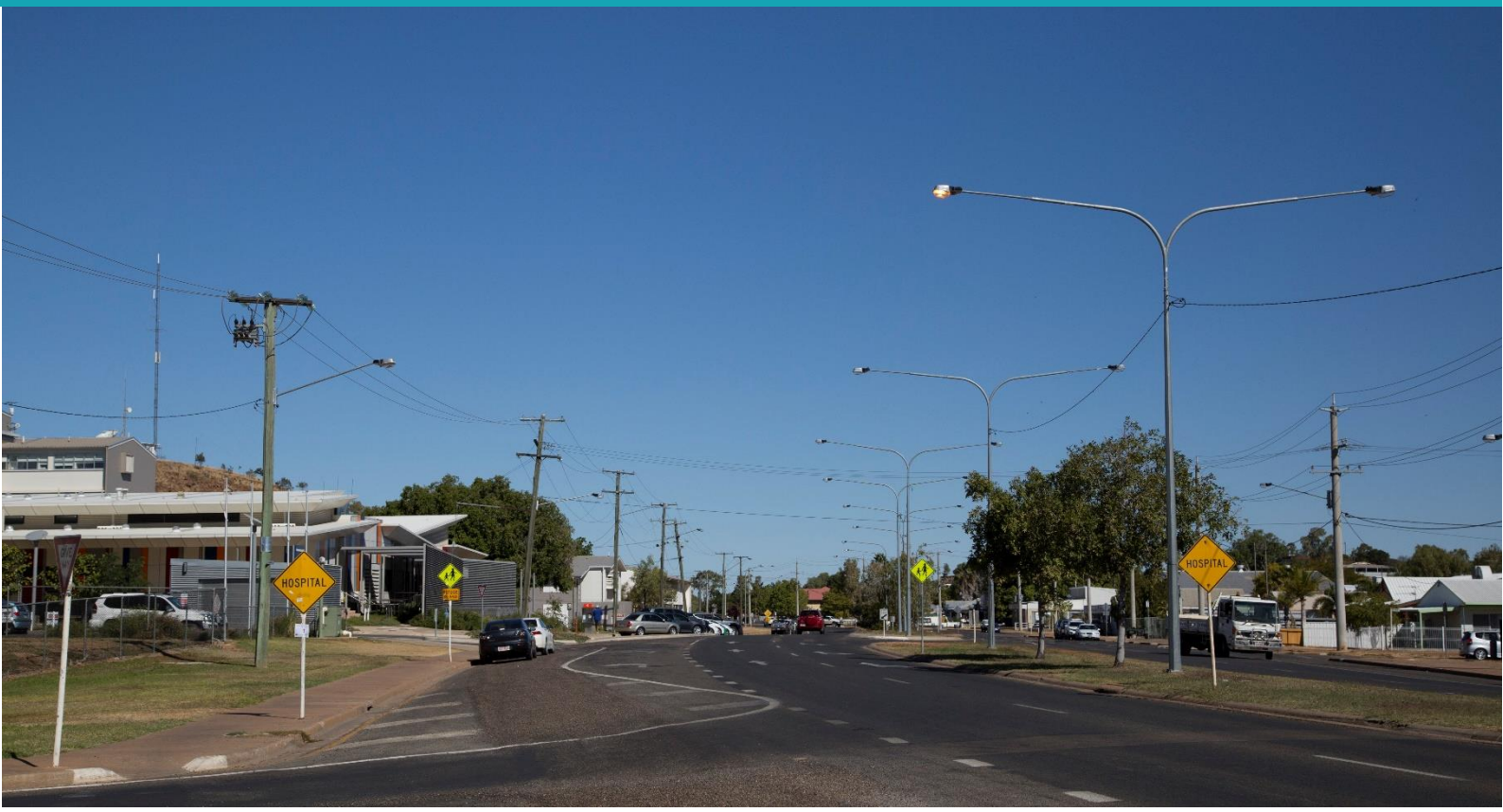
National Rural Health Alliance

Draft National Healthcare Interoperability Plan

13 December 2021



… healthy and
sustainable rural,
regional and remote
communities

National
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Draft National Healthcare Interoperability Plan

The National Rural Health Alliance (the Alliance) welcomes the opportunity to provide feedback on the Draft National Healthcare Interoperability Plan.

