

National Strategic Framework for Rural and Remote Health

Foreword

The National Strategic Framework for Rural and Remote Health has been developed through collaboration between the Commonwealth, and State and the Northern Territory governments by the Rural Health Standing Committee. It presents a national strategic vision for health care for Australians living in regional, rural and remote areas.

The Framework recognises the unique challenges of providing health care in rural and remote Australia and the importance to all Australians of providing timely access to quality and safe health care services, no matter where they live.

Significant consultation was undertaken across all jurisdictions with policy makers, peak bodies, such as the National Rural Health Alliance, and a wide range of other rural stakeholder groups to inform development of the Framework. The time, input and advice of all involved is acknowledged and appreciated.

The Framework is intended for use by all engaged in the planning, funding and delivering of health services in regional, rural and remote Australia – governments, communities, local health service providers, advocacy and community groups and members of the public. It aims to identify the systemic issues that most require attention to improve health outcomes for rural and remote Australians, such as access; appropriate models of care; a sustainable workforce; the development of collaborative partnerships; and, governance approaches, ensuring that differences between health services and communities are respected and without impeding local planning.

The Framework will provide continuity of strategy development and provide the foundation to support a nationally coordinated approach to effective service delivery, whilst enabling flexibility to recognise local circumstances.

The National Strategic Framework for Rural and Remote Health was endorsed by the Standing Council on Health at their meeting on 11 November 2011. The Rural Health Standing Committee will continue to promote and use the Framework to support policy development; health care planning; and, program delivery in the changing landscape of Australian health care in the years to come.

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Executive summary

The planning, design, funding and delivery of quality, contemporary health care is universally a complex and challenging task.

This is irrespective of setting, community and population characteristics, economic circumstances and individual health status.

In rural and remote Australia the complexity is magnified by unique characteristics and challenges. These necessitate the development and application of a dedicated framework which supports a nationally coordinated approach that is also adaptable to local conditions.

Health care planning, programs and service delivery models must be adapted to meet the widely differing health needs of rural communities and overcome the challenges of geographic spread, low population density, limited infrastructure and the significantly higher costs of rural and remote health care delivery.

In rural and remote areas, partnerships across health care sectors and between health care providers and other sectors will help address the economic and social determinants of health that are essential to meeting the needs of these communities.

Purpose and scope

The National Strategic Framework for Rural and Remote Health promotes a national approach to policy, planning, design and delivery of health services in rural and remote communities.

The Framework has been developed through the Australian Health Ministers' Advisory Council's (AHMAC) Rural Health Standing Committee (RHSC)¹ with the valued input of the National Rural Health Alliance and a wide range of other rural health stakeholders.

The Framework is directed at decision and policy makers at the national, state and territory levels. It emphasises the need for health and prevention services, programs, workforce and supporting infrastructure designed to meet the unique characteristics, needs, strengths and challenges experienced in rural and remote parts of the country.

By providing this direction and identifying the systemic issues that most require attention, the Framework aims to improve health outcomes and return on investment for rural and remote Australians.

While primarily a tool for government, the Framework may also be useful to communities, local health service providers and community groups to help identify and develop new and innovative ways to address specific needs or unique characteristics of their local area or region.

The Framework is designed to encompass the full range of health-related services provided in rural and remote settings. This includes prevention and screening, early intervention, treatment and aged care services, and the delivery of specific health services including primary health care, hospital and emergency care, mental health, dental health, maternity health and preventative health.

¹RHSC is a standing committee established under the Australian Health Ministers' Advisory Council (AHMAC) to provide advice on, and to progress, national issues relevant to improving health services in rural, and remote Australia. Membership of the RHSC comprises the Australian Government and the governments of all States, the Northern Territory, and New Zealand.

It also recognises the needs of specific population groups, including older people, babies and children, Aboriginal and Torres Strait Islander people, people with chronic disease, refugees and people from culturally and linguistically diverse backgrounds.

Why a Framework for Rural and Remote Health?

In January 2009 the Australian Health Ministers' Advisory Council (AHMAC) tasked the Rural Health Standing Committee (RHSC) to develop a National Strategic Framework for Rural and Remote Health that would:

- define an agreed vision and direction for rural health
- define an agreed set of national rural health priorities, reflecting common issues and challenges across jurisdictions
- align with the timetable and directions of the national health reform agenda and process
- align with state and territory initiatives in rural and remote health.

This new strategic approach builds on the previous framework document, *Healthy Horizons: a Framework for Improving the Health of Rural and Remote Australians. Outlook 2003-2007* ('Healthy Horizons 2003-2007').

The focus is set with a broad policy perspective, identifying the key priority issues that commonly face rural and remote health services and service delivery. It allows the Commonwealth, states and territories to continue to develop and implement health and other related policies and plans, yet highlights the need for governments to consider the potential implications and application of these policies and plans in rural and remote settings.

By promoting a concerted effort across several fronts targeting the design, delivery and structure of health services, enhancing health technologies and infrastructure, supporting the health workforce and community capacity, the Framework will help this nation move towards its overall health goals, and reduce the inequalities in health outcomes and service delivery that are currently experienced by rural and remote Australians.

The National Strategic Framework for Rural and Remote Health

Vision

People in rural and remote Australia are as healthy as other Australians.

To achieve this Vision, the Framework sets the following goals:

Goals

Rural and remote communities will have:

1. Improved access to appropriate and comprehensive health care
2. Effective, appropriate and sustainable health care service delivery
3. An appropriate, skilled and well-supported health workforce
4. Collaborative health service planning and policy development
5. Strong leadership, governance, transparency and accountability.

Outcome areas

The Framework addresses each goal under five outcome areas. These are:

Outcome area 1: Access

Outcome area 2: Service models and models of care

Outcome area 3: Health workforce

Outcome area 4: Collaborative partnerships and planning at the local level

Outcome area 5: Strong leadership, governance, transparency and performance.

Under each outcome area, the Framework sets out the objectives and strategies that have been developed to help achieve each goal.

The rural context

For the purpose of this Framework, the term ‘rural and remote’ is used to encompass all areas outside Australia’s major cities. This includes areas that are classified as inner and outer regional (RA2 and RA3) and remote or very remote (RA4 and RA5) under the Australian Standard Geographical Classification System (see Box 1).

In terms of total land area, the largest remoteness category is ‘very remote’ or RA5. This category covers over 5.5 million km² (72.5%) of Australia, with ‘remote’ (RA4) the second largest at 1.02 million km² (13.2%). The ‘outer regional’ (RA3) and ‘inner regional’ (RA2) categories respectively cover 10.8% and 3.2% of Australia’s land area. A map of Australia’s remoteness areas is provided in Figure 1.

Major urban centres within inner and outer regional areas are considered to be within the context of this Framework. These centres have a key role in providing a hub for health care for rural and remote communities, including preventative healthcare, specialist outreach and emergency retrieval services, infrastructure and training centres.

It is widely accepted that remote and very remote communities experience particular issues and challenges associated with their geographic isolation and so the Framework acknowledges the need to differentiate between remote and rural (or regional) Australia.

As at June 2009, 68.6% of the population resided in Australia’s major cities. Of the total population, 29.1% resided in regional areas and just 2.3% lived in remote or very remote Australia (ABS 2010a).

Table 1: Estimated Resident Population by Remoteness (2009)

	Estimated Resident Population (2009)	Percent of total population
Major Cities	15,068,655	68.63%
Inner Regional	4,325,467	19.70%
Outer Regional	2,062,966	9.40%
Remote	324,031	1.48%
Very Remote	174,137	0.79%
Total	21,955,256	100.00%

Source: Adapted from ABS (2010). Regional Population Growth, Australia, 2008-09

Outside our capital cities, the largest population growth in 2008-09 occurred along the Australian coast. High growth rates were recorded in the regional areas of the Gold Coast, Sunshine Coast, Townsville and Cairns in Queensland, Lake Macquarie in New South Wales, and in Capel, Mandurah and Port Hedland in Western Australia.

Population declines mainly occurred in inland rural Australia, particularly in the north-east and south-east of Australia and in parts of rural Western Australia. Some declines were in areas strongly associated with mining activity, including Broken Hill (New South Wales) and Coolgardie (Western Australia).

Box 1: Classifying ‘remoteness’

The Australian Standard Geographical Classification – Remoteness Areas system (ASGC-RA) is a geographic classification system that was introduced on 1 July 2010.

Developed by the Australian Bureau of Statistics, the ASGC-RA allows quantitative comparisons between ‘city’ and ‘country’ Australia. The ASGC-RA classification system is based on 2006 Census data, and allows data from census collection districts to be classified into broad geographical categories called Remoteness Areas (RA’s).

The RA categories are defined in terms of the physical distance of a location from the nearest urban centre (i.e. access to goods and services) based on population size.

There are five RA categories under the ASGC system:

RA1 – Major Cities of Australia

RA2 – Inner Regional Australia

RA3 – Outer Regional Australia

RA4 – Remote Australia

RA5 – Very Remote Australia

Health services

Health services in rural and remote areas are very different to their city counterparts.

Facilities are generally smaller but play a vital role in the provision of community-wide integrated health services that may include mental health services, oral health, community and aged care, and social services.

Rural and remote health services are more dependent on primary health care services, particularly those provided by General Practitioners (GPs). Facilities are generally smaller, provide a broad range of services (including community and aged care), have less infrastructure and locally available specialist services, and provide services to a more dispersed population.

These characteristics usually create some unique challenges for health services delivery. However, they also provide opportunities for innovation. Rural and remote services can benefit from innovative approaches such as multi-disciplinary care, using new technologies in the diagnosis and care of patients, and training and expanding scopes of practice for doctors, nurses and other health care workers. The many and varied services provided through rural and remote facilities enables their communities to host interesting, professionally satisfying and meaningful jobs.

Such innovations have contributed towards improvements in access to health services and the quality of care for many rural and remote Australians. In addition, the integrated nature of rural and remote health services places them in a particularly strong position to pursue, and benefit from, the primary care agenda of the current national reforms.

Yet it is widely recognised that further reforms and improvement are still necessary. Health service planning and delivery have traditionally been developed in the context of metropolitan settings. This has resulted in service models and models of care that are better designed to meet the needs of larger cities and towns than those of rural, regional and remote communities.

Traditional training approaches and funding mechanisms have led to the uneven distribution of health care professionals across the country.

This can be seen in the disparity in the number of health care professionals between metropolitan and the most remote parts of the country. For example, in 2006 very remote areas had (AIHW 2009):

- 58 generalist medical practitioners per 100 000 population (compared to 196 per 100 000 in capital cities)
- 589 registered nurses per 100 000 population (compared to 978 per 100 000 in major cities)
- 64 allied health workers per 100 000 population (compared to 354 per 100 000 in major cities).

Almost a quarter (23%) of people living in outer regional and remote areas felt they waited longer than was acceptable for an appointment with a GP, compared with 16% of those living in major cities. People living in outer regional and remote areas were also four and a half times as likely as those living in major cities to travel over one hour to see a GP (ABS 2011).

In addition to needing to travel further to access health services, people living in rural and remote areas generally receive a smaller share of overall health spending (NRHA, 2010).

This is generally related to:

- fewer available GPs, specialist nurses and health professionals
- more limited access to specialist services.

With these entrenched inequities and complex challenges, achieving better health services and, consequently, improving health outcomes for rural and remote Australians is not an easy task. It requires significant and long term commitment, with a consistent and cooperative effort across governments, and the health industry, education and community sectors.

Rural and Remote Hospitals

Hospital services are an essential component of a contemporary health care system and are particularly important for people who live in rural and remote settings. Achieving more equitable access to hospital services is a very significant issue for rural communities.

Not only do rural patients require access to local hospital services, but they also require planned and predictable access to the more specialised and tertiary type hospital services that are only provided at some major regional locations and in metropolitan centres.

