all of that is therapeutic, learning how to weave for women or fishing for men."*

First Nations participant, North West sub-region

"The outcomes we achieve are amazing. We service over 4,000 active clients and have a very active SEWB team connected to the clinic, which is a really strong focus. We interconnect people. They may have a drug and alcohol issue, so we make sure referrals go through, and the inter-relationship happens really quickly. Holistic health model, come in for one touch point and access another."

First Nations participant, North East sub-region

These findings underscore the need for a more holistic and accessible approach to addressing AOD issues through First Nations-led models of care.

Quantitative data related to the prevalence of mental ill-health across all age groups was explored and the key findings were:

- First Nations Peoples in the Murray PHN catchment were more likely to report a mental health condition compared to the national rate. At 20.2 per 100 people, the highest rate of mental health conditions was reported in Central Victoria (PHIDU, 2021).

Refer to Tables 12 and 13 in previous section for rates of self-reported mental health conditions in all ages and 0-14 years age groups.

Domain: Access to services

No.	Insight	Implication	Heard from
10	There continues to be a trend of First Nations individuals presenting with acute and chronic health issues, which may have been avoided with preventative or early intervention support.	Continuous and adequate funding is needed to support health prevention and early intervention activities.	First Nations voices Non-First Nations voices

The consultations highlighted that many First Nations individuals seek care for preventable acute health issues, noting a clear need for increased engagement with the healthcare system that promotes prevention and early intervention activities across all stages of life. Participants stressed the importance of maintaining consistent engagement from early childhood through adulthood, emphasising the significance of holistic, lifelong care and fostering health-promoting behaviours.

"Cancer diagnosis and other chronic health conditions are only getting diagnosed in really late stages of life."

First Nations participant, Central Victoria sub-region

Several factors contribute to this issue, including competing priorities, other life pressures that may deter First Nations individuals from seeking timely healthcare, and a lack of funding that targets health promotion activities, resulting in low levels of health literacy. Participants stressed the need for increased funding for preventative and early intervention support, noting that investing in these areas can lead to significant cost savings for the government by reducing hospitalisations for acute and chronic conditions. In addition, consultations highlighted frustration over the inconsistent provision of annual Aboriginal and Torres Strait Islander Peoples' health checks across the catchment, which are crucial for preventative care. This was emphasised in the consultations,

"in our town, we get visiting doctors who come to Australia and do their placement, so they are unaware of it [the Closing the Gap scheme]. We are constantly having to advocate for this"

First Nations participant, Central Victoria sub-region

"When a community person doesn't go through an ACCHO and instead uses a GP that isn't aware of Closing the Gap and chronic care plans, this regularly brings challenges because it means that the doctors or the people treating them doesn't know what they are doing, which can cause a barrier to the healthcare they are receiving."

First Nations participant, Central Victoria sub-region

The finding that First Nations Peoples are presenting with acute health issues is supported by quantitative data indicating a high rate of potentially preventable hospitalisations (PPHs) and non-urgent ED presentations among First Nations individuals, which is further described in the next section.

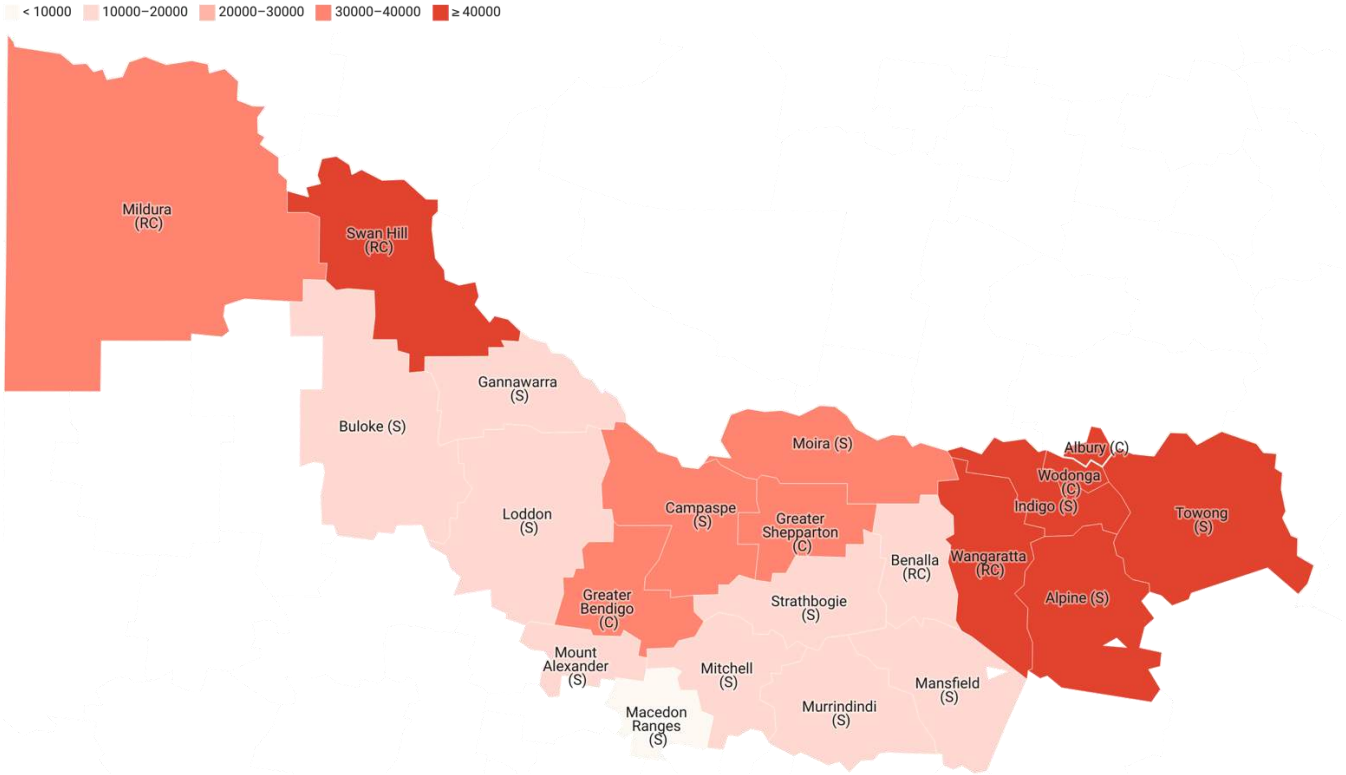
Non-urgent ED presentations

Rates of semi-urgent and non-urgent ED presentations (*see Glossary*) can provide an indication of the extent to which they could have been better managed in the community, noting that data on GP-type ED presentations is not publicly available.

Although the average age-standardised rate (ASR) of semi-urgent and non-urgent ED presentations per 100,000 First Nations Peoples in the catchment was lower than the national rate (30,351 vs. 34,005), it was higher than the state rate (26,056). In some LGAs, such as Albury (C) and LGAs within the Wodonga IARE, the rate of semi-urgent and non-urgent ED presentations in First Nations Peoples was more than two times that of the state[9].

This variation across the catchment is illustrated in **Figure 2.**

Figure 2: ASR of semi-urgent and non-urgent ED presentations per 100,000 First Nations Peoples across the Murray PHN catchment (PHIDU, 2019-20)



[9] It is worth noting that data captured on semi-urgent and non-urgent ED presentations occurred in the same time period as the onset of the COVID pandemic and the subsequent restrictions imposed in Victoria. This may have impacted the likelihood of First Nations Peoples accessing care from EDs.

Potentially preventable hospitalisations

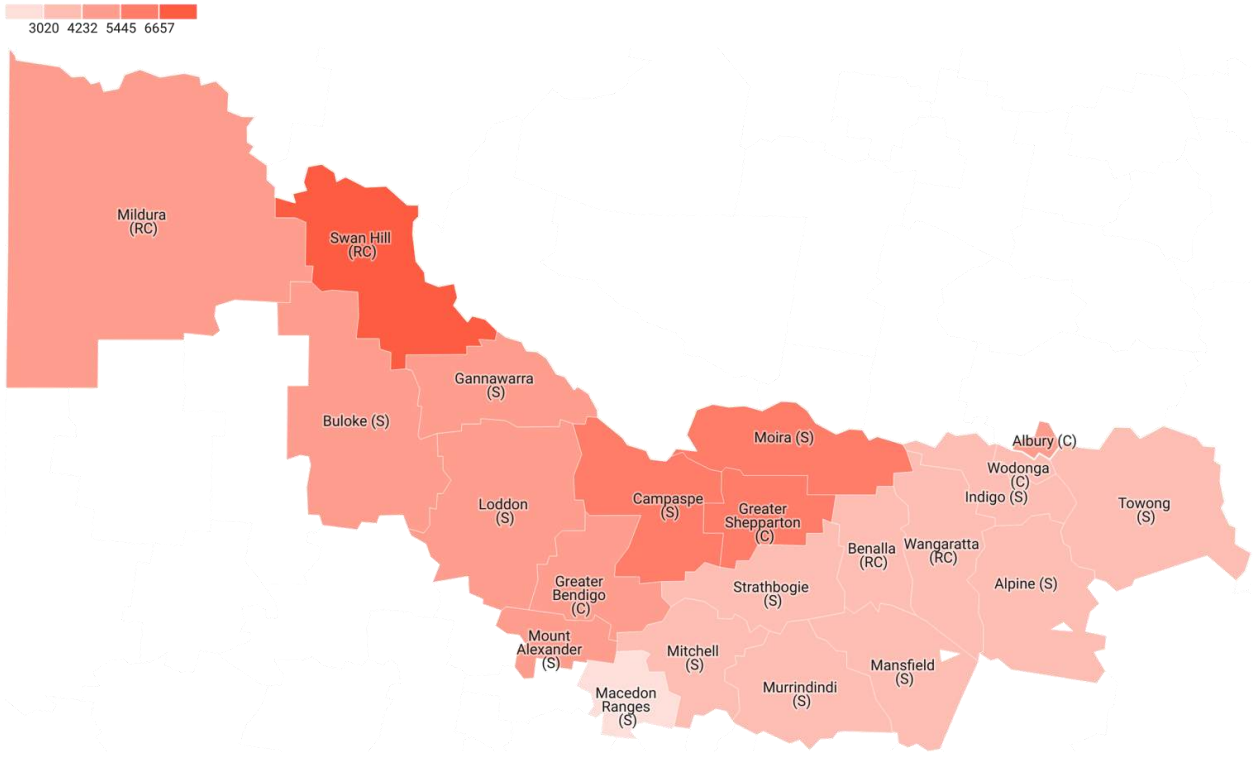
As illustrated in **Table 15,** although First Nations Peoples in Murray PHN had rates of PPHs lower than the First Nations national rate, they were significantly higher than the total population. For all PPHs, the First Nations catchment rate was double the total catchment population rate, increasing to almost three times higher within the 25 – 44-year age group.

Table 15: Average annual rate of PPHs (all conditions) (PHIDU, 2017/18 - 2019/20)

		Avg annual ASR potentially preventable hospital admissions (all conditions) per 100,000 people					
		All	Aged 0 -14 years	Aged 15 – 24 years	Aged 25 – 44 years	Aged 45 – 64 years	Aged 65+ years
First Nations	Catchment	4432.0	2671.1	2223.8	4069.8	6496.3	19967.2
	State	4558.9	2458.8	2618.3	3964.0	8063.6	17555.9
	National	5619.0	3251.3	2665.6	5146.3	10918.5	17735.3
% of difference between catchment vs. state		**-2.8%**	**8.6%**	**-15.1%**	**2.7%**	**-19.4%**	**13.7%**
Total population	Catchment	2852.3	1345.3	1410.5	1630.2	2277.0	7256.2
	State	2162.5	1189.8	1034.7	1171.9	2057.5	6070.5
	National	2205.1	1402.2	1080.7	1154.5	2038.1	6114.7
% of difference between First Nations catchment vs. total catchment population		**55.4%**	**98.5%**	**57.7%**	**149.7%**	**185.3%**	**175.2%**

Figure 3 illustrates the variation across the catchment in the rate of PPHs, with the highest rates found in Swan Hill (RC), Greater Shepparton (C), Moira (S), and Campaspe (S).

Figure 3: Average annual rate of PPHs per 100,000 First Nations Peoples across the Murray PHN catchment (PHIDU, 2017/18 - 2019/20)



For chronic PPHs, specifically, the First Nations catchment average rate was slightly above the First Nations national rate and double the total population ("mainstream") national rate. This also varied across the Murray PHN catchment, with the highest rates also found in Swan Hill (RC), Greater Shepparton (C), Moira (S) and Campaspe (S).

With the exception of chronic congestive heart failure and COPD, the First Nations catchment average was higher than the First Nations national rate across all the different chronic PPH types (refer to **Table 16**).

Table 16: Average annual rate of chronic PPHs by type (PHIDU, 2017/18 - 2019/20)

		Avg annual ASR of chronic PPHs per 100,000 people						
		All chronic PPHs	Chronic angina	Chronic asthma	Chronic congestive heart failure	COPD	Chronic diabetes complications	Chronic iron deficiency anemia
First Nations	**Catchment**	2209.6	219.2	254.6	210.2	636.8	478.2	501.5
	State	2142.5	147.8	243.4	164.6	583.3	512.2	435.3
	National	2188.8	162.2	228.4	251.3	650.5	469.9	225.3
% of difference between catchment vs. state		**3.1%**	**48.3%**	**4.6%**	**27.7%**	**9.2%**	**-6.6%**	**15.2%**
Total population	**Catchment**	1421.8	116.4	107.3	228.1	325.6	209.0	381.8
	State	1141.0	73.1	104.1	196.5	208.2	215.2	278.3
	National	1036.7	78.0	103.3	194.0	240.5	182.4	167.2
% of difference between First Nations catchment vs Total catchment population		**55.4%**	**88.3%**	**137.3%**	**-7.8%**	**95.6%**	**128.8%**	**31.4%**

These insights are further supported by data indicating that First Nations Peoples in the catchment area are more likely to have three or more long-term health conditions than the First Nations national rate (8.0 vs. 5.9 per 100 First Nations Peoples). This rate was almost three times the mainstream national rate (3.0 per 100 people).

Additionally, First Nations Peoples in the catchment area have higher rates of various health conditions (arthritis, asthma, cancer, heart disease, COPD, mental health and stroke) compared to the national rate, underscoring the pressing need for targeted preventative measures and early intervention initiatives.

Despite these challenges, many ACCHOs have implemented effective strategies to promote preventative and early intervention care, such as health promotion events and community health days (as previously described in **Insight 6**).

No.	Insight	Implication	Heard from
11	Transport issues are impacting the ability of First Nations Peoples to be able to access the services they need.	There is a need to ensure that First Nations People have access to affordable and Culturally Safe transport options and, where possible, support for First Nations People to travel in ways that reflect family and kinship structures.	First Nations People Non-First Nations People

Transport issues, including those related to availability, cost and rurality, and the cost of accessing services were some of the biggest challenges and barriers to service access raised in consultations across the catchment.

Participants, both service providers and Community members, highlighted that transport is an ongoing issue. According to participants, there are very limited transport options between smaller communities or towns on the outskirts and the ACCHOs. At the same time, ACCHOs highlighted that they are currently not funded enough to provide transport for communities where they are based further away, despite being considered in the same region. With minimal access to transport or funding for transport, First Nations People often will not access essential services because they cannot afford to do so.

"We currently have four workers who are trying to provide transport for over 300 people."

First Nations participant, North West sub-region

Transport for specialist services or services not offered in the region is also a concern, with many service providers highlighting that it is difficult, due to staffing and resourcing, to support First Nations People when they are required to travel elsewhere to receive medical care. One service provider highlighted that if First Nations People from their community need to go to Melbourne for care, 20 to 30 people will visit them in the hospital before they make the journey. This is a result of fear, which is held by many First Nations People that if someone needs to leave to access care, there is a chance that they may die and not be able to return, so they need to say their 'goodbyes' before they go. As a result, they will often see First Nations People refusing to travel, even if they are doing so to receive life-saving care because they are afraid of not returning or dying away from their family and Community.

"Blackfella way is having the whole tribe there - especially if someone is passing, but there's not much consideration of culture or the ways that these things work [when funding transport and out-of-country travel]."

First Nations participant, North East sub-region

As such, when First Nations People are required to travel, it was emphasised that the current system does not support them or consider cultural needs and ways of being. There is often limited funding or support for the patient to travel, let alone support or recognition of kinship structures and family dynamics - often leaving First Nations People isolated from their families and support systems to receive the care they need.

Another service provider highlighted that they cannot offer patient transport to Melbourne, but instead provide telehealth options so people can connect with specialist services locally. However, it was highlighted that telehealth and other digital health options are not always an appropriate way of addressing transport issues, noting that the clients they are supporting experience higher levels of disadvantage.