The Alliance

The Alliance comprises 42 national members (see Appendix 1) and is focused on improving the health and wellbeing of the 7 million people residing outside our major cities. Our members include health consumers, healthcare professionals, service providers, health educators, students and the Indigenous health sector. Comprehensive representation of the rural health sector enables us to work toward our vision of 'healthy and sustainable rural, regional and remote communities'.

We advocate for local solutions to local issues, recognising that metropolitan solutions do not necessarily work in rural, regional and remote (hereafter, rural) communities.

Introduction

The Alliance recognises the benefits of interoperability for health systems, health professionals and health consumers. According to a nationwide survey conducted in 2016, one in six people saw three or more health professionals for the same condition. Among those, 12 per cent reported that there were issues caused by a lack of communication between the health professionals.[1]

Increased interoperability has the potential to improve the scope for high value care, reduce duplication and errors, facilitate multidisciplinary team care and continuity of care, provide better data and information to inform resourcing and investment decisions, promote more efficient and cost-effective use of funding, and inform population health and research.

Improving interoperability has been identified as a key priority for healthcare, including in the context of the draft Primary Health Care 10 Year Plan. The Consultation Draft of Australian's Primary Health Care 10 Year Plan 2022 – 2032[2], includes a priority action area which seeks to improve quality and value through data-driven insights and digital integration. This includes supporting and scaling up data development and linkage projects and considering additional regulatory approaches to support privacy and consent, data security, software interoperability and clinical decision support tools.

The Report from the former National Rural Health Commissioner *Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia* also includes a recommendation to invest in allied health data and infrastructure. The report recommends a National Allied Health Data Strategy, the major focus of which is on allied health workforce data including workforce distribution and demand, as well as high-quality allied health data with a commonly understood meaning that can be accessed with ease and confidence. While a range of allied health data is known to be collected, it is disparate and not widely accessible. Some data is available for those allied health professions regulated by the Australian health Practitioner Regulation Agency, however, data from professions self-regulating via the National Alliance of Self-Regulating Health Professions and other independently regulated allied health professions is not widely accessible, or included in many mainstream workforce data collections, including those from the Australian Bureau of Statistics. Currently, allied health data is collected using different standards, definitions, at different levels of detail and for different purposes.

This priority is also recognised through the Australian Government's Practice Incentives Program eHealth Incentive (ePIP). ePIP aims to encourage general practices to keep up to date with the latest developments in digital health and adopt new digital health technology, including ensuring practices have compliant clinical software systems, standards compliant secure messaging capability, recording diagnoses for patients electronically, using nationally recognised disease classification systems or terminology, electronic transfer of prescriptions and requirements relating to accessing and updating the My Health Record system.

The Alliance's submission will respond to the key questions provided as part of the consultation and provide some general feedback on a range of additional issues we have identified.

RESPONSE TO KEY QUESTIONS

INTEROPERABILITY PRINCIPLES

Does the Alliance support the Interoperability Principles in Section 3.1, or should some principles be amended, added or removed?

RESPONSE

1. Health information is discoverable and accessible. Discoverable and accessible health information is key to supporting healthcare providers to deliver quality health care to their patients. It is equally important for individuals to have access to their personal health information to help them to manage their own health. This principle must have regard to Principle 2 so that privacy and consent requirements are fully met.