Equity of access for country people must be measured not only by the ratio of hospital beds and facilities available locally to given populations but also by:

- the standards of safety and quality of rural and remote hospital services
- the alignment of services provided with local needs
- availability and sustainability of an appropriately trained and skilled workforce
- the existence of planned and effective systems to provide safe and predictable access to hospital services at local, regional and metropolitan centres as required.

For most rural and remote communities, equitable access is restricted by:

- the frequent need to travel great distance to access basic hospital services
- the difficulties involved in accessing more specialised services in regional and metropolitan centres including travel, accommodation, and financial, family and employment related impacts
- the limited availability of private hospital and related health care services in many parts of rural Australia and the consequent lack of choice for country people.

With increasing remoteness, the size and type of hospital service also changes. As seen in **Table 2**, the number of large, specialised hospitals decreases with distance from major cities, and hospital facilities become smaller and more likely to provide multi-purpose and non-acute services.

Table 2: The diversity of public hospitals, 2008-09

(Source: adapted from AIHW 2010a)

Number of hospitals

Hospital type	Location				Service provided			
	Major cities	Regional	Remote	Total	Emergency departments ^(a)	Accident emergency services ^(b)	Outpatient clinics ^(c)	Elective surgery ^(d)
<i>Principal referral</i>	50	23	1	74	74	74	69	74
<i>Specialist women's and children's</i>	11	0	0	11	9	11	11	11
<i>Large</i>	23	17	1	41	38	41	36	34
<i>Medium</i>	22	70	0	92	34	90	11	55
<i>Small acute</i>	0	110	40	151	18	148	2	33
<i>Psychiatric</i>	10	9	0	19	0	3	0	0
<i>Rehabilitation</i>	6	2	0	8	0	7	1	1
<i>Mothercraft</i>	8	0	0	8	0	8	0	0
<i>Small non-acute</i>	13	62	11	86	4	83	1	2
<i>Multi-purpose services</i>	0	47	32	79	0	79	0	3
<i>Other</i>	32	78	77	187	6	173	0	1
Total	175	418	162	756	183	717	131	214

(a) This is the number of hospitals reporting episode-level non-admitted patient emergency department care data to the National Non-admitted Patient Emergency Department Care Database.

(b) This is the number of hospitals reporting establishment-level accident and emergency occasions of service data to the National Public Hospital Establishments Database.

(c) This is the number of hospitals reporting outpatient clinic-level non-admitted patient data to the National Outpatient Care Database.

(d) This is the number of hospitals reporting episode-level data to the Elective Surgery Waiting Times Data Collection.

This creates further complexities for planning, managing and delivering public hospital services in rural and remote locations as they:

- are generally smaller than metropolitan centres
- have high fixed costs of operation
- are less able to achieve the economies of scale experienced in large hospitals
- are often the default service provider in the absence of private sector options, adequate primary health and aged care services provision
- consistently struggle to attract and retain a sustainable skilled clinical workforce.

Health status

It is important to recognise that the health of Australians in rural and remote areas is generally poorer than that of people who live in major cities and towns. This is why the Framework's overarching vision is to improve their health outcomes.

The Australian Institute for Health and Welfare's report, *Australia's health 2010*, identifies several areas of concern, particularly:

- higher mortality rates and lower life expectancy
- higher road injury and fatality rates
- higher reported rates of high blood pressure, diabetes, and obesity
- higher death rates from chronic disease
- higher prevalence of mental health problems
- higher rates of alcohol abuse and smoking
- poorer dental health
- higher incidence of poor antenatal and post-natal health
- higher incidence of babies born with low birth weight to mothers in very remote areas.

There is also the issue of higher risks of injury associated with agricultural production. Agriculture has lagged behind other high risk industries (such as construction, manufacturing and transport) in terms of improvements in safety performance, reduction of workers compensation claim rates and number of deaths (Work Safe Australia 2009).

The differing health status of Australians between rural and remote areas and major cities is discussed in Box 2, using specific examples relating to mental health and dental health.

Box 2: Rurality, distance and prevalence link to health outcomes

Mental health

In 2007, people living outside major cities (RA2-5) were 1.1 times as likely as their city counterparts to have had a mental disorder at some point in their life (lifetime mental disorder). Rates of substance use disorders were higher outside major cities, due mainly to the higher rates of risky alcohol consumption in these areas.

There is evidence to suggest that the higher prevalence of mental health problems in rural communities is due to socioeconomic disadvantage, a harsher natural and social environment, loneliness and isolation, and fewer available health services.

In 2004–2006, suicide deaths were 1.3 times higher in areas outside major cities. In particular, suicide rates among male farmers and farm workers were higher than those among the general male population.

Dental health

Adults living outside major cities were also more likely to have poorer dental health, such as more tooth loss and untreated decay. They were also less likely to have visited the dentist in the previous 12 months than those in major cities.

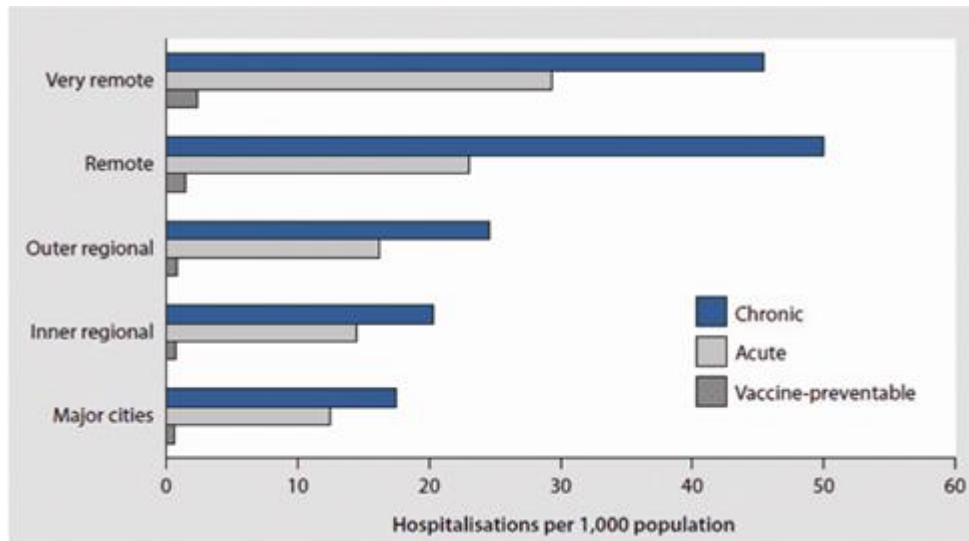
Among persons aged 55–74 years, those living outside major cities were nearly twice as likely to have no teeth as their city counterparts.

Source: AIHW (2010b)

People in rural and remote areas also have different patterns of service use. For example, people in outer regional and remote areas tend to use hospital emergency departments as a source of primary care to a greater extent than people in cities (AIHW, 2010b).

People living outside major cities are also more likely to be admitted to hospital for conditions that could have potentially been prevented through access to non-hospital services and care (Figure 2). These issues are consistent with the generally lower availability of health professionals in these areas.

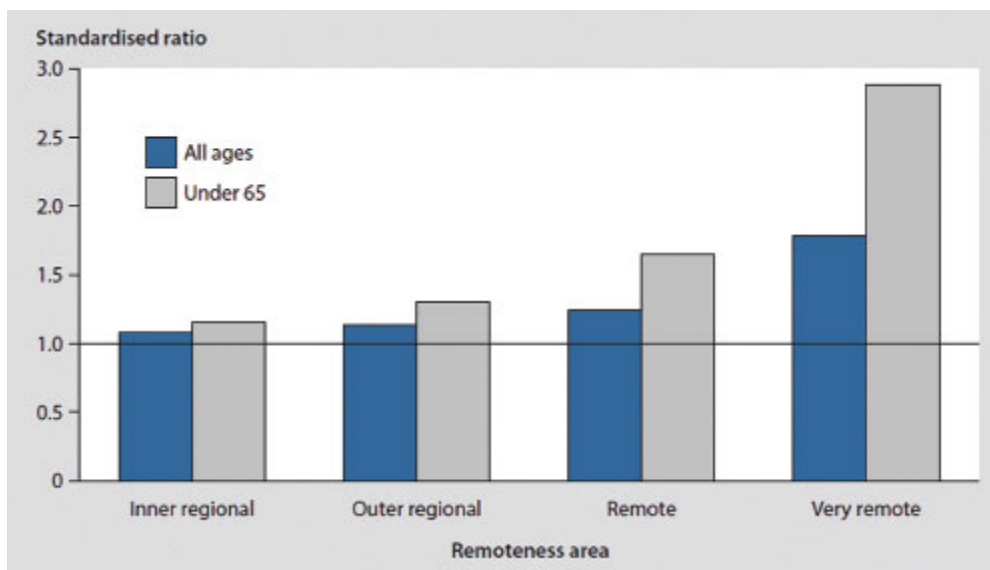
Figure 2: Rates of potentially preventable hospitalisations by broad categories, by remoteness areas of usual residence, 2007-08



Source: AIHW (2010b), Australia's health 2010

Figure 3 demonstrates that overall mortality rates increase with remoteness. For example, in 2004-2006, death rates in inner and outer regional areas were 1.1 times as high as in major cities, while the rates in very remote areas were 1.8 times as high.

Figure 3: Mortality ratios compared with Major Cities, by Remoteness Area, 2004-06



Source: AIHW (2010b), Australia's health 2010

Some of the higher mortality rates in remote areas can be explained by the higher proportion of Aboriginal and Torres Strait Islander people living in these areas.

The Australian Institute of Health and Welfare (2010b) notes that for the period 2005-2007, the life expectancy at birth was estimated to be 67 years for Indigenous males and 73 for Indigenous females. Life expectancy of non-Indigenous Australians is estimated to be 79 for males and 83 for females—a difference of 12 years for males and 10 years for females.

Key contributing factors are:

- cardiovascular disease—the leading cause of Indigenous mortality and disease burden
- diabetes—particularly a very high prevalence of Type 2 diabetes
- injuries—the third leading cause of death and hospitalisation of Indigenous Australians
- respiratory system diseases—including asthma, chronic obstructive pulmonary disease, influenza and pneumonia
- cancer—particularly lung, cervical and liver cancer.

The reasons why health status remains much worse for Indigenous Australians are complex, but represent a combination of general factors such as education, employment, housing, income and socioeconomic status—as well as access to appropriate health services.

Additional factors associated with addressing Indigenous health care needs include overcoming language and cultural barriers and supporting Indigenous people to enter health care and medical professions.

Australian governments have committed to improving the health and welfare of Indigenous Australians under the Closing the Gap initiatives through the Council of Australian Governments (COAG). These represent a coordinated, multi-sector approach to addressing the substantial health and other disadvantages experienced by Indigenous people.

The targets set by governments are outlined in Box 3.

Box 3: Closing the Gap targets

The *Closing the Gap* strategy in the National Indigenous Reform Agreement (2008) has set targets to:

- close the life expectancy gap within a generation
- halve the gap in mortality rates for Indigenous children under five within a decade
- ensure access to early childhood education for all Indigenous four year olds in remote communities within five years
- halve the gap in reading, writing and numeracy achievements for Indigenous children within a decade
- halve the gap for Indigenous students in Year 12 attainment rates by 2020
- halve the gap in employment outcomes between Indigenous and non-Indigenous Australians within a decade

The strategies outlined in this Framework align with and will support these government commitments relating to Indigenous health and welfare.

Determinants of health

A variety of factors can influence the health of individuals and communities. These include environmental and socioeconomic factors, community capacity and individual behaviours.

Australia's health 2010 highlights the differences between the metropolitan and rural and remote populations in relation to the social determinants of health. These include:

- lower levels of income, employment and education
- higher occupational risks, particularly associated with farming and mining
- geography and the need for more long distance travel
- access to fresh foods
- access to health services.

For all these reasons it is essential that health service planning and delivery in rural and remote settings takes account of these social factors, and recognises the role of other sectors such as housing, education, infrastructure and transport, in maintaining the health of those who live in these communities.

Remoteness

It is particularly important to note that, as the distance from major cities and regional centres increases, disease risk factors and levels of illness increase.

