Murrindindi Shire Council & Murrindindi Health Network

Health and Aged Care Workforce Strategy Network Plan

Internal Report & Findings – December 2025

MURRINDINDI HEALTH NETWORK

Murrindindi Shire Council

NMC NINETY MILE CONSULTING


We acknowledge the Traditional Owners
of the lands of the Murrindindi Shire
region and pay our respects to Elders
past, present and emerging

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Reader Notes - Report Structure

The project is being conducted across 4 phases to provide a comprehensive strategic health network and workforce plan which includes the current state analysis, co-design workshops, integrated service model development, and business case creation

This report provides an integrated view of the Current and Future State of healthcare and aged care services across Murrindindi, forming the evidence base for a strategic and forward-looking Health Network Plan. The Current State analysis establishes a clear picture of what is happening in the region today through comprehensive data review, stakeholder input, community engagement, and service mapping. It identifies key gaps, workforce challenges, barriers, and opportunities shaping local health outcomes. Building on these insights, the Future State and Options Analysis evaluates four strategic pathways for network integration, translating the 12 priority elements into viable implementation approaches. Together, these phases move the network from understanding present challenges to making informed, future-focused decisions.

This Report

1. Review & Analyse

- Consultation & Engagement
- Data Analysis & Service Mapping
- Stakeholder Workshops
- Gap & Needs Assessment

This phase explores Murrindindi's existing health service environment, identifying challenges, strengths, and barriers through comprehensive data analysis, community surveys, stakeholder consultations, and service mapping. It establishes a clear baseline for planning.

2. Identify & Co-Design

- Future State Design
- Financial and Economic Analysis
- Evidence-Based Model Review
- Options Development

- Develops four distinct strategic options addressing the 12 priority elements. Partners can select or combine elements to create a tailored network solution.

3. Develop Model & Implementation Plan

- Design of Integrated Service and Workforce Model
- Workforce Strategy Development
- Phased Implementation Plan
- Governance and Partnership Framework Development

Designs the integrated model based on partner-selected option or hybrid. Includes workforce strategy, implementation roadmap, and governance framework ready for execution.

Separately Presented

4. Long-Term Impact & Business Cases

- Business Case Development
  - Finalise strategic priorities based on co-design input
  - Define detailed service and workforce activities aligned to each priority
  - Identify 10-15 priority initiatives for immediate implementation
- Submit business cases for submission-implementation
- DoH and LHSN Roundtable Discussion

Based on stakeholder feedback, this final phase will translate the agreed strategic priorities into a detailed, phased implementation plan. This will include specific activities, resourcing, responsibilities, timelines, governance, and success measures.

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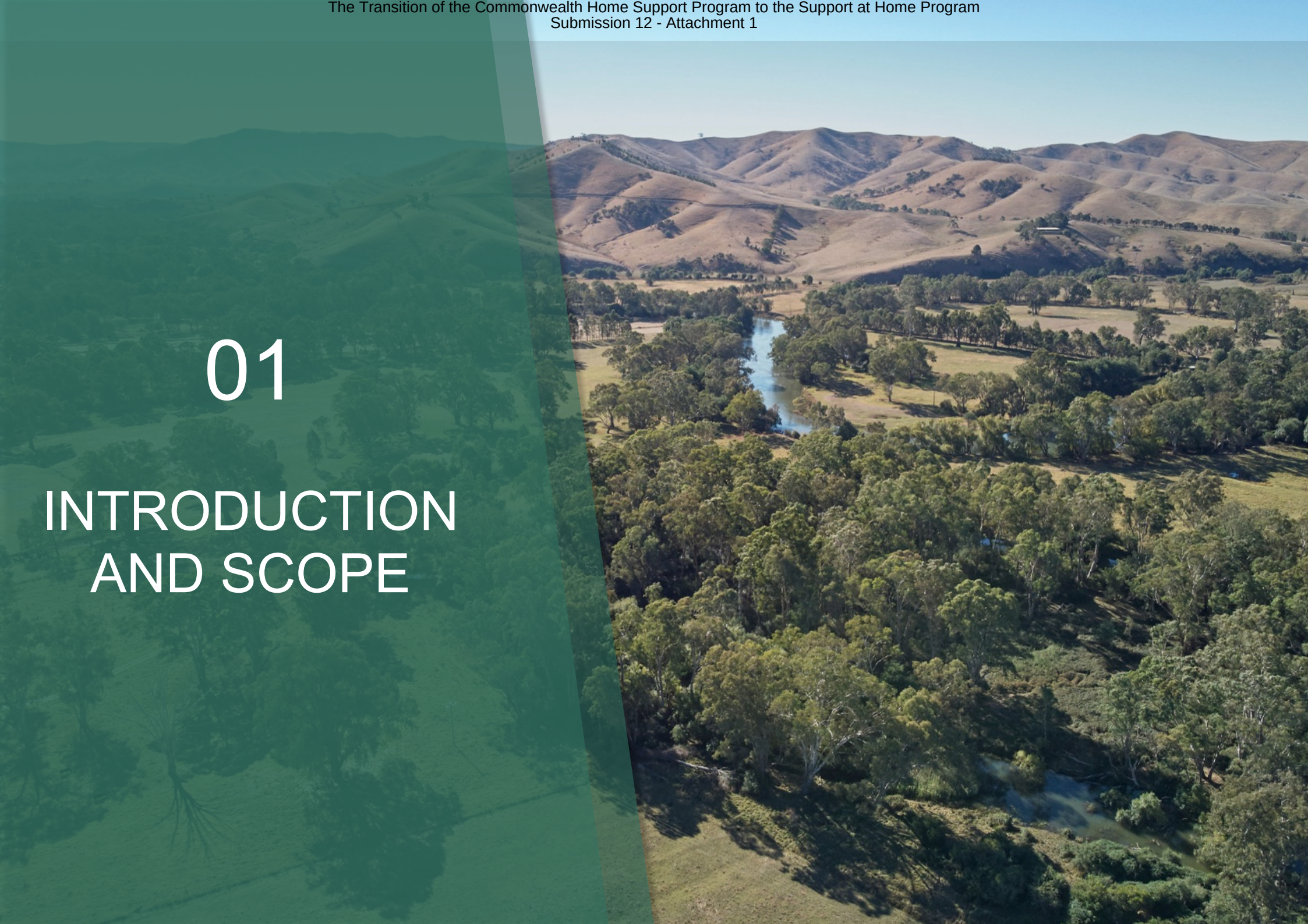
INTRODUCTION AND SCOPE



Background

Murrindindi Shire faces interconnected healthcare challenges including workforce shortages, an ageing population, service gaps, and economic transition from forestry industry decline, creating an immediate need for strategic intervention to ensure sustainable, locally-accessible health, and aged care services

Context and Setting

The Shaping the Future Health Workforce for Murrindindi project represents a strategic initiative aimed at optimising healthcare services and improving local workforce capacity to meet current and future demands across Murrindindi Shire. Led by Murrindindi Shire Council (MSC) in partnership with the Murrindindi Health Network, this project is funded through the Victorian Forestry Transition Program, which is designed to help communities navigate long-term planning, foster innovation, and diversify the local economy to support economic growth and adapt to industry transitions.

Murrindindi Shire serves a geographically dispersed population across key townships, including Yea, Alexandra, Kinglake, and Marysville, with the region experiencing demographic and economic transitions. The Shire's healthcare landscape is characterised by a mix of public and private providers, including the Murrindindi Health Network - a consortium of six local health and community organisations working collaboratively to strengthen local healthcare access and workforce capacity.

Current Challenges

The region faces multiple interconnected healthcare challenges that have created an urgent need for strategic intervention:

Workforce and Service Delivery Pressures:

- Critical workforce shortages across health and aged care sectors
- Difficulty attracting and retaining qualified healthcare professionals in rural settings
- Limited availability of specialist services within the region
- Fragmented service delivery across multiple small providers

Demographic and Geographic Challenges:

- Ageing population requiring increased healthcare and aged care services
- Geographically dispersed communities with limited transport access
- Sustainable growth is anticipated in Alexandra, Kinglake, Eildon, and Yea, further straining existing services
- Rural isolation creating barriers to service access and workforce retention

Economic and Structural Changes:

- Transitioning forestry industry impacting local employment and economic base
- Service leakage requiring residents to travel outside the Shire for healthcare
- Significant hidden costs including government-subsidised patient transport services, ambulance transfers, and carer burden
- Limited infrastructure capacity to meet growing demand

Key Drivers and Project Objectives

Health reforms, economic transition, and service integration needs drive the immediate requirement for strategic workforce planning to ensure sustainable and locally-accessible healthcare for Murrindindi's rural communities

Key Drivers For This Project

Murrindindi's workforce shortages and service delivery challenges are creating significant barriers to healthcare access for local communities. These existing pressures are being intensified by major health and aged care reforms currently transforming Victoria's service landscape, presenting both immediate implementation challenges and strategic opportunities for innovative service redesign.

Policy and Reform Context

- Major health and aged care reforms are reshaping service delivery across Australia. As of November 2025, the Support at Home program will replace existing home care packages with a new market-based model, creating risks around continuity of care and affordability for smaller communities.
- Victoria's ongoing mental health reforms emphasise stronger integration between primary care, mental health, and aged care services, requiring new models of collaboration to meet local needs.
- The establishment of Victorian Health Service Networks (HSNs) aims to strengthen regional planning and integration, but also introduces complexity for rural areas that rely on cross-boundary access and consistent referral pathways.

Economic Drivers

- The Victorian Forestry Transition Program provides funding for economic diversification following industry transition. A critical driver is "service leakage"- the substantial costs when residents travel outside the region for healthcare, including patient transport schemes and ambulance transfers. Localising services presents significant economic opportunities alongside improved health outcomes.

Community Integration Needs

- Murrindindi's dispersed geography and small population make isolated service provision unsustainable. Innovative collaborative models combining public, private, and community providers are essential to build local workforce capacity and serve evolving health and aged care needs effectively.

Project Objectives

Primary Objective

To review current health and care service provision across Murrindindi, develop evidence-based improvement options, and deliver actionable recommendations with business cases that enhance health and aged care outcomes for dispersed rural communities.

Specific Objectives

1. Assess existing healthcare infrastructure, workforce capacity, and service delivery while identifying gaps, barriers, and duplications. Quantify total economic costs including service leakage and transport expenses.
2. Research and co-design innovative rural service delivery models through stakeholder engagement, incorporating partnerships, shared services, telehealth, and outreach while ensuring equity and accessibility.
3. Create comprehensive workforce planning addressing current shortages and future needs through 2035, focusing on local workforce attraction, retention, and development based on demographic and health trends.
4. Develop actionable implementation plans with performance indicators, governance structures, and sustainable funding pathways aligned with state and national health reforms.

Current State Methodology

A dual approach was used to develop a Network Plan that is informed by the community, service providers, and key system stakeholders

	Elements	Description
Qualitative Approach	Local Stakeholder Consultations	Conducted over **40** in-person and virtual one-on-one consultations with key local providers, community groups, and RTOs.
	Board Consultation	Conducted one-on-one consultation with Board Chair of the Murrindindi Health Network to align the strategic directions of each organisation with the preliminary findings.
	Key System Consultations	Consulted key system stakeholders, including Eastern Health, Northern Health, and the Department of Health, to identify and align the systematic future direction and current barriers in the region.
Quantitative Approach	Community & Staff Survey	Gathered community **(>100)** and healthcare workers **(>35)** responses, which help assess the Shire community's lived experience, health behaviour, and needs.
	Data & Artefacts	Requested relevant plans, policies, and data to support demographic analysis and service assessment.
	Desktop Research	Utilised sources such as ABS Census, Economy ID, PHIDU, MBS, and others to gather data on housing, population, education, health, service demand and supply for regional analysis.
	Benchmarking Findings	Continued to conduct comprehensive benchmarking studies with selected health networks and healthcare providers with similar demographics and challenges, to serve as a comparison tool.

The Murrindindi Health Network Plan was developed using a dual approach that combined meaningful stakeholder engagement with robust data analysis. The qualitative stream included over 40 one-on-one consultations, in total, to gather local and systematic insights. This was complemented by a quantitative stream involving a community survey, analysis of data and policies, desktop research using sources like ABS and PHIDU, and benchmarking with similar organisations to inform future priorities.

Qualitative Approach

More than 40 stakeholders across West and East Murrindindi participated in the engagement activities, ensuring diverse representation and incorporating the community's voice

How We Engaged the Stakeholders

5
Board chairs consulted

7
Key system stakeholders consulted

15+
Healthcare workers consulted

11
Healthcare organisations were engaged

6
RTOs, community houses and groups were engaged

More than 40 community members, local providers, healthcare workforce, and system stakeholders were consulted in the development of this plan, ensuring a diverse representation of stakeholder profiles was being brought along in the journey. The profiles include healthcare workers to present the sector's workforce, RTOs, community houses and groups, healthcare organisations, key system stakeholders, and board chairs.

Quantitative Approach

To ensure data-driven decision-making, a comprehensive analysis using plans and strategies, datasets, and input from stakeholders and benchmarking was conducted

How We Analysed the Shire

6
Comparable organisations and networks were benchmarked to share findings

>100
Community members completed the survey

>8
Plans & Strategies were reviewed

>60
Datasets were source

Australian Bureau of Statistics

phn EASTERN MELBOURNE
An Australian Government Initiative

economy.id

VicHealth

PHIDU
TORRENS UNIVERSITY AUSTRALIA

MBS Online
Medicare Benefits Schedule

To support data-driven decision-making, a comprehensive quantitative analysis was conducted. This included sourcing diverse datasets, analysing inputs from the community survey and benchmarking, and reviewing plans and strategies. The plan and strategies considered were from health network members, Council, RTOs, and key system stakeholders (i.e., Eastern Health, Northern Health, Department of Health, St Vincent).

Quantitative Approach: Community Survey

The Community Survey, which is available online, received more than 100 responses from the residents in the Shire

Community Survey

- Experience in accessing care
- Awareness of local health services
- Health behaviour and service destination
- Aspirations and future needs

Promotion Channels

Community Houses

Consulted Stakeholders

The online Community Survey received over 100 responses, capturing input on key themes such as health behaviours, patient flow destinations, healthcare service quality comparison between within the Shire and outside the Shire, and service awareness. The survey was promoted through channels including the Council's Facebook and utilising the consulted stakeholders' networks to reach a broad audience across the region.

Project Scope - Areas of Focus

This project is focused on four key areas for health and aged care workforce development, service delivery, care coordination, and sustainability planning, using approaches that address system-wide challenges from an integrated rural health perspective

Four Areas of Focus

To guide the analysis, this project is focused on four critical areas of health and aged care service delivery in rural communities:

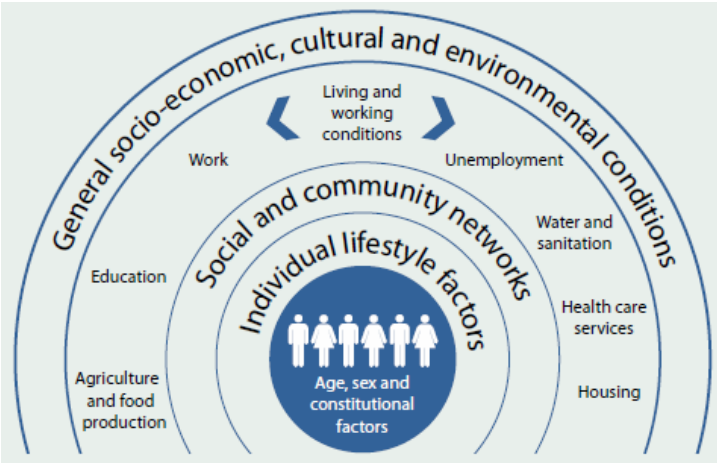
Healthcare & Clinical Services	Access to comprehensive healthcare services, including primary care, specialist services, and emergency care for all age groups across the region. This includes acute care, chronic disease management, and preventive health programs.	• General practice and primary care • Specialist consultations and visiting services • Emergency and urgent care • Chronic disease management • Preventive health programs • Maternal and child health services
Aged Care & Support Services	Community-based and residential aged care services essential for supporting older adults to age in place or receive appropriate care. Ensuring older adults can access quality care close to home is a priority for rural sustainability.	• Home care packages and Support at Home (Support at Home starts 1 Nov 2025; new Aged Care Act commences 1 Nov 2025) • Residential aged care facilities • Respite care services • Community aged care programs • Carer support services
Allied Health & Mental Health	Allied health and mental health services support comprehensive care delivery, addressing both physical and psychological wellbeing. These services are essential for early intervention and ongoing support across all age groups.	• Psychology and counselling services • Physiotherapy and occupational therapy • Speech pathology and dietetics • Mental health crisis support • Community mental health programs • NDIS allied health services
Workforce Development & Integration	Workforce planning and service integration support the sustainability of health services through strategic recruitment, retention, and collaborative service delivery models that maximise resources and improve outcomes.	• Workforce attraction and retention programs • Shared service arrangements • Telehealth and technology integration • Cross-provider collaboration • Professional development and training • Service coordination platforms

Social Determinants of Health:

The model of social determinants of health underpins this project's approach. This model recognises that health outcomes are influenced by a range of external factors, including:

- Economic stability, such as employment opportunities and income security in rural areas.
- Physical environment, like housing quality, transport access, and geographic isolation factors.
- Social and community context, including family support networks, community connections, and cultural factors.

Addressing workforce and service delivery challenges through this lens ensures consideration of not only immediate service access but also the broader environmental and social factors that impact health service provision and outcomes in rural communities.



NMC Health Network Evaluation Framework

This project utilises a purpose-built Health Network Evaluation Framework to assess the Murrindindi health network, using lenses that reflect what matters most to public health outcomes and service systems

NMC will apply a purpose-built **Health Network Evaluation Framework** to assess the current state, using lenses that reflect what matters most to public health outcomes and service systems-ensuring the review captures how well services are functioning, where improvements are needed, and how they align with expectations for effective, connected, and sustainable care.

NMC Health Network Evaluation Framework

Service access	Workforce	Local training	Health outcomes (GP-sensitive)	Health literacy and navigation
The extent and patterns of how residents access care and the availability, timeliness, and proximity of in-scope services across the region.	Capacity, stability, and sustainability of the workforce delivering services, including reliance on temporary staff and enabling conditions.	Breadth, consistency, and retention impact of local education pathways, placements, and rotations across disciplines.	The outcomes for conditions most influenced by primary care quality and shared-care coordination, and the extent of avoidable utilisation.	The clarity, reach, and usability of information and channels that help residents find, understand, and use services.
Metrics 1. Assess the availability of specialist services and core diagnostics, including after-hours coverage. 2. Review the travel distance and time required for residents to access routine care and treatments. 3. Examine wait times and referral pathways for priority services. 4. Analyse the frequency and drivers of low-acuity transfers to metropolitan hospitals. 5. Evaluate the consistency of referral and booking protocols across providers.	**Metrics** 1. Review the use of standardised referral, discharge, and handover processes. 2. Assess how effectively referrals, tests, and follow-up are tracked to closure. 3. Examine the processes for post-discharge contact and follow-up for complex cohorts. 4. Evaluate the level of interoperability and data-sharing between providers. 5. Review how responsibility is allocated and managed for complex cases.	**Metrics** 1. Assess the number and spread of student placements and clinical rotations across disciplines. 2. Examine how well training pathways contribute to retaining staff locally. 3. Evaluate the extent of reliance on agency or locum staff to fill rosters. 4. Assess the consistency of skill coverage across townships and service sites. 5. Review the presence and use of formal agreements with universities, RTOs, and health partners.	**Metrics** 1. Analyse the rate of potentially preventable hospitalisations across the region. 2. Review emergency department presentations that could be managed in primary care. 3. Examine the level of follow-up after hospital discharge. 4. Review indicators of chronic disease management and control. 5. Analyse screening participation and the stage at which conditions are typically diagnosed.	**Metrics** 1. Assess resident confidence in understanding and navigating the health system. 2. Review the clarity and consistency of next-step instructions at points of care. 3. Evaluate the accessibility and usability of digital directories and e-referral systems. 4. Review how effectively navigation queries are resolved across different channels. 5. Assess the reach and impact of outreach initiatives for low-access populations.

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02

REGIONAL PROFILE

Regional Profile - Section Overview

An introduction to this sections review of the Murrindindi region, including demographic analysis, population trends, settlement details and lived experience. Examples of data sources to support analysis provided

Regional Profile Review of the Murrindindi Shire

To inform the development of the Network Plan, a regional profile review was undertaken. This provides a shared understanding of the community, their health outcomes, and the workforce and service environment.

The review focused on three areas:

- Resident Characteristics & Demographic Change - identifying the current profile of residents and projected shifts in age, population growth, and settlement patterns.
- Health Outcomes - analysing key health indicators and service utilisation to highlight priority issues and trends.
- Lived Experience Personas - translating data into stories that illustrate how local demographics, health outcomes, and service access intersect in people's day-to-day lives.

This baseline enables stakeholders to clearly see the region's needs and plan for future service and workforce priorities.

For a detailed list of sources used and the utilisation, visit Appendix O

Data Collection Approach

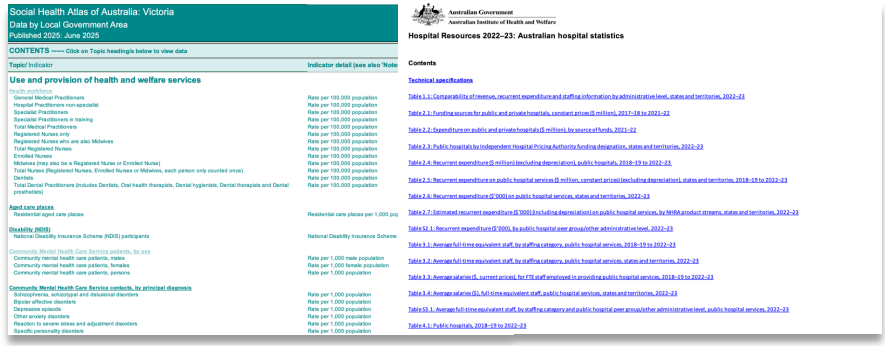
The regional profile review draws on a wide range of reputable data sources, including the Australian Bureau of Statistics (ABS), Remplan, .id Community Profile, and PHIDU. These datasets were supplemented with sector reports and local intelligence to ensure coverage of demographic, workforce, economic, and health factors. Where possible, the analysis was aligned with Council data collections and planning frameworks to provide consistency and a shared evidence base for future decision-making.

Elements of this section

1. **Demographic Profile & Projections** - examining population size, age distribution, workforce characteristics, and economic drivers to understand current conditions and future shifts.

2. **Health Profile -** assessing community health outcomes and behaviours to highlight priority issues and risk factors.

3. **Personas -** illustrative profiles of community cohorts that integrate socio-economic determinants with lived experience, bringing data to life through representative stories.


Social Health Atlas of Australia: Victoria
Data by Local Government Area
Published 2025: June 2025

CONTENTS ------ Click on Topic heading/s below to view data

Topic/ Indicator | Indicator detail (see also 'Note

Use and provision of health and welfare services

Australian Government
Australian Institute of Health and Welfare

Hospital Resources 2022–23: Australian hospital statistics

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Table S3.1: Average full-time equivalent staff, by staffing category and public hospital peer group/other administrative level, public hospital services, 2022–23

Table 4.1: Public hospitals, 2018–19 to 2022–23

Example of resources utilised for current state analysis

Regional Profile - Snapshot

A demographic overview of the Murrindindi area, detailing population changes, community characteristics, regional connectivity and geographic dispersion across the region.

Key Statistics

15,603
Est. 2024 Population

17,450
Projected 2036 Population

50
Median Age

1,710
Born overseas

25%
Avg. Income spent on Housing

The Murrindindi Local Government Area is projected to experience notably low population growth of approximately 0.93% per year, which is below the regional Victorian average of 1.1%. This suggests relatively low levels of inward migration and natural population increase. Murrindindi is also an ageing population with a median age of 50, having increased from 45 since 2011. This change in profile highlights a growing need for health service delivery change and optimisation for the region.

Tourism to Murrindindi rebounded strongly post-2021, peaking in 2023 and easing in 2024 but remaining above 2021-22 levels. Visitor nights also dipped in 2024, suggesting more day-trippers and shorter stays. This translates to predictable peaks in unscheduled, same-day demand (urgent care, GP after-hours, pharmacy) rather than inpatient bed-days.

The region's geographic context also presents unique service delivery challenges. Located over an hour's drive from Greater Melbourne, Murrindindi lacks direct rail access, with the nearest connection in Seymour. The population is highly dispersed across the LGA.

Regional Connectivity

Public Transport
Bus, Coach, Community Car

Seymour
Nearest Station

Distance to Melbourne
(By Road Vehicle)

Yea	132km	1 hr 44 mins
Eildon	139km	2 hr 20 mins
Marysville	97km	1hr 50 mins
Kinglake	59km	1hr 20 mins
Alexandra	164km	2 hrs 9 mins

Sources:
- Australian Bureau of Statistics, QuickStats, Murrindindi (LGA) 2021
- Future in Victoria, Estimated Resident Population Projection, 2026 to 2036 (2023)

Regional Profile - Cultural Diversity

Key insight into the country of origin, language use in the Murrindindi region, and the Indigenous populations' current health outcome challenges

Indigenous Community

22 Median Age	**53.1%** Female
183 2013 Population	**259** 2021 Population

Health Outcomes

37% **One or more long-term health condition**

1.8x **Higher standardised death rate** compared to non-indigenous Australians

1 in 5 Reported both **mental health challenges** and **risky alcohol & substance** use

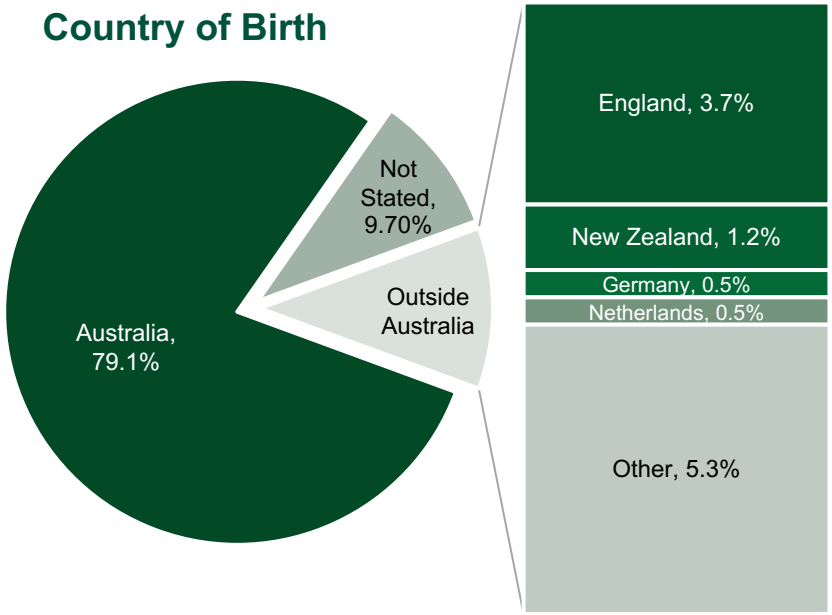
Sources:
- Australian Bureau of Statistics, QuickStats, Murrindindi (LGA) 2016 & 2021
- PHIDU, ATSI Social Health Atlas, 2023
- National Aboriginal and Torres Strait Islander Survey, 2024

The Aboriginal community in Murrindindi represents a small but significantly younger population compared to the broader region.

This group is predominantly female and experiences poorer-than-average health outcomes, including higher rates of long-term health conditions and elevated mental health challenges.

These disparities underscore the need for targeted Aboriginal health initiatives and highlight the potential benefits of broader systemic improvements in areas such as drug, alcohol, and mental health services.

Country of Birth



Languages Used at Home

87.7%
Only speak English at home

Italian
Second most used language

Murrindindi has a predominantly Australian-born population, with relatively low levels of cultural and linguistic diversity compared to Victoria as a whole. A small proportion of residents are born overseas, most commonly from English-speaking countries, and few households speak a language other than English at home. While this demographic profile can support social cohesion, it also means there may be limited local experience in delivering culturally tailored services, highlighting the importance of inclusive service design to ensure accessibility for all community members, including newer migrant populations.

Regional Profile - Employment & Education

Overview of the Shire's population's employment and education outcomes, providing insight into top industries and occupations of employment

Employment

52% Full-time

35% Part-time/Casual

9% Away from Work [1]

4% Unemployed

56.8% **Indigenous population participation rate**

Top Employment Industries

- **Education & Training**
- **Health Care & Social Assistance**
- **Agriculture, Forestry & Fishing**
- **Accommodation & Food Services**
- **Construction**

Top Occupations of Employment

- 19% Technicians and Trades Workers
- 18% Managers
- 14% Professionals
- 12% Community and Personal Service Workers

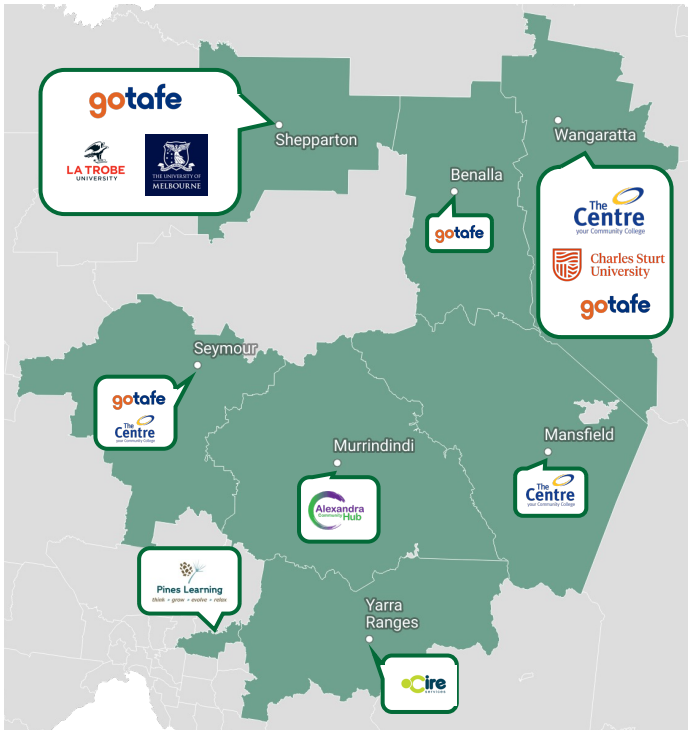
(1) Counts employed people who reported 0 hours of work the week before the Census or did not state their hours of work.

Employment in Murrindindi reflects a diverse regional economy. Full-time work remains the dominant pattern across most industries, supported by a significant share of part-time and casual positions linked to seasonal demand and flexible work preferences. The Shire's largest employment sectors include education and training, health care and social assistance, and agriculture with each contributing to a balanced mix of professional, technical and service-based roles.

Within this profile, strong representation in health and community services highlights the influence of an ageing population and a steady demand for care roles. Trades and managerial occupations also feature prominently, indicating depth in practical, supervisory and non-clinical skills. Collectively, this suggests that while health remains a key local employer, Murrindindi's workforce capacity extends across multiple industries and job types that can support broader economic and service needs.

Regional Profile - RTO Options

Overview of RTOs' availability within and around the shire, along with the current partnership with members of the Health Network

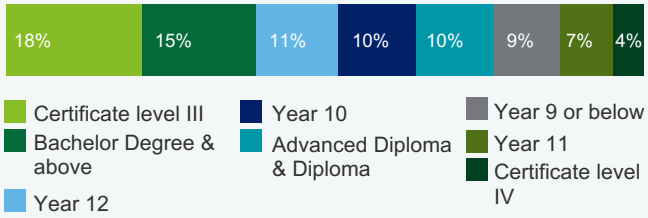


The partnering RTOs are spread across both clinical and non-clinical areas, mostly at certificate, diploma or short-course level which aligns with Murrindindi's qualification profile. Locally, Alexandra Hub provides foundation courses that build core skills, meaning there is no healthcare-related RTO based locally. Therefore, while health is a top area of interest which suggest demand exists, it is not strongly captured locally. As a result, residents pursuing health qualifications, particularly those requiring university pathways, must travel outside the region, creating barriers to study and completion. This additional effort increases the risk of drop-off in regional education pathways and delayed return migration for the youth workforce

Education

18%

Of the population attained a certificate level III, marking the largest type of education attained



Top 5 Fields of Study

19.6%	Engineering & Technologies
10.3%	Management & Commerce
9.3%	Architecture & Building
8.4%	Education
8.2%	Health

Murrindindi Health Network Members' Training Partners

Level of education	Clinical-related study[1]	Both	Non clinical-related study[2]
Certificate, diploma, and course	The Centre your Community College; fyi training; ACN; Dementia Care International	cire services; gotafe; Pines Learning think • grow • evolve • relax	mat MEDICAL ADMINISTRATION TRAINING; Alexandra Community Hub; COMPLETE HOSPITALITY TRAINING; MONARCH INSTITUTE RTO 22530
University-level	SWINBURNE UNIVERSITY OF TECHNOLOGY; RMIT UNIVERSITY; LA TROBE UNIVERSITY		

[1] Clinical-related study: Courses and qualifications that directly build health or care delivery capability (e.g., nursing, aged care, mental health, allied health, first aid, immunisation, wound care, dementia care).

[2] Non-clinical-related study: Courses that strengthen broader workforce or community capacity but do not involve direct health or clinical care (e.g., business, leadership, WHS, digital skills, hospitality, project management, Auslan).

Regional Profile - Socioeconomic Analysis

Breakdown of socioeconomic dispersion in the region with the current housing & income data within Murrindindi region.

Relative Socio-Economic Index

Kinglake (SA2)	1039
Yea (SA2)	995
Alexandra (SA2)	989
Marysville	992
Eildon	931

Least disadvantaged
1
2
3
4
5
Most Disadvantaged

Source:
- Murrindindi Shire Council, Yea Structure Plan 2025
- Murrindindi Shire Council, Alexandra East Development Plan 2025
- Murrindindi Shire Council, Key Worker Housing Strategy 2024
- Murrindindi Shire Council, Eildon Key Worker Housing

Housing Growth – Council's Masterplan and Strategy

The Victorian Government has set a target of

3,350 new homes

by 2051 in Murrindindi Shire with Council expects that **Yea should aim to deliver a third of it**

Murrindindi Shire has the capacity equating to

≈15 years of housing supply (or additional 1,174 lots)

within **existing zoned land**, as per the Key Worker Housing Strategy 2024

The Alexandra East Development Plan Area aims to facilitate

340 residential lots

by 2030 in the area

The Eildon Key Worker Housing project aims to have

14 houses (33 bedrooms in total)

to be constructed by June 2026

Availability - Previous 12 months

Area	House Sold	Interested Buyers	Avg. Days on Market	House Leased	Interested Renters	Avg. Days on Market
Alexandra	49	585	66	24	72	22
Yea	37	628	128	29	62	26
Kinglake	31	1216	43	3	-	14

While Murrindindi's SEIFA scores sit below the national average, the variation across townships reflects more than just economic disparity. Areas such as Kinglake record comparatively higher SEIFA rankings, though this apparent advantage often mirrors a rural profile of larger land holdings rather than stronger local economies or service access. These same spatial patterns coincide with emerging housing growth potential. The Shire has an estimated 15 years of housing supply within existing zoned land, with significant developments, for instance, the Eildon Key Worker Housing project already underway. With population and workforce growth expected to accelerate, investment in local services and infrastructure will be critical to both improve access for current residents and accommodate the scale of future housing development.

Regional Profile - Infrastructure

Overview of enabling infrastructure in the shire, which influences service accessibility and workforce attraction

Transport

35%
Own 2 motor vehicles

Alexandra - Seymour
Coach (including Yea and Molesworth) with approx. one service a day

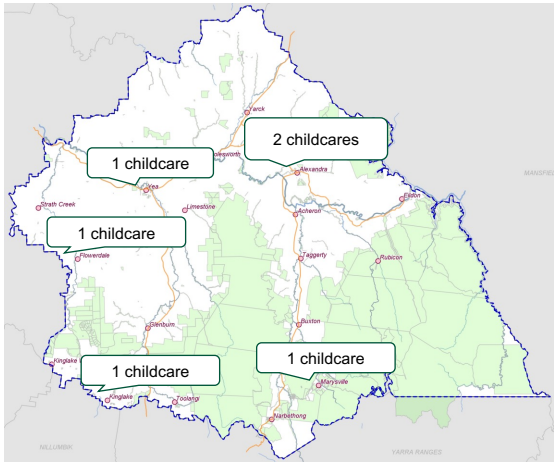
Route 684 Bus
Cover Eildon, Alexandra, Marysville and surrounding areas with approx. one service a day

2 Community Transports
Up for booking and provided by the Council, including Moving Murrindindi and Community Bus

Health Infrastructure

3 Sites under YMDH, all in Yea	**2** Sites under ADH, located in Alexandra and Marysville	**1** Sites under Menzies Support, located in Alexandra	**7** Sites under Council, including MCH (Alexandra, Flowerdale, Kinglake, Marysville, Toolangi, and Yea) and Kinglake Ranges Health Centre
1 Sites under Kellock Lodge, located in Alexandra	**1** Site under Darlingford UGNH, located in Alexandra	**1** Site under Omnia (Nexus Primary Health), located in Kinglake	

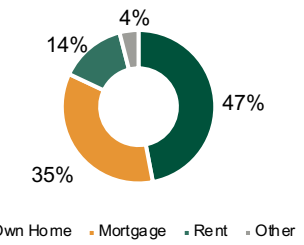
Workforce Supporting Infrastructure



Source:
- State Government of Victoria, Rental Report - Quarterly: Quarterly Median Rents by LGA
  Department of Transport & Planning, Property sales statistics

$483,750
Median price of property for sale (2024)

$394 per week
Median rent (2024)



Infrastructure Analysis

Infrastructure in Murrindindi presents clear challenges for health service access and workforce planning:

- Public transport is minimal, with only one coach and bus service per day, leaving most residents reliant on private vehicles or small-scale community transport programs.
- Health infrastructure spans multiple small sites, and with support from district nursing and outreach programs. However, residents still rely on larger hospitals if the local capacity is not sufficient for their needs.
- Housing supply has contracted significantly since 2021, with limited availability and rising prices creating barriers for both local residents and potential health workers seeking to relocate.

These factors mean that transport and housing are not just community issues but critical workforce enablers, directly shaping the region's capacity to attract, retain, and support health professionals.

Regional Profile - Health Indicators

Summary and analysis of population health data and indicators for Murrindindi Shire residents

Health Indicators

	Murrindindi	Victoria
Current Smoker ASR per 100	14.6	14.3
Above a healthy weight (obese) ASR per 100	35.8	29.9
Mental Health Conditions ASR per 100	10.1	8.7
Deaths from suicide & self-inflicted injuries 0 to 74 years, Avg. annual ASR per 100,000	20.3	10.9
Increased Chronic Disease Risk ASR per 100	67.7	67.1
Arthritis ASR per 100	9.5	8.1
Asthma ASR per 100	9.5	8.3
Heart Disease ASR per 100	3.8	3.8
Live with a Profound or Severe Disability % of Population	6.0%	5.4%
NDIS Recipient ASR per 100	2.2	2.5
Adult Fair/Poor Dental Health Self-reported, %	26.9%	22.3%
Death related to alcohol and illicit drugs, 2021 Rate per 100,000	39	17.7
Cancer Incidents Avg. annual ASR per 100,000	603	548
Breast Cancer Screening Participation Rate	49.7%	51.1%
Cervical Cancer Screening Participation Rate, %	60.7%	69.6%
Bowel Cancer Screening Participation Rate, %	46.0%	43.9%

Health Indicator Analysis

The health outcomes in Murrindindi carry significant long-term implications for both community wellbeing and health system demand.

- Elevated obesity and chronic disease risk drive higher incidence of diabetes, cardiovascular disease, and musculoskeletal conditions, placing sustained demand on primary and specialist care.
- Mental health conditions are prevalent, with a suicide rate nearly double the state average. This highlights the need for accessible community-based services, expanded counselling, psychiatric, and allied health workforce capacity.
- Alcohol and other drug death rate is more than twice the Victorian average, signalling service gaps in prevention, harm minimisation, withdrawal and rehabilitation pathways, and reinforces the need for integrated mental health and AOD service planning.
- High rates of arthritis and asthma contribute to chronic morbidity, functional impairment, and increased use of general practice and hospital services.
- Poor oral health continues to drive preventable hospitalisations and inequities in rural health outcomes.
- Cancer screening participation shows mixed results: bowel screening rates are above average, but lower breast and cervical screening rates indicate the need for targeted outreach and women's health promotion.

Together, these trends suggest a growing demand for a multidisciplinary workforce, particularly in mental health, chronic disease management, AOD, and oral health, supported by preventive care, outreach models, and strategies to address affordability and access barriers.

Regional Profile - Health Conditions

An analysis of resident admissions benchmarked against state and neighbouring LGAs

Health Outcomes

Condition	Murrindindi % higher than Vic avg.	Admissions per 100,000	
		Murrindindi	Regional Victoria
Diabetes	64.6%	365.9	253.3
Mental Health Related	23.6%	1222.6	1,020.5
Cancer	75.8%	2765.4	1,933.8
Nervous System	39.9%	1583.1	1,267.5
Circulatory System Diseases	48.5%	2393.9	1,907.4
Respiratory System Diseases	60.7%	1634.5	1,216.5
Digestive System Diseases	75.3%	4247.4	3,341.2
Musculoskeletal System and Connective Tissue Diseases	46.2%	1550.7	1,356.8
Genitourinary System Diseases	67.0%	2047.1	1,408.8
Injury, Poisoning, Other	70.3%	4433.7	2,961.4

Health Outcomes Analysis

Health outcomes in Murrindindi reveal consistently higher hospital admission rates than the Victorian average across nearly every major condition, reflecting the combined pressures of chronic disease prevalence, service access limitations, and the region's dispersed geography.

The largest gaps are seen in cancer (+75.8%), digestive system diseases (+75.3%), injuries and poisoning (+70.3%), and genitourinary diseases (+67.0%), while diabetes (+64.6%) and respiratory conditions (+60.7%) also stand out as major contributors to hospital demand. Even in conditions where the gap is smaller, such as nervous system (+39.9%), circulatory system (+48.5%), and musculoskeletal (+46.2%) diseases, Murrindindi remains well above the state average.

These outcomes are closely linked to the challenges of providing healthcare across a geographically dispersed shire with limited local specialist and hospital services. Many residents face long travel distances for diagnostic, treatment, or follow-up care, which delays early intervention and increases reliance on hospital admissions when conditions escalate.

The elevated hospitalisation rates, therefore, should not only be seen as a reflection of higher disease burden, but also as an indicator of structural service constraints and geographic inequities. Without addressing transport barriers, strengthening local service availability, and improving integration across health pathways, Murrindindi residents will continue to experience avoidable admissions and poorer health outcomes compared to neighbouring LGAs and the state.

Regional Profile - Community Survey Snapshot

Survey responses showing preventive health screening participation rates across different health check types and age groups over the past six months

6/10 Have had a **general health screening** within the past 6 months

3/10 Have had a **heart & vascular health screening** within the past 6 months

2/10 Have had a **cancer screening** within the past 6 months

2/10 Have had a **bone & joint health screening** within the past 6 months

5/10 Have received **immunisation** within the past 6 months

3/10 Have had a **vision & hearing screening** within the past 6 months

65-74 years old

Completed the highest number of screening types on average, with around **2.8 screenings per respondent in this age group** in the past six months

25-44 years old

Completed the lowest number of screening types on average, with around **1.8 screenings per capita in this age group** in the past six months

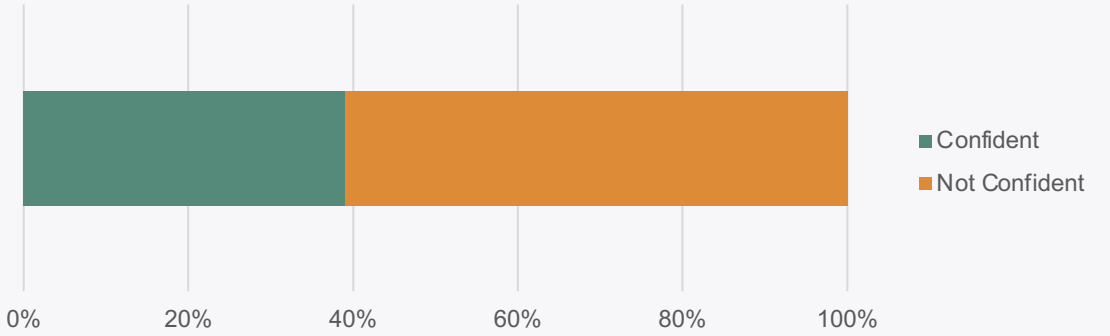
General health screenings show good uptake (6/10 respondents), while more specialised screenings like bone health, vision, and hearing show lower participation rates. Moreover, the data reveal significant age-related differences in preventive healthcare utilisation, with older residents (65-74) completing an average of 2.8 screening types compared to younger adults (25-44), averaging 1.8 screenings. The data indicates that preventive healthcare engagement increases with age, likely reflecting both higher health risks and better understanding of screening benefits among older residents. This pattern suggests opportunities to enhance screening awareness and accessibility for younger working-age populations, while building on the strong preventive healthcare foundation already established among older community members through targeted outreach and education programs.

Regional Profile - Community Survey Snapshot cont.

Survey responses showing residents' confidence in knowing local healthcare services and preferred information sources for health service awareness

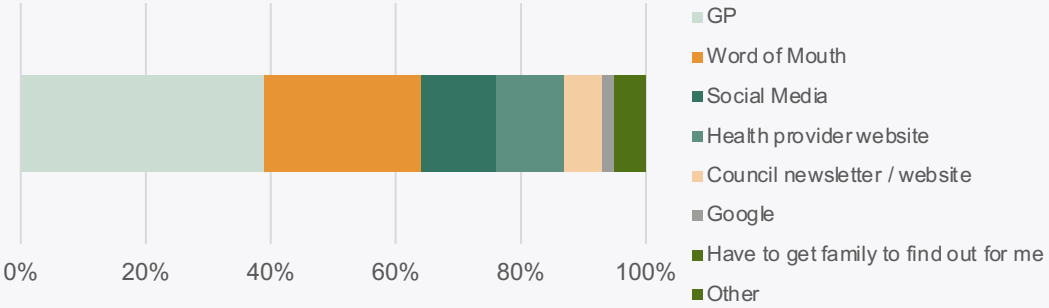
61% of respondents

Are not confident in knowing available services in the area



39% of respondents

Find out about available services through their GPs



The service awareness data reveals a significant information gap, with 61% of respondents lacking confidence in knowing available local services, highlighting the need for enhanced community communication strategies.

Among those who do seek health information, GPs emerge as the primary source (39% of respondents), followed by word of mouth, social media, and health provider websites as secondary channels.

This pattern suggests residents rely heavily on personal healthcare interactions and informal networks for service information, while digital channels like social media and provider websites play supporting roles.

The high proportion of residents unsure about available services, combined with GP-centred information seeking, indicates opportunities to strengthen both formal communication channels and GP practices' role as information hubs.

Regional Profile - Personas: Overview

The persona framework integrates life-stage and socioeconomic analysis to show how health outcomes evolve through the interaction of structural, intermediary and system-level determinants

Personas: Overview

Six personas were developed using insights from current state findings, stakeholder engagement and community consultations across health service areas.

Each persona represents a distinct stage in life, from infancy through to older age, showing how access, service use and support networks shift as residents' circumstances and priorities evolve. Together, they provide a whole-of-life view of how health and wellbeing are experienced locally.

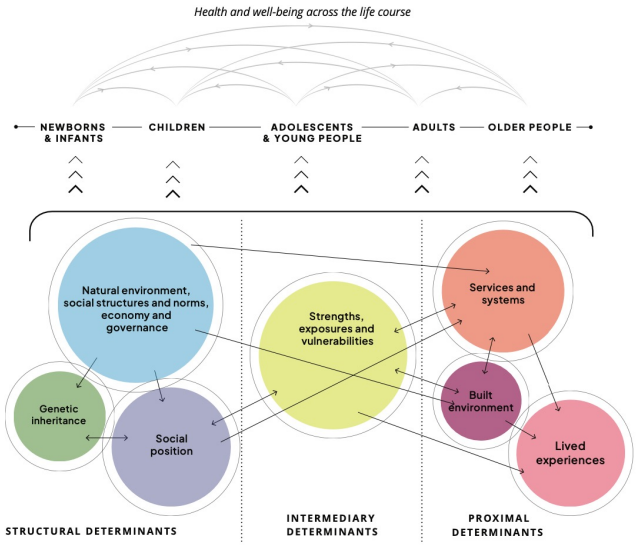
Methodology:

- **Data Collection:**
  - Insights drawn from stakeholder workshops, interviews and community surveys.
  - Quantitative data (demographics, service use, workforce trends) combined with qualitative narratives from residents and providers.
- **Persona Creation:**
  - Synthesised findings into six life-stage archetypes, each overlaid with socioeconomic context (high SEIFA, low SEIFA and vulnerable groups).
  - Considered geographic, social and economic determinants influencing access to healthcare, transport and community supports.
- **Framework Alignment:**
  - Mapped local lived-experience insights against the WHO Health and Well-being Across the Life Course framework to illustrate how structural, intermediary and proximal determinants shape wellbeing trajectories.