The Alliance supports the principle that health information is discoverable and accessible. It is particularly important for rural Australians who have higher levels of disease and injury and poorer access to and use of health services[3] to have ready access to comprehensive and accurate health information. It is also particularly important to facilitate continuity of care where patients are supported through multiple primary healthcare providers such as locums or fly-in/fly-out practitioners or for people living in rural and remote communities who must travel to major centres to access comprehensive or speciality care.

2. Use of health information supports individual choice and access to information. The roles of security, privacy and consent must be considered and regulated in relation to using and sharing health information. Australians expect to be in control of their health information, including who can access it and when, and that it is handled in accordance with privacy legislation.

The Alliance supports this principle. However, individual choice and access to information can be challenging for people living in rural and remote communities. Limited access to primary health care often means that there is little choice of healthcare provider. Rural areas have up to 50 per cent fewer health providers than major cities including general practitioners (GPs), physiotherapists, psychologists, dentists, pharmacists, optometrists and podiatrists.[4] Individual choice and access to information can also be constrained in rural and remote areas due to connectivity challenges and difficulties with bandwidth and service reliability.

3. National Healthcare Identifiers are used across the healthcare sector. National Healthcare Identifiers are essential for interoperability. Wider use of national healthcare identifiers will support interoperable digital systems and solutions. Healthcare identifiers support information sharing by

accurately identifying healthcare recipients, healthcare providers and healthcare organisations involved in an exchange. This inspires confidence that information is only accessible by approved healthcare providers and that an approved healthcare provider has shared information for the right individual.

While the Alliance recognises the importance of national healthcare identifiers, the rollout and application of national healthcare identifiers should not disadvantage any groups of Australians. Equity of access to healthcare, including national healthcare identifiers, requires that all Australians, including those living in remote communities, and/or Aboriginal and Torres Strait Islander peoples, and low socio-economic communities are not disadvantaged.

4. National digital health standards and specifications are agreed and adopted. To seamlessly transfer health information between individuals and providers, and ensure that the sender and recipient consistently understand the information, it is essential to have agreed terminology and digital health standards and specifications. It will be necessary to develop these using a transparent and consensus-based approach. As part of adoption, software and processes should adhere to national conformance rules.

The draft Plan identifies that the Australian Digital Health Agency (ADHA) is taking the lead in the development of, agreement to and adoption of national digital health standards and specifications. It is important that ADHA focus on including not only state and territory governments, including public health and hospital stakeholders, but ensure there is comprehensive consultation with peak health professional bodies and health consumers.

Not only is it important that all health professional bodies are consulted, but that the views of healthcare professionals operating in rural and remote Australia are included. This is particularly true for small rural practices operating in thin markets, with a small population base and frequently limited by poor digital infrastructure. When considering the implications of national digital health standards and specifications, the support requirements for smaller rural practitioners will be different to larger metropolitan practitioners. Similarly, there will be differences in the support required by professions for whom the interoperability of digital systems is less developed, such as allied health practitioners.

Greater clarity is required on how digital health standards will be implemented, including who is responsible for ensuring that the standards are implemented consistently and how peak professional health bodies will be supported to provide education and communication to their members.

Alliance members have noted that a rating system to verify compliance of vendors with the digital health standards would greatly facilitate health practitioners to choose compliant systems and the Alliance anticipates that ADHA will pay a significant role in verifying and communicating compliance of vendors with the digital standards.

5. The value of care delivered increases as more digital health systems are connected. Investing in interoperable systems produces a network effect, in which value increases as more digital systems are connected and can meaningfully communicate. Implementing digitally enabled models of care that incorporate one or more of the core foundational components of interoperability – such as identifiers, standards and terminology – will foster a more advanced and innovative digital environment that is more convenient for users and enables better integration and healthcare delivery across different care settings.

There are many potential benefits for people living in rural and remote Australia from systems which enable better integration and healthcare delivery across different care settings, with an associated

increase in higher value care. However, it is important that the unique barriers to enabling full access to these benefits for the 7 million Australians living outside major cities and their healthcare providers are considered and overcome as part of the Interoperability Plan.