The cost of providing health services also increases with remoteness, while the availability of existing infrastructure and workforce become more limited. In addition to changes in the geography, population demographics change with increasing remoteness.

According to 2006 Census data, 24% of Indigenous people in Australia live in either remote or very remote areas. Some states have a significantly higher proportion of Indigenous people living in these areas, particularly the Northern Territory (81% of its Indigenous population) and Western Australia (41% of its Indigenous population) (ABS 2007).

Remote Australia covers about 85% of the Australian land mass, predominantly in northern and central Australia. Remote areas can include sizable towns with good access to a range of services, such as Broome, Ceduna, Broken Hill, Alice Springs and Mt Isa. More commonly, remote communities are much smaller and services may be limited or not available at all. Many of Australia's islands are also classed as 'remote'.

People may live hundreds of kilometres from their nearest major centre and the availability of public and private transport can be limited. Travel can be difficult or impossible at certain times of the year, especially if roads become impassable in wet weather.

For Australians living in remote areas generally and, particularly, Indigenous communities' access to a range of food items, including fruit and vegetables, can be limited. This is often due to the higher costs of handling and transporting goods to remote communities, the lack of appropriate storage facilities within communities, and the lack of suitable local produce to purchase.

The rural and remote challenge for health service delivery

The combined impact of fewer resources, poorer access to services, limited availability of key health professionals, poorer health status, lower socioeconomic

status, distance and travel mean that rural and remote communities and the health challenges they face are significantly different from those that confront metropolitan Australia.

These differences mean that health care planning, program development and service delivery models that are appropriate for city based communities, do not necessarily translate well into rural settings.

This is most likely to occur if health policies and programs are formulated around broad assumptions that:

- an appropriately skilled and trained workforce is readily available
- consumers and providers live in reasonable proximity to services
- adequate community and social infrastructure exists to support health services, and
- all the key components of the system including primary health, aged care, hospital services, private options, emergency service and community support are in place.

Not only are such assumptions less applicable to rural and remote communities, additional factors will also add further complexity to health service delivery in rural and remote settings.

The availability and cost of housing, among other external factors, can have a significant effect on the ability of a region to attract and retain staff and can impact on the cost of operating services. This is particularly an issue in regions where industry and mining are growing rapidly and the cost of housing has become prohibitively high, or building stock is very limited.

Rural and remote services are unlikely to enjoy the same economies of scale as metropolitan-based services, and many small rural facilities experience a significant administrative burden on their limited resources due to multiple accreditation, accountability and reporting requirements.

When these factors combine, small rural health facilities and service providers can find it harder to maintain their viability, and may struggle to continue providing the services their communities need.

The challenge then, is to design, deliver and support rural and remote health services using more flexible, innovative, and locally appropriate solutions, without compromising the quality and safety of care. This also requires due consideration to issues associated with low patient volumes, which can impact both the viability and the quality and safety of services.

These solutions will, of course, need to occur within the framework of the overall national health care system, and reflect the evolving environment in health care reform.

Rural and remote health service delivery is not the same

While differences between rural and metropolitan communities are easily recognised, it is important to recognise there are also wide variations between rural and remote communities.

These variations may relate to geography, community and population characteristics, socioeconomic circumstances, infrastructure and health status, which can strongly influence the health of individuals and communities or their ability to access health services.

As a consequence, no ‘one size fits all’ approach can be applied across all parts of rural and remote Australia.

This Framework therefore embraces as key principles that health service planning and delivery for rural and remote settings should:

- recognise and value the social, cultural and geographic diversity of these communities
- encourage the development of locally relevant solutions based on local needs.

The policy context

The need for a specific policy approach addressing the health needs of rural and remote Australians was recognised with the launch of the first *National Rural Health Strategy*, which was endorsed by Health Ministers in March 1994.

This Strategy not only raised the profile of rural and remote health issues, it provided a useful vehicle to guide national policy, facilitate progress and highlight key priority issues.

In 1999, the *Healthy Horizons Framework 1999-2003* was developed and endorsed by Australian governments. This framework was developed in collaboration with the National Rural Health Alliance, and is acknowledged as contributing to an increase in effort and resources towards rural and remote health at the time.

This was followed by the release of *Healthy Horizons Framework: Outlook 2003-2007* (‘Healthy Horizons 2003-2007’).

A review of Healthy Horizons 2003-2007 was completed in May 2008. The review indicated there was still a need for a nationally consistent approach for rural and remote health in Australia.

It recognised that the Healthy Horizons Framework provided a useful guideline for action but that changes were necessary to reflect the contemporary issues in rural and remote health and to identify new and innovative solutions.

The new Framework also challenges the perception that the success of the entire health care system can be judged solely on the quality of services offered in urban facilities. Access to quality services that respond to the health needs of all Australians, including those living in rural and remote areas, needs to be considered on its own merits.

Developing the National Strategic Framework

There are many examples of excellent efforts to deliver services to rural, remote and remotely located Aboriginal and Torres Strait Islander communities. In many instances, these initiatives are driven by the personal commitment of individuals and health professionals in the community, rather than by any systemic planning at the local, regional or state level. Without the support of appropriate service planning and delivery models, these efforts risk losing their ability to be sustained into the future.

Looking at the achievements and challenges identified by earlier work, in 2009 the RHSC and representatives of the National Rural Health Alliance identified a set of national rural health priorities, reflecting common issues and challenges across jurisdictions.

In early 2010, the RHSC conducted national consultations and a review of national and jurisdictional planning documents to inform the development of the National Strategic Framework for Rural and Remote Health. During this process, 232 people

attended eleven consultation workshops held in capital cities and selected regional centres across Australia.

Individual and group interviews were also conducted with 112 interested parties, and 22 written submissions were received. The organisations that participated in this process are listed at [Appendix A](#).

Information from these workshops, interviews, written submissions and the document review were considered together with input from the states, territories, and Commonwealth governments in the development of this Framework.

Key messages from the consultations included:

- sustainability is the foremost challenge for health service delivery in rural and remote Australia
- a high number of initiatives that have not produced the expected return on investment because of the often stop-start nature of short term project or program funding
- a lack of workforce flexibility
- the lack of capacity to tailor service delivery models and funding programs to the unique characteristics of rural and remote settings and communities creates a barrier to access and equity.

Where does this Framework fit with other health policies and plans?

The demand for health services across Australia is increasing as our population ages and more people are living with chronic disease. To ensure our health system can continue to cope with this ever increasing demand, all governments agreed to implement significant reforms across the health system as whole.

These reforms seek to deliver better health outcomes and a sustainable health system by:

- helping patients receive more seamless care across sectors of the health system
- improving quality of care through higher performance standards, greater transparency and stronger engagement with local clinicians
- providing a secure funding base for health and hospitals into the future.

The Framework is designed to integrate with existing policies and planning at the national, state and local levels, and does not restrict governments from developing their own policies and plans in the future.

By providing a much needed focus on specific issues and solutions relevant to rural and remote health, the Framework aims to inform and influence decision-making to achieve better outcomes for all rural and remote Australians.

The Framework will operate within the overarching context of the national health reforms agreed by the Council of Australian Governments (COAG) in February 2011 (**Box 4**). It will also support, and be supported by, other key national policy directions in health including:

- the National Primary Health Care Strategy (2010)
- National Preventative Health Taskforce, Australia: the healthiest country by 2020 (2009)
- the Maternity Services Plan (2010)
- the Fourth National Mental Health Plan (2010)
- Australia's National Oral Health Plan 2004–2013
- the National Men's Health Policy (2010)

- National Indigenous Reform Agreement (Closing the Gap) (2008).

Box 4: National Health Reform

On 13 February 2011, the Commonwealth, State and Territory governments agreed to a suite of national reforms to ensure the quality and sustainability of Australia's health and hospital system.

The reforms aim to ensure the Australian health system can meet the increasing demands of an ageing population and rising rates of chronic disease, and take advantage of improvements and innovations in medical and other technologies.

In relation to Australia's public hospitals, the reforms aim to:

- share the future cost of growth in the efficient price and service provision equally between the States and the Commonwealth
- establish a national approach to activity based funding for public hospitals, with provision for block funding smaller rural hospitals where required
- ensure strong national standards to improve clinical safety and quality in hospitals and health care settings
- enhance transparency on the performance of hospitals and health care services, including primary health care services.

Governance and management of hospital services will be devolved through Local Hospital Networks, to give communities and clinicians a greater say in decisions that affect their local area.

The reforms also intend to relieve the stress on hospitals by strengthening and supporting primary health care services. A central component of the reforms involves the establishment of Medicare Locals.

Medicare Locals aim to improve coordination and integration of primary health care in local communities, address service gaps, and make it easier for patients to navigate their local health care system. In particular, Medicare Locals will:

- help people access services by linking local medical and other health professionals and services
- work with Local Hospital Networks to ensure primary health care services and hospitals work together for better patient care
- plan and support local after hours face-to-face GP services
- identify where local communities are missing out on services they might need and coordinate services to address those gaps
- support primary care health providers to adopt and meet quality standards.

Overall, the national health reforms intend to enable Australia's health system to respond to local community needs while maintaining longer term sustainability and quality of care. This will be supported by investments in:

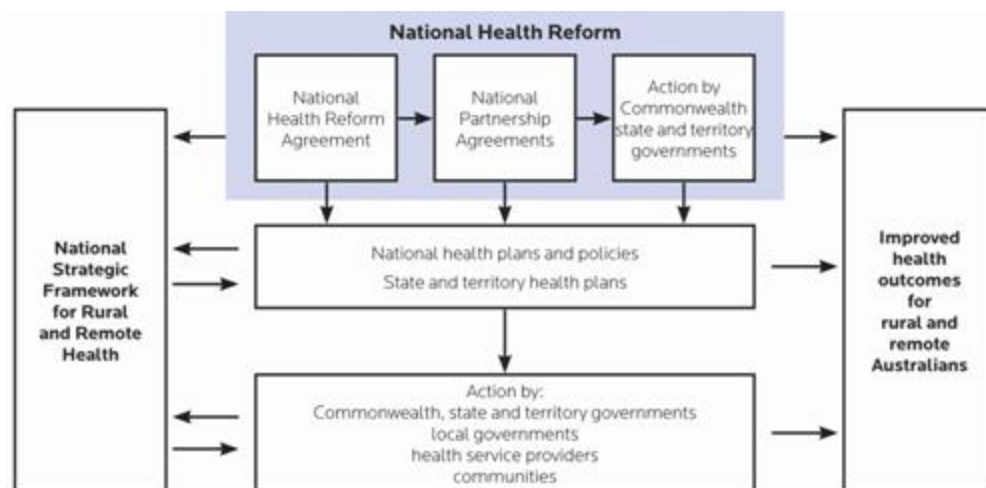
- the health care workforce
- infrastructure and technology
- performance reporting and accountability.

Health Workforce Australia (HWA) is undertaking a complementary piece of work that will align with this Framework. HWA's work, as it relates to the Framework, focuses specifically on innovation and reform initiatives for the rural and remote health workforce. HWA will develop a Rural and Remote Health Workforce Innovation and Reform Strategy to provide a more detailed treatment of rural and

remote workforce issues and to build on the higher level directions advocated in this Framework. Through its work plan, HWA will invest in rural and remote health workforce innovation and reform initiatives identified during the development of its Strategy.

The key directions, objectives and strategies outlined in the Framework will also provide the necessary rural and remote perspective to improve policy development and planning at the Commonwealth, state and territory levels of government over the next five years (see **Figure 4**).

Figure 4: The National Strategic Framework and its relationship to national and state policy and planning²²



² The National Health Reform Agreement was signed by the Commonwealth, states and territories on 2 August 2011.

The focus of this Framework is set with a broad policy perspective, identifying the key priority areas that face rural and remote health services and service delivery. It allows the Commonwealth, states and territories to continue to develop and implement health and other related policies and plans, yet highlights the need for governments to consider the potential implications and application of these policies and plans in rural and remote settings.