"We are getting more and more clients, and highly disadvantaged clients, as a lot of them don't have vehicles."

Non-First Nations participant, North East sub-region

No.	Insight	Implication	Heard From
12	Service costs are a barrier for First Nations Peoples accessing healthcare.	There is a need for increased access to low and no-cost health services for First Nations Peoples.	First Nations voices Non-First Nations voices

Consultation participants consistently highlighted service costs as a barrier to accessing healthcare for First Nations Peoples. This issue was raised in relation to Community members and families accessing mainstream general services, where bulk billing services are limited across the catchment.

Participants noted that many mainstream services are not aware of, or use, the Closing the Gap programs and interventions to completely subsidise or provide co-payments for First Nations healthcare. One First Nations participant from the North West sub-region put it plainly, *"There's no Closing the Gap with the mainstream services".* Specifically, in areas without a local ACCHO, consultation participants highlighted that there are low numbers of 715 health checks provided.

Participants also raised service costs as a barrier to follow-up or specialist care, noting that providing referrals to specialists who First Nations individuals will not be able to afford to see is not providing adequate care pathways for people.

No.	Insight	Implication	Heard From
13	There are opportunities to further support First Nations People in ways that encourage them to engage by meeting them where they are.	Innovative models, such as outreach models, are effective at providing Culturally Safe care that reduces barriers to access for First Nations Peoples.	First Nations People Non-First Nations People

Outreach models were highlighted throughout the consultation process as an innovative way to meet First Nations Peoples in ways that encourage and support them to access services, and receive adequate healthcare on their terms.

Strong Solution 3: *Mobile outreach van*

One ACCHO uses a medical van to visit different areas in their region and park in places where First Nations People feel safe and comfortable accessing services. They highlighted that by having an outreach van integrated in a local space, it has enabled it to become more socialised in the community. While some First Nations People stop by to have a quick yarn and socialise, others use the van to receive medical attention by the nurse, doctor or dietician. Since using the van, the ACCHO has noticed, anecdotally, that people feel safer and more comfortable, evidenced by their bringing along family and other Community members to access the service.

The ACCHO identified that this model has been effective for a number of reasons, including:

- they make sure that they park the van somewhere where First Nations People feel safe and comfortable to access the service
- First Nations People feel like they are being listened to when they attend the service
- the people working in the van have the expertise to meet the needs of the community e.g. drug and alcohol worker, nurse, doctor and dietician
- the van is perceived by the community as reliable, and people know that they can go there when it is in town to get the support they need
- Community members are champions of the van and support others to access it, building connection and a sense of community.

During the consultations, other service providers also highlighted the importance of outreach services as providing safe and accessible ways for First Nations People to access and learn about health. One service provider highlighted that they recently held a cultural day and organised for a breast screening outreach service to come along to talk to the people attending. Of the 10 Community members who participated in the cultural day, eight had never had a breast screen before, which highlighted the value of sharing or promoting health on cultural days to draw First Nations People in. As highlighted previously (see **Insight 6**), often these strong solutions work because they take an opportunistic approach to health; they meet First Nations Peoples in places where they are already going and engage them in ways that are gentle, appropriate and provide choice and control.

No.	Insight	Implication	Heard from
14	There are extensive wait times across the region for allied health services, which is impacting First Nations Peoples' ability to receive holistic, wraparound care.	Supporting ACCHOs with infrastructure and to enable equity of access and fair competition in the allied health market will help in reducing wait times.	First Nations People Non-First Nations People

Access to specialist and allied health services was highlighted as impacting First Nations Peoples' ability to receive the healthcare needed across the catchment. In particular, service providers underscored that there are currently extensive waitlists to access allied health services such as: mental health/psychology, AOD services, podiatry, occupational therapy and speech pathology.

While waitlists are more than 12 months long in some cases, most participants indicated that they generally need to wait a few months for allied health support, which impacts the ability of ACCHOs and other service providers to support First Nations People while they wait for these services.

"We're at a point now in our Home Care Packages where I can't find an occupational therapist to get a shower rail assessment."

Non-First Nations participant,
Goulburn Valley sub-region

There were two key reasons for the allied health waitlist:

1. **Lack of infrastructure**

One ACCHO highlighted that, despite the waitlists, it has eight allied health providers waiting to provide services to its patients. The ACCHO highlighted that if it had the infrastructure to provide a space for these services to operate out of, it would allow First Nations People to receive care while ensuring they are doing so in a way that is also culturally appropriate and easily accessible.

"We need money, and we need infrastructure. We know what we need to do, and we know what we need to provide for our community, but we need the money and the infrastructure to do it."

First Nations participant,
Goulburn Valley sub-region

2. **Maintaining the allied health workforce despite market competition**

Another ACCHO highlighted that they cannot pay the allied health practitioners a rate that is competitive with the rates the NDIS can pay, which is impacting their ability to retain their working relationships with these practitioners.

During stakeholder consultations an example was provided of an allied health organisation that provides fly-in and fly-out services for rural and remote areas of Australia which was significantly more expensive than employing professionals locally due to high private rates and travel costs. This also makes it challenging to recruit allied health professionals when salaries are higher in private markets.

"The bottom line is we are losing all of our allied health to NDIS, and unless we do something, we are going to lose everything. The waitlists out of here are too big, and things are too expensive. We can't keep up."

Non-First Nations participant,
Central Victoria sub-region

No.	Insight	Implication	Heard from
15	First Nations Elders and older people provide an integral contribution to the wellness and health of their communities. However, there is a misalignment with the support provided and available to them.	Elders and older First Nations People should have opportunities to access Culturally Safe aged care, including residential, palliative and end-of-life care.	First Nations People Non-First Nations People

It was highlighted, predominantly by First Nations Peoples, that there is limited culturally appropriate aged care, specifically residential-based aged care, throughout the catchment. Despite the catchment having a higher than average proportion of the population aged 65+ years (refer to **Appendix B** for more detail), some ACCHOs highlighted that there are minimal identified Aboriginal beds in aged care facilities, which often means that if First Nations People want to use these, they have to leave their Community to receive care. Similarly, the same ACCHO also highlighted that aged care facilities often have their own residential GP who visits and attends to the residents; however, it is difficult to ensure that the services they provide are Culturally Safe and appropriate for the First Nations People receiving care.

"They have to go to [the bigger town] to get an Aboriginal bed in an aged care facility… But if they have to travel, then people also won't be able to visit them."

Non-First Nations participant,
Central Victoria sub-region

Similarly, there was discussion about the impact that Elders have on everyone around them and the care and support they provide for others that is not always returned to them when they reach the later stages of life.

"A lot of the Elders are caring for their children and grandchildren, but then have no one there advocating or supporting them."

First Nations participant,
North West sub-region

"We have a lot of Elders who are living in their house, experiencing high levels of Elder abuse, and everyone's living with them. We need aged care where they can look after themselves but they're safe and got their community."

First Nations participant,
North West sub-region

For example, there were stories shared of Elder abuse and older First Nations Peoples who are living in precarious living situations and need to be able to access services where they will be safe, supported and surrounded by Community. As such, these spaces must encourage autonomy and choice, letting First Nations People take care of themselves where they can but do so in a way that reflects Community and allows them to continue to thrive.

No.	Insight	Implication	Heard from
16	There is currently a gap in services, especially culturally appropriate services, in the after hours period, which is impacting First Nations Peoples' ability to receive timely and appropriate healthcare.	First Nations People need to feel supported and safe when accessing services in the after hours period, including having Aboriginal staff available when after hours care is sought and received.	First Nations People Non-First Nations People

Throughout the catchment, service providers emphasised that there is currently a lack of Culturally Safe service options for First Nations People to access in the after hours period. In most regions, the only options in the after hours period are attending EDs or an urgent care clinic (UCC). This is supported by the National Health Service Directory (NHSD), which currently does not identify any Aboriginal health services available during the after hours period. This is a concern as many participants highlighted that there is an apprehension from Community in attending these services due to barriers around cost (not knowing if they will be charged to attend a UCC as this often varies), safety (see **Insight 17**), and the appropriateness of these services in meeting the needs of First Nations People. The lack of after hours services could be contributing to rates of PPHs in the catchment.

In some instances, service providers highlighted that, as a result, AHWs in the Community attend to these First Nations People in the after hours period. Despite this being beyond their 'working responsibility', many of the AHWs we spoke to saw this more as a cultural responsibility (refer to **Insight 5)**. Providing an opportunity for AHLOs and AHWs in the mainstream system to extend their working hours to cover the after hours period may decrease the unpaid cultural load, and at the same time also provide more Culturally Safe services during this after hours period.

"I work 24/7 for community. I will always have my phone on and go and visit people if necessary or be their 'family' if they need me to be or they don't have other people there to do so... My first role here is community. I am a community member first, and an employee second. Community should always be a priority, and this is the way I have always worked."

First Nations participant,
Central Victoria sub-region

Several ACCHOs indicated that funding services to have an after hours clinic, even if this is only open one or two nights a week or for some time over the weekend, would allow them to attend to the families who cannot attend clinics during the regular staffed hours. One ACCHO emphasised that although this area needs significant funding, it was *"extremely necessary".* They emphasised that *"Monday mornings are our busiest time of the week because we are catching up on everyone that needed services on the weekend and couldn't get them"* (Non-First Nations Voice, North East sub-region). However, for ACCHOs to deliver after hours care, this would require resources to cover the additional cost of staffing with penalty rates, increased insurance and security, etc.

Culturally Safe care

No.	Insight	Implication	Heard from
17	First Nations People experience racism and are not receiving Culturally Safe healthcare in mainstream health services.	Mainstream services must offer Culturally Safe and accessible services by: • identifying and addressing racism • deepening their cultural capabilities • embracing flexibility • strengthening collaboration. They should be held to account for this by commissioning bodies.	First Nations People Non-First Nations People

It was emphasised in our consultations that the most significant barrier for First Nations People in accessing healthcare is the lack of Cultural Safety when using mainstream health services. Two critical reasons for low Cultural Safety were highlighted in consultations:

1. Racism

Many consultation participants talked about racism as a crucial barrier to accessing healthcare, noting it had become worse following the 2023 referendum.

One First Nations person highlighted that *"it feels like we have gone back 10-15 years following the referendum,"* and, as a result, *"it feels like there has been an increase of racism in the community".* There was a similar sentiment across the catchment, with another non-First Nations participant highlighting that *"systemic racism across the public health system is rife, and we hear about it on a daily basis. Regardless of whether our patients access mental health, community health, or the hospital, whether deliberate or not, it's how it's felt".*

According to participants, racism includes deliberate racism and unconscious bias. It was highlighted that bias plays a significant role in the care that First Nations People receive, with one First Nations person highlighting that *"services need to address their own cultural biases and their underlying racism that is impacting their ability to treat people in an unbiased way".*

Consultations provided examples of bias playing out in several ways, including:

- not prioritising First Nations People if, or when, they present to ED and instead making them wait for more extended periods than non-First Nations People that are presenting, despite their health needs appearing of similar or higher urgency
- mainstream services preconceived ideas of why First Nations People are presenting (e.g. to get access to medications) and use this as a reason to dismiss or not assess them properly.

One participant shared a personal story of a family member who was turned away from receiving healthcare as they dismissed them as wanting 'drugs', with the person later dying from

a condition that would have been detected had the service conducted a proper assessment. One First Nations person importantly highlighted that:

"Racism is impacting people at a life and death level. If we don't have this [bigger] *shift, if we just have these RAPs and cultural safety, then in 10-20 years, we'll be in even worse situations."*

First Nations participant,
Central Victoria sub-region

2. A lack of understanding of Cultural Safety and how it can be maintained

In response to racism and to meet required standards, mainstream health services undertake Cultural Safety training and activities. Participants highlighted that these activities often feel more like a 'tick box' exercise, rather than an actual understanding of what it means to be Culturally Safe and how it can, and should be, implemented and upheld.

As one First Nations person emphasised, *"*[I] *notice that often the words, cultural safety, are used but then that's it. Words are used and put on a shelf", highlighting that there is a "real misunderstanding and lack of understanding of what cultural safety actually is".* When services do not respect traditions, beliefs and First Nations culture, it, in turn, makes First Nations People feel unsafe and deters them from wanting to access services. Cultural Safety involves a genuine and ongoing commitment from service providers. As one First Nations person highlighted*, "you don't learn about culture in a two-day workshop".*

Interestingly, there was a distinction between non-First Nations service providers and First Nations providers in their approach to Cultural Safety.

While most non-First Nations organisations cited that they do Cultural Safety training or 'Asking the Question: Improving the Identification of Aboriginal People' training through Health Education and Training, many First Nations organisations highlighted that these standard 'tick box' training exercises are not enough. They underscored that mainstream services need to be doing *"truth-telling action plans"* because their *"Cultural Safety plans are not deep"*, which is *"doing more harm than good".* In addition to anti-racism training, one person highlighted that mainstream services need to have monthly access to debriefing and shared learning sessions, as well as embedding individual and collective accountability measures.

To address these challenges, consultation participants highlighted the role that Murray PHN and other commissioning bodies can play in ensuring accountability of anti-racism and Cultural Safety practice.

In particular, consultation participants suggested two ways that commissioning bodies can adopt a greater role in holding services to account:

1. Providing direction in funding agreements and contracts as to the Cultural Safety activities required by mainstream services, and ensuring these go beyond one-off training and 'tick the box' exercises.

   As one provider highlighted, *"If Murray PHN told services, you need to be doing X, Y, Z and it's important for everyone,"* then people would need to listen to it. They emphasised that coming from a non-First Nations service provider perspective, it *"would help with changing* [cultural safety] *within mainstream services by giving them the directive. This is what's expected and makes us accountable… People need to be made properly accountable."*

2. Ensuring that funding provided to mainstream services is being used for the provision of services to First Nations People.

Consultation participants from ACCHOs highlighted that ensuring self-determination involves funding that matches community needs. They mentioned cases where mainstream services receive funding but aren't providing services for First Nations Peoples, with a lack of accountability attached to these funding allocations, which allows them to do so.

Supports and services

No.	Insight	Implication	Heard from
18	Collaboration and service integration are important ways of ensuring that First Nations People receive appropriate care for a wide range of needs.	ACCHO and mainstream services should be encouraged and supported to collaborate and integrate, instead of competing against one another for funding.	First Nations People Non-First Nations People

Through the consultations, it became apparent that it is essential for services to work together to provide holistic support for First Nations People with complex and intersecting health needs. While there are good examples of how ACCHOs are working in partnership with other services (see **Strong Solution 4** below), it was also identified that, as a result of funding arrangements, services are often 'in competition' with one another for funding, which impacts their ability to work together in a unified system. As one First Nations individual highlighted, *"There are a lot of different services, but they are operating in siloes and competing against each other."*

This competition often means that service providers offer similar types of services, which, although providing First Nations People with choice and control, disincentivises services from providing adequate service navigation, linkages and referral pathways across different services.

Despite this, the consultations highlighted an appetite from some ACCHOs in the catchment to develop strong partnerships, with one ACCHO underlining that there is *"strength in numbers and being able to advocate with a larger voice and share and learn best practice from one another*". It was also noted that working with other local stakeholders across the catchment will help *"understand the collective need and represent that back to funding bodies and peak organisations so they can support new initiatives that are arising".*

Strong Solution 4: Partnership arrangements

A number of ACCHOs emphasised the importance and benefit that having self-determined partnership agreements with other services can have on their ability to offer holistic and integrated care for their Community. Self-determined partnerships involve collaborative arrangements where ACCHOs exercise autonomy and decision-making authority. These partnerships prioritise culturally appropriate care, respect for First Nations knowledge and practices, and equitable resource sharing, aiming to improve health outcomes and empower community-controlled services.

Some case studies of different partnership models are highlighted below:

- Mungabareena Aboriginal Co-operation has a working relationship with the local correctional facility, providing monthly visits to work with the men and facilitating cultural activities e.g. artwork. The ACCHO highlighted the success of this model in providing First Nations People in custody with a purpose, adopting a focus on holistic wellbeing and cultural connectedness.
- Strong collaboration between Albury Wodonga Aboriginal Health Service and the local health service that jointly fund an Aboriginal maternity and midwifery health worker that allows the obstetrician to work between both services. They also provide cultural birthing kits through the AHW and have a good referral process between the two services, making it easier for expecting parents to receive care and access the supports they need.