6. The interoperability system design is informed by national digital health system maturity. Different healthcare organisations operate at different levels of maturity. It is important to identify and consider these levels when designing solutions that can best enhance interoperability without impacting service delivery and access. A minimum level of digital capability is required to participate in an interoperable health system.

The Draft Plan proposes a baseline survey of interoperability covering GPs, pharmacies and hospitals. Prior to the baseline survey of interoperability covering GPs, pharmacies and hospitals, consideration should be given to an audit of software packages available through vendors, across the spectrum of health professionals (i.e. beyond the scope of just GPs, pharmacies and hospitals, to embrace allied health, medical and surgical specialists and community health providers).

The baseline survey should then also move beyond GPs, pharmacies and hospitals, to the wider health sector as outlined above. Doing a baseline survey with the currently proposed narrower focus, may result in an understatement of the complexity of the interoperability challenge. A narrow survey will not pick up the large number of diverse software providers and options in, for example, allied health.

7. Core national healthcare digital infrastructure is used across the healthcare sector. All healthcare organisations should use the existing core national digital infrastructure as a trusted national system, this will drive standardisation and interoperability across the health system. For example, the National Health Services Directory (NHSD) should be used for discovering healthcare providers and healthcare services. As the use of national infrastructure increases, so too will the volume of information within it, increasing its utility. Other core national infrastructure includes the My Health Record system, the Healthcare Identifiers Service (HI Service), National Clinical Terminology Service (NCTS) and the National Authentication Service for Health (NASH).

The Alliance supports utilising existing systems to drive standardisation and interoperability where appropriate to avoid duplication and “reinventing the wheel”. However, while existing systems might have the potential to be fit-for-purpose, it needs to be clear that these systems will be appropriately resourced and maintained, and responsibility for resourcing and maintaining these systems clearly articulated and accountability monitored. The National Health Services Directory, for example, will not be accepted as a useful and trusted resource unless it is maintained and regularly updated. Unless there is clear responsibility and accountability, these foundational systems will not achieve their intended outcomes. If it is just left to individual health practitioners or practices to maintain the Directory, without any incentive to do so, it will not be fit-for-purpose. Successful implementation of Provider Connect Australia will also significantly facilitate the provision of accurate, up-to-date information, while reducing administrative burden.

8. Investment supports interoperability. To move to an interoperable healthcare system, it is essential that decision-making about future investments considers methods for capturing, sharing and managing clinical information. Procurement documentation should include consistent requirements that enforce the need for interoperability.

The Alliance supports the need for investment in interoperability to fully realise the benefits of digital health innovation. The Alliance considers that a range of strategies will be necessary to support the successful implementation of the complex elements of health interoperability across the healthcare system and throughout the country. It is important that investment be strategic and co-ordinated to

complement a range of incentives to support and promote interoperability. The Alliance is particularly concerned that no sector of the health system be excluded from the benefits of improved interoperability due to the complexity of the issues, a lack of financial or technical support, or access to infrastructure.

To this end, the Alliance support investment in digital health infrastructure to support the full spectrum of health professionals, with a particular focus on compatibility and interoperability, including with My Health Record and pathology and diagnostic imaging data systems.

Recommendations:

The Alliance recommends the addition of a principle highlighting the importance of ensuring that all health practitioners, including allied health, are equally supported and incentivised to move to an interoperability environment and that the implementation opportunities are considered and applied consistently across all health professions, both public and private health systems and all regions of Australia.

The Alliance recommends that there are clear lines of responsibility and accountability for ensuring that systems are maintained, updated and reliable.

The Alliance recommends that an audit of software packages available through vendors to the full spectrum of health professionals be conducted and made publicly available prior to a baseline survey of interoperability. This baseline survey of interoperability should not be limited to GPs, pharmacies and hospitals as proposed in the draft Plan, but should embrace the full spectrum of health professionals, including allied health professionals. A narrow survey could result in an understatement of the complexity of the interoperability challenges.