By promoting a concerted effort across several fronts targeting the design, delivery and structure of health services, enhancing health technologies and infrastructure, supporting the health workforce and community capacity, the Framework will help this nation move towards its overall health goals, and reduce the inequalities in health outcomes and service delivery that are currently experienced by rural and remote Australians.

National Strategic Framework for Rural and Remote Health

Vision

People in rural and remote Australia are as healthy as other Australians.

To reach this Vision, the following five goals are set:

² The National Health Reform Agreement was signed by the Commonwealth, states and territories on 2 August 2011.

Goals

Rural and remote communities will have:

1. Improved access to appropriate and comprehensive health care
2. Effective, appropriate and sustainable health care service delivery
3. An appropriate, skilled and well-supported health workforce
4. Collaborative health service planning and policy development
5. Strong leadership, governance, transparency and accountability.

Principles

The following principles will apply across health service planning and delivery for rural and remote settings:

- EQUITY in access to SUSTAINABLE health services
- recognise and value the SOCIAL, CULTURAL AND GEOGRAPHIC DIVERSITY
- support INNOVATIVE, FLEXIBLE, RESPONSIVE, QUALITY and SAFE services
- support a SUSTAINABLE HEALTH WORKFORCE
- COMMUNITY engagement and capacity building
- LOCALLY RELEVANT SOLUTIONS for local needs
- PARTNERSHIPS with community, health professionals, industry and governments
- develop and use the EVIDENCE BASE
- ACCOUNTABILITY and TRANSPARENCY in governance, service planning and delivery
- embrace new and existing TECHNOLOGY.

Key outcome areas

In seeking ways to improve planning and delivery of health care in rural and remote Australia across all service types, health priority issues and population groups, a number of key themes consistently emerged.

These themes formed the basis of the five outcome areas now identified in this Framework, namely:

Outcome area 1: Access

Outcome area 2: Service models and models of care

Outcome area 3: Health workforce

Outcome area 4: Collaborative partnerships and planning at the local level

Outcome area 5: Strong leadership, governance, transparency and performance.

Each outcome area links directly to one of the five key goals. The following chapters discuss the opportunities and challenges that relate to each outcome area, and identify the objectives and strategies developed to help achieve the goal.

While each outcome area is important in its own right, the Framework acknowledges the interrelations between them all and recognises that specific action under one outcome area can also support the goals of others. For example, successfully addressing workforce development will depend on access to information and communication technology and telehealth initiatives to overcome isolation. E-Health can be used not only for clinical purposes but also for continuing professional

education, patient education and administration, thus supporting the outcome areas relating to innovative and flexible models of care, and increasing access to services.

By identifying overall objectives and strategies under each outcome area, the Framework will help governments to work more consistently and collaboratively, while maintaining the flexibility for governments, services and communities to find and implement solutions that best fit their needs.

Outcome area 1: Access

Introduction

People living in rural and, especially, remote areas of Australia cannot access the range of health care services that are available to people living in urban areas.

While acknowledging that some high cost, specialised services cannot be provided locally, the ability to access health care services including primary medical care in rural and remote Australia tends to drop with increasing remoteness, as seen in the table below (NRHA 2010).

Table 3: Services received by remoteness, 2006-07 – as a proportion of services received in Major cities

Service Type	Inner Regional	Outer Regional	Remote	Very Remote
MBS GP services	84%	79%	71%	54%
MBS specialist services	74%	59%	38%	30%
MBS allied health services	75%	45%	24%	9%

Source: NRHA (2010).

Improving access can be highly complex and challenging. While many major health strategy documents address aspects of health care access, few target the unique challenges of delivering services in rural and remote communities or the specific needs of those who live there.

However, many jurisdictions have established or enhanced services in rural and remote areas by developing service models which are sustainable and achieve safe, quality care. This has resulted in more proximate access to a range of services such as renal dialysis, cardiac, and stroke.

This is why the Framework aims to provide a clear focus on the issues and factors that decision makers at all levels of the health system need to be mindful of when considering health services in the rural and remote context.

The factors that determine the level of access to health care service are often more complex in rural and remote communities. External factors such as workforce supply, the cost associated with delivering services to isolated areas, and the availability of infrastructure and equipment will influence which services are provided in a specific location. Additionally, the use of services by consumers is also an important determinant.

People in rural and remote areas needing to access health services are often influenced by:

- travel distance to relevant health services, including the availability of transport and the cost of travel
- uncertainty about how to use and access services, including the availability of emergency care and retrieval services
- cultural and language barriers

- poorer understanding of health issues and how to access health services.

In the rural and remote setting, an obvious barrier to accessing health services is language and culture. This is particularly the case for Aboriginal and Torres Strait Islander peoples, refugees, and people from culturally and linguistically diverse backgrounds. Other considerations, such as the availability of male or female health practitioners, can also influence a person's decision to seek medical attention.

Past experience will also influence whether people seek assistance. Many consumers and providers report that people are often required to travel without support and over long distances to major cities for specialist appointments. These appointments are often poorly coordinated, and may be delayed or cancelled. An unpleasant experience can lead to people preferring to live with their condition than to go through another distressing process.

Similarly, lack of access to family support and child care can limit a person's ability or willingness to be away for extended periods of time to receive treatment. This is an issue particularly when early treatment may prevent the condition worsening and, potentially, leading to avoidable morbidity and mortality.

State, territory and Commonwealth governments are responding to the challenges with a range of approaches including:

- providing supplementary primary health care services where they may otherwise not be sustainable
- establishing specialist services in regional centres
- integrating and coordinating services, including health, aged care, and community services
- providing culturally appropriate care to remote Indigenous communities
- patient assisted travel schemes
- providing specialist outreach services to areas of need
- supporting emergency retrieval services, for example the Royal Flying Doctor Service
- supporting the use of information communication technologies, including telehealth and e-Health initiatives.

Meeting community needs – the Central Highlands Community Health Centre, Ouse (Tasmania)

The Central Highlands Community Health Centre was developed to address an extreme mismatch between the services provided (i.e. acute in-patient beds) and community need, in a predominantly farming area with a rapidly ageing population. The Centre now provides a wide range of home-based care packages and services, including Extended Aged Care in the Home, Community Aged Care Packages, Home and Community Care services, Post-acute Care Programs, palliative care, and Meals On Wheels.

The Centre also provides a GP service, telehealth facilities, health promotion, chronic disease self-management and a day centre, which are supported by a community transport program, regional ambulance services (including helicopter retrieval), nurse-led clinics and clear referral pathways to acute services.

Efforts are being made to support more integrated, flexible and coordinated approaches to improve access to services in rural and remote areas. These include better design and use of infrastructure, more flexible funding arrangements, and

adapting the workforce to better meet rural and remote health needs. In some instances, services have co-located to make better use of scarce resources and increase operational efficiency, which is particularly important in small rural and remote facilities.

While GP practices and acute care services are more commonly taking this approach, a range of other services can also benefit, including aged care facilities, community health, private providers, and ambulance and retrieval services. In addition to providing an avenue to improve access to services, co-location can also support the long-term viability of these services.

Information technology also offers substantial benefits in improving access to services in rural and remote areas and can be used to support a wide range of situations including:

- accessing secondary and specialist clinical advice
- managing emergency and unplanned presentations
- outpatient presentations
- pre- and post-operative care
- clinical education and skills development
- state- or nation-wide collaboration among clinicians.

Transport and distance are identified as major barriers to access. This can affect clients, their carers and service providers (in relation to the provision of outreach services).

Support is available to patients who need to travel to health services outside their local area. These are provided through a range of services and schemes including: arrangements with local transport providers, community transport providers and non-emergency transport services. There are also Patient Assisted Travel Schemes (PATS) in each State and Territory, which provide financial support towards the cost of travel and accommodation.

There are variations between state and territory PATS, which can create challenges for consumers, carers and their families. Issues identified by rural stakeholders include: the range of services that can be accessed; the level of entitlements; and inconsistencies when consumers need to move across administrative, program or jurisdictional boundaries. These variations reflect the different geography, demography and service provision in each of the states and territories. These issues must also be considered in developing appropriate PATS responses in each state and territories, as many jurisdictions are also investing in increasing services closer to home.

Better access involves more than just delivering timely, affordable and quality health services to people living in rural and remote areas of Australia. The Framework also promotes the need to build peoples' understanding of how to manage their health, and about when and how to use available health services. It also encourages governments, the health sector and communities to look at smarter ways to use health service infrastructure, accommodation, transport and technologies.

Using technology to improve access to services

Mental Health Emergency Care Rural Access Project (New South Wales)

The *Mental Health Emergency Care Rural Access Project* aims to improve access to emergency mental health services and treatment in rural and remote hospitals

emergency departments across western NSW. A specialist team at Bloomfield Hospital in Orange provides assessments for mental health clients in remote and rural hospitals via videoconference 24 hours a day, 365 days a year.

With the support of the expert team, people who needed to travel hundreds of kilometres to receive expert clinical assessment, can often be cared for in their local hospital. The team also provides training and specialist advice to local clinicians, providing them with the skills to confidently manage mental health presentations.

Cardiac Clinical Management in rural emergency departments (South Australia)

South Australia is developing an integrated, digitally-based and state-wide cardiac clinical management network that includes:

- upgraded equipment to Country Health SA hospitals and health units that have an emergency department
- a state-wide, centrally-supported cardiac clinical management network, iCCnet SA
- a digitally-based system to enable transmission and assessment of electrocardiograms (ECGs), comparison with past ECGs, and ability to provide these records to multiple health providers involved in the patient journey.

The upgrade will assist country emergency departments to manage potentially critical situations and achieve better health outcomes through more rapid assessment and reducing the necessity for inter-hospital transfers.

When combined, these different approaches will help to achieve the overarching Goal 1:

Rural and remote communities will have improved access to appropriate and comprehensive health care

Strategies to help realise this goal are outlined in the following table.

Outcome area 1: Access

Goal 1: Improved access to appropriate and comprehensive health care for people living in rural and remote Australia

Objectives	Strategies
<p><i>Objective 1.1</i></p> <p>Better access to timely, affordable and quality health services for people living in rural and remote Australia</p>	<ul style="list-style-type: none"> • Work with Local Hospital Networks and Medicare Locals and/or other appropriate governance structures to identify, assess and coordinate clinically appropriate health services to meet local needs. • Develop mechanisms to support, integrate and coordinate services to meet local needs, including services within medical, allied and primary health care and other health service streams, and aged care, community services and emergency retrieval. • Develop funding mechanisms and incentives that support best use of information communication technologies for delivery of health services.
<p><i>Objective 1.2</i></p> <p>Improved health and health system literacy for people living in rural and remote</p>	<ul style="list-style-type: none"> • Develop community engagement and education strategies that promote preventative health and early intervention. • Better inform consumers about the services and support programs available to them.

Objectives	Strategies
Australia	<ul style="list-style-type: none"> • Work with consumers and health professionals to promote understanding of how the health system works, including emerging technologies such as e-Health. • Work with target population groups, including older people, Aboriginal and Torres Strait Islander peoples, people with chronic disease, refugees, and people from culturally and linguistically diverse backgrounds, to develop and implement strategies that address barriers to access, including language and specific cultural requirements.
<p><i>Objective 1.3</i></p> <p>Better health service infrastructure and accommodation, transport and information communication technologies</p>	<ul style="list-style-type: none"> • Facilitate developing national standards for patient travel and assistance. • Invest in the development of technology and infrastructure tailored for local health service needs. • Support the adoption of information and communications technology for e-Health, telehealth and electronic health record applications. • Promote adherence to national e-Health standards.

Outcome area 2: Service models and models of care

Introduction

Two key elements in delivering health services are:

1. the way health services are structured and operate—that is, the service model
2. the way care is provided to patients, including clinical pathways, the patient journey and clinical guidelines—that is, the models of care.

To achieve better outcomes in access and equity it is necessary to develop and apply service models and models of care that are appropriate for, and respond to, the unique challenges of delivering quality care in rural and remote settings and that support continuity of care.