Key Findings:

- Health and wellbeing needs shift predictably across life stages, with early-years access reliant on parental awareness and older-age access constrained by navigation complexity
- Travel distance, service affordability and workforce shortages remain common barriers at every stage of life
- Youth and working-age residents experience inconsistent continuity of care due to short-term funding and service age cut-offs
- Older residents face digital and system navigation challenges, particularly when using My Aged Care and allied health referral systems

System Thinking: Alignment with Global Framework



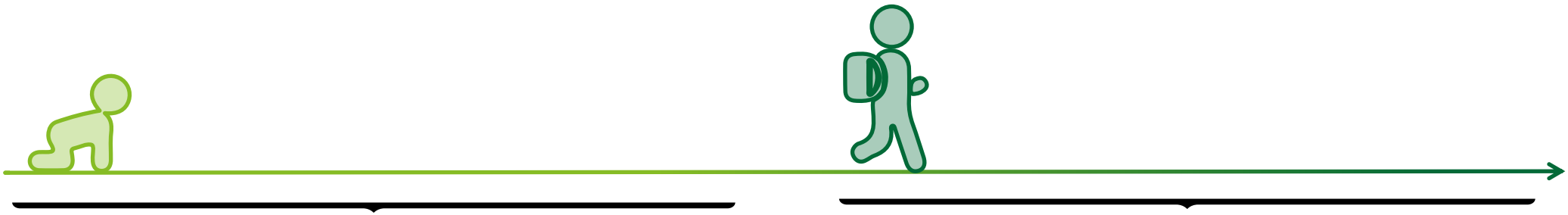
This analysis aligns with the WHO life-course model, recognising that health and wellbeing are shaped by interconnected determinants:

- **Structural determinants**: social position, education, income, governance.
- **Intermediary determinants**: strengths, vulnerabilities and life exposures.
- **Proximal determinants**: built environment, service systems and lived experience.

By integrating these determinants into persona design, the model captures both individual experience and system dependency — showing how early advantage or disadvantage amplifies over time and how local service capacity can either reinforce or reduce inequity.

Regional Profile – Community Personas

Seven life-stage personas, developed through stakeholder and community engagement, show how residents' experiences and access needs evolve as they move through different stages of life in the Murrindindi Shire



Newborns and Infants (0–1 year)

This stage centres on birth, early bonding and rapid development. Infants rely entirely on parents or carers for health, transport and decision-making. The family's knowledge, confidence and capacity strongly shape outcomes.

Support networks: Parents and extended family, maternal and child health nurses, midwives, immunisation clinics, early parenting centres.

Transport: Fully dependent on parents for transport, usually by private car. Travel distance to maternal and child health appointments or hospitals can affect attendance.

Health focus: Breastfeeding and nutrition, immunisation, safe sleep, early development checks, post-natal and perinatal mental health, respiratory infections.

Key barriers:

- Access: Long waitlists for early parenting support, limited weekend appointments.
- Financial: Out-of-pocket travel costs, childcare and unpaid leave pressures.
- Infrastructure: Limited local allied health and birthing services in smaller towns.
- System: Parental health literacy is critical; many parents struggle to navigate scattered information and referral pathways across maternal, GP and community health systems.

Children (1–9 years)

Children are developing motor skills, language and social awareness. Families focus on stable routines, school readiness and balanced nutrition. Parents remain the main decision-makers, with engagement in early education and sport influencing health outcomes.

Support networks: Parents, teachers, early-years educators, child health nurses, school wellbeing staff, sport coaches.

Transport: Car or school bus reliant. Limited local child-specific services mean some families travel to regional hubs.

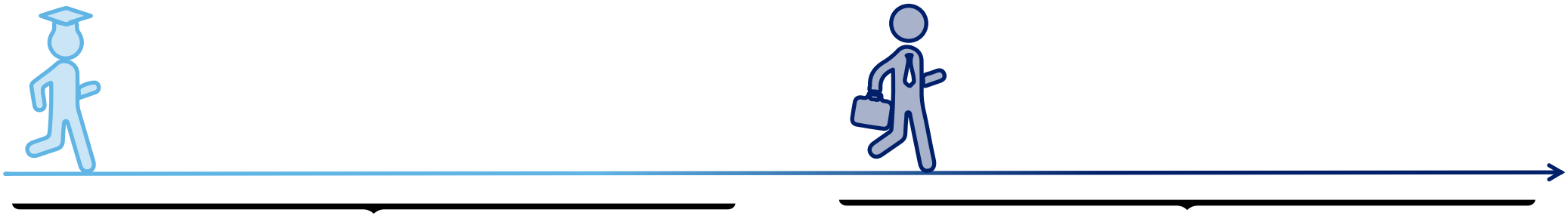
Health focus: Oral health, nutrition, physical activity, asthma, allergies, vision and hearing checks, injury prevention, developmental or behavioural assessments.

Key barriers:

- Access: Shortage of child psychologists, speech and occupational therapists.
- Financial: Cost of extracurricular activities and private allied health services.
- Infrastructure: Lack of accessible play and recreation spaces in smaller towns.
- System: Parents require strong health literacy to recognise early warning signs and coordinate referrals, considering there is room for tighter coordination between school, primary health, and community wellbeing programs.

Regional Profile – Community Personas

Seven life-stage personas, developed through stakeholder and community engagement, show how residents' experiences and access needs evolve as they move through different stages of life in the Murrindindi Shire



Adolescents (10–19 years)

Adolescents begin asserting independence while navigating education, identity and social change. Mental health, confidence and peer connection are central. Many rely on schools or peers for information, which can vary in quality. Confidentiality and trust heavily influence whether they seek care.

Support networks: Parents, teachers, school wellbeing teams, youth workers, sports clubs, online peers.

Transport: Under-18s rely on parents or school buses. Older teens tend to be working on getting their driver's license.

Health focus: Mental health, sexual and reproductive health, substance awareness, injury prevention, nutrition, acne, asthma and early lifestyle-related risks (obesity, vaping, alcohol).

Key barriers:

- Access: Few youth-friendly or confidential health options locally.
- Financial: Low personal income limits independence and healthcare choice.
- Infrastructure: Limited safe social spaces and after-hours services.
- System: Short-term funding and rigid age cut-offs (too old for child services, too young for adult care) interrupt care continuity. Health literacy is developing; many rely on informal sources that can be unreliable.

Young Adults (20–29 years)

Young adults transition into work, higher education or parenthood. Many leave the Shire for study or employment, while those remaining often juggle casual jobs and rising living costs. Preventive health tends to be low priority unless linked to sport or pregnancy. Confidence in navigating services improves but can still be limited by cost and time.

Support networks: Partners, peers, employers, university or TAFE support services, GPs, online communities.

Transport: Primarily car users. Public transport is limited, affecting appointment access for those without reliable vehicles.

Health focus: Reproductive health, contraception, mental wellbeing, substance use, musculoskeletal injury, sexual health, early chronic disease risk, workplace stress.

Key barriers:

- Access: Limited bulk-billing and mental health services.
- Financial: Cost of living, rent, and gap fees deter routine care.
- Infrastructure: Few young-adult community or recreation spaces.
- System: Health literacy varies widely. Many people know how to find information online, but with the busy lives they lead, this often results in reactive rather than preventive engagement.

Regional Profile – Community Personas

Seven life-stage personas, developed through stakeholder and community engagement, show how residents' experiences and access needs evolve as they move through different stages of life in the Murrindindi Shire

Adults (30–44 years)

Adults are often raising families, building careers and managing debt. Time scarcity, work commitments and childcare demands lead to delayed health care. Many experience early chronic disease risks tied to stress, diet and inactivity. Digital literacy is high, but sustained engagement in preventive care is inconsistent.

Support networks: Partners, children, extended family, colleagues, community and sport networks.

Transport: Car dependent, with frequent travel between towns or to regional centres for appointments.

Health focus: Preventive screening, stress and mental wellbeing, hypertension, diabetes, musculoskeletal pain, reproductive and parenting health, respiratory illness, immunisation updates.

Key barriers:

- Access: Difficulty booking appointments outside work hours, GP shortages.
- Financial: High out-of-pocket costs for dental and allied health.
- Infrastructure: Few after-hours clinics and long travel times.
- System: Health literacy is moderate; adults understand general advice but often under-estimate preventive care value or rely on ad-hoc online information rather than structured follow-up.

Middle-Aged Adults (45–59 years)

This group often manages multiple roles as workers, parents and carers for ageing relatives. Health conditions such as hypertension, diabetes and arthritis become more common. Awareness of preventive checks rises but is constrained by workload and rural service limits.

Support networks: Spouses, adult children, extended family, workplace peers, GPs, chronic disease support programs.

Transport: Highly car dependent; those with mobility issues may start using community transport for longer trips.

Health focus: Chronic disease management, cancer screening, cardiovascular health, menopause, mental wellbeing, sleep and weight management.

Key barriers:

- Access: Specialist appointments require travel to regional or metro hospitals.
- Financial: Cost of frequent medication and travel adds up.
- Infrastructure: Limited local diagnostic and rehabilitation services.
- System: Health literacy varies. Many can manage routine conditions but struggle to coordinate between multiple specialists and funding schemes, leading to fragmented care.

Regional Profile – Community Personas

Seven life-stage personas, developed through stakeholder and community engagement, show how residents' experiences and access needs evolve as they move through different stages of life in the Murrindindi Shire

Older Adults (60 years and over)

Older adults focus on maintaining independence, mobility and social connection. Many manage chronic illnesses while volunteering or caring for others. Physical decline, bereavement and financial pressure can affect wellbeing. Digital ability varies, influencing how they engage with My Aged Care and telehealth.

Support networks: Partners, adult children, neighbours, carers, social clubs, GPs and allied health professionals.

Transport: Gradual shift from driving to reliance on community or family transport.

Health focus: Chronic disease management (cardiovascular, diabetes, arthritis, COPD), falls prevention, mental health, medication management, dementia, pain control and vaccination.

Key barriers:

- Access: Long waits for aged-care assessments and allied health.
- Financial: Fixed incomes limit access to private care or home modifications.
- Infrastructure: Housing not suited for mobility aids; limited accessible community spaces.
- System: Health literacy needs increase. Many must navigate complex My Aged Care and health insurance systems, requiring informed carers or support workers to manage appointments, medications and care packages.

Regional Profile – Community Personas

The model maps how socioeconomic advantage, life stage and service access combine to influence residents' health and wellbeing trajectories over time

Trajectories Of Health & Well-being Across The Life Course

Early conditions set the trajectory for lifelong health

Children from lower socioeconomic backgrounds start with poorer health and developmental outcomes, which compound across adolescence and adulthood.

Preventive access and literacy drive resilience

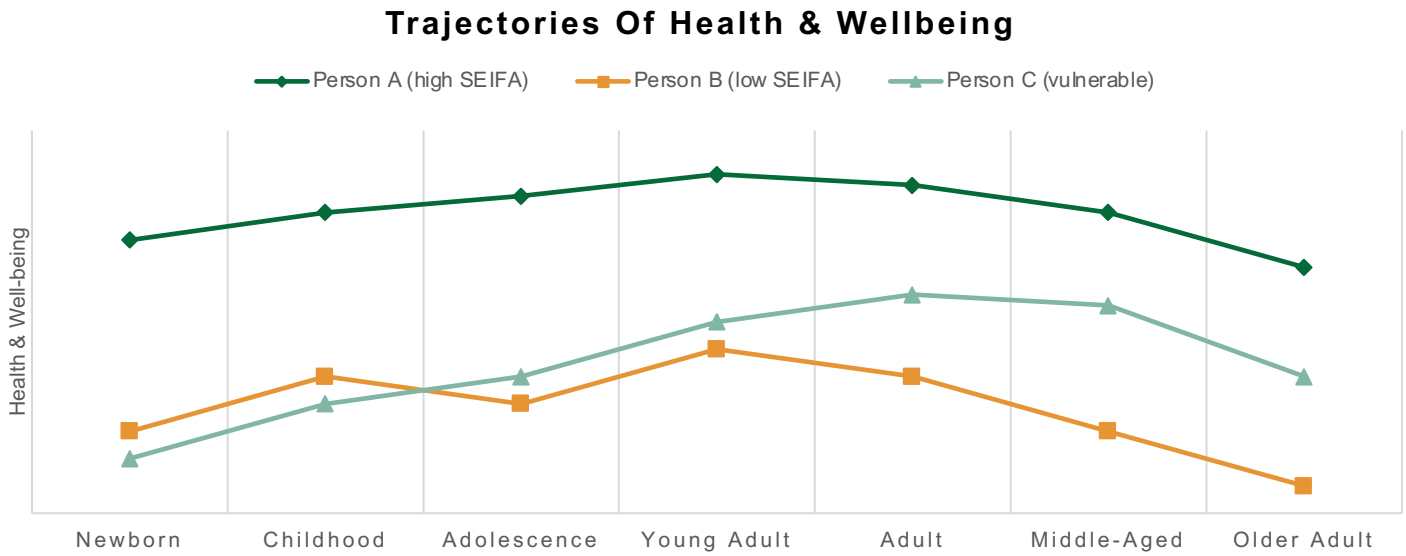
Communities with higher health literacy and easier access to care show stronger recovery from life events and better long-term wellbeing.

Socioeconomic inequities deepen with age

Over the lifespan, disparities in income, education and social capital widen. Adults in stable employment maintain consistent health, while those facing economic strain, casual work or long travel distances experience higher rates of chronic disease and earlier physical decline.

Local systems influence long-term equity

Access to reliable primary care, transport and social infrastructure determines how well communities age. Regions with coordinated local services and community programs see slower health decline and reduced reliance on acute or crisis-based systems in later life.



The trajectories illustrated on the right depict how health and well-being evolve across the life course under different socioeconomic conditions. Each line reflects a distinct life pathway, shaped by the interplay between income, education, location and access to care. These models translate community insight into a visual representation of cumulative advantage and disadvantage.

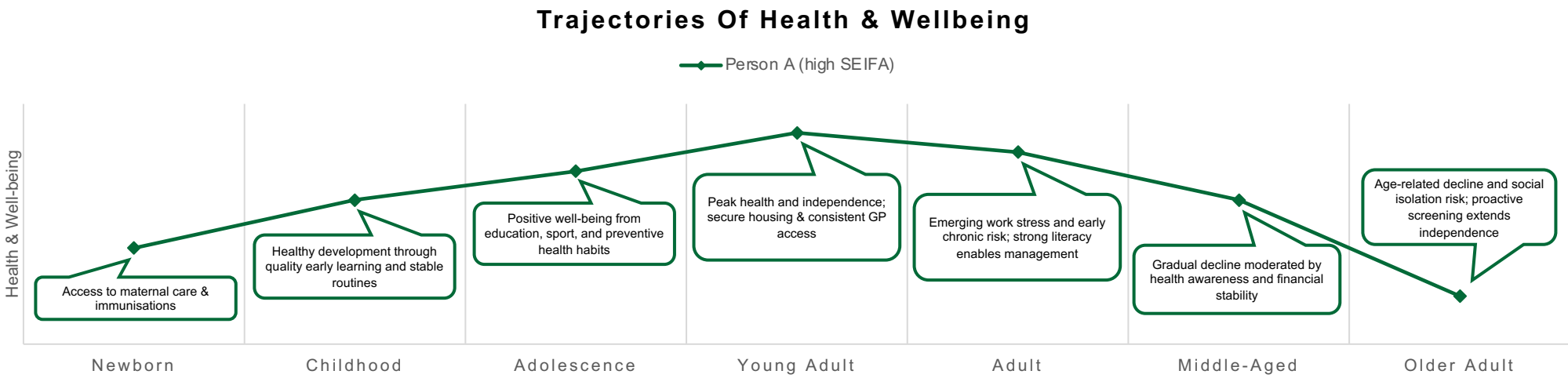
For residents in stable employment and secure housing, wellbeing remains consistently high, buoyed by preventive health literacy, regular screening and strong social networks. For lower-income families, disadvantage emerges early and persists, reflected in lower participation in early learning, reduced preventive care, and poorer ageing outcomes. Meanwhile, vulnerable or migrant households often experience a slow but steady improvement as community programs, education and culturally safe care strengthen their health literacy and trust in local services.

These trajectories highlight the interdependence of social and health systems, which reinforce that wellbeing is not defined by clinical care alone, but by the social, economic and environmental foundations established across each stage of life.

Regional Profile – Community Personas

The model maps how socioeconomic advantage, life stage and service access combine to influence residents' health and wellbeing trajectories over time

Trajectories Of Health & Well-being – Person A



Residents from higher-income households experience strong early stability and lifelong service access.

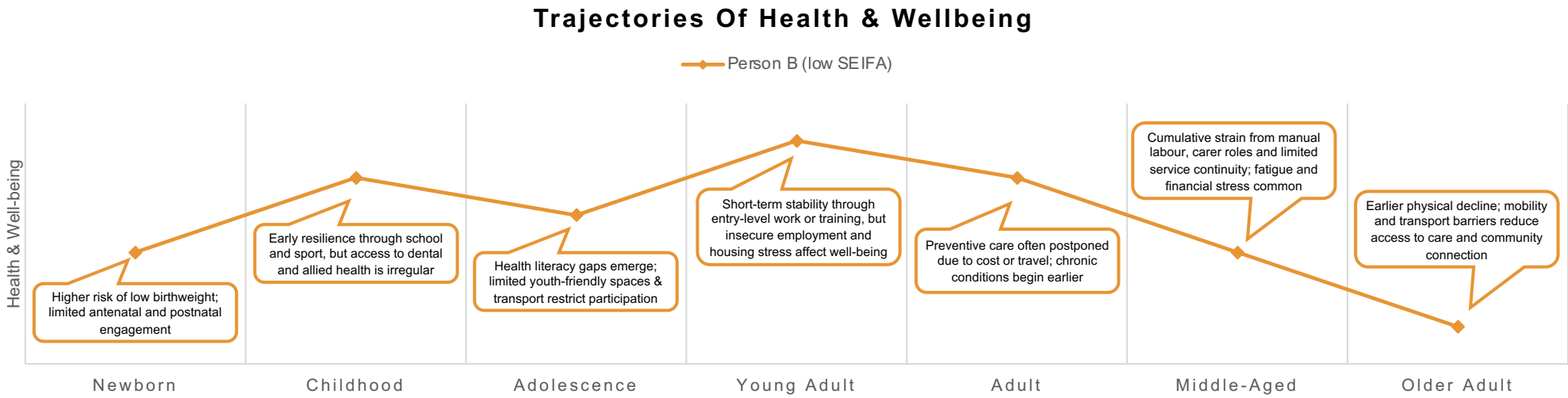
- Early advantage: Secure housing, nutritious diets and engaged parenting support healthy development. Families confidently navigate MCH programs and early-years pathways, often supplementing local care with regional services when needed.
- Sustained wellbeing: Preventive habits are routine. Private insurance and mobility enable out-of-shire GP and specialist care, sustaining long-term provider relationships and proactive screening.
- Emerging risks: Mid-life stress and early chronic issues appear but are managed through literacy, flexible income and telehealth access. Preventive behaviour and digital confidence keep care consistent even when local capacity fluctuates.
- Older age: Financial security and home ownership support ageing in place. Social connection, volunteering and purpose become central to maintaining wellbeing as physical capacity gradually declines.

Overall, this group demonstrates how socioeconomic advantage and health literacy buffer the limitations of a rural health system. Their ability to self-fund, travel and advocate for care sustains wellbeing longer and leads to a slower, well-managed decline in later life — a trajectory shaped less by resource scarcity and more by sustained connection and agency.

Regional Profile – Community Personas

The model maps how socioeconomic advantage, life stage and service access combine to influence residents' health and wellbeing trajectories over time

Trajectories Of Health & Well-being – Person B



Residents from lower-income households face fluctuating employment, higher living costs and limited access to consistent healthcare.

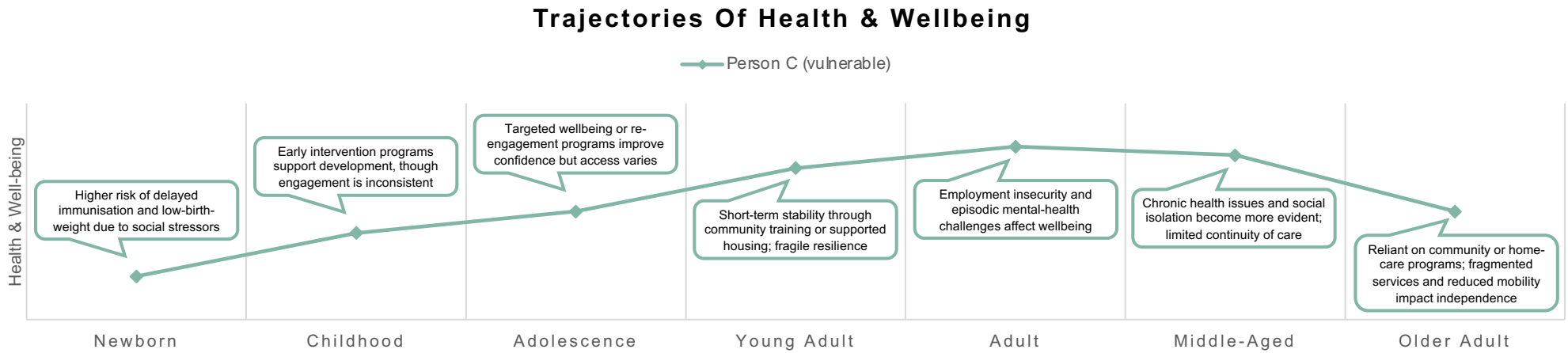
- Early disadvantage: Financial pressure and transport barriers reduce participation in maternal and child health programs. Preventive care often competes with immediate household needs.
- Variable wellbeing: School and sport provide short-term stability, but access to dental, allied health and youth programs is irregular. Health literacy gaps and limited transport restrict engagement through adolescence.
- Cumulative strain: Insecure work and rental stress dominate adulthood. Preventive checks are postponed, leading to earlier chronic conditions and greater reliance on acute care.
- Later life decline: Manual labour and caring responsibilities accelerate fatigue and physical wear. Limited continuity of care and isolation increase vulnerability in older age.

Overall, this group experiences wellbeing shaped less by choice and more by circumstance. Financial insecurity, inconsistent access and transport dependency compound across life, resulting in earlier decline and stronger reliance on overstretched local systems.

Regional Profile – Community Personas

The model maps how socioeconomic advantage, life stage and service access combine to influence residents' health and wellbeing trajectories over time

Trajectories Of Health & Well-being – Person C



Residents experiencing long-term vulnerability (e.g., disability, unstable housing, social isolation or chronic unemployment) face fragmented service access and fluctuating well-being across life.

- Early years: Families often engage with support services late due to stigma, transport or awareness barriers. Developmental screening and immunisation rates are inconsistent, though early-intervention programs provide short bursts of improvement when contact occurs.
- Adolescence to young adulthood: Re-engagement initiatives through schools, youth workers or community housing help rebuild stability, but outcomes vary with staff turnover and short-term funding. Many rely on public transport or outreach programs to stay connected.
- Adulthood: Irregular employment and episodic mental-health conditions create financial stress and limited continuity of care. Reliance on emergency or visiting services is common, with preventive care disrupted by cost or eligibility thresholds.
- Later life: Mobility issues and limited social networks heighten isolation. Dependence on community care and volunteer programs grows as health literacy and digital access decline.

Overall, this group's well-being is shaped by service fragility rather than personal capacity. Gaps in program continuity, transport, and workforce stability produce cyclical vulnerability, showing brief improvements followed by decline, which highlights the importance of sustained, wrap-around supports rather than episodic intervention.

Regional Profile - Summary

A summary and analysis of the Murrindindi region, including population trends, socioeconomic status, health outcomes and community personas

Murrindindi's ageing, dispersed population combined with transport barriers, housing shortages, and elevated health risks creates systemic access and workforce pressures. Strategic investment must focus on local service availability, integrated workforce solutions, and transport-aware models of care.

Demographics & Population
- Population: 15,600 (2024), projected 17,450 by 2036 (0.93% annual growth, below regional average).
- Ageing population: 75+ cohort expected to increase by **113%** by 2036.
- Uneven township growth: Yea and Marysville expanding, Eildon declining.

Geography & Infrastructure
- Highly dispersed communities, over an hour's drive from Melbourne.
- Limited public transport (one bus/coach daily); heavy reliance on private vehicles.
- Housing shortages, rising rents, and limited childcare hinder workforce attraction.
- Patchy internet and mobile coverage compounds access issues.

Socioeconomic Context
- Several towns fall within the most disadvantaged 40% nationally (SEIFA).
- Cost of living pressures: 25% of income spent on housing; limited affordable rentals.
- Seasonal and casual employment common; workforce participation uneven.

Health Outcomes
- Higher than state averages for obesity, arthritis, asthma, mental health conditions, suicide, and cancer incidence.
- Lower screening rates (breast, cervical) and high rates of dental avoidance due to cost.
- Hospital admissions significantly above state averages across almost all major conditions.

Community Insights & Lived Experience
- Barriers: transport, affordability, service gaps (children's health, oral health, dialysis, chemotherapy).
- Workforce challenges: shortages, professional isolation, reliance on casual/agency staff.
- Personas highlight struggles of older residents, families under stress, and aspiring/overseas-trained health workers.

Framework Assessment

Service access
- Highly dispersed geography and poor public transport make residents reliant on private vehicles.
- Long travel times to metropolitan Melbourne

Workforce
- Workforce shortages across health and aged care with reliance on casual and agency staff.
- Professional isolation and limited supervision capacity weaken retention and continuity of care.

Local Training
- No locally based health RTOs or higher education pathways.
- Students must leave the region to train, reducing retention and slowing the local workforce pipeline.

Health Outcomes
- Hospital admission rates significantly exceed Victorian averages across most major conditions.
- Lower cancer screening rates and high levels of dental avoidance contribute to preventable demand.

Health Literacy & Navigation
- 61% of surveyed residents are not confident in navigating the health system.
- Service information is fragmented, with limited digital literacy and outreach for disadvantaged groups.

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03

SERVICE MAPPING

Service Mapping - Section Overview

An introduction to this sections mapping of health service delivery Murrindindi region, including network organisation capability, workforce, services and gap analysis.

Health providers and services in the Murrindindi Shire

To support the development and strategic analysis of the innovation plan, network member profiles were established providing an overview of services across the region.

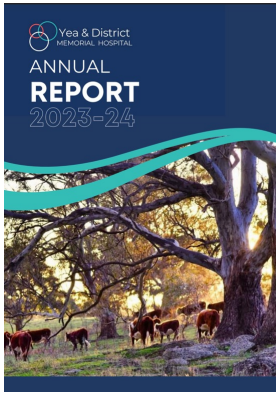
Firstly, organisations were assessed for their service delivery, range & catchment in the region, workforce details and network context. This provides an overview of each member's profile and role in the Murrindindi Shire.

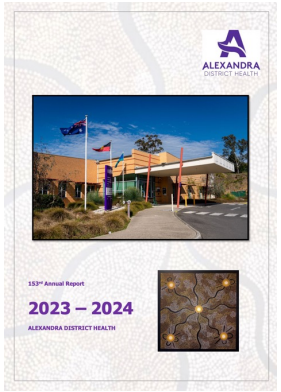
These profiles enable the analysis of service delivery across the region, determining demand in hospitals, aged care, GPs, allied health and disability support. Identifying gaps in service access and availability is a key outcomes of the plan, strengthening healthcare access for Murrindindi residents.

Data Collection Approach

The organisation service mapping was compiled from online, publicly available sources and NMC's consultation and data gathering process. This includes organisation's annual reports, advertised services, workforce data and health reporting platforms. Where possible, the analysis was aligned with Council data collections and planning frameworks to provide consistency and a shared evidence base for future decision-making.

For a detailed list of sources used and the utilisation, visit Appendix O





AIHW

myagedcare

Australian Bureau of Statistics

Elements of this section

1. **Network Member Profiles** - a comprehensive overview of each network member's organisational capability. This outlines their description, workforce, services, range & catchment.

2. **Service Mapping** - detailed service capability mapping, highlighting areas of delivery to the community and where gaps may present across the region.

Yea & District MEMORIAL HOSPITAL

ALEXANDRA DISTRICT HEALTH

DARLINGFORD UPPER GOULBURN NURSING HOME

Kellock Lodge Alexandra Inc. RESIDENTIAL AGED CARE

omnia Community Health

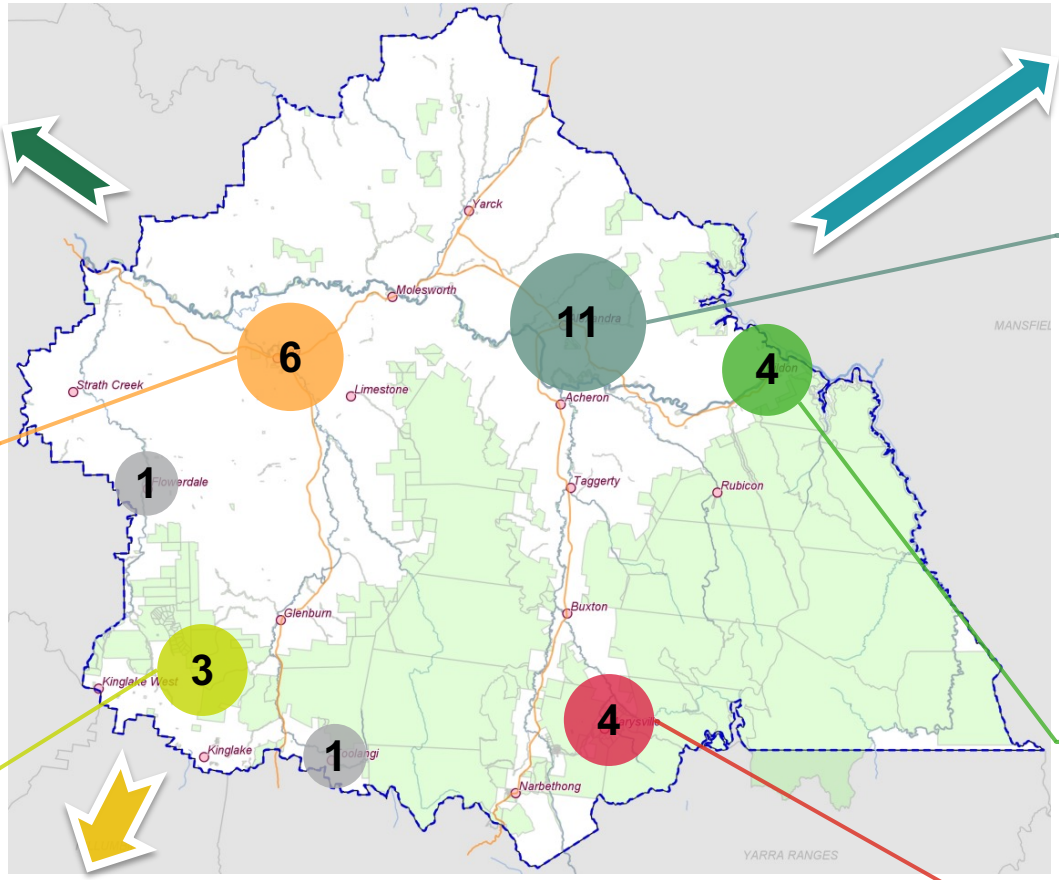
nexus Primary Health

Menzies SUPPORT SERVICES

Service Mapping - Service Overview

An overview of the key health providers in the shire and those that provide significant service access for residents out of region.

Health Providers by Township



Seymour:
Seymour District Memorial Hospital
Seymour Medical Clinic
Goulburn River Group Practice

Yea:
Yea & District Memorial Hospital
Yea Medical Centre
Yea Pharmacy
Yea Podiatry Clinic
Progression Physiotherapy & Performance
Yea Physiotherapy & Sports Injury Clinic
Maternal & Child Health Centre

Kinglake:
Omnia (Nexus Primary Health)
Maternal & Child Health Centre
Peter T Keuffer - Psychologist

Mansfield:
Mansfield District Hospital
Mansfield Medical Clinic
Central General Practice

Alexandra:
Alexandra District Health (ADH)
Alexandra Family Medical Centre
Alexandra Medical Centre
Alexandra Optical Services
Alexandra Community Pharmacy
Alexandra Physiotherapy
Bloom Hearing Specialists
People Valued Psychology
Menzies Support Service
Kellock Lodge
People Valued Psychology
Maternal & Child Health Centre

Eildon:
Darlingford UG Nursing Home
ADH Eildon
Terry White Pharmacy Eildon
Maternal & Child Health Centre

Marysville:
ADH Marysville
Marysville Medical Centre
Marysville Pharmacy Excellence
Maternal & Child Health Centre

Melbourne & Other:
Northern Hospital
Austin Hospital
St Vincent's Hospital
Healesville Medical Centre
Box Hill Hospital
Healesville Hospital & Yarra Valley Health
Yarra Ranges Health
Angliss Hospital
Healesville Hospital GP Clinic
Omnia (Nexus Primary Health)
Maternal & Child Health Centre - Flowerdale, Toolangi
Peter T Keuffer - Psychologist

Note: This list is not exhaustive but intends to show the significant providers to Murrindindi residents across service types.

Hospital - Yea & District Memorial Hospital

An overview and analysis of Yea & District Memorial Hospital, located in Yea, detailing their service offerings, catchment area and workforce overview

Yea & District Memorial Hospital

Yea & District Memorial Hospital (YDMH) is a small rural hospital primarily serving the western half of the Murrindindi Shire. Residents access a range of available services through primarily nurse-led care.

YDMH operates the Rosebank Hostel and Nursing home, delivering residential aged care services at the hospital campus. These operate at relatively full capacity and account for a significant portion of YDMH's hotel & allied service staff. Moreover, the hospital runs a district nursing program, which provides home care support under My Aged Care.

Patient flow primarily goes towards the northern fringes of Melbourne, with The Northern hospital receiving the highest portion of western Murrindindi residents. This is mainly due to geographic restrictions and road-conditions limiting access to east Melbourne services

Hospital	Aged Care	Disability Support	Allied Health	Health Promotion	Oral Health	Mental Health	AOD
✓	✓	✓	✓	✓		✓	

Primary & Aged Care

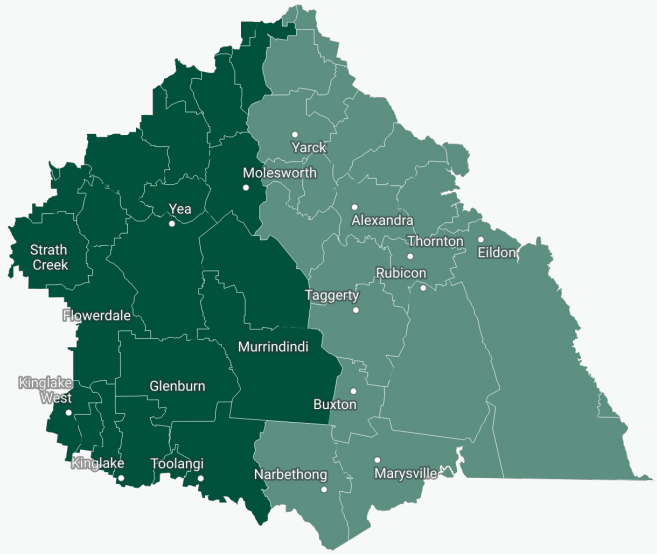
Residential Aged Care:
- Rosebank Hostel (Occupancy rate: 93.61%)
- Rosebank Nursing Home (Occupancy rate: 96.16%)

Primary health services: mental health, community health, and limited-access urgent care.

Acute Care

Median acute separations per annum: 132
Median urgent & emergency care admissions per annum: 50
Median Diagnostic-Related Groups (>5 seps) per annum: N/A
Median Clinical Capability Levels:
- Adult Perioperative - Level 1 (Local Anesthetic Only)

Median ICU hours delivered per annum: N/A
Median proportion of elective separations with NWAU>4.0: N/A
Median health service site beds: 10
Avg. length of stay for overnight/multiday care: to be sourced
Avg. local self-sufficiency for acute care: 2%*
Medical practitioners/specialists: Seasonal clinicians, which includes one visiting GP



Population Size	Age Profile	Average Travel Time Complex Health Service Site Care
8,386	48	1-1.5 hours (to Northern Health & Eastern Health)

Labour Category	Yea & District Memorial Hospital (Average Monthly FTE)	
	2023	2024
Nursing	26.76	25.32
Medical Support	0.42	0.99
Seasonal Clinicians	0.10	0.18
Ancillary Staff (Allied Health)	1.39	1.89
Hotel & Allied Services	13.86	17.74

Source:
- Yea & District Memorial Hospital, Annual Report 2023-24
- Australian Bureau of Statistics, 2021 Census All persons QuickStats Year & Kinglake (SA2)

Hospital - Alexandra District Health

An overview and analysis of Alexandra District Health, located in Alexandra, detailing their service offerings, catchment area and workforce overview

Alexandra District Health

Alexandra District Health (ADH) operates out of their Alexandra hospital facility, typically serving residents of eastern Murrindindi. ADH provides acute care admission, allied health services and hosts travelling specialists.

ADH includes an urgent care clinic, supported by nurses, local GP's and the Victorian Virtual Emergency Department (VVED). While the hospital does not operate an aged care facility, the district nursing program offer home care service under CHSP.

Due to geographical separation, patient flow is primarily directed towards Eastern Health locations in Healesville, Ringwood and Box Hill. This aligns with Victorias recently introduced LHSN groupings, that put ADH with Eastern Health, but at odds with YDMH's typical flow.

Hospital	Aged Care	Disability Support	Allied Health	Health Promotion	Oral Health	Mental Health	AOD
✓		✓	✓	✓		✓	

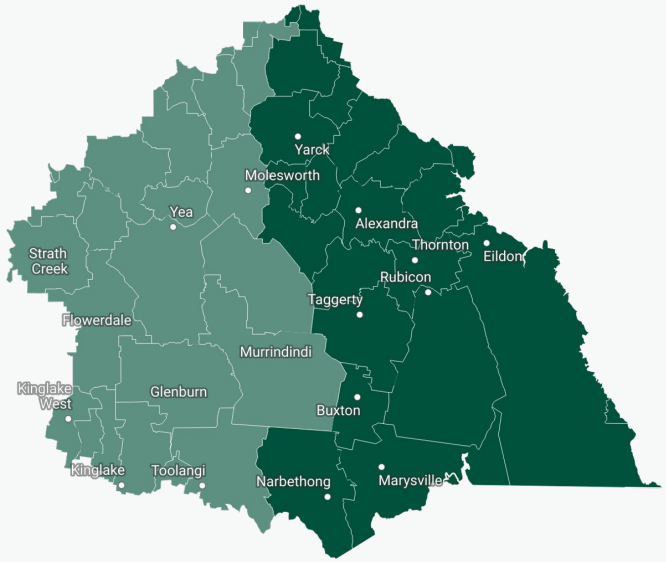
Primary & Aged Care

Residential Aged Care: None
Primary health services: mental health, community health, and limited-access urgent care.

Acute Care

Median acute separations per annum: 752
Median urgent & emergency care admissions per annum: 140
Median Diagnostic-Related Groups (>5 seps) per annum: N/A
Median Clinical Capability Levels:
- Adult Perioperative - Level 2 (Sedation, some general anaesthesia)
- Maternity - NA

Median ICU hours delivered per annum: NA
Median proportion of elective separations with NWAU>4.0: to be sourced
Median health service site beds: 25
Avg. length of stay for overnight/multiday care: to be sourced
Avg. local self-sufficiency for acute care: 13%*
Medical practitioners/specialists: Seasonal clinicians and local GP



Population Size	Age Profile	Average Travel Time Complex Health Service Site Care
6828	51	1-1.5 hours (to Eastern Health)

Labour Category	Alexandra District Health (Average Monthly FTE)	
	2023	2024
Nursing	27.86	28.10
Medical Support	0.55	1.00
Seasonal Clinicians	2.39	1.98
Ancillary Staff (Allied Health)	8.07	6.44
Hotel & Allied Services	9.04	8.84

Source:
- Alexandra District Health, Annual Report 2023-24
- Australian Bureau of Statistics, 2021 Census All persons Alexandra (SA2)
- Australian Institute of Health & Welfare, 2023-34

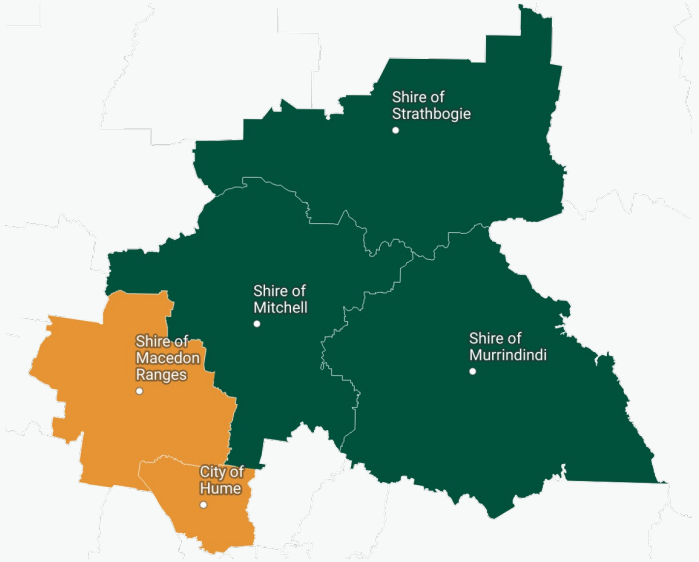
Community Health Service – Omnia Community Health

An overview and analysis of Omnia Community Health (formerly Nexus Primary Health), operating a clinic in Kinglake, detailing their service offerings, catchment area and workforce overview

Omnia Health
(Formerly Nexus Health)

Omnia Health operates a community health facility in Kinglake, servicing the southern part of Murrindindi Shire. The merger between Nexus Health and Sunbury and Cobaw Community Health was designed to strengthen resourcing and integration across borders. The service provides allied health, counselling and community support programs, with a strong emphasis on outreach and preventative care for rural populations.

Omnia's service model has evolved from its original funding base in Mitchell Shire, which continues to shape its geographic focus and eligibility parameters. While residents in Kinglake benefit from direct access to Omnia's clinic, broader service delivery across Murrindindi is constrained by program funding boundaries and travel feasibility. As a result, access for northern and central townships is more limited, with service expansion dependent on new or shared funding arrangements.



Hospital	Aged Care	Disability Support	Allied Health	Health Promotion	Oral Health	Mental Health	AOD
		✓	✓	✓		✓	✓

Population Size	Age Profile	Average Travel Time Complex Health Service Site Care
371,471	43	1 hour (to Northern Health & Eastern Health)

Service Overview

Kinglake Location:

1 Full-time GP
(recruiting a second)

3,127 Appointments
(2023-34)

Mixed-billing Clinic
(Medicare card holders, Pensioners, DVA, Healthcare card holders, under 16s

Offerings:

- GP Services
- Allied Health
- Chronic Disease
- Women's Health
- Pediatrics
- Minor Procedures
- Specialty Support
- Diagnostics & Pathology

Labour Category	Omnia Health (Average Monthly FTE)	
	2023	2024
Nursing	To be sourced	To be sourced
Medical Support	To be sourced	To be sourced
Seasonal Clinicians	To be sourced	To be sourced
Ancillary Staff (Allied Health)	To be sourced	To be sourced
Hotel & Allied Services	To be sourced	To be sourced

Source:
- Australian Bureau of Statistics, 2021 Census All persons Murrindindi, Mitchell, Strathbogie, Macedon Rangers, and Hume (LGA)

Aged Care - Kellock

An overview and analysis of Kellock Lodge, located in Alexandra, detailing their service offerings, catchment area and workforce overview

Kellock Lodge Alexandra

Kellock Lodge is a single-site residential aged care provider operating close to full capacity across its 50 beds. The service focus is on residential care, supported by allied health, with other care options such as memory support and home care accessed through external providers. Workforce growth over the past year has been achieved mainly through part-time and casual roles, which supports flexible coverage but also underscores the importance of strategies to strengthen workforce stability and continuity of care.

Kellock Lodge Alexandra Inc.
RESIDENTIAL AGED CARE

Hospital	Aged Care	Disability Support	Allied Health	Health Promotion	Oral Health	Mental Health	AOD
☐	☑	☐	☑	☐	☐	☐	☐

Service Overview

50 beds

40-59 residents

91-100% Occupancy Rate

Offering

- ✓ Residential Aged Care
- ✗ Memory Support Unit
- ✗ Independent Living Unit
- ✗ Assisted Living Units
- ✗ Home Care

Labour Category	Kellock Lodge Alexandra	
	2023	2024
Full time employees	3	5
Part time employees	67	72
Casual employees	26	53
Estimated number of volunteers	5	3

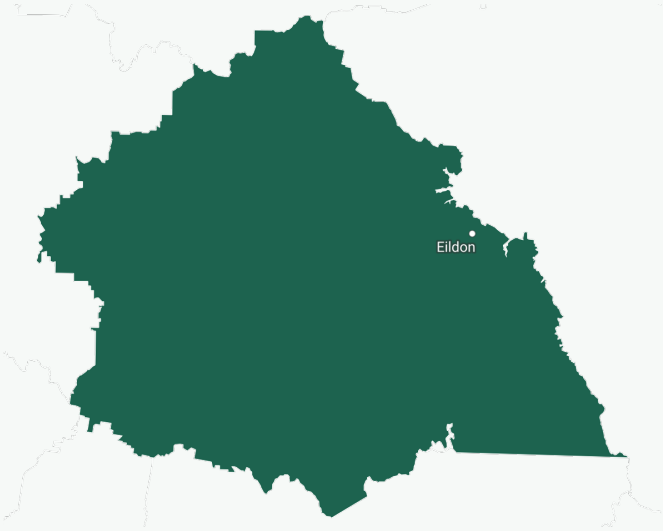
Source:
- Australian Charities and Not-for-profit Commission, Kellock Lodge Alexandra Inc Annual Information Statement 2024
- My Aged Care, Kellock Lodge

Aged Care - Darlingford Upper Goulburn Nursing Home

An overview and analysis of Darlingford Upper Goulburn Nursing Home, located in Eildon, detailing their service offerings and workforce overview

Darlingford Upper Goulburn Nursing Home

Darlingford Upper Goulburn Nursing Home is a residential aged care provider with 51 beds, currently operating at a moderate occupancy of around 61-70%. Service scope is limited to residential care, without memory support or step-down options. Workforce composition has shifted over the past year, with an increase in full-time and casual staff alongside a reduction in part-time roles. Unlike other providers, Darlingford does not report a volunteer base, highlighting a more traditional staffing model.



Hospital	Aged Care	Disability Support	Allied Health	Health Promotion	Oral Health	Mental Health	AOD
	✓						

Service Overview

51 beds

20-39 residents

61-70% Occupancy Rate

Offering

- ✓ Residential Aged Care
- ✗ Memory Support Unit
- ✗ Independent Living Unit
- ✗ Assisted Living Units
- ✗ Home Care

Labour Categories	Darlingford Upper Goulburn Nursing Home Inc	
	2023	2024
Full time employees	3	7
Part time employees	55	47
Casual employees	5	16
Estimated number of volunteers	0	0

Source:
- Australian Charities and Not-for-profit Commission, Darlingford Upper Goulburn Nursing Home Inc Annual Information Statement 2024
- My Aged Care, Darlingford Upper Goulburn Nursing Home Inc

Disability Support - Menzies Support Services

An overview and analysis of Menzies Support Services, located in Alexandra, detailing their service offerings and workforce overview

Menzies Support

Menzies Support is a local disability and aged care provider with service delivery concentrated in community participation programs and core in-home supports. These services form an important foundation for people with disability in Murrindindi, offering day-to-day assistance and opportunities for inclusion. Workforce capacity is modest, with a mix of full-time, part-time, and casual staff supported by volunteers. This structure provides flexibility for service delivery but also highlights the importance of maintaining a stable workforce to meet evolving participant needs.

Hospital	Aged Care	Disability Support	Allied Health	Health Promotion	Oral Health	Mental Health	AOD
☐	☑	☑	☐	☐	☐	☐	☐

Service Overview

384 participants supported

2 service streams delivered

Offering

- ✗ Supported Independent Living (SIL)
- ✗ Specialist Disability Accommodation (SDA)
- ✗ Short-Term Accommodation / Respite
- ✓ Community Participation & Day Programs
- ✓ In-Home Support (Core Supports)
- ✗ Support Coordination / Plan Management

Labour Categories	Dame Pattie Menzies Centre Inc (FTE)	
	2023	2024
Admin	9.8	6.8
Support workers - Part time and casual	24	13

Source:
- Australian Charities and Not-for-profit Commission, Dame Pattie Menzies Centre Inc Annual Information Statement 2024

Regional Profile - Township Population & Age Growth

An overview of changes in populations per township in the region and analysis of age demographic trends for the Shire

Township Population

Towns	2016	2021	%
Alexandra (SA2)	**6,337**	**6,828**	**+7.7%**
Alexandra	2,695	2,801	+3.9%
Marysville	394	501	+27.2%
Eildon	974	944	-3.1%
Yea (SA2)	**3,560**	**4,182**	**+17.5%**
Yea	1,587	1,789	+12.7%
Kinglake (SA2)	**3,844**	**4,204**	**+9.4%**
Kinglake	1,536	1,662	+8.2%
Kinglake West	1,166	1,305	+11.9%
Kinglake Central	345	413	+19.7%

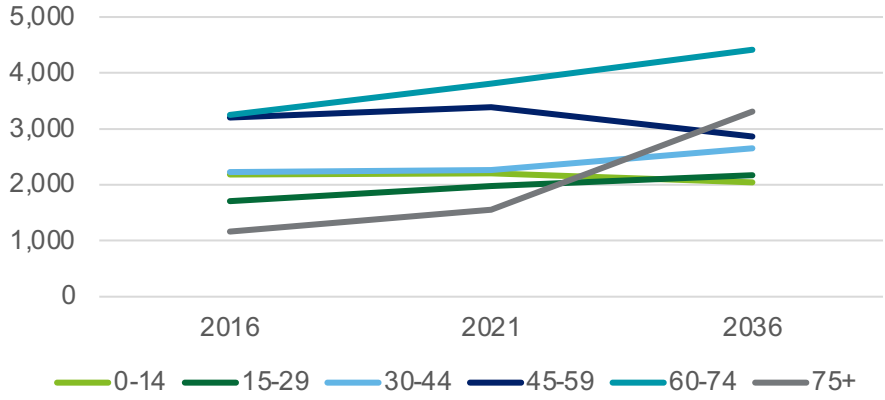
SA2 Data	Suburbs and Localities (2021), formerly named as State Suburbs in 2016

Between the 2016 and 2021 Census periods, several areas within Murrindindi are showing positive growth, with **Yea in SA2 data size and Marysville as Suburbs and Localities are showing the biggest growth**. In contrast, **Eildon experienced a population decline**, reflecting **ongoing economic and service-related pressures** in the area. These shifts point to **uneven growth across the region**, which has implications for **equitable service planning and infrastructure investment**.