Holistic balance

No.	Insight	Implication	Heard from
19	The current funding is focused on outputs and targets, not providing flexible funding opportunities to allow service providers to deliver holistic care.	More long-term and flexible funding, focused on achieving positive outcomes, will enable service providers to provide more holistic care for First Nation People.	First Nations People Non-First Nations People

Throughout the consultations, the service providers highlighted that supporting First Nations holistic health needs is often difficult due to the rigid funding buckets, the criteria to access services, and a lack of funding for health promotion and education. They highlighted that the money that ACCHOs and other service providers get is often tied to different grants or funding buckets and, therefore, can only be used in specific instances, as opposed to being used to address the arising health needs. Some service providers also highlighted that this, in turn, impacts the ability to refer clients to other services, as it also impacts their output and ability to achieve targets. In contrast, others indicated that it's restricting their ability to provide things to their Community despite knowing a need exists.

This was raised as an issue across the board; however, there were also three distinct areas where service providers highlighted challenges:

1. Supporting access to the NDIS

Participants highlighted that it is challenging to support Community members accessing NDIS services, emphasising that navigating assessments, using care packages and navigating the system are all challenging when limited allied health or other services are available, and limited funding is allocated to the ACCHOs to support patients.

One ACCHO highlighted that *"there are things that community need but that don't fit the categories, such as prosthetics. There are a lot of restrictions, i.e. monitoring, but not with a finger prick, as this isn't covered in the guidelines"* (Non-First Nation participant, North East sub-region).

2. Performing routine 715 checks

715 health checks are annual holistic health checks for First Nations Peoples. They aim to identify whether individuals are at risk of illness or developing chronic conditions.

These checks are routinely completed by Aboriginal Medical Services or mainstream, bulk billing clinics, free of charge. Although 715 checks are an identified benefit to the Community, the consulted service providers highlighted that there is often not enough community awareness or health promotion around 715 checks to encourage and support First Nations People to get them completed; however, they also indicated that they do not have enough funds to be doing this health promotion as a part of unfunded regular business. Service providers also highlighted a lack of awareness that these checks can be completed by mainstream, bulk billing clinics and, in turn, mainstream service providers are often unclear on if, and when, these should be done.

Although ACCHOs did emphasise they were doing 715 checks where they could, they also indicated that they are seeing an increase in the number of First Nations People presenting with acute, chronic conditions (see **Insight 10**). They highlighted that this could have been diagnosed earlier if there had been more health promotion and education for the Community around getting routine checks such as the 715s.

"Community don't have the awareness that they can get it [715 check] *done at bulk billing clinic. It's hard to promote them when it is at the discretion of the GPs."*

Non-First Nations participant,
Goulburn Valley sub-region

3. Chronic care management

It was highlighted in the consultation process that there is a current misalignment between funding bodies' expectations of chronic care management and the reality for many ACCHOs and AHWs carrying out chronic care management in communities. Currently, the chronic care management system is set up to enable people to be discharged from the program after a certain period. However, the guidelines to discharge people from the program are misaligned with cultural acceptability and obligations. One ACCHO, who reported that they currently have 100 First Nations People on a chronic care plan with only 1 FTE to manage these cases, reflected this difficulty in discharging patients. They highlighted that the misalignment between funding bodies' requirements and their cultural obligations to the Community means they cannot provide proper case management and care for their patients on chronic care plans due to restrictive funding.

"It's culturally unacceptable to tell an Elder you can no longer care for them and discharge them, but the people we report to don't understand cultural obligations, so they don't see the issue with this."

First Nations participant,
Goulburn Valley sub-region

Outside of these three areas, service providers also highlighted the difficulty of receiving short-term funding grants. One participant explained that when there is a lack of ongoing funding, it is difficult to evaluate the programs you are running to understand if they are working or having a long-term impact e.g. contributing towards Closing the Gap. One First Nations service provider highlighted, anecdotally, that they *"know that what we are doing is working, but there's no money to sustain the programs…"*

Similarly, we heard that the challenge with capped funding also means that strict reporting and KPIs (see **Insight 4** on PHN reporting requirements) often do not work when supporting First Nations Peoples.

Care on Country

No.	Insight	Implication	Heard from
20	Place-based care should be prioritised to ensure connection to Community, culture and family.	There should be support for initiatives that are place-based and allow First Nations People to access care locally.	First Nations People Non-First Nations People

Throughout the consultation process, it was highlighted that, where appropriate, First Nations People should be supported to access care on Country or in their Community through face-to-face, place-based efforts. Participants raised that many ACCHOs provide place-based care in their existing services (as further outlined in **Insight 1),** and that it is currently difficult for some communities across the catchment to achieve this due to geographic distance. Noting that current data (often used to inform decision-making on funding allocations) favours larger or rural towns. While ACCHOs' experience in this area was noted, it wasn't specified that mainstream services should not be supported to provide place-based care. With participants from some areas highlighting instead the provision of local Culturally Safe services at all would be an improvement.

"Solutions need to be place-based, not 100kms away."

Non-First Nations participant,
Goulburn Valley sub-region

For example, a First Nations service provider in the Mitchell Shire spoke about the significant need for further services and support for their Community members; however, quantitative data, including the Composite Index Score (CIS) results presented in ***Section 4***, highlighted Mitchell Shire as an area with very low need.

Despite the catchment's geographical spread, there is minimal support for First Nations People who are required to travel to access services when these are unavailable locally, as previously emphasised (see **Insight 11**). Adopting place-based strategies, such as innovative outreach models (see **Insight 13**), should be encouraged to ensure that people can receive care locally.

Similarly, we heard that some service providers offer telehealth to improve access and reduce the need for travel, however this is sometimes a barrier for people who prefer to receive care face-to-face or do not have the ability to access telehealth from home.

Access and use of acute services for primary care related presentations

Quantitative data related to the extent of service access by First Nations People in the catchment was explored through the use of ED for health needs that could have been addressed in primary care settings, to provide an indication of service availability and access.

An ED presentation that could have been avoided and managed by a GP is defined by those that:

- are allocated a Triage Category 4 (semi-urgent) or 5 (non-urgent)
- did not arrive by ambulance, or police or correctional vehicle
- were not admitted to the hospital, not referred to another hospital or did not die.

Although data on GP-type ED presentations was not publicly available, the rate of semi-urgent and non-urgent ED presentations provide an indication of the extent that could have been better managed in the community[10].

The rate of semi-urgent and non-urgent ED presentations by First Nations Peoples across the catchment was lower than the national rate (but higher than the state rate), this differed significantly across the IAREs within the catchment.

Key findings were:

- The rate of semi-urgent and non-urgent ED presentations by First Nations Peoples across the catchment was lower than the national rate. However, this differed significantly across the catchment (PHIDU, 2019-20).
- There was also variation across the LGAs, with the highest rate found in Albury (C) at 58,714, suggesting that more than half of First Nations Peoples in this area present to the ED for non-urgent or semi-urgent concerns. This rate was 2.2 times higher than the state rate. The LGAs within the Wodonga IARE had the second highest rate (52,206), which was 54 per cent higher than the national rate (see **Table 17**).
- The rate of all PPHs across Murray PHN is lower than the national rate across all age groups, with the exception of the 65+ age group, which was 12.6 per cent higher. However, the rate of chronic PPHs were slightly higher (0.9%) in the Murray PHN catchment compared to the national rate (2,210 vs. 2,189) (PHIDU, 2017/18 – 2019/20).

[10] It is worth noting that data captured on semi-urgent and non-urgent ED presentations occurred in the same time period as the onset of the COVID pandemic and the subsequent restrictions imposed in Victoria. This may have impacted the likelihood of First Nations Peoples accessing care from EDs.

Table 17: ASR per 100,000 Aboriginal and Torres Strait Islander People who presented to ED for concern that assessed as Triage Category 4 (semi-urgent) or 5 (non-urgent), by IARE and highest rate (PHIDU, 2019-20)

IARE	LGA Name	ASR per 100,000 people non-urgent and semi-urgent ED presentations
Albury	Albury (C)	58714.2
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	52206.4
Swan Hill	Swan Hill (RC)	47627.2
Mildura	Mildura (RC)	38390.5
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	38272.6
Bendigo	Greater Bendigo (C)	35055.4
Wallan - Seymour	Mitchell (S)	12329.9
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	12274.2
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	10308.1
Macedon Ranges - Moorabool	Macedon Ranges (S)	9417.2
Catchment		**30350.6**
National		**34004.0**
State		**26055.8**

**Red shading indicates equal or higher than state benchmark*

Table 18 presents the rate of ED presentations for disease related to:

- non-urgent and semi-urgent mental health and behavioural disorders
- non-urgent and semi-urgent respiratory system diseases e.g. COPD, asthma
- non-urgent and semi-urgent digestive system diseases e.g. cancer, irritable bowel syndrome
- non-urgent and semi-urgent musculoskeletal system and connective tissue diseases e.g. back pain, osteoporosis, rheumatoid arthritis
- non-urgent and semi-urgent genitourinary system diseases e.g. urinary tract infections, kidney disease
- mental health and behavioural disorders (all).

For all five data indicators that assessed semi-urgent and non-urgent ED presentations, there were higher rates per 100,000 First Nations Peoples in the Murray PHN catchment, on average, to the national rate. In particular, semi-urgent and non-urgent ED presentations related to diseases of the genitourinary system and musculoskeletal system were higher than the national rate.

Although the rate of all ED presentations related to mental health and behavioural disorders was lower than the state rate, those that were categorised as either semi-urgent or non-urgent were higher.

It is worth noting that the rates were considerable higher in Albury (C), specifically:

- the rate of all ED presentations related to mental health and behavioural disorders was higher than the state rate (7,925 vs. 4,120 per 100,000 First Nations Peoples)
- the rate of semi-urgent and non-urgent ED presentations related to mental health and behavioural disorders was 1.4 times higher the state rate (2,381 vs. 1,092 per 100,000 First Nations Peoples).

Table 18: ASR per 100,000 Aboriginal and/or Torres Strait Islander People (all ages) for non-urgent and semi-urgent ED presentations by condition and IARE (PHIDU, 2019-20)

IARE	LGA Name	Mental health and behavioural disorders	Respiratory system disease	Digestive system disease	Musculoskeletal system and connective tissue diseases	Genitourinary system tissue diseases
Albury	Albury (C)	2380.6	3095.5	3319.6	5403.7	2438.2
Bendigo	Greater Bendigo (C)	1907.8	1601.1	1706.2	6043.3	1565.6
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	1286.3	4926.9	2118.7	2903.1	1071.4
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	..	976.5	658.8	1530.3	..
Macedon Ranges - Moorabool	Macedon Ranges (S)	..	658.2	..	576.1	..
Mildura	Mildura (RC)	1563.9	2132.8	3710.8	3325.6	2153.8
Swan Hill	Swan Hill (RC)	2126.8	3896.3	3278.2	3585.9	1133.8
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	..	899.8	..	..	960.2
Wallan - Seymour	Mitchell (S)	..	..	..	860.2	593.1
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	1198.8	4269.2	2535.7	4332.4	2253.4
Catchment		**1486.0**	**2619.8**	**2105.3**	**3127.1**	**1541.6**
National		**1465.1**	**2395.2**	**1790.0**	**2229.2**	**1033.7**
State		**1091.8**	**1764.7**	**1430.7**	**1832.6**	**988.9**

**Red shading indicates equal or higher than state benchmark*

Table 19: ASR per 100,000 Aboriginal and/or Torres Strait Islander Peoples ED presentations for mental and behavioural disorders by IARE (2019-20, PHIDU)

IARE	LGA Name	ASR of ED presentations for mental and behavioural disorders per 100,000 First Nations people
Albury	Albury (C)	7925.2
Swan Hill	Swan Hill (RC)	7240.3
Bendigo	Greater Bendigo (C)	7015.2
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	4920.2
Mildura	Mildura (RC)	3774.9
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	2977.5
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	1949.5
Macedon Ranges - Moorabool	Macedon Ranges (S)	1433.5
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	1122.2
Wallan - Seymour	Mitchell (S)	995.0
Catchment		**3196.3**
National		**4270.6**
State		**4120.5**

**Red shading indicates equal or higher than state benchmark*

Potentially preventable hospitalisations

A potentially preventable hospitalisation (**PPH**) refers to a hospital admission that could have been prevented had there been timely and appropriate provision of primary or community-based healthcare.[11]

The rate of PPHs for First Nations Peoples, overall and according to each group, is demonstrated in **Table 20**.

On average, the rate of PPHs across the Murray PHN region is lower than the national rate across all age groups, except for the 65+ age group, which was 12.6 per cent higher. The North West sub-region had the highest rate of PPHs across all age groups, with the exception of the 25 – 44 year old age group.

Table 20: Rate of all PPHs in the Murray PHN catchment by region and age-group (PHIDU, 2017/18 – 2019/20)

Avg annual ASR of potentially preventable hospital admissions (all conditions) per 100,000 First Nations people						
Region	**All**	**Aged 0 - 14 years**	**Aged 15 -24 years**	**Aged 25 – 44 years**	**Aged 45 – 64 years**	**Aged 65+ years**
Central Victoria	5249.7	2804.6	2312.7	5070.6	7548.7	24282.2
Goulburn Valley	4107.0	2574.5	2464.4	3734.7	5688.5	19088.2
North East	3563.7	2590.2	1719.6	3430.2	5395.2	12888.1
North West	6034.5	2857.5	2939.2	4777.7	9294.1	33411.6
Catchment	**4432.0**	**2671.1**	**2223.8**	**4069.8**	**6496.3**	**19967.2**
State	**4558.9**	**2458.8**	**2618.3**	**3964.0**	**8063.6**	**17555.9**
National	**5619.0**	**3251.3**	**2665.6**	**5146.3**	**10918.5**	**17735.3**
% of difference between catchment and state rates	**-2.8%**	**8.6%**	**-15.1%**	**2.7%**	**-19.4%**	**13.7%**

Rate above state and national rate
LGS(s) with the highest rate

At an LGA level, Swan Hill (RC) had the highest rate of PPHs, with rates above the national rate for all age groups, except the 0 – 14 year old cohort. In particular, the rate of all PPHs in this location was 40 per cent above the national rate, and the rate of PPHs for the 65+ year old age group was three times the national rate. This is presented in **Table 21.**

[11] AIHW. (2021). *Potentially preventable hospitalisations in Australia by age groups and geographic areas, 2017-18.* Retrieved 24 July 2023 from: http://www.aihw.gov.au

Table 21: Rate of all PPHs in the Murray PHN catchment by LGA and age-group (PHIDU, 2017/18 – 2019/20)

Avg annual ASR of potentially preventable hospital admissions (all conditions)							
Rank	**Sub-region**	**All**	**Aged 0 – 14 years**	**Aged 15 -24 years**	**Aged 25 – 44 years**	**Aged 45 – 64 years**	**Aged 65+ years**
North East	Albury (C)	5400.2	3156.8	2646.3	7026.1	7896.4	16059.7
	Alpine (S)	3298.5	2379.1	1438.6	2958.9	5787.9	9514.9
	Benalla (RC)	3308.3	2834.7	2049.7	2810.5	3162.7	19735.0
	Indigo (S)	3298.5	2379.1	1438.6	2958.9	5787.9	9514.9
	Mansfield (S)	3308.3	2834.7	2049.7	2810.5	3162.7	19735.0
	Towong (S)	3298.5	2379.1	1438.6	2958.9	5787.9	9514.9
	Wangaratta (RC)	3298.5	2379.1	1438.6	2958.9	5787.9	9514.9
	Wodonga (C)	3298.5	2379.1	1438.6	2958.9	5787.9	9514.9
North West	Buloke (S)	4899.6	2832.3	1761.5	4057.6	6066.8	27910.3
	Mildura (RC)	5334.5	2827.3	4141.6	3892.5	10493.4	17922.2
	Swan Hill (RC)	4869.4	2912.8	2914.4	6383.0	11322.2	54402.4
Central Victoria	Campaspe (S)	6547.9	3022.4	3284.0	6261.3	12297.4	25108.9
	Gannawarra (S)	4899.6	2832.3	1761.5	4057.6	6066.8	27910.3
	Greater Bendigo (C)	5002.0	2503.4	2994.8	6919.2	7245.9	12571.3
	Loddon (S)	4899.6	2832.3	1761.5	4057.6	6066.8	27910.3
	Mount Alexander (S)	4899.6	2832.3	176135	4057.6	6066.8	27910.3
Goulburn Valley	Greater Shepparton (C)	6547.9	3022.4	3284.0	6261.3	12297.4	25108.9
	Macedon Ranges (S)	1807.9	1192.8	2152.9	1022.1	1259.7	12405.2
	Mitchell (S)	3121.6	2539.6	1966.5	3242.2	1951.4	12436.1
	Moira (S)	6547.9	3022.4	3284.0	6261.3	12297.4	25108.9
	Mount Alexander (S)	4899.6	2832.3	176135	4057.6	6066.8	27910.3
	Murrindindi (S)	3308.3	2834.7	2049.7	2810.5	3162.7	19735.0
	Strathbogie (S)	3308.3	2834.7	2049.7	2810.5	3162.7	19735.0
Catchment		**4432.0**	**2671.1**	**2223.8**	**4069.8**	**6496.3**	**19967.2**
State		**4558.9**	**2458.8**	**2618.3**	**3964.0**	**8063.6**	**17555.9**
National		**5619.0**	**3251.3**	**2665.6**	**5146.3**	**10918.5**	**17735.3**
% of difference between catchment and state average		**-2.8%**	**8.6%**	**-15.1%**	**2.7%**	**-19.4%**	**13.7%**

Rate above state and national rate
LGS(s) with the highest rate

Chronic potentially preventable hospitalisations

Chronic condition-related PPHs are those that could have been prevented and managed in primary healthcare to prevent the worsening or exacerbation of symptoms leading to hospitalisation.