In Australia, significant investment has been made to improve health services in rural and remote communities and to create better, more flexible approaches to care. Yet there remains scope to apply and expand new and innovative approaches in delivery.

The multi-purpose service model, progressively implemented since 1993, provides an innovative approach for small scale, integrated and flexible services designed to meet the health and aged care needs of small rural communities. It also provides the venue for innovative models of care with linked clinical pathways, able to focus on improving the patient journey.

A range of other innovative models are available including fly-in/fly-out services, hub and spoke, cluster, as well as the provision of outreach specialist services.

Determining which model, or combination, is most appropriate will depend on the individual needs, resources, and social and cultural characteristics of the community it is to be applied to.

Multipurpose Service Program

The *Multipurpose Service (MPS) Program*, established in 1993, is a partnership between the Commonwealth and State Governments to address the problems of access to, and sustainability of, health services in small rural communities. The

program pools Commonwealth and State funding and sets aside the normal program guidelines and constraints to allow small communities to integrate acute and aged care services.

Multipurpose services bring together a range of health and residential aged care services on one site. GP and ambulance services may also be co-located. The program benefits small rural communities by enabling older residents to ‘age in place’ and provides small rural communities with access to a range of coordinated acute, aged care and community services.

For example, New South Wales has made a significant commitment to the development of multi-purpose services since 1993 through the construction of facilities to bring together a range of health services and residential aged care services on one site.

A total of 52 MPS facilities are now operational across New South Wales, delivering services that might otherwise have been unsustainable.

To address the specific challenges of rural and remote settings, successful models have demonstrated the following features:

- a multi-disciplinary approach
- integration and coordination
- flexibility in design, funding, workforce and resource allocation
- sustainability and responsiveness to local need and capacity
- culturally safe and appropriate.

There are many examples of innovative models being implemented at the state, regional and local levels across Australia. It is clearly important to identify which are successful and to consider their potential for application across other rural and remote settings.

Establishing and strengthening links and patient referral pathways with services in metropolitan and larger regional centres will enable rural and remote services to better access secondary consultation, specialist advice and emergency services when needed.

As well as developing the appropriate networks and communications links, there may also be a need to establish partnerships and agreements to facilitate cross-network and cross-border coordination, resource sharing and patient transfers—particularly when patients need to cross a state or territory border to access health services.

Another element identified as needing improvement is the provision of health promotion and prevention programs.

While many programs provide health education, screening, immunisation and prevention services that are easily accessible in urban centres, their reach becomes more limited as distance from these centres increases.

Networking Cancer Services - CanNET (Western Australia)

The *Cancer Australia Cancer Services Network National Demonstration (CanNET) Program* was established to develop networked cancer services between rural and specialist services, providing opportunities to share learnings and to reduce duplication of effort and resources.

The program aims to develop a model that would enable appropriate access to specialist oncology services in regional Western Australia, using multidisciplinary team processes and services that reflected the point of view of rural cancer patients.

The program led to a higher than expected increase in referrals for radiotherapy and chemotherapy, following the introduction of multidisciplinary led care planning for cancer care.

Successful elements of this program will be rolled out across the remainder of rural Western Australia, including multidisciplinary team processes, appropriate referral pathways and multidisciplinary cancer education. Continuing challenges include securing long term funding for the program and promoting culture change among specialists regarding the delivery of specialist cancer care away from metropolitan Perth.

Information communication technology will improve the provision of, and access to, these services. However, alternative approaches may be needed for specific health issues such as breast or prostate cancer screening, and for particular target groups including older persons, Aboriginal and Torres Strait Islander communities and remote populations.

While designing appropriate delivery models and models of care is important, these models must be sustainable and deliver quality care in line with contemporary practice. Many innovations in rural and remote communities have been driven by dedicated individuals but later lapse as they lack the appropriate facilities or ongoing support to maintain them.

To achieve sustainable health services it is critical to support service delivery with the appropriate funding arrangements, infrastructure and technology, training and development, and skilled workforce.

The Framework seeks to improve the delivery of services to rural and remote Australia under Goal 2:

Rural and remote communities will have effective, appropriate and sustainable health care service delivery

This goal focuses on improving the design and integration of services, encouraging innovation and flexibility, and optimising service capacity to ensure rural and remote health services can meet consumer and community needs now and into the future. Strategies are outlined in the following table.

Outcome area 2: Service models and models of care

Goal 2: Effective, appropriate and sustainable health care in rural and remote settings

Objectives	Strategies
<p><i>Objective 2.1</i> Improved integration between service providers across and within primary health care, specialist care, acute care, Indigenous health and aged care</p>	<ul style="list-style-type: none"> • Ensure local work practices coordinate locally based and visiting health service providers. • Build relationships between local service providers and larger centres to complement locally provided care. • Support infrastructure development that promotes more integrated and multi-disciplinary care.

Objectives	Strategies
	<ul style="list-style-type: none"> • Introduce and support service models that recognise alternative models of primary health care that use a range of innovative approaches, including innovation in workforce roles.
<p><i>Objective 2.2</i></p> <p>Enhanced innovation in service design, including flexible funding for rural and remote health services</p>	<ul style="list-style-type: none"> • Support research to improve health service design and delivery. • Identify successful innovations in health service delivery and assess them for sustainability, scalability and transferability across other rural and remote settings. • Implement appropriate and flexible funding mechanisms for rural and remote health services, including telehealth services delivered from a distance.
<p><i>Objective 2.3</i></p> <p>Health service design that better meets local consumer and community needs</p>	<ul style="list-style-type: none"> • Support the involvement of local consumers and health providers in health service design. • Develop health policies and programs that acknowledge and address the uniqueness and challenges of delivering health services in rural and remote communities. • Promote multi-disciplinary and flexible models of care, and provide the necessary supports for these models to ensure sustainability. • Support collaborative care and planning through training and support for key professionals outside the health sector. • Support development of evidence to underpin service planning, design and delivery, and to inform the community.
<p><i>Objective 2.4</i></p> <p>Improved capacity for health promotion and disease prevention</p>	<ul style="list-style-type: none"> • Support the development of integrated, coordinated and appropriate health promotion and prevention activities that target key health priorities and target groups in rural and remote communities.
<p><i>Objective 2.5</i></p> <p>Improved cross-border and cross-network coordination and patient flows</p>	<ul style="list-style-type: none"> • Negotiate cross-border and cross-network agreements for the provision of health care services, transport and accommodation.

Outcome area 3: Health workforce

Introduction

Attracting and retaining a skilled health workforce are key challenges facing health services across Australia as a whole—but workforce supply has reached a critical level in many rural and remote communities.

The number of doctors, dentists and oral health practitioners, mental health professionals, and allied health professionals in rural and remote areas is substantially lower per capita (DOHA 2008).

There is a greater reliance on overseas trained professionals and international medical graduates (IMGs) to address critical shortages in rural and remote areas.

In remote communities a high percentage of health care services are provided by nurses and Aboriginal health workers.

Governments recognise the need to actively address the maldistribution of the health workforce and have introduced programs to encourage health professionals to live and work in rural and remote areas.

While financial incentives may go some way to addressing the problem it is evident that a much broader, multi-pronged approach is needed, firstly, to attract all types of health professionals and, secondly, to encourage them to stay longer.

Rural Workforce Incentives (National)

To improve the health workforce in regional, rural and remote Australia, the Australian Government's *Rural Health Workforce Strategy*, covers a range of programs providing both financial and non-financial support for rural doctors.

Introduced in July 2010, the General Practice Rural Incentives Program (GPRIP) aims to encourage doctors to relocate to rural and remote areas for the first time with financial incentives of up to \$120,000. Doctors already working in rural and remote locations may also access increased retention payments.

Enabling rural doctors to access adequate time for rest and professional development is an important factor in encouraging workforce retention. To assist this aim, the *National Rural Locum Program (NRLP)* has provided locum support for Rural GPs, Specialist Obstetricians, and GP Anaesthetists since 2009-10. In addition, the *Rural Locum Education Assistance Program (Rural LEAP)* began in February 2010 and provides financial assistance to urban GPs who provide four weeks of paid locum placements in a rural or remote area.

Medical students who choose to train and work in rural and remote communities are able to have their HECS debts reimbursed under the *HECS Reimbursement Scheme*. As of 1 July 2010, doctors are also able to reduce the period for reimbursement of the cost of their medical studies.

Recruiting the right workforce

The need for rural health practitioners to be multi-skilled is widely recognised. While the scope and nature of their work requires good generalist skills, much of the training for rural health professionals is conducted in metropolitan institutions by specialists who are removed from the realities of working in the rural health setting (Humphries et al 2002).

In terms of attracting skilled health professionals it is important to recognise the preconceptions about working in rural and remote communities. These generally relate to:

- professional and social isolation (for the health professional and their spouse and family)
- poorer local amenities and infrastructure
- limited training and professional development opportunities
- the difficulties of delivering services in geographically isolated areas, including long-distance travel, extended working hours, and lack of locum support.

The disparity in the incomes earned between specialist medical practitioners and generalist medical practitioners also contributes to the shortage of general practitioners. 'Procedural' specialties, such as surgery, will typically command higher

levels of income and therefore attract more practitioners than general or family practice (Cheng et al 2010).

While these factors all contribute to the workforce maldistribution in rural areas, rural practice is also seen as a natural environment for workforce innovation.

Recent innovations include expanded roles for practice nurses, nurse practitioners and allied health therapy assistants. The Productivity Commission (2005) has noted that many such innovations have the potential to provide the basis for system-wide changes in health workforce arrangements.

While rural practitioners appear to be more comfortable with a more multi-disciplinary team approach and broader scopes of practice, there is still a need to overcome the barriers that exist between professional disciplines and within training institutions to further develop and implement these approaches.

While earnings vary slightly between states and territories, GPs who practise in outer regional, rural and remote Australia are eligible for payments under government incentive schemes, and there may be a lower number of competing practitioners in rural and remote areas.

Governments and communities can also actively challenge the common perceptions of working in rural and remote settings by:

- promoting the advantages of rural and remote practice, including opportunities to develop a broader range of skills and experience
- increasing local capacity to 'grow your own' workforce, as students originating from rural and remote communities are more likely to return to work in these communities
- improving available health facilities and accommodation, including addressing the cost and availability of quality and safe housing
- ensuring health professionals have access to peer and locum support, and opportunities for training and continuing professional development
- utilising information technology to support distance-based social and professional relationships and activities.

It should also be recognised that health services also experience workforce shortages in non-clinical areas, such as management, finance and health information. To minimise the impact it is necessary to provide support and training for non-clinical workers, and to explore opportunities for small health and hospital networks to share their administrative, financial, and health information infrastructure and staff.

Retaining rural and remote health professionals

Workforce development has tended to focus on medical practitioners, however, the entire health workforce needs to be developed in keeping with cross-disciplinary and generalist requirements. In the overall remodelling of health practice in rural and remote areas, inter-professional education and ongoing training will be essential.

There is a critical need to expand existing scopes of practice and create new roles to optimise workforce capacity and to meet health care needs. The development of more advanced roles for rural GPs, including obstetrics, surgery and anaesthetics, and for nurse practitioners is seen as a useful strategy to strengthen and maintain a skilled rural health workforce.

It is also important to consider the roles and scopes of practice of a wide range of other health care workers including remote health workers, nurses, allied health workers, midwives, Indigenous health workers and vocationally trained workers.

Rural Generalist Medicine (Queensland)

In August 2005, the Queensland Government announced the recognition of a new category of senior doctor called the 'Rural Generalist'. Rural Generalist training commenced in 2007 within the Rural Generalist Pathway.

Queensland officially recognised Rural Generalist Medicine in 2008. As a specialist equivalent medical discipline, Rural Generalists can:

- gain a professional status and a service value equivalent to that of a medical specialist
- receive a specialist-level remuneration package, including a 'private practice' allowance.

The Rural Generalist Pathway provides supported training through medical school to Rural Generalist Medicine practice.