Demographic projections highlight a **rapidly ageing population**, with the number of residents aged **75 and over expected to more than double** in the coming years. This trend will place **considerable strain** on local health and community services, particularly in relation to hospital capacity, allied health, in-home care, and residential aged care. Strategic planning will be essential to meet the escalating demand and to support older residents to age well within their communities.

Age Growth

Age Group (MSC)	2016	2021	2036	% Change (2021-2036)
0-14	2,181	2,205	2,044	**-7.3%**
15-29	1,708	1,983	2,172	**+9.5%**
30-44	2,228	2,265	2,653	**+17.1%**
45-59	3,198	3,388	2,864	**-15.5%**
60-74	3,250	3,814	4,415	**+15.8%**
75+	1,164	1,549	3,310	**+113.7%**



Sources:
- Australian Bureau of Statistics, QuickStats, Murrindindi (LGA) 2016 & 2021
- Future in Victoria, Estimated Resident Population Projection, 2026 to 2036 (2023)

Local Service Capability & Capacity

Profiling local service capacity and workforce foundations across hospitals, aged care and community health

Service Map

Hospitals

Yea & District Memorial Hospital (YDMH)	Alexandra District Health (ADH)
Acute, residential aged care (Rosebank Hostel & Nursing Home), allied & community health, district nursing, health promotion	Acute, urgent care, allied health, visiting specialists, community health, district nursing, health promotion
132 separations p.a., 50 ED admissions, aged care 93–96% occupancy	752 separations p.a., 140 ED admissions

Aged Care

Kellock Lodge (Alexandra)	Darlingford Upper Goulburn Nursing Home (Eildon)
Residential aged care	Residential aged care
50 beds, 91–100% occupancy	51 beds, 61–70% occupancy

Community Health

Omnia Community Health (Kinglake)
GP, allied health, mental health, AOD, disability support, health promotion
~1–2 GPs, 3,127 appointments (2023–24)

Disability Support

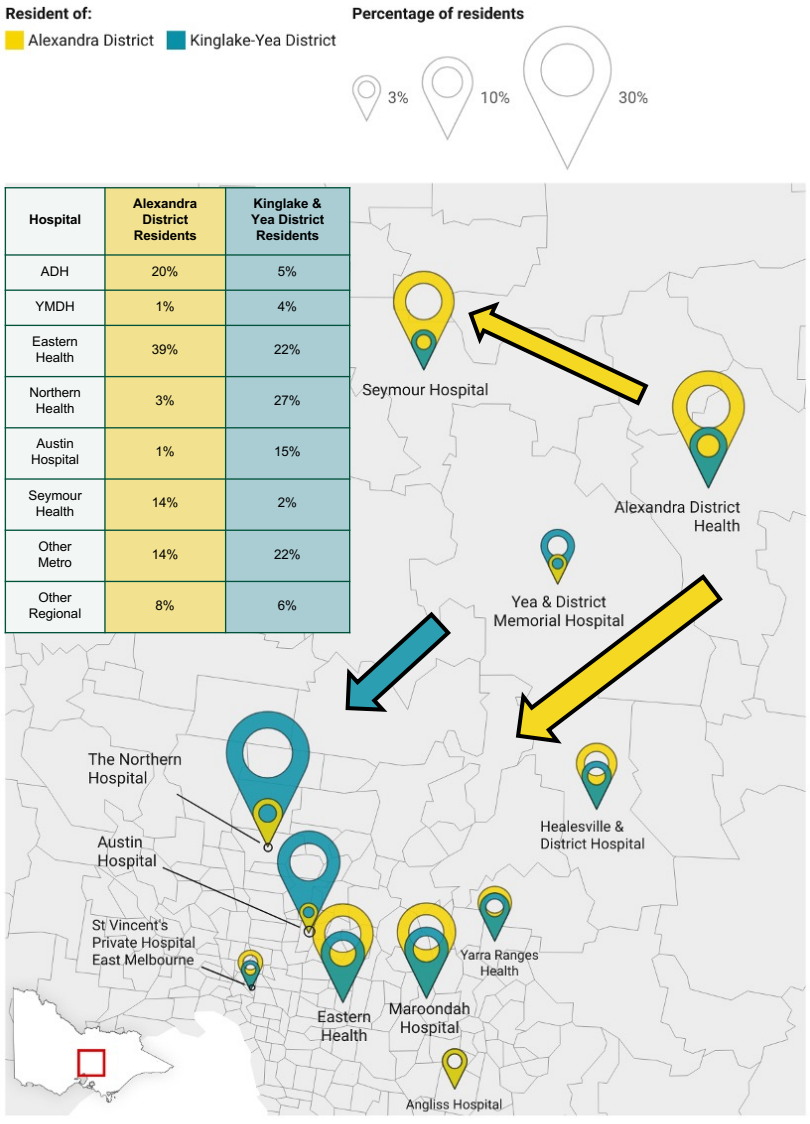
Menzies Support Services (Alexandra)
Community Participation, Day Programs and In-Home Support (Core Supports), Aged Care Services
384 participants

Key Takeaways

- Oral health access is limited, with no dedicated public dental service currently operating in the Shire.
- Acute care capacity is small, with hospitals primarily focused on stabilisation, sub-acute, and aged care support.
- Community health services provide the main platform for prevention, allied health, and mental health access across localities.
- Aged care is well distributed but relies on a flexible, part-time workforce to maintain coverage.
- Disability supports are locally based in Alexandra but modest in workforce scale and geographic reach.

Service Mapping - Patient Flow

A breakdown of patient flow and self-sufficiency analysis for the Murrindindi region, noting the geographical and population differences that impact health services.



Hospital	Alexandra District Residents	Kinglake & Yea District Residents
ADH	20%	5%
YMDH	1%	4%
Eastern Health	39%	22%
Northern Health	3%	27%
Austin Hospital	1%	15%
Seymour Health	14%	2%
Other Metro	14%	22%
Other Regional	8%	6%

Self-Sufficiency	Patient Flow - West	Patient Flow - East
15.8% 2023-24	**The Northern Hospital** **Austin Hospital** **Seymour Health**	**Eastern Health** **(Healesville, Maroondah, Boxhill)** **Other Metro**

Persona Findings

” As an Eildon resident, her secondary and tertiary care (i.e., dialysis) is already linked with Eastern Health”

“Their work in Alexandra sees patients already flow to Eastern/St Vincent’s… her patients would flow more to the north for mental health”

“Her mental health services are managed through GV Health, her family is naturally drawn north for support”

“They naturally associate higher-level hospital access with Northern/Epping, as this is the common pathway for local residents in the Kinglake & Yea region”

Implications

Murrindindi records a **self-sufficiency rate of 15.8%** for admitted acute care, with admissions coming out of Alexandra and Yea health services and service areas.

- ADH’s focus on acute and surgical services reflects their alignment with low-mid acute service areas, while also offering mental health, allied health, and health promotion
- Yea & District Memorial Hospital delivers a broad mix of services including low acuity acute care, health promotion, allied health, mental health, aged care and community programs

Patient flow across the region is shaped by both geography and system access.

- Residents in Yea and Kinglake generally seek acute, emergency, or specialist care at Northern and Austin hospitals.
- Those in west Murrindindi more often present to the Northern hospitals or Seymour.
- These patterns are reinforced by historic service models, transport routes, and road conditions.
- Flow is influenced by VVED access and Ambulance Victoria pathways, which redirect patients to metropolitan hospitals when regional capacity is insufficient.

Service Mapping - Summary

A summary and analysis of services in the Murrindindi region, service types, organisations and qualitative survey insights

The Service Map confirms that while small local services provide valuable community care, the region depends heavily on metropolitan and neighbouring health services. Addressing gaps in key specialties, strengthening workforce stability, and improving referral/navigation pathways will be critical to building a more sustainable and equitable local system.

Demographics & Geography
- Services are spread across small towns with low critical mass, limiting acute and specialist capacity.
- Patients regularly travel to Northern, Austin, and Eastern Health for higher-level care.
- Regional self-sufficiency is only **15.8%**, with most care delivered outside the Shire.

Health & Service Availability
- Alexandra District Health and Yea & District Memorial Hospital together provide the region with a comprehensive mix of services, spanning acute and surgical care, aged care, community health, allied health, and health promotion.
- Residential aged care is near full occupancy at Kellock Lodge and Rosebank, while Darlingford UGNH has lower occupancy.
- Disability support is concentrated in Menzies Support Services, with limited coverage across other providers.

Workforce & Capacity
- Services rely on small, part-time, casual, and seasonal workforces, impacting continuity and supervision.
- Allied health provision is thin and variable across the entire region
- Volunteers provide additional support in aged care, but coverage is inconsistent across the region.

Gaps & Challenges
- Major service gaps in **children's health, oral health, dialysis, chemotherapy, and specialist access**.
- Fragmented referral and service coordination pathways make navigation difficult for residents.
- Workforce shortages, low self-sufficiency, and reliance on out-of-region care create structural inequities in access.

Framework Assessment

Service access
- Regional self-sufficiency is very low (15.8%), with major outflow to Northern, Austin, and Eastern Health.
- Key service gaps: dialysis, chemotherapy, oral health, and children's services.

Workforce
- Heavy reliance on small, casual, and seasonal workforces impacts continuity.
- Allied health coverage is patchy, with limited supervision capacity.

Local Training
- Few structured training pathways or local placements.
- Dependence on external RTOs/universities limits retention.

Health Outcomes
- Gaps in chronic disease management and oral health drive preventable hospital transfers.
- Low local acute care capacity leads to avoidable reliance on metropolitan hospitals.

Health Literacy & Navigation
- Referral and coordination pathways are fragmented across providers.
- Residents face confusion about service access, particularly for specialist and urgent care.

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4

FUTURE STATE

LOCAL SERVICE DEMAND

4.1 Service Demand - Section Overview

An overview of service demand in the Murrindindi region, analysing current patterns, pressures, and gaps across key sectors, and their implications for the health network

Service Demand & Forecast Overview

This section analyses current service use across Murrindindi and models how demand will change over the next 10–15 years. It examines how rising chronic conditions, NDIS participants, ageing population, mental health needs, harmful alcohol use, and acute presentations interact with local workforce depth, service availability, transport access and referral pathways. The analysis highlights where services can be effectively provided locally and where continued reliance on neighbouring regional and metropolitan providers will remain necessary.

Data Collection Approach

Demand forecasting was developed using trend analysis of historical service use (2016–2021) combined with population projections and age-specific growth rates. Future demand (2026–2036) was modelled by applying condition-specific incidence and utilisation trends to projected population profiles.

Data sources included ABS, PHIDU, Remplan, hospital admissions datasets and sector reports, supplemented with local intelligence from YDMH, ADH and community providers. This triangulation ensured forecasts accounted for rural utilisation patterns, transport barriers, local service gaps and the impact of low workforce coverage.

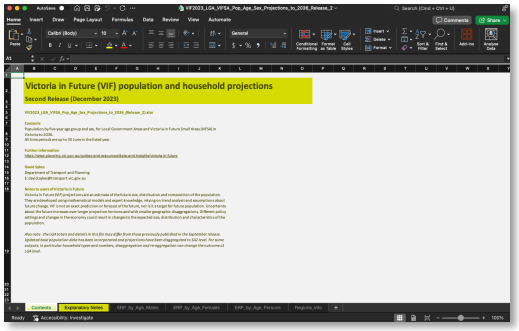
For a detailed list of sources used and the utilisation, visit Appendix O

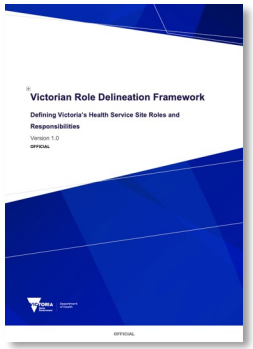
Elements of this section

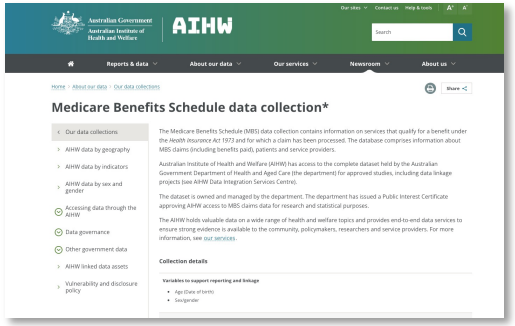
1. **Current service demand –** the baseline picture of service use across acute care, primary care, mental health, disability support, aged care, oral health, and AOD.

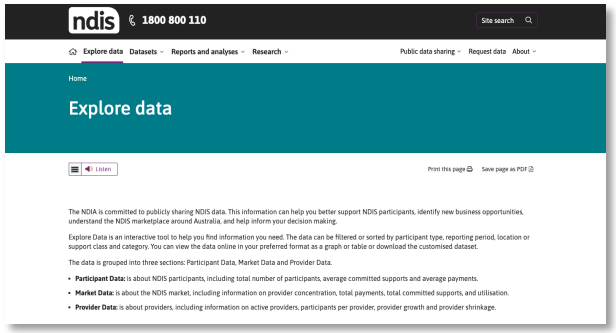
2. **Forecast service demand** – modelled growth in acute, mental health, chronic conditions, AOD, aged care, disability support and allied health.

3. **Map & key takeaways** - Service demand mapped across the region, highlighting future needs and gaps in healthcare delivery.



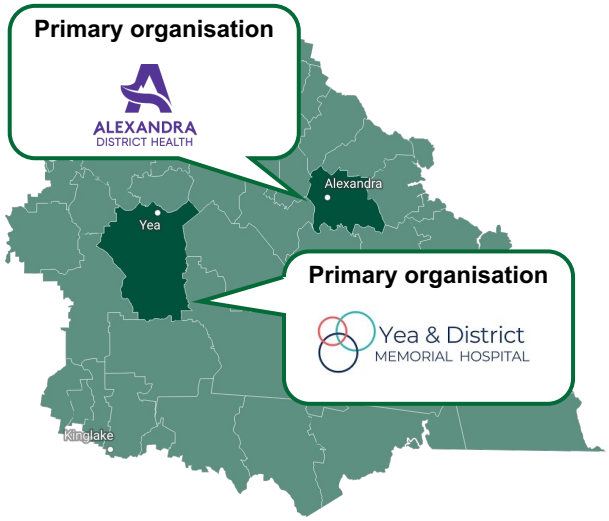






4.6 Service Demand - Hospitals: Demand Analysis

Service demand forecasting for the Murrindindi region, by major clinical admissions group, to provide a basis for workforce and delivery planning to meet future demand



Alexandra District Hospital and Yea & District Memorial Hospital admissions by Major Clinical Related Group

		Future Supply (Based on Current Supply)			
Murrindindi Region Admissions	**2024**	**2025**	**2026**	**2027**	**2028**
Diagnostic GI Endoscopy	277	284.2	291.6	299.3	307.1
Ophthalmology	104	106.7	109.5	112.4	115.3
Non Subspeciality Medicine	79	80.9	82.7	84.6	86.6
Gynaecology	38	38.5	39	39.5	40.0
Neurology	72	74.2	76.4	78.7	81.1
Orthopaedics	42	43.3	44.7	46.2	47.7
Endocrinology	38	38.7	39.4	40.1	40.8
Haematology	25	25.5	25.9	26.4	26.9
Gastroenterology	27	27.5	28	28.5	29.0
Non Subspecialty Surgery	26	26.3	26.7	27	27.4
Immunology & infections	15	15.2	15.4	15.6	15.8
Respiratory Medicine	11	11.3	11.6	11.9	12.2
Clinical Cardiology	8	8.2	8.4	8.6	8.8
Oncology	3	3.1	3.2	3.2	3.3

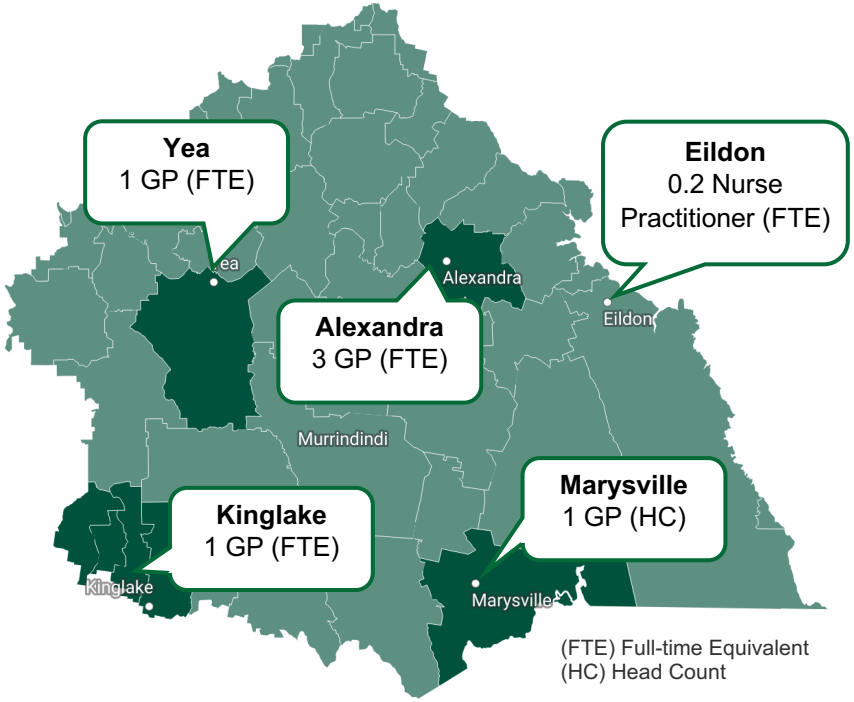
Source: Victorian Government Department of Health, System Planning – Inpatient and Emergency Department data products (2024)

For a breakdown of calculations and assumptions, visit Appendix A

The forecast shows steady growth across most diagnostic areas from 2024-2027, led by services strongly linked to ageing and chronic disease. **Orthopaedics, Neurology, Ophthalmology, Cardiology, Oncology and Diagnostic GI Endoscopy** rise fastest, reflecting the sharp increase in residents aged 75+ and higher rates of arthritis, stroke risk and cancer. Moderate gains are seen in **General Medicine, Endocrinology, Gastroenterology and Haematology**, while **Gynaecology, Immunology & Infections and Non-subspecialty Surgery** grow more slowly as they are less age-dependent. Overall, activity is trending upward across all groups, highlighting the need to sustain and, in some specialties, expand capacity to meet rising demand.

4.7 Service Demand - GPs: Demand Analysis

Service demand forecasting for the Murrindindi region, to provide a basis for workforce and delivery planning to meet future demand



Murrindindi Region	Current Demand 2023	Current Demand 2024	Current Demand 2025 (Forecast)	Future Supply (Based on Current Supply) 2026	Future Supply (Based on Current Supply) 2027	Future Supply (Based on Current Supply) 2035 (based on population forecasts)
GP (Total Service Instances P.A)	116,130	116,647	117,044	117,683	118,205	122,462

For a breakdown of calculations and assumptions, visit Appendix B

Demand Leakage

422 **Active patients from Murrindindi at major Mansfield GP clinic**

287 **Attended appointments in the previous 12 months**

Sources:
- *PHIDU, Social Health Atlas (LGA data), published September 2025*
- *Australian Institute of Health and Welfare, Medicare Benefits Schedule (MBS) funded services, last updated 27 November 2025*
- *CGP Clinic Mansfield, active patient and appointment data, retrieved August 2025*

GP Screening Uptake

46% **Bowel Cancer Screening Participation Rate**

50% **Breast Cancer Screening Participation Rate**

60% **Cervical Cancer Screening Participation Rate**

Murrindindi is served by approximately **five General Practitioners (GPs)**, located across Yea, Alexandra, Kinglake, and Marysville. However, **Eildon stands out as a significant service gap**, relying solely on a visiting nurse practitioner one day per week. This uneven distribution creates **barriers to equitable access**, particularly for more remote communities, and places added strain on surrounding practices to absorb demand.

Medicare Benefits Scheme (MBS) claims for GP services in the region show only minor growth year-on-year, with projections indicating a **5.5% increase by 2035**. While legislative changes such as **expanded prescribing rights** for nurse practitioners and pharmacists may moderate demand on GPs, this effect will likely be outweighed by the pressures of an **ageing population**, which is expected to drive higher levels of **chronic disease management, multimorbidity, and ongoing primary care needs**.

Together, the hospital and GP demand analysis shows a small, thinly spread system already experiencing steady growth in activity and leakage out of the region. The following pages model how underlying health conditions are expected to evolve to 2036, providing a needs-based view of future demand that underpins the network options and workforce plan.

4.8 Service Demand - Hospital & GP: Demand Projections (1/2)

Chronic and acute health conditions are projected to rise steadily across Murrindindi, placing increasing pressure on local hospital and GP services and reinforcing the need for integrated prevention and coordinated care

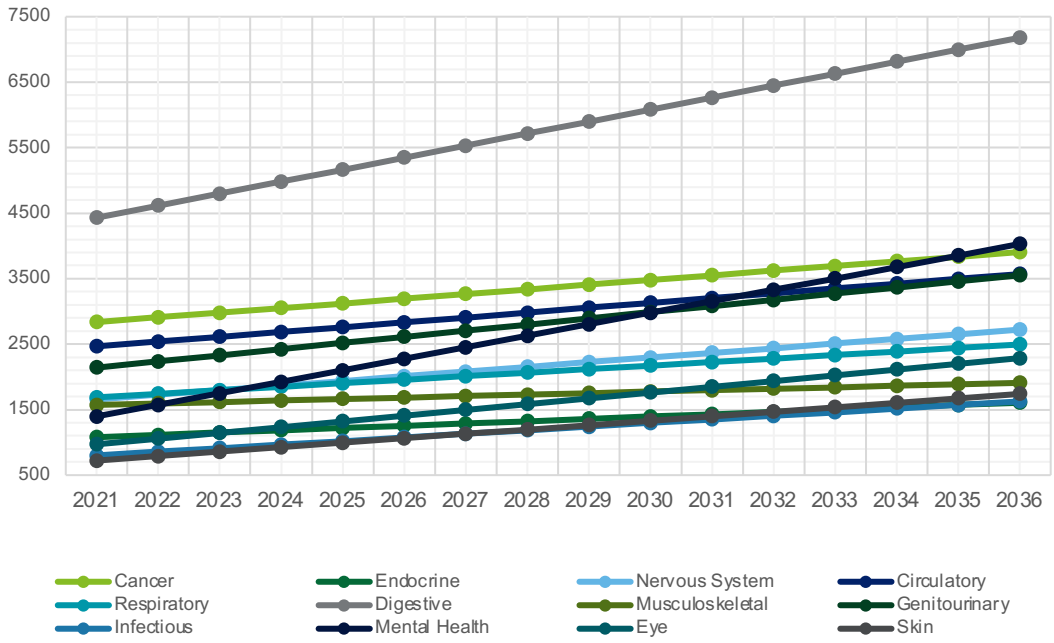
Health Condition Modelling

- The forecast shows consistent growth across all major chronic condition groups. Circulatory disease, musculoskeletal conditions and cancer account for the largest absolute volumes, reflecting an ageing population with higher rates of arthritis, stroke and heart disease.
- Endocrine, respiratory, digestive and genitourinary conditions also trend upwards year-on-year, adding to demand for diagnostics, specialist clinics and GP management.

Chronic Conditions								
Year	Cancer	Endocrine	Nervous System	Circulatory	Respiratory	Digestive	Musculo-skeletal	Genitourinary
2016	1558.4	522.9	686.1	1228.8	1326.2	2179.8	973.7	960.2
2017	1702.2	623.4	891	1501.9	1564.1	2577.4	1106.8	1237.6
2018	1846	724	1096	1775	1802	2975	1240	1515
2019	1903	677	999	1521	1521	3050	1038	1370
2020	2765	1044	1583	2393	1634	4247	1550	2047
2021	2836.4	1079	1654.2	2466.5	1687.8	4430.3	1572.4	2141
2022	2907.8	1114.1	1725.4	2540	1741.6	4613.5	1594.9	2235.1
2023	2979.2	1149.1	1796.6	2613.5	1795.4	4796.8	1617.3	2329.1
2024	3050.6	1184.1	1867.8	2687	1849.1	4980	1639.7	2423.1
2025	3122	1219.2	1939	2760.5	1902.9	5163.3	1662.2	2517.1
2026	3193.4	1254.2	2010.2	2834	1956.7	5346.5	1684.6	2611.2
2027	3264.8	1289.2	2081.4	2907.5	2010.5	5529.8	1707	2705.2
2028	3336.2	1324.3	2152.7	2981	2064.3	5713.1	1729.5	2799.2
2029	3407.6	1359.3	2223.9	3054.5	2118.1	5896.3	1751.9	2893.3
2030	3479	1394.4	2295.1	3128	2171.9	6079.6	1774.4	2987.3
2031	3550.4	1429.4	2366.3	3201.5	2225.6	6262.8	1796.8	3081.3
2032	3621.8	1464.4	2437.5	3275	2279.4	6446.1	1819.2	3175.3
2033	3693.2	1499.5	2508.7	3348.5	2333.2	6629.3	1841.7	3269.4
2034	3764.6	1534.5	2579.9	3422	2387	6812.6	1864.1	3363.4
2035	3836	1569.5	2651.1	3495.5	2440.8	6995.9	1886.5	3457.4
2036	3907.4	1604.6	2722.3	3569	2494.6	7179.1	1909	3551.5

Forecast Health Conditions' Demand Based on Needs

- This modelling uses historical hospital separations and GP activity by condition group (2016–2022), combined with population and ageing projections, to estimate needs-based demand to 2036.
- Projections assume current models of care continue (i.e. a "business as usual" scenario) with no major change in prevention, access, or networked service delivery.
- The outputs provide a baseline against which the impact of the proposed Murrindindi Health Network options can be assessed.



Source: PHIDU, Social Health Atlas (LGA data), published September 2025

For a breakdown of calculations and assumptions, visit Appendix C

4.9 Service Demand - Hospital & GP: Demand Projections (2/2)

Mental health and other ambulatory-sensitive conditions are expected to grow rapidly, highlighting the importance of local, community-based responses and shared models of care

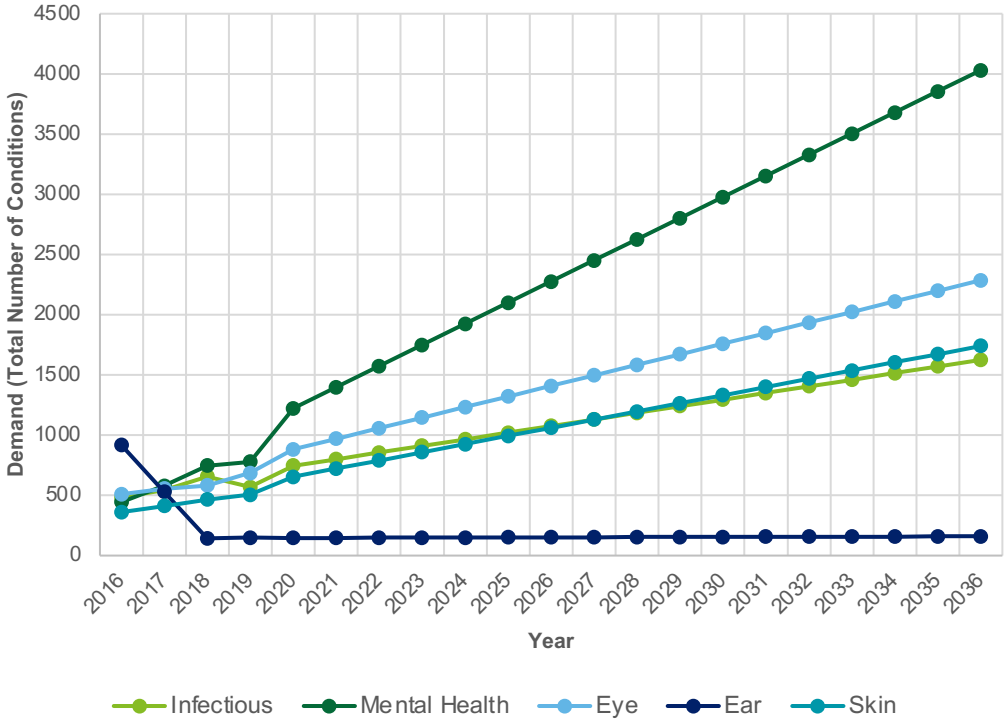
Health Condition Modelling

- Mental health stands out as one of the fastest-growing demand areas, with projected volumes rising sharply over the modelling period. This will increase pressure on EDs, inpatient units and community-based psychosocial supports if local capacity and early intervention are not strengthened.
- Demand for eye, skin and other ambulatory-sensitive conditions also increases steadily from a smaller base, reflecting both ageing and rising chronic disease risk factors. Infectious disease demand remains relatively stable but at a higher level than in 2016, underscoring the need to maintain surveillance and vaccination programs.

Chronic Conditions (cont.)				
Year	Infectious	Eye	Ear	Skin
2016	483.7	510	917	360.9
2017	545.3	555.6	530	411.4
2018	656	581	143	466
2019	570	687	148	504
2020	746	883	146	654
2021	801.1	970.7	146.9	721.9
2022	856	1,058.40	147.8	789.8
2023	910.9	1,146.20	148.6	857.7
2024	965.9	1,233.90	149.5	925.6
2025	1020.8	1,321.70	150.4	993.5
2026	**1075.7**	**1,409.40**	**151.2**	**1061.4**
2027	1130.7	1,497.10	152.1	1129.3
2028	1185.6	1,584.90	153	1197.1
2029	1240.5	1,672.60	153.8	1265
2030	1295.5	1,760.40	154.7	1332.9
2031	**1350.4**	**1,848.10**	**155.6**	**1400.8**
2032	1405.3	1,935.90	156.5	1468.7
2033	1460.3	2,023.60	157.4	1536.6
2034	1515.2	2,111.40	158.2	1604.5
2035	1570.1	2,199.10	159.1	1672.4
2036	**1625.1**	**2,286.90**	**160**	**1740.3**

Forecast Health Conditions' Demand Based on Needs

- Taken together, these projections confirm that future demand growth is driven as much by chronic and mental health conditions as by acute episodes, reinforcing the case for networked care coordination, stronger primary care partnerships and the local Health & Learning Hub proposed under Option 1.



Source: PHIDU, Social Health Atlas (LGA data), published September 2025

For a breakdown of calculations and assumptions, visit Appendix C

4.10 Service Demand - Aged Care: Demand Analysis

Aged care demand in Murrindindi will rise sharply over the next decade as the 65+ population grows from around 3,800 people in 2021 to more than 6,300 by 2036

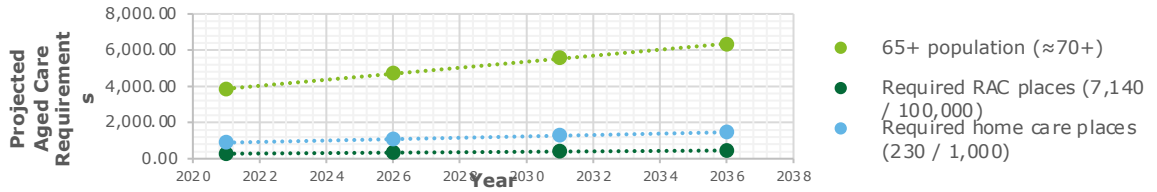
Current Aged Care Supply

Current Demand	
Murrindindi	**2023**
Number of Residential Bed	126
Number of Residents	100
Number of CHSP Home support Clients	779

Note: Aged care demand in Murrindindi will rise sharply over the next decade as the 65+ population grows from around 3,800 people in 2021 to more than 6,300 by 2036. Applying national planning ratios, this translates into demand for approximately 450 residential aged-care (RAC) places and around 1,450 home-care places by 2036.

Projected Aged Care Demand

Year	65+ population (≈ 70+)	Required RAC places	Required home-care places
2021	3,828.0	273.3	880.4
2026	4,729.45	337.7	1,087.8
2031	5,564.16	397.3	1,279.8
2036	6,320.86	451.3	1,453.8



Source:

- *Kellock Lodge Alexandra, ACNC Annual Information Statement – workforce data (2021–24)*
- *Darlingford Upper Goulburn Nursing Home Inc., ACNC Annual Information Statement – workforce data (2021–24)*
- *Stakeholder consultations, aged care bed numbers (2024)*

For a breakdown of calculations and assumptions, visit Appendix D

These projections highlight several planning implications:

- The older population will grow strongly, driving sustained demand for both RAC beds and community-based care.
- Residential providers have already increased staffing and occupancy; if growth continues without clear ratios, headcount could outstrip what is needed per resident or per place.
- Workforce planning needs to shift from “how many staff can we hire?” to “what mix and FTE do we need for each RAC place and home-care client?”, using these projections as the anchor.

Overall, Murrindindi will need a coordinated strategy that expands residential capacity in line with the projected 451 RAC places, while substantially scaling home-support workers across nursing, personal care, domestic assistance and allied health. With demand peaking around 2036, early action is required to secure infrastructure, recruit and retain rural aged-care staff, and use the new Aged Care Act 2024 reforms to build integrated models that support ageing in place alongside high-quality residential options.

4.11 Service Demand - Allied Health: Demand Analysis

Service demand forecasting for allied health in Murrindindi, to understand whether current workforce and clinic capacity can keep pace with future need

Current Allied Health Supply

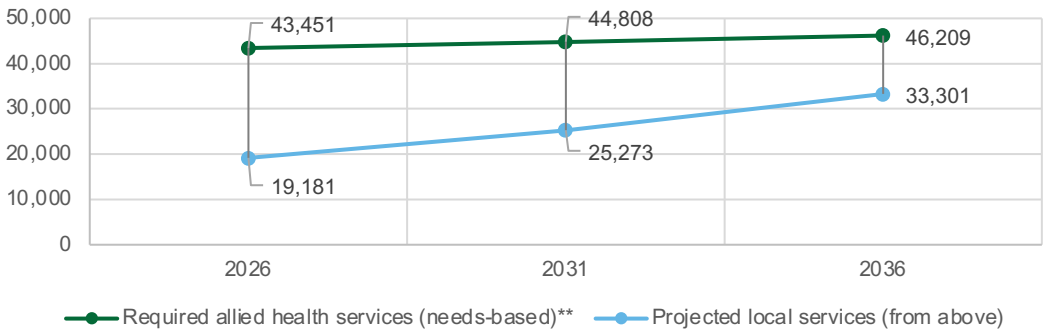
Physiotherapist	Podiatry	Occupational Therapist
Speech Pathology	Dietetics	Exercise Physiology

Note: Two of the three speech pathologists in Alexandra primarily support children
Sources: *Australian Institute of Health and Welfare, Medicare Benefits Schedule (MBS) funded services, last updated 27 November 2025*
For a breakdown of calculations and assumptions, visit Appendix E

Year	Basis	Projected local allied health services*
2023	Actual	16,255
2024	Actual	16,540
2025	Annualised from YTD (to May)	18,151
2026	Trend projection	**19,181**
2031	Trend projection	**25,273**
2036	Trend projection	**33,301**

Future Allied Health Demand

Year	Population	Required allied health services (needs-based)**	Projected local services (from above)	Service gap (Required – Projected)
2026	15,048	**43,451**	19,181	**≈24,270 fewer services**
2031	15,518	**44,808**	25,273	**≈19,535 fewer services**
2036	16,003	**46,209**	33,301	**≈12,908 fewer services**



Allied health services are central to meeting local needs in areas such as physiotherapy, podiatry, occupational therapy, dietetics, speech pathology and exercise physiology. In 2023, Murrindindi residents used around 16,255 MBS-funded allied health services, increasing slightly to 16,540 in 2024. If current patterns continue, local use is projected to reach about 19,200 services by 2026, 25,300 by 2031 and 33,300 by 2036.

When we compare this to a needs-based benchmark (around 102.6 allied health services per 100 residents), the gap becomes clear. On this basis Murrindindi would need around 43,500 services in 2026, 44,800 in 2031 and 46,200 in 2036. Even with projected growth, local residents are expected to receive 12,000–24,000 fewer services per year than would be required to meet benchmark levels of need.

Without changes to how services are planned and delivered, this shortfall will translate into longer wait times, missed early intervention opportunities and greater leakage to out-of-region providers, particularly for people with complex, chronic or age-related conditions.

4.12 Service Demand - Disability Support: Demand Analysis

Service demand forecasting for the Murrindindi region, to provide a basis for workforce and delivery planning to meet future demand

Current Disability Demand

Current Demand			
Period	Active providers	Participants per provider	**Estimated participants**
Q1 FY24/25	681	0.47	**320**
Q2 FY24/25	682	0.49	**334**
Q3 FY24/25	703	0.49	**344**
Q4 FY24/25	752	0.47	**353**

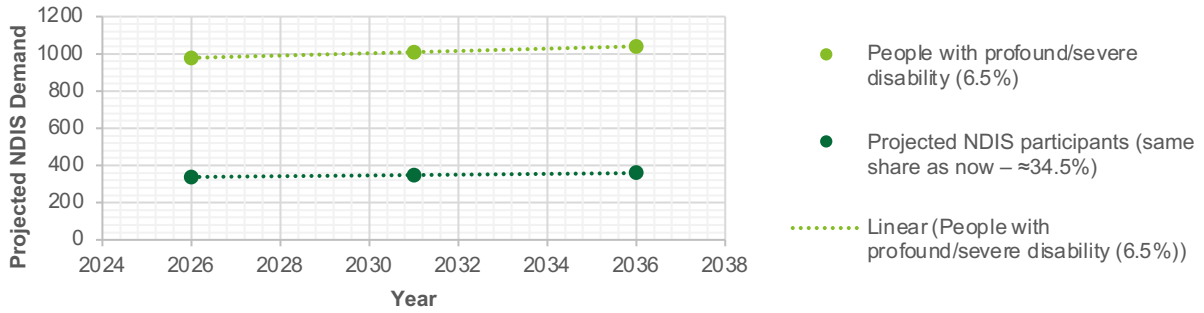
- **Average participants ≈ 338 across the year.**
- **Average participants per provider ≈ 0.48.**

Sources:
- *National Disability Insurance Agency, Participants by Local Government Areas dataset (2025)*
- *PHIDU, Social Health Atlas (LGA data), published September 2025*

For a breakdown of calculations and assumptions, visit Appendix F

Projected Disability Demand

Year	People with profound/severe disability (6.5%)	**Projected NDIS participants** (same share as now – ≈34.5%)
2026	978	**338**
2031	1,009	**348**
2036	1,040	**359**



The number of **National Disability Insurance Scheme (NDIS) participants** in Murrindindi is projected to grow substantially, from **1,297 in 2024** to **1,485 in 2027**, reaching **2,177 by 2035**. This rising demand will place increasing pressure on **local disability support organisations**, many of which already operate with **limited workforce capacity and geographic coverage**. Recent changes to **NDIS policy**, including adjustments to **travel payment arrangements**, are reshaping **provider viability** in rural regions, with smaller organisations particularly vulnerable to **reduced margins**.

These shifts risk **constraining service availability** at a time of growing need, reinforcing the importance of **sustainable provider models, workforce retention strategies, and collaborative service planning** to ensure **equitable access** for participants across the shire.

Compounding this challenge, **Murrindindi's ageing population** is expected to generate additional demand for **NDIS and disability-related services**, particularly in areas of **functional impairment, mobility support, and complex care coordination**. The overlap between **ageing-related disability** and **chronic disease** will require a more **integrated approach** between aged care, primary health, and disability providers. Without **proactive planning**, the intersection of **higher participation rates** and **ageing-driven demand** may further stretch already limited resources, creating **service gaps** and **longer wait times** for participants.

4.13 Service Demand - Mental Health: Demand Analysis

Service demand forecasting for the Murrindindi region, to provide a basis for workforce and delivery planning to meet future demand

Current Mental Health Service Demand

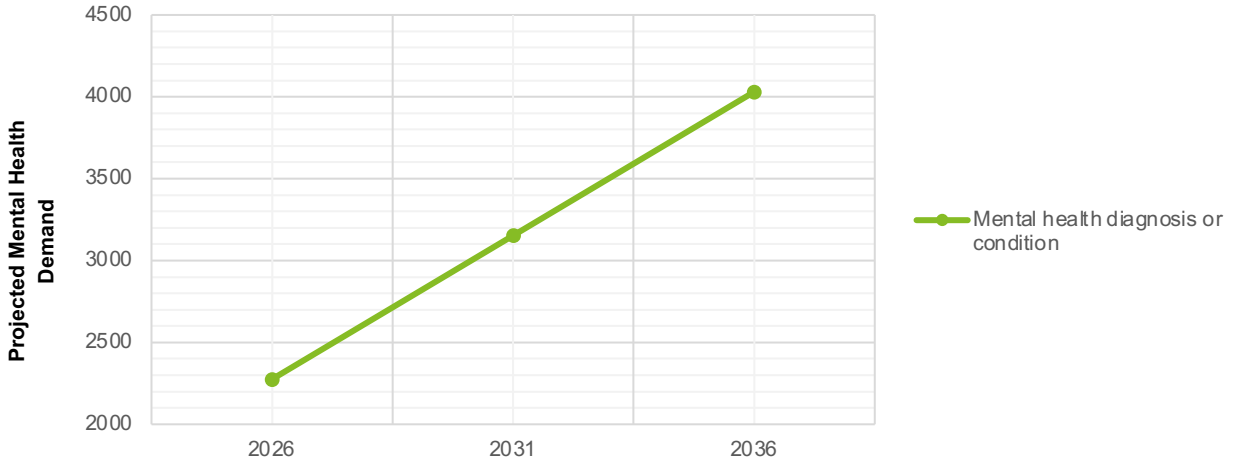
Current Demand (rate per 100,000)	
Period	Mental health diagnosis or condition
2016	444.1
2021	2444

Sources:
- *PHIDU, Social Health Atlas (PHN and LGA data), published December 2024*

For a breakdown of calculations and assumptions, visit Appendix G

Projected Mental Health Demand

Year	Mental health diagnosis or condition
2026	2275.2
2031	3152.8
2036	4030.5



Mental health demand is increasing sharply across Murrindindi, with the number of residents presenting with a mental health diagnosis rising from 1,397 in 2021 to more than 4,030 by 2036. This growth reflects rising psychosocial stress, increased prevalence of anxiety and depression, and greater identification of mental health needs through primary care.

The projected increase will place significant pressure on GPs, counselling, crisis response and care coordination, particularly given limited local mental health workforce and reliance on regional and metropolitan services for higher-acuity care. Strengthened local early-intervention pathways, youth mental health supports and integrated MH - AOD responses will be essential to manage this rising demand.

4.14 Service Demand - AOD: Demand Analysis

Service demand forecasting for the Murrindindi region, to provide a basis for workforce and delivery planning to meet future demand

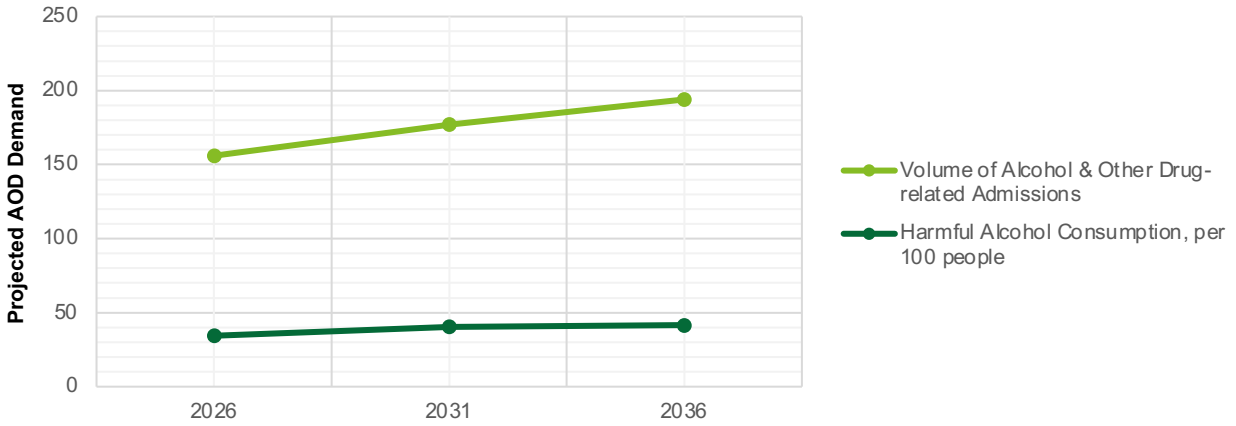
Current AOD Service Demand

Current Demand		
Period	Volume of Alcohol & Other Drug-related Admissions	Harmful Alcohol Consumption, per 100 people
2016	126	22.6
2021	137	28.5

Sources: *AODstats (Alcohol and Other Drugs Knowledge Centre), volume of admissions and harmful consumption dataset, retrieved November 2025*
For a breakdown of calculations and assumptions, visit Appendix H

Projected AOD Demand

Year	Volume of Alcohol & Other Drug-related Admissions	Harmful Alcohol Consumption, per 100 people
2026	156	34.4
2031	177	40.4
2036	194	41.6



Alcohol and drug-related service demand in Murrindindi is projected to increase significantly over the next decade. Hospital admissions for AOD-related issues are expected to rise from 137 in 2021 to 194 by 2036 (a 42% increase) while harmful alcohol consumption is forecast to grow from 28.5 to 41.6 per 100 people over the same period. These trends reflect persistent risk factors such as social isolation, limited early intervention services, and inadequate access to local detox, counselling, and recovery pathways.

This rising demand will further stretch Murrindindi's already limited AOD and mental health workforce, particularly in crisis response, withdrawal support, and aftercare. Without strengthened local prevention programs, brief interventions in primary care, and community-based recovery options, the burden will continue to fall on GPs, emergency departments, and metro rehabilitation services, which will deepen the cycle of crisis-led care. The data underscores the need for a locally coordinated, workforce-supported approach to AOD service delivery.

4.15 Service Demand – Oral Health: Demand Analysis

Service demand and risk profiling for the Murrindindi region, to provide a basis for planning local dental workforce and models of care

Current Oral Health Service Demand

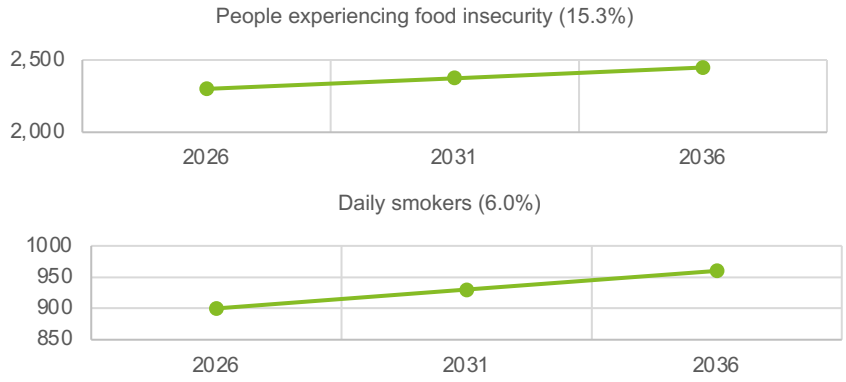
Local Government Area	Preventable Dental Hospitalisations per 100,000
Murrindindi	174.3
Victoria	103.5
% higher than Vic avg.	**+68.4%**

Sources: *PHIDU, Social Health Atlas (LGA data), published September 2025*
For a breakdown of calculations and assumptions, visit Appendix I

Indicator	Murrindindi	Victoria	Notes
Food insecurity	**15.3%**	12.0%	Higher food insecurity → higher caries risk
Daily smokers	**6.0%**	5.9%	Similar but slightly higher smoking; increases periodontal disease & oral cancer risk
Avg decayed/missing/filled teeth, 3–5 yrs	**0.46**	1.30	Murrindindi children in public dental care appear to have fewer affected teeth
Avg decayed/missing/filled teeth, 6 yrs	**0.68**	2.19	As above
Avg decayed/missing/filled teeth, 12 yrs	N/A (small sample)	1.54	No reliable local estimate
Water fluoridation	Murrindindi **not optimally fluoridated (2024)**	–	Structural risk factor for tooth decay

Projected Dental Demand

Year	Total population	People experiencing food insecurity (15.3%)	Daily smokers (6.0%)
2026	15,048	**≈2,300**	**≈900**
2031	15,518	**≈2,374**	**≈930**
2036	16,003	**≈2,448**	**≈960**



All indicators point to significant latent demand for dental services in Murrindindi:

- Children's experience and severity of tooth decay are comparable to or worse than Victorian averages by age 12, despite the absence of any local dentists.
- Higher rates of daily smoking and pockets of food insecurity create ongoing adult oral-health risk, from gum disease to oral cancers, which cannot be managed locally.
- Non-optimal water fluoridation in Alexandra and Yea further increases population-level risk and reinforces the case for proactive, community-based oral-health promotion and treatment.
- Taken together, these factors indicate strong demand for a locally anchored dental service model (e.g. visiting public dental clinics, mobile dental vans, or shared dental workforce linked to the proposed university/health hub). Without such a model, preventable disease, avoidable hospitalisations and travel-related hardship will continue to escalate over the next decade.

