



National Rural Health Alliance

**Submission to the Australian Commission on Safety and Quality
in Healthcare: Consultation on the initial draft of the National
Safety and Quality Health Service Standards (third edition)**

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Equitable, healthy and
sustainable rural,
regional and remote
communities across
Australia.



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Introduction

The National Rural Health Alliance (the Alliance) welcomes the opportunity to provide feedback on the initial draft of the National Safety and Quality Health Service (NSQHS) Standards (third edition), developed by the Australian Commission on Safety and Quality in Health Care (the Commission).

The Alliance is the peak body for rural, regional and remote (hereafter rural) health in Australia, comprising [57 national member organisations](#). Our members include healthcare professionals, service providers, health and medical educators and trainers, researchers, medical and health practitioner students, the Aboriginal and Torres Strait Islander health sector and organisations that deliver care for rural and remote Australians. The Alliance works to improve the health and wellbeing of the more than 7.4 million (close to 30%) Australians who live outside of Australia's *Major Cities*.

People living in rural Australia experience poorer access to health services, health professionals and on average, higher rates of disease, injury hospitalisation and preventable mortality than people living in *Major Cities* (AIHW 2025). In 2023-24, the rate of potentially preventable hospitalisations was 1.8 times as high in *Remote* areas and 2.8 times as high in *Very Remote* areas as in *Major Cities*. (AIHW 2025). These disparities reflect the interaction of health need, geography, workforce availability, socioeconomic circumstances and access to timely and appropriate care.

The Alliance supports the overall direction of the initial draft of the NSQHS Standards (third edition) and welcomes the response to many of the issues raised through the first consultation. The Alliance's earlier submission supported nationally consistent expectations for safety and quality while emphasising that implementation needs to be practical, flexible and appropriate to different geographic and service contexts, particularly for smaller rural and remote services operating with limited workforce, infrastructure and access to specialist expertise (NRHA 2025).

This initial draft gives greater prominence to equity, workforce sustainability, culturally safe care, integrated care, digital technologies and continuous improvement. The Alliance also welcomes the Commission's recognition that implementation and assessment should be proportionate to the size, scope, complexity, clinical risk profile, service model and digital maturity of individual health services, rather than requiring uniform implementation models (ACSQHC 2026a).

These are important considerations for rural health services, which commonly operate with smaller workforces, limited specialist availability, greater reliance on locums, visiting and outreach models, longer transfer and travel distances, thin or failed service markets and variable digital connectivity. They also sit within a broader context of inequitable access to health funding, workforce and services. The 2026 Forgotten Health Spend estimates an annual health expenditure gap of \$9.23 billion for people living outside metropolitan Australia in 2024–25, equivalent to an average of \$1,218 per person yearly. The gap was most pronounced in small rural towns (MM 5), with the gap reaching \$6,605 per person age standardised, equating to an estimated aggregated deficit of almost \$12 billion (NRHA, forthcoming).

The NSQHS Standards cannot address these structural inequities in isolation. They can, however, ensure that risks arising from geography, limited-service availability, workforce constraints and

fragmented care pathways are recognised and appropriately managed. This submission responds to the Commission's six consultation questions through a rural lens, focusing on how the draft's commitments to equity and proportionate implementation can be translated into requirements that work effectively across different service contexts (ACSQHC 2026b). The Alliance also acknowledges clinical research has also been integrated across the third edition through incorporation of the principles of the National Clinical Trials Governance Framework (ACSQHC 2026c). Rather than treating it as a separate response, the Alliance has incorporated its feedback on clinical research within the relevant consultation questions below.

1. How well do the Standards reflect key safety and quality priorities? What is missing?

The initial draft NSQHS Standards (third edition) reflects many of the priorities raised in the Alliance's first submission and provides considerably stronger recognition of equity and the operating environment in which health services provider care (NRHA 2025). The Alliance particularly welcomes the explicit statement that equity includes addressing disparities between metropolitan, regional, rural and remote health services (ACSQHC 2026a p. 11). However, geographic equity is less visible within the individual requirements and there is a need to strengthen the connection between geography, access and safety and quality.