Between 2017-18 to 2019-20, the average annual rate of chronic-related PPHs per 100,000 First Nations Peoples in the Murray PHN catchment was similar to the national rate (2,209.6 vs. 2,188.8).

At an LGA level, the rate of chronic-related PPHs was highest in Swan Hill (RC) at 4,584.9 per 100,000 population, which was double the national rate. High rates were also observed collectively in Campaspe (S), Greater Shepparton (C) and Moira (S). This is illustrated in **Table 22.**

Table 22: ASR of PPHs (chronic conditions) per 100,000 Aboriginal and/or Torres Strait Islander People, by IARE (PHIDU, 2017/18 – 2019/20)

IARE	LGA Name	Avg annual ASR of PPH (chronic conditions) per 100,000 First Nations people
Swan Hill	Swan Hill (RC)	4584.915
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	3671.7
Mildura	Mildura (RC)	2534.427
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	2503.993
Bendigo	Greater Bendigo (C)	2484.946
Albury	Albury (C)	2353.543
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	1636.079
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	1516.972
Wallan - Seymour	Mitchell (S)	950.2144
Macedon Ranges - Moorabool	Macedon Ranges (S)	542.7
Catchment		2209.591
National		2188.829
State		2142.484

**Red shading indicates equal or higher than state benchmark*

Except for chronic congestive heart failure and COPD, there were higher rates of chronic-related PPHs for all types in the Murray PHN catchment, on average, compared to the national rate. In particular, the rate of PPHs related to chronic angina was higher than the state rate. High rates were also observed for chronic congestive heart failure and chronic iron deficiency, which were higher than the state rate.

Notably, Swan Hill (RC) had higher than the state/national rates across all six chronic condition types. In addition, the same LGA had the highest rates of PPHs for four out of the six chronic PPH types. This is demonstrated in **Table 23.**

Table 23: Average annual rate per 100,000 Aboriginal and/or Torres Strait Islander Peoples for chronic condition-related PPH, by type, in the Murray PHN catchment by IARE (PHIDU, 2017/18 – 2019/20)

IARE	LGAs	Chronic angina	Chronic asthma	Chronic congestive heart failure	COPD	Chronic diabetes complications	Iron deficiency
Albury	Albury (C)	254.0	315.1	175.3	371.4	869.5	245.5
Bendigo	Greater Bendigo (C)	131.3	531.5	95.8	480.6	983.4	209.9
Campaspe - Shepparton - Moira	Campaspe (S), Greater Shepparton (C), Moira (S)	185.9	228.5	296.8	1141.5	694.3	1056.2
Castlemaine - Kerang	Buloke (S), Gannawarra (S), Loddon (S), Mount Alexander (S)	199.6	178.1	174.2	653.5	698.5	586.8
Macedon Ranges - Moorabool	Macedon Ranges (S)	..	..	..	..	195.9	..
Mildura	Mildura (RC)	206.3	271.2	262.8	706.2	463.8	582.2
Swan Hill	Swan Hill (RC)	384.0	594.9	675.3	1676.2	666.7	521.0
Upper Goulburn Valley	Benalla (RC), Mansfield (S), Murrindindi (S), Strathbogie (S)	293.3	..	169.0	220.6	299.8	506.6
Wallan - Seymour	Mitchell (S)	..	..	..	..	..	310.9
Wodonga	Alpine (S), Indigo (S), Towong (S), Wangaratta (RC), Wodonga (C)	175.9	192.5	146.5	516.0	157.6	224.1
Catchment		**219.2**	**254.6**	**210.2**	**636.8**	**478.2**	**501.5**
National		**162.2**	**228.4**	**251.3**	**650.5**	**469.9**	**225.3**
Total population		**78.0**	**103.3**	**194.0**	**240.5**	**182.4**	**167.2**
State		**147.8**	**243.4**	**164.6**	**583.3**	**512.2**	**435.3**

Domain: Workforce

No.	Insight	Implication	Heard from
21	The catchment's rural nature, and the challenges of recruiting and retaining First Nations identified staff, are leading to an insufficient workforce to meet demand adequately. Alongside First Nations identified staff, GPs were highlighted as a particular need.	Increased recruitment and retention of GPs is needed to meet the demand across the catchment. Service providers also need additional support to attract and retain a First Nations local health workforce.	First Nations voices Non-First Nations voices

Throughout the catchment, consultation participants emphasised the pressing need for an increased workforce, particularly GPs and First Nations-identified health staff such as Aboriginal Health Practitioners (AHP), Aboriginal Health Workers (AHW) and Aboriginal Liaison Officers (ALO). This need is especially acute in the more remote areas of the catchment, where workforce challenges are even more pronounced.

"We need more AHWs so we can do succession planning... instead, workers are leaving because they can get paid four times more elsewhere."

Non-First Nations individual, Central Victoria sub-region

Consultations highlighted a significant shortage of GPs, leading to long waitlists and frustration among Community members who can't book appointments when needed. Service providers discussed the challenge of finding GPs to work in regional, rural and remote areas. As a result, it was highlighted that many GPs working in the region are locums or GPs trained overseas who often do not understand the complexities of working in First Nations health.

ACCHOs and other services also discussed the significant challenge of recruiting and retaining AHPs, AHWs and ALOs, specifically needing more First Nations men in identified roles to enhance workforce diversity and representation across genders. Without sufficient staff in these roles, services find it difficult to build trust and relationships with First Nations individuals and communities. One ACCHO suggested the ideal approach would be to have an AHW attached to every GP in their clinic to improve outcomes and provide holistic care. This approach would lead to better outcomes and ensure the ACCHO can review all holistic health indicators and provide proactive support i.e. eye checks, ear checks, smoking cessation.

"If our ALOs go on leave, we can't backfill. Across the board, it's quite hard."

First Nations participant, Goulburn Valley sub-region

ACCHOs and mainstream services face challenges in competing for, and retaining, staff. A few participants mentioned some strain between mainstream and ACCHO services as they compete for the same trained staff. Many ACCHOs attributed this to several reasons, including staff getting a higher salary, having more job security, clearer roles and responsibilities, and better career pathways elsewhere.

The rural nature of the catchment, coupled with recruitment and retention challenges, has created a workforce shortage that hampers providing culturally appropriate care to First Nations communities. Addressing these issues requires collaborative efforts to attract, train and retain GPs and qualified identified staff, and ensure gender representation.

No.	Insight	Implication	Heard from
22	Traineeships in ACCHOs and the health system are effectively increasing the First Nations-identified health workforce.	ACCHOs and the health sector require support to sustain and expand traineeships, which includes actively promoting health career pathways to young members of the Community.	First Nations voices

In consultations, ACCHOs highlighted their experiences using traineeships to increase the number of AHPs, AHWs and ALOs in their workforce. However, they've identified some key areas where improvements can be made to strengthen this pathway and attract more individuals.

One crucial aspect is ensuring there are clear pathways and job opportunities for trainees once they complete their training.

"We don't have the next generation coming through and this is what we need to stay ahead."

First Nations participant,
Central Victoria sub-region

ACCHOs also raised the need for adequate mentoring and cultural support to set trainees up for success. Noting that this is crucial to developing a new workforce, especially in the area of complex First Nations care. **Strong Solution 5** provides an example of a program to ensure new trainees have the support needed to navigate their roles effectively.

Consultations highlighted the opportunity to encourage more young First Nations People to consider careers in healthcare by engaging them early. Participants raised opportunities to promote vocational education and training (VET) subjects in schools and generate interest within the Community, especially in rural areas where encouraging individuals to stay local could assist with workforce shortages (refer to **Insight 21**).

To build a sustainable workforce in ACCHOs and mainstream health services, it's crucial to provide robust support systems that facilitate employment opportunities, engage young First Nations People early, and offer ongoing mentorship and cultural support throughout traineeships. These initiatives could increase the number of First Nations People in the healthcare workforce and ensure their long-term success and retention.

Strong Solution 5:

One consultation spoke to the successful traineeship program at Bendigo & District Aboriginal Co-operative, which was recently presented at the VAACHO Partnership Program.

The program is structured so that the cultural mentor takes precedence over the line manager in supporting AOD traineeships for First Nations Peoples.

The quantitative data on the existing workforce was explored for registered Aboriginal and Torres Strait Islander Health Practitioners.

The key findings were:

- In 2022, there were 16 APHRA-registered Aboriginal and Torres Strait Islander Health Practitioners practicing in the Murray PHN catchment, with majority, seven or 44 per cent, based in Mildura (RC) (Commonwealth Health Workforce Data, 2022).

Workforce - Aboriginal and Torres Strait Islander Health Practitioners

Based on Commonwealth Health Workforce Data, there were 16 registered Aboriginal and Torres Strait Islander Health Practitioners practising in the Murray PHN catchment.

As presented in **Table 24**, there was variation across the catchment, with the highest rate of Aboriginal and Torres Strait Islander Health Practitioners in North West with 1.9 per 1,000 First Nations Peoples. This rate was double the catchment and state rate, and more than 4.5 times the national rate.

Table 24: No. of Aboriginal and Torres Strait Islander Health Practitioners and per 1000 First Nations people, ranked according to region with the highest rate per 1000 First Nations Peoples (Commonwealth Health Workforce Data, 2022)

Rank	Region	No. of Aboriginal and Torres Strait Islander Health Practitioners	No. of Aboriginal and Torres Strait Islander Health Practitioners per 1,000 First Nations People
1	North West	10	1.9
2	Central Victoria	6	0.7
3	Goulburn Valley	0	0.0
4	North East	0	0.0
Catchment		**16**	**0.9**
State		**30**	**0.8**
National		**664**	**0.4**

*As per **Table 25**, at an LGA level, the majority, seven or 44 per cent, practised in Mildura (RC). However, the highest rate per 1,000 First Nations Peoples was in Swan Hill (RC) at 3.1. There were also 18 LGAs where there was no practising Aboriginal and Torres Strait Islander Health Practitioner.*

Table 25: No. of Aboriginal and Torres Strait Islander Health Practitioners and per 1000 First Nations Peoples, ranked according to the LGA with the highest rate per 1000 First Nations Peoples (Commonwealth Health Workforce Data, 2022)

Rank	LGA	No. of Aboriginal and Torres Strait Islander Health Practitioners	No. of Aboriginal and Torres Strait Islander Health Practitioners per 1,000 First Nations Peoples
1	Swan Hill (RC)	3	3.1
2	Mildura (RC)	7	2.7
3	Campaspe (S)	3	2.6
4	Greater Bendigo (C)	3	1.1
5	Albury (C)	0	0.0
6	Alpine (S)	0	0.0
7	Benalla (RC)	0	0.0
8	Buloke (S)	0	0.0
9	Gannawarra (S)	0	0.0
10	Greater Shepparton (C)	0	0.0
11	Indigo (S)	0	0.0
12	Loddon (S)	0	0.0
13	Macedon Ranges (S)	0	0.0
14	Mansfield (S)	0	0.0
15	Mitchell (S)	0	0.0
16	Moira (S)	0	0.0
17	Mount Alexander (S)	0	0.0
18	Murrindindi (S)	0	0.0
19	Strathbogie (S)	0	0.0
20	Towong (S)	0	0.0
21	Wangaratta (RC)	0	0.0
22	Wodonga (C)	0	0.0
Catchment		**16**	**0.9**
State		**30**	**0.8**
National		**664**	**0.4**

Section 3: Regional profiles

North West sub-region

Approximately 3,700 First Nations Peoples reside in the North West sub-region of the Murray PHN catchment, representing 20 per cent of the total First Nations population (ABS, 2021). Available data also indicates that approximately 27 per cent of the region's First Nations population (about 1,901 individuals) are between 0 and 14, and 21 per cent (about 779 individuals) are 45 and older. The region includes three LGAs of Buloke, Mildura and Swan Hill. Current data sources are limited due to small population size and borders. One service provider suggested a more accurate method would be to "*draw a 150km radius around a town, including parts of NSW*" to capture the actual population and health need in this region.

ACCHOs in the region

- Mallee District Aboriginal Services
- Murray Valley Aboriginal Co-operative.

Key findings

Barriers to accessing healthcare and the provision of health and wellbeing services

Domain	Finding
Autonomy, empowerment and recognition	**The current healthcare model is not working for First Nations Peoples.** The region has the second highest rate of multi-morbidities, the highest rates of PPHs, and the second highest rate of semi-urgent and non-urgent ED presentations in the catchment. Consultations highlighted that First Nations-led holistic healthcare models are needed. The North West also had the highest rate of First Nations Peoples (aged 15 years and over) with fair or poor self-assessed health, which was 20 per cent higher than the state rate.
Work, roles and responsibilities	**First Nations Peoples are bearing too much of the colonial load.** Staff working in mainstream services were asked to do organisational Cultural Safety work and communities were being asked for consultation to complete services' Reconciliation Action Plans.
Social and emotional wellbeing	**There is increasing and significant need for mental health services, especially for crisis and acute conditions.** The data shows that the region had the second-highest number of service contacts per 100 First Nations Peoples delivered by Murray PHN-commissioned mental health service providers.
	There is a specific need for culturally appropriate youth mental health services. Consultations noted that funding comes in and out for youth services, and there are limited Culturally Safe options for First Nations youth.
Access to services	**ACCHOs have insufficient funding to provide holistic care, and the funding provided comes with burdensome reporting requirements.** Participants asked for more flexible funding for place-based responses.
	Costs, transport and service criteria make accessing healthcare difficult for First Nations Peoples. Consultation participants spoke to the increasing healthcare costs, the challenge of meeting identity criteria to access services and a lack of low-cost transport options. Due to the IRSEO scores of Swan Hill and Mildura, the region is collectively the most socioeconomically disadvantaged in the catchment.

	There is a lack of GPs, local specialist services, and local AOD withdrawal and rehabilitation programs.
	First Nations People and children need to leave the region to access healthcare services that are not available locally. Participants noted this can separate families and people from their Country. They raised the deep trauma these practices cause for First Nations Peoples, given the ongoing trauma and distress from the Stolen Generation and the importance of connection to Country and family.
Workforce	**Services face challenges in recruiting and retaining a sufficient identified workforce to support First Nations Peoples and communities.** They highlighted the difficulties in attracting identified staff in rural towns with low numbers of First Nations Peoples going into working in healthcare.

Enablers to access and opportunities to support the region

Domain	Finding
Autonomy, empowerment and recognition	**Holistic healthcare is working to support First Nations Peoples across the region.** Examples raised included ACCHOs providing outreach services in the home and schools to meet communities where they are and a mainstream service employing well-respected local Aboriginal workers and listening to their feedback.
	Increased anti-racism and Cultural Safety training and practice supported by higher levels of accountability could support greater Cultural Safety. Consultation participants emphasised the need for Cultural Safety, not just awareness, and long-term accountability on services to do this work. They noted that mainstream services need to provide quality care that understands and recognises First Nations' ways of working.
Access to services	**The Loddon Mallee Aboriginal Reference Group supports ACCHOs across the region.** The self-determined group made up of the relevant ACCHO CEOs provides useful coordination, sharing of resources and support between organisations.
	There are opportunities to increase awareness and knowledge of the health service system and facilitate collaboration between services to enable smooth transitions for First Nations People accessing care. Consultation participants spoke to the need for services to work together to provide holistic care and continue to respond to community needs. They raised a lack of knowledge in the Community of what different services provide and the slow process of sharing discharge notes between mainstream and ACCHO services.
Workforce	**Building connections with local TAFEs and engaging with Year 11 and 12 students could increase the First Nations-identified workforce.**

Central Victoria sub-region

Approximately 4,600 First Nations Peoples reside in the Central Victoria sub-region, which is equal to 25 per cent of the total First Nations population in the Murray PHN catchment (ABS, 2021). Available data also indicates that approximately 35 per cent of the region's First Nations population (or 1,598 individuals) were aged between 0 – 14 years, while around 24 per cent (about 1,122 individuals) are 45 and older. The region covers six LGAs: Campaspe, Gannawarra, Greater Bendigo, Loddon, Macedon Ranges and Mount Alexander.