4.16 Current Service Map - Summary

A summary and analysis of services in the Murrindindi region, service types, organisations and qualitative survey insights

High reliance on a small, thinly spread GP workforce

- Only ~5 GPs servicing the whole shire, with Eildon covered by a visiting NP one day/week.
- This creates equity gaps, long waits, and GP burnout.
- Chronic disease management, MH/AOD review appointments, and preventive care are already exceeding routine GP capacity.

Allied health supply falls far short of needs

- Physiotherapy, OT, speech pathology, dietetics, and podiatry volumes are well below needs-based benchmarks.
- Demand gap = 12,000–24,000 fewer services per year, depending on discipline.
- This leads to early intervention delays, which consequently cause higher acute presentations and preventable admissions.

Rising chronic and acute hospital demand, with limited specialist coverage

- Strong growth in circulatory, cancer, musculoskeletal, respiratory and GI conditions.
- ADH and YDMH hospital activity increasing steadily but constrained by small bed numbers and very limited on-site diagnostics.
- Neurology, oncology, cardiology, orthopaedics and endoscopy demand reliant on metro providers.

Disability demand growing, especially NDIS psychosocial support

- NDIS participants are projected to increase to ~2,177 by 2035.
- With rising psychosocial disability and an ageing population, this means complex clients with overlapping MH, neurocognitive and chronic needs.
- Local provider capacity is limited; travel payment changes put small providers at risk.

Mental health and AOD demand rising fastest

- Mental health diagnoses are increasing sharply; demand is projected to triple by 2036.
- AOD admissions + harmful alcohol use increasing year-on-year.
- Local MH/AOD workforce shortage + lack of crisis response = ED presentations + police involvement used as default pathways.

Oral health access is limited, leading to high preventable hospitalisations

- Murrindindi's preventable dental admissions are 68% higher than Victoria.
- Only two private dentists + no public dental service locally.
- Low-income and transport-limited residents face major barriers.

Ageing population accelerating aged-care demand

- 65+ population to grow from ~3,800 to >6,300 by 2036.
- RAC places will need to increase significantly; home-care needs will expand even faster.
- Workforce shortages in home support, allied health, nursing, and personal care will intensify.

4.17 Future Health Forecasts Summary

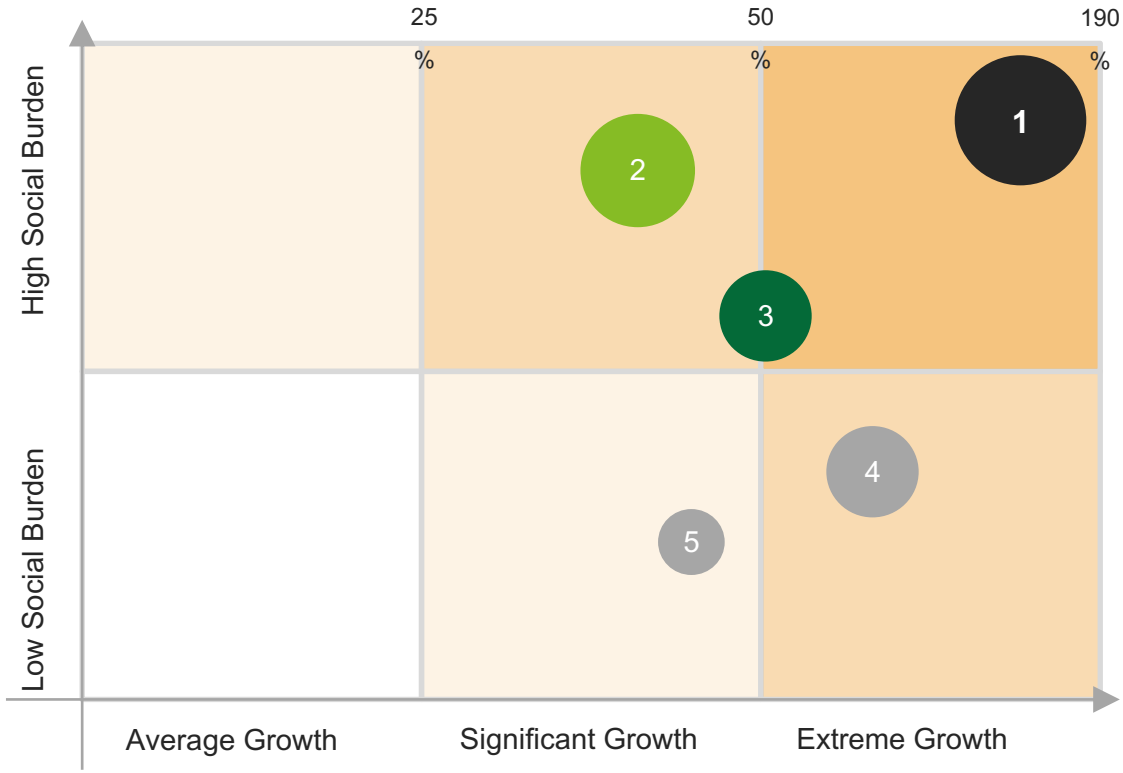
Utilising consistent historical data sources, future health service demand can be forecast using modelling to indicate the areas of most critical to the ongoing health of Murrindindi residents.

Modelling Highlights Escalating Future Demand:

Future demand modelling shows that Mental Health, AOD, and Chronic Conditions will drive the most significant pressure across the Murrindindi health system by 2036. Mental health demand is projected to grow by almost 190%, sitting in the 'extreme growth / high social burden' quadrant. AOD presentations and chronic condition admissions also show strong growth, compounding pressure on already limited GP, allied health, crisis response, and hospital capacity. Aged-care demand will rise steadily as the 65+ population expands, while allied health demand increases across all disciplines, widening current supply gaps. Together, these trends signal a future where demand outpaces local service capacity without coordinated prevention, stronger community-based care, and a sustainably expanded workforce.

Forecast Increase (by 2036)

1	Mental health demand	190%
2	AOD demand	42%
3	Chronic condition admissions	50%
4	Aged-care bed requirements	60%
5	Allied health demand	40–70%



Forecast Increase vs Social Burden Matrix

Key Takeaway:

Mental health, AOD, and chronic disease growth will drive the significant pressure across the system, demanding strengthened primary care, community-based responses and a coordinated workforce plan to prevent escalating acute demand.

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5

FUTURE STATE

WORKFORCE

5.1 Workforce - Section Overview

Profiling current workforce and forecasting future needs - grounded in staff survey insights, provider data, and regional demand analysis

Workforce forecasting

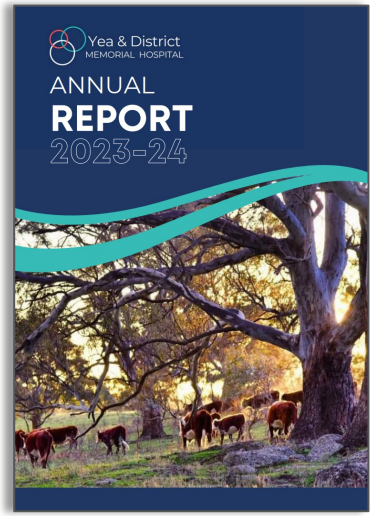
This section outlines the current workforce profile across health, aged care and disability services in Murrindindi, and the approach used to forecast future workforce needs. It integrates staff survey insights, provider data, government datasets and regional benchmarks to build a consistent view of workforce depth, role distribution, career pathways and recruitment patterns.

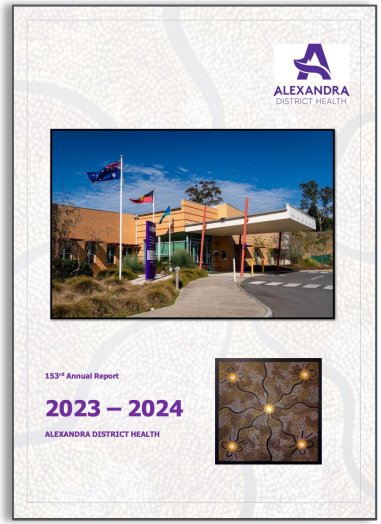
Data Analysis Approach

The analysis examines the composition of the workforce across hospitals, primary care, aged care, disability support, mental health and allied health, highlighting differences in staffing models, training pipelines and reliance on external or agency staff. Workforce data is paired with population and service-demand forecasts to model the workforce required to maintain safe, locally accessible care over the next decade.

This section provides the evidence base for later planning on workforce sustainability, regional collaboration and future training models.

For a detailed list of sources used and the utilisation, visit Appendix O



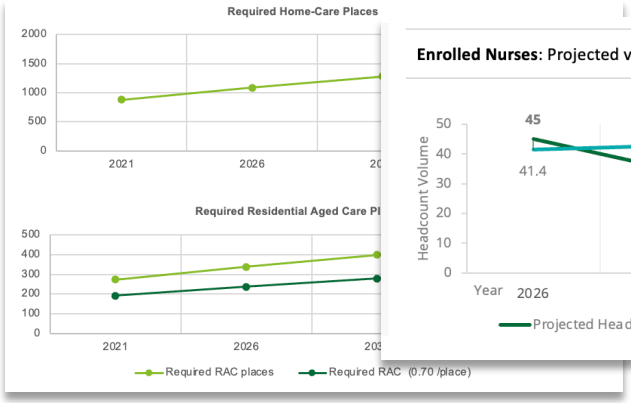


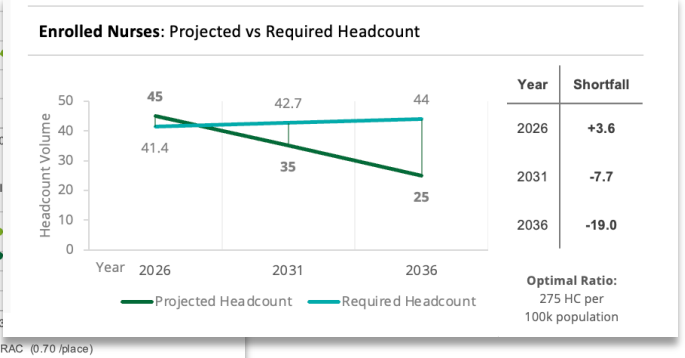
Elements of this section

1. **Staff Survey Findings** - Workforce profile and career-stage insights drawn from survey data, focusing on employment patterns, mobility, and attraction/retention factors.

2. **Sector-specific Workforce** - Overview of current workforce composition across healthcare, aged care, disability support and primary care providers.

3. **Future Workforce Requirements** - Modelling of projected workforce needs based on population change, demand growth and optimal staffing benchmarks.





5.2 Workforce - Survey Overview

Profiling current workforce and forecasting future needs - grounded in staff survey insights, provider data, and regional demand analysis

90%
Are from the shire, half of them lives within 0-20 kilometers from their workplace

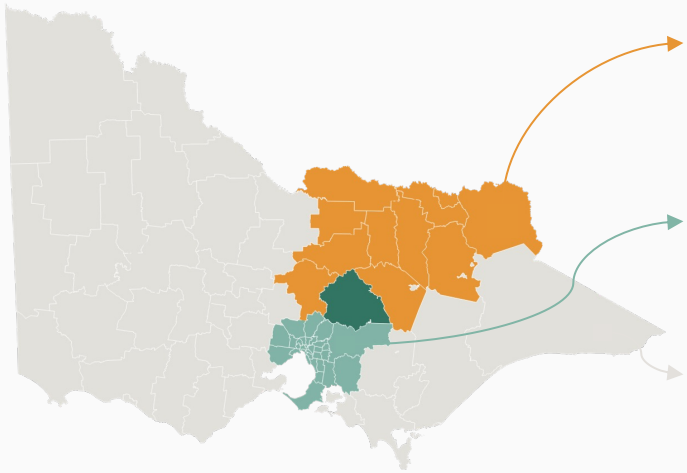
58%
Of clinical staff are not conducting home visit

33%
Have Diploma qualification

75%
Of the workforce are working part-time

10%
Relocated to the shire for their current roles

Mental Health Clinicians, RN, and EN
As the top roles



50%
Move from within the Hume region

25%
Move from Melbourne

25%
Move from other Victorian region

Identified Challenges

- Accommodation
- Finding a community group or social connection
- Accessing health services
- Employment opportunity for self or partner

For a breakdown of calculations and assumptions, visit Appendix J

5.3 Workforce - Survey

Insights are drawn from staff survey responses and regional workforce evidence, illustrating how attraction and retention factors shift across career stages in Murrindindi's disability support sector

Part-time is the top employment type for both clinical and non-clinical staff

Although the second top employment for clinical staff is casual, and full-time for non-clinical staff

Early workforce start at the age of 25-44 and late workforce are within 45-64 years old for both healthcare and aged care

Although the age range for both early and late workforce are older in disability support

Location is the common reason that attract staff, both clinical and non-clinical to their work (23%)

	Clinical Staff	Non-Clinical Staff
Early Career	• Pay and financial security • Location • Work hours and rostering	• Work life balance • Location • Career development • Pay and financial security
Mid Career	• Career development opportunities • Organisational culture and team environment • Nature of the work	• Work hours and rostering • Nature of the work • Alignment with organisational mission
Late Career	• Work hours and rostering • Organisational culture and team environment • Nature of the work	• Location • Nature of the work • Work-life balance

Organisational culture, workload (including travel and physical demand), and career change are common reasons for leaving across sectors

Retirement is also a common reason, primarily for late workforce

Aged Care	• Professional development opportunities • Travel • Career change
Disability Support	• Pay • Professional development opportunities • Career change
Healthcare	• Lack of management support • Organisational culture • Workload (including travel and physical demand)

For a breakdown of calculations and assumptions, visit Appendix J

5.4 Workforce - Medical Workforce

An analysis of hospital and medical workforce, including regional distribution, for services inside and neighbouring the Shire

Murrindindi Workforce Data

Local Government Area	General Medical Practitioners per 100,000	Total Medical Practitioners per 100,000	Specialists per 100,000	Specialists in Training per 100,000	Registered Nurses per 100,000	Midwives per 100,000	Enrolled Nurses per 100,000
Murrindindi	32.3	64.6	0	19.4	490.9	32.3	305.3
Optimal Ratios	110–120	350–400	130–150	-	900-1,100	60-70	250-300

Labour Category	Alexandra District Health (Average Monthly FTE)		Yea & Memorial District Health (Average Monthly FTE)	
	2023	2024	2023	2024
Nursing	27.86	28.10	26.76	25.32
Medical Support	0.55	1	0.42	0.99
Seasonal Clinicians	2.39	1.98	0.10	0.18

Sources:
- *PHIDU, Social Health Atlas (LGA data), published September 2025*
- *Alexandra District Health, average monthly FTE workforce data (2023–2024)*
- *Yea & District Memorial Hospital, average monthly FTE workforce data (2023–2024)*

Optimal Rates: (GP) RACGP & AIHW; (Total Medical) Human Resources for Health; (Specialists) OECD & WHO; (Nursing) Review of Australian Government Health Workforce Programs & OECD

Analysis of Service Workforce

Murrindindi's workforce is well below need: GPs 32.3/100k (≈70% under optimal), total medical 64.6/100k (≈80% under), no resident specialists, and a thin training pipeline (19.4/100k vs Vic 63.9). RN supply is 499.9/100k (~50% under optimal), midwives 32.3/100k (~50% under), while ENs are comparatively higher (305.3/100k), signalling a skill-mix skew that drives transfers for higher-acuity care and delays for diagnostics.

Nursing supply is also thin: Registered Nurses sit at 499.9 per 100,000 (≈50% below the optimal 900–1,100) and midwives at 32.3 per 100,000 (≈50% below the optimal 60–70). Enrolled Nurses are 305.3 per 100,000, slightly above the optimal midpoint (≈+11%), signalling a skill-mix that leans toward ENs and increases reliance on escalation/transfer for higher-acuity care. These gaps align with observed access constraints-longer travel times to step-up services, higher risk of potentially preventable hospitalisations, and delays for time-sensitive diagnostics and procedures.

Overall, the profile points to a small, resilient team operating with low medical density, thin RN/midwife supply, and minimal specialist presence. Addressing pipeline, skill-mix, and outreach-while shoring up diagnostics-will be critical to improving access, reducing transfers, and lifting in-shire self-sufficiency.

5.5 Workforce - Hospital Projections & Requirements

Workforce shortfalls in nursing represent critical barrier to meeting future demand, without coordinated regional training and strengthened pathways, care delivery and primary care will remain constraint as demand rises

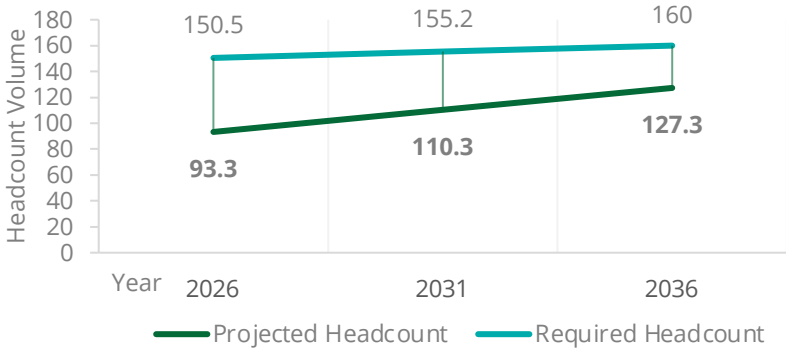
Growing Registered Nursing Shortfall

- Rising reliance on agency staff and thin in-house coverage already limit Service Access and care continuity across local hospitals.
- The absence of local training pipelines and limited supervision capacity constrain Workforce and Local Training growth, leading to higher turnover and reduced retention.
- As chronic disease and aged-care demand rises, the nursing gap is expected to worsen, driving more inter-hospital transfers and increasing the risk of preventable hospitalisations and service disruptions.

GP Shortfall Limits Primary Care Access

- EN supply is projected to fall well below requirement as aged-care and chronic-care demand grows, with a 19 FTE shortfall expected by 2036.
- Workforce issues (e.g., reliance on casual staff and limited supervision) mirror RN shortages, signalling an emerging Workforce gap across all inpatient and residential settings.
- Reduced EN availability will constrain safe care coverage in smaller sites, increasing Service Access pressures and shifting greater workload onto RNs.

Murrindindi Registered Nurses: Projected vs Required Headcount

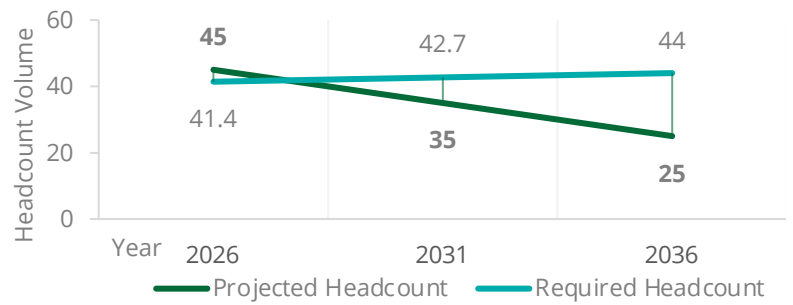


Year	Shortfall
2026	-57.2
2031	-44.9
2036	-32.7

Optimal Ratio:
1000 HC per
100k population

Sources: *PHIDU, Social Health Atlas (LGA data), published September 2025*
For a breakdown of calculations and assumptions, visit Appendix K

Murrindindi Enrolled Nurses: Projected vs Required Headcount



Year	Shortfall
2026	+3.6
2031	-7.7
2036	-19.0

Optimal Ratio:
275 HC per
100k population

Sources: *PHIDU Social Health Atlas (LGA data), published September 2025*
For a breakdown of calculations and assumptions, visit Appendix K

5.7 Workforce - Practitioner Projections & Requirements

GP deficits (equivalent to more than doubling the current workforce) will limit chronic disease management, delay routine care, and increase preventable hospitalisations

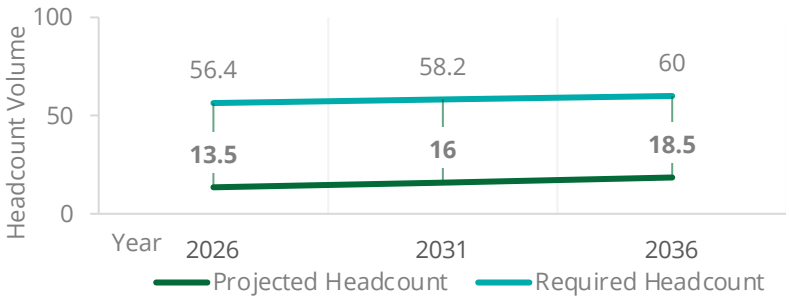
Persistent Medical Practitioner Gap

- A small GP workforce and the absence of resident specialists contribute to long waits, fragmented care and high leakage to regional centres, widening Service Access inequities.
- Low placement availability and professional isolation undermine recruitment and retention, deepening Workforce and Local Training constraints.
- Without intervention, ongoing shortfalls will exacerbate late presentations, increase preventable admissions, and reduce capacity for chronic disease, mental health and aged-care management.

GP Shortfall Limits Primary Care Access

- Persistent GP shortages, combined with travel distances for routine and urgent care, continue to restrict Service Access across the shire.
- Lack of local training pathways and professional isolation reinforce this ongoing Workforce weakness, making recruitment and retention increasingly challenging.
- As demand grows, fewer GPs will increase late presentations, avoidable transfers and preventable complications, deepening Health Outcomes and navigation challenges.

Murrindindi Medical Practitioners: Projected vs Required Headcount

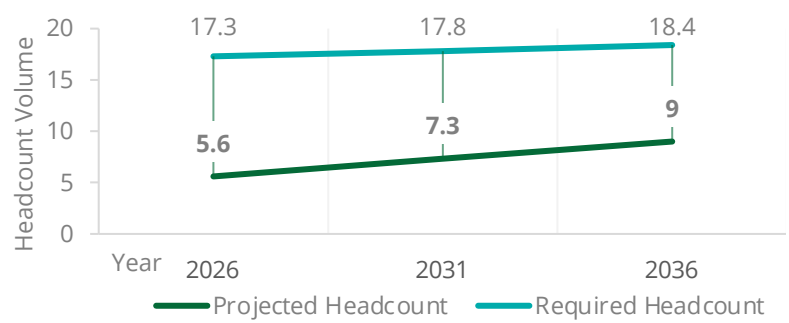


Year	Shortfall
2026	-42.9
2031	-42.2
2036	-41.5

Optimal Ratio: 375 HC per 100k population

Sources: *PHIDU Social Health Atlas (LGA data), published September 2025*
For a breakdown of calculations and assumptions, visit Appendix K

Murrindindi General Practitioners: Projected vs Required Headcount



Year	Shortfall
2026	-11.7
2031	-10.5
2036	-9.4

Optimal Ratio: 115 HC per 100k population

Sources: *PHIDU Social Health Atlas (LGA data), published September 2025*
For a breakdown of calculations and assumptions, visit Appendix K

5.8 Workforce - Aged Care

An analysis of the Aged Care workforce based on the distribution in the shire and the comparison with neighbouring LGAs

Current Murrindindi Aged Care Supply

Year	Full-time employees	Part-time employees	Casual employees	Volunteers	**Total paid staff** (FT + PT + casual)
2023	6	122	31	5	**159**
2024	12	119	69	3	**200**
2026	24	113	145	**3**	**282**
2031	54	98	335	**3**	**487**
2036	84	83	525	**3**	**692**

Based on the population forecast and national planning ratios, Murrindindi will need around 316 FTE of residential aged-care staff and 87 FTE of home-care staff by 2036, up from about 191 FTE and 53 FTE respectively in 2021.

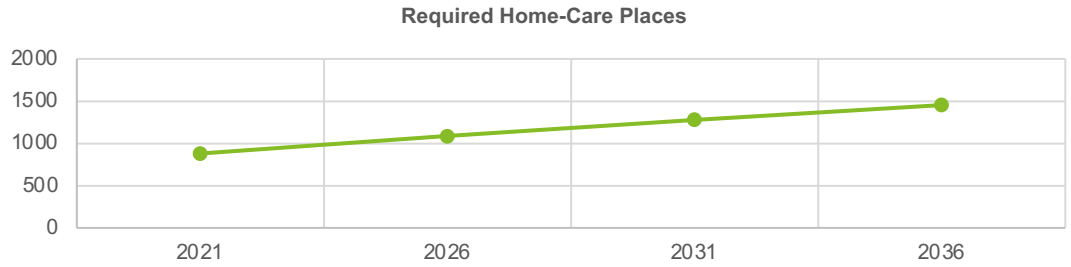
The strongest growth is in RAC staffing, which needs to increase by roughly 65% over the planning period to maintain the 200 care-minutes standard, while home-care FTE needs to increase by around 65% to support expanded community-based care. These figures provide a clear FTE target for workforce planning across nursing, personal care and allied health roles in both residential and home settings.

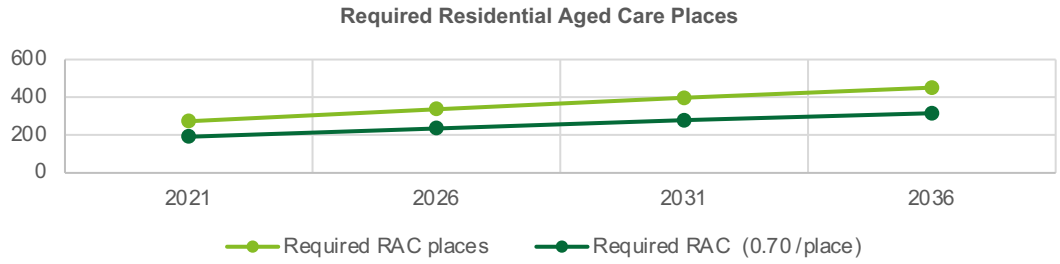
Assumptions:

- RAC care minutes: Australian reforms set a minimum of 200 care minutes per resident per day.
- 1 FTE ≈ 38 hours/week = 1,976 hours/year ≈ 118,560 minutes.
- 200 × 365 ÷ 118,560 ≈ 0.62 FTE per occupied bed for direct nursing + personal care.
- Allowing ~15% for leave, supervision and rostering inefficiency → ~0.70 FTE per RAC place (planning assumption).
- Home care intensity: assume an average of 2–2.5 hours of direct support per client per week across CHSP / home-care levels.
- That is ~115 hours/year → about 0.06 FTE per home-care place (planning assumption).

Future Murrindindi Aged Care Supply Requirements

Year	65+ population (≈70+)	Required RAC places	**Required RAC FTE** (0.70 FTE/place)	Required home-care places	**Required home-care FTE**(0.06 FTE/place)
2021	3,828.0	273.3	**191.3 FTE**	880.4	**52.8 FTE**
2026	4,729.45	337.7	**236.4 FTE**	1,087.8	**65.3 FTE**
2031	5,564.16	397.3	**278.1 FTE**	1,279.8	**76.8 FTE**
2036	6,320.86	451.3	**315.9 FTE**	1,453.8	**87.2 FTE**





Sources:

- *ACNC, Annual Information Statement – Kellock Lodge Alexandra (workforce data), 2023–24*
- *ACNC, Annual Information Statement – Darlingford Upper Goulburn Nursing Home (workforce data), 2023–24*

For a breakdown of calculations and assumptions, visit Appendix L

5.9 Workforce - Allied Health

Service demand forecasting for allied health in Murrindindi, to understand whether current workforce and clinic capacity can keep pace with future need

Current Allied Health Supply

Year	Actual allied health FTE (Murrindindi)
2017	15.41
2018	14.16
2019	14.42
2020	13.90
2021	13.71
2022	15.15
2023	15.87

Physiotherapist	**Podiatry**	**Occupational Therapist**
Speech Pathology	**Dietetics**	**Exercise Physiology**

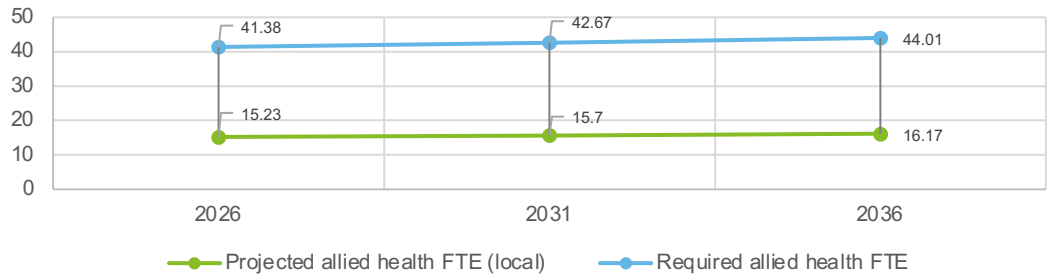
Note: Two of the three speech pathologists in Alexandra primarily support children
Sources: *Victorian Government Department of Health, Knowledge Bank – Health Workforce FTE dataset (2020)*
For a breakdown of calculations and assumptions, visit Appendix M

Allied health staffing in Murrindindi has remained relatively flat over time and sits well below the indicative benchmark of 275 FTE per 100,000 population. The historical line shows only modest change in total FTE from 2017–2023, and the simple projection out to 2026, 2031 and 2036 continues that fairly flat trajectory.

When we overlay the required FTE based on population and the national benchmark, the gap between local supply and the “optimal” level is clear and persistent. Even as the population grows, the modelled allied health workforce does not keep pace with what would be expected at national rates. It’s important to note that this chart only captures allied health employed by the two public health services – private and NGO providers will add to the real capacity – but it does highlight that the publicly funded allied workforce is relatively small compared with population-based benchmarks.

Future Allied Health Supply

Year	Projected allied health FTE (local)	Population	Optimal allied health FTE per 100k	Required allied health FTE	Gap (Projected – Required)
2026	15.23	15,048	275	41.38	**-26.15**
2031	15.70	15,518	275	42.67	**-26.97**
2036	16.17	16,003	275	44.01	**-27.84**



This chart estimates the number of allied health service events that would be required in Murrindindi if residents used allied health at the national rate of 102.6 services per 100 people per year. As the total population increases, the volume of services needed rises steadily across 2026, 2031 and 2036.

The key message is that even modest population growth translates into thousands of additional allied health contacts each year. This puts pressure not only on workforce numbers, but also on clinic space, outreach models, and referral pathways. It provides a useful demand baseline when considering whether current sessional capacity, appointment availability and outreach coverage are sufficient.

5.10 Workforce - Disability & NDIS

An analysis of the Disability & NDIS workforce based on the distribution in the shire and the comparison with neighbouring LGAs

Current Disability Services' Supply

Labour Categories	Dame Pattie Menzies Centre Inc (FTE)	
	2023	2024
Admin	9.8	6.8
Support workers - Part time and casual	24	13

Period	Active NDIS providers	Participants per provider	**Estimated NDIS participants**	**Estimated FTE***
Q1 FY24/25	681	0.47	320	80.0 FTE
Q2 FY24/25	682	0.49	334	83.5 FTE
Q3 FY24/25	703	0.49	344	86.0 FTE
Q4 FY24/25	752	0.47	353	88.2 FTE
Approx. current average	**≈705**	**0.48**	**≈338**	**≈84 FTE**

Even if prevalence stays at 6.5%, Murrindindi will need around 245–260 FTE disability support workers by 2036 to provide this level of support to everyone with profound/severe disability. If local prevalence were to rise towards the national 7.9% figure, required FTE increases to ~300–316 FTE.

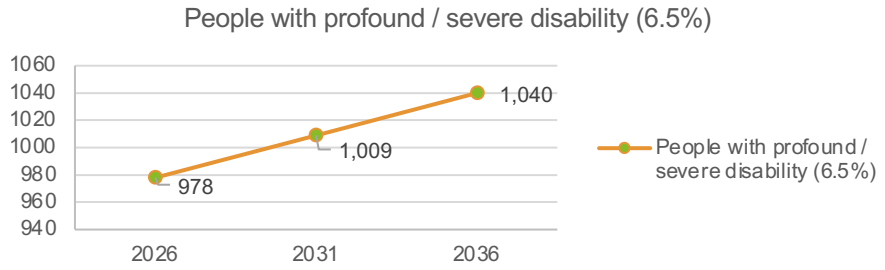
Comparison with NDIS-linked demand

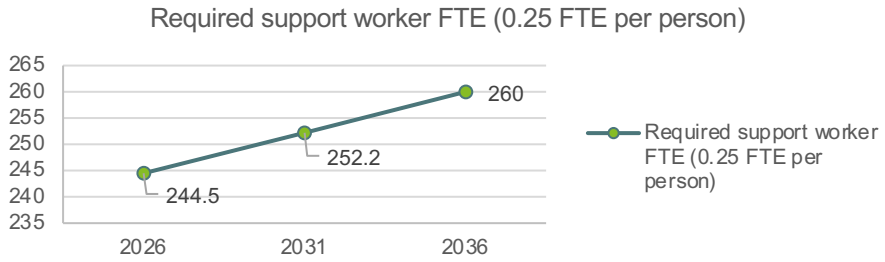
- Current NDIS data suggest around 338 participants, with projections rising modestly to about 360 participants by 2036 if coverage rates remain stable. Applying the same 0.25 FTE per participant gives approximately:
- 2026: ~338 participants → 85 FTE | 2031: ~348 participants → 87 FTE | 2036: ~359 participants → 90 FTE
- Compared with the needs-based requirement of 245–260 FTE, this implies a gap of roughly 160–170 FTE that is currently filled by a mix of unpaid carers, mainstream services or unmet need.

These projections highlight that, if Murrindindi aims to provide consistent paid support to most people with profound/severe disability, the direct disability support workforce would need to grow significantly beyond the level implied by current NDIS participation alone.

Future Disability Services' Demand

Year	Population	People with profound / severe disability (6.5%)	**Required support worker FTE (0.25 FTE per person)**	If prevalence rose to 7.9% – required FTE
2026	15,048	978	**244.5 FTE**	297.2 FTE
2031	15,518	1,009	**252.2 FTE**	306.5 FTE
2036	16,003	1,040	**260.0 FTE**	316.0 FTE





Sources:

- *PHIDU, Social Health Atlas (LGA data), published September 2025*
- *National Disability Insurance Agency, Provider dataset – Participants by Local Government Areas (2025)*

For a breakdown of calculations and assumptions, visit Appendix N

5.11 Workforce – Current Workforce Summary

A summary and analysis of healthcare and aged care workforce shows constrains limiting continuity of care and highlights the need for local training, retention, and integration

Small, thinly spread medical workforce

- Only ~5 GPs servicing the shire; very low GP-per-capita ratio compared with Victoria.
- Heavy reliance on part-time clinicians, NP outreach and metro referrals.
- Creates long waits, fragmented continuity and avoidable transfers.

Disability & NDIS workforce thin and unstable

- Support worker FTE well below estimated need; high turnover and split roles.
- Psychosocial disability demand outpacing local capacity, increasing reliance on external providers.
- Providers report difficulties with travel time, rostering and sustainable hours.

Nursing workforce under strain

- RN supply sits well below optimal benchmarks; high reliance on casual/agency staff.
- EN supply is decreasing over time, constraining aged-care and inpatient coverage.
- Limited supervision pathways restrict new-graduate retention and upskilling.

Aged-care workforce stretched by rising complexity

- Residential aged-care relies on a small RN/EN base with limited specialist coverage.
- Home-care staffing insufficient for rising CHSP demand and complex needs.
- Volunteer reliance high; workforce ageing accelerates turnover risk.

Allied health coverage well under needs

- Physiotherapy, OT, dietetics, podiatry and speech pathology sit far below needs-based levels.
- Local AH services operate part-time or rotate from neighbouring LGAs, limiting early intervention.
- Gaps drive higher hospital activity and preventable deterioration.

Workforce is highly local, but recruitment is hard

- ~90% of staff live locally, but only 10% relocated in for their role - low attraction rate.
- Staff report challenges with housing, community connection and partner employment.
- High proportion of part-time work (75%) limits service depth and after-hours coverage.

5.12 Workforce - Future Workforce Summary

Utilising consistent historical data sources, the future health workforce can be forecast using modelling to indicate the areas of most critical to the ongoing health of Murrindindi residents.

Modelling Highlights Escalating Future Workforce:

Future workforce modelling indicates substantial growth required across all major clinical and support roles by 2036, reflecting rising demand for chronic disease management, aged-care services, mental health, and AOD responses. Registered nursing demand increases the most in absolute terms, requiring an additional 66.7 headcount, driven by expanding hospital activity, ageing residents, and rising case complexity. Medical practitioner requirements also grow sharply, with demand for general practitioners and medical specialists increasing by over 43 headcounts, highlighting the region's ongoing vulnerability to long waits, fragmented care and high out-of-region transfers.

Enrolled nurse numbers will also need to rise to maintain safe inpatient and aged-care coverage as home-care and residential aged-care demand accelerates. Allied health FTE requirements increase by 28 - 29 FTE, reflecting strong projected need across physiotherapy, occupational therapy, speech pathology, dietetics and podiatry. The most significant increase is in disability support roles, with an estimated 176 additional FTE required to meet rising NDIS participation, psychosocial disability needs, and growing complexity in the ageing cohort.

Required increase of headcount by 2036

1	Registered Nurses	**160** (+66.7)
2	Medical Practioners	**60** (+43.5)
3	Enrolled Nurses	**44**
4	General Practitioners	**18.4** (+12.8)

Required increase of total FTE by 2036

1	Allied Health	**44.01**(+28.78)
2	Support Worker	**260** (+176)

Key Takeaway:

By 2036, workforce requirements across nursing, medical practice, allied health and disability support will grow far beyond current local capacity, reinforcing the need for regional training pathways, stronger generalist models, and shared workforce solutions to maintain safe, sustainable care.

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06

FUTURE STATE

Benchmarking And Literature Review

6.1 Research - Overview

The Future State Analysis defines what the local health and workforce system should look like to remain sustainable and responsive

Future State Approach

The Future State Analysis outlines what a sustainable, integrated and locally responsive health and community services system for Murrindindi should look like. It translates the 12 Future State Priority Elements into clear expectations for service configuration, workforce mix, governance, and partnerships across the region.

This section brings together the evidence base that informs the Murrindindi Health Network Future State.
It consolidates three major inputs:

1. National Benchmarking of Regional Health Services – A review of eight comparable Victorian and interstate health services to understand how similar organisations manage workforce constraints, service distribution, governance rhythms, prevention, shared services, digital enablement and community engagement.

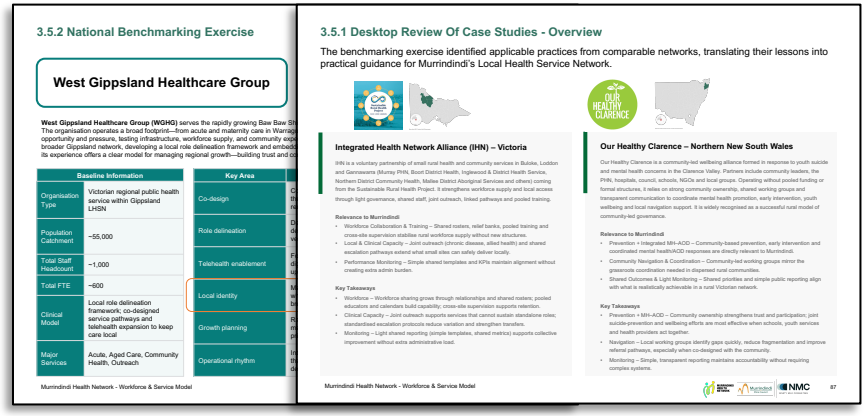
2. Desktop Review of National & International Case Studies – Analysis of five proven models — including IHN, Our Healthy Clarence, Bradford & Craven, Imperial County ACH and Ontario Health Teams — to identify practical, rural-appropriate mechanisms for collaboration, navigation, shared outcomes, prevention and workforce sustainability.

3. Public Health Impacts in Murrindindi – A social and economic analysis quantifying how current fragmentation affects mortality, chronic disease, mental health, preventable hospitalisation, aged-care delays, productivity, and workforce inefficiency, establishing the case for a coordinated local network.

For a detailed list of sources used and the utilisation, visit Appendix O

Methodology

Benchmarking	Reviewed eight comparable regional health services to identify viable rural models for workforce, governance, service distribution, prevention, shared services and integration.
Literature review	Analysed five national and international collaboration models to extract transferable mechanisms for coordinated care, navigation, shared outcomes and community-led prevention.
Public Health Impact Analysis	Assessed the social and economic impacts of Murrindindi's current fragmentation across mental health, chronic disease, aged care, preventable hospitalisation and workforce efficiency.
Results	The Future Priorities and Initiatives that define Murrindindi's desired health and workforce system.



Visual representation benchmarking, literature review, and modelling

6.2.1 Research - National Benchmarking Overview

The benchmarking exercise identified applicable practices from comparable networks, translating their lessons into practical guidance for Murrindindi's Local Health Service Network.

As part of the future-focused planning for the Murrindindi Health Network (MHN), a comprehensive benchmarking process was undertaken to identify how comparable health networks & services across regional Victoria are addressing similar workforce challenges. Benchmarking provides critical insight into effective clinical, community and workforce strategies, enabling MHN to draw on lessons from peer organisations that operate in similar contexts.

Purpose of Benchmarking

The benchmarking process aims to:

- Identify innovative, evidence-based workforce practices being implemented by similar regional health multi-campus services and networks.
- Understand how others are responding to shared challenges in areas such as delivery, workforce, collaboration and community.

Benchmarking Activities

This component of the project involved:

- Desktop analysis of strategic and workforce planning documents from selected health services.
- One-on-one benchmarking interviews with executives at peer organisations to capture insights into implementation, lessons learned, and impacts.
- Summary and analysis of learnings, including key takeaways, gold-nugget findings and relevance to the Murrindindi context

Outcomes:

This findings of this process will:

- Inform the development of MHN's business case and actions with practical, proven strategies.
- Provide peer-validated solutions to sector challenges, and empower the Murrindindi Health Network to better facilitate collaboration and shared outcomes

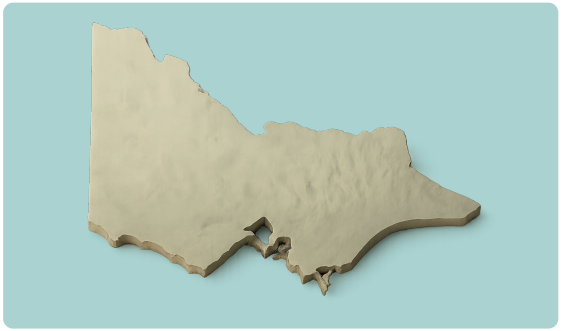
Eight regional health services were selected for benchmarking based on factors such as service size, geographic location, demographic similarities, and relevance of their workforce strategies. These include:

- **West Gippsland Healthcare Group**
- **Flinders and Upper North LHN**
- **Bendigo Health**
- **Limestone Coast LHN**
- **Tasmania Health – Northern Region**
- **Albury Wodonga Health**
- **Dhelkaya Health**
- **NCN Health**

6.2.2 Research - National Benchmarking Exercise

West Gippsland Healthcare Group

WEST GIPPSLAND HEALTHCARE GROUP
Caring for our Community



West Gippsland Healthcare Group (WGHG) serves the rapidly growing Baw Baw Shire, where an influx of young families has increased demand on local health services. The organisation operates a broad footprint-from acute and maternity care in Warragul to community and aged care across surrounding towns. Growth has brought opportunity and pressure, testing infrastructure, workforce supply, and community expectations. WGHG has focused on maintaining local identity while integrating within the broader Gippsland network, developing a local role delineation framework and embedding genuine co-design to guide service change. For the Murrindindi Health Network, its experience offers a clear model for manageing regional growth-building trust and coordination without losing the sense of local ownership.

Baseline Information	
Organisation Type	Victorian regional public health service within Gippsland LHSN
Population Catchment	~55,000
Total Staff Headcount	~1,000
Total FTE	~600
Clinical Model	Local role delineation framework; co-designed service pathways and telehealth expansion to keep care local
Major Services	Acute, Aged Care, Community Health, Outreach

Key Area	WGHG Practice / Description	Learning for MHN
Co-design	Community and staff were involved from the outset, shaping service changes and reducing resistance to reform.	Embed co-design in planning so communities see reform as collaboration, not loss of local control.
Role delineation	Developed a clear local framework defining what care occurs at Warragul versus metro sites.	Create similar clarity across Alexandra, Yea, and metro partners to avoid overlap and service gaps.
Telehealth enablement	Focused on community readiness and digital literacy to ensure telehealth uptake and trust.	Pair technology upgrades with local digital navigators and training to increase effective telehealth use.
Local identity	Maintained strong community identity while integrating operations within the broader Gippsland network.	Celebrate each hospital's identity while aligning systems and governance under the East Metro & Murrindindi LHSN.
Growth planning	Rapid population growth required matching workforce, infrastructure, and primary care capacity.	Use demographic forecasts to prioritise housing and workforce initiatives for growth areas like Kinglake and Yea.
Operational rhythm	Introduced daily coordination routines that improved cross-site awareness and decision-making.	Establish regular multi-site huddles to strengthen alignment between Murrindindi sites and metro partners.

6.2.3 Research - National Benchmarking Exercise

Flinders and Upper North Local Health Network

Government of South Australia

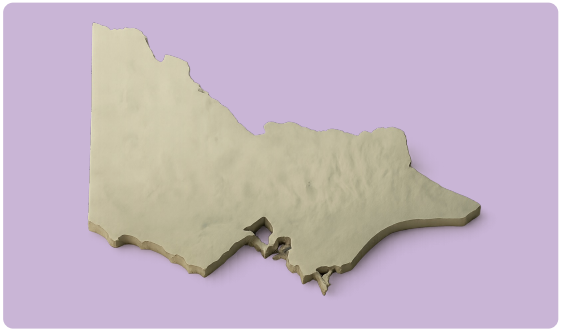
Flinders & Upper North LHN spans a vast and sparsely populated region of South Australia, anchored by Port Augusta, Whyalla and Quorn hospitals. The network's challenge lies in maintaining safe, sustainable services across wide distances and small communities while addressing workforce shortages and reliance on locums. FUNLHN has invested heavily in building local capability through rotations, training partnerships and telehealth-enabled outreach, supported by consistent governance rhythms and transparent communication. Its focus on workforce stability and distributed service delivery offers valuable lessons for the Murrindindi Health Network, where dispersed sites and rural workforce constraints demand coordinated planning and regional collaboration.

Baseline Information	
Organisation Type	Regional SA Health Board-governed network
Population Catchment	~45,000
Total Staff Headcount	~1,200
Total FTE	~850
Clinical Model	Multi-campus, distributed model with shared specialist rosters and telehealth-enabled outreach
Major Services	Acute, Aged Care, Community Health

Key Area	WGHG Practice / Description	Learning for MHN
Workforce stability	Introduced multi-year workforce plans and shared rotations to reduce locum reliance.	Apply similar 3-year workforce strategy to strengthen retention and reduce agency use across sites.
Regional collaboration	Shared clinical rosters and rotational placements balanced workload and capability between hospitals.	Use rotational models between Alexandra, Yea and metro partners to build experience and coverage.
Telehealth integration	Telehealth embedded as standard practice to connect remote towns with specialists at hub hospitals.	Strengthen telehealth pathways to link rural Murrindindi sites with Eastern Health and St Vincent's specialists.
Leadership rhythm	Regular cross-site forums and predictable governance structures supported consistent decision-making.	Establish clear decision calendars and regular executive huddles to coordinate across LHSN partners.
Community communication	Transparent messageing maintained public confidence through service redesign and workforce transition.	Communicate openly about service changes to preserve trust during network planning stages.
Training partnerships	Collaborated with universities to grow rural clinical placements and support local recruitment pipelines.	Build strong ties with regional universities and RTOs to develop a "grow-your-own" workforce model.

6.2.4 Research - National Benchmarking Exercise

Bendigo Health



Bendigo Health is the anchor tertiary service for the Loddon Mallee region, providing specialist, subacute, mental health, and community services to more than 300,000 people. As a major referral hub, it faces the dual challenge of supporting smaller regional hospitals while manageing increasing demand on its own facilities. Its strength lies in using scale strategically-leverageing centralised systems, education partnerships, and shared-service models to extend capability across the region. Bendigo Health's maturity as a teaching hospital, combined with its leadership in regional collaboration and data-driven planning, provides valuable guidance for the Murrindindi Health Network on how a tertiary partner can support smaller services without eroding local autonomy.

Baseline Information	
Organisation Type	Regional tertiary public health service – anchor for Loddon Mallee Network
Population Catchment	~300,000
Total Staff Headcount	~4,500
Total FTE	~3,200
Clinical Model	Tertiary hub supporting regional spokes; advanced specialty care, training and education partnerships
Major Services	Major tertiary hospital, sub-acute, mental health, community health sites

Key Area	WGHG Practice / Description	Learning for MHN
Regional leadership	Acts as the tertiary hub, coordinating clinical pathways and workforce support across Loddon Mallee.	Use Eastern Health as a similar anchor partner to coordinate specialised care and training for Murrindindi.
Shared services	Consolidated ICT, procurement, and analytics functions to reduce costs and reinvest in clinical priorities.	Explore shared back-office models across network partners to improve efficiency and redirect savings to care access.
Education partnerships	Deep partnerships with La Trobe and Monash underpin local training pipelines and research capacity.	Strengthen relationships with regional universities to create consistent training pathways for local clinicians.
Workforce planning	Workforce dashboards and data systems enable proactive monitoring of vacancies and trends.	Develop shared workforce data visibility across all Murrindindi sites to guide collective planning and recruitment.
Clinical governance	Predictable governance rhythms and service planning ensure alignment between tertiary and regional hospitals.	Introduce structured governance forums and planning cycles with metro partners to sustain momentum.
Community integration	Extends mental health, community, and outreach programs to maintain continuity of care post-discharge.	Replicate integration with PHNs and community services to support local continuity of care in rural areas.