The Alliance further recommends that interoperability implementation consider how relevant patient data can be shared across the National Disability Insurance Scheme, aged care and mental health systems to maximise the utility of data sharing and maximise the benefits to health consumers.

IMPLEMENTATION ACTIONS

Are there any key actions missing to promote the objectives of this Plan? (A consolidated list of actions can be found in Section 10)
Would you like to see any changes to the scope or time-frame of the proposed actions?
Are there any actions that your organisation would like to be involved in progressing, and what would that involve?

RESPONSE

The list of key actions to promote the objectives of the plan is comprehensive and the Alliance appreciates that the list includes clear articulation of the agencies responsible for implementation, either as a lead or support agency.

What is less clear from the key actions is how health professions and health consumers will be engaged in the process. There is extensive engagement with government agencies, some mention of software vendors and one mention of clinical peak bodies under Action 5.1.

However, the Alliance believes that early and ongoing consultation with the full spectrum of health professionals and health consumers will be critical to the successful adoption and implementation of

the Plan. The full spectrum of health professionals need to be part of early consultation and co-design of implementation strategies. It will be important that systems should support how health professionals work, rather than health professionals having to adapt their practices to meet the requirements of systems. Further, despite the fact that Australians are traditionally early adopters of new technologies and innovations, if the digital health systems do not meet the needs of health consumers, are not easy to understand and navigate and do not address concerns around privacy and security, there will be ongoing resistance to wide-spread adoption.

The current lack of discussion in the draft Plan regarding engagement and co-design with health professions and consumers, has also resulted in the Plan having a focus on government processes rather than a Plan which acknowledges the role of health providers and consumers as an important part of planning, development and implementation.

The Actions are focussed on high level principles and planning, with less focus on "on-the-ground" implementation. It is not clear how the high-level actions involving primarily government agencies will translate to engagement and action for smaller professional groups and individual practitioners. The implications for small, particularly rural, practitioners are not clear. There is a should be a greater focus on connecting the high-level technical planning and discussions and the implications for on-the-ground practitioners.

Comments on specific key actions are provided below.

Action 6.1 notes that *Healthcare providers will specify interoperability requirements in procurement requests.* How broad is this definition of healthcare providers? The agencies listed as responsible are limited to government agencies.

Action 6.9 – *The Agency to collaborate with stakeholders on the development of an agreement for use by each organisation holding personal health information that stipulates the terms and conditions for sharing, discovering and acquiring information from other organisations*. The Draft Plan identifies the lead agencies for this work, and includes the Australasian Digital Health Institute. Whilst the Australasian Digital Health Institute has a diverse range of members, is this membership sufficient in scope and authority to comprehensively address the implications of holding and sharing the personal health information for each organisation holding personal health information? How will this key action be progressed to ensure that the full scope of health providers, including those in rural and remote Australia, are consulted? The range of stakeholders in scope for consultation for this significant piece of work is extensive. How does the Agency propose to ensure that all affected stakeholders have been adequately consulted?

Action 6.10 *The Agency to collaborate on the development of consistent definitions to support health information sharing that supports interoperability and communication of health information.* There will be a broad range of stakeholders with strong levels of interest in this action. How does the Agency propose to ensure that all affected stakeholders have been adequately consulted?

Action 8.1 *The Agency will develop and undertake a survey of hospital, pharmacy and GP organisations to provide a benchmark for the level of interoperability.* The current baseline data collections focus on GPs, pharmacists and hospitals. How and when will baseline information be collected for the full range of health services including allied health professionals, medical and surgical specialists, nurse practitioners, and the broader health sector such as early childhood health?