The practice of Rural Generalists includes rural general practice and hospital-based practice with at least one advanced skill in a specialist discipline. Rural Queensland will benefit from the priority advanced rural skills of obstetrics, anaesthetics, Indigenous health, emergency medicine and surgery.

In the future, Rural Generalist Medicine increases the prospect of rural and remote communities being well supplied with doctors seeking rather than being coerced into rural service.

It also potentially improves the chances of Indigenous communities being well supplied with doctors whose advanced skills in Indigenous health will provide a medical service dedicated to their unique needs.

In developing initiatives for a sustainable rural and remote health workforce, there is now sufficient evidence to bring the focus of recruitment strategies towards shorter retention cycles. In place of expectations of GPs staying in town for decades, workforce planning should focus on three to seven year cycles, dependent on the workforce group. This re-orientation of strategy requires ongoing efforts and continual succession planning.

Planning for education and training in rural and remote areas needs to recognise that the professional, personal and community-based activities of health care providers often overlap in small communities. Health care providers and health service managers are often effectively 'on call' continuously and, therefore, special effort is required to enable them to undertake their continued training and development.

Workforce planning, education and professional development should involve active partnerships with the tertiary education sector and other national bodies, such as professional colleges, national peak bodies, and the national accreditation and registration system.

An example of a successful model that combines specialist roles for nurses, with the appropriate training, guidelines and partnerships to support them is outlined below:

Remote Area Nursing Emergency Guidelines and Training (Victoria)

There are fifteen Bush Nursing Centres (BNCs) located in remote and isolated communities throughout rural Victoria. BNCs provide key primary health and emergency stabilisation services to these communities. Due to the remoteness of these

communities, BNC nurses may be the only health care professionals available to provide first line care in the event of a medical or trauma emergency.

BNCs can employ Remote Area Nurses (RANs) who are up-skilled to provide time critical emergency response and stabilisation care in the absence of a medical officer or paramedic. The regulatory framework in Victoria provides for RANs to have the delegated responsibility to provide emergency care provided that they have completed annual competency based training based on the Victorian Remote Area Nurses Emergency Guidelines (RANEG).

A key component of this model is the partnership between BNCs and Ambulance Victoria. Ambulance Victoria conduct annual competency based training and provide peer support and mentoring to the RANs. RANs through joint dispatch arrangements with Ambulance Victoria provide a first response to emergency calls in their community and are able to arrive and commence emergency care to patients substantially prior to paramedic or medical officer assistance.

The Framework seeks to build a health workforce that meets the needs of rural and remote communities through better recruitment, training and continual professional development, and retention of skilled health professionals and non-clinical health workers to achieve Goal 3:

Rural and remote communities will have an appropriate, skilled and well-supported health workforce

Strategies are outlined in the following table.

Outcome area 3: Health workforce

Goal 3: Rural and remote Australia has an appropriate, skilled and well-supported health workforce

Objectives	Strategies
<p><i>Objective 3.1</i> Improved recruitment, retention and distribution of rural and remote health service providers</p>	<ul style="list-style-type: none"> • Support training placements to rural and remote practices across all health professions. • Consider supply of appropriate infrastructure for health service staff including housing and health service facilities, where market failure has contributed to a lack of availability or high cost. • Introduce flexible workload management and support by providing after-hours call centre services, professional networks and readily accessible locum support. • Promote safe and healthy workplaces, particularly in high risk areas, ensuring professional and inappropriate physical isolation are addressed. • Bundle financial and non-financial incentives to address the broad range of factors that affect workforce supply and distribution. • Develop communication strategies that promote the rewards of careers in rural and remote areas. • Identify strategies to attract and retain health service support staff. • Routinely evaluate and improve workforce support programs to ensure they contribute towards a more equitable distribution of rural and remote

	health service providers.
<p><i>Objective 3.2</i></p> <p>Build a health workforce that meets the needs of local communities</p>	<ul style="list-style-type: none"> • Identify opportunities for new or expanded roles and varying of the skill mix of multi-disciplinary team members to enhance services. • Explore flexibility in the scope of practice for all health service providers and promote more advanced skill roles for GPs and nurses. • Implement innovative funding mechanisms for services delivered by non-medical health service providers. • Identify and explore options for addressing legislative, regulatory and other barriers that limit the full service capacity of rural and remote health professionals. • Recognise and support the role of GP proceduralists and nurse practitioners in delivering health services in rural and remote settings. • Promote interdisciplinary training to reduce barriers between health care professionals. • Introduce new professional and semi-professional roles such as vocational and tertiary trained assistants, transport providers and coordinators, and telehealth/e-Health coordinators. • Ensure preventative health becomes an important element of skills development for the rural health workforce. • Introduce technology and other efficiency measures to assist the workforce to address the health needs of communities.
<p><i>Objective 3.3</i></p> <p>Improved availability of training and continuing professional development programs for rural and remote health professionals</p>	<ul style="list-style-type: none"> • Ensure workforce has access to appropriate and well supervised clinical training, education and continuing professional development opportunities, including better use of ICT for training delivery and support. • Develop opportunities for rural and remote GPs to access training in advanced skills. • Promote expansion of scholarship, clinical placement, and bonded scholarship programs to all health disciplines. • Target clinical training placements to areas of workforce need. • Develop appropriate funding mechanisms to support distance supervision of remote practitioners and new and emerging health service providers.

Outcome area 4: Collaborative partnerships and planning

Introduction

To address the complexities of rural and remote health it is necessary to plan and design health services and health policy specifically ‘for rural by rural’ rather than trying to adapt and apply a metropolitan health care model.

This would ensure consideration of the specific needs of Aboriginal and Torres Strait Islander and geographically isolated populations, and the great diversity between rural and remote communities.

Enhancing health services in the Pilbara (Western Australia)

The health system in the Pilbara region, in the north of Western Australia, was placed under serious stress due to a rapid pace in resource development, increasing population, and demand for services in the region.

The Pilbara Industry's Community Council (PICC) was formed in 2007 to provide a multi-lateral approach to plan for the current and future sustainability of the Pilbara, involving a range of government and industry sectors.

The PICC aims to strengthen investment in services and achieve outcomes that are critical to the State's development in a coordinated and collaborative manner. The PICC identified supporting sustainable health services as a priority, given its role as a key enabler for continuous resource development in the region.

In late 2009, the WA government and PICC announced the three year *Enhancing Health Services in the Pilbara initiative*.

A range of projects have been funded through this partnership to strengthen emergency response capability across the region, improve access to specialist medical services, increase Indigenous employment in local health services, expand sexual and family health services, provide staff accommodation units at Newman, upgrade three small hospitals in the region, and undertake service planning for two other small hospital services.

Local planning

Local and regional level planning has an important role in ensuring sustainable health care in rural and remote areas by helping to identify:

- the individual characteristics of an area and the specific needs of the people who live there
- the services, infrastructure and workforce that are already available, and what aspects may need to be improved or developed
- gaps in health service provision in the area and some possible reasons for this
- opportunities for creating linkages and partnerships between key stakeholders, governments, health and other community services, and other sectors including local industries.

The benefits of local planning include:

- delivering more integrated and sustainable health services
- services that better target the local need
- more effective utilisation of existing facilities, resources and workforce
- greater community input and engagement.

Implementation of the Strategy for Planning Country Health Services (South Australia)

Recognising the need to improve health outcomes for country people, the *Strategy for Planning Country Health Services in South Australia (the Strategy)* was released in December 2008, following detailed discussions and consultation with rural and regional residents and health professionals. The *Strategy* provides a framework, including planning principles, planning milestones and a delineation framework to inform the development of the 10 year health service plans for local hospitals and health services.

Throughout 2009-2010, Health Advisory Councils, local health services and the Country Health SA Planning Projects Team worked towards developing a total of thirty three 10 year local health service plans across country South Australia. In several locations, Health Advisory Councils and local health services agreed to use a cluster or sub-cluster wide approach in their planning. This approach presented an integrated picture across the cluster and effectively enabled an approach to share and strengthen health services for the overall catchment needs.

The 10 year plans outline the health service's vision for their catchment area in regard to service delivery, capital works, workforce development and other needs. The work presents a ground-up approach to planning future health service needs across country South Australia. A range of community engagement strategies have been implemented including surveys, focus groups, community stalls, online questionnaires, interviews and building on previous consultations. The contributions made by the Health Advisory Councils is well acknowledged and a key factor in the success of the local planning process.

The national health policy, planning, funding and resource allocation landscape is changing with the implementation of the national health reforms³.

With the introduction of Medicare Locals and the Local Hospital Networks, these changes will offer a major opportunity to promote collaboration and partnerships that support the development of local solutions.

The expertise needed to formulate and implement local area health service plans is not well distributed across rural and remote Australia. Accordingly, there is a need to build the capacity of health service managers and providers and provide the necessary skills to work within a more multi-disciplinary and integrated framework.

Building partnerships for healthier communities

A fundamental element in local and regional planning is identifying and establishing strong and effective linkages and partnerships.

Fostering local partnerships and collaborations helps to draw together and get the best out of the local, state and Commonwealth investment in health and human services.

These partnerships can be developed between different levels of government, or between sectors (including health, education, housing, employment and regional development). Within the health care sector it is also important to consider the opportunities to develop partnerships across the public, private, not-for-profit and community controlled sectors.

Stronger partnerships help promote a more effective use of available resources, improve the transition of patients between health services, and help to coordinate action to improve patient access and outcomes or address the social determinants of health.

³ 3 As agreed by COAG on 13 February 2011.

Healthy partnerships in the Ntaria Aboriginal Community (Northern Territory)

The Northern Territory Department of Health, the Western Aranda Health Aboriginal Corporation (WAHAC) and community members have developed a strong partnership to develop supportive environments for healthy choices and respond to community health needs in the Ntaria Aboriginal community.

A nutritionist, Preventable Chronic Disease Nurse and Health Promotion Officer work in partnership with community members to respond to community-identified health issues by supporting:

- nutrition and exercise groups for family groups and chronic disease groups
- education for mothers at the Families As First Teachers playgroup
- promotion of healthy choices at the local stores
- School Nutrition Program workers and building the capacity of Health Centre and WAHAC Staff, including Aboriginal Health Workers, to provide nutrition education.

Beyond the delivery of services, collaborative partnerships also have a valuable role in developing tools for providing safe and quality services and for supporting continuous quality improvement and evaluation.

Community engagement and consultation are important factors in ensuring health care planning in rural and remote settings is both relevant and appropriate. Accessing local knowledge not only provides a more accurate picture of the particular health issues and requirements of a rural or remote community, it can also help identify otherwise missed opportunities and resources that can help deliver these services. Additionally, stronger connections between health services and communities help to build a better understanding of the relationship between peoples' health and the wider social, economic and physical environment, which will ultimately have a positive influence on overall health outcomes.

As discussed in outcome area 2, the networks between services located in rural and remote areas and their counterparts in urban centres need to be cultivated.

Strengthening mutually respectful relationships between rural and remote services and the more specialised services in larger regional and metropolitan centres is essential. This will ensure the safety and continuity of quality health care for rural and remote consumers who must travel to access high cost, high technology, and specialised health services.

Providers of health services in these larger centres also need to demonstrate a greater appreciation of the different life context of rural and remote consumers and the additional challenges they face to access these services.

Collaborative development of primary health care clinical guidelines (Queensland)

Clinical practice guidelines to support clinicians in state-wide, rural and remote primary health care facilities have been developed by the Office of Rural and Remote Health (Cairns) Primary Health Care Team. These include the Primary Clinical Care Manual and Chronic Disease Guidelines.

The development and review of the guidelines are undertaken by expert clinical and non-clinical personnel across a range of government and non-government agencies, including: the Apunipima Cape York Health Council; Royal Flying Doctor Service;

Queensland Ambulance; New South Wales Health Service (Greater Western Health Service); James Cook University; Queensland Aboriginal and Torres Strait Island Health Council; Queensland Poisons Information Centre; Royal Australian Navy – Fleet Health Support Unit; and Queensland Health.