Within this region, the floods, the Stolen Generation and the 2023 failed referendum were highlighted as key concerns impacting First Nation People during the consultations.

ACCHOs in the region

- Njernda Aboriginal Corporation
- Bendigo & District Aboriginal Co-operative
- Mallee District Aboriginal Services (Kerang).

Key findings

Barriers to accessing healthcare and the provision of health and wellbeing services

Domain	Finding
Autonomy, empowerment and recognition	**There is a need to address the health concerns of the community and acknowledge the expertise that ACCHOs and First Nations service providers hold in knowing the needs of their Community**, which can be limited by restrictive and inefficient funding.
Health and chronic conditions	**The region has the second highest rate of potentially preventable hospitalisations (PPHs) in the catchment** and the highest rate of PPHs occurred in First Nations Peoples aged 65+ years, which was 38 per cent higher than the state rate.
Social and emotional wellbeing	**There is a need for culturally appropriate mental healthcare** to support the prevalence of mental illness across the region. Services raised the specific need for culturally appropriate services for First Nations youth.
	Anxiety, depression, PTSD, autism and ADHD are significant mental illness profiles in this region. Mental health and alcohol and other drugs were quite prevalent areas of concern in their community - especially for youth. This is supported by the data that emphasised that the region had the highest rate of reported mental health conditions in the catchment. This is largely driven by the rate in Bendigo, which was the second highest rate in the catchment by LGA.
Access to services	**There is a need for prevention and early intervention funding and interventions** however there is insufficient funding for early intervention, especially in non-health organisations. Often this means First Nations services that are making a positive impact are not being recognised or funded for what they are doing.

	There are significant challenges with access to services with increasing demand and increasing waitlists.
	Accessing allied health was highlighted as a big barrier, with some highlighting that even if their clients are on the NDIS, they still have very long waitlists to be seen, with some waitlists being up to 12 months. This is important to highlight as the data demonstrates that the region has the highest rate of First Nations Peoples with a profound or severe disability in the catchment.
	Mainstream services do not feel like an appropriate option for First Nations Peoples in the region. It was highlighted that there is a lack of culturally appropriate services in the region across all areas of support; youth services, allied health, mainstream primary care.
	It was highlighted that there are currently no Aboriginal maternity services in the region, with First Nations People having to travel to Melbourne to have a baby for cultural birthing services. At times, First Nations People have been away from their home for multiple weeks to have a baby.
Workforce	**There are significant workforce challenges in the region, making it hard for the region to keep up with the demand for services.** A lot of participants highlighted the shortages of staff, particularly Aboriginal Health Practitioners (AHPs) and the difficulty recruiting and retaining staff.

Enablers to access and opportunities to support the region

Domain	Finding
Access to services	**Collaborations, partnerships and integration in the region could be improved as an enabler for First Nations People in accessing better care.**
	Services need to be adaptable and meet the needs of the First Nations People accessing the service regardless of the policies e.g. if people want 10 people in the room while birthing and/or on an end-of-life journey, this needs to be allowed in order to ensure they are being Culturally Safe.
Workforce	**There is a need for increased training and support for AHPs, and the need for more traineeships**. Identified positions are also required in services following the completion of traineeships to support First Nations People to enter the workforce.

Goulburn Valley sub-region

Approximately 5,400 First Nations Peoples reside in the Goulburn Valley sub-region, which is equal to 29 per cent of the total First Nations population in the Murray PHN catchment (ABS, 2021). Available data also indicates that approximately 36 per cent of the region's First Nations population (about 1,901 individuals) are between 0 and 14, while around 24 per cent (about 1,291 individuals) are 45 and older.

The region covers five LGAs; Greater Shepparton, Mitchell, Moira, Murrindindi and Strathbogie, however approximately 70 per cent of the population for the region reside in Greater Shepperton. As such, it was highlighted in the consultations that there are difficulties for those living outside of Greater Shepperton in travelling and accessing care due to their rural nature.

ACCHOs in the region

- Rumbalara Aboriginal Co-Operative.

Key findings

Barriers to accessing healthcare and the provision of health and wellbeing services

Domain	Finding
Autonomy, empowerment and recognition	**Mainstream services often lack identified roles and positions, making them unsafe for First Nations People to attend**. Although the region had the lowest rate of semi-urgent and non-urgent ED presentations by First Nations Peoples, this was related to the lack of Cultural Safety in mainstream services. Despite the hospital having an Aboriginal Liaison Officer (ALO), other service providers noted that they do not have the capacity to take on every person who presents at the hospital, meaning that a lot of First Nations People will choose not to go to the hospital, or if they do, they will leave before being seen.
	There is insufficient funding to provide holistic care, and the funding provided comes with burdensome reporting requirements. Participants highlighted that the reporting requirements are the same regardless of the size of the grant, often meaning they will not apply for grants below a certain amount. They also highlighted that the lack of funding for early intervention and prevention means that they are unable to provide holistic care.
Work, roles and responsibilities	**Burnout is currently highlighted as being common for ALOs across the region**, as First Nations People in these roles are carrying the cultural load for their entire Community.
Access to services	**The geographical spread and low supply of First Nations health services make accessing Culturally Safe care quite difficult for many First Nations People in the region.** Most of the care is provided in Shepparton, which is making it very difficult for surrounding areas to access services.
	Transport was highlighted as a barrier for access. Service providers highlighted that there is limited public transport to travel across the region.
	The distance between the ACCHO and other surrounding towns makes it difficult for the ACHHO to provide outreach services due to a lack of funding,

	resources and staffing. As a result, pockets of the region do not have access to an ACCHO or their services.
	The ACCHO currently requires proof of Aboriginality to access their services, which was highlighted as a barrier for some First Nations People in accessing care.
	There is limited access to allied health services, with long waitlists across the region. Podiatry, occupational therapy, youth mental health and AOD services were highlighted as services with higher need or longer waitlists. The ACCHO indicated that if they had the infrastructure, they would be able to offer more allied health services, however without funding this is not possible.
Workforce	**There currently are not enough identified roles to meet the region's needs**, however, this would contribute to a safer cultural experience for First Nations People accessing services. As the identified workforce grows appropriate cultural supports are needed to prevent burnout and enhance wellbeing.

Enablers to access and opportunities to support the region

Domain	Finding
Autonomy, empowerment and recognition	**Service providers highlighted the need for the ACCHO to be clearer around which services they are providing to different areas of the region**, both to Community and to the PHN. With increased transparency, service providers highlighted this could allow measures that ensure that all First Nations People in the region have access to culturally appropriate care, even if the ACCHO cannot, realistically, service them.
	Mainstream services in the region highlighted that it would be useful to have more local data shared with them so that they can tailor their services to the needs in their region. This might look like doing targeted health promotion or looking to partner with First Nations service providers to deliver Culturally Safe services to areas that are underserviced.
Health and chronic conditions	**Funding for health promotion and early intervention could help in detecting and treating health concerns before they become acute.** The LGAs of Murrindindi and Strathbogie had two of the highest rates of multi-morbidity in First Nations children aged 0-14 years. It was also highlighted that there has been a rise in First Nations People being diagnosed with chronic conditions, which could have better outcomes with early intervention.
Access to services	**More funding for infrastructure could help the ACCHO to support and host more allied health workers and GPs.** The ACCHO highlighted that they have people who would be able to go provide more allied health services, but no room to host them.

North East sub-region

Approximately 5,100 First Nations People reside in the North East sub-region of the Murray PHN catchment, representing 27 per cent of the total First Nations population (ABS, 2021). The region covers eight LGAs: Albury, Alpine, Benalla, Indigo, Mansfield, Towong, Wangaratta and Wodonga.

ACCHOs in the region

- Albury Wodonga Aboriginal Health Service (AWAHS)
- Mungabareena Aboriginal Cooperation.

Key findings

Barriers to accessing healthcare and the provision of health and wellbeing services

Domain	Finding
Autonomy, empowerment and recognition	**Burdensome reporting requirements for ACCHOs,** with consultation participants noting that the reporting requirements are the same across all service funding opportunities, regardless of size.
	Organisational change is required to build Cultural Safety. However, the lack of information on the number of First Nations clients is often used as a reason not to commit to increased safety, although it was noted that 'Ask the Question' training is helping with this. There are currently extensive waitlists for doctors, with the GPs in the area facing high workloads which is adding a barrier to being able to secure time for training and perform Culturally Safe practice.
Social and emotional wellbeing	**Lack of sufficient mental health services with long waitlists, a lack of culturally appropriate holistic support and a lack of support for co-existing AOD and mental health concerns.** 2021 Census data indicates that the region has the highest rate of reported mental health conditions by First Nations Peoples (aged 0 – 14 years) and the second highest rate of reported mental health conditions (across all age groups) in the Murray PHN catchment, which was highest in the Wodonga IARE (including LGAs of Alpine, Indigo, Towong, Wangaratta and Wodonga).
Access to services	**There is a lack of adequate funding for ACCHOs**. Consultations revealed that ACCHOs need more infrastructure and funding to meet service demand. They emphasised that funding is insufficient to support the extra time and care required for holistic, person-centred care for First Nations Peoples.
	Systemic racism is experienced across the health system. Participants highlighted that prior experiences of racism cause First Nations Peoples to delay or avoid accessing care, and identified a need for high-quality mainstream service options to support choice and control for First Nations Peoples.
	Rising costs to access healthcare and specialists, which is concern for this region where there is socioeconomic disadvantage.
	Transport and support to attend appointments and referrals in Melbourne. Participants noted that the level of support varies greatly from different services and includes considerations such as food and accommodation.

	Inadequate funding to support transport to access regular healthcare in the region. ACCHOs in the region highlighted that they provide substantial, but inadequately funded, transport services for clients.
	Difficulties in service provision across large geographical areas. ACCHOs highlighted examples where Community members request services from towns such as Mansfield and Yarrawonga. These areas sit between the catchments of Rumbalara and AWAHS, and these ACCHOs are unable to provide outreach services across the large area. A lack of local services was also noted for Benalla and other smaller towns across the region.
	Lack of sufficient GP services and no services providing out of hours care.
	A lack of appropriate services for older First Nations Peoples and Elders. Data shows that the highest rate of PPHs in the region occurred in First Nation People aged 65+. However, this rate was still 27 per cent lower than the state rate.
	The region has the highest rate of semi-urgent and non-urgent ED presentations by, and multi-morbidities (three or more long-term conditions) in, First Nations Peoples in the catchment.
Workforce	**Challenge of recruiting trained Aboriginal Health Practitioners and Aboriginal Health Workers.** ACCHOs highlighted they can't compete with the salaries that mainstream services are able to provide. However, it was noted that traineeships work well to increase the identified workforce.

Enablers to access and opportunities to support the region

Domain	Finding
Autonomy, empowerment and recognition	**Opportunity for Murray PHN to provide clearer directives on Cultural Safety requirements and hold services accountable to it.** This will ensure momentum at senior/executive levels for the organisational change required.
	Opportunity to coordinate Cultural Safety work in mainstream services to share knowledge and skills, and to collaborate on initiatives e.g. development of Reconciliation Action Plans.
Health and chronic conditions	**Need to increase preventative health initiatives to support good health outcomes for First Nations Peoples.** This includes promoting 715 health checks, health education, and support for Community and social connection.
Access to services	**Increased funding for outreach services.** For example, the AWAHS medical van was highlighted as a successful solution to providing care outside of Albury/Wodonga. The van provides outreach services, with staff able to build trust and connections with local community.

	Increased use of digital health, including digital home monitoring of chronic diseases, to support high-quality person-centred care. Providing more digital options could potentially address barriers to accessing supports.
	Partnerships and collaboration enabling person-centred care. Examples include Mungabareena working with correction services to build Cultural Safety. Another exemplar collaboration was between AWAHS maternity and Albury Wodonga Health midwifery to support First Nations mums.
Workforce	**Need for increased First Nations workforce across the region's hospitals and mainstream health services,** noting that this provides a strong signal that services are dedicated to Cultural Safety.

Section 4: Research summaries

Research area 1: Self-determination in First Nations healthcare and the service system

Self-determination empowers Aboriginal communities to take charge of their health and wellbeing. It's a foundational right of Indigenous Peoples, as captured in the Australian endorsed UN Declaration of on the Rights of Indigenous Peoples.[12] Self-determination is about choice, participation and control. It involves the freedom of First Nations People to choose their political status and economic, social and cultural development.[18] In healthcare, self-determination means empowering Aboriginal communities to make decisions about their health and wellbeing. This includes choosing where they receive care, ensuring cultural appropriateness, and having control over how services are delivered. In this way, it extends beyond access and involves empowering ACCHOs and other First Nations providers to govern themselves and tailor service delivery to meet the specific needs of their communities. As highlighted in Korin Korin Balit-Djak, a "one-size-fits-all" approach isn't effective. Each Victorian Aboriginal community is unique, and their self-determined solutions should be respected. The recent Yoorrook for Justice Report further clarifies what self-determination means for First Nations Peoples in Victoria, describing it as “the power to shape and make decisions about the systems, laws, policies and programs that affect… (First Nations) Communities, families and children”[13].

The role of ACCHOs

The consultations highlighted the valuable role that ACCHOs play, including:

- providing complex care that addresses health, social and cultural considerations
- facilitating place-based care and outreach services to maintain connection to family and country
- supporting communities to build their health literacy, empowering individual self-determination.

Adopting a holistic approach to care, which varies according to an individual’s life stage and local needs, is a unique feature of ACCHOs that differs from the medical model. As a result, they experience a number of challenges, including:

- burdensome PHN reporting requirements
- challenges recruiting staff (including First Nations roles within ACCHOs)
- funding constraints that limit holistic care
- high demand for mental health and after hours services.

Key policy documents

There are a number of Victorian and Australian Government policy documents that highlight the important role of self-determination in healthcare, including:

- The National Agreement on Closing the Gap (2020) is built on the principle of self-determination through shared decision-making between governments and First Nations Peoples, a focus on strengthening the community-controlled sector, and improving access to data for Aboriginal and Torres Strait Islander people.
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 seeks to achieve the goal of parity in Aboriginal and Torres Strait Islander health workforce, support self-determination through their role in mainstream services.

[12] Australian Human Rights Commission 2010. *The Community Guide to the UN Declaration on the Rights of Indigenous Peoples*

[13] Yoorrook Justice Commission, Yoorrook for Justice: Report into Victoria's Child Protection and Criminal Justice Systems (2023), https://www.yoorrook.gov.au/wp-content/uploads/2023/08/Yoorrook-for-justice-report.pdf [2023-09-29]

- Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017 - 2027 *(Victorian)* has self-determination as the overarching policy and implementation driver, highlighting the role it has in all aspects of planning, and program/service development and implementation in health services.
- Victorian Department of Health Strategic Plan 2023 - 2027 seeks to improve First Nations health through self-determination, including by informing the design of the health system, building stronger ACCHOs, and ensuring self-determined Aboriginal research and education.
- Victorian Health Workforce Strategy (2024) highlights the need to increase the Aboriginal and Torres Strait Islander health workforce, supporting self-determination, and aiming to be equal with the Victorian Aboriginal and Torres Strait Islander population.

Examples of self-determined healthcare

Case study 1: ACCHOs provide excellent person-centred care during the COVID-19 pandemic[14]	
Need	The potentially catastrophic effects of COVID-19 on Aboriginal and Torres Strait Islander communities prompted the need for swift, effective action.
Approach	In March 2020, a National Aboriginal and Torres Strait Islander COVID-19 Advisory Group was established to support First Nation communities in developing local response plans. The Advisory Group, which included the National Aboriginal Community Controlled Health Organisation (NACCHO) and the Australian Department of Health and Aged Care, quickly generated an Emergency Response Management Plan through co-design and shared decision-making. NACCHO also collaborated with the government to develop a funding model that enabled local communities to create and implement local plans. During the vaccine rollout, ACCHOs played a crucial role in developing locally relevant communication campaigns, accelerating vaccine distribution, and addressing vaccine misinformation and hesitancy.
Outcome	ACCHOs' success during the COVID-19 response highlighted the value and strength of community-controlled organisations. The pandemic emphasised the unique ability of ACCHOs, supported by the coordination of NACCHO, to respond rapidly and effectively to a national public health crisis.
Case study 2: Northern Territory PHN's outreach health model[15]	
Need	First Nations People living in rural and remote areas of the Northern Territory (NT) do not have easy access to health services.
Approach	When commissioning this program, NT PHN engaged with stakeholders (such as ACCHOs) to identify opportunities and processes. They took a 'whole of system' approach to evaluating funding and commissioning.
Outcome	The Outreach Health Services program, which was co-designed with a range of stakeholders, aims to increase access to various health services, including SEWB services. After engaging different communities across the NT, a Resource Distribution Model was developed and used to allocate appropriate regional funding. This led to the establishment of working groups in each of the regions of the NT, which now collaborate to monitor the outreach program and guide the NT PHN.