6.2.5 Research - National Benchmarking Exercise

Limestone Coast Local Health Network

Government of South Australia

Limestone Coast LHN serves around 67,000 people across South Australia's southeast, operating hospitals in Mount Gambier, Millicent, and Naracoorte alongside community and aged care programs. The network has focused on transforming independent local services into a coordinated system while maintaining public trust and access. A central challenge has been manageing community perceptions of service loss during rationalisation and ensuring transport and workforce sustainability across dispersed sites. By prioritising transparency, community engagement, and long-term workforce planning, Limestone Coast has demonstrated how open communication and regional alignment can drive network cohesion. For the Murrindindi Health Network, its approach provides clear lessons on transparency, community confidence, and workforce sustainability within geographically spread systems.

Baseline Information	
Organisation Type	Regional SA Health Board-governed network
Population Catchment	~67,000
Total Staff Headcount	~1,700
Total FTE	~1,200
Clinical Model	Hub-and-spoke model with shared acute capacity and role delineation to reduce duplication
Major Services	Acute, Aged Care, Community Health, Mental Health

Key Area	WGHG Practice / Description	Learning for MHN
Transparency	Publicly committed to "no reduction in service access" to build community trust through change.	Adopt transparent, repeated commitments to protect confidence as services realign across Alexandra, Yea and metro partners.
Community engagement	Involved communities in decision-making to explain rationale and co-design transitions.	Engage local communities early to turn consultation into genuine partnership on service design.
Transport planning	Addressed patient transport gaps by assessing contracts and advocating for system-level solutions.	Map and strengthen transport links to ensure equitable access between rural sites and metro services.
Workforce sustainability	Implemented a 3-year Sustainable Medical Workforce Strategy to reduce locum dependency.	Develop a multi-year workforce plan that builds permanent staff pipelines and reduces locum costs.
Communication	Framed reform as improvement, not loss-focusing on quality, safety, and sustainability.	Use positive, plain-language messageing to position service changes as smart growth, not withdrawal.
Cultural change	Shifted from independent sites to networked operations through consistent messageing and trust-building.	Prioritise relationship-building among partners to move from competition to collaboration across Murrindindi sites.

6.2.6 Research - National Benchmarking Exercise

Tasmania Health – Northern Region

Tasmanian Government

The Northern Region of Tasmania Health, anchored by Launceston General Hospital, delivers acute, subacute, mental health, and community services to roughly 140,000 people across a vast regional and rural catchment. The network operates within a centralised state structure but faces local challenges typical of regional systems-ageing infrastructure, workforce shortages, and service duplication across small towns. Over recent years, the Northern Region has strengthened integration through telehealth, statewide workforce initiatives, and standardised governance frameworks that link its hospital and community sites. For the Murrindindi Health Network, its experience underscores how a large but resource-constrained regional network can coordinate services and workforce development through consistent governance, digital integration, and strong educational partnerships.

Baseline Information	
Organisation Type	State-run regional division of Tasmanian Health Service
Population Catchment	~140,000
Total Staff Headcount	~3,800
Total FTE	~2,600
Clinical Model	Regional referral network with outreach and virtual-care integration for rural coverage
Major Services	Launceston General Hospital as regional hub plus community and rural health facilities

Key Area	WGHG Practice / Description	Learning for MHN
Telehealth integration	Embedded telehealth as a core function connecting rural sites with the Launceston hub.	Strengthen telehealth and digital health links between Murrindindi hospitals and metro partners to expand access.
Statewide workforce strategy	Implemented unified workforce planning and rotational placements across regions.	Develop coordinated workforce rotations across the LHSN to stabilise staffing and share expertise.
Governance consistency	Used standardised governance and escalation processes to align decision-making across sites.	Apply clear governance rhythms and escalation pathways across Murrindindi and Eastern Health partners.
Education partnerships	Partnered with the University of Tasmania to expand rural clinical placements and retention.	Establish formal training pathways with regional universities to build a local workforce pipeline.
Service integration	Strengthened links between hospital, community, and primary care to improve continuity of care.	Deepen integration with GPs, PHNs and community programs to improve local care transitions.
System learning	Used centralised data and review processes to identify statewide improvement priorities.	Introduce shared learning dashboards to track network performance and improvement progress.

6.2.7 Research - National Benchmarking Exercise

Albury Wodonga Health

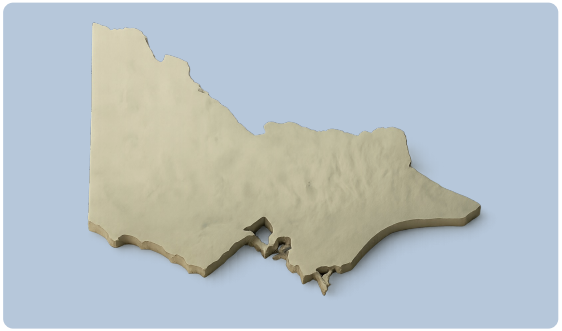
Albury Wodonga Health operates across the NSW–Victoria border, serving more than 300,000 people through two major campuses and multiple community sites. As Australia's only formal cross-border health service, it provides a unique view into how governance, funding and workforce settings shape collaboration. AWH's dual-state structure has forced innovation in workforce mobility, shared education partnerships, and system-first planning to overcome the inefficiencies of differing state models. The service has demonstrated how flexibility, consistent communication, and a sustainability-focused narrative can enable reform even within complex administrative environments. For the Murrindindi Health Network, AWH's approach offers valuable insight into workforce flexibility, funding collaboration, and how to balance accountability between multiple system partners.

Baseline Information	
Organisation Type	Cross-border public health service with dual-state accountability
Population Catchment	~300,000
Total Staff Headcount	~3,300
Total FTE	~2,400
Clinical Model	Integrated acute and community services; focus on cross-site workforce mobility and education partnerships
Major Services	Acute, Sub-acute, Regional Community Health

Key Area	WGHG Practice / Description	Learning for MHN
Cross-border governance	Operates within two state systems, requiring aligned priorities and shared accountability.	Use governance structures that balance influence and accountability across Murrindindi's metro and rural partners.
Workforce mobility	Enables staff to move seamlessly between hospital and GP settings through shared employment frameworks.	Develop flexible cross-site contracts and rotations across network partners to improve retention and experience.
Education partnerships	Built strong links with CSU, La Trobe and UNSW to train and retain local clinicians.	Expand education partnerships to grow local talent pipelines and reduce reliance on metropolitan recruitment.
Back-office efficiency	Consolidated logistics, procurement and administration to reinvest savings into clinical services.	Explore shared back-office systems to redirect savings toward workforce and community access initiatives.
System-first culture	Frames reform as sustainability rather than cost-cutting to maintain staff and public trust.	Position LHSN changes as long-term sustainability measures to build shared ownership among partners.
Clinical integration	Shared clinical service planning across border ensures consistent care and referral pathways.	Align clinical pathways across Eastern Health, St Vincent's, and local hospitals to create seamless network care.

6.2.8 Research - National Benchmarking Exercise

Dhelkaya Health



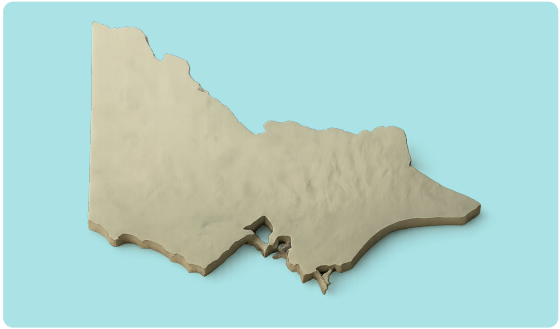
Dhelkaya Health, formed through the amalgamation of Castlemaine Health and Maldon Hospital, serves around 20,000 residents across Mount Alexander Shire. The organisation has used its merger to create an integrated model that connects acute, community, aged care, and primary services under one governance structure. Its key challenges include consolidating systems, uniting organisational cultures, and sustaining workforce supply across small rural campuses. By embedding prevention, wellness and community partnerships at the centre of care delivery, Dhelkaya has reframed what "integration" means at the local level-building services around people rather than facilities. For the Murrindindi Health Network, this experience demonstrates how smaller services can achieve network maturity through cultural alignment, shared systems, and strong community connection.

Baseline Information	
Organisation Type	Amalgamated Victorian public health service
Population Catchment	~20,000
Total Staff Headcount	~600
Total FTE	~400
Clinical Model	Integrated acute, primary and community model emphasising prevention and local partnerships
Major Services	Acute, Aged Care, Community Health

Key Area	WGHG Practice / Description	Learning for MHN
Integration	Unified acute, community, and aged care under one governance and clinical framework.	Coordinate planning and workforce across hospitals and community programs for more seamless local care.
Cultural alignment	Managed a successful merger by focusing on shared values and transparent communication.	Prioritise relationship-building and clear communication as foundations for cross-organisational collaboration.
Prevention focus	Embedded wellness and early intervention programs to reduce hospital demand.	Strengthen preventative and community health initiatives across Murrindindi to manage rising demand.
Workforce flexibility	Cross-trained staff to work across multiple care settings, improving coverage and job variety.	Use shared roles and rotations to maintain workforce stability across small rural sites.
Community partnerships	Worked closely with local groups and councils to co-design programs addressing local health priorities.	Engage local governments and community partners in service design to strengthen community ownership.
System integration	Streamlined digital and administrative systems following amalgamation to support efficiency and continuity.	Pursue shared systems and data platforms with partner services to simplify coordination and reporting.

6.2.9 Research - National Benchmarking Exercise

NCN Health



NCN Health was formed in 2019 through the merger of three small health services in northern Victoria - Numurkah, Cobram and Nathalia. It serves a population of around 22,000 people across three towns and has become a model for rural integration and resilience. The organisation's focus has been on sustaining acute and aged care services in low-volume environments, improving clinical governance, and building shared workforce capacity. Despite limited scale, NCN has achieved stability through strong leadership, transparent communication, and cross-campus collaboration. For the Murrindindi Health Network, NCN's experience highlights how small rural services can thrive in a networked model through trust, shared systems, and a flexible workforce approach.

Baseline Information	
Organisation Type	Multi-campus Victorian public health service
Population Catchment	~22,000
Total Staff Headcount	~700
Total FTE	~400
Clinical Model	Shared workforce and governance structure sustaining acute and aged care services across sites
Major Services	Acute, Aged Care, Community Health

Key Area	WGHG Practice / Description	Learning for MHN
Network integration	Unified three health services under one governance and operational framework.	Use a single governance rhythm across Murrindindi sites to improve coordination and shared decision-making.
Workforce sharing	Established a shared workforce pool and cross-site rotations to cover service gaps.	Implement flexible rotations between hospitals and community programs to address workforce shortages.
Leadership stability	Strong, consistent leadership maintained trust and direction through merger transition.	Invest in stable executive and clinical leadership to guide cultural and operational integration.
Community engagement	Sustained transparent dialogue with communities to manage expectations and maintain trust.	Communicate early and often with local communities to ensure understanding of network changes.
Aged care integration	Strengthened alignment between aged care and acute services to support continuity of care.	Mirror integrated aged care pathways across Murrindindi's network to enhance service efficiency and outcomes.
Operational efficiency	Streamlined systems and back-office functions across sites to reduce duplication.	Pursue shared ICT and admin systems across partners to reinvest savings into clinical priorities.

6.2.10 Research - Benchmarking: Best Practices

The following findings outline practical actions MHN and network organisations can implement from peer health services, based on benchmarking insights

Workforce planning: Workforce dashboards and data systems enable proactive monitoring of vacancies and trends.
Develop shared workforce data visibility across all Murrindindi sites to guide collective planning and recruitment.

Community engagement: Involved communities in decision-making to explain rationale and co-design transitions.
Engage local communities early to turn consultation into genuine partnership on service design.

Education partnerships: Partnered with the University of Tasmania to expand rural clinical placements and retention.
Establish formal training pathways with regional universities to build a local workforce pipeline.

Back-office efficiency: Consolidated logistics, procurement and administration to reinvest savings into clinical services.
Explore shared back-office systems to redirect savings toward workforce and community access initiatives.

Prevention focus: Embedded wellness and early intervention programs to reduce hospital demand.
Strengthen preventative and community health initiatives across Murrindindi to manage rising demand.

Community engagement: Sustained transparent dialogue with communities to manage expectations and maintain trust.
Communicate early and often with local communities to ensure understanding of network changes.

6.3.1 Research - Desktop Review: Case Studies

The desktop review identified relevant practices from comparable regional networks, translating their lessons into practical guidance for the Murrindindi Health Network.

As part of the future-focused planning for the Murrindindi Health Network (MHN), a structured desktop scan was undertaken to understand how comparable networks across Australia and internationally organise collaboration, workforce, digital enablement, navigation and shared-care pathways. This review provides insight into practical, low-burden models suited to rural health systems, enabling MHN to draw on proven examples from services that operate in similar contexts.

Purpose of the Desktop Review

- Identify small-scale, rural-appropriate models of clinical, community and workforce collaboration.
- Understand how other regions coordinate care, stabilise workforce, share functions and strengthen access pathways.
- Extract design principles aligned with MHN's 12 Future Priority Areas, with clear relevance to the Murrindindi context.

Desktop Review Activities

- Reviewing service plans, network models, workforce strategies and governance documents from selected health services.
- Analysing national and international case studies to understand implementation, enablers and lessons learned.
- Synthesising key takeaways to identify what elements are adaptable to Murrindindi's scale, maturity and resource profile.

Outcomes:

- Inform MHN's future operating model and business case with evidence-backed, context-relevant options.
- Highlight practical mechanisms to improve coordination, workforce sustainability, and community access.
- Provide validated design features that strengthen collaboration across local partners.

Three networks were selected based on relevance, scale, and comparable rural challenges:

Integrated Health Network Alliance (IHN) – Victoria

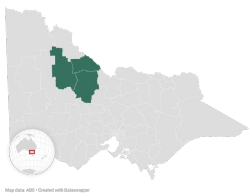
Our Healthy Clarence – Northern New South Wales

Imperial County Accountable Community for Health – USA

Bradford District & Craven Health and Care Partnership

6.3.2 Research - Desktop Review: Case Studies

The benchmarking exercise identified applicable practices from comparable networks, translating their lessons into practical guidance for Murrindindi's Local Health Service Network.



Integrated Health Network Alliance (IHN) – Victoria

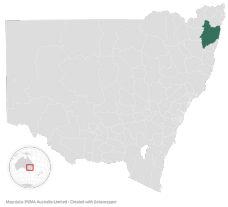
IHN is a voluntary partnership of small rural health and community services in Buloke, Loddon and Gannawarra (Murray PHN, Boort District Health, Inglewood & District Health Service, Northern District Community Health, Mallee District Aboriginal Services and others) coming from the Sustainable Rural Health Project. It strengthens workforce supply and local access through light governance, shared staff, joint outreach, linked pathways and pooled training.

Relevance to Murrindindi

- Workforce Collaboration & Training – Shared rosters, relief banks, pooled training and cross-site supervision stabilise rural workforce supply without new structures.
- Local & Clinical Capacity – Joint outreach (chronic disease, allied health) and shared escalation pathways extend what small sites can safely deliver locally.
- Performance Monitoring – Simple shared templates and KPIs maintain alignment without creating extra admin burden.

Key Takeaways

- Workforce – Workforce sharing grows through relationships and shared rosters; pooled educators and calendars build capability; cross-site supervision supports retention.
- Clinical Capacity – Joint outreach supports services that cannot sustain standalone roles; standardised escalation protocols reduce variation and strengthen transfers.
- Monitoring – Light shared reporting (simple templates, shared metrics) supports collective improvement without extra administrative load.



Our Healthy Clarence – Northern New South Wales

Our Healthy Clarence is a community-led wellbeing alliance formed in response to youth suicide and mental health concerns in the Clarence Valley. Partners include community leaders, the PHN, hospitals, council, schools, NGOs and local groups. Operating without pooled funding or formal structures, it relies on strong community ownership, shared working groups and transparent communication to coordinate mental health promotion, early intervention, youth wellbeing and local navigation support. It is widely recognised as a successful rural model of community-led governance.

Relevance to Murrindindi

- Prevention + Integrated MH–AOD – Community-based prevention, early intervention and coordinated mental health/AOD responses are directly relevant to Murrindindi.
- Community Navigation & Coordination – Community-led working groups mirror the grassroots coordination needed in dispersed rural communities.
- Shared Outcomes & Light Monitoring – Shared priorities and simple public reporting align with what is realistically achievable in a rural Victorian network.

Key Takeaways

- Prevention + MH–AOD – Community ownership strengthens trust and participation; joint suicide-prevention and wellbeing efforts are most effective when schools, youth services and health providers act together.
- Navigation – Local working groups identify gaps quickly, reduce fragmentation and improve referral pathways, especially when co-designed with the community.
- Monitoring – Simple, transparent reporting maintains accountability without requiring complex systems.

6.3.3 Research - Desktop Review: Case Studies

The benchmarking exercise identified applicable practices from comparable networks, translating their lessons into practical guidance for Murrindindi's Local Health Service Network.

CACHI
CALIFORNIA ACCOUNTABLE COMMUNITIES FOR HEALTH INITIATIVE

Bradford District and Craven
Health and Care Partnership
ACTasONE

Imperial County Accountable Community for Health – USA

The Imperial County ACH is a cross-sector partnership linking health, behavioural health, social services, public health and community groups to address long-standing inequities in a rural border region. Working with pooled budgets, it aligns partners around shared wellness goals, joint governance and collective priorities. Multi-agency groups focus on prevention, chronic disease, behavioural health and social determinants, with strong emphasis on community voice and shared accountability.

Relevance to Murrindindi

- Prevention & Early Intervention – Demonstrates how rural areas can align around shared prevention and wellbeing goals.
- Integrated Mental Health & AOD – Offers guidance for linking MH–AOD with community and primary care.
- Shared Outcomes & Monitoring – Shows practical ways to use unified outcomes across diverse partners.
- Community Navigation & Coordination – Community and lived-experience groups illustrate models for simple, locally driven navigation.

Key Takeaways

- Prevention – Shared goals unify partners; community-designed initiatives strengthen engagement.
- Mental Health & AOD – Cross-agency coordination and MH–AOD integration support earlier intervention.
- Monitoring – Common outcomes guide collective effort without shared digital systems.
- Navigation – Social-service and community partnerships improve navigation.

Bradford District & Craven Health and Care Partnership

The Bradford District & Craven Partnership is a place-based component of the UK Integrated Care System, bringing together NHS providers, local government, primary care and community organisations to improve population health. The model uses joint governance, shared outcomes, neighbourhood teams and coordinated investment in mental health, children's services and community wellbeing. While much larger in scale, the partnership formed data-sharing initiatives across the members, allowing the partnership's vision and actions to improve based on the community's needs.

Relevance to Murrindindi

- Preventive Health & Early Intervention – Bradford's population-health focus, early-intervention programs and multi-agency wellbeing work align with Murrindindi's prevention priorities (albeit at a larger scale).
- Performance Monitoring & Shared Outcomes – The partnership created Digital First, which is an initiative involving all health services to work collaboratively in sharing information as part of a new tech-driven health improvement program.
- Community Navigation & Local Coordination – Neighbourhood teams and place-based working groups provide ideas for simple, community-centred coordination models.

Key Takeaways

- Prevention – Community-wide prevention and early intervention work best when partners share goals and act collectively across public health, community and primary care.
- Monitoring – Linking information together from across services to better understand how patients move across and which intervention program works best.

6.3.5 Research - Desktop Review: Public Health Impacts

Access to comprehensive, locally delivered health services produces measurable benefits for individuals, families, and regional economies

Social Implications of Health Access in Murrindindi

Access to integrated, equitable, and locally delivered healthcare is a critical determinant of wellbeing in rural communities. In regions like Murrindindi, the intersection of geographic isolation, ageing demographics, and workforce shortages has produced widening health inequities and significant social cost. Evidence across Victoria and Australia demonstrates that fragmented health systems not only drive poorer health outcomes but also limit participation, resilience, and social cohesion.

1. Life Expectancy and Premature Mortality

- Murrindindi's *Potential Years of Life Lost (PYLL)* is **51.5 per 1,000** compared with **35.7 per 1,000 in Victoria** (PHIDU 2023) - an **excess of 15.8 years per 1,000 people**.
  Scaled to the Shire's population (15,179), this equates to **≈240 years of life lost annually** due to preventable conditions.
- Applying the nationally recognised *Value of a Statistical Life-Year (A$222,000)* (Treasury 2023) yields an annual **social loss of ≈A$53 million** in forgone healthy life and productivity potential.

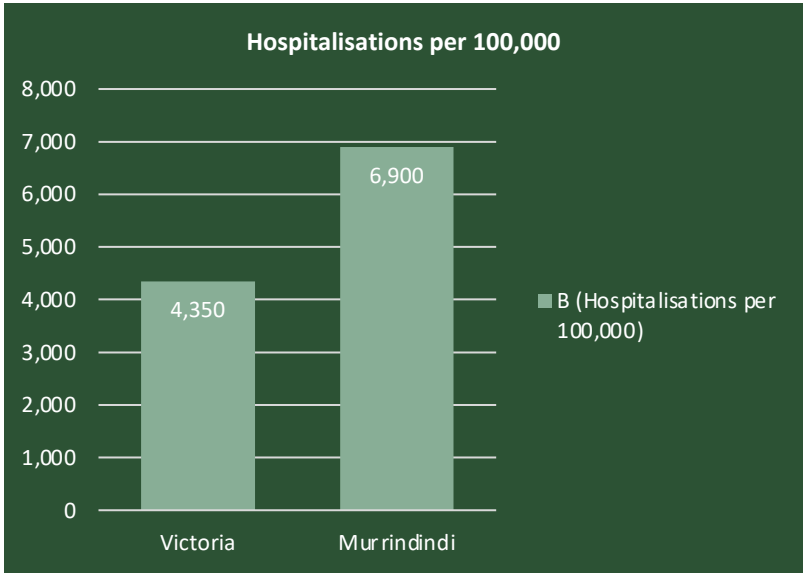
2. Chronic Disease and Quality of Life

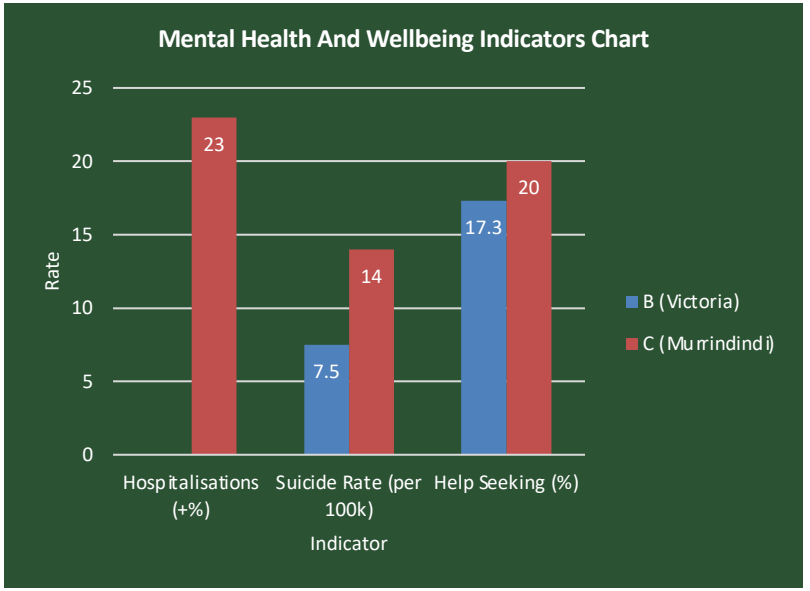
- With obesity (+38%), arthritis (+71%) and heart disease (+48%) above Victorian levels, an estimated **1,800 residents** live with avoidable disability or restricted activity.
- Using AIHW burden-of-disease coefficients (0.12 DALY per case at A$150,000 per DALY), this equates to **≈A$32 million in annual wellbeing loss**, or **A$2,100 per person affected**.

3. Mental Health and Social Participation

- Murrindindi's *mental health hospitalisations* are **23.6% higher** than the state average, resulting in roughly **260 additional admissions** and **3,200 extra bed-days** annually.
  At an average of A$330 per lost workday (Productivity Commission, 2022), this equals **A$1.05 million in lost productivity**.
- Suicide rates (14.2 vs 7.6 per 100,000) suggest **≈6 preventable deaths per year**, representing a further **A$1.3 million in lifetime earnings loss**.
  Socially, older residents' falls and transport isolation reduce volunteering and participation by **≈18%**, equivalent to **1,500 volunteer hours monthly**, valued at **A$740,000 annually** (ABS 2022).

In total, poor health access in Murrindindi results in an estimated **A$87–90 million annual social and wellbeing loss** - equal to **4.5 healthy life-years lost per 10 residents each decade**. Investment in integrated, locally delivered care under the *Murrindindi Health Network Future State* could recover up to **30% (≈A$26 million)** of this value within five years through prevention, early intervention, and reduced hospitalisation.





All sources provided in appendices

6.3.6 Research - Desktop Review: Public Health Impacts

Investing in local and integrated health systems generates strong returns across multiple economic dimensions

Economic Implications of Health Access in Murrindindi

The financial cost of Murrindindi's fragmented health system extends across hospital expenditure, workforce inefficiency, aged-care delays, and lost local economic output. These are quantifiable at the local scale using national health economics data.

1. Preventable Hospitalisation and Treatment Costs

- Murrindindi's preventable hospitalisation rate (**6,900 per 100,000**) is **57% higher** than Victoria's (4,400). This equates to **≈1,050 avoidable admissions annually** (6.9% of population × Vic average rate). At A$6,030 per admission (Vic DHHS 2023), the excess system cost equals **≈A$6.3 million annually**. Each 10% reduction in preventable admissions would save **≈A$630,000 per year**, validating the case for local chronic-disease and outreach programs.

2. Workforce Shortages and Reliance Costs

- With **five GPs across four practices (32 per 100,000)** - one-third the state density - the Shire spends heavily on locums and agency staff.
  Assuming one-third of GP hours covered by temporary contracts at a **40% premium**, this adds **≈A$1.2 million annually** in inefficiency costs.
  Training and retaining just two additional local clinicians would yield **≈A$900,000 annual savings** in agency and patient-transport expenditure (Hooker et al., 2023).

3. Productivity and Economic Participation

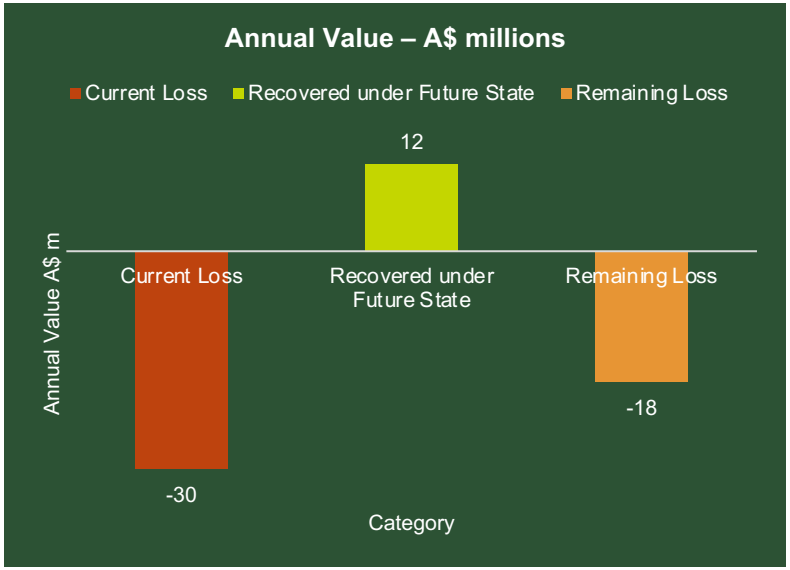
- Higher chronic disease prevalence (obesity, arthritis, heart disease) leads to **≈31,000 lost workdays annually** (9.8 days × 3,200 working-age cases).
  At A$330 per day, this represents **A$10.2 million in lost local productivity**, or **2.8% of the Shire's estimated GRP (A$360 million)**.

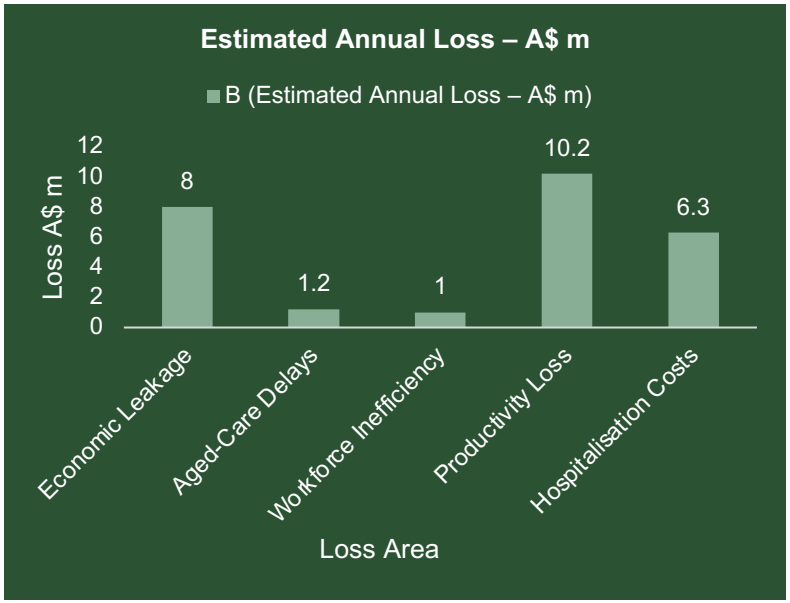
4. Aged-Care Access and Hospital Bed-Days

- Delayed access to residential and home care adds **≈450 bed-days annually** (scaled from 438,000 national total).
  At A$2,600 per bed-day, this equals **A$1.17 million per year**, or 5% of total local hospital operating cost (DoH 2023).

Collectively, Murrindindi's fragmented system generates an estimated A$25–30 million annual economic loss. Implementing the Murrindindi Health Network Future State model would:

- Reduce avoidable costs by A$6–8 million per year,
- Improve workforce efficiency by A$1 million, and
- Retain A$4 million in local economic value - a total net benefit of ≈A$12–13 million annually, or A$60 million over five years.





All sources provided in appendices

6.3.7 Research - Desktop Review: Summary

The benchmarking exercise identified applicable practices from comparable networks, translating their lessons into practical guidance for Murrindindi's Local Health Service Network.

The case studies show that successful rural and regional networks share several core features that directly align with Murrindindi's future priorities:

- **Shared Workforce & Local Capacity** – Shared rosters, relief banks and pooled supervision stabilise small rural workforces without new structures. Joint outreach expands local clinical breadth (chronic disease, MH–AOD, prevention) while standardising escalation pathways. (Elements: Workforce Collaboration; Local Training & Development; Local & Clinical Capacity)
- **Prevention, Early Intervention & Community-Led Models** – Strong networks invest in community-led wellbeing groups, early intervention pathways and cross-sector prevention. Locally designed models (e.g. Our Healthy Clarence, ACHI) show how schools, councils, PHNs, NGOs and health services share population-health goals. (Elements: Preventive Health; Integrated MH–AOD; Transport & Access; Community Navigator)
- **Navigation, Care Coordination & Local Governance** – Neighbourhood and community working groups identify system gaps, streamline referrals and reduce duplication, especially for MH–AOD and chronic disease. Governance is light-touch and transparent, maintaining accountability without heavy bureaucracy. (Elements: Navigator & Coordination System; Ease & Accessibility; Integrated MH–AOD)
- **Shared Outcomes, Monitoring & Data Standards** – High-performing networks use simple shared templates, common indicators and unified dashboards across partners. Collective outcomes strengthen accountability and align organisational effort. (Elements: Performance Monitoring; Digitally Enabled Platforms; Digital Enablement)
- **Relationship-Driven, Place-Based Collaboration** – Success depends on local ownership, consistent partner engagement and strong community voice - not scale or new entities. Rural alliances thrive when partners focus on a small set of shared priorities delivered consistently across towns. (Elements: Workforce Collaboration; Community Navigator; Local Capacity)

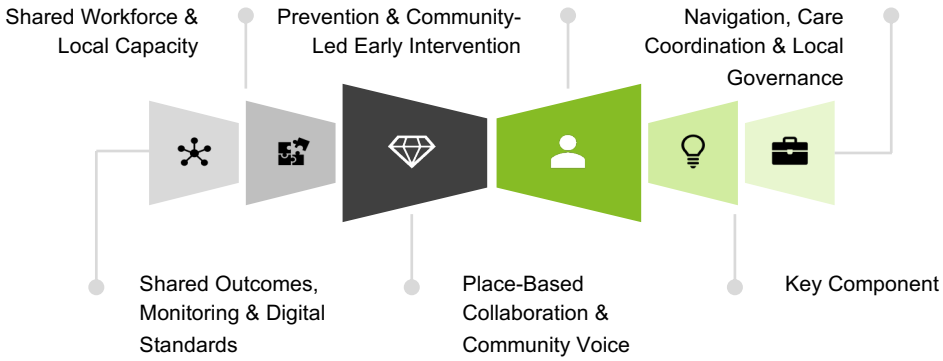
The public health impact assessment highlighted the following findings:

High preventable hospitalisation burden
- Murrindindi records 6,900 preventable admissions per 100,000 (57% above Vic),
- This excess alone costs A$6.3 million annually, with each 10% reduction saving A$630,000.

Chronic disease and mental health impacts
- Chronic disease prevalence (obesity, arthritis, heart disease) is well above Victorian levels, affecting ~1,800 residents with avoidable impairment.
- Mental health hospitalisations are 23.6% higher, suicide rates remain disproportionately elevated, and social participation is significantly reduced.

Economic and workforce pressures
- Reliance on locums and agency staffing costs A$1.2 million each year, with another A$900k in extra agency and transport expenditure.
- Lost workdays due to health conditions cost ~A$10.2 million annually, or 2.8% of the Shire's economic productivity.

The benchmarking and public-health impact review revealed six system-wide insights that should inform how Murrindindi shapes its future health and workforce model.



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07

DEVELOP PLAN

GAP ANALYSIS

7.1 Gap & Needs Analysis - Overview

The gap and needs analysis combines current-state data and engagement, with future state analysis, and explains under-utilisation and areas of strategic focus to improve health access and outcomes in Murrindindi

Gap & Needs Analysis Overview

Identify the major gaps and the associated needs that drive avoidable travel, delays, fragmented care, and poorer outcomes.

- Gap = a persistent shortfall in access, coordination, capability, or outcomes.
- Need = the enabling condition required to close that shortfall.

Problem framing
Residents move between local and metropolitan services. Where local specialist input, diagnostics, and coordination are thin, people travel, present later, and repeat their story. Workforce depth and training capacity limit what can be done locally. Lower screening and navigation confidence suppress prevention.

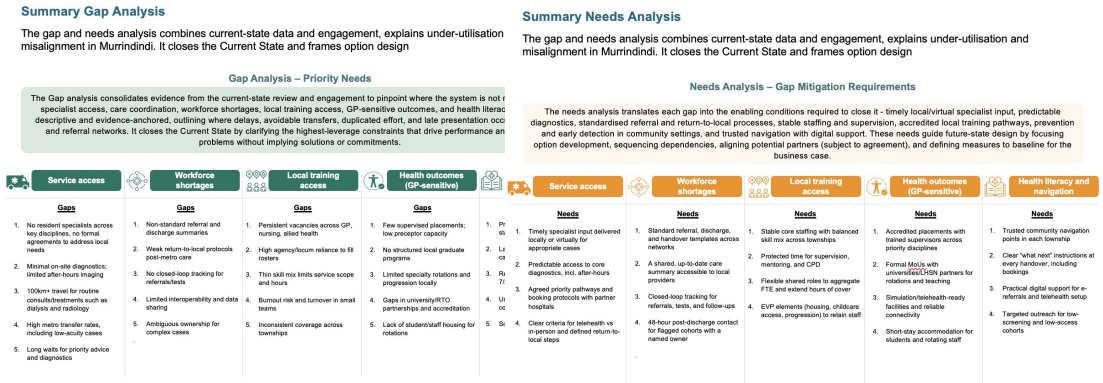
Priority gap domains
- Specialist access and diagnostics
- Care coordination and return-to-local pathways
- Workforce depth, training, and supervision
- Outcomes in GP-sensitive conditions
- Health literacy and service navigation

Resulting needs
- Timely local/virtual specialist input
- Standard, cross-network referral and discharge processes
- Local training capacity and structured pipelines
- Prevention and early detection uplift
- Community-embedded navigation and literacy supports

Use of this section
Feeds option design, partner discussions, baselining, and the business case.

Methodology

Regional Profile	Quantitative indicators, service activity, referral and transfer patterns, screening rates, and outcome benchmarks.
Engagement	Interviews and surveys with providers, consumers, and community organisations covering access, navigation, and workforce.
Gap Analysis	Prioritised gap list with evidence anchors; needs statements and dependency map to inform options and business casing.
Results	A prioritised gap list, a needs map, and a clear hand-off into option design.



Visual representation gap and needs analysis summary

7.2 Gap & Needs Analysis - Summary: Gap Analysis

The gap and needs analysis combines current-state data and engagement, explains under-utilisation and misalignment in Murrindindi. It closes the Current State and frames option design

Gap Analysis - Priority Needs

The Gap analysis consolidates evidence from the current-state review and engagement to pinpoint where the system is not meeting demand: specialist access, care coordination, workforce shortages, local training access, GP-sensitive outcomes, and health literacy. Each gap is descriptive and evidence-anchored, outlining where delays, avoidable transfers, duplicated effort, and late presentation occur across towns and referral networks. It closes the Current State by clarifying the highest-leverage constraints that drive performance and experience problems without implying solutions or commitments.

Service access

Gaps

1. No resident specialists across key disciplines, no formal agreements to address local needs
2. Minimal on-site diagnostics; limited after-hours imageing
3. 100km+ travel for routine consults/treatments such as dialysis and radiology
4. High metro transfer rates, including low-acuity cases
5. Long waits for priority advice and diagnostics

Workforce

Gaps

1. Non-standard referral and discharge summaries
2. Weak return-to-local protocols post-metro care
3. No closed-loop tracking for referrals/tests
4. Limited interoperability and data sharing
5. Ambiguous ownership for complex cases

.

Local training

Gaps

1. Persistent vacancies across GP, nursing, allied health
2. High agency/locum reliance to fill rosters
3. Thin skill mix limits service scope and hours
4. Burnout risk and turnover in small teams
5. Inconsistent coverage across townships

Health outcomes (GP-sensitive)

Gaps

1. Few supervised placements; low preceptor capacity
2. No structured local graduate programs
3. Limited specialty rotations and progression locally
4. Gaps in university/RTO partnerships and accreditation
5. Lack of student/staff housing for rotations

Health literacy and navigation

Gaps

1. Preventable admissions above state rates
2. Later-stage presentation for cancer/chronic disease
3. Repeat ED presentations and 7/30-day readmissions
4. Uneven diabetes/COPD/CHF control indicators
5. Screening-to-treatment leakage

7.3 Gap & Needs Analysis - Overview: Needs Analysis

The gap and needs analysis combines current-state data and engagement, explains under-utilisation and misalignment in Murrindindi. It closes the Current State and frames option design

Needs Analysis - Gap Mitigation Requirements

The needs analysis translates each gap into the enabling conditions required to close it - timely local/virtual specialist input, predictable diagnostics, standardised referral and return-to-local processes, stable staffing and supervision, accredited local training pathways, prevention and early detection in community settings, and trusted navigation with digital support. These needs guide future-state design by focusing option development, sequencing dependencies, aligning potential partners (subject to agreement), and defining measures to baseline for the business case.

Service access

Needs

1. Timely specialist input delivered locally or virtually for appropriate cases
2. Predictable access to core diagnostics, incl. after-hours
3. Agreed priority pathways and booking protocols with partner hospitals
4. Clear criteria for telehealth vs in-person and defined return-to-local steps

Workforce

Needs

1. Standard referral, discharge, and handover templates across networks
2. A shared, up-to-date care summary accessible to local providers
3. Closed-loop tracking for referrals, tests, and follow-ups
4. 48-hour post-discharge contact for flagged cohorts with a named owner

.

Local training

Needs

1. Stable core staffing with balanced skill mix across townships
2. Protected time for supervision, mentoring, and CPD
3. Flexible shared roles to aggregate FTE and extend hours of cover
4. EVP elements (housing, childcare access, progression) to retain staff

Health outcomes (GP-sensitive)

Needs

1. Accredited placements with trained supervisors across priority disciplines
2. Formal MoUs with universities/LHSN partners for rotations and teaching
3. Simulation/telehealth-ready facilities and reliable connectivity
4. Short-stay accommodation for students and rotating staff

Health literacy and navigation

Needs

1. Trusted community navigation points in each township
2. Clear “what next” instructions at every handover, including bookings
3. Practical digital support for e-referrals and telehealth setup
4. Targeted outreach for low-screening and low-access cohorts

7.4 Current State Summary - Plan Priority Elements

Synthesis of Regional Profile, Engagement, and Gap & Needs to direct shortlisting of evidence-informed model priority areas which must be addressed for a successful plan

Across all pillars, the most critical needs are workforce stability, coordinated training pathways, and improved access systems. Solutions will focus on building local capacity, enhancing coordination, and embedding digital and community-based navigation supports to create a sustainable, self-sufficient regional health network.

Service access

Focus Areas

- Specialist access and visiting service coverage
- Local diagnostic capacity and after-hours availability
- Referral and transfer coordination between metro and local services
- Transport accessibility and equity

Workforce

Focus Areas

- Workforce stability and retention
- Inter-provider coordination and shared workforce models
- Data sharing, discharge, and referral standardisation
- Supervision and leadership capacity

Local training

Focus Areas

- Local training and placement infrastructure
- Partnerships with RTOs and universities
- Clinical supervision and preceptor development
- Workforce pipeline and retention pathways

Health outcomes (GP-sensitive)

Focus Areas

- Chronic disease management and early intervention
- Shared-care coordination across providers
- Supervised rural placements and clinical rotations
- Improved continuity between hospital and community care

Health literacy and navigation

Focus Areas

- Community navigation and outreach programs
- Digital access and referral information systems
- Screening-to-treatment coordination
- Health literacy and communication supports

These 12 Priority Design Elements represent the strategic building blocks for transforming Murrindindi's health system from its current fragmented state into an integrated, sustainable health network. Each element translates specific gaps and opportunities identified in the current state analysis into actionable intervention areas that can be developed into detailed business cases.

Priority Future State Design Elements

Digital Enablement (telehealth, wearables, PAS etc.,)	Enhanced Local and Clinical Capacity			
Preventive Health and Early Intervention Models	Integrated Mental Health and AOD Services	Workforce Collaboration	Digitally Enabled Service Delivery Platforms	Community Navigator and Care Coordination System
Local Training and Workforce Development	Infrastructure and Workforce Retention Support	Transport and Access Enhancement Program	Performance Monitoring and Network Processes	Ease and Accessibility for Community and Advocates

7.5.1 Network Plan - Overview

Following the current state review, future demand modelling and gap analysis, the project team and partners have agreed on 12 priority elements - translating evidence into clear areas of focus

From Analysis To Priorities

- The current and future state analysis highlighted where Murrindindi's health, aged care and disability system is working well and where it is under the greatest strain.
- Drawing on workshops, interviews and data, we distilled these findings into 12 priority elements that capture the most important system and service changes needed over the next 5–10 years.

What The 12 Elements Cover

- The priority elements span digital enablement, local clinical capacity, prevention and early intervention, mental health, workforce, transport, data and performance, and how people move through the system (navigation and care coordination).
- Together, they describe the core building blocks of a more connected, locally accessible and sustainable health network for the Shire.

How The Elements Will Be Used

- The pages that follow provide a concise analysis of each priority element – outlining the evidence, key gaps and desired future state.
- These insights then form the framework for the options, investment focus and business cases that follow, ensuring every proposed initiative can be traced back to an identified need in the current and future state analysis.

Priority Areas:

- Digital Enablement (telehealth, wearables, PAS etc.)
- Enhanced Local and Clinical Capacity
- Preventive Health and Early Intervention Models
- Integrated Mental Health and AOD Services
- Workforce Collaboration
- Digitally Enabled Service Delivery Platforms
- Local Training and Workforce Development
- Infrastructure and Workforce Retention Support
- Transport and Access Enhancement
- Performance Monitoring and Network Processes
- Community Navigator and Care Coordination System
- Ease and Accessibility for Community and Advocates

7.5.2 Defining the Priority Areas

Priority Area 1: Digital Enablement (telehealth, wearables, PAS etc.)

Digital health tools such as telehealth, remote monitoring, and electronic patient systems are bridging geographic gaps in care. Strengthening digital infrastructure allows clinicians to collaborate seamlessly, enhances patient follow-up, and ensures equitable access to quality healthcare regardless of location or mobility barriers.

Desired Outcomes

- 30% reduction in travel requirements for specialist consultations
- Real-time access to patient information across all network partners
- 50% of appropriate consultations delivered via telehealth
- Reduced duplicate tests and investigations through shared records
- Earlier detection of health deterioration through remote monitoring

Strategic Alignments

Service access	Expands specialist reach and improves after-hours/diagnostic availability.
Health outcomes (GP-sensitive)	Supports chronic disease monitoring and coordinated GP-sensitive care.
Health literacy and navigation	Strengthens digital referral pathways and patient information access.

Priority Area 2: Enhanced Local and Clinical Capacity

Building local clinical capacity enables residents to access more care locally and reduces unnecessary transfers to larger centres. Strengthening shared outreach, supervision and diagnostics improves responsiveness and allows smaller sites to safely deliver higher-acuity care.

Desired Outcomes

- 60% increase in specialist services delivered in local community settings
- 40% reduction in patient travel for routine specialist appointments
- 25% reduction in missed appointments due to distance/transport barriers
- Improved early intervention through increased local access
- Enhanced clinical capability in aged care reducing hospital transfers

Strategic Alignments

Service access	Builds reliable local clinical services and referral pathways.
Workforce	Addresses stability, supervision and coordinated staffing models.
Health outcomes (GP-sensitive)	Improves care continuity and capability for chronic disease management.

7.5.3 Defining the Priority Areas

Priority Area 3: Preventive Health and Early Intervention Models

Preventive and early intervention models focus on keeping people healthy and connected before illness escalates. It relies on coordinated outreach, screening, and education programs that strengthen community wellbeing, reduce avoidable hospital presentations, and direct limited health resources toward proactive care.

Desired Outcomes

- 20% reduction in preventable hospitalisations for chronic conditions
- 30% increase in early detection of diabetes, cardiovascular disease, and cancer
- Improved community health literacy scores by 35%
- 15% reduction in emergency department presentations for primary care issues
- Enhanced chronic disease self-management among 60% of targeted population

Strategic Alignments

Health outcomes (GP-sensitive)	Targets earlier intervention for chronic and GP-sensitive conditions.
Health literacy and navigation	Relies on outreach, screening and community understanding of risks.

Priority Area 4: Integrated Mental Health and AOD Services

Mental health and alcohol and other drug (AOD) needs often intersect, requiring coordinated, compassionate responses. This means connecting clinical and psychosocial supports across services, strengthening shared care planning, and local follow-up to ensure people receive consistent, stigma-free care close to home.

Desired Outcomes

- 50% reduction in mental health crisis emergency department presentations
- Mental health assessment available at every primary care visit when indicated
- 40% reduction in wait times for mental health services
- Integrated care plans addressing both mental and physical health for 80% of patients
- Increased early intervention reducing acute mental health admissions by 30%

Strategic Alignments

Service access	Improves continuity across mental health and AOD clinical pathways.
Health outcomes (GP-sensitive)	Improves continuity across mental health and AOD clinical pathways.
Health literacy and navigation	Increases community access, referral clarity and early help-seeking.

7.5.4 Defining the Priority Areas

Priority Area 5: Workforce Collaboration

Preventive and early intervention models focus on keeping people healthy and connected before illness escalates. It relies on coordinated outreach, screening, and education programs that strengthen community wellbeing, reduce avoidable hospital presentations, and direct limited health resources toward proactive care.

Desired Outcomes

- 25% improvement in workforce utilisation across network partners
- 30% reduction in reliance on expensive agency/locum staff
- 40-60 FTE working in shared arrangements across multiple partners
- 20% improvement in staff retention rates
- Enhanced service continuity with better coverage of leave and vacancies

Strategic Alignments

Workforce — Directly aligns with placement, supervision and education partnerships.

Local training — Supports retention, skill development and a sustainable pipeline.

Priority Area 6: Digitally Enabled Service Delivery Platforms

Integrating digital systems enables consistent, data-driven care across the network. Standardising electronic referrals, reporting, and telehealth platforms reduces duplication and ensures clinicians and partners can access the right information at the right time, improving safety, efficiency, and coordination.