Action 9.3 *The Agency will review the effectiveness of current incentives and assess what additional mechanisms are required to support and accelerate interoperability.* For interoperability to be widely

embraced and actioned across the full spectrum of health professionals, there will need to be strategies to incentivise interoperability. The comments in the General Feedback section below expand on this concept. For example, how will current incentives promote change for small health practices. Why would a small practitioner change from a system which is currently working effectively, to a new system where there is no guarantee that it will meet their needs and will involve significant expense both financial and time?

Recommendation:

The Alliance recommends that further information be provided to stakeholders regarding how early and ongoing consultation with the full spectrum of health professionals, including allied health, and health consumers will be incorporated into the Plan.

Currently the Plan, including the key actions, has a focus on high level principles and planning. While it is acknowledged that this is the intention of the Plan in its current form, it is not clear how the high-level actions primarily involving government agencies will translate to engagement and action for the full spectrum of health professionals. The Alliance recommends that more detailed information on the proposed implementation implications be provided. There should be a greater focus on connecting the high-level technical planning with implications for practitioners on-the-ground.

INTEROPERABIITY INITIATIVES

Which, if any, of the implementation initiatives in section 7.4 would you like prioritised for delivery and why?

RESPONSE

The Alliance notes that the initiatives outlined as driving and enabling interoperability were identified following prior consultation with stakeholders. The draft Plan states that these initiatives will leverage the foundations of interoperability. The Alliance is keen to ensure that each of the key categories of initiatives are rolled out in an equitable way, so that the full range of healthcare providers (and their associated consumers), including those providers in rural and remote Australia, have access to the benefits and advantages of interoperability.

Recommendation:

The Alliance recommends that the proposed interoperability initiatives outlined at section 7.4 of the Draft Plan be planned and implemented in an equitable way, ensuring that no sectors of the health system or parts of the country are disadvantaged in the rollout of the interoperability framework.

GENERAL FEEDBACK

Implementation

It is acknowledged that a lack of standards impacts vendors working together. Ultimately the goal is software that works well, meets the needs of clients and exchanges data easily. There is a view that there is currently no clear path to this end.

Principle 4 states that “National digital health standards and specifications are agreed and adopted”. As has been noted in the Alliance feedback on specific elements of the Draft Plan, it is focussed on

high level principles and planning, with less focus on “on-the-ground” implementation. It is not clear from the Draft Plan how this high-level vision will facilitate consideration of integration of interoperability across the system for individual practitioners, in particular small and or/rural practitioners.

Health practitioners face many barriers in embracing and adopting the changes required for successful implementation. The current implementation strategies and responsible parties are focussed on government agencies and government-to-government consultation. Only one implementation initiative mentions professional bodies. How does the high-level government allocation of responsibilities translate to change on the ground for health practitioners?

It has been suggested that to ensure the “on-the-ground” implications for rural practitioners are considered in the planning and delivery of the interoperability agenda, health practitioners need to be part of early consultation and co-design of implementation strategies. To this end, strategic planning and implementation at the government-to-government level and at the “on-the-ground” practitioner level should occur concurrently. If this does not happen, implementation may take decades. For example, when looking at the overarching structures and foundational activities like identity, standards and information sharing, the plan should consider how this will translate to and be implemented by the small, on-the-ground practitioners.

Incentives – systems and vendors

These comments again reference principle 4 “National digital health standards and specifications are agreed and adopted”. It has been noted in the draft Plan that ADHA sets the standards. However, for vendors to operationalise the standards there needs to be an incentive to adopt them, or incentives for market-driven pressure for adoption. For example, there has been significant, rapid innovation occurring in the context of COVID. To achieve this change, the government provided a range of incentives across the digital health environment to promote rapid uptake. A similar strategy of incentives will be necessary to promote and drive interoperability change.

It is unlikely that these incentives and changes will be driven by the market alone. Similar to the COVID initiatives, government leadership, intervention and financial incentives will be an important driver of change. There is a role for government to create incentives, either through investment or through regulatory or administrative requirements. Vendors need to be resourced to deliver what industry wants rather than leveraging off their goodwill. It is also important that incentives are implemented in a way that fosters co-operation without stifling innovation.