This collaborative engagement ensures that clinicians in rural and remote facilities have access to concise, evidence-based clinical guidelines that apply in both the geographical and clinical setting. This supports rural and remote clinicians in providing expert care, therefore improving patient outcomes.

The guidelines are aimed at multidisciplinary team members including nurses, midwives, health workers and medical officers. The target population is rural and remote residents including Indigenous peoples. The Primary Clinical Care Manual is also used by Health Departments in Victoria, New South Wales, Western Australia, and Queensland.

This Framework recognises the importance of collaborative health service planning in rural and remote Australia and sets Goal 4:

Rural and remote communities will have collaborative health service planning and policy development

The strategies outlined aim to help achieve this goal by challenging planners and policy makers to better meet the specific needs of rural and remote communities, to utilise available resources and workforce, and to develop positive and effective partnerships within and beyond the health care sector.

Outcome area 4: Collaborative partnerships and planning

Goal 4: Collaborative health service planning and policy development in rural and remote Australia

Objectives	Strategies
<p><i>Objective 4.1</i></p> <p>Improved planning and decision making that address locally identified health needs</p>	<ul style="list-style-type: none"> • Support consumers and community members to be meaningfully engaged in health service planning and monitoring and evaluation. • Identify and address barriers to health service access through effective policy development and planning processes. • Improve the collection and availability of local health services data to enhance local health service planning.
<p><i>Objective 4.2</i></p> <p>Enhanced use of locally available health and human service resources</p>	<ul style="list-style-type: none"> • Maximise the use of existing health and human service infrastructure across government, non-government, private and community controlled sectors. • Identify opportunities for collaboration and information sharing between health services and other local social service sectors in the planning and delivery of health services. • Support resourcing arrangements that allow the flexible use of funds to reduce gaps and duplication of effort.
<p><i>Objective 4.3</i></p>	<ul style="list-style-type: none"> • Implement collaborative partnerships in health service

Improved health service planning within and beyond the health service sector	<p>planning, policy development and funding that involve services across the health care sector including public, private, not-for-profit, and community controlled services.</p> <ul style="list-style-type: none"> • Foster partnerships and cooperation with different levels of government (local, state and Commonwealth) and with other relevant sectors, including education, housing, employment, industry and regional development. • Support coordinated clinical networks at the local level that includes acute care, aged care and primary health care practitioners. • Promote flexible and cross-border and cross-network health service planning and delivery arrangements. • Introduce innovative resourcing arrangements that encourage regional and metropolitan care providers to support service provision in rural and remote communities.
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Outcome area 5: Strong leadership, governance, transparency and performance

Introduction

Leading and managing health services in rural and remote areas can be more challenging than in larger centres. The specific issues faced by smaller rural health services, including more limited resources and budgets, can create even more pressure for staff in the day-to-day running of services.

This Framework seeks to identify ways in which stronger leadership and governance can better serve the health needs of rural and remote communities, and to ensure the sustainability, quality and safety of their health services.

To provide a sound foundation for sustainable, efficient, safe and quality health services there is a need to:

- support good governance and management through improved access to training, skills development and tools that reflect the needs of rural and remote settings
- attract and retain skilled and experienced managers and administrative support
- support performance and continuous quality improvement.

The Commonwealth, state and territory governments all have a role in providing policy leadership, developing support tools and incentives, and monitoring the performance and quality of the health system from the local to national level.

Many jurisdictions have programs aimed at building a complement of skilled health service managers, yet there remains a need to build upon these efforts to meet the particular needs of rural and remote health services.

With the introduction of new primary health care organisations these changes offer a major opportunity to promote leadership through greater collaboration and partnerships that encourage and support the development of local solutions.

Health board members and service managers may also face the particular challenge of balancing their fiduciary duties with the needs and wants of local special interests. In smaller communities people often sit on several, sometimes competing, boards or management committees that may cross a range of government, non-government, community-controlled and private sectors. In these instances, providing strong orientation and training and ongoing mentoring and support will help to avoid potential conflicts of interest.

At the patient care level, appropriate clinical governance is essential to assure the community and those responsible for maintaining quality and safety that a competent clinical workforce is in place.

Supporting Clinical Governance (Queensland)

Credentialing and Scope of Practice for Rural and Remote Districts

The Office of Rural and Remote Health Clinical Support Unit (established in 2008) provides clinical governance services to five Queensland rural and remote Health Service Districts of Mt Isa, Cape York, Torres and Northern Peninsula, Central West and South West.

The Office set up a Credentialing and Scope of Clinical Practice Committee to assist District CEOs regarding the credentials and scope of clinical practice for general practitioner staff within rural and remote facilities. The committee has uniform standards for assessing practitioners' qualifications and experience, and applies these across both locum and permanent staff.

The Committee has representatives from each of the five Districts, as well as the Royal Australian College of General Practitioners, Australian College of Rural and Remote Medicine, and James Cook University. It also includes specialist representation in Emergency Medicine, Obstetrics and Gynaecology, Anaesthetics and Surgery.

Continuous Quality Improvement in Primary Health Care

The Primary Health Care Quality Improvement and the Audit and Best Practice in Chronic Disease (ABCD) team supports continuous quality improvement and evaluation in primary health care settings across Queensland, with a focus on Indigenous health.

Collaborating with key stakeholders, the team supports continuous quality improvement in primary health care by:

- facilitating annual clinical audit and systems assessment cycles and workshops on quality improvement to support the delivery of evidence-based services
- providing evidence-based tools and training to enable primary health services to incorporate evidence into practice for child, maternal, preventive and chronic disease health services
- providing access to web-based information and reporting system that enables primary health care centres to integrate continuous quality improvement processes into routine work activities
- linking quality initiatives such as the Healthy for Life program, National Primary Care Collaboratives, accreditation requirements, and Queensland Health key performance indicators
- supporting ongoing research and publication of findings.

All jurisdictions have policies and processes in place for accreditation and credentialing, defining scopes of practice, and for developing clinical practice

guidelines. The challenge is to ensure these policies, guidelines and processes appropriately reflect the specific needs and requirements of delivering and managing health services in rural and remote settings.

Improving accountability and performance

The collection, analysis and reporting of performance data is necessary to inform policies, program development, resource allocation and quality improvement. Using timely and good quality data will also enhance the capacity of health service systems to understand and respond to changing local health needs.

Governments have also recognised that greater transparency on the performance of health services will help to drive improved performance, and will help patients make informed choices about their health care.

Under the national health care reforms, a new performance and accountability framework will be introduced that includes national standards and transparent reporting. The aim is to provide Australians with transparent and nationally comparable performance data and information on their local hospitals and health services.

The ability to deliver on these overarching national health goals and targets will rely, in part, on achieving better health outcomes in rural and remote Australia.

Data indicators and performance targets on system performance and health outcomes are specified at both the national and jurisdictional levels, and are generally applied equally across urban, rural and remote areas. Yet indicators and targets that are appropriate for urban areas are not necessarily appropriate for rural and remote settings. And in many cases, targets and indicators that may be appropriate for rural areas are not necessarily appropriate for remote areas.

There is therefore a need to:

- develop and identify suitable data indicators for assessing health status, system performance and outcomes in the rural and remote context
- improve the quality and consistency of data collection, including the use of geographic classifications and the need to better reflect the socioeconomic features of rural and remote communities
- improve collection of health status and outcome data for remote localities and Aboriginal and Torres Strait Islander communities.

Aboriginal Health Key Performance Indicators (Northern Territory)

The Aboriginal Medical Services Alliance of the Northern Territory, the NT Department of Health and Families, and the Commonwealth Department of Health and Ageing worked in partnership to develop Key Performance Indicators for Aboriginal Health.

In 2009, collaboration between the partners resulted in the achievement of a major milestone: the generation of community-level, Aboriginal Health Key Performance Indicator reports for 82 Government and Non-Government Aboriginal Primary Health Care service providers across the Northern Territory.

With the support of Continual Quality Improvement facilitators, the data from these reports is increasingly used in communities and by service providers to plan, monitor and improve Primary Health Care service delivery in the Northern Territory.

Recognising the more limited resources and capacity of rural and remote health services to provide service data, it is imperative that any reporting and monitoring arrangements:

- are appropriate and relevant to rural and remote settings
- provide meaningful, timely and useful data
- do not increase unnecessary administrative burden on services
- feed back to services to support further quality improvement and recognise achievements.

To address the challenges and issues this Framework seeks to work towards Goal 5:

Rural and remote communities will have strong leadership, governance, transparency and accountability

A number of strategies are outlined to help enhance the leadership and governance skills and capacity for rural and remote health services, to improve the use and quality of data needed to support sound planning and decision making, and to improve accountability and performance.

Outcome area 5: Strong leadership, governance, transparency and performance

Goal 5: Strong leadership, governance, transparency and accountability for rural and remote health services

Objectives	Strategies
<p><i>Objective 5.1</i> Improved capacity for local leadership and governance of health services</p>	<ul style="list-style-type: none"> • Recognise the role of rural community leaders and the challenges of leadership in rural and remote settings. • Develop relevant leadership and governance tools. • Identify strategies to attract and retain good managers. • Provide clinical and non-clinical governance training that is tailored to rural and remote settings as a part of ongoing professional development. • Develop effective support mechanisms for health service managers. • Develop mechanisms that support regional collaboration and cooperation in leadership. • Ensure a balance between clinical and corporate governance to achieve safe sustainable health services.
<p><i>Objective 5.2</i> Enhanced availability and use of data for planning and decision making</p>	<ul style="list-style-type: none"> • Collect and make available local health services data to enhance local health service planning. • Promote the use of high quality, local population health data in planning and decision-making, and identify gaps or areas for improving data collection. • Support research that evaluates the impact of new and emerging governance and management

Objectives	Strategies
	structures, and provides an authoritative evidence base for future design.
<p><i>Objective 5.3</i></p> <p>Increased accountability and transparency in the delivery of rural and remote services</p>	<ul style="list-style-type: none"> • Establish reporting arrangements that maximise the use of existing indicators and data collections, and avoids unnecessary administrative burden on health services. • Identify gaps in reporting where further development of performance indicators may be required. • Develop health service planning and reporting templates and frameworks appropriate for use in rural and remote settings.

Glossary of key terms

Key terms	Description
Aboriginal health worker	Aboriginal and Torres Strait Islander health workers provide clinical and primary health care for individuals, families and community groups. They deal with patients, clients and visitors to hospitals and health clinics and assist in arranging, coordinating and providing health care in Aboriginal and Torres Strait Islander community health clinics.
AHMAC	Australian Health Ministers' Advisory Council – advisory body to the AHMC but also operates as a body of officials to advance efficiency in the delivery of health services through a coordinated or joint approach on matters of mutual interest.
AHMC	Australian Health Ministers' Conference – comprises the Australian Government, state, territory and New Zealand ministers with direct responsibility for health matters.
Allied health professionals	Tertiary qualified health professionals who apply their skills to diagnose, restore and maintain optimal physical, sensory, psychological, cognitive and social function. They include, but are not limited to: Aboriginal health workers, audiologists, nutritionists and dietitians, occupational therapists, optometrists, pharmacists, physiotherapists, podiatrists, psychologists, and social workers.
COAG	Council of Australian Governments (COAG) – the peak intergovernmental forum in Australia. COAG comprises the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association.
Community health care	Diagnostic, therapeutic and preventative health services provided for individuals in the community, funded by the states and territories. These services may share a number of characteristics of primary care and primary health care services, and provide more specialised community based health services for defined target groups, for example post-acute care, aged care, mental health, and drug and alcohol services.