Desired Outcomes

- Single point of access for patients to book appointments across all network services
- 90% of referrals completed within network with digital handoff
- 50% reduction in time to access appropriate service through improved coordination
- Real-time service capacity visibility enabling efficient patient flow
- Elimination of duplicate data entry and improved care plan adherence

Strategic Alignments

Service access — Streamlines referrals and improves timely access to services.

Health literacy and navigation — Enhances information flow and digital wayfinding.

Health outcomes (GP-sensitive) — Supports shared-care and continuity across providers.

7.5.5 Defining the Priority Areas

Priority Area 7: Local Training and Workforce Development

Expanding local training and placement opportunities helps Murrindindi attract, develop and retain skilled professionals. Partnerships with universities, RTOs and health services build a workforce that is locally trained, clinically supported and more likely to stay long-term.

Desired Outcomes

- 40-60 clinical placements annually across all network partners
- 50% of graduates from local placements accepting employment within network
- Reduced time-to-competency for new staff familiar with network operations
- 15-20 scholarships annually for local residents pursuing health careers
- Partnership with regional university established with guaranteed placement capacity

Strategic Alignments

Workforce — Directly aligns with placement, supervision and education partnerships.

Local training — Supports retention, skill development and a sustainable pipeline.

Priority Area 8: Infrastructure and Workforce Retention Support

Modern, well-equipped facilities, housing and staff amenities improve morale and retention. Investing in workforce housing, wellbeing programs and flexible work models helps Murrindindi attract and retain skilled professionals, fostering a sustainable and positive workforce culture.

Desired Outcomes

- 25% improvement in workforce retention rates over 3 years
- Shared accommodation for 15-20 staff reducing housing barriers
- Modern, well-equipped facilities meeting contemporary practice standards
- 20% reduction in time-to-recruit for priority positions
- Improved staff satisfaction scores related to work environment

Strategic Alignments

Workforce — Addresses stability, retention, and supportive working conditions.

Local training — Improves placement quality and supervisory capacity.

Service access — Ensures facilities can support reliable service coverage.

7.5.6 Defining the Priority Areas

Priority Area 9: Transport and Access Enhancement Program

Reliable transport is essential for equitable access to care in Murrindindi, where distance and limited public options remain major barriers. Expanding coordinated community transport, outreach clinics, and mobile services will reduce missed appointments, strengthen continuity and ensure all residents can reach essential care and support.

Desired Outcomes

- 50% reduction in missed appointments due to transport barriers
- Coordinated transport available for 80% of non-emergency medical appointments
- 200+ volunteer driver trips monthly supporting community access
- 30% reduction in transport-related barriers reported by patients
- Integration of transport booking with appointment scheduling system

Strategic Alignments

Service access	Responds to transport barriers and inequity across towns.
Health literacy and navigation	Helps people reach the right services with guided pathways.

Priority Area 10: Performance Monitoring and Network Processes

Establishing practical performance frameworks enables the network to track progress, share insights and drive continual improvement. Strengthening shared data systems supports transparency, evidence-based planning and smarter resource allocation across Murrindindi's interconnected health services.

Desired Outcomes

- Comprehensive network dashboard with real-time performance data across all partners
- Quarterly public reporting on network outcomes and performance
- Integrated data collection minimising additional burden on staff
- Evidence-based service improvements implemented through regular review cycles
- Network meeting or exceeding 85% of performance targets

Strategic Alignments

Workforce	Improves data-driven supervision, collaboration and workload planning.
Service access	Tracks referral flow and access gaps across sites.
Health outcomes (GP-sensitive)	Monitors chronic condition pathways and continuity metrics.

7.5.7 Defining the Priority Areas

Priority Area 11: Community Navigator and Care Coordination System

Community navigators and care coordinators act as trusted connectors between people and services, helping residents, especially those with complex or multiple needs, navigate care systems with confidence. This model reduces service fragmentation, supports smooth transitions and ensures people receive the right care, in the right place, at the right time.

Desired Outcomes

- Every person with complex needs (3+ chronic conditions) has assigned care coordinator
- 35% reduction in preventable hospitalisations for coordinated patients
- 50% reduction in time to access appropriate services through navigation support
- 90% of care plans actively shared across all treating providers
- Improved patient experience scores, particularly for those with complex needs

Strategic Alignments

Health literacy and navigation	Strengthens guidance, outreach and service linkage.
Service access	Reduces barriers and supports smoother referral journeys.
Health outcomes (GP-sensitive)	Enhances continuity for people with complex or chronic needs.

Priority Area 12: Ease and Accessibility for Community and Advocates

Simplifying information, referral and feedback processes makes the health system more approachable and trusted. This priority strengthens advocacy, transparency and co-design with the community, ensuring services are developed with people rather than for them.

Desired Outcomes

- 100% of network services meeting accessibility standards within 3 years
- Single, consistent entry point for all network services
- Consumer representatives embedded in all governance and planning processes
- Communications available in priority languages and accessible formats
- Community satisfaction scores improved by 40% for ease of access

Strategic Alignments

Health literacy and navigation	Improves communication, information access and support.
Service access	Addresses system complexity and makes services easier to reach.

7.5.8 Priority Areas Conclusion

A unified 12-priority framework that transforms Murrindindi's health system into a connected, accessible and future-ready network delivering better care for every community.

Priority Areas Overview

Together, these priority areas create a stronger, more connected regional health system that improves access, strengthens the workforce, and delivers safer, earlier and more coordinated care for the community. These priority areas will provide a foundation for the network plan and options analysis in the upcoming section, focusing network efforts across defined and validated priorities to ensure all previous work is considered in the final network plan and business cases.

Key Takeaways

One Connected Regional System

Creates a unified direction for all partners, lifting consistency, reducing duplication and enabling coordinated planning across towns and services. It establishes shared goals and governance so the region functions as one coordinated network rather than isolated providers.

Better Local Access and Reduced Travel

Expands local service capability, strengthens digital care, and improves transport coordination so residents receive more care close to home and earlier. This reduces travel burden, improves continuity and ensures timely access across geographically dispersed communities.

A Sustainable, Supported Workforce Pipeline

Builds shared supervision, placements, housing and training pathways, supporting retention, reducing locum reliance and stabilising clinical coverage. These mechanisms make the region more attractive, strengthen staff capability and create long-term workforce stability.

Earlier Intervention and Stronger Community Wellbeing

Strengthens screening, prevention, navigation and integrated mental health/AOD pathways to reduce avoidable admissions and keep people well for longer. Earlier detection and coordinated support help prevent escalation and improve overall community health outcomes.

Safer, Smarter and More Connected Care Pathways

Standardises digital platforms, referrals, reporting and shared care planning, enhancing continuity, reducing delays and enabling data-driven improvements. Real-time information sharing improves safety, reduces duplication and supports evidence-based decision-making.

A More Navigable and Inclusive Health System

Improves accessibility, communication and co-design mechanisms so people understand where to go, feel supported, and help shape service planning. Clearer pathways and stronger community participation make the system easier to use and more responsive to local needs.

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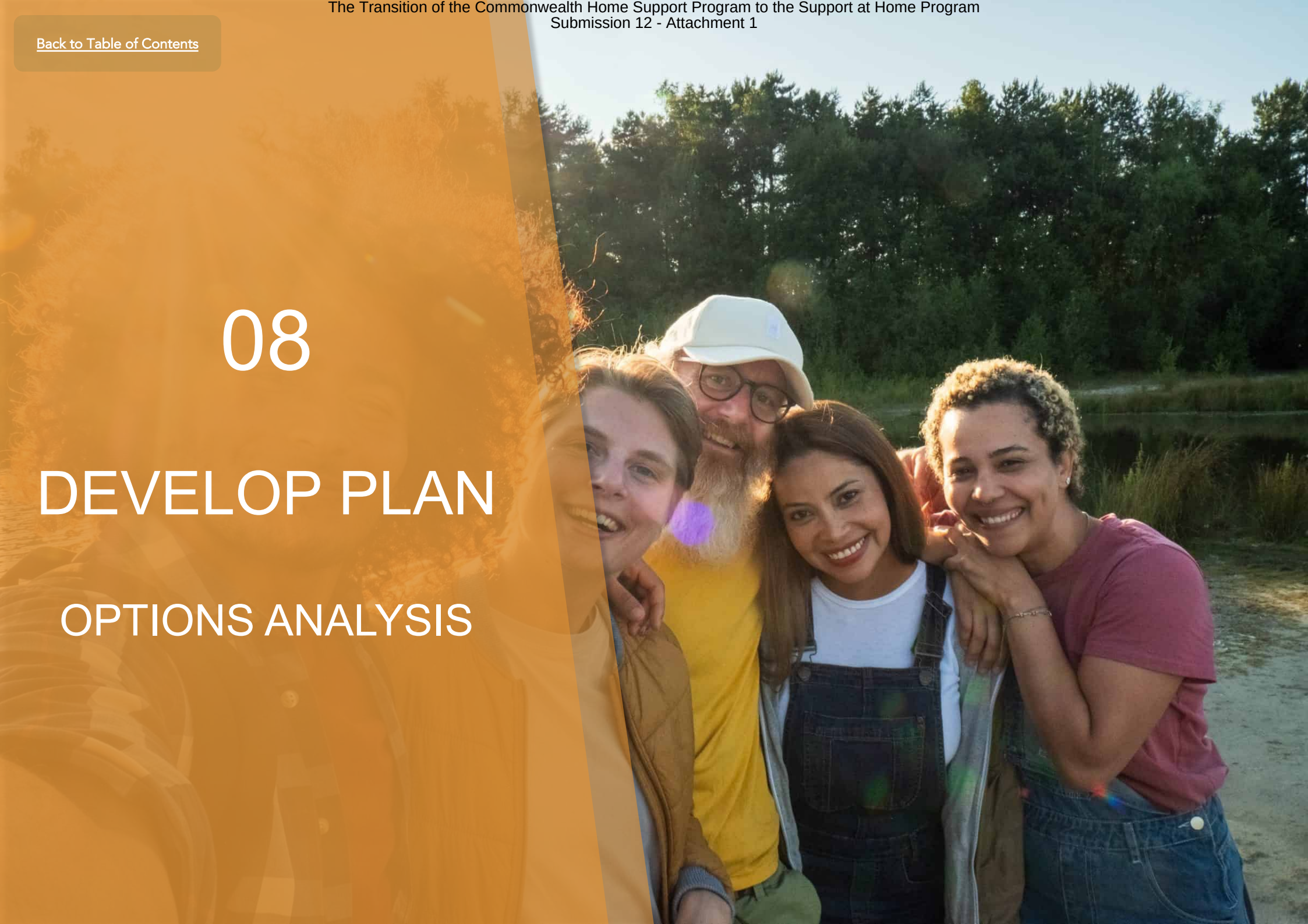
08

DEVELOP PLAN

OPTIONS ANALYSIS



8.1 Options Analysis – Overview

The Options Analysis defines what the local health and workforce system should look like to remain sustainable and responsive

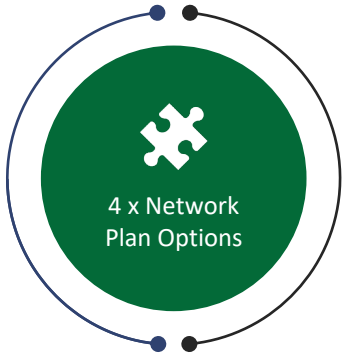
Options Analysis Approach

NMC's options analysis is a structured approach for developing and comparing multiple strategic approaches to implementing the 12 priority elements into a single plan with supporting Business Cases. Rather than defaulting to a single network plan, this process creates 3-5 distinct options that differ in:

- *Sequencing - Which elements are implemented first, which are delayed*
- *Intensity - How comprehensively each element is developed (basic vs. advanced implementation)*
- *Partnership model - Who leads, who contributes, governance structure*
- *Investment scale - Total resource commitment and funding approach*
- *Risk profile - Conservative vs. transformational approaches*
- *Timeframe - Accelerated (3 years) vs. phased (5-7 years) implementation*

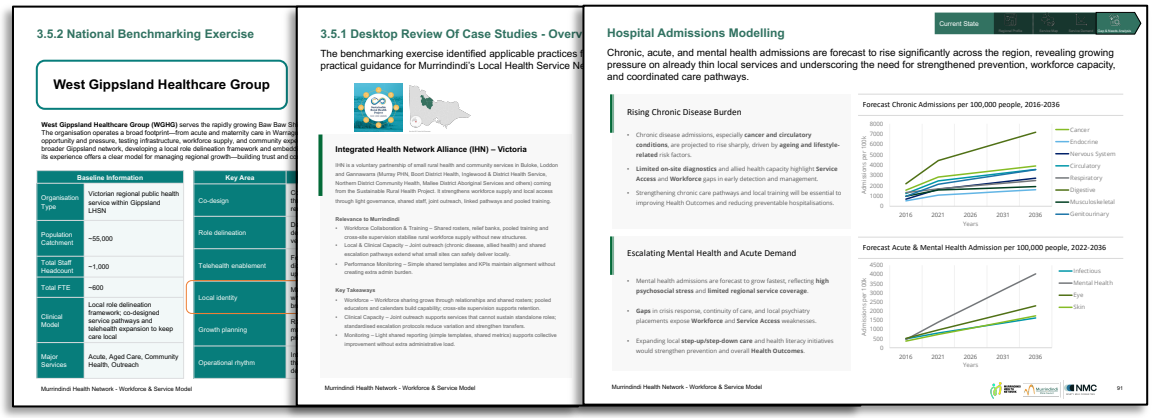
Options Analysis Framework

01 Overview
02 Element-by-Element Specifications
03 Governance & Partnership Model
04 Financial Plan
05 Implementation Roadmap
06 Impact & ROI Assessment
07 Workforce Plan
08 Risk Assessment
09 Performance Framework



Methodology

Define	Establish the key variables that will differentiate options. Based on the 12 priority elements, identify which dimensions are most relevant for Murrindindi's network context.
Develop	Create 3-5 distinct options, each representing a coherent strategic approach. Give each option a descriptive name that captures its essence.
Build	Develop a comprehensive network plan for each option. Each plan will include all framework elements to enable fair comparison.
Evaluate and Select	Systematically evaluate each option against agreed criteria to enable objective comparison and informed decision-making.



Visual representation final option development

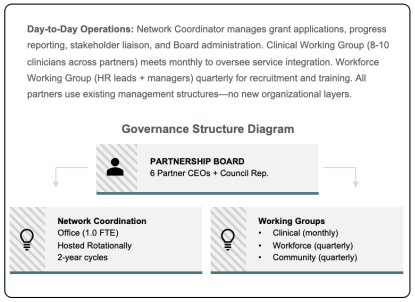
8.2 Options Analysis Framework – Methodology (1/3)

Each option's governance and financial sustainability was comprehensively assessed to ensure organisational feasibility and long-term viability for Murrindindi's partnership context

GOVERNANCE AND PARTNERSHIP MODEL

Each option proposes a different governance structure defining how partners work together, make decisions, and share accountability. We evaluate four key dimensions across all options:

1. Legal Structure: Does the option create a formal legal entity (company, trust) or operate through partnership agreements? Entities enable employment and asset ownership but increase complexity and cost.
2. Decision-Making Authority: Who decides what, and how? Options range from consensus-based CEO meetings (collaborative but slower) to formal boards with voting rights (clear but requires surrendering autonomy).
3. Employment Model: Are network staff employed by a central entity, individual partners, or shared across organisations? This fundamentally affects HR complexity, liability, and workforce flexibility.
4. Partner Roles and Accountability: What does each partner contribute and control? Clear role delineation prevents duplication and conflict.



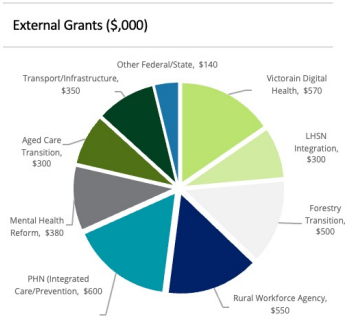
	ADH	YMDH	Kellock/Darl/ Menzies	Nexus	Council	Network Office
Digital Infrastructure	A	C	C	C	I	R
Care Coordination	C	C	R	C	I	A
Preventive Programs	C	C	C	I	A/R	I
Transport	I	I	C	I	A/R	C
Training Placements	R	R	C	C	I	A
Mental Health	R	R	C	R	I	A
Grant Applications	C	C	C	C	C	R/A

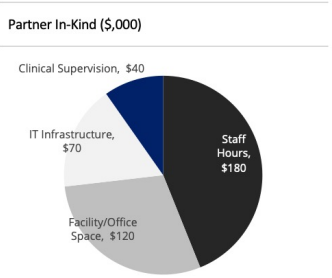
R =Responsible, A =Accountable, C =Consulted, I =Informed

FINANCIAL PLAN

Financial viability determines whether options are achievable and sustainable. We assess four critical financial dimensions:

1. Total Investment Required: Capital and operating costs over the implementation period. Options range from $2M (Community-Centered Pragmatic) to $4.5M (Digital-Enabled Lean).
2. Funding Sources: Ratio of external grants vs. partner contributions. All options prioritisation external funding (85-95%) recognising partner financial constraints. We identify specific grant programs targeted for each option.
3. Funding Risk Profile: Dependency on few large grants (higher risk) vs. multiple small grants (more resilient). Options relying on single major grants (e.g., Victorian Digital Health Innovation Fund $1.4M) create critical funding dependencies.
4. Sustainability Model: How ongoing operations are funded post-implementation. Options transition through: recurrent grants, partner base budget absorption, usage fees, or self-sustaining revenue models.





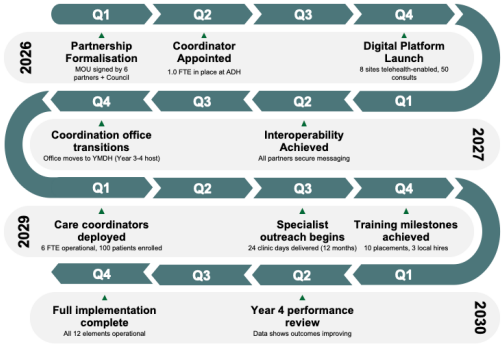
8.3 Options Analysis Framework – Methodology (2/3)

Implementation timelines and expected returns were comprehensively modelled to assess whether each option is achievable given partner capacity and delivers meaningful value justifying investment

IMPLEMENTATION ROADMAP

Implementation feasibility is critical-good plans fail through poor execution. We map detailed implementation timelines examining:

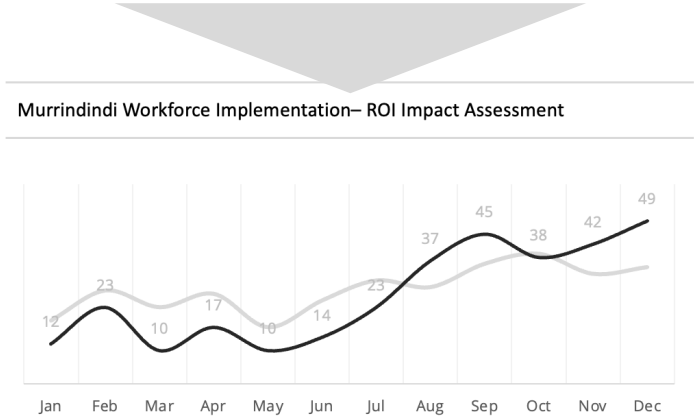
- Sequencing Logic: Why elements are ordered this way. Does the option require foundations before services (Option 1: digital first, then services) or deliver services immediately (Option 3: quick wins)?
- Critical Path Dependencies: What must happen before other activities can proceed? Digital platforms must work before care coordinators can use them; housing must be available before recruiting relocating staff.
- Milestone Gates: Decision points where partners assess progress and decide to proceed, adjust, or pause. Early milestones demonstrate viability before major investment.
- Timeframe Realism: Can implementation be achieved in proposed timeline given partner capacity? Three-year intensive programs (Option 4) pressure organisations differently than five-year phased approaches.



IMPACT AND RETURN ON INVESTMENT

Investment must deliver value-to community health outcomes AND financial sustainability. We assess impact across three dimensions:

- Health Outcomes: Measurable improvements in preventable hospitalisations, chronic disease management, mental health, access to care. Targets based on evidence from comparable networks and population health modeling.
- Economic Returns: Financial savings from avoided hospitalisations, reduced emergency presentations, workforce efficiencies, travel cost savings. Conservative estimates using established health economics.
- Social Return on Investment: Non-financial community benefits-reduced isolation, improved equity, workforce development, community confidence. Qualitative but crucial for community value.
- 10-Year ROI Calculation: We project returns over 10 years (not just implementation period) because health infrastructure investments compound benefits over time. Options with higher upfront costs (digital infrastructure, workforce creation) show improving returns as initial investment amortisations.



8.4 Options Analysis Framework – Methodology (3/3)

Workforce requirements, implementation risks, and success metrics were comprehensively evaluated to ensure each option's operational feasibility and measurable accountability

WORKFORCE PLAN

Workforce availability determines service delivery capacity. We assess workforce requirements, recruitment strategies, and sustainability:

- Total FTE requirements (network-employed + partner-employed)
- Role categories (care coordinators, clinical, administrative, digital specialists)
- Recruitment strategies (local-first, graduate pipelines, experienced recruitment, international)
- Employment models (who employs, how deployed, professional development)

Role/Category	Year 1	Year 2	Year 3	Year 4	Year 5	Employment Model
Network Coordinator	10,000	10,000	10,000	10,000	10,000	10,000
Care Coordinators	-	2,000	4,000	6,000	8,000	10,000
Mental Health Clinicians	10,000	12,000	14,000	16,000	18,000	20,000
Health Promotion Officers	-	4,000	8,000	12,000	16,000	20,000
Care Coordinators	-	2,000	4,000	6,000	8,000	10,000
Mental Health Clinicians	10,000	12,000	14,000	16,000	18,000	20,000
Health Promotion Officers	-	4,000	8,000	12,000	16,000	20,000
Health Promotion Officers	-	4,000	8,000	12,000	16,000	20,000
Profit / Loss	**(10,000)**	**(8,000)**	**(6,000)**	**(4,000)**	**(2,000)**	**-**	**2,000**

RISK ASSESSMENT

Risk Categories Across All Options:

- Financial risk (grant funding failure, cost overruns, sustainability)
- Technology risk (platform failures, integration issues, cybersecurity)
- Workforce risk (recruitment failure, turnover, skill gaps)
- Governance risk (partner withdrawal, decision-making conflicts)
- Change management risk (organisational overwhelm, resistance)
- Community acceptance risk (service model rejection, equity concerns)
- Risk Rating: Likelihood (Low/Medium/High) × Impact (Low/Medium/High/Critical) → Residual Risk after mitigation.

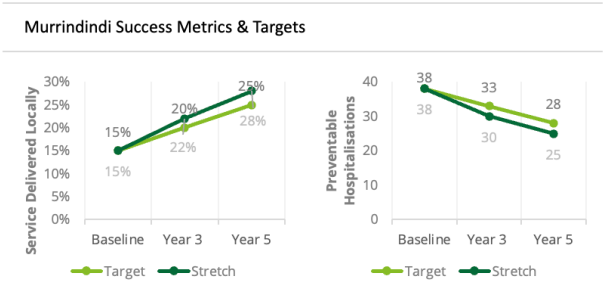
	Identified Risks	Likelihood	Impact	Mitigation	Residual Risk
1	**External Funding Shortfall** Grant applications unsuccessful or delayed, threatening implementation timeline.			Phased implementation—pause if grants fail; diversify across 8-10 funding sources; Forestry Transition anchor ($500k) secured; partners pre-commit to in-kind even if cash grants lower; business cases emphasize ROI	
2	**Partner Commitment Fatigue** Five-year timeframe tests organizational endurance, particularly through CEO changes, competing priorities, or financial pressures.			Rotating coordination distributes burden; early wins (telehealth, placements) build momentum; quarterly Board meetings keep visibility; CEO succession planning includes network orientation; demonstrate partner benefits (e.g., shared recruitment reduces costs)	
3	**Workforce Recruitment Failure** Rural health workforce shortage is systemic; Murrindindi competes with hundreds of rural LGAs for same small talent pool.			Local-first recruitment for coordinators; university partnerships guarantee placement pipeline; shared roles improve job appeal; housing support addresses key barrier; competitive salaries benchmarked to metro; flexibility (part-time, job share)	
4	**Technology Implementation Delays** Digital enablement assumes existing systems can be connected; may discover incompatibility requiring expensive workarounds.			Pilot telehealth at 2 sites before full rollout; leverage Victorian digital health expertise; realistic timelines (18 months not 6); contingency—manual processes continue if digital delayed; vendor support contracts included	
5	**Community Resistance To Change** Service changes may trigger community anxiety about "losing" local services, particularly if visiting specialists replace some local visits.			Co-design from Year 1; community reps on Board; transparent communication about what's changing/what's protected; pilot services gather feedback before expansion; celebrate local staff in new roles; emphasize "addition not subtraction"	

Difficulty: Low Medium High

PERFORMANCE FRAMEWORK

What gets measured gets managed." Performance frameworks define success metrics and accountability:

- Health outcomes (hospitalisations, ED presentations, chronic disease management)
- Access & equity (services delivered locally, wait times, community reach)
- Workforce stability (vacancy rates, turnover, agency usage)
- Partnership health (partner satisfaction, financial sustainability, community awareness)
- Monitoring Approach: Frequency (monthly/quarterly/annual), data sources (automated vs. manual), accountability mechanisms, public reporting.



8.5 Network Options Overview

This overview introduces four integration pathways, outlining distinct approaches partners can take depending on their readiness, priorities and appetite for organisational, digital and workforce change.

Options Analysis – List of Options

OPTION 1

Staged Integration

Build strong foundations systematically before scaling services.

Best suited for partners seeking methodical transformation with manageable implementation burden.

OPTION 2

Workforce-First Collaboration

Solve workforce shortages first – everything else follows.

Core foundation – activated in Years 1–5.
Addresses dominant workforce barriers through shared roles, a regional training hub, student placements, and coordinated retention strategies.

OPTION 3

Community-Centred Pragmatic

Deliver visible community benefits quickly with minimal organisational disruption.

Core foundation – activated in Years 1–5.
Drives immediate community impact through time-bound alliance projects, navigation initiatives, transport solutions, and prevention programs.

OPTION 4

Digital-Enabled Lean Integration

Use digital infrastructure to enable comprehensive integration at a fraction of traditional cost.

Supporting enabler – phased 2026–2030.
Right-sized digital tools (telehealth, shared calendars, dashboards) are tailored to rural bandwidth and capacity to support navigation, workforce coordination, and system integration.

OPTION 5

Form New Network Entity

Build strong governance foundations systematically before scaling services.

Governance pathway – available if the Alliance model proves successful. Provides future formalisation pathway for a mature network, enabling centralised employment, shared resourcing, and asset management.

Develop Plan | Gap Analysis | Options Analysis | Business Case

8.6.1 Network Option 1 – Staged Integration: Overview

A new shared-services Network Entity established by ADH, Y&DMH, Omnia, local aged care, community services and Council to deliver agreed network functions with clear accountability, pooled capability and consistent performance oversight.

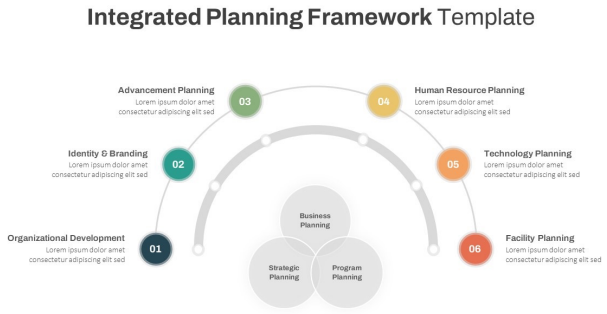
Staged Integration

Plan Overview

A staged transition to a formal Network Entity that strengthens local services without merging them. The entity provides a dedicated "backbone" to coordinate shared services across Murrindindi (e.g., navigation, workforce pipeline, transport coordination, performance monitoring and grants). This option is typically activated after the Alliance model demonstrates sustained impact and partner readiness, enabling deeper integration where it adds value (e.g., central employment of shared roles, pooled funding administration, standardised processes and reporting).

What the plan entails

- Establish a legal entity (e.g., company limited by guarantee) with member organisations and an independent, skills-based Board.
- Define membership, decision rights and accountability through a Network Constitution + Service Agreements (what the entity does and does not do).
- Employ or host a Network Executive / Program Office (shared roles) to deliver cross-network priorities and manage delivery discipline.



Strengths

- Highest accountability model: clear ownership, decision rights, delivery discipline and benefit realisation.
- Enables shared staffing and pooled capability that small services cannot sustain individually.
- Improves funding competitiveness (single pipeline, coordinated bids, consistent reporting and acquittals).

What it looks like for residents

- One clear front door (phone/online/in-person) connecting people to the right service across health, aged care and disability.
- People with complex needs are supported by a care coordinator, who helps with referrals, appointments, transport and follow-up.
- More services are delivered locally through coordinated outreach and shared workforce models, reducing travel to larger centres.
- Faster pathways, fewer "handball" referrals, and clearer information about what support exists and how to access it.

How partners work together

- Member organisations appoint representatives to a Network Board / Members Council with independent leadership and agreed decision rights.
- A small Network Program Office runs delivery: action tracking, risk/issue management, milestone reporting and partner coordination.
- Shared KPIs and a minimum data set support consistent reporting (PPH, mental health demand, access, workforce pipeline, etc.).

Develop Plan | Gap Analysis | Options Analysis | Business Case

8.6.2 Network Option 1 – Staged Integration: Overview

A new shared-services Network Entity established by ADH, Y&DMH, Omnia, local aged care, community services and Council to deliver agreed network functions with clear accountability, pooled capability and consistent performance oversight.

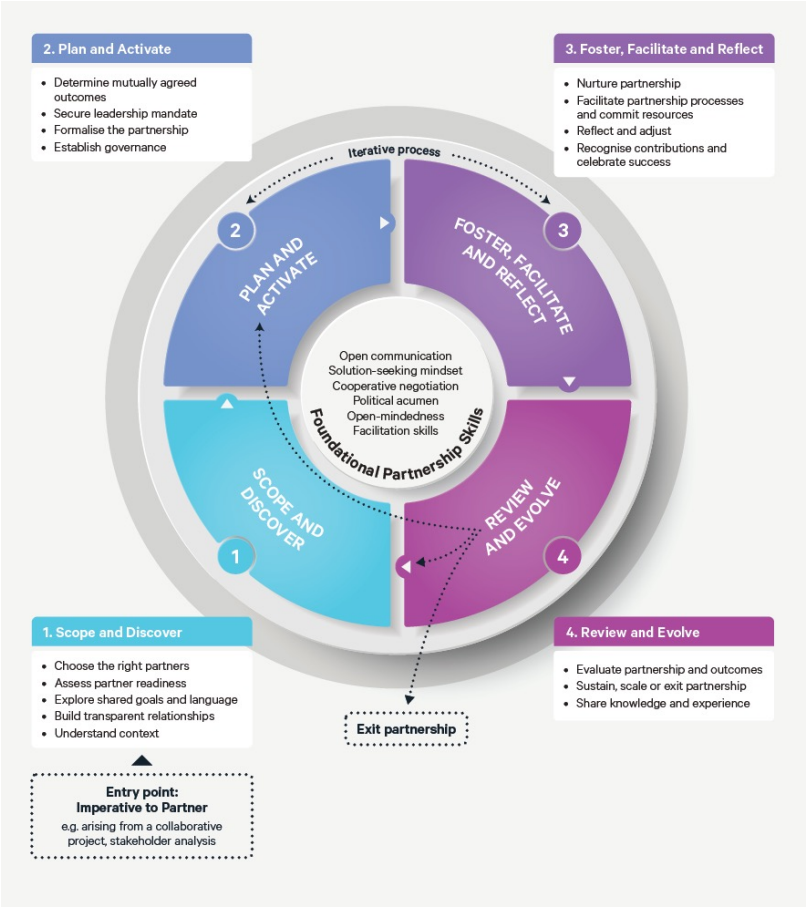
Staged Integration

Workforce & local training / "learning hub":

- Establish a Network Workforce and Learning Platform as a core function of the entity (not a bolt-on), with clear accountability, KPIs and resourcing.
- Formalise MOUs with university and TAFE partners (e.g., La Trobe, Deakin, GOTAFE and relevant rural training programs) to deliver "learn where you live" pathways across nursing, allied health, mental health, disability and aged care.
- Create a distributed Murrindindi Health and Learning Hub using existing sites (Alexandra, Yea, Eildon, local aged care and community settings), enabling placements and supervised practice without reliance on new builds.
- Fund a network-employed Clinical Education Coordinator (and/or placement brokerage function) to: broker placements and rotations across partners, support supervisors and streamline onboarding/credentialing, coordinate education days and joint professional development, and set realistic, measurable targets (e.g., placement volume, conversion-to-employment, vacancy duration reduction, retention uplift) that build a sustainable local pipeline over time.

Funding & viability:

- Establish a clear, transparent funding model with three streams:
  - Core backbone funding (lean overhead: governance, PMO, reporting)
  - Program funding (flagship initiatives funded via grants and commissioning)
  - Partner contributions (modest cash + in-kind, with caps and annual review)
- Use the entity to increase investability by providing: single grant pipeline, consistent reporting, measurable outcomes, and central acquittal capability.
- Apply "no unfunded mandate" principles: functions only scale when resourcing is secured and agreed by members.



Risks

- x Autonomy and trust risk (perception of central control) → lock in boundaries via constitution + service agreements; member decision rights; independent chair.Partner fatigue / uneven buy-in → simple, light governance; early, visible wins in each town.
- x Bureaucracy risk → lean staffing model; capped overhead; annual operating plan approval; quarterly performance reporting.
- x Data and privacy risk → minimum data set first; staged uplift; clear data governance and consent pathways.

8.6.3 Network Option 1 – Staged Integration: Overview

A new shared-services Network Entity established by ADH, Y&DMH, Omnia, local aged care, community services and Council to deliver agreed network functions with clear accountability, pooled capability and consistent performance oversight.

Digital Enablement

The Network Entity sets minimum digital standards across partners and delivers practical enablement (shared service directory, digital referral pathways, telehealth coordination, secure information-sharing protocols). Focus is on interoperability and usability, not replacing existing clinical systems.

Enhanced Local and Clinical Capacity

The Network Entity coordinates outreach and shared clinical capacity (e.g., visiting services, shared clinics, rotational roles) based on agreed demand priorities and workforce availability. It manages scheduling, stakeholder alignment and evaluation so local capacity grows without duplicating effort.

Preventive Health and Early Intervention Models

The Network Entity coordinates prevention initiatives across towns using a common framework and shared evaluation, aligning partners around a small number of high-impact programs (chronic disease risk, falls, mental wellbeing, screening pathways). Programs are staged and scaled only when funded.

Integrated Mental Health and AOD Services

The Network Entity enables a consistent stepped-care approach across providers through shared intake/navigation, agreed escalation pathways, coordinated outreach and follow-up. The priority is continuity (fewer gaps and repeat crises) and clear roles between primary care, community services and hospitals.

Transport and Access Enhancement

The Network Entity operates a coordinated access function (central booking, transport partnerships, volunteer coordination, eligibility guidance, appointment bundling) to reduce missed care and travel burden. It standardises processes and reporting so access support is reliable and measurable.

Performance Monitoring and Network Processes

The Network Entity owns the network minimum data set, dashboard reporting, and a quarterly performance rhythm. It maintains shared templates and processes (project tracking, risk/issues, action registers), enabling partner boards to see delivery progress and impact in one place.

Community Navigator and Care Coordination System

The Network Entity employs/hosts a navigation and care coordination team as a shared network service. The team provides a single front door, triage, referral coordination, practical support (appointments/transport), and follow-up for people with complex needs across health, aged care and disability.

Ease and Accessibility for Community and Advocates

The Network Entity maintains a single access entry point (phone/online), a clear service finder, and common consumer-friendly information across towns. It supports a Consumer Advisory Group and establishes feedback loops so service changes reflect lived experience and local priorities.

Workforce Collaboration

The Network Entity coordinates shared workforce mechanisms that reduce fragility, such as shared relief/backfill arrangements, cross-site rotations, joint recruitment campaigns, shared onboarding, and structured professional development. The focus is to stabilise services first, then grow capacity.

Infrastructure and Workforce Retention Support

The Network Entity coordinates retention enablers that are hard for individual services to manage alone (workforce housing partnerships, accommodation pathways for students/locums, shared workspace access, orientation support). This is structured as “enablers”, not major capital delivery.

Digitally Enabled Service Delivery Platforms

The Network Entity enables consistent use of fit-for-purpose tools to improve access and continuity (online booking where appropriate, secure messaging workflows, shared referral forms, virtual care coordination). Implementation is staged and aligned to workforce readiness and service priorities.

Local Training and Workforce Development

The Network Entity runs a distributed learning platform across existing sites, coordinating placements, supervision support and “learn where you live” pathways with universities/TAFEs. Targets focus on measurable pipeline outcomes (placements, conversions to employment, retention), not aspirational commitments.

Develop Plan | Gap Analysis | Options Analysis | Business Case

8.7.1 Network Option 2 - Workforce-First Overview

A rolling project stream where the Alliance runs 2–3 cross-service projects at any time (e.g. chronic disease outreach, after-hours primary care, oral health access), using a standard collaborative-care methodology

Workforce-First

Plan Overview

A flexible workforce-sharing model where partners remain independent employers but coordinate shared roles, sessional arrangements, and workforce development through formalised partnership agreements. Over ~4–5 years, Murrindindi builds a coordinated workforce pool using sessional contracts, rotation agreements, and leverageing existing capacity from Community Interlink, Omnia, and Eastern Health without creating new employment entities.

What the plan entails

- No new legal entity or employer – all staff remain employed by existing organisations (ADH*, Y&DMH, Omnia, Community Interlink, aged care providers).
- Partners develop sessional purchase agreements where organisations "buy" clinical sessions from each other (e.g., ADH physiotherapist provides 1 day/week at Yea; Omnia mental health clinician delivers 2 sessions/week at Dame Pattie aged care).
- Council acts as coordinator (not employer) using existing procurement frameworks to facilitate agreements, maintain workforce database, and coordinate scheduling.
- Leverage Community Interlink's established workforce model and NDIS infrastructure to extend health system capacity.
- Build on the Eastern Health partnership for graduate placements, supervision, and rotating positions without local employment burden.

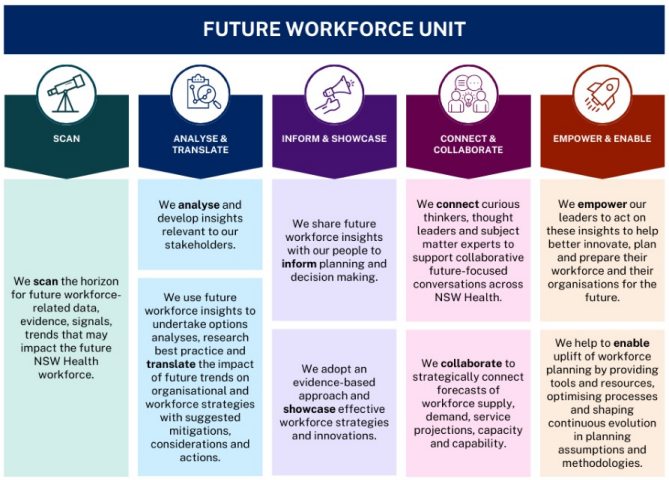
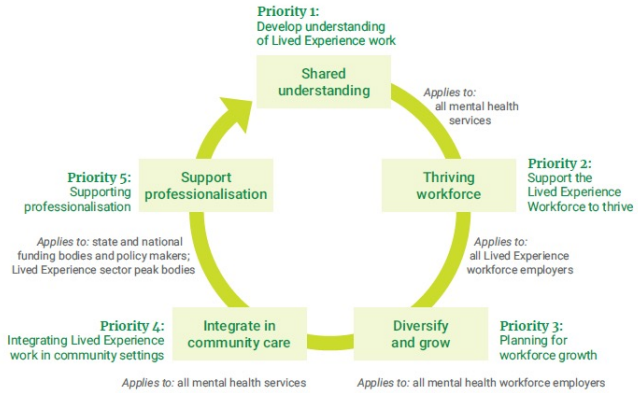


Figure 1. Priorities for Lived Experience workforce development



What it looks like for residents

- Residents see more consistent allied health, mental health, and specialist services across towns as clinicians rotate between sites on regular schedules.
- The same physiotherapist might work at Alexandra District Health two days, Yea one day, and an aged care facility one day – residents experience consistent care regardless of location.
- Services previously unavailable due to recruitment challenges (e.g., occupational therapy, speech pathology) become accessible through shared arrangements.

How partners work together

- Quarterly Workforce Coordination meetings (CEOs/service managers) to review sessional arrangements, identify gaps, and coordinate recruitment.
- Annual contracting round where partners agree on sessional purchases for the coming year (e.g., "ADH purchases 52 x 0.5-day physiotherapy sessions from Omnia").
- Shared supervision arrangements reduce professional isolation for part-time clinicians working across multiple sites.
- Joint recruitment campaigns for hard-to-fill roles, with successful candidates offered split positions across partners.

Develop Plan | Gap Analysis | Options Analysis | Business Case

8.7.2 Network Option 2 - Workforce-First Overview

A rolling project stream where the Alliance runs 2–3 cross-service projects at any time (e.g. chronic disease outreach, after-hours primary care, oral health access), using a standard collaborative-care methodology

Workforce-First

Workforce & local training / "learning hub":

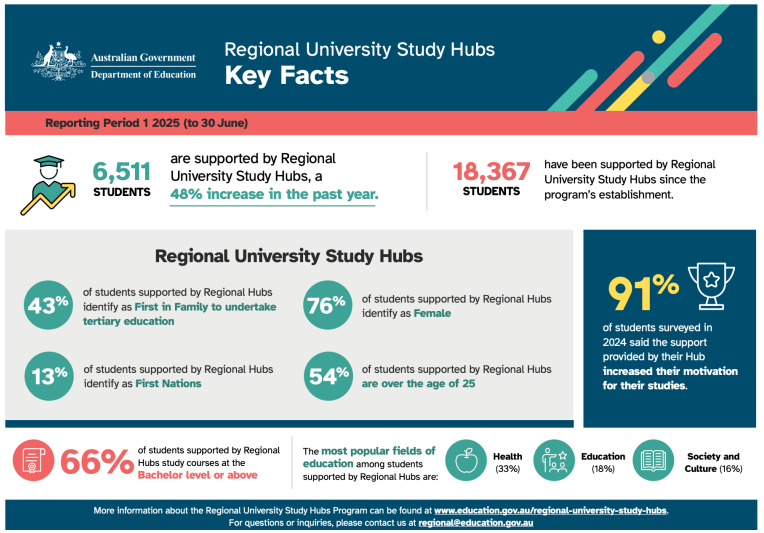
- Create an anchored Health & Learning Hub coordination function at Alexandra/Yea using existing infrastructure (no new building).
- Formal MoUs with universities and TAFEs to deliver coordinated placements across all partner sites, with students experiencing hospital, aged care, community health, and primary care settings in integrated rotations.
- Eastern Health becomes the primary employer of graduate/early-career clinicians who rotate through Murrindindi sites (rather than local partners employing directly), reducing HR burden while building workforce.
- Community Interlink provides workforce development expertise, particularly for personal care attendants and support workers who can work across health and aged care settings.
- Expand placements to 20–25 students per year coordinated across sites, with 4–6 local hires per year transitioning from placements or early-career rotations.
- Support upskilling and transition programs for displaced forestry workers into health/aged care roles through partnerships with RTOs.

Funding & viability:

- 85–90% from external grants: Rural Health Workforce Innovation grants, PHN flexible funding, Eastern Health LHSN integration funding, workforce attraction/retention programs.
- Partner contributions: In-kind supervision time, existing space for visiting clinicians, participation in joint recruitment.
- Revenue neutral for partners – sessional arrangements priced at cost-recovery, with potential for small efficiency gains through reduced locum/agency use.

Risks

- X Sessional arrangements don't materialisation → Start with 2–3 proven arrangements (e.g., existing Omnia relationships), scale gradually; use Eastern Health rotations as fallback.
- X Industrial relations/HR complexity → Clear service agreements defining professional boundaries, supervision, and liability; early union consultation.
- X Uneven participation across partners → Minimum participation commitments in partnership agreement; rotate coordination responsibilities.
- X Workforce still unavailable despite coordination → Strengthen ties to Community Interlink for workforce pool; increase Eastern Health graduate placements; bundled recruitment for regional roles.



Health Outcome	Baseline	Year 3	Year 5 +	Lives Impacted (Annual, Year 5+)
Preventable hospitalisations avoided	38 per 1,000	34 per 1,000	30 per 1,000	**112 people/year**
Mental health crises prevented	145/year	125/year	105/year	**40 people/year**
Chronic disease better managed	~1,200	~1,300	~1,400	**350 in coordination program**
Consistent mental health services	Episodic visiting	3 sites embedded	All sites embedded	**4-5 FTE consistent presence**
Improved local allied health access	15.8% self-sufficiency	19%	22%	**850+ additional people/year**
Workforce stability enables continuity	22% agency/locum	16%	12%	**88% permanent workforce**

Develop Plan | Gap Analysis | Options Analysis | Business Case

8.7.3 Network Option 2 - Workforce-First Overview

A rolling project stream where the Alliance runs 2–3 cross-service projects at any time (e.g. chronic disease outreach, after-hours primary care, oral health access), using a standard collaborative-care methodology

Workforce-First

Digital Enablement

The workforce entity standardises clinical systems and telehealth platforms across its employed staff so digital tools are used consistently wherever they work in Murrindindi.

Enhanced Local and Clinical Capacity

Community Interlink extends successful NDIS allied health outreach model to health services. ADH* physiotherapist provides 1 day/week to Yea via sessional contract. Funding: RWAV Workforce Innovation grants ($80-150K), partner cost-recovery sessional fees.

Preventive Health and Early Intervention Models

Partners coordinate existing prevention programs (Council's Maternal Child Health, community health chronic disease clinics) via shared calendar. Pool health promotion budgets for joint campaigns. Funding: VicHealth Local Government Partnership ($30-60K annually).

Integrated Mental Health and AOD Services

Omnia mental health clinicians provide sessional outreach to aged care facilities and ADH/Y&DMH wards via existing PHN contracts. Implement Partners in Recovery collaborative care model for complex clients. Funding: PHN Mental Health integration funding ($60-100K).

Transport and Access Enhancement

Council coordinates existing volunteer driver schemes (currently fragmented) using Transport Connection grants ($40-60K). Sessional clinicians scheduled to align with Council bus routes to townships. VPTAS information provided with all specialist referrals.

Performance Monitoring and Network Processes

Light-touch monitoring via quarterly workforce coordination reports: sessional arrangement utilisation, vacancy rates, locum usage. Shared metrics via Victorian Healthcare Association rural benchmarking (free). Council coordination function (0.5 FTE) compiles simple dashboard.

Community Navigator and Care Coordination System

Leverage existing Omnia care coordination for mental health clients, Community Interlink NDIS Local Area Coordinators. Add 1-2 FTE aged care navigators via CHSP/Support at Home funding. Train in NSW Agency for Clinical Innovation Care Coordination principles.

Ease and Accessibility for Community and Advocates

Improve existing service websites with consistent information. Each partner maintains own entry points but cross-refers efficiently. Share printed service directory updated quarterly. Low-cost approach focusing on better coordination vs. new infrastructure.

Workforce Collaboration

Formalisation sessional purchase agreements using HealthShare Victoria Workforce Solutions framework. ADH/Y&DMH share theatre-trained nurses via quarterly rotations. Omnia extends existing allied health outreach to include aged care facilities. Monthly workforce coordination meetings.

Infrastructure and Workforce Retention Support

Council prioritisations key worker housing allocation for health/aged care workforce. Partners contribute to RWAV Accommodation Grant applications ($30-70K). Community Interlink shares office/hot-desk space at Alexandra for visiting sessional clinicians.

Digitally Enabled Service Delivery Platforms

Use existing practice management systems (Medical Director, Best Practice) plus Argus Connect for inter-service communication. Coordinate My Care (free Victorian rollout) for shared care plans. Eastern Health extends read-only access to discharge summaries for ADH/Y&DMH.

Local Training and Workforce Development

Eastern Health employs 3-4 graduate nurses/allied health with 3 days/week Murrindindi rotations via RWAV Rural Generalist Training Program. La Trobe RUSON coordinates nursing student placements. Funding: RWAV Clinical Training ($100-180K), Health Workforce Australia Rural Health Multidisciplinary Training grants.