It is critical that the full spectrum of health professionals be included early in the planning and implementation discussions. This will avoid implementation problems whereby vendors are faced with competing priorities, attempting to meet the possibly differing requirements of both government and health practitioners.

Incentives – health practitioners

In addition to incentives encouraging health systems and vendors to adopt interoperability standards, strategies must also be developed to ensure there are appropriate incentives for the various health professions and individual health practitioners. There are large sectors of the health workforce with little engagement in this process. Planning for interoperability will need to incorporate strategies to engage and incentivise individual practitioners.

There are currently a large number of systems being used by the range of health professionals. For example, around 120 different systems are used by allied health alone. Whilst it appears there is

work underway to encourage some parts of the health sector to improve the interoperability of their systems, particularly where there is less diversity of systems, a significant challenge remains in addressing interoperability for those professions where there is greater diversity of systems and profession specific needs.

As well as the variety of health professions, the Interoperability Plan will need to consider how to engage with and incentivise the move to interoperable systems for individual health practices. Why would a small practitioner change their current effective systems to a new system where there is no guarantee that it will meet their needs and will involve significant expense, both financial and administrative, and potential disruption to clients and services?

The take up of secure messaging in pharmacy provides an example of the need for incentives and structure in the move to interoperability. For pharmacists, there are costs involved in accessing secure messaging services. There are currently multiple providers who do not interact with each other. Before pharmacists can commit to investing in secure messaging, they need to be confident that a critical mass of their clients are utilising a service in order to make the investment worthwhile. It is not cost effective to pay to access multiple secure messaging providers. There will not be extensive take up of secure messaging until there is system interoperability.

Recommendation:

The current draft Plan does not articulate the process for engaging with the full range of health professions, including those with complex interoperability challenges and profession specific needs, or the process for engaging and incentivising small practices. To address this issue, the draft Plan must identify a clear path to engage and incentivise the range of health professions (including small businesses).

To provide an additional level of clarity, it is important for the draft Plan to include an indicative timeline for the rollout of the interoperability implementation process.

Education

It is not clear from the draft Plan what formal structures are in place for educating the range of health professionals about the move to interoperability, proposed stages, critical decision points, business cases, and timelines.

The Plan would benefit from further information about structured plans for engaging health professionals and supporting attitudinal change. As part of promoting attitudinal change, it will be important to address professional concerns regarding data security and privacy, data transfers and accessibility, and ongoing access to and ownership of medical and medication records.

Recommendation:
The draft Plan should consider what health professionals need to know to plan for interoperability. They need advice on the processes and implications for their systems, and benefits to their practices and clients, as well as information to address privacy and data access concerns.

Digital inclusion and literacy

Principle Two states “Use of health information supports individual choice and access to information”. In order to realise this principle, the draft Plan will need to consider the digital inclusion and literacy of health professionals and health consumers. This is particularly relevant for rural and remote health practitioners and consumers. The Australian Digital Inclusion Index tracks

and reports on digital inclusion in Australia.[5] The divide between metropolitan and regional areas is marked. In 2021, metropolitan areas recorded an average Index score of 72.9 (1.8 points higher than the national score). Regional areas, however, recorded an Index score of 67.4. Cyber safety is also a significant concern for digitally excluded Australians, with concern about privacy and scams rising 3 per cent between 2020 and 2021. In 2021, 20 per cent of digitally excluded Australians are so concerned about privacy and scams that it limits their internet use.

The higher proportion of older Australians living in regional Australia also has implications for the successful rollout of the interoperability agenda. Digital ability scores align closely with age, with young adults under 34 receiving a score of 81.6 — 17.2 points higher than the national average (64.4), and 54.4 points higher than that of Australians over 75 (27.2). This age-gap is evident across each digital ability component and increases as tasks become more complex.