Workforce availability and capability

Requirements 1.13 and 1.17 provide a stronger basis for recognising workforce as a safety and quality issue. Requirement 1.13(e) specifically requires services to respond to risks to patient care arising from workforce gaps or pressures, while requirement 1.17 addresses orientation of agency staff, locums and rotating staff, access to supervision and senior clinical support, and alignment of workforce capability with patient care requirements (ACSQHC 2026a p.20 and p.22).

These provisions are particularly important in rural settings, where workforce shortages can affect the availability and continuity of local services. In 2024, *Very Remote* areas had 2.7 full-time equivalent medical practitioners per 1,000 population compared with 4.8 per 1,000 population in *Major Cities* (AIHW 2026). Cortie et al. (2024) similarly found that MM 5 communities had the lowest workforce availability per capita across general practitioners, other medical practitioners, nurses and midwives, and allied health professionals.

The Alliance recommends that guidance supporting requirement 1.13 clarify that workforce gaps and pressures may create risks to service continuity, clinical supervision and escalation, safe scope of practice and timely access to care. This would recognise the patient safety implications of workforce instability without making individual health services responsible for resolving broader workforce shortages.

Workforce capability in rural settings also depends on health professionals being supported to work to a broad or full scope of practice. While the design and funding of workforce programs sit beyond the NSQHS Standards, implementation should not advertently narrow safe scope of practice and should align with broader efforts to establish supported rural generalist pathways across nursing and allied health.

Geographic access

Requirement 1.25 requires health services to identify populations at risk of poorer health outcomes and act to improve care for those populations. While the broader equity framework expressly recognises geographic disparities, the requirement itself does not identify geography, distance or service availability (ACSQHC 2026a p.25).

For people living in rural Australia, access can be integral to safety and quality. A clinically appropriate referral or treatment plan may not achieve its intended outcome where the service is unavailable locally, travel or transfer cannot occur within a clinically appropriate timeframe, or the necessary workforce is not available or the cost to do so is prohibitive.

Stigma and discrimination

The initial draft of the NSQHS Standards (third edition) provides a strong foundation for addressing discriminatory care, including through requirements 1.12, 1.25 and 2.10, which address consumer feedback, clinical and organisational risk, and workforce interactions (ACSQHC 2026a p.19, p.25 and p.35). The Alliance considers there would also be value in explicitly recognising stigma within these existing provisions.

Recent consumer research found that more than one in three respondents to Australia's Health Panel reported being treated differently or unfairly during a healthcare experience, with unfair treatment affecting trust and willingness to seek care in the future (CHF 2026). While these findings are not specific to rural Australia, they are particularly relevant in settings where consumers may have limited choice of provider, there is a constant revolving door of providers and few alternatives if they disengage from a service.

The Alliance recommends that:

- Guidance supporting requirement 1.13 recognise that workforce gaps, inconsistent service delivery and pressures may create risks to service continuity, clinical supervision and escalation and timely access to care.
- Implementation guidance recognises broad and full scope of practice, supported by appropriate education, supervision and clinical governance.
- Requirement 1.25 or its supporting guidance explicitly recognise geographic location, distance and limited service availability as factors that can contribute to poorer outcomes and safety risks.
- Stigma be recognised alongside bias and discrimination within existing governance, workforce and consumer feedback provisions, including requirements 1.12, 1.25 and 2.10, rather than through a separate compliance requirement.

2. What changes would strengthen the Standards to support the delivery of high-quality care and better health outcomes?

The Alliance supports the draft's shift towards outcomes rather than uniform approaches to implementation. As outlined under Question 1, geography, workforce and service availability shape the context in which high-quality care is delivered in rural Australia. The same safety and quality outcome may therefore be achieved through a different combination of local, regional, visiting and digitally enabled services.

A small rural hospital, for example, may appropriately rely on regional clinical governance, shared specialist expertise, retrieval services, network-wide systems or remote clinical support. This is consistent with the Alliance's broader position that national frameworks need to account for service scale, geography, thin markets, workforce shortages, funding and infrastructure constraints (NRHA 2026). Further comments on proportionate implementation and shared systems are provided under Question 6.

The Alliance also welcomes stronger provisions on cultural safety, including requirements relating to Aboriginal and Torres Strait Islander local leadership, workforce and data governance. Continued partnership with Aboriginal and Torres Strait Islanders peoples, communities and organisations will be important as implementation resources are developed to ensure these provisions support locally appropriate and culturally safe care.