8.8.1 Network Option 3 - Community-Centred: Overview

A Community Service Alliance model where each organisation retains full control of its services and workforce, but commits to a shared work program

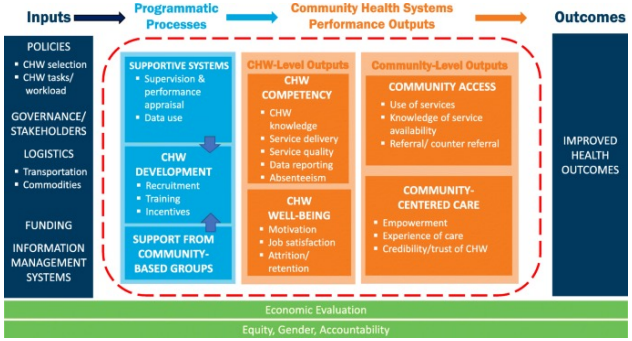
Community-Centred

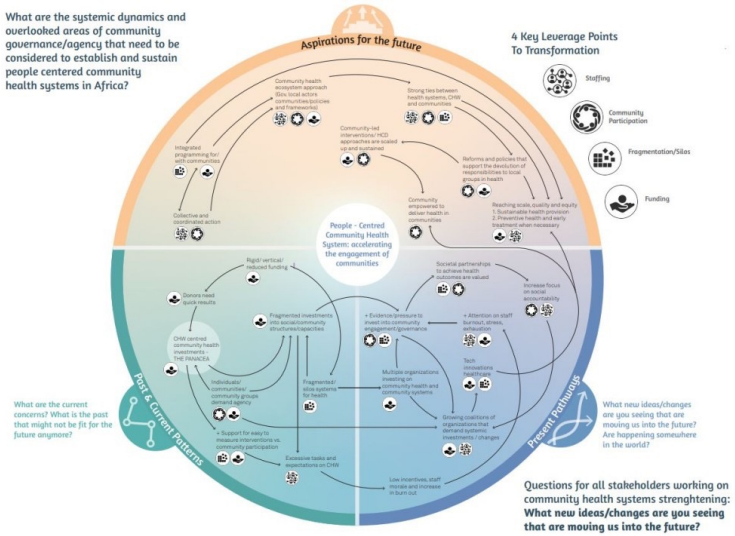
Plan Overview

A Community Service Alliance model that delivers visible improvements in priority areas through focused, time-bound projects while maintaining full partner autonomy. Rather than building permanent structures, Option 3 uses alliance agreements and targeted initiatives (2-year cycles) to address the most pressing community needs: access, navigation, transport, and prevention. Partners select 6–8 joint projects aligned to the 12 priority elements, delivering tangible benefits while learning to work together effectively.

What the plan entails

- Simple Alliance Agreement between network members – no new legal entity.
- 2-year project cycles selecting 6–8 priority initiatives each cycle (e.g., community health navigators, coordinated transport, allied health outreach to aged care, after-hours mental health access, chronic disease group programs, dental visiting clinics).
- Alliance Facilitator (0.8 FTE) coordinates projects, maintains shared calendar, supports evaluation, and manages joint reporting (hosted by Council).
- Shared principles and light data sharing for project evaluation, but funding and core staffing remain with individual organisations.
- Embedded training hub approach: coordinate existing placement activity across sites without central management.





What it looks like for residents

- Visible service improvements in specific areas: coordinated transport booking for medical appointments, community navigators helping access services, allied health outreach to small towns, group-based chronic disease programs, better after-hours mental health support.
- Residents increasingly recognise local providers are working together, even if branding and service entry points remain mostly separate.
- Quick wins in Year 1: Transport coordination operational, first community navigator hired, shared after-hours mental health phone line established, allied health outreach schedule published.

How partners work together

- Alliance Steering Group (CEOs/execs) meets quarterly to review project progress and select priorities for upcoming cycles.
- Every 2-year cycle, partners collaboratively select 6–8 joint projects mapped against the 12 priority elements (minimum 1 project per element category over 5 years).
- Project working groups (operational staff) meet monthly to coordinate delivery, share learnings, and solve practical issues.
- Shared placement calendar coordinates student rotations across ADH*, Y&DMH, aged care, Omnia, and GPs – no central Hub employer, but coordinated scheduling.

8.8.2 Network Option 3 - Community-Centred: Overview

A Community Service Alliance model where each organisation retains full control of its services and workforce, but commits to a shared work program

Community-Centred

Workforce & local training / “learning hub”:

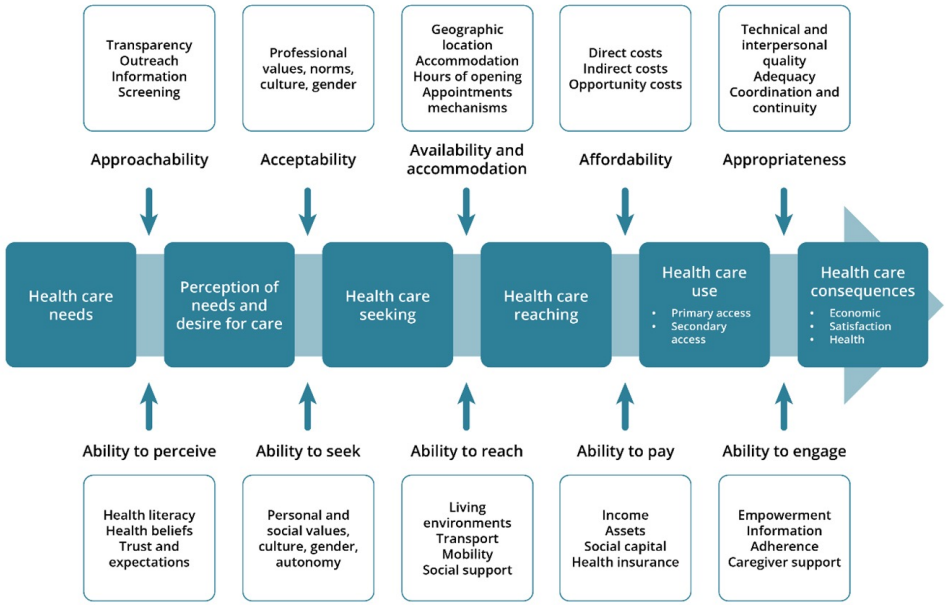
- Embedded Training Hub model: Each organisation commits minimum student placements and supervision hours annually (formal agreement targets):
- ADH: 4-6 placements/year* - Y&DMH: 4–6 placements/year - Aged care providers: 6–8 placements/year combined - Omnia: 3–4 placements/year - Disability services: 2–4 placements/year
- Coordinated placement calendar managed by Alliance Facilitator maximisations student exposure to integrated care pathways (e.g., student experiences hospital → aged care → community health → GP practice over 8-week rotation).
- University/TAFE MoUs for nursing, allied health, and mental health placements, with focus on short rural rotations and project-based student work (quality improvement, pathway mapping, community health promotion).
- Shared supervision networks reduce isolation for part-time clinicians through monthly case discussions, peer learning sessions, and access to metropolitan specialist mentoring (via Eastern Health telehealth).
- Target 12–18 placements per year coordinated across sites, with 2–4 local hires per year emerging from placement pathways.

Funding & viability:

- Total investment: approx. $2.0–2.5M over 5 years
- Funding drawn from multiple discrete grants attached to each project area:
- PHN: Mental health integration, chronic disease programs, care coordination - Regional development: Transport, community health promotion - Aged care: Home care transition support, CHSP enhancement - Rural workforce: Student placement support, supervision

Risks

- x Fragmented effort / "pilotitis" → Structured 2-year cycles with clear project selection criteria; maximum 6–8 active projects; formal exit criteria and evaluation.
- x Short-term grant dependency → Design projects that can scale into business-as-usual if successful; build evidence for future recurrent funding.
- x Limited impact on structural workforce gaps → Position Alliance as stepping-stone to more integrated options; maintain focus on projects that visibly improve community access in near term.
- x Variable participation across partners → Minimum participation commitments in Alliance Agreement; rotate project leadership to distribute workload and build shared ownership.



8.8.3 Network Option 3 - Community-Centred: Overview

A Community Service Alliance model where each organisation retains full control of its services and workforce, but commits to a shared work program

Community-Centred

Digital Enablement

Alliance implements specific project digital needs only: HotDoc booking for allied health outreach, simple shared Google Calendar for transport coordination, Signal/WhatsApp for care team communication. Minimal infrastructure investment; use free/low-cost consumer tools.

Enhanced Local and Clinical Capacity

Alliance Year 1-2 projects: Monthly visiting dental clinic (DHSV Mobile Dental van), podiatry outreach to aged care (2 days/month), after-hours GP coverage arrangement. Funding: RWAV Outreach Support grants ($40-80K), partner service fees.

Preventive Health and Early Intervention Models

Alliance coordinates existing partner prevention activities: Council's Healthy Eating Active Living, community health diabetes group programs, Omnia mental health literacy workshops. Joint application for VicHealth Healthy Eating grants ($30-50K annually). Reduce duplication.

Integrated Mental Health and AOD Services

Alliance project establishes single mental health phone line (1300 number) routing to Omnia, GP mental health nurses, headspace. Modelled on One Door Mental Health (Mind Australia) approach. Funding: PHN Mental Health Access Improvement ($50-90K).

Transport and Access Enhancement

Alliance Year 1 priority project: Coordinated transport booking system using existing Council, volunteer driver, VPTAS resources. Single phone number for medical transport coordination. Funding: Transport Connection Community Transport Program grants ($40-70K annually).

Performance Monitoring and Network Processes

Alliance Facilitator (0.8 FTE) collates project-specific indicators only: transport trips, navigation contacts, joint clinic sessions delivered. Quarterly reporting to Steering Group. Use Victorian Healthcare Association rural benchmarking for context (free participation).

Community Navigator and Care Coordination System

Alliance Year 1-2 project employs 2 FTE community navigators using Community Health Integrated Program (CHIP) model. Based in GP practices/community health, help residents access services. Funding: PHN Care Coordination & Supplementary Services ($80-120K annually).

Ease and Accessibility for Community and Advocates

Alliance develops simple printed service directory and basic website (WordPress template) listing all partner services, contacts, locations, hours. Updated quarterly. Consumer representatives on Alliance Steering Group provide feedback. Low-cost, high-visibility approach.

Workforce Collaboration

Alliance project-based collaboration: Shared after-hours roster pilot (6 months), combined allied health recruitment campaign, joint PD days (quarterly). Partners remain independent employers. Modelled on South West Alliance of Rural Health light-touch collaboration.

Infrastructure and Workforce Retention Support

Alliance leverages existing assets ad-hoc: Council housing for students, partner hot-desk space for visiting clinicians, shared meeting rooms. No new infrastructure. Alliance applies jointly for RWAV Accommodation grants as opportunities arise.

Digitally Enabled Service Delivery Platforms

Alliance uses Coordinate My Care (free Victorian rollout) for project-specific clients only (chronic disease, high ED users). Partners maintain own systems; shared care plans for ~50-80 complex clients annually. Simple templates for joint projects.

Local Training and Workforce Development

Alliance coordinates existing placement activity via shared calendar. Each partner commits minimum placements: ADH* (6), Y&DMH (4), aged care (6), Omnia (3). Alliance Facilitator (0.8 FTE) coordinates logistics. Funding: RWAV Clinical Training Support ($30-60K).

Develop Plan | Gap Analysis | Options Analysis | Business Case

8.9.1 Network Option 4 - Digital-Enabled Overview

Digital-Enabled

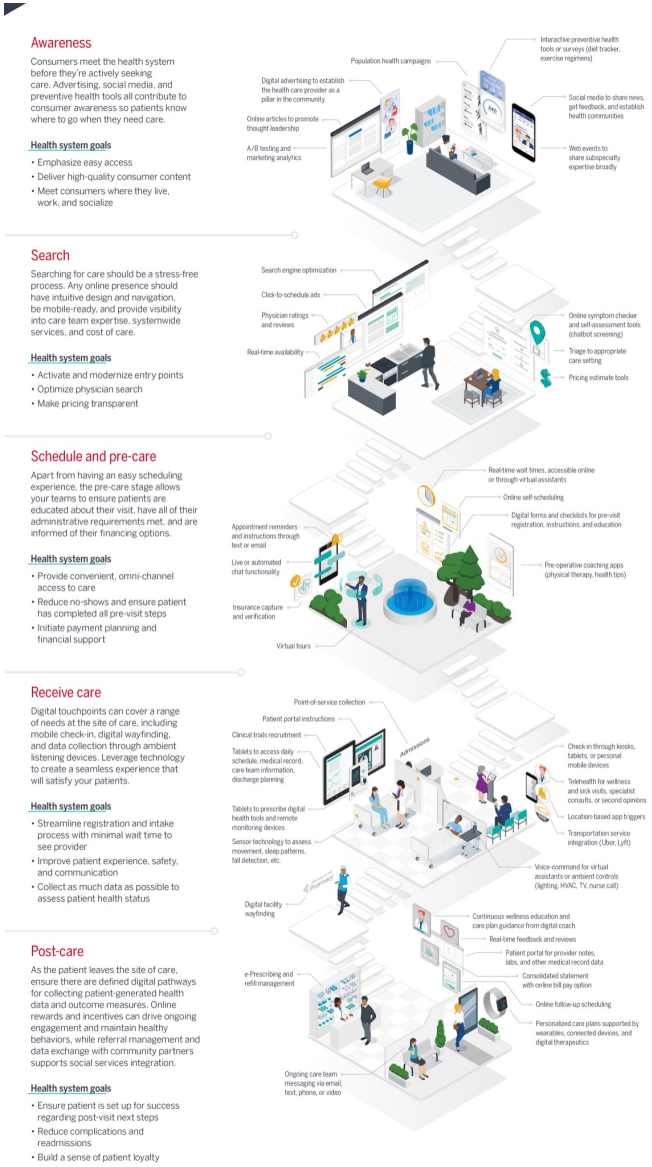
A digitally enabled Murrindindi Digital Health & Learning Network that connects every provider, town and training site through shared virtual care, data and education platforms

Plan Overview

A community-focused digital integration model that uses technology to connect residents with local primary care, community health, aged care, and disability services through coordinated digital platforms. Rather than building telehealth to specialists, Option 4 creates a community health ecosystem where GPs, community health workers, aged care providers, disability support coordinators, and care navigators work seamlessly together using shared digital tools. Over ~5 years, this delivers a single digital front door for community services, remote monitoring for ageing-in-place, virtual multidisciplinary care coordination, and community-based prevention programs - all focused on keeping people well and independent in their communities.

What the plan entails

- Build a single digital front door for residents (phone, web, app, AI platform) that routes people to local services, virtual clinics or after-hours support.
- Implement shared digital tools across partners: common care-planning platform, secure messageing, virtual MDT meetings, e-referrals and shared results.
- Establish region-wide virtual clinics (chronic disease, mental health, paediatrics, oral health triage, aged care in-reach) delivered by local and metropolitan clinicians.
- Use integrated data (hospital, GP, community, aged care, ambulance) to create demand, risk and equity dashboards for the Network Board and partners.
- Offers the greatest potential step change in access and equity, especially for small towns, older residents and people with transport barriers.
- Strong value for workforce – better supervision, peer support and training without needing large on-site specialist teams.



What it looks like for residents

- Residents call one number or visit one website to access information about ALL community services - GPs, community health, physiotherapy, aged care support, disability services, mental health, transport options.
- Older residents living at home have simple monitoring devices (e.g., medication reminders, fall alerts, vital signs monitors) that connect them to community nurses who can intervene early before problems escalate.
- People with chronic conditions receive SMS appointment reminders, educational videos about self-management, and can message their community health nurse or GP practice with questions between visits.
- Families caring for ageing parents can see the care plan online, coordinate with multiple providers (GP, community health, aged care, physio), and know who to contact for different needs.

How partners work together

- Community Health Integration Committee meets monthly to review digital platform usage, identify coordination gaps, plan virtual MDTs.
- Shared care coordination for complex clients: Virtual case conferences (fortnightly) where all providers involved with a resident discuss integrated care planning, with rotating chair across organisations.
- Common digital infrastructure: Partners agree on shared platforms for care planning, secure messageing, appointment coordination - focus on tools that connect community services, not hospital systems.
- Community health data dashboard: Aggregated (de-identified) data showing community health patterns, service access gaps, population health trends to guide joint service planning.

8.9.2 Network Option 4 - Digital-Enabled Overview

A digitally enabled Murrindindi Digital Health & Learning Network that connects every provider, town and training site through shared virtual care, data and education platforms

Digital-Enabled

Workforce & local training / "learning hub":

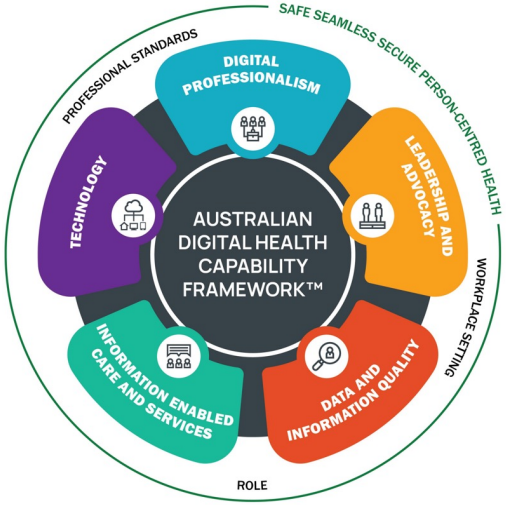
- Health & Learning Hub as Community Health Innovation Centre: Focus on training community health workers, care coordinators, aged care staff, and disability support workers in digital tools, integrated care approaches, and person-centered community-based practice.
- Community health placements: Students experience integrated community health rotations across GP practices, community health, aged care facilities, disability services, and home-based care - learning to coordinate across the community health ecosystem.
- Peer learning networks: Monthly virtual professional development sessions where community health staff share learnings, case studies, challenges - reducing isolation for small rural practices.
- Community health micro-credentials: Short courses in care coordination, health coaching, motivational interviewing, digital health tools - accessible online, relevant to community health workforce.
- Target 18–25 community health placements per year (nursing, allied health, social work, health promotion), with 4–6 local hires per year into community health roles.

Funding & viability:

- PHN flexible funding: Care coordination, digital health navigation, chronic disease prevention
- Aged Care Digital Innovation grants: Remote monitoring for ageing-in-place, virtual aged care support
- NDIS Information, Linkages and Capacity Building: Disability access to digital services
- Commonwealth Primary Care enhancement: GP integration with community health
- Victorian Community Health Innovation: Digital navigation, health literacy programs
- Council/partner contributions (10%): In-kind venues for training, existing IT infrastructure, staff time for platform design

Risks

- X ✗ Digital literacy barriers (especially older residents) → Extensive community education program; volunteer tech mentor network; maintain phone-based access alongside digital; design for simplicity.
- X ✗ Technology platforms don't integrate/interoperate → Start with simple, proven tools (SMS, basic web forms); choose platforms with open APIs; phase integration over time; accept some manual coordination initially.
- X ✗ Privacy and data security concerns → Clear governance protocols; community consultation about data use; adherence to My Health Record framework; regular privacy audits.
- X ✗ Insufficient community uptake → Intensive community engagement and education; partner with trusted community organisations; demonstrate quick wins; offer face-to-face alternatives initially.



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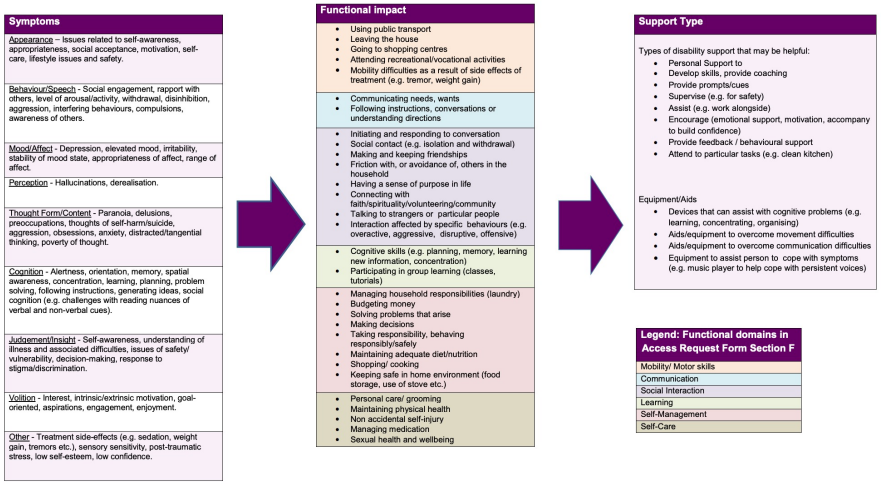


Develop Plan | Gap Analysis | Options Analysis | Business Case

8.9.3 Network Option 4 - Digital-Enabled Overview

A digitally enabled Murrindindi Digital Health & Learning Network that connects every provider, town and training site through shared virtual care, data and education platforms.

Digital-Enabled

Digital Enablement

Implement HealthDirect Service Finder integration, Australian Digital Health Agency My Health Record active engagement, SMS appointment reminders via HotDoc. Build community health digital hub website (one phone number, service directory). Funding: Commonwealth Digital Health grants ($80-150K).

Enhanced Local and Clinical Capacity

Deploy GP2GP telehealth using existing Practice Incentive Program support. Community health nurses access virtual geriatric/paediatric advice via TelehealthConnect (Safer Care Victoria). Monthly virtual MDTs via Zoom Healthcare. Funding: PHN After Hours Program, RWAV Telehealth Support.

Preventive Health and Early Intervention Models

Deliver Chronic Disease Self-Management Program (Stanford) via Zoom, automated SMS health coaching using Get Healthy Service platform, virtual group exercise classes. Funding: VicHealth Digital Health Innovation ($50-100K), PHN Health Promotion commissioning.

Integrated Mental Health and AOD Services

Implement digital One Door Mental Health model (Mind Australia): single phone/web entry integrating Omnia, GP mental health nurses, headspace. Add Beyond Blue NewAccess coaching via phone/video. Funding: PHN Digital Mental Health ($100-180K annually).

Transport and Access Enhancement

Digital transport booking via CoRe Connect (existing transport coordination platform), virtual services reduce travel needs (50% of groups via Zoom), VPTAS application support online. Funding: Transport Connection grants ($50-90K annually).

Performance Monitoring and Network Processes

Implement POLAR GP data extraction, Victorian Healthcare Association rural network benchmarking, real-time community health dashboard via Microsoft Power BI. Quarterly community health reports published online. Automated data collection reduces burden. Funding: PHN Data Analytics support.

Community Navigator and Care Coordination System

Deploy 3-4 FTE navigators with tablets using Coordinate My Care platform. Clients access care plans via MyGov/My Health Record. Modelled on Alfred Health Hospital Admission Risk Program (HARP). Funding: PHN Care Coordination ($120-200K), aged care Support at Home transition funding.

Ease and Accessibility for Community and Advocates

Single digital front door: 1300 number, HealthDirect-integrated website, mobile-friendly booking. Digital health literacy program via Council libraries, tech mentor volunteers. Consumer portal showing appointments, care plans, service options. Funding: Victorian Digital Health Innovation ($100-180K).

Workforce Collaboration

Virtual case conferences (fortnightly) using Zoom Healthcare (HIPAA-compliant), shared on-call via afterhours.gp platform, virtual peer support groups for isolated clinicians. Digital rostering via HealthRoster. Funding: PHN Workforce Innovation, RWAV Professional Development grants ($40-80K).

Infrastructure and Workforce Retention Support

Provide tablets/laptops for mobile community health workers, home monitoring devices via Tunstall Healthcare, WiFi upgrades at community venues for virtual groups. Funding: Aged Care Digital Innovation grants ($80-150K), RWAV Infrastructure Support.

Digitally Enabled Service Delivery Platforms

Implement Coordinate My Care statewide platform (free rollout), POLAR GP data extraction for population health, ResearchMed secure messageing. Care plans accessible to clients via My Health Record. Funding: Commonwealth Practice Incentive Program, Victorian Integrated Care Fund ($150-250K).

Local Training and Workforce Development

Deliver virtual supervision via Zoom Healthcare, online micro-credentials via Australian College of Rural & Remote Medicine, digital health training via Safer Care Victoria eLearning. Students access virtual tutorials reducing travel. Funding: RWAV Education Support, Health Workforce Australia grants.

Develop Plan | Gap Analysis | Options Analysis | Business Case

8.10.1 Network Option 5 – New Network Entity

A unified network entity strengthens coordination, workforce stability and digital integration, creating a seamless system that delivers more consistent, accessible care across Murrindindi.

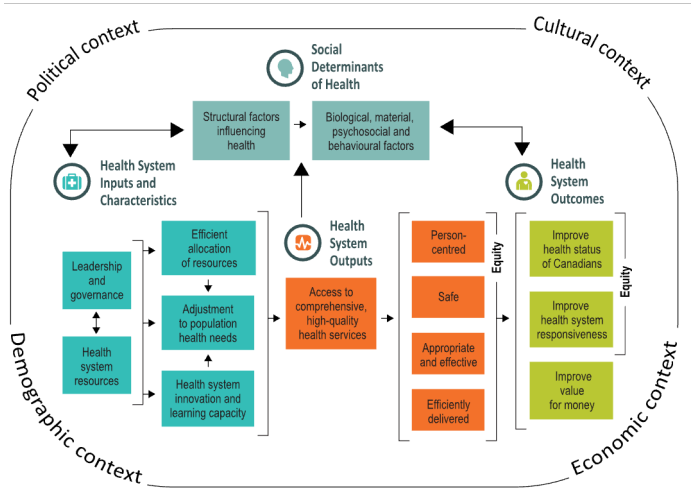
Network Entity

Plan Overview

A unified network entity that provides shared workforce, digital infrastructure, funding coordination and service integration across Murrindindi. Rather than each organisation operating alone, the entity acts as the backbone for navigation, mental health pathways, joint workforce planning, integrated digital tools, and pooled grant delivery. Over five years, this creates a stable, data-driven, professionally governed system that strengthens local services, improves access, and supports sustainable workforce growth—while all providers retain full autonomy over their core operations. The entity unlocks major grants, enables integrated teams, reduces duplication and builds long-term system capability.

What the plan entails

- Establish a Company Limited by Guarantee employing network staff (navigators, MH team, training coordinator, data/finance roles).
- Create shared back-office functions: grant writing, HR support, finance/contract management, IT/digital enablement, communications.
- Hold pooled funding from PHN, State and Commonwealth, enabling larger-scale programs and integrated care teams.
- Implement unified tools – shared care plans, digital coordination systems, integrated transport coordination, prevention program scheduling.
- Strengthen accountability through professional governance, a skilled board and a Network CEO.



What it looks like for residents

- One coordinated system: clearer pathways between hospitals, GPs, aged care, mental health, disability and community services, delivered under a shared integration framework.
- Faster access to joined-up support through navigators, integrated MH pathways, shared care plans and streamlined referrals.
- More services delivered locally or virtually, with better prevention programs, outreach clinics and coordinated follow-up after hospital visits.
- Residents see consistency across providers, reducing confusion about “who does what” and improving continuity of care.

How partners work together

- Members (ADH, YDMH, Omnia, aged care providers, disability providers, Council) become entity members, each retaining full autonomy over their core services.
- A Network CEO and shared services team coordinate integration, workforce, digital and funding activities.
- Entity board governs network roles, pooled grants, digital tools and shared infrastructure; member boards govern their own local services.
- Joint planning occurs through the Alliance Steering Group, ensuring shared priorities, reporting, evaluation and program alignment.

Develop Plan | Gap Analysis | Options Analysis | Business Case

8.10.2 Network Option 5 – New Network Entity

Shared governance and centralised workforce and training functions build a stronger, more sustainable health system, supported by coordinated funding streams and clear risk management.

Network Entity

Workforce & local training / “learning hub”:

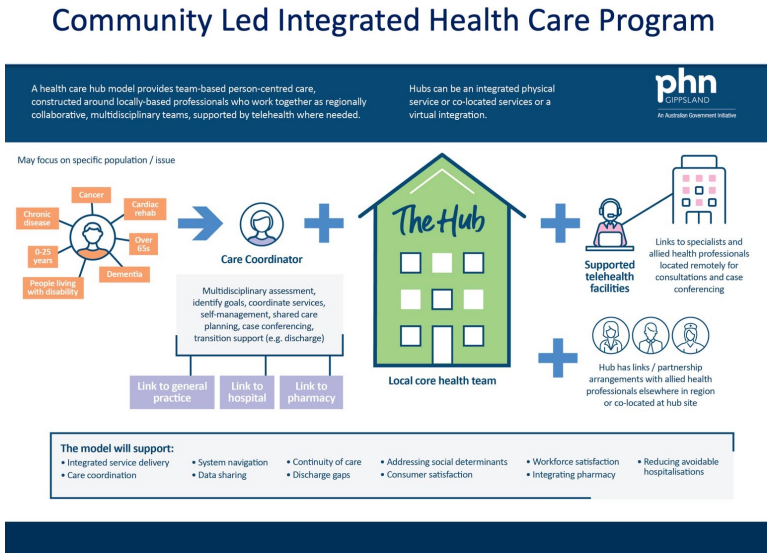
- Entity employs a Clinical Education Coordinator to run the Murrindindi Health & Learning Hub, strengthening local placements, supervision and employment pathways.
- Scales coordinated placements to 40–50 per year, linking hospitals, aged care, disability and primary care into a single training system.
- Builds structured rural pathways: Cert III → EN → RN, disability support, allied health assistant, with local delivery through partner RTOs.
- Enables integrated workforce solutions such as rotating allied health/MH teams, rural graduate pathways with Eastern Health, and shared supervision networks.
- Provides workforce stability: reduced vacancy duration, improved retention, clearer career pathways and coordinated housing options.

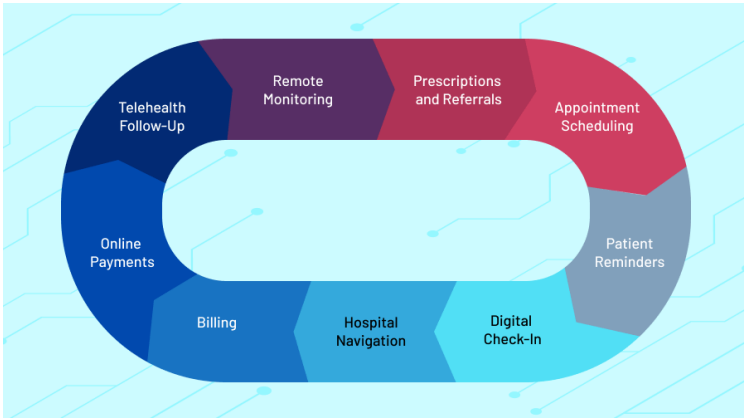
Funding & viability:

- Access to major investment streams requiring a single accountable entity: PHN block contracts, Victorian Network Development funding, rural integration grants.
- Pooled budget of $500k–$800k per year once fully operational, with 85–90% funded externally.
- Members contribute modest cash ($10–25k each) plus in-kind support (supervision, space, IT access), while the entity manages grants, acquittals and reporting.
- Shared services generate significant cost avoidance: reduced duplication, consolidated procurement, streamlined reporting and improved grant success.

Risks

- x Governance complexity → Mitigated through a skilled independent board, clear separation between entity and member responsibilities, and defined escalation pathways.
- x Change fatigue or perceived loss of autonomy → Addressed through transparent communication, opt-in service integration, and retaining full control of core services.
- x Financial sustainability → Managed through diversified funding, staged establishment, and transitioning successful programs into recurrent PHN or State funding.
- x Recruitment for entity roles → Mitigated by clear rural career pathways, competitive employment conditions and integration with Eastern Health training networks.





8.10.3 Network Option 5 – New Network Entity

Twelve priority areas shape how the new entity drives integration by aligning digital, workforce, access, prevention and clinical capability to deliver a connected, future-ready network.

Network Entity

Digital Enablement

The entity provides unified digital governance, contracting and training, enabling shared care planning tools, secure messaging, telehealth platforms and integrated dashboards across all providers. This ensures consistent digital standards and unlocks larger digital health grants.

Enhanced Local and Clinical Capacity

Entity-employed clinicians support integrated chronic disease clinics, post-discharge follow-up and multidisciplinary reviews. Centralised coordination improves coverage across townships and stabilises clinical capacity through pooled roles and rural rotation pathways.

Preventive Health and Early Intervention Models

Pooled funding enables network-wide prevention programs delivered consistently across sites. The entity coordinates scheduling, evaluation and grant acquittals for falls programs, chronic disease groups and health promotion initiatives.

Integrated Mental Health and AOD Services

A network-wide MH team employed by the entity supports integrated triage, shared care plans and coordinated follow-up. Unified governance strengthens links between Omnia, GPs, headspace and regional MH services, improving early intervention and reducing fragmentation.

Transport and Access Enhancement

Entity governance supports unified transport coordination, funding, and digital scheduling. A single accountable organisation strengthens grant eligibility and ensures transport, outreach clinics and access initiatives are consistently delivered shire-wide.

Performance Monitoring and Network Processes

A network-level data function develops shared dashboards, monitors outcomes and reports to all members. The entity standardises KPIs, evaluation cycles and improvement processes, enabling evidence-driven decisions and stronger accountability.

Community Navigator and Care Coordination System

Navigators are employed by the entity, enabling consistent training, supervision and caseload management across the region. Shared care plans and unified governance allow navigators to coordinate across hospitals, GPs, aged care, disability and MH providers seamlessly.

Ease and Accessibility for Community and Advocates

The entity creates a cohesive community-facing system: clearer entry points, more consistent communication, shared digital tools, and unified service information. This reduces confusion, improves access and ensures residents experience the network as a coordinated whole.

Workforce Collaboration

The entity becomes the shared workforce engine—recruiting network roles, coordinating rotations, streamlining HR processes and reducing duplication. This allows flexible deployment of allied health, MH clinicians and navigators across all member sites.

Infrastructure and Workforce Retention Support

Shared services streamline recruitment, onboarding, housing coordination and back-office systems. The entity supports development of key worker accommodation and standardised workforce retention initiatives across all members.

Digitally Enabled Service Delivery Platforms

A single contracting point allows adoption of common platforms (care coordination, telehealth, referral tools, dashboards). Entity-led procurement and digital governance create a consistent user experience for providers and residents.

Local Training and Workforce Development

The entity runs the Health & Learning Hub, coordinating placements, delivering local VET pathways and supporting supervision across sectors. Centralised coordination increases placement volume, strengthens retention and builds a sustainable local workforce pipeline.

8.10 Network Options Analysis – Comparing Future Models

Summary of the four shortlisted network options, comparing governance, cost, workforce model, digital enablement, risk and scalability to support a preferred future Health & Learning Network for Murrindindi.

Summary Comparison Table

Dimension	Option 1: Staged Integration	Option 2: Workforce Collaboration	Option 3: Community-Centered	Option 4: Digitally Enabled Services
Governance	Partnership agreement, no entity	Sessional contracts, Council coordination	Alliance agreement, project-based	LHSN integration, service agreements
Total Investment (5 years)	$3.8–4.2M	$1.8–2.3M	$2.0–2.5M	$2.8–3.5M
External Funding Target	90%	85–90%	90%	85%
Implementation Complexity	Moderate	Low-Moderate	Low	Moderate-High
Workforce Model	Distributed Hub, independent employers	Sessional sharing, Eastern Health rotations	Coordinated placements, independent	Eastern Health employment, rotations
Digital Infrastructure	Incremental upgrades, shared tools	Minimal, coordination focus	Project-specific only	Full platform integration (Eastern Health)
Time to First Benefits	12–18 months	6–12 months	3–6 months	12–24 months
Risk Level	Moderate	Low-Moderate	Low	Moderate
Scalability	High – can build toward entity later	Moderate – depends on workforce availability	Limited – project-based	High – Eastern Health infrastructure
Community Visibility	Moderate – builds gradually	Moderate – improved access	High – quick wins in priority areas	High – new telehealth services
Best Suited For	Partners seeking methodical transformation with manageable burden	Partners wanting practical workforce solutions without entity creation	Partners wanting visible results without major organisational change	Partners ready to leverage grants and metro partnership for rapid access expansion

Reader Notes - Next Steps

The following steps will convert this Options Analysis into a practical, phased Murrindindi Health Network Plan. These steps mirror the project structure and set clear expectations for finalising the preferred network model and supporting business cases

1. Options Analysis Complete

This options analysis has translated current-state evidence and consultation findings into four distinct strategic pathways. The analysis includes:

- Four comprehensive network options addressing the 12 priority elements
- Detailed governance, financial, workforce, and implementation frameworks for each option
- Viability assessment of funding sources, platforms, and partnerships
- Element-by-element specifications showing how each option addresses regional needs
- Risk assessment and mitigation strategies

Outputs: Four validated network options ready for partner review and decision-making.

2. Network Partner Alignment

Following Project Control Group validation, we will engage network partners to align on the preferred strategic direction. This involves:

- Presenting the four options to network members and other partners
- Facilitating structured discussions on viability, preferences, and concerns for each option
- Identifying which elements from different options should be combined into the final network plan (hybrid approach)
- Validating partnership commitments, governance preferences, and implementation readiness
- Confirming funding priorities and external grant targeting strategy
- Building shared ownership and consensus on the network's strategic direction

Outputs: Partner-endorsed preferred option (or hybrid combination), confirmed governance model, partnership commitments, and agreed implementation priorities.

3. Final Network Plan & Business Cases

Following partner alignment, we will develop the final comprehensive network plan and investment-ready business cases. This includes:

- Designing the integrated service and workforce model based on partner-selected option(s)
- Building detailed workforce strategy: roles, recruitment pipelines, training pathways, and retention approaches
- Producing phased 5-year implementation roadmap with sequencing, milestones, and decision gates
- Defining governance framework, partnership agreements, and decision-making structures
- Developing business cases covering problems, options, benefits, costs, risks, and funding pathways tailored for grant applications
- Creating performance dashboard specification and monitoring framework

Output: Final network plan, implementation roadmap, governance framework, and multiple business cases ready for funding submission (early December 2025).

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09

APPENDICES

Appendix A: Hospital Admission Forecasting

The modelling for the projected admission considered population growth, ageing impact, and local health outcome history as the key drivers

Assumptions

Population:

Historical Increase: +1.01%

Ageing Impact:

Strong Age Related: +1.6%

Moderate Age Related : +0.8%

Mixed/Mild Age Related : +0.3%

Local Health History

- **Arthritis burden → Orthopaedics:** +0.6%
- **Higher disability/NDIS → Neurology & General Medicine:** +0.4% (Neuro), +0.3% (Gen Med)
- **Higher mental-health need → General Medicine (non-subspecialty):** +0.2%

Diagnosis	Age Band	Local Uplift	Est % increase
Diagnostic GI Endoscopy	Strong	0	2.61
Ophthalmology	Strong	0	2.61
Non Subspeciality Medicine	Moderate	+0.5%	2.31
Gynaecology	Mild/mixed	0	1.31
Neurology	Strong	+0.4%	3.01
Orthopaedics	Strong	+0.6%	3.21
Endocrinology	Moderate	0	1.81
Haematology	Moderate	0	1.81
Gastroenterology	Moderate	0	1.81
Non Subspecialty Surgery	Mild/mixed	0	1.31
Immunology & infections	Mild/mixed	0	1.31
Respiratory Medicine	Strong	0	2.61
Non Subspecialty Medicine	Moderate	+0.5%	2.31
Clinical Cardiology	Strong	0	2.61
Oncology	Strong	0	2.61

Projected activity by diagnosis in Murrindindi is modelled by applying three compounding drivers to 2024 baseline volumes. The first driver is **population growth**, using an annual increase of approximately 1.01% to reflect expected changes in resident numbers. The second driver is an **ageing uplift**, applied at varying strengths depending on the age-sensitivity of each diagnosis; services such as ophthalmology, cardiology, oncology, neurology and orthopaedics receive stronger uplifts due to well-established utilisation patterns among older cohorts. The third driver is a **local health-burden adjustment**, introduced where regional indicators show above-average need, including higher rates of arthritis, disability and NDIS participation, and mental health diagnoses. **These drivers are applied transparently and compounded year-on-year**, producing forecasts that reflect the combined influence of demographic growth, population ageing and Murrindindi's documented health profile. This approach provides a realistic view of emerging demand pressures and supports planning for capacity, workforce and service allocation.

Appendix B: General Practice (GP) Service Demand and Supply Forecasting

Approach for modelling GP demand using MBS service trends and population-based utilisation forecasts

Data

- **MBS GP attendance data** for 2023–2024 (total service instances for the Murrindindi region).
- Forecasted 2025 activity based on recent historical trends.
- **Population forecasts to 2035**, used to derive long-term demand.
- Assumed GP utilisation rate (services per person per year) derived from baseline service volumes.

Output

- **Current demand** for GP services (2023–2025).
- **Future supply** based on existing workforce capacity (2026–2027).
- **Population-driven GP demand for 2035**, indicating future pressure on service capacity.
- Table summarising annual GP service instances across all projection years.

Limitations

- Trend-based supply projections assume **no change in GP workforce**, recruitment, retirements, or practice closures.
- MBS data does not include:
  - nurse practitioner services
  - urgent care clinics
  - after-hours deputising services
- Utilisation rate is assumed constant over time; does not account for:
  - increased multimorbidity
  - sector-wide GP shortages
  - changes in telehealth uptake
- Long-term demand does not model GP availability, only *need*.

Methodology

Estimating current GP service demand (2023–2025)

Historical MBS service volumes were used to create a short time series (2020–2024). A linear trend was applied to project forward to 2025:

$$ProjectedGPServices_{2025} = a \cdot t + b$$

Forecasting future GP service supply (2026–2027)

To understand capacity based on the current GP workforce, the short-term forecast extends the historical trend under the assumption that:

- GP workforce numbers remain stable
- Average services delivered per GP per year remain unchanged

Thus:

$$FutureSupply_{y} = SupplyTrend_{2024} \times (1 + ghistorical)(y - 2024)$$

This produces supply-side projections for 2026 and 2027.

Estimating long-term GP service demand (2035)

Long-term demand is population-driven. A GP utilisation rate was calculated from the baseline:

$$UtilisationRate = \frac{GPServices_{2024}}{Population_{2024}}$$

This rate is applied to the future population:

$$Demand_{2035} = Population_{2035} \times UtilisationRate$$

Appendix C: Chronic Condition Forecasting

Approach for forecasting chronic-condition activity using population growth and age-sensitivity factors

Data

- Historical activity by major diagnostic category (Cancer, Endocrine, Nervous system, Circulatory, Respiratory, Digestive, Musculoskeletal, Genitourinary, Infectious, Eye, Ear, Skin) from **2016–2023**.
- Categories reflect **aggregated MBS/primary care activity** or **separated diagnostic groupings** from previously supplied datasets.
- Population forecasts for Murrindindi to 2036.
- Age-specific utilisation patterns (older cohorts have higher activity rates across most chronic conditions).

Output

- Forecasted activity by major diagnostic category from **2024 to 2036**.
- Transparent year-on-year growth reflecting:
  - baseline volumes
  - population growth
  - ageing-driven utilisation increases
- A consolidated dataset allowing identification of **highest-growth conditions** (Digestive, Cancer, Circulatory, Musculoskeletal).
- This output underpins workforce, clinic capacity, GP service planning and system-level modelling.

Limitations

- Assumes **constant annual growth rates**; does not account for sudden changes in disease prevalence, technology, or service models.
- Ageing sensitivity factors are **category-level**, not disease-level.
- Activity does not separate:
  - private vs public encounters
  - initial vs follow-up visits
  - in-person vs telehealth

Methodology

Applying population growth uplift

A fixed annual population growth factor was applied to each diagnostic stream:

$$PopUplift_y = (1 + g)$$

Where:

- g = annual population growth rate for the LGA
- Applied uniformly to all diagnostic groups

Applying ageing sensitivity by diagnostic category

Conditions more sensitive to ageing (e.g., Cancer, Circulatory, Musculoskeletal, Eye) received an additional uplift per year:

$$HomeCarePlaces_y = \begin{cases} Strong\ (higher\ annual\ factor) \\ Moderate\ (mid\ factor) \\ Mild\ (small\ factor) \end{cases}$$

Each diagnostic stream therefore grows at a constant, category-specific annual rate, matching the fixed year-on-year increments you see in the data.

Forecast calculation

$$ProjectedActivity_{c,y} = Baseline_{2023c} \times (1 + PopUplift + AgeingUpliftc)^{(y - 2023)}$$

This produces a smooth annual increase consistent with the linear increments in your dataset.

Appendix D: Forecasted Aged Care Demand

Approach for modelling RAC and home-care demand using population forecasts and planning ratios

Data

- **Population forecast (65+):** Used as a proxy for the 70+ cohort due to data availability.
- **National planning ratios** for aged care supply:
  - **Residential Aged Care (RAC):** 7,140 places per 100,000 people aged 70+.
  - **Home Care Packages (HCP):** 230 places per 1,000 people aged 70+.
- Ratios reflect **national planning benchmarks** used to estimate required aged care capacity.

Output

- Projected **RAC place requirements** increasing from **273 (2021)** to **338 (2026)**, **397 (2031)** and **451 (2036)**.
- Projected **home-care place requirements** increasing from ~**880 (2021)** to **1,088 (2026)**, **1,280 (2031)** and **1,454 (2036)**.
- Tables showing population 65+ and required RAC and home-care places across 2021, 2026, 2031, 2036.
- Combined charts displaying 65+ population growth against required aged-care places.

Limitations

- **Use of 65+ population as proxy for 70+** may produce a modest over-estimate of required places.
- **National planning ratios** may not fully reflect utilisation patterns or service availability in a rural context.
- Requirements represent **benchmark capacity**, not actual funded or deliverable service levels.
- Estimates assume **consistent population definitions and ratio applicability** across projection years.

Methodology

Estimating required RAC places

RAC requirements were calculated by applying the national per-capita planning ratio to the projected older population.

$$RACPlaces_y = \frac{Population_{65+,y} \times 7{,}140}{100{,}000}$$

Where:

- y = forecast year
- 65+ population is used as a proxy for the 70+ cohort

Estimating required home-care places

Home-care requirements were derived using the national planning ratio of 230 places per 1,000 older residents.

$$HomeCarePlaces_y = \frac{Population_{65+,y} \times 230}{100{,}000}$$

These figures estimate the number of HCP-equivalent places needed to meet benchmark service levels.

Alignment with existing services

Modelled home-care requirements were compared against the existing baseline of 766 CHSP home-support clients to understand future growth needs.

Appendix E: Forecasted Required Allied Health Demand

Approach for estimating total allied health service demand using per-capita utilisation benchmarks

Data

- **Service demand (per-capita utilisation)**
- Benchmark utilisation: **102.6 allied health services per 100 people per year** (equivalent to **1.026 services per person**).
- Population forecasts for 2026, 2031, 2036.
- **MBS-funded allied health services**
- Actual local MBS-funded allied health services:
  - 2023: **16,255**
  - 2024: **16,540**
  - 2025 (annualised): **18,151**
- Trend-fit projections:
  - 2026: **19,181**
  - 2031: **25,273**
  - 2036: **33,301**

Output

- Projected **total allied health service demand** for 2026, 2031, 2036.
- Trend-based projection of **local MBS-funded** allied health services.
- **Service gap analysis** showing the difference between required services and projected local MBS-funded services.
- Charts/tables illustrating:
  - Required vs projected services
  - Estimated shortfall
  - Growth in demand relative to MBS activity

Limitations

- Per-capita utilisation benchmark does not account for local disease burden, ageing profile or unmet need.
- MBS-funded data excludes services provided via **private payment, NDIS, CHSP, hospital outpatient clinics or community programs**.
- Trend projection assumes stable provider participation, billing behaviour and Medicare policy settings.
- Different allied health disciplines have varying service intensities; benchmark treats them as a combined category.

Methodology

Estimating required allied health service volume

Demand was estimated by applying the per-capita utilisation benchmark to the projected population for each forecast year.

$$RequiredServices_y = \frac{Population_y \times 102.6}{100}$$

Where:

- y = forecast year (2026, 2031, 2036)
- Benchmark reflects average annual utilisation of physiotherapy, OT, podiatry, dietetics, psychology, social work and other allied health services.

This provides an estimate of total allied health service episodes required to meet population need.

Projecting MBS-funded allied health activity

Local MBS-funded activity (2023–2025) was trend-fitted using a linear model:

$$ProjectedMBSServices_y = c \cdot y + d$$

This produces expected MBS-funded service volumes in 2026, 2031 and 2036, assuming current participation, billing patterns and local service availability continue.

Identifying the service shortfall

The gap between required and projected represents the service shortfall.

Appendix F: Forecasted Disability Support Demand

Approach for forecasting NDIS participant demand using disability prevalence and current coverage patterns

Data

- **Current NDIS participant estimate:** ~338 (derived from FY24/25 provider × caseload ratios).
- **Participants per provider:** Average ~0.48 (from four quarterly observations).
- **Total population forecasts** for 2026, 2031, 2036.
- **Prevalence of profound/severe disability:**
  - Local estimate: **6.5%**
  - National benchmark: **7.9%**
- These inputs provide both a **baseline disability need** and a **coverage-based mechanism** for forecasting future NDIS participant numbers.

Output

- Forecasted **NDIS participant numbers** for 2026, 2031 and 2036.
- Forecasted total **profound/severe disability population** under 6.5% and 7.9% prevalence scenarios.
- Tables comparing underlying disability need with the expected share receiving NDIS-funded supports.
- Provides a forward view of **demand for disability services** independent of provider or workforce constraints.

Limitations

- The 34.5% coverage ratio is derived from current patterns and assumes **no future changes to NDIS access, eligibility, or early-intervention reforms**.
- Does not incorporate **age structure**, specific diagnostic growth, or functional severity changes across cohorts.
- Prevalence-based demand does not reflect **unmet need** or **service avoidance** (e.g., people eligible but not enrolled).
- Does not account for potential **policy-driven participant reclassification** or planned NDIS reform impacts.

Methodology

Estimating needs-based disability demand

Projected total disability need was calculated by applying prevalence assumptions to the forecast population base.

$$Need_y^{6.5\%} = Population_y \times 0.065$$

$$Need_y^{7.9\%} = Population_y \times 0.079$$

Where:

- y = forecast year
- Values represent all people with profound or severe disability who may require disability support (NDIS-funded or otherwise).

Projecting NDIS participants

The current NDIS coverage ratio was calculated as:

$$Coverage = \frac{338}{978} \approx 0.345$$

Where 978 = estimated number of people with profound/severe disability in 2026 at 6.5% prevalence.