[14] Department of Health. (2021). *National Aboriginal and Torres Strait Islander health plan 2021-2031*.

[15] Northern Territory PHN. *Outreach Health*. Retrieved from: http://www.ntphn.org.au/programs/outreach-health/ .

Research area 2: Culturally Safe and accountable systems to improve healthcare access and outcomes

Cultural Safety is understood to improve First Nations health and wellbeing outcomes through increased access, enhanced service delivery, and a health service system where racism is addressed and First Nations cultural strengths, values and differences are respected[16]. In this way, Cultural Safety is required at an individual, service and a system level and it's about *how* care is provided, as opposed to *what* care is provided.

For example, Cultural Safety requires practitioners to deliver safe, accessible and responsive health care that is free of systemic racism by:

- recognising and responding to the power imbalance between practitioner and patient
- reflecting on their knowledge, skills, attitudes, practising behaviours, and conscious and unconscious biases[17].

Consultations conducted through the Health Needs Assessment (HNA) highlighted a general lack of understanding of Cultural Safety in health services, including how it can be maintained. Participants stressed the importance of ensuring services are increasing their cultural capability, which is more than building cultural awareness. While participants noted existing work underway to support increased Cultural Safety, including training and relationship building, and the need to increase the First Nations-identified staff in mainstream services. Consultation participants also highlighted the role of Murray PHN to increase the level of accountability of mainstream services in Cultural Safety.

The concepts of racism and the Cultural Safety continuum, including how they emerged in the HNA, are further outlined below.

1. Racism in healthcare

Racism has a continuing and ongoing impact on the health outcomes of First Nations Peoples[18]. It manifests as the negative assumptions, attitudes and behaviours that impact on the quality of care they receive and their safety[19].

The HNA consultations identified experiences of racism across the Murray PHN catchment, which are reflected in First Nations Peoples experiencing delays in treatment and lengthy ED wait times. This aligns with research highlighting the health inequities caused by First Nations patients experiencing delayed or limited access to hospital procedures and cardiac-related specialist services, and higher rates of discharge against medical advice compared to non-First Nations Peoples patients[20].

2. The Cultural Safety continuum

The AIHW Monitoring Framework for Cultural Safety in Healthcare puts Cultural Safety on a continuum that begins with cultural awareness and progresses to Cultural Safety[21]. Cultural awareness is a basic understanding of diverse cultures found in a population, while Cultural Safety is defined as above.

Consultations highlighted that although mainstream services in the catchment may support their staff to participate in one-off Cultural Safety training, they don't necessarily commit to the ongoing critical reflection of health practitioner knowledge, practising behaviours and power differentials required to reach the level of Cultural Safety defined in this continuum.

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[16] Australian Institute of Health and Welfare. (n.d.). *Cultural safety in health care for Indigenous Australians: Monitoring framework*.

[17] Department of Health. (2021). *National Aboriginal and Torres Strait Islander Health Plan 2021–2031* (p. 52).

[18] Australian Government Department of Health. (2022). *Position statement: Impacts of racism on the health and wellbeing of Indigenous Australians*.

[19] National Aboriginal Community Controlled Health Organisation. (n.d.). *Systemic racism in health*.

[20] Australian Institute of Health and Welfare. (2023, May). *Racism and Indigenous Wellbeing, Mental Health, and Suicide*.

[21] Department of Health. (2021). *National Aboriginal and Torres Strait Islander health plan 2021-2031*

Key policy documents

There are various Victorian and Australian Government policy documents that highlight opportunities, or resources to leverage building Cultural Safety and eliminating racism in healthcare, including:

- National Agreement on Closing the Gap (2020) is specifically focused on transforming government organisations by identifying and eliminating racism.
- User Guide for Aboriginal and Torres Strait Islander Health, Australian Commission on Safety and Quality in Health Care (2017) includes a guide to improving Cultural Safety, detailing the benefits and requirements for taking action, the key tasks and strategies.
- Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 focuses on creating a Culturally Safe health workforce, increasing Indigenous participation and ensuring access to Culturally Safe services.
- Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Health supports the Australian health system in providing culturally responsive services, with a focus on six key domains, which include communication and workforce development.
- Cultural Safety in Health Care for Indigenous Australians Monitoring Framework (2023) focuses on the monitoring of culturally respectful healthcare through assessing patient experience and access.
- National PHN Strategy 2023 - 2024 identifies a priority to improve access to culturally appropriate mainstream care services.
- Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017 - 2027 *(Victorian)* includes *Priority Area 3:1 Culturally safe health and human services* as part of the required health system reform in Victoria.
- Victorian Aboriginal and Torres Strait Islander cultural safety framework (2021)https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1 provides a continuous quality improvement model to enhance Culturally Safe health service environments and workplaces, and encourages ongoing learning for individuals and organisations.
- Victorian Department of Health Strategic Plan 2023 - 2027 includes key deliverables related to Culturally Safe services and culturally respectful Aboriginal research and evaluation.

Examples of developing Culturally Safe care

Case study 1: Waminda's Model of Systemic Decolonisation – providing Culturally Safe healthcare in which Indigenous culture and knowledge are respected[22]	
Need	To address the importance of trauma- and violence-informed care, the Waminda South Coast Women's Health and Welfare Aboriginal Corporation (an ACCHO) sought to enhance their provision of Culturally Safe services through workforce capability, interagency partnerships, and building understanding of colonisation, racism and whiteness.
Approach	Waminda used lived experience and storytelling to understand how colonisation and racism affect families and local communities.

[22] Cullen, P., Mackean, T., Worner, F., Wellington, C., Longbottom, H., Coombes, J., Bennett-Brook, K., Clapham, K., Ivers, R., Hackett, M., & Longbottom, M. (2020). Trauma and Violence Informed Care Through Decolonising Interagency Partnerships: A Complexity Case Study of Waminda's Model of Systemic Decolonisation. *International journal of environmental research and public health*, *17*(20), 7363. https://doi.org/10.3390/ijerph17207363

Outcome	Three themes emerged throughout Waminda's decolonisation approach: 1. Effective interagency partnerships are essential and complex. ACCHO staff are constantly advocating for their clients and communities, developing and maintaining partnerships can be challenging and ACCHO staff often have to push back when the Community is no longer at the centre of conversations. 2. Waminda's programming for non-First Nations staff went beyond cultural competency training. Participants reflected on whiteness and white privilege during workshops and were also taught about effective allyship, historical events in Australia, and the impacts of transgenerational and intergenerational trauma. 3. To decolonise partnerships, it is essential to generate a shared experience and common language, as well as ensuring that everyone understands they have a 'role to play' in addressing structural and institutional racism.
Case study 2: The Krurungal Community Pathway Connector (CPC) as a Culturally Safe connection point and referral service[23] [24]	
Need	Aboriginal and Torres Strait Islander people may require tailored information and one-on-one support to navigate the health services system.
Approach	Recognising that Krurungal Aboriginal & Torres Strait Islander Corporation, a local community-controlled organisation, was providing essential social and emotional wellbeing support outside of its program structures, Gold Coast PHN (GCPHN) wished to better facilitate this work. Through a co-design workshop with Krurungal, local community representatives, and GCPHN, the Krurungal Community Pathway Connector (CPC) came to be what it is today – a four-week program that is long enough to put in place an appropriate mix of services around clients, but short enough for the individual to avoid becoming overly reliant on the service. Krurungal CPC receives financial support from the GCPHN through a flexible funding pool intended to drive mental health reform, and Krurungal CPC also engages in flexible reporting. While the reporting template is as detailed as for most funded PHN programs, there is greater flexibility in the activities that are entered in the fields, enabling workers to record less structured engagements (i.e. follow-up phone calls) as legitimate work under the program.
Outcome	By collaborating across the community and mainstream services sectors, Krurungal CPC enables Aboriginal and Torres Strait Islander people to access culturally appropriate services for a range of issues.

[23] Krurungal. (n.d.). *Our range of high quality programs to meet your needs*. Retrieved July 3, 2024, from https://krurungal.com.au/high-quality-programs-krurungal/

[24] Gold Coast Primary Health Network. (n.d.). *Krurungal community pathway connector*. Retrieved July 3, 2024, from https://gcphn.org.au/commissionedservices/krurungal-community-pathway-connector/

Research area 3: Addressing service gaps related to improving social and emotional wellbeing

Social and emotional wellbeing (**SEWB**) is the foundation of physical and mental health for First Nations Peoples – reflecting a holistic view of health and the connection that it has to land, sea, culture and spirituality. Social, political and historical factors can also influence wellbeing. Although social and emotional wellbeing concerns are distinct from mental ill-health, they can interact and influence each other.[25]

The Gee et al. (2014) SEWB Model offers a framework with seven interconnected domains: body and behaviours, mind and emotions, family and kinship, Community, culture, Country and land, and spirituality and ancestors[26]. These domains nurture strong First Nations identities within a collectivist framework. However, external factors like social determinants of health can disrupt SEWB. These include historical, political and cultural influences that impact access to resources and power dynamics in the community.

The Health Needs Assessment revealed significant gaps in SEWB services across the Murray PHN catchment. To bridge this gap, activities and services that strengthen connections to the SEWB domains while minimising the negative effects of these external factors need to be considered. This two-pronged approach can address the unique needs of First Nations communities and foster overall wellbeing.

Key policy documents

There are a number of Victorian and Australian Government policy documents that highlight the importance of SEWB for First Nations communities including:

- The National Agreement on Closing the Gap (2020) includes three SEWB-related outcome areas, including: 1) First Nations Peoples enjoy long and healthy lives; 2) enjoy high levels of SEWB; and 3) First Nations children thrive in their early years.
- National Aboriginal and Torres Strait Islander Health Plan 2021-2031 seeks to achieve prioritised SEWB through strengths-based approaches that embrace a holistic view and harness protective factors *(Priority 6).*
- National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031 highlights the need to build SEWB skills and qualifications in the First Nations health workforce.
- Balit Murrup Aboriginal Social and Emotional Wellbeing Framework 2017 2027 (Victorian) presents four domains to improve SEWB: 1) access to culturally responsive services; 2) a strong, skilled and supported workforce; 3) supporting resilience, healing and trauma recovery; and 4) integrated and seamless service delivery.
- Victorian Department of Health Strategic Plan 2023 - 2027 includes the importance of building the Aboriginal SEWB focus.

[25] AIHW. *Aboriginal and Torres Strait Islander Health Performance Framework. 1.18 Social and emotional wellbeing.*

[26] Transforming Indigenous Health & Wellbeing. (2021). *SEWB fact sheet*.

Examples of increasing access to social and emotional wellbeing services:

Case study 1: The Central Australia Aboriginal Congress' Health Services Division provides a comprehensive range of culturally appropriate services targeting the social, emotional, cultural, and physical health and wellbeing of First Nations Peoples.[27]	
Need	For more than 50 years, the congress has provided primary healthcare services for Aboriginal and Torres Strait Islander people and has worked to address relevant social and economic determinants of health.
Approach	The congress offers a range of SEWB services, including AOD support, a child and youth assessment and therapeutic service, psychological support, social and cultural support, and 'Link Up' support.
Outcome	Each of the services was designed with Cultural Safety and accessibility in mind. For example, Congress' Social and Emotional Wellbeing service provides consumers with psychologists who help consumers navigate relationships with their mob and address other concerns. Additionally, through the AOD support service, consumers can yarn with an Aboriginal Care Management Worker (and a translator, if necessary) to generate a recovery plan.
Case study 2: The National Empowerment Project's Cultural, Social and Emotional Wellbeing (CSEWB) Program in Western Australia[28][29]	
Need	There is an apparent lack of services that address SEWB and the other social determinants of health that contribute to disproportionately high rates of mental health disorders in First Nations communities.
Approach	The National Empowerment Project's CSEWB Program, initially funded in Queensland in 2014-2016 by the Queensland Mental Health Commission, is a suicide prevention program for First Nations Peoples that aims to promote SEWB and reduce distress, as well as empower communities to address the social determinants of health. The design of the program was based on consultation with 11 Aboriginal and Torres Strait Islander communities in response to high rates of psychological distress, self-harm and suicide. At the core of the program is reclaiming an Aboriginal discourse and acknowledging the role of colonisation in disrupting the mental health and wellbeing of Aboriginal and Torres Strait Islander Peoples. The CSEWB Program, developed using Graham Gee's SEWB model, implements a decolonising strategy and perspective that is deeper than most discourse on mental health. Instead of focusing on individual ill-health and symptom reduction, the CSEWB Program emphasises a whole-of-life understanding of health centring around wellness, harmony and balance. During the program, participants engage through community groups, mentorship opportunities and leadership development workshops. Through the program, First Nations Peoples are equipped with skills in problem-solving, conflict resolution, communication and goal-setting that support positive change. Program facilitators foster conversations around family structures in the context of the Stolen Generation and intergenerational trauma; managing conflict and healthy relationships; and Aboriginal self-determination. Over the course of the program, participants are reconnected with family, Community, history and Culture during yarning sessions and story-telling.

[27] Central Australian Aboriginal Congress. *Our Organisational Structure*. Retrieved from: http://www.caac.org.au/about-us/our-organisational-structure/

[28] Dudgeon, Pat, Kate L. Derry, Carolyn Mascall, and Angela Ryder. (2022). Understanding Aboriginal Models of Selfhood: The National Empowerment Project's Cultural, Social, and Emotional Wellbeing Program in Western Australia. *International Journal of Environmental Research and Public Health,* 19 (7), 4078. https://doi.org/10.3390/ijerph19074078

[29] *CSEWB PROGRAM*. (n.d.). National empowerment. https://www.nationalempowermentproject.org.au/csewb-program

Outcome	Participants have reported positive changes in their lives as a result of CSEWB Program. Individuals described having developed their aspirations and abilities, in addition to having strengthened their motivation to overcome significant challenges and disadvantages endured in their lives. It appears that through a framework of SEWB that focuses on strengthening cultural identity, it is possible to increase an individual's sense of belonging, connection to Country, and focus on family and community connections. The program was found to reduce Community members' experiences of psychological distress and hopelessness by facilitating a sense of empowerment and agency.

Section 5: Policy summaries

The information below provides a snapshot of the key developments relevant to First Nations health at a national level to guide Murray PHN's future commissioning activities.

National Agreement on Closing the Gap

The *National Agreement on Closing the Gap* holds significant relevance to the provision of support for First Nations healthcare. As a national commitment, it seeks to address the stark disparities in health outcomes between First Nations and non-First Nations Peoples in Australia. For Murray PHN, it provides a framework for collaborative action with First Nations communities, organisations and governments to improve health outcomes.

The National Agreement on Closing the Gap encompasses several areas that focus on addressing the social determinants of health and improving access to primary healthcare services for First Nations communities. Some key aspects include:

- **Access to culturally appropriate primary healthcare:** Closing the Gap initiatives prioritise improving access to primary healthcare services that are Culturally Safe and responsive to the needs of First Nations Peoples. This involves supporting ACCHOs and other primary health providers in delivering culturally appropriate care.
- **Chronic disease management:** Chronic diseases, such as diabetes, cardiovascular disease and respiratory conditions, disproportionately affect First Nations populations. Closing the Gap targets include strategies to enhance prevention, early detection and management of these conditions through primary healthcare interventions.
- **Maternal and child health:** Improving maternal and child health outcomes is a priority in the National Agreement on Closing the Gap. This involves initiatives to support prenatal care, maternal health services, early childhood development programs and immunisation services in primary healthcare settings.
- **Mental health and wellbeing:** Mental health disparities between First Nations and non-First Nations Peoples are significant. Closing the Gap initiatives aim to improve mental health outcomes by increasing access to culturally appropriate mental health services and integrating mental health support into primary healthcare settings.
- **Health workforce capacity building:** Enhancing the capacity of the primary healthcare workforce to deliver Culturally Safe and effective care is crucial. Closing the Gap strategies include workforce development programs, cultural competency training, and initiatives to increase the recruitment and retention of First Nations health professionals.
- **Preventative health:** Addressing health risk factors and promoting preventative health measures are essential to Closing the Gap efforts. Primary healthcare plays a vital role in delivering preventative health services such as health assessments, screening programs and health promotion activities tailored to the needs of First Nations communities.