Clinical research and equitable access

The Alliance welcomes the integration of clinical research within the initial draft of the NSQHS Standards (third edition), and the intent to embed the National Clinical Trials Governance Framework within routine safety and quality systems. Requirements 1.08 and 1.09(f) strengthen organisational accountability and consumer partnerships, while requirements 2.21(e) and 2.23 address transitions of care, access and research options, information and informed consent (ACSQHC 2026a p. 17-18 and p. 42-43).

Geographic equity should, however, be more explicit within these requirements. Rural Australians can face substantial travel, workforce and infrastructure barriers to participating in clinical trials, and rural communities remain under-represented in trial participation. Australian research has identified decentralised and co-design clinical trials as an important opportunity to improve rural access (Walsh et al. 2024). Requirements 1.11(c) appropriately recognises flexible and decentralised research delivery models to improve accessibility, participation and equity for Aboriginal and Torres Strait Islander peoples (ACSQHC 2026a p.19). This should be retained and complemented by implementation guidance that supports geographically equitable access for rural communities more broadly, including through teletrial, satellite-site and other decentralised models where clinically and ethically appropriate.

For smaller rural health services, participation in clinical research should not depend on replicating metropolitan research infrastructure locally. Proportionate arrangements should allow services and clinicians to participate through shared or networked research governance, workforce training and support from larger trial sites, with clear accountability for participant safety and continuity of clinical care.

Digital equity

Digital technologies are an important component of rural service delivery, particularly where telehealth and shared digital systems improve access to specialist expertise and support continuity across geographically dispersed services. Requirement 1.17(h) appropriately requires consideration of the clinical effectiveness, safety, equity and workforce impacts of digital tools and technologies (ACSQHC 2026a p.22).

Digital delivery is not an alternative and does not address geographic inequity by itself. A review of Australian telehealth policies found a strong focus on rural access but more limited attention to affordability, continuation of care, digital inclusion and culturally safe care, with weak equity monitoring (Wang et al. 2026). Implementation guidance therefore needs to consider connectivity and consistency, affordability and digital capability, as well as whether an appropriate alternative is available where digital care cannot be safely or equitably accessed.

The Alliance recommends that implementation guidance:

- recognise that safe and effective shared, networked and place-based models can meet the intent of the NSQHS Standards, with further consideration of proportionate implementation as outlined under Question 6.

- make geographic equity explicit within clinical research requirements and clarify that requirements 2.23(a) can be met by offering or facilitating access to approved research options, including referral, teletrial, satellite-site and other decentralised models where appropriate.
- support proportionate, networked research governance for smaller rural services, with clear roles and responsibilities between primary trial sites, satellite sites and local clinicians.
- require consideration of connectivity, affordability and digital capability when assessing the equity of digitally enabled models, with suitable alternatives available where required.
- continue to be developed in partnership with Aboriginal and Torres Strait Islander peoples, communities and organisations to support locally appropriate and culturally safe implementation.

3. How well do the Standards support care delivery and coordination across services, settings and providers?

The stronger focus on coordinated and connected care is particularly relevant to rural Australia. Requirements 2.19 to 2.22 establish expectations for coordination across the continuum, structured clinical handover, management of risks associated with transitions between settings and levels of clinical capability, and accurate and timely exchange of information at discharge and transfer (ACSQHC 2026a p.41 and p.42).

Rural patients may move between primary care, small rural hospitals, regional and tertiary services, Aboriginal Community Controlled Health Services, visiting specialists (often in cities), outreach services and retrieval providers within a single care pathway. Additionally, in primary health care, clinical handover frequently occurs asynchronously, across organisational boundaries and between members of multidisciplinary teams, rather than through formal admission, discharge or shift-based processes. A systematic review identified communication between providers, service availability and geographic access as important barriers to continuity of care for rural and remote patients (Street et al. 2019). More recent findings from Australia's Rural Health Consumer Panel found a median wait of 21 days and travel distance of 20 kilometres for referred follow-up care, increasing to 42 days and 53 kilometres for medical specialist care, with cost, wait times and distance the most frequently reported barriers to access (Dangerfield et al. 2026).