Future NDIS participant numbers are projected by maintaining this coverage rate:

$$ProjectedNDISParticipants_y = Needy^{6.5\%} \times 0.345$$

This reflects expected participant growth assuming stable eligibility criteria, access pathways and scheme settings.

Appendix G: Forecasted Mental Health Demand

Approach for forecasting mental-health prevalence using PHIDU rates and population growth

Data

- **PHIDU Social Health Atlas (PHN and LGA data)**, December 2024 release.
  - Provides prevalence of **mental-health diagnosis or long-term mental condition** per 100,000 population.
  - Derived from AIHW modelled small-area estimates.
- **Population forecasts** for Murrindindi for 2026, 2031 and 2036.
- Baseline prevalence rate (per 100,000) taken from the latest PHIDU reporting period.
- These inputs provide the baseline mental-health need for the LGA.

Output

- Forecasted number of people with a **mental-health diagnosis or long-term mental health condition** for 2026, 2031 and 2036.
- Chart showing clear upward trend driven by population growth and ageing.
- Summary table linking:
  - baseline PHIDU rate
  - forecasted population
  - projected cases per year
- This provides a high-level estimate of **mental-health service demand** relevant to primary care, community mental-health services, psychology, and crisis response.

Methodology

Converting prevalence into number of affected residents

The PHIDU rate was applied to the forecasted population for each projection year:

$$PeopleWithMHCondition_y = \frac{Population_y \times RateMH}{100{,}000}$$

Ageing-adjusted uplift (implicit)

Because mental-health burden typically increases with age and the region's older cohort grows over time, a fixed ageing sensitivity factor was added to the projection. This results in:

- Moderate annual growth rather than flat scaling
- Smooth, linear increases as shown in the chart (2026→2031→2036)

Mathematically represented as:

$$ProjectedMH_y = BaselineMH \times (1 + g_{pop} + g_{age})^{(y\ -\ 2023)}$$

Limitations

- PHIDU estimates are modelled and may differ from local service utilisation or diagnostic patterns.
- Prevalence rates are **held constant**, meaning projections do not capture:
  - changes in diagnostic practice
  - increased community awareness
  - unmet need not captured in surveys
- Age-specific prevalence was not applied directly (PHIDU does not provide age-band mental health rates).
- Does not differentiate:
  - severity levels
  - episodic vs chronic illness

Appendix H: Forecasted AOD Service Demand

Approach for forecasting alcohol and other drug-related admissions and harmful consumption using AODstats baseline rates and population growth

Data

- **AODstats (Alcohol and Other Drugs Knowledge Centre)** – national dataset providing:
  - Volume of **alcohol and other drug-related hospital admissions**
  - Rates of **harmful alcohol consumption** per 100 people
- Latest available AOD admission and consumption rates for Murrindindi.
- **Population forecasts** for 2026, 2031 and 2036.
- AOD risk patterns indicating higher prevalence among:
  - younger adults
  - socioeconomically disadvantaged groups
  - people with comorbid mental-health conditions
- These datasets form the baseline for projecting future AOD-related demand.

Output

- Forecasted **AOD-related hospital admissions** for 2026, 2031, 2036.
- Forecasted **harmful alcohol consumption rate per 100 people** for each projection year.
- Line chart illustrating proportional growth in harmful consumption and admissions over time.
- Table linking baseline rates, ageing adjustments and projected population.

Limitations

- Admissions projections assume **stable statewide admission rates** and do not capture sudden changes in service availability, policing, or harm-minimisation policy.
- Harmful consumption estimates do not differentiate between binge drinking, chronic heavy use, and drug-specific risk groups
- Age-sensitivity factor is applied at the **population level**, not per-cohort level.
- AODstats data may underrepresent **unreported or untreated AOD harm**, particularly in rural areas.

Methodology

Estimating AOD-related admissions

Baseline AOD-related admission rates (per 100,000 population) from AODstats were applied to forecasted population for each projection year:

$$Admission_y = \frac{Population_y \times AdmissionRate}{100{,}000}$$

Adjusting for demographic risk and ageing

Because harmful alcohol use and drug-related hospitalisations rise with age — and the LGA's older adult population is growing — a small ageing-sensitivity factor was applied:

$$ProjectedAdmissions_y = BaselineAdmissions \times (1 + gpop + g_{age})^{(y - 2023)}$$

Ageing-adjusted uplift (implicit)

PHIDU and AODstats provide harmful alcohol consumption as a rate per 100 people. This rate was held constant and scaled using the ageing-adjusted growth factor:

$$HarmfulConsumption_y = BaselineRate \times (1 + g_{age})^{(y - 2023)}$$

Appendix I: Forecasted Oral Health Demand

Approach for estimating preventive oral-health demand using local risk indicators

Data

- **Local oral-health risk indicators** (Murrindindi profile):
  - Food insecurity: **15.3%** (Vic: 12%)
  - Daily smoking: **6.0%** (Vic: 5.9%)
- **Population forecasts** for 2026, 2031, 2036.
- These indicators are used as **proxies** for elevated oral-health service need, particularly for public or subsidised dental care.

Output

- Forecasted number of adults at elevated risk for oral-health issues (food insecurity and daily smoking).
- Estimates of implied **additional preventive dental visits per year** required to meet need.
- Tables showing high-risk population counts and associated preventive-visit requirements for 2026, 2031 and 2036.

Limitations

- Risk groups may **overlap** (e.g., smokers experiencing food insecurity); totals may therefore **overstate** unique individuals.
- Risk indicators reflect **correlates**, not direct measures of dental disease or treatment need.
- Assumes one additional preventive visit per high-risk adult; does not reflect variation in clinical need or treatment intensity.
- Does not incorporate **child oral-health data**, treatment waiting lists, or public dental service capacity.

Methodology

Identifying population at elevated oral-health risk

Risk-exposed populations were estimated by applying local prevalence rates to forecast population totals.

$$RiskFoodInsecurity_y = Population_y \times 0.153$$

$$RiskDailySmokers_y = Population_y \times 0.06$$

Where:

- y = forecast year
- Values represent adults with increased likelihood of preventable oral disease or unmet dental need.

Estimating preventive dental demand

This provides an indicative estimate of additional oral-health activity required to meet preventive needs.Where 978 = estimated number of people with profound/severe disability in 2026 at 6.5% prevalence.

Future NDIS participant numbers are projected by maintaining this coverage rate:

$$ProjectedNDISParticipants_y = Needy^{6.5\%} \times 0.345$$

This reflects expected participant growth assuming stable eligibility criteria, access pathways and scheme settings.

Appendix J: Staff Survey

Overview of the correspondent of the staff survey survey, which shared across the Murrindindi Health Network

42 responses
Total responses

76%
Own a house or have a mortgage

0-20 kilometers
Distance to travel to work

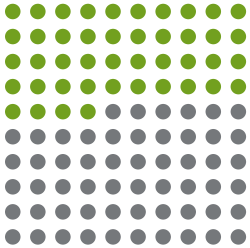
33%
Obtained diploma

36%
Undertaking further education

41%
Considering undertaking further education

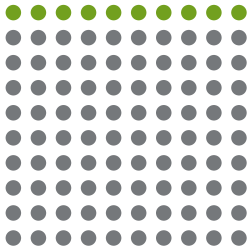
Work in Healthcare

44%



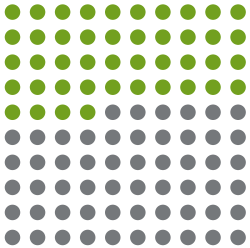
Work in Disability Support

10%



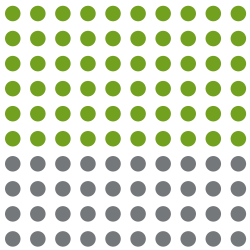
Work in Aged Care

44%



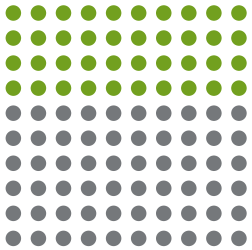
Clinical Staff

60%



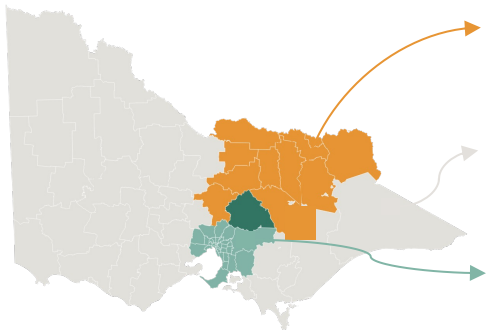
Non-clinical Staff

40%



10%
Relocated to the shire for their current roles

Mental Health Clinicians, RN, and EN
As the top roles



50%
Move from within the Hume region

25%
Move from other Victorian region

25%
Move from Melbourne

Identified Challenges

Accommodation

Finding a community group or social connection

Accessing health services

Employment opportunity for self or partner

Appendix J: Staff Survey - Healthcare

Findings are based on staff survey feedback and regional workforce research, mapping how attraction and retention factors differ across career stages in Murrindindi's healthcare sector

Early Workforce

25-44	0-20 km	Bachelor / Diploma	Part-time
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Location and convenience	Workload and physical demands
Career development opportunities	Organisational culture challenges
Work hours and rostering flexibility	Travel requirements
Pay and financial stability	Career change
Supportive culture and team environment	

Mid Careers

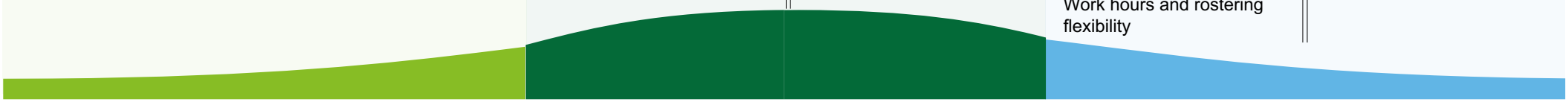
25-44	20-50 km	Bachelor	Part time
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Alignment with organisational mission	Lack of management support
Organisation's brand and reputation	Organisational culture challenges
Location and convenience	Travel requirements
Career development opportunities	High workload
Supportive culture and team environment	
Nature of the work	

Late Career

45-64	0-20 km	Bachelor / Master	Part time / Full-time
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Location and convenience	Retirement or transition to reduced hours
Nature of the work	
Career development opportunities	Limited professional development or changing role needs as they age
Work-life balance	
Pay and financial stability	Travel requirements
Alignment with organisational mission	
Work hours and rostering flexibility	



<1 year | 1-2 year | 2-5 year | 5-10 year | 10-15 year | >15 year

Most healthcare staff live locally and work part time, reflecting a community-based workforce. Except mid-career employees who often commuting 20 to 50 kilometres, which increases travel time, workload across sites and turnover risk. This group is most affected by fatigue and limited management support. Early-career staff are motivated by flexibility and growth, while late-career staff prioritise balance and meaningful roles. Retention efforts should focus on reducing travel demands for mid-career staff and creating adaptive, mentoring-based roles for experienced clinicians

Appendix J: Staff Survey - Aged Care

Findings are drawn from staff survey responses and sector research, showing how attraction and retention factors differ across early, mid, and late career stages in Murrindindi's aged care workforce

Early Workforce

18-24	0-20 km	Diploma	Part time
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Financial stability	Pay and limited professional development opportunities
Location and convenience	
Work hours and rostering flexibility	Desire for career change
Work-life balance	Travel requirements
Alignment with organisational mission	
Supportive and well-resourced workplace	

Mid Careers

25-44	0-20 km	Diploma / Cert III	Part time
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Financial stability	Pay and limited professional development opportunities
Location and convenience	
Supportive culture and team environment	Desire for career change
Nature of the work	Travel requirements
Work hours and rostering flexibility	
Alignment with organisational mission	

Late Career

45-64	0-20 km	Diploma	Part time
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Location and convenience	Retirement or transition to reduced hours
Nature of the work	
Supportive culture and team environment	Physical and emotional fatigue
Work hours and rostering flexibility	
Financial Stability	
Work-life balance	
Quality workplace conditions and facilities	

Most staff across career stages work part time and live within short commuting distance of their workplace, reflecting a strong localised workforce. Pay, flexibility, and supportive culture remain consistent motivators across all cohorts. However, limited professional development and travel requirements emerge as shared reasons for turnover. Late-career staff value work-life balance and quality workplace conditions, indicating that flexible rostering and recognition of experience will be central to long-term retention.

Appendix J: Staff Survey - Disability Support

Insights are drawn from staff survey responses and regional workforce evidence, illustrating how attraction and retention factors shift across career stages in Murrindindi's disability support sector

Early Workforce

45-64	0-20 km	Cert III	Part time
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Financial stability	Pay and limited professional development opportunities
Location and convenience	Desire for career change
Work hours and rostering flexibility	
Employee benefits	
Alignment with organisational mission	
Quality workplace conditions and facilities	

Mid Careers

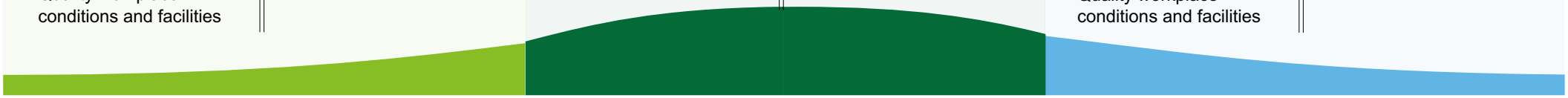
45-64	0-20 km	Cert III	Full time
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Financial stability	Travel requirements
Location and convenience	Desire for career change
Supportive culture and team environment	Limited professional development
Nature of the work	Workload and administrative pressures
Work hours and rostering flexibility	
Work-life balance	

Late Career

75+	0-20 km	Bachelor	Casual
Years old	Commute distance	Qualification	FTE

What Attracts Staff to the Job	What Drives Staff to Leave
Location and convenience	Desire for reduced hours / less intensive duties
Nature of the work (type of clients, service model)	Retirement
Supportive culture and team environment	Physical and emotional fatigue
Work hours and rostering flexibility	
Work-life balance	
Quality workplace conditions and facilities	



The disability support workforce skews older, with many staff entering the sector mid- or late-career, often after transitioning from other professions. Most work part time and live locally, valuing stability, supportive teams, and purpose-driven work. Travel requirements, limited progression pathways, and physical demands are shared reasons for exit. Sustaining this workforce will depend on recognising their experience, offering flexible duties, and promoting pathways for mentoring or peer-support roles to extend tenure.

Appendix K: Clinical health workforce vs optimal ratios

Approach for modelling workforce supply and assessing gaps against optimal ratios

Data

Headcount by profession (GPs, medical practitioners, RNs, ENs, midwives, dentists) for 2020–2023, sourced from the Network's workforce dataset.
Population projections for Murrindindi (total population).
Optimal workforce ratios per 100,000 population used for requirement modelling:

- GP = 115
- Medical practitioner (total) = 375
- RN = 1,000
- EN = 275
- Midwife = 65

Ratios reflect **national planning benchmarks** and provide the reference level for estimating required workforce capacity.

Output

- Workforce projections showing **future supply vs benchmark requirement** for each profession.
- Quantified **workforce gaps** for 2026, 2031 and 2036.
- Tables and line charts illustrating supply, requirement, and gap trajectories.

Limitations

- A short time series (four years) means **trend projections may be sensitive to year-to-year variability**, especially for small professions.
- Analysis uses **headcount rather than FTE**, which may overstate supply for professions with significant part-time employment.
- Optimal workforce ratios are **national benchmarks** and may not fully reflect service delivery realities in a rural setting.
- Projections assume **consistent data definitions** across years; any changes in reporting may affect comparability.

Methodology

Workforce supply projection

A linear model was fitted to the historical headcount series (2020–2023) for each profession.

$$ProjectedHeadcount_{y,p} = ap \cdot y + bp$$

Where:

p = profession

y = forecast year (2026, 2031, 2036)

a_p,b_p = parameters estimated from the fitted trendline for profession

Boundary rule: If the projection produced negative values for low-volume professions, headcount was constrained at zero.

Calculating required workforce

Required headcount was derived by applying the optimal ratio to projected population.

$$RequiredHeadcount_{y,p} = \frac{Population_y \times OptimalRatiop}{100{,}000}$$

This gives the benchmark-aligned workforce size needed to service the projected population in year y.

Workforce gap analysis

The workforce gap represents the difference between the projected supply and the benchmark requirement.

Appendix L: Aged Care Workforce Requirements and Supply Projections

Approach for estimating aged-care workforce requirements and projecting residential care provider supply

Data

- **Residential aged care (RAC)**
  - Direct care requirement: **200 minutes per resident per day**.
  - Annual FTE capacity: 1 FTE=38 hrs/week=1,976 hrs/year≈118,560 minutes/year
  - Resulting FTE per RAC place: $\frac{200\times365}{118560} \approx 0.62$ FTE
  - Additional **15% allowance** for supervision, leave and rostering logistics → ≈0.70 FTE per RAC place
- **Home care**
  - Average direct care time: **2–2.5 hours per client per week** (≈115 hrs/year).
  - Resulting FTE per home-care place: $\frac{115}{1976} \approx 0.06$ FTE
- Headcount data for **2023 and 2024**, broken into full-time, part-time, and casual staff.

Output

- Required FTE for **residential aged care** and **home care** across 2021–2036.
- Comparison of required RAC and home-care FTE against residential aged-care provider headcount trajectories.
- Stacked workforce charts showing evolving workforce mix (FT, PT, casual).
- Tables illustrating demand-side FTE requirements vs supply-side workforce levels.

Methodology

Required RAC and home-care FTE

Required FTE is derived by multiplying the FTE-per-place ratio by the modelled number of required places (from your Aged Care Demand appendix).

$$FTE_{RAC,\,y} = RequiredRACPlaces_y \times 0.70$$

$$FTE_{HC,\,y} = RequiredHomeCarePlaces_y \times 0.06$$

Where:

$y \in \{2021, 2026, 2031, 2036\}$

Residential aged-care workforce projections (provider supply)

To illustrate potential workforce supply trajectories, a simple headcount projection was applied:

1. Headcount was **summed across Darlingford and Kellock** for each category (FT, PT, casual).
2. A linear extrapolation from 2023 → 2024 was applied to generate indicative staff counts for: $y \in \{2021, 2026, 2031, 2036\}$
3. Total workforce supply estimated as: $TotalStaff_y = FT_y + PT_y + Casual_y$

Limitations

- FTE-per-place ratios are based on national averages and may not fully capture **acuity variation**, night-shift requirements or rural workforce constraints.
- Home-care FTE assumptions reflect **direct care hours only**, excluding travel time, administration, case management or multidisciplinary inputs.
- Provider workforce projection relies on **only two data points**, making the trend highly speculative; results should be interpreted as indicative only.
- Provider headcount data represents **headcount, not FTE**, with no adjustment for hours worked or casual loadings.
- Does not incorporate **volatility in recruitment, turnover, or agency staffing**, which materially affect RAC workforce availability.

Appendix M: Future Allied Health Workforce Supply

Approach for projecting public allied health workforce supply and assessing the gap to benchmark requirements

Data

- **Public allied health workforce (supply)**
  - Historical FTE for:
    - **Allied Health – Science**
    - **Allied Health – Therapy**
  - From **Alexandra** and **Yea** health services, 2017–2023.
  - Aggregated to form a single public allied health FTE series.
- **Benchmark requirement**
  - Target allied health workforce benchmark: **250–300 FTE per 100,000 population**.
  - Mid-point applied for modelling: **275 FTE per 100,000**.
- **Population forecasts**
  - Total population for 2026, 2031 and 2036.

Output

- Public allied health FTE trend showing **actual (2017–2023)** and **projected (2026–2036)** supply.
- Benchmark-aligned required FTE for 2026, 2031 and 2036.
- Workforce gap analysis comparing:
  - projected public FTE
  - required benchmark FTE
  - resulting workforce shortfall
- Charts illustrating FTE trajectories and the size of the supply gap.

Limitations

- Public allied health data covers **only Alexandra and Yea services**; private, NGO, NDIS-funded and itinerant providers are not included.
- Linear extrapolation from a **short and potentially noisy** time series may not reflect future recruitment or funding changes.
- Benchmark ratio applies an **average across all allied health disciplines**; local skill-mix or service-model differences are not captured.
- Uses FTE, not headcount; actual service capacity may vary due to part-time patterns, vacancies and casual staffing.

Methodology

Projecting public allied health FTE

Historical FTE from Alexandra and Yea was combined to create a 2017–2023 time series. A linear trend was fitted and extended to future forecast years:

$$ProjectedFTE_y = a \cdot y + b$$

Where:

- $y \in \{2021, 2026, 2031, 2036\}$
- Model provides an indicative trajectory of public-sector allied health workforce supply.

Estimating benchmark-aligned allied health FTE

Required FTE was calculated by applying the benchmark ratio to forecast population:

$$RequiredFTE_y = \frac{Population_y \times 275}{100{,}000}$$

This represents the recommended allied health workforce needed to service the local population at benchmark levels.

Identifying the workforce gap

The workforce gap represents the difference between the projected supply and the benchmark requirement.

Appendix N: Future Disability Workforce Supply

Approach for estimating disability support worker FTE under population need

Data

- **Projected NDIS participants** for 2026, 2031 and 2036 (from demand modelling using a 34.5% coverage assumption).
- **Prevalence-based disability estimates:**
  - Local estimate: **6.5%** of population with profound/severe disability.
- **Support intensity assumption:**
  - People with profound/severe disability require, on average, **9–10 hours of paid support per week**.
  - With a 38-hour FTE week → **0.25 FTE per person** (≈ 4 clients per support worker).
- These inputs allow estimation of total disability-support FTE required and the share likely to be funded/serviced through NDIS.

Output

- Forecasted **needs-based FTE** required to support all people with profound/severe disability (6.5% and 7.9% scenarios).
- Forecasted **NDIS-funded FTE** implied by projected NDIS participants.
- Quantification of the **FTE gap** representing unmet or informally met support needs.
- Tables comparing:
  - Disability cohort size
  - Required FTE (population-based)
  - NDIS-linked FTE
  - Resulting FTE shortfall

Methodology

Needs-based support worker FTE (all people with profound/severe disability)

Represents the total paid support workforce needed to service the entire disability cohort, regardless of funding source.

$$SupportFTE_y^{6\cdot5\%} = Need y^{6\cdot5\%} \times 0.25$$

Where:

$y \in \{2026, 2031, 2036\}$

Need_y is the projected number of people with profound/severe disability.

This produces a population-level FTE requirement.

NDIS-linked support worker FTE

Represents the paid workforce implied by NDIS-funded participants only.

$$NDISSupportFTE_y = ProjectedNDISParticipantsy \times 0.25$$

This reflects the portion of support delivered through NDIS plans rather than through informal care or mainstream supports.

Limitations

- The assumption of **0.25 FTE per person** is an average; support needs vary substantially across disability types and levels.
- Does not account for **complex participants** requiring significantly more than 10 hours/week.
- FTE modelling does not capture **travel inefficiencies, casualisation, or part-time patterns**, which are common in rural disability support work.
- Uses projected NDIS participants derived from current **coverage ratios**; future policy reforms may change eligibility or support intensity.
- Does not include the workforce implications of **informal care substitution**, respite needs, or capacity constraints among local providers.

Appendix O: Data Utilised

A summary of key data sources used to inform planning and assessment, including internal reports provided by network members and state and national data

Research Name	Category	Brief Description	Used
Victorian Government Department of Health, System Planning – Inpatient and Emergency Department data products (2024)	Service Activity	Provide and analysis on where residents of Murrindindi Shire go for what type of admitted care, which includes acute admitted activity by residents of Murrindindi Shire by district and emergency presentations by residents of Murrindindi Shire by District	Future State - Local Service Demand: Hospital Demand Analysis
National Disability Insurance Agency, Provider dataset – Participants by Local Government Areas (2025)		The National Disability Insurance Agency (NDIA) Provider dataset reports the number of active NDIS providers operating within each Local Government Area. The dataset outlines quarterly counts of registered providers and average participants per provider, supporting analysis of service availability and market capacity at a local level.	Future State - Workforce: Disability Services' Supply
CGP Clinic Mansfield, active patient and appointment data, retrieved August 2025		CGP Clinic Mansfield provided de-identified patient utilisation data outlining active patients from Murrindindi and their appointment attendance over the past 12 months. The dataset reflects cross-border GP use patterns and helps quantify demand leakage to neighbouring primary care providers.	Future State - Local Service Demand: GP Leakage
GEN (AIHW Aged Care Data), People using aged care by region – Residential Care (service location), 30 June 2024		This GEN dataset reports the number of people living in residential aged care facilities by service location as at 30 June 2024. It provides a snapshot of residential care utilisation and supports assessment of local bed availability and aged care capacity.	Future State - Local Service Demand: Current & Projected Aged Care Service Demand Analysis
GEN (AIHW Aged Care Data), People using aged care by region – Home Support (recipient location), 2023–24		This GEN dataset provides counts of people receiving Commonwealth Home Support Programme (CHSP) services by recipient location in 2023–24. It offers insight into the scale and geographic distribution of older adults accessing entry-level aged care support across the region.	Future State - Local Service Demand: Current & Projected Aged Care Service Demand Analysis
Australian Institute of Health and Welfare, Medicare Benefits Schedule (MBS) funded services, last updated 27 November 2025		The Australian Institute of Health and Welfare (AIHW) publishes Medicare Benefits Schedule (MBS) data that records every GP and allied health service claimed under Medicare. The dataset provides counts of GP and allied health service instances by year, showing how many Medicare-funded GP and allied health consultations residents receive.	Future State - Local Service Demand: GP and Allied Health Demand and Supply Analysis & Forecasting
AODstats (Alcohol and Other Drugs Knowledge Centre), volume of admissions and harmful consumption dataset	Health Outcome	AODstats provides national and regional data on alcohol- and drug-related harm, including mortality, hospitalisations, and harmful consumption. The platform compiles data from AIHW, ABS, and state health agencies into an accessible, regularly updated dataset for public health analysis.	Future State - Local Service Demand: Current & Projected AOD Service Demand Analysis
National Disability Insurance Agency, Participant dataset – Participants by Local Government Areas (2025)		The NDIA Participant dataset provides quarterly counts of NDIS participants by Local Government Area. It includes the number of active participants and demographic distribution, enabling estimates of local demand for disability services and comparison across reporting periods.	Future State - Local Service Demand: Current & Projected Disability Demand
PHIDU, Social Health Atlas (PHN and LGA data), published December 2024		The PHIDU Social Health Atlas (PHN and LGA data) provides demographic, health status, and service-use indicators aligned to the 2021 ASGS geography. The December 2024 release includes mental health–related diagnostic prevalence, enabling analysis of the scale and distribution of mental illness across the region. This dataset supports population health profiling and informs local service planning.	Future State - Local Service Demand: Current & Projected Mental Health Demand

Appendix O: Data Utilised

A summary of key data sources used to inform planning and assessment, including internal reports provided by network members and state and national data

Research Name	Category	Brief Description	Used
PHIDU, Social Health Atlas (LGA data), published September 2025	Health Outcome and Workforce	The PHIDU Social Health Atlas of Australia provides detailed population and social health indicators at the Local Government Area level. It compiles demographic, socioeconomic, health status, service access, healthcare workforce, and risk factor data using national sources aligned to the 2021 ASGS. The dataset supports place-based analysis by presenting comparable, standardised metrics across LGAs.	Future State - Local Service Demand: - Forecast Health Conditions' Demand Based on Needs - Current & Projected Disability Demand - Current & Projected Oral Health Service Demand Future State - Workforce: Murrindindi Healthcare Workforce Headcount & FTE (GP, Medical Practioner, Specialist, RN, EN, Midwives, Support Worker)
Alexandra District Health, average monthly FTE workforce data (2023–2024)	Workforce	Alexandra District Health supplied average monthly FTE workforce data for nursing, medical support, and seasonal clinician roles across 2023 and 2024. The dataset provides insight into staffing capacity and workforce composition within the primary and acute care services based in Alexandra.	Future State - Workforce: Current and Historic Average Monthly FTE
Yea & District Memorial Hospital, average monthly FTE workforce data (2023–2024)		Yea & District Memorial Hospital provided average monthly FTE workforce data for 2023 and 2024, covering nursing, medical support, and seasonal clinician categories. The information outlines local workforce capacity and supports understanding of service delivery capability within the Yea catchment.	Future State - Workforce: Current and Historic Average Monthly FTE
Kellock Lodge Alexandra, ACNC Annual Information Statement – workforce data (2021–24)		Kellock Lodge Alexandra's ACNC Annual Information Statement provides self-reported workforce data for the 2023–24 period, including full-time, part-time, casual and volunteer staffing. This information supports analysis of the organisation's operational capacity and contributes to regional estimates of the aged care workforce.	Future State - Workforce: Current and Historic Headcount of Workforce (full-time, part-time, casual, and volunteer)
Darlingford Upper Goulburn Nursing Home Inc., ACNC Annual Information Statement – workforce data (2021–24)		Darlingford Upper Goulburn Nursing Home Inc.'s ACNC Annual Information Statement outlines workforce composition for 2023–24, detailing full-time, part-time, casual and volunteer staff levels. The dataset informs understanding of workforce availability and service capability within the local aged care sector.	Future State - Workforce: Current and Historic Headcount of Workforce (full-time, part-time, casual, and volunteer)
Victorian Government Department of Health, Knowledge Bank – Health Workforce FTE dataset (2020)		The Knowledge Bank Health Workforce dataset provides full-time equivalent (FTE) counts across key clinical, nursing, and allied health roles. The 2020 dataset presents standardised workforce estimates that support benchmarking and workforce planning across Victorian regions.	Future State - Workforce: Current, Projected, and Future Requirement of Allied Health Workforce Supply
BDC Partnership, "Community Partnerships" overview (2025)		The BDC Partnership site describes how Bradford District & Craven has organised 13 Community Partnerships — networks of statutory, voluntary and community organisations working locally (30,000–50,000 population footprints). It explains how these community-level partnerships collaborate with primary care, local government, and the VCSE sector to address inequalities, tailor services to local needs, and deliver integrated health and social care through a bottom-up, community-driven model.	Future State – Benchmarking And Literature Review: Desktop Review Case Study

Appendix O: Data Utilised

A summary of key data sources used to inform planning and assessment, including internal reports provided by network members and state and national data

Research Name	Category	Brief Description	Used
Murray PHN, "Rural Healthcare Hubs funded" media release (2024)	Case Study	This media release announces funding for the Rural Healthcare Hubs initiative under the IHN Alliance, outlining the planned service integration across multiple rural health services within the Murray PHN region. It helps contextualise regional primary care planning, partnerships, and the establishment of integrated community health models through the Integrated Health Network Alliance (IHN).	Future State – Benchmarking And Literature Review: Desktop Review Case Study
Powell N, Dalton H, Perkins D, Considine R, Hughes S, Osborne S, Buss R, Our Healthy Clarence: A Community-Driven Wellbeing Initiative, International Journal of Environmental Research and Public Health (2019)		This peer-reviewed article documents the development and outcomes of the 'Our Healthy Clarence' initiative, a community-led mental health and wellbeing program in northern NSW. It outlines the collaborative governance model, local engagement approach, and multi-sector partnerships that shaped the initiative, highlighting how rural communities can build sustainable, locally driven responses to mental health challenges. The case provides an example of effective place-based planning and collective impact in a regional Australian context.	Future State – Benchmarking And Literature Review: Desktop Review Case Study
Funders Forum on Accountable Health, Imperial County ACH: Case study (2018)		This case study provides an in-depth overview of the Imperial County Accountable Community for Health (ACH) in southern California, detailing the governance structure, portfolio of community health interventions, funding and sustainability strategies, and implementation challenges. It outlines efforts across clinical care, social services, community engagement, and public health — offering a practical example of a multi-sector partnership model aiming to improve population health, care quality, and equity. This makes the report a valuable reference when discussing integrated community-health models or regional health-service design in rural/regional contexts.	Future State – Benchmarking And Literature Review: Desktop Review Case Study
The King's Fund, Place-Based Partnerships Explained (2022)		This UK publication outlines what place-based partnerships are, their purpose, typical population scale, and how they integrate health, social care, community services and local government to deliver outcomes tailored to local needs. It explains the governance structures, roles, and expected functions of these partnerships — providing a conceptual and policy framework that helps contextualise international examples such as the Bradford model.	Future State – Benchmarking And Literature Review: Desktop Review Case Study
BDC Partnership, "Community Partnerships" overview (2025)		The BDC Partnership site describes how Bradford District & Craven has organised 13 Community Partnerships — networks of statutory, voluntary and community organisations working locally (30,000–50,000 population footprints). It explains how these community-level partnerships collaborate with primary care, local government, and the VCSE sector to address inequalities, tailor services to local needs, and deliver integrated health and social care through a bottom-up, community-driven model.	Future State – Benchmarking And Literature Review: Desktop Review Case Study

Opportunities and Grants

Examples of select opportunities list to be mapped to final network plan, final list to be provided upon completion

Program/Initiative/ Platform	Type	Provider/Source	Amount/Value	Viability	Specific Application to Option 1	Evidence/Notes
RWAV Clinical Training Funding	Funding	Rural Workforce Agency Victoria	$150-250K annually	HIGH	Fund 0.6 FTE Clinical Education Coordinator role, supervision payments to partners, student accommodation support	Y&DMH already has GOTAFE pipeline showing readiness; La Trobe RUSON participation demonstrates capacity
RWAV Workforce Innovation Grants	Funding	Rural Workforce Agency Victoria	$80-200K per project	HIGH	Fund Network Coordination Office establishment (Year 1), shared workforce arrangements, visiting specialist clinics	Similar grants funded Loddon Mallee clinic-sharing models; ideal for network coordination establishment
PHN Care Coordination & Supplementary Services (CCSS)	Funding	Murray PHN	$120-180K annually	HIGH	Fund 2-3 FTE care coordinators for complex clients (chronic disease, high ED use, post-discharge)	Omnia and YD&MH already commissioned by Murray PHN showing established relationship; CCSS explicitly for care coordination
PHN Mental Health Stepped Care Commissioning	Funding	Murray PHN	$80-120K annually	HIGH	Integrated mental health pathways, embedded MH clinician at ADH/Y&DMH, coordination with Omnia services	Murray PHN currently commissions Omnia; network-level commissioning logical extension
HealthPathways	Platform	HealthPathways Community	Free + minimal annual license	HIGH	Clinical decision-support for GPs and community health, standardised referral pathways, reduce variation	Free for rural Victorian LGAs; widely adopted across Victoria; proven effective for small rural networks
Coordinate My Care	Platform	Safer Care Victoria	Free	HIGH	Shared care planning for complex clients, visible to all providers including GPs, community health, aged care	Statewide Victorian rollout ongoing; no cost barrier; addresses care coordination priority
La Trobe RUSON (Rural Undergraduate Support & Coordination)	Program	La Trobe University	Partnership (no cost)	HIGH	Coordinate nursing student placements, support supervision, "learn where you live" pathways Cert III→EN→RN	Y&DMH already participates; established relationship; supports 15 placements/year target
GOTAFE Partnerships	Program	GOTAFE	Partnership (minimal cost)	HIGH	Cert III Aged Care, EN programs, local delivery at Alexandra/Yea sites, transition pathways for displaced forestry workers	Y&DMH consultation specifically mentions GOTAFE nursing students feeding into local workforce - proven pipeline
RWAV Accommodation Grants	Funding	Rural Workforce Agency Victoria	$30-70K	HIGH	Upgrade Council's existing Eildon key worker housing (4 units), support student short-term accommodation	Council already has housing stock; consultation notes emphasise accommodation as critical success factor
Transport Connection Community Transport Program	Funding	Dept of Transport Victoria	$40-80K annually	HIGH	Expand existing Council community transport, coordinate volunteer driver schemes, integrate with appointment booking	Council already operates transport; consultation notes identify transport as major barrier (50% reduction in missed appointments target)
Practice Incentive Program (PIP) - Digital Health	Funding	Commonwealth (via ADHA)	$50-100K annually across practices	HIGH	GP practice implementation of HotDoc booking, secure messageing (Argus), My Health Record active use	Existing program, automatic eligibility for participating practices; no special application required
Victorian Healthcare Association Small Rural Health Services Benchmarking	Program	VHA	Free for members	HIGH	Network-level benchmarking (preventable hospitalisations, GP-sensitive admissions, workforce metrics), peer learning	Free participation; provides context for performance monitoring without building custom systems
RWAV Infrastructure Support Grants	Funding	Rural Workforce Agency Victoria	$50-150K	MODERATE-HIGH	Hot-desk clinical spaces at Alexandra/Yea Hub sites, telehealth equipment, training room upgrades at existing facilities	ADH has land for expansion, Y&DMH developing gym/clinical spaces - infrastructure readiness demonstrated
Council In-Kind Contributions	Resource	Murrindindi Shire Council	In-kind ~$80-120K annually	HIGH	Office space for Network Coordination Office (1.0 FTE), meeting venues, community transport coordination, existing key worker housing	Consultation notes: Council strategic priority is health workforce; twice applied for Regional University Study Hub funding

Opportunities and Grants

Examples of select opportunities list to be mapped to final network plan, final list to be provided upon completion

Program/Initiative/ Platform	Type	Provider/Source	Amount/Value	Viability	Specific Application to Option 1	Evidence/Notes
Eastern Health LHSN Integration Funding	Funding	Victorian Dept of Health (via LHSN)	$100-200K	MODERATE-HIGH	Support Eastern Health employment of 3-4 FTE graduates rotating to Murrindindi (60-70% local time), digital platform access	Consultation notes: Statement of Expectations driving "more care closer to home"; workforce rotations explicit opportunity identified by Eastern Health COO
Community Interlink Workforce Development Model	Partnership /Framework	Community Interlink	Partnership leverageing RTO relationships	HIGH	Leverage established NDIS workforce training, "Earn and Learn" approaches, extend to health system roles (PCAs working across health/aged care)	Consultation notes: Community Interlink explicitly identified as having successful workforce development model, RTO partnerships, growing capacity
RWAV Workforce Innovation Grants	Funding	Rural Workforce Agency Victoria	$80-150K per project	HIGH	Fund Council-based workforce coordination function (1.5 FTE), establish sessional workforce database/scheduling system, shared supervision support	Specifically designed for innovative workforce-sharing arrangements; Option 2's sessional model ideal fit
Health Workforce Australia Rural Generalist Training Program	Funding	Commonwealth	$150-250K for structured rotations	MODERATE	Fund structured rotation program for Eastern Health-employed nurses/allied health with majority time in Murrindindi	Rural generalist programs explicitly supported; addresses recruitment burden while building local capacity
PHN Care Coordination & Supplementary Services (CCSS)	Funding	Murray PHN	$80-120K annually	HIGH	Fund care coordination functions leverageing existing Omnia model, extend to aged care settings via Community Interlink	Omnia already delivers PHN-commissioned care coordination; extension to aged care/broader community logical
HealthShare Victoria Workforce Solutions	Platform	Safer Care Victoria	Subsidised access	HIGH	Relief register for shared casual coverage across sites, formalised sessional contract templates, shared on-call arrangements	Addresses high locum/agency use (22% baseline); provides framework for ADH/Y&DMH shared theatre nurse rotations
Coordinate My Care	Platform	Safer Care Victoria	Free	HIGH	Shared care plans for clients receiving services from multiple sessional providers across sites, ensure continuity despite rotation	Free; addresses coordination challenge of sessional workforce model
RWAV Accommodation Grants	Funding	Rural Workforce Agency Victoria	$30-70K	HIGH	Support Council key worker housing for Eastern Health rotating staff, short-term accommodation for sessional clinicians	Consultation notes emphasise accommodation as critical success factor for rotations; Council has existing Eildon housing
Eastern Health Clinical Supervision Framework	Resource	Eastern Health	Partnership resource	HIGH	Established supervision structures for rotating graduates, virtual case conferences, professional development for Murrindindi-based staff	Consultation notes: Eastern Health COO explicitly mentions supervision as critical success factor they can provide
Omnia Existing Care Coordination Model	Resource/Partnership	Omnia Primary Health	Existing capacity to leverage	HIGH	Extend proven Omnia care coordination approach to broader community via sessional arrangements, share coordination expertise with partners	Consultation notes: Omnia has established care coordination; sessional model can scale this expertise across network
Council Coordination Capacity	Resource	Murrindindi Shire Council	In-kind coordination + procurement framework	HIGH	Council hosts workforce coordination function (1.5 FTE), uses existing procurement frameworks to facilitate sessional contracts between partners	Council procurement expertise reduces administrative burden; neutral coordinator role maintains partner autonomy
PHN Mental Health Integration Funding	Funding	Murray PHN	$60-100K annually	HIGH	Sessional mental health clinician outreach to aged care facilities (Dame Pattie), ADH/Y&DMH wards, GP practices	Consultation notes: Omnia mental health clinicians well-positioned for sessional outreach; addresses gap in aged care mental health
GOTAFE Partnership	Program	GOTAFE	Partnership + potential RTO funding	HIGH	Certificate III programs deliverable locally, sessional arrangement with ADH/Y&DMH aged care for trainee placements	Consultation notes: Y&DMH-GOTAFE pipeline proven; sessional model extends this to aged care sector via Community Interlink
Loddon Campaspe Network Shared On-Call Model	Framework	Loddon Campaspe rural health services	Framework reference (no cost)	MODERATE-HIGH	Proven model for ADH/Y&DMH shared after-hours nursing/allied health coverage via sessional arrangements	Evidence-based approach addressing after-hours gaps; consultation notes show willingness to share management roles already
Practice Incentive Program (PIP) - Digital Health	Funding	Commonwealth (via ADHA)	$50-100K annually across practices	HIGH	GP practices implement tools supporting sessional clinician coordination (online booking, secure messageing for visiting clinicians)	Minimal new infrastructure needed; leverages existing systems; PIP funds optimisation

Opportunities and Grants

Examples of select opportunities list to be mapped to final network plan, final list to be provided upon completion

Funding / Program / Initiative / Platform	Type	Provider / Source	Amount / Value	Viability	Specific Application to Option 3	Eligibility
PHN Flexible Funding Pool (Mental Health, Chronic Disease, AOD, Navigation, After-Hours)	Recurrent / Commissioning	Victorian Primary Health Networks	$150k–$600k per project	**High**	Community navigator, chronic disease care coordination, AOD navigation, after-hours mental health line, outreach calendar	Health services, NGOs, councils, community orgs; must address PHN priorities and demonstrate service integration
Rural Health Innovation Fund (RHIF)	Competitive Grant	Victorian Department of Health	$100k–$600k per project	**High**	Alliance projects, shared-care pathways, transport pilots, digital coordination, outreach	Public health services, ACCHOs, rural providers; must improve regional access or workforce capacity
Rural Health Multidisciplinary Training (RHMT) Program	Workforce / Education	Commonwealth Department of Health (via universities)	Variable per placement; in-kind + student fees	**High**	12–18 placements/year, supervision network, training hub, rotating rural exposure	Universities partnering with rural services; services must host students + provide supervision
Workforce Incentive Program (WIP) – Multidisciplinary Teams	Workforce Incentive	Commonwealth Department of Health	Varies – supports allied health & nursing embedding in GP teams	**Medium**	Chronic disease outreach, integrated allied health, MH workers in GP spaces	GP clinics + allied health teams; must expand access to multidisciplinary care
Community Transport Program Grants	Transport / Access	Vic Dept of Transport + Local Council	$20k–$150k	**High**	Year 1 transport coordinator, medical transport pilot, volunteer driver coordination	Local councils, community orgs; must improve transport disadvantage
Better at Home / Virtual Care Expansion	Digital / Telehealth	Victorian Department of Health	$50k–$400k	**Medium–High**	Telehealth supervision, remote mentoring, shared case discussions	Health services implementing telehealth-supported care pathways
Healthy Communities / Health Promotion Funding (VicHealth & State)	Prevention	VicHealth / Victorian Government	$30k–$250k	**High**	Prevention pilots, community-led wellbeing groups, AOD prevention, MH literacy	Local services, NGOs, councils; must address wellbeing, prevention, equity
Regional Development Australia (RDA) – Place-Based Grants	Regional Development	Australian Government	$50k–$300k	**Medium**	Cross-agency workforce model, digital coordination tools, integration pilots	Organisations delivering regional growth, access, workforce or digital uplift
Stronger Communities Programme (SCP)	Infrastructure / Equipment	Australian Government	$2.5k–$20k	**High**	Shared equipment, digital tools, meeting rooms, small infrastructure for outreach	Community-based orgs; requires federal MP nomination; small capital only
Aged Care Transition / Better Care Fund	Aged Care / Integration	Australian Government / Aged Care	Variable	**Medium**	Aged care transitions, chronic disease supports, joint care coordination	Aged care providers, health services, councils; must link to improved community care
Philanthropy (Gandel Foundation, Myer Foundation, HMS Trust, Movember, Beyond Blue)	Project Grants	Philanthropic Trusts	$20k–$500k	**Medium–High**	Navigation, prevention, youth MH, community connectors, outreach	Not-for-profits, health services, community groups; must demonstrate rural equity focus
Innovative Models of Care (IMOC) Program	Service Innovation / Workforce	Victorian Department of Health	$200k–$1.5M depending on proposal scale	**High** – directly designed for integration, collaboration, and rural workforce reform	Funds Alliance-style care models, shared workforce models, extended scope roles, chronic disease integration, care coordination, community navigation, multidisciplinary team trials, telehealth-supported care, and place-based pilots	Public health services, ACCHOs, and eligible community providers; proposals must demonstrate innovation, measurable access improvements, multi-agency collaboration, and alignment with Victorian Care Reform directions

Opportunities and Grants

Examples of select opportunities list to be mapped to final network plan, final list to be provided upon completion

	Program / Initiative / Platform	Type	Provider / Source	Amount / Value	Viability	Specific Application to Option 3	Evidence / Notes
Victorian Digi-Health	**Regional Health Infrastructure Fund (RHIF)**	Capital infrastructure & ICT	Victorian Department of Health	~$790m program; individual grants from ~$200k to multi-million	**High** – proven regional capital fund, strong alignment	Fund shared telehealth rooms, digital clinical workstations, PACS access, network upgrades across Alexandra, Yea, Marysville, Kinglake, RACFs	Supports digital infrastructure upgrades; used extensively across rural Victoria
	Better at Home	Virtual care & home-based care program	Victorian Government	$120.9m initial + $698m later expansion	**High** – direct alignment with virtual care	Underpin virtual ward, remote monitoring, virtual outpatient programs across towns; embed standardised remote kits	Statewide initiative promoting telehealth and virtual care
	GP Innovation Grants (Dementia/MCI Models of Care)	Practice-level innovation grants	Victorian Department of Health	$45,000 per GP practice	**Medium** – dementia-focused but flexible for digital workflows	Seed funding for GP-level digital adoption, shared pathways, tele-geriatric MDTs, data sharing templates	Supports innovative models of care in general practice
	Victorian Health Grants Portal (Telehealth & Community Health)	Multi-stream (telehealth, community health, innovation)	Victorian Gov (Health Grants Portal)	Varies by stream (typically $50k–$500k)	**Medium–High** depending on stream	Pilot telehealth models, shared chronic disease digital pathways, digital care coordination tools	Central portal for all DoH programs
	Victoria's Digital Future Now / Gigabit State / Connecting Victoria	Digital connectivity infrastructure	Victorian Government	~$626m across 6 years	**High** – already funded and rolling out	Underpin network-wide broadband & mobile reliability; ensure every provider, campus, community centre and training facility has baseline connectivity	Targets regional broadband and mobile blackspots
Commonwealth	**Commonwealth Virtual Care & Hospital Outreach Package**	Virtual care, outreach, aged care upskilling	Commonwealth Government	~$882.2m	**High** – direct alignment with virtual care and outreach	Fund virtual care workforce, remote monitoring, hospital-in-the-home, digital escalation pathways and aged care virtual support	National budget measure 2024–25
	Innovative Models of Care (IMOC)	Rural primary care model grants	Commonwealth (previous rounds)	Historically $200k–$1.5m per project	**Medium** – round closed but strong precedent	Extend Yea IMOC project principles into region-wide virtual care and digital service navigation	Supports trials of new rural care models
Murray PHN	**Murray PHN – Digital Health Program**	Digital enablement for primary care	Murray PHN	Mostly in-kind support; occasional small grants	**High** – directly in region	Onboard all GPs, allied health, AOD, mental health into shared digital platforms; staff training & secure messageing	PHN mandate includes digital capability uplift
	Murray PHN – Digital Health for Aged Care	Digital upgrades, devices, IT support	Murray PHN	Grants provided to 75 RACFs previously	**High** – strong fit for aged care digital enablement	Digitally enable Alexandra/Yea RACFs; integrate them into virtual ward and tele-GP models	Supports virtual access and after-hours care
	Murray PHN Telehealth Training & Support	Training and capability building	Murray PHN	Delivered through PHN programs	**High** – easy access	Embed into a Murrindindi training hub; standardise telehealth workflows; upskill staff	PHN provides telehealth guidance, templates, governance
Workforce	**Workforce Training Innovation Fund (WTIF)**	Workforce & skills development	Victorian Government (Skills First)	$50k–$5m	**High** – ideal for a learning network	Fund digital health micro-credentials, simulation training, care coordinator upskilling, rural virtual care competencies	Funding for innovative industry-training co-design
	Skills Solutions Partnerships	Co-designed workforce solutions	Victorian Skills Authority	Varies (project-based)	**Medium–High**	Fund a Digital Health Learning Hub with TAFEs/unis + health services; multi-provider training pathways	Supports partnership-based training design
	Local Philanthropy (e.g., FRRR, local trusts)	Community health innovation	Philanthropic	$5k–$50k typical	**Medium**	Co-fund digital literacy, equipment, community training, youth and seniors' tech engagement	Often supports rural digital inclusion