National Aboriginal and Torres Strait Islander Health Plan 2021-2031

The *National Aboriginal and Torres Strait Islander Health Plan 2021 - 2031*, established in the context of The National Agreement on Closing the Gap, outlines the national policy for improving health and wellbeing outcomes for First Nations Peoples over the next 10 years.

Developed in partnership with Aboriginal and Torres Strait Islander communities, health organisations, and stakeholders, the plan sets key objectives and targets for ensuring that First Nations Peoples have access to culturally-centred health services that are prevention-focused, Culturally Safe and are responsive, equitable and free of racism. The plan includes priorities in terms of enablers of change, prevention areas to focus on, specific strategies to improve the health system and ways to ensure a culturally informed evidence base.[30]

Australia's Primary Health Care 10 Year Plan 2022-2032

Australia's Primary Health Care 10 Year Plan 2022-2032, which intends to strengthen the role of primary healthcare in the overall health system, provides an agenda for primary healthcare reform that centres on future-focused healthcare, person-centred primary healthcare supported by funding reform, and locally delivered integrated care. Within these three reform streams are 12 action areas, all resulting from significant consultation and input from many stakeholders across Australia. The key components of the plan are person-centred care, integrated care, digital health, workforce development, health equity, quality and safety, and financial sustainability.[31]

National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031

The *National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan 2021–2031* outlines actions to attract, recruit and retain workers in the health sector, with the overarching goal being for First Nations People to be fully represented in the workforce by 2031, and for there to be Culturally Safe and responsive care delivery available to Aboriginal and Torres Strait Islander people.

The plan is guided by six overarching strategic directions, all of which support the ongoing development of the size, capability and capacity of the Aboriginal and Torres Strait Islander health workforce. Several of these directions include ensuring that the workforce has the necessary skills, capacity and leadership across all health disciplines, roles and functions; ensuring that the next generation of Aboriginal and Torres Strait Islander people will be properly trained and equipped to meet the future health needs of their communities; and ensuring that Aboriginal and Torres Strait Islander people have successful transitions into the workforce and access to clear career pathways.[32]

2020 to 2025 National Health Reform Agreement (NHRA)

The *2020 to 2025 National Health Reform Agreement* (NHRA) between the Australian Government and all state and territory governments seeks to improve health outcomes for all Australians by providing better coordinated and joined-up care in the community, and ensuring the future sustainability of Australia's health system.

The goals of the NHRA are to deliver safe, high-quality care in the right place, at the right time; prioritise prevention and help people manage their health across their lifetime; drive best-practice and performance using data and research; and improve efficiency and ensure financial sustainability. Furthermore, included in this agreement are six long-term reforms that aim to support better-coordinated care in the community, focus on prevention, keep people healthier longer and reduce pressure on hospitals.[33]

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[30] Australian Government Department of Health, 2021

[31] Australian Government Department of the Prime Minister and Cabinet, 2020

[32] Australian Government Department of Health, 2022

[33] Australia Department of Health. (2020).

The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025

The *National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025* details strategies and initiatives for the Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards to cultivate a Culturally Safe health workforce, increase Aboriginal and Torres Strait Islander participation in the registered health workforce, ensure greater access for First Nations Peoples to Culturally Safe health services, and use their leadership to influence additional Australian entities. These strategies and initiatives may be used to guide the work of PHNs in addressing racism and Cultural Safety in the health sector.[34]

User Guide for Aboriginal and Torres Strait Islander Health

The *User Guide for Aboriginal and Torres Strait Islander Health* provides guidance for healthcare professionals and organisations delivering healthcare services to First Nations Peoples in a Culturally Safe and appropriate manner.

Included in the guide are six actions: working in partnership with First Nations communities, addressing the health needs of First Nations Peoples, implementing and monitoring targeted strategies, improving cultural competency, creating a welcoming environment and appropriately identifying people of Aboriginal and/or Torres Strait Islander origin. Action 1.21, specifically, is a guide on improving cultural competency. The resource details the benefits of taking action, the key tasks, suggested strategies (e.g. partnering with local Aboriginal and Torres Strait Islander communities to steer strategies for improving the cultural competency of the workforce) and supporting evidence.[35]

Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Health

The *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Health* aims to 'support the corporate health governance, organisational management and delivery of the Australian health system to further embed safe, accessible and culturally responsive services,' with the intended audience primarily being the Australian public health system.

The document provides information on existing health disparities, racism and discrimination against First Nations Peoples, and the critical role of the health workforce to achieve culturally respectful services. In particular, the document identifies six domains and focus areas: 1) whole-of-organisation approach and commitment; 2) communication; 3) workforce development and training; 4) consumer participation and engagement; 5) stakeholder partnership and collaboration; and 6) data planning, research and evaluation.[36]

Cultural Safety in Health Care for Indigenous Australians Monitoring Framework

The *Cultural Safety in Health Care for Indigenous Australians Monitoring Framework* aims to ensure accountability in the First Nations healthcare sector.

The tool was developed to assess and monitor the implementation and effectiveness of Cultural Safety practices in healthcare services for First Nations Peoples. It includes three modules: 1) culturally respectful health care services; 2) patient experience of health care; and 3) access to health care services. Modules 1 and 2 are, perhaps, most relevant to embedding the concept of Culturally Safe healthcare in practice, with information regarding organisational approach and commitment, communication and cultural services, workforce development and training, fair treatment and overcoming cultural barriers, and consumer engagement and stakeholder collaboration.[37]

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[34] Australian Health Practitioner Regulation Agency and the National Boards. (2020).

[35] Australian Commission on Safety and Quality in Health Care. (2017).

[36] Australian Government Department of Health, (2016).

[37] Australian Institute of Health and Welfare. (2023)

Victorian Aboriginal and Torres Strait Islander Cultural Safety Framework

The *Victorian Aboriginal and Torres Strait Islander Cultural Safety Framework* was developed to 'help mainstream Victorian health, human and community services and the department to create Culturally Safe environments, services and workplaces.'

The document aims to address the historical and systemic issues that have contributed to the health inequities and disparities experienced by First Nations Peoples. Key elements of the framework include establishing how leadership and governance can support the implementation of Culturally Safe principles, building strong partnerships with First Nations Peoples so they can be involved in decision-making around the services they receive, promoting environments where First Nations Peoples feel safe and understood, and enhancing the cultural competence of healthcare providers and organisations in Victoria.[38]

Report: 'Racism and Indigenous Wellbeing, Mental Health and Suicide'

The report '*Racism and Indigenous Wellbeing, Mental Health, and Suicide'* is a resource that provides background on racism in Australia, including its impacts, key issues, the policy context, existing programs and initiatives, strategies, approaches and best practices.

It provides an overview of how racism impacts First Nations Peoples in their access to healthcare, specifically from a mental health perspective. The report details the ways in which racism has affected the care provided to First Nations Peoples in health service settings, and further details its impact on psychological distress, disengagement with health services and not seeking care when needed. Other key topics include the relationship between experiences of racism and increased rates of anxiety, depression and use of AOD; the perspectives of First Nations communities and leaders; and the policy recommendations for policy makers and healthcare providers.[39]

Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017 - 2027

Korin Korin Balit-Djak Aboriginal health, wellbeing and safety strategic plan 2017 - 2027 is Victoria's framework for improving the health, wellbeing, and safety of First Nations Victorians over the course of 10 years.

In line with the Victorian Government's commitment to self-determination for First Nations Peoples, the document details five domains of focus: 1) Aboriginal community leadership; 2) prioritising Aboriginal culture and community; 3) system reform across the health and human services sector; 4) safe, secure, strong families and individuals; and 5) physically, socially and emotionally healthy Aboriginal communities. Within each domain are priority areas, as well as strategic directions and actions.

Other key themes in the plan are Cultural Safety, health equity, SEWB, community engagement, education and training for the health workforce and community leaders, data and research, and essential partnerships.[40]

[38] Victorian Department of Health. (2021).

[39] Australian Institute of Health and Welfare. (2023).

[40] Victorian Department of Health and Human Services. (2017).

Balit Murrup Aboriginal Social and Emotional Wellbeing Framework 2017 2027

Victoria's *Balit Murrup Aboriginal Social and Emotional Wellbeing Framework 2017 2027* is a companion document to *Korin Korin Balit-Djak: Aboriginal Health, Wellbeing and Safety Strategic Plan 2017–2027*, providing a strategic framework for improving SEWB and mental health of First Nations Peoples in Victoria over 10 years.

The document outlines four key domains for change: 1) improving access to culturally responsive services; 2) supporting resilience, healing and trauma recovery; 3) building a strong, skilled and supported workforce; and 4) ensuring integrated and seamless service delivery. Within each domain are strategic priorities, immediate actions and longer-term deliverables.

Other themes in the document are the importance of cultural connectedness, SEWB services, holistic health approaches, community leadership and participation, prevention and early intervention, and mechanisms for monitoring and evaluation. The document also importantly lists key partners and stakeholders.[41]

Victorian Department of Health Strategic Plan 2023 - 2027

The *Victorian Department of Health Strategic Plan 2023 - 2027* outlines seven strategic priorities for the health and wellbeing of Victorians: 1) to keep people healthy and safe in the community, 2) providing care closer to home; 3) keep innovating and improving care; 4) improve Aboriginal health and wellbeing; 5) move from competition to collaboration; 6) cultivate a stronger and more sustainable workforce; and 7) ensure a safe and sustainable health, wellbeing and care system.

For each strategic priority, there are specific deliverables, initiatives and outcomes that define what will constitute success. Additionally, the document outlines a risk management plan, as well as an asset and financial outlook.[42]

National PHN Strategy 2023 - 2024

The *National PHN Strategy 2023-2024* outlines the purpose, objectives, key functions and role of PHNs in supporting health reform through local innovation. The document further describes, in detail, the three core functions of PHNs (coordinate, commission and capacity build), the 11 areas of funding and the 2023-2024 priority areas, as well as the key stakeholders to engage.[43]

Victorian Health Workforce Strategy

The *Victorian Health Workforce Strategy* outlines a strategy for attracting, developing and retaining the experienced health workforce required to deliver quality healthcare in Victoria.

The document highlights five focus areas for change: 1) increasing the supply of priority rules; 2) strengthening rural and regional workforces; 3) improving employee experience; 4) building future roles and capabilities; and 5) leveraging digital data and technology.

These five focus areas inform 12 action areas related to workforce planning, workforce recruitment and retention, workforce development and training, workforce diversity and equity, workforce wellbeing, innovation and technology, and collaboration and partnerships.[44]

[41] Victorian Department of Health. (2017).

[42] Victorian Department of Health. (2023).

[43] Australian Government Department of Health. (2023).

[44] Victorian Department of Health. (2024).

Section 6: Data sources and definitions

Quantitative data definitions

Three key terms have been adopted to describe the key findings emerging from the quantitative data. The definition adopted for these terms are as follows:

- **Catchment rate:** Refers to the rate for all First Nations Peoples residing in the Murray PHN catchment
- **State rate:** Refers to the rate for all First Nations Peoples in Victoria
- **National rate:** Refers to the rate for all First Nations Peoples across Australia
- **Mainstream state/national rate:** Refers to the rate relevant to the entire population in Victoria or nationally.

Datasets used

To inform this Health Needs Assessment, data was collected, consolidated and analysed according to three key categories:

- **Need** - demographic and population health data that provide an indication of the increased likelihood for primary health services
- **Unmet demand** - data that reflects the potential implications resulting from limited access to appropriate primary health services
- **Supply** - the extent of existing primary health services.

Data across these three key categories was extracted from a range of quantitative datasets accessed via Murray PHN, third-party providers and publicly available sources. The datasets that were used are outlined in **Table 26** below.

Appendix A contains a detailed list of the data indicators analysed and presented in this document***.***

Australian Bureau of Statistics (ABS)

Australian Institute of Health and Wellbeing (AIHW)

Public Health Information Department Unit (PHIDU).

Analysis of data at a geographical level

All data presented in this document is at an LGA level to allow for comparisons across the catchment. In addition, and where possible, age-standardised rates (ASR), rates and proportions, rather than absolute numbers, have been used to enable the 22 LGAs in the Murray PHN catchment to be ranked and compared over time.

In total, Impact Co. has analysed 61 different data indicators. In conducting the analysis, each variable was ranked to demonstrate the extent of variation across the LGAs relative to each other. It must also be noted that most of the data related to First Nations Peoples in the catchment was available at the ABS-defined Indigenous Area (IARE) level, which was then analysed according to their relevant LGA.

In addition, in recognition that Murray PHN operates from four regional offices in the catchment, the data were also analysed at a regional level. The four regions, including the corresponding LGAs and IARE within the subregional boundary, are outlined in **Table 26** below.

Table 26: Regions in the Murray PHN catchment, including corresponding LGAs and IAREs

Region	LGA	IARE
Central Victoria	Campaspe (S)	Campaspe - Shepparton - Moira
	Gannawarra (S)	Castlemaine - Kerang
	Greater Bendigo (C)	Bendigo
	Loddon (S)	Castlemaine - Kerang
	Mount Alexander	Castlemaine - Kerang
Goulburn Valley	Greater Shepparton (C)	Campaspe - Shepparton - Moira
	Macedon Ranges (S)	Macedon Ranges - Moorabool
	Mitchell (S)	Wallan - Seymour
	Moira (S)	Campaspe - Shepparton - Moira
	Murrindindi (S)	Upper Goulburn Valley
	Strathbogie (S)	Upper Goulburn Valley
North East	Albury (C)	Albury
	Alpine (S)	Wodonga
	Benalla (RC)	Upper Goulburn Valley
	Indigo (S)	Wodonga
	Mansfield (S)	Upper Goulburn Valley
	Towong (S)	Wodonga
	Wangaratta (RC)	Wodonga
	Wodonga (C)	Wodonga
North West	Buloke (S)	Castlemaine - Kerang
	Mildura (RC)	Mildura
	Swan Hill (RC)	Swan Hill

Rurality

The Murray PHN catchment covers an area of approximately 100,000 square kilometres, spanning from Mildura in the northwest to Woodend in the south, across to Seymour and up to Albury. The entire catchment is outside metropolitan Melbourne, so Murray PHN is considered a rural catchment. However, based on the Modified Monash Model (MMM), areas in the catchment are considered rural or regional.

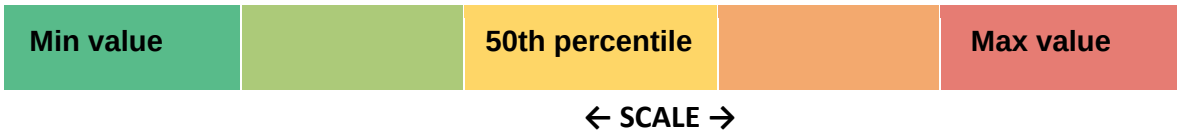
The Australian Department of Health and Aged Care uses MMM to classify a location as a city, rural, remote or very remote. Based on remoteness and population size, the MMM uses a scale from MM 1 (major city) to MM 7 (very remote).

Presentation of quantitative findings

Throughout the report, tables and maps were included to present the results from the quantitative analysis. For the detailed analysis of each data indicator in **Appendix B**, each table adopts a colour scale to allow readers to easily see the magnitude of each indicator and results compared to other LGA/region geographies.

The colour scale legend is shown below. The minimum (smallest) value is green, the midpoint (50th percentile) is yellow and the maximum (largest) value is red. The colour scale also reflects the potential 'demand' for primary health services.

Note: *For data indicators related to the existing 'supply' of primary health or community-based services, the colour scale has been reversed.*



Stakeholder consultations

Impact Co. (referred to as the 'project team' hereafter) conducted a series of consultations with stakeholders and Community members from across the catchment to understand the health needs of the First Nations population. The consultations were conducted with ACCHOs, First Nations organisations, First Nations Community members and mainstream services providing services to First Nations Peoples across the catchment.

Murray PHN provided an original list of organisations and Community members to be initially invited, with invitees encouraged to suggest or extend the invitation to other relevant parties to participate.

ACCHOs were prioritised in the consultation process, and provided with the opportunity to nominate whether a consultation would involve staff, Community members or both. All seven ACCHOs in the region took part in the consultation process in some way.

The consultations that took place included:

- Focus group interviews with 19 staff from five ACCHOs
- Community yarns with 42 Community members and staff at two ACCHOs
- Interviews with two First Nations individuals with coordinating roles in the catchment
- Interviews with four staff from three First Nations Corporations
- Six focus groups with 23 staff from 18 mainstream services who provide services to First Nations Peoples.

Overall, 90 participants took part in the consultation process, with 64 (or 71%) identifying themselves as a First Nations individual.