Key terms	Description
e-Health	The use and application of information and communication technologies in the health sector. It covers the use of digital information stored and transmitted electronically – for clinical, educational and administrative purposes.
General Practitioner (GP)	A registered medical practitioner who is qualified and competent for general practice in Australia. A general practitioner has the skills and experience to provide whole person, comprehensive, coordinated and continuing medical care and maintains professional competence for general practice.
GP proceduralist	A general medical practitioner that has advanced skills and qualifications to perform procedures in obstetrics, anaesthetics, emergency care and/or general surgery.
Information and communication technologies (ICT)	Describes a wide range of technologies designed to facilitate communication and the flow of information, including: computers, the Internet, email, videoconferencing, telehealth and mobile technologies.
Local Hospital Networks (LHN)	Single or small group of public hospitals with a geographic or functional connection. Local Hospital Networks will be established under the national health and hospital reforms to enable the operational management of public hospitals to be devolved to the local level.
Medicare Locals	Network of independent primary health care organisations linked to local communities and health professionals to be established under the national health and hospital reforms to improve access to care and integration across GP and primary health care services.
Multi-disciplinary care	A multi-disciplinary team involves a range of health professionals, from one or more organisations, that work together to deliver patient care. A multidisciplinary team may include general practitioners, practice nurses, community health nurses, allied health professionals and health educators.
Multi-purpose services(MPS)	Integrated health and aged care services that provide flexible and sustainable service options for small rural and remote communities. Services can include: aged care (residential and home care), Home and Community Care services (including community nursing), domestic assistance and meals on wheels, respite care, acute care, emergency services, mental health services, and allied health services.
Nurse practitioner	Registered nurse with advanced educational preparation and experience, who is authorised to practice in an expanded nursing role, including prescribing medicines and ordering and interpreting investigations and tests that may have traditionally been performed by other health professionals.
Primary care	Also referred as primary medical care. Community-based services which often constitute the first point of contact for people experiencing an illness. Its focus is clinical services provided by GPs, practice nurses, primary/community health care nurses, early childhood nurses and community pharmacists.

Key terms	Description
Primary health care	Incorporates primary care, but has a broader focus through providing a comprehensive range of generalist services by multidisciplinary teams that include not only GPs and nurses, but also allied health professionals and other health workers, such as multicultural health workers and Indigenous health workers, health education, promotion and community development workers.
Remoteness Area (RA)	The Remoteness Area structure within the Australian Bureau of Statistics Australian Standard Geographical Classification breaks down geographical regions into five categories: Major cities, Inner regional, Outer regional, Remote and Very remote. It is updated to take into account factors such as new road networks, new area boundaries and actual services provided through centres.
Rural Generalist	<p>A rural medical practitioner who is credentialed to serve in:</p> <ul style="list-style-type: none"> • hospital and community-based primary medical practice • hospital-based secondary medical practice, without supervision by a medical specialist in at least one specialist medical discipline (commonly but not limited to obstetrics, anaesthetics and surgery) • hospital and community-based public health practice.
Scope of practice	Scope of practice is the spectrum of roles, functions, responsibilities, activities and decision-making capacity that individuals within a medical or health care profession are educated, competent and authorised to perform.
Telehealth	The use of electronic information and communication technologies to provide and support health care when distance separates the participants.

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Appendix A: Consultation participation

Workshop schedule

Date	Location
11 February 2010	Brisbane
18 February 2010	Melbourne
22 February 2010	Sydney
25 February 2010	Adelaide
25 February 2010	Burnie
26 February 2010	Hobart
2 March 2010	Canberra
9 March 2010	Alice Springs
9 March 2010	Townsville
11 March 2010	Darwin
11 March 2010	Perth

Participating Stakeholder Organisations:

(Note: organisations may have had more than one representative participating)

Queensland

Blue Care North Queensland

Burke Shire Council

Cape York Health Service District, Department of Communities

Central Region, Queensland Country Women's Association

Central Western Queensland Remote Area Planning & Development Board

Centre for Rural and Remote Health

Country Women's Association

CRANaplus

Department of Communities various areas

Faculty of Medicine, Health and Molecular Science, James Cook University

Health Consumers Queensland

Health Quality and Complaints Commission

Health Workforce Queensland

Mackay Health Community Council

Mercy Health and Aged Care, Catholic Health Australia

Mount Isa Health Community Council

Queensland Ambulance Service

Queensland Council of Social Service

Queensland Health – various areas

Regional Organisation of Councils of Cape York & Torres Shire

Royal Flying Doctor Service Queensland

Rural Townsville Health Service District

Townsville Health Service District

Victoria

Alpine Health

Barwon Health

Bass Coast Regional Health

Booth District Health

Department of Rural and Indigenous Health, Monash University

Flynn Health Consulting

General Practice Alliance of South Gippsland

Health Issues Centre

Indigenous Allied Health Australia

Kerang District Health

Kilmore & District Hospital

Kyabram & District Health Services

Kyneton District Health Service

Latrobe Regional Hospital

Loddon Mallee Rural Health Alliance

Maldon Hospital

Maryborough District Health Service

National Rural Health Alliance

Royal Australian College of General Practitioners

Rural Health Workforce Australia

Rural Workforce Agency Victoria

Seymour District Memorial Hospital

Victorian Healthcare Association

Women's Health Loddon Mallee

New South Wales

Ambulance Service of NSW, Southern Region

Cancer Council NSW

Cancer Voices NSW

Centre of Rural and Remote Mental Health

Council of Social Services of NSW

Country Women's Association

Dubbo Division of GPs

Health Advisory Council, Greater Southern Area Health Service

Health Advisory Council, Greater Western Area Health Service

Hunter New England Area Health Service
Integrated Cardiovascular Clinical Network SA
Northern Rivers University Department of Rural Health School of Public Health,
University of Sydney
NSW Department of Health – various areas
NSW Institute of Rural Clinical Services & Teaching
NSW Rural Doctors Network
Optometrists Association Australia, Rural Advisory Group
Royal Flying Doctors Service
Rural and Remote Health Priority Taskforce
Rural Critical Care Taskforce

South Australia

Adelaide to Outback
Aged & Community Services SA & NT Inc.
Australian Medical Association (SA)
Board Health Advisory Council, Country Health SA
Bordertown and District Health Advisory Council Inc.
Central Northern Adelaide Health Service Cancer Services
Coorong Health Service
Country Health SA - various areas
Country Patient Services, SA Ambulance Service
Eastern Eyre Health Advisory Council Inc.
Eudunda Kapunda Health Advisory Council Inc.
Faculty of Health Science, Flinders University
Flinders University Rural Clinical School
Health Consumers Alliance Inc
Health Consumers of Rural and Remote Australia
Health Services Union
Hills Southern Fleurieu Kangaroo Island, Country Health SA Hospital Inc.
Kingston/Robe Health Advisory Council Inc.
Lower North Health Advisory Council Inc.
Mallee Health Service
Mid-West Health Advisory Council Inc.
Murray Bridge Soldiers' Memorial Hospital Health Advisory Council Inc.
Northern Yorke Peninsula Health Advisory Council
Nursing Services, Casterton Memorial Hospital
Penola and Districts Health Advisory Council Inc

Rural Doctors Workforce Agency

SA Ambulance Service

SA Country Health Network

SA State Emergency Service

Small Business & Regional Development, Department of Trade & Economic Development

Sturt Fleurieu GP Education and Training

Waikerie & Districts Health Advisory Council Inc.

York Peninsula Health Advisory Council Inc.

Tasmania

Alcohol and Drug Service North/North West

Allied Health Services, North West Regional Hospital

Ambulance Tasmania

Australian Nursing Federation

Break O' Day Health Resource Association Inc.

Department of Health and Human Services various areas

Diabetes Education Services, Diabetes Tasmania

General Practice Tasmania Limited

Health Consumers of Rural and Remote Australia

Huon Eldercare

Mental Health Services

Rural Alive and Well

Southern Tasmania Area Health Service

University of Tasmania

Australian Capital Territory

AMA Rural Medical Committee, Australian Medical Association

Australia Institute of Health and Welfare

Australian GP Network

Australian Health Care and Hospitals Association

Australian Rural Health Education Network (ARHEN)

Clinical Oncological Society of Australia

Consumers Health Forum of Australia

Department of Health and Ageing – various areas

Health Consumers of Rural and Remote Australia

National Rural Health Alliance

National Rural Health Students' Network, Rural Health Workforce Australia

Pharmaceutical Society of Australia
Rural Doctors Association of Australia
Rural Pharmacy, Charles Sturt University
Rural Programs, Health Support Programs Branch, Medicare Australia

Northern Territory

Aboriginal Medical Service Alliance Northern Territory
Alice Springs Hospital
Allied Health Academic, Centre for Remote Health
Australian Dental Association's Rural Dentists Network
Australian Nursing Federation NT
Bosom Buddies Breast Cancer Support
Central Australian Practitioners Association
Centre for Remote Health
Council Remote Area Nurses Australia
Department of Health and Ageing – various areas
Frontier Services
General Practice Network NT
Gove District Hospital
Heart Foundation NT
Indigenous Program, The Fred Hollows Foundation
Menzies School of Health Research
Northern Territory General Practice Education
NT Department of Health and Families – various areas
Office of Aboriginal and Torres Strait Islander Health
Pharmacist, RWM Consulting
Physician, Alice Springs Hospital
Physiotherapist, Tangentyere Council
Remote/Barkly Allied Health Team, Aged & Disability Program, Central Australia
St John's Ambulance
Strategic Workforce Planning
Tangentyere Council

Western Australia

Australian Physiotherapy
Cancer Services Division, Cancer Council
Combined Universities Centre for Rural Health
Council of Remote Area Nurses of Australia
Health Consumers' Council

National Rural Health Alliance
Postgraduate Medical Council of Western Australia
Royal Flying Doctors Service
Rural Health West
Silver Chain Nursing Association
South West Gynaecology
St John Ambulance
St John Ambulance Country Service
WA Country Health Service – various area
WA Department for Health – various areas
WA GP Network
WA General Practice Education and Training Ltd

Interviews:

Aboriginal and Torres Strait Islander Health Strategy Unit, Queensland Health
Australian Institute for Health and Welfare
Centre for Health Care Improvement, Queensland Health
Chief Financial Officer, NSW
Chief Medical Advisor, SA Health
Clinical and State-wide Services, Queensland Health
Clinical Workforce Planning and Coordination, Queensland Health
Commonwealth Department of Health and Ageing – various areas
Flinders Island Nursing, Tasmania
General Practice Workforce
Greater Southern Area Health Service, NSW Health
Greater Western Area Health Service, NSW Health
Health Gains Planning, NT Department of Health & Families
Hunter New England Area Health Service
Monash University, School of Rural Health (Bendigo)
Department of Health (Victoria)
National Rural Health Alliance North Coast Area Health Service, New South Wales
North West Area Health Service, Tasmania
Northern Area Health Service, Tasmania
Office of Aboriginal and Torres Strait Islander Health (NT), Department of Health and Ageing
Office of Director General, New South Wales
Office of Rural and Remote Health, Queensland Health

WA Health

Health Planning and Infrastructure Division, Queensland Health

Rural and Remote Medical Services, Queensland Health

Rural Doctors Association (Qld)

Services for Australian Rural and Remote Allied Health

Allied Health, SA Health

Service Operations, SA Health

Southern Area Health Service, Tasmania

Statewide and Mental Health Services, Department of Health and Human Services (Tasmania)

Strategic Policy, Funding and Intergovernmental Relations Branch, Queensland Health

System Reform, Care Reform, Department of Health and Human Services (Tasmania)

Systems Performance & Aboriginal Policy, Department of Health and Families, NT

Victorian Healthcare Association

Written submissions received:

Alice Springs Hospital

Australian Association of Consultant Physicians

Australian Medical Association

Australian Rural Health Education Network

Bluecare

Bosom Buddies Breast Cancer Support

Cancer Council Australia and Clinical Oncological Society of Australia

Central Highlands Community Health Council

Charleville Health Community Council

Council for Remote Area Health Nurses

Friends of the Alliance

Hunter New England Health

Optometrists Association Australia

Pharmaceutical Society of Australia

Royal Australian and New Zealand College of Obstetricians and Gynaecologists

Rural Critical Care Taskforce, New South Wales

RWM Consultancy (pharmacist)

Southern Highlands Division of General Practice

Women's Health Victoria