Affordability also remains central to closing the digital divide. This is a particular issue for rural and remote Australia, with a higher proportion of rural Australians having lower socio-economic status that metropolitan Australians. Based on the Australian Digital Inclusion Index affordability measure, 14 per cent of all Australians would need to pay more than 10 per cent of their household income to gain quality, reliable connectivity.

Recommendation:

The draft Plan needs to address the broader requirements of a successful rollout of the interoperability agenda, to ensure that the critical foundations of access to the benefits of digital health are overcome, including ensuring the most disadvantaged communities (including those in rural remote Australia, older Australians and low socio-economic Australians) have access to digital health and are literate in the use of and benefits of digital health.

Infrastructure

For all geographic areas of Australia to implement the interoperability agenda and effectively transition to a digitised health system, reliable, affordable, and adequate access to digital infrastructure - including broadband - is essential. Many areas of rural and remote Australia require significant upgrades to digital infrastructure, with poor network coverage and difficulties accessing high speed and consistent internet.

Recommendation:

For a successful rollout of digital health and the interoperability agenda, equitable access to digital health infrastructure across all geographic areas is essential.

Appendix 1: National Rural Health Alliance members

42 organisations with an interest in rural health and representing service providers and consumers

Allied Health Professions Australia (Rural and Remote Committee)	Exercise & Sports Science Australia
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)	Federation of Rural Australian Medical Educators
Australasian College of Health Service Management (Regional, Rural and Remote Special Interest Group)	Isolated Children's Parents' Association
Australasian College of Paramedicine	National Aboriginal Community Controlled Health Organisation
Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
Australian Chiropractors Association (Aboriginal and Torres Strait Islander Rural and Remote Practitioner Network)	National Rural Health Student Network
Australian College of Midwives (Rural and Remote Advisory Committee)	Optometry Australia (Rural Optometry Group)
Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)	Pharmaceutical Society of Australia (Rural Special Interest Group)
Australian College of Rural and Remote Medicine	Royal Australasian College of Medical Administrators
Australian Dental Association (Rural Dentists' Network)	Royal Australasian College of Surgeons (Rural Surgery Section)
Australian General Practice Accreditation Limited	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Australian Healthcare and Hospitals Association	Royal Australian and New Zealand College of Psychiatrists
Australian Indigenous Doctors' Association	Royal Australian College of General Practitioners (Rural Faculty)
Australian Nursing and Midwifery Federation (rural members)	Royal Far West
Australian Paediatric Society	Royal Flying Doctor Service
Australian Physiotherapy Association (Rural Advisory Council)	Rural Doctors Association of Australia
Australian Psychological Society (Rural and Remote Psychology Interest Group)	Rural Health Workforce Australia
Australian Rural Health Education Network	Rural Pharmacists Australia
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	Services for Australian Rural and Remote Allied Health
Council of Ambulance Authorities	Society of Hospital Pharmacists of Australia
CRANAplus	Speech Pathology Australia (Rural and Remote Member Community)

[1] CSIRO 2018. Future of Health Shifting Australia's focus from illness treatment to health and wellbeing management. https://www.csiro.au/en/work-with-us/services/consultancy-strategic-advice-services/csiro-futures/future-health

[2] Australian Government Department of Health 2021. Consultation Draft – Future focussed primary health care: Australia's Primary Health Care 10 Year Plan 2022-2032. Canberra. Viewed 16 November 2021, https://consultations.health.gov.au/primary-care-mental-health-division/draft-primary-health-care-10-year-plan/

[3] Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 10 November 2021, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

[4] Australian Institute of Health and Welfare 2019. Rural & remote health. Cat. no. PHE 255. Canberra: AIHW. Viewed 08 January 2021, https://www.aihw.gov.au/reports/rural-remote-australians/rural-remote-health

[5] https://www.digitalinclusionindex.org.au/