Across the catchment, this included engaging with:

- Six organisations in the North West sub-region
- Nine organisations in the Central Victoria sub-region
- Seven organisations in the Goulburn Valley sub-region
- Eight organisations in the North East sub-region.

Questions posed throughout consultations were focused on the following areas:

- The greatest health access needs, the critical barriers to access and existing strong solutions to increase access for Aboriginal and Torres Strait Islander Community members

- The greatest service provision needs for services supporting Aboriginal and Torres Strait Islander communities, the barriers to service delivery and existing strong solutions to support the delivery of services
- Experiences of Cultural Safety, or lack thereof, and actions to build Cultural Safety and understanding with services
- Integration across the health service system, including between ACCHO and mainstream services, Murray PHN, and other areas for specialist health services.

The complete consultation guide can be found in ***Appendix C.***

First Nations-led consultations

Two First Nations consultants were part of the project team that conducted this health and service needs analysis, who were involved in all aspects of the project, including leading each consultation (except for one individual interview due to illness), identifying key themes, and developing insights and recommendations.

When determining the significance of comments in developing qualitative insights, the project team weighted First Nations comments more heavily than non-First Nations participants, ensuring their perspectives had a greater influence on the HNA findings.

Data gaps and limitations

In future work with ACCHOs and First Nations communities, the impacts of domains with limited or no insights collected through this process should also be further scoped and examined, which were:

Domains	Data gaps
Autonomy, empowerment and recognition	1:1 Respect
Family and Community	2.1: Family and friends 2.3 Cultural connectedness 2.4 Disconnection from family and Community
Culture, spirituality and identity	3.1: Elder role/governance 3.2: Spirituality 3.3: Culture
Country	4:1: Care of Country 4:2 Return to Country
Basic needs	5.3: Safety and security 5.4 Future planning
Work, roles and responsibilities	6.1: Caring responsibilities 6.2: Cultural responsibilities 6.4: Other roles and responsibilities
Access to services	10.6: Cultural healing practices
Workforce	11.1 Culturally Safe ways of care 11.2 Joy in the workforce

Quantitative data limitations

As highlighted in **Insight 3**, ACCHOs queried the accuracy of the quantitative data that was publicly available, noting that it may not be accurate. For this reason, communities stressed the need to interpret the quantitative data presented in this report cautiously and alongside the qualitative insights.

Other limitations include:

- First Nations health data can be inaccurate due to its reliance on identification. Factors such as under-identification, misclassification and data quality issues can all affect the data reliability.
- We note that only a subsection of the Macedon Ranges, Mitchell and Murrindindi LGAs lies within the Murray PHN catchment. However, the data presented in this Health Needs Assessment reflect the entire LGA geographic region, particularly with respect to the estimated resident population (ERP). This is in recognition that proportions or rates of data indicators extracted from publicly available sources reflect the entire geographic region.
- As noted earlier, most data describing the health needs and unmet demand for First Nations Peoples in the catchment were only available at an IARE level. As noted in **Table 26**, some IARE boundaries cover multiple regions of the Murray PHN catchment (e.g. Campaspe-Shepparton-Moira and Upper Goulburn Valley). For this reason, an average value was applied to the corresponding LGAs.
- Quantitative data to measure the extent of existing supply was limited to data provided by Murray PHN. Although primary health service data was requested from ACCHOs as part of this process, this was not included as it would skew the results towards regions that provided data.

Qualitative data limitations

- Input from First Nations Community members not employed in the health sector was limited. Community yarns were conducted when specific ACCHOs requested the consultations be held in this way. Other ACCHOs chose for Impact Co. to speak to staff members (noting that First Nations staff members both within ACCHOs and other services are also Community members). Consequently, engagement with Community members not employed in health services varied across the catchment.

Appendices

Appendix A: Glossary

Word or term	Definition
SEWB	Social and emotional wellbeing is the foundation of physical and mental health for First Nations Peoples, reflecting a holistic view of health and the connection that it has to land, sea, culture and spirituality. Social, political and historical factors can also influence wellbeing. Although social and emotional wellbeing concerns are distinct from mental illness, they can interact and influence each other.[45]
Multi-morbidities	Three or more long-term conditions.
Aboriginal Community Controlled Health Organisation (ACCHO)	As defined in *Australia's Primary Health Care 10-Year Plan 2022-2032*, an ACCHO is 'a primary healthcare service initiated and operated by the local Aboriginal community to deliver holistic, comprehensive and culturally appropriate healthcare to the community which controls it, through a locally elected board of directors'.
Holistic	With respect to First Nations Peoples, a holistic view of health expands beyond the absence of disease or illness, and includes consideration of physical, social, emotional, cultural, spiritual and ecological wellbeing, for individuals and the community.[46]
Self-determination	An ongoing process of ensuring that First Nations Peoples are able to make decisions about matters that affect their lives. It is an exercise of choice, participation and control.[47]
Colonial load	The load placed on First Nations People by settlers and institutions. It includes biases, assumptions, expectations and entitlement held by settlers.
Mainstream services	Refers to services that are provided for all population groups.
GP-type ED presentation	An ED presentation that could have been avoided and managed by a GP is defined by those that[48]: ● are allocated a Triage Category 4 (semi-urgent) or 5 (non-urgent) ● did not arrive by ambulance, police or correctional vehicle ● were not admitted to the hospital, not referred to another hospital or did not die.

[45] AIHW – Aboriginal and Torres Strait Islander Health Performance Framework. 1.18 Social and emotional wellbeing. Retrieved from: http://www.indigenoushpf.gov.au

[46] Australian Government Department of Health and Ageing. (2013). National Aboriginal and Torres Strait Islander Health Plan 2013 – 2023. Canberra: Australian Government Department of Health and Ageing.

[47] Australian Human Rights Commission. Self-determination and Indigenous peoples. Retrieved from: http://www.humanrights.gov.au

[48] AIHW (AIHW). (2017). *National Healthcare Agreement: PI 19- Selected potentially avoidable GP-type presentations to emergency departments, 2016.*

Appendix B: Quantitative data indicators

Domain: Family and Community

Description	Source	Year	Geography	Calculations
MMM Weightings	Murray PHN	-	GP catchments	-
Estimated resident population Aged 0 – years Aged 5 – 9 years Aged 10 – 14 years Aged 15 – 24 years Aged 25 – 44 years Aged 45 – 64 years Aged 65+ years	ABS	2021	LGA	-
Proportion of 2021 resident population who identify as Aboriginal and/or Torres Strait Islander	PHIDU	2021	LGA	Number of Indigenous persons 2021/ ERP2021

Domain: Basic needs

Description	Source	Year	Geography	Calculations
Indigenous Relative Socioeconomic Outcomes Index (IRSEO)	PHIDU	2021	IARE	-
% of Aboriginal and/or Torres Strait Islander Peoples living in appropriate sized housing	PHIDU	2021	IARE	Inverse of crowded dwellings
% of Aboriginal and/or Torres Strait Islander Peoples without financial stress from mortgage or rent	PHIDU	2021	IARE	Inverse of low-income households under financial stress from mortgage or rent

Domain: Work, roles and responsibilities

Description	Source	Year	Geography	Calculations
% of Aboriginal and/or Torres Strait Islander Peoples employment	PHIDU	2021	IARE	Inverse of unemployment

Domain: Physical health

Description	Source	Year	Geography	Calculations
Proportion of the Aboriginal population with a profound or severe disability	PHIDU	2021	IARE	Number of people with a profound or severe disability / EPR 2021
ASR per 100 Aboriginal and/or Torres Strait Islander People (aged 15 years and over) with fair or poor self-assessed health	PHIDU	2018-19	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who have three or more long-term health conditions	PHIDU`	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People (aged 0 – 14 years) who have two or more long-term health conditions	PHIDU`	2021	IARE	
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported arthritis	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported asthma	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported cancer	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported dementia	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported diabetes	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported heart disease	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported kidney disease	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported COPD	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported they had a stroke	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People (0 – 14 years) who reported they had asthma	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People who reported a mental health condition	PHIDU	2021	IARE	-
ASR per 100 Aboriginal and/or Torres Strait Islander People (0 – 14 years) who reported a mental health condition	PHIDU	2021	IARE	-

Domain: Social and emotional wellbeing

See Domain: Physical health (above)

Domain: Access to services

Description	Source	Year	Geography	Calculations
ASR of potentially preventable hospitalisations (all) per 100,000 Aboriginal and/or Torres Strait Islander People • 0 – 14 years • 15 – 24 years • 25 – 44 years • 45 – 64 years • 65+ years	PHIDU	2017/18 – 2019/20	IARE	-
ASR of chronic condition-related PPH per 100,000 Aboriginal and/or Torres Strait Islander People	PHIDU	2017/18 – 2019/20	IARE	
ASR of PPHs for chronic angina per 100,000 Aboriginal and/or Torres Strait Islander People	PHIDU	2017/18 – 2019/20	IARE	-
ASR of PPHs for chronic asthma per 100,000 Aboriginal and/or Torres Strait Islander People	PHIDU	2017/18 – 2019/20	IARE	-
ASR of PPHs for congestive cardiac failure per 100,000 Aboriginal and/or Torres Strait Islander People	PHIDU	2017/18 – 2019/20	IARE	-
ASR of PPHs for COPD per 100,000 Aboriginal and/or Torres Strait Islander People	PHIDU	2017/18 – 2019/20	IARE	-
ASR of PPHs for diabetes complications per 100,000 Aboriginal and/or Torres Strait Islander People	PHIDU	2017/18 – 2019/20	IARE	-
ASR of PPHs for chronic iron deficiency per 100,000 Aboriginal and/or Torres Strait Islander People	PHIDU	2017/18 – 2019/20	IARE	-
ASR of non-urgent and semi-urgent ED attendances per 100,000 Aboriginal and/or Torres Strait Islander People	PHIDU	2019-20	IARE	
ASR of non-urgent and semi-urgent ED attendances per 100,000 Aboriginal and/or Torres Strait Islander People for diseases of the respiratory system	PHIDU	2019-20	LGA	-
ASR of non-urgent and semi-urgent ED attendances per Aboriginal 100,000 population for diseases of the digestive system	PHIDU	2019-20	LGA	-

ASR of non-urgent and semi-urgent ED attendances per 100,000 Aboriginal and/or Torres Strait Islander People for diseases of the musculoskeletal system and connective tissue	PHIDU	2019-20	LGA	-
ASR of non-urgent and semi-urgent ED attendances per 100,000 Aboriginal and/or Torres Strait Islander People for diseases of the genitourinary system	PHIDU	2019-20	LGA	-
ASR of non-urgent and semi-urgent ED attendances per 100,000 Aboriginal and/or Torres Strait Islander People related to mental health and behavioural disorders	PHIDU	2019-20	LGA	-
ASR of ED attendances per 100,000 Aboriginal and/or Torres Strait Islander People related to mental health and behavioural disorders	PHIDU	2019-20	LGA	

Domain 11: Workforce

Description	Source	Year	Geography	Calculations
No. of Aboriginal and Torres Strait Islander Health Practitioners	Commonwealth Health Workforce Data	2022	LGA	-
No. of Aboriginal and Torres Strait Islander Health Practitioners per 1000 First Nations Peoples	Commonwealth Health Workforce Data	2022	LGA	(No. of Aboriginal and Torres Strait Islander Health Practitioners /ERP2021)*1000

Appendix C: Consultation guide

The guide below includes the context for three differing types of consultations and the questions used in each.

ACCHO consultations

The ACCHO consultations considered and included issues previously raised with Murray PHN regarding each ACCHO's community and service needs. The pre-consultation document provided this information as a basis for each consultation. Murray PHN was also interested in testing some specific data with each ACCHO; this was provided in the pre-consultation deck and followed up after the consultation. The resulting data will be shared with Murray PHN separately to this report.

Each ACCHO decided which cohort to engage for their consultation, which could include staff and/or Community members. Recognising that ACCHO staff are regularly Community members as well, the questions below need to be addressed at a high level. The facilitators adapted the questions to suit the audience in each focus group.

1. Thinking about the greatest need for your community regarding access to services, what is crucial to discuss today?

   Prompt: after hours, chronic disease, emotional and social health, wellbeing, ageing strong, general practice access, specialist service access, location, health screening, allied health, prevention, workforce (recruitment, retention, training), AOD.

2. Thinking about key barriers for the community to access the care they need, what would they be?
3. Thinking about strong solutions to ensuring access to care, what do they look like? Do you have examples of programs that are working well?
4. Thinking about your organisation, what are its greatest needs regarding the provision of services to meet community needs?

   Prompt: after hours, chronic disease, emotional and social health and wellbeing, ageing strong, general practice access, specialist service access, location, health screening, allied health, prevention, workforce (recruitment, retention, training), specific services for age groups.

5. Thinking about key barriers for your organisation to deliver the services the community needs, what would they be?
6. Thinking about strong solutions to supporting the delivery of services, what do they look like?

   Prompt: Digital health services.

7. Thinking about integration with necessary services outside of your organisation as part of the bigger primary health service (hospitals, private providers, specialists), what is the greatest need?
8. What are examples of how this looks when working well?
9. What are the main barriers to support better integration?

   Prompt if needed: What, if any, impact is racism having on the provision of services for Aboriginal and Torres Strait Islander clients?

10. Is there anything else you would like to add?
11. Murray PHN has heard in the past that the data they are working from in the First Nations space is incorrect. They're interested in ensuring they have reliable data for this health needs assessment. The pre-consultation deck included some validation questions on this data, can we follow up with someone within the service to test and update this information where appropriate?

Western health service consultations

These consultations included a mix of non-Aboriginal community-controlled health services. The high-level questions are the same as those above, with the inclusion of a question about Cultural Safety.

1. Thinking about the greatest access needs for your Aboriginal and Torres Strait Islander clients, what is crucial to discuss today?

   Prompt: after hours, chronic disease, emotional and social health, wellbeing, ageing strong, general practice access, specialist service access, location, health screening, allied health, prevention, workforce (recruitment, retention, training), AOD.

2. Thinking about key barriers for your Aboriginal and Torres Strait Islander clients to access the care they need, what would they be?
3. Thinking about strong solutions to ensuring access to care for your Aboriginal and Torres Strait Islander clients, what do they look like? Do you have examples of programs that are working well?
4. Thinking about your organisation, what are its greatest needs regarding the provision of services to meet Aboriginal and Torres Strait Islander client's needs?

   Prompt: after hours, chronic disease, emotional and social health and wellbeing, ageing strong, general practice access, specialist service access, location, health screening, allied health, prevention, workforce (recruitment, retention, training), specific services for age groups.

5. Can you tell us a little about what your organisation is doing to create and ensure Cultural Safety for your Aboriginal and Torres Strait Islander clients?
6. Thinking about key barriers for your organisation to deliver the services your Aboriginal and Torres Strait Islander community needs, what would they be?
7. Thinking about strong solutions to supporting the delivery of services, what do they look like?

   Prompt: Digital health services.

8. Thinking about integration with necessary services outside of your organisation as part of the bigger primary health service (hospitals, private providers, specialists), what is the greatest need?
9. What are examples of how this looks when working well?
10. What are the main barriers to support better integration?
11. Is there anything else you would like to add?

First Nations organisations consultations

The organisations invited to participate in these consultations had limited relationships with Murray PHN. In this context, facilitators may have clarified the scope of the discussion to ensure participants are clear on the areas that can be influenced through the Needs Assessment process.

1. Thinking about the greatest need for your community regarding access to services, what is crucial to discuss today?

   Prompt: after hours, chronic disease, emotional and social health, wellbeing, ageing strong, general practice access, specialist service access, location, health screening, allied health, prevention, workforce (recruitment, retention, training), AOD.

2. Thinking about key barriers for your community to access the care they need, what would they be?
3. Thinking about strong solutions to ensuring access to care, what do they look like? Do you have examples of programs that are working well?
4. Thinking about your organisation, what are its greatest needs regarding providing services to meet community needs?

Prompt – after hours, chronic disease, emotional and social health and wellbeing, ageing strong, general practice access, specialist service access, location, health screening, allied health, prevention, workforce (recruitment, retention, training), specific services for age groups.

5. Thinking about key barriers for your organisation to deliver the services the community needs, what would they be?
6. Thinking about strong solutions to supporting the delivery of services, what do they look like?

   Prompt: Digital health services.
7. Thinking about integration with necessary services outside of your organisation as part of the bigger primary health service (Hospitals, private providers, specialists), what is the greatest need?
8. What are examples of how this looks when working well?
9. What are the main barriers to support better integration?

   Prompt if needed: What, if any, impact is racism having in the provision of services for Aboriginal and Torres Strait Islander clients?
10. Is there anything else you would like to add?