Furthermore, continuity of care has relational, management and informational dimensions. In rural communities, relational continuity can be particularly important: a patient may need to leave their community for specialist, hospital or research-related care, while their ongoing relationship with a known local clinician remains central to follow-up and longer-term management. Requirements 2.19 to 2.22 should therefore recognise not only transfer of information, but also continuity of the care plan and the ongoing clinical relationship where appropriate (ACSQHC 2026a p.41-42). These issues reinforce the geographic access concerns outlined under Question 1 and demonstrate that continuity depends not only on the transfer of information and responsibility, but on whether onward care can reasonably be accessed. A referral or discharge plan cannot provide effective continuity where the receiving service is unavailable or cannot be accessed within an appropriate timeframe.

Requirement 2.19(c) should make clear who retains responsibility for monitoring, follow-up and escalation while a person awaits referral, transfer, retrieval or follow-up; responsibility should not become unclear merely because a referral has been made.

This issue has been highlighted through the [Collaborative Health Care \(CHC\) Initiative](#) being led by one of the Alliance's member organisations, Whiddon (provider of aged care). The project has focused on developing and testing collaborative models of care for older Australians interacting with hospitals, aged care services and community supports. The project has identified that when providers are supported to work together around a common consumer journey, outcomes can be improved through earlier intervention, better coordination and clearer shared responsibility for care. It has also reinforced the importance of effective coordination and information sharing where consumers move between services operating under different governance, funding and delivery arrangements (Whiddon 2026).

Recommendation

The Alliance recommends:

- requirements 2.19 to 2.22 recognise access to onward care and coordination across organisational, sectorial and jurisdictional boundaries as part of effective continuity, including clear responsibility for care while patient await referral, transfer, retrieval or follow-up.
- Requirements 2.19(c), supported by requirements 2.21 and 2.22, clarify accountability for ongoing care while patients await referral, transfer retrieval or follow-up, including escalation where the intended receiving service is unavailable or delayed.
- Implementation guidance support shared governance, information-sharing and escalation arrangements across health, aged care and community services and Commonwealth-state funding interfaces, without making individual health service responsible for resolving structural system gaps.

4. Are the Standards easy to understand and free from duplication?

The consolidation of the existing eight Standards into three integrated Standards should assist in reducing fragmentation between related safety and quality requirements. The initial draft NSQHS Standards (third edition) also appropriately recognises that similar implementation strategies may apply across multiple requirements and that identifying these links can reduce duplication of effort (ACSQHS 2026a, p.7).

This will be particularly important for small rural services, where the same staff may hold clinical, quality, governance and operational responsibilities. Clearer links between related requirements would help services understand where an existing system, process or source of evidence can satisfy more than one requirement. The implications for accreditation and compliance burden are discussed further under Question 6.

Recommendation

The Alliance recommends that implementation resources clearly cross-reference related requirements and include practical examples for small rural hospitals, multipurpose services, remote and very remote services, services reliant on locum or visiting workforces and services reliant on locum or visiting workforce and services operating as part of larger regional networks. Examples should demonstrate the intent and expected outcome of a requirement without prescribing a particular organisational structure.

5. How well do the Standards help health services learn, reflect and improve over time?

The Alliance welcomes the stronger emphasis on using data, patient experience and outcomes to support continuous improvement. Requirements 1.28 and 1.29 require services to collect, review and use clinical quality and risk information, including feedback, complaints, patient experience and outcomes, while requirement 1.31 requires services to use data to assess care quality, integration and opportunities for improvement (ACSQHC 2026a, pp 27-28).

For rural health services, these data need to be locally meaningful. National or jurisdictional averages can obscure substantial geographic differences in service availability, access and outcomes, while small population sizes can limit conventional benchmarking. AIHW has similarly identified limited reporting for smaller geographic areas as a significant rural health data gap, noting this can obscure variation in access, health status and workforce availability (AIHW 2025).

As discussed under Question 3, recurrent problems with referrals, transfers and access to follow-up care may provide important information about local safety and quality risks. Other measures may reflect workforce-related service interruptions or risks specific to the local model of care. Providing flexibility to use locally meaningful indicators would support continuous improvement while recognising the diversity of rural service settings.

Recommendation

The Alliance recommends that implementation guidance support rural health services to identify and use locally relevant indicators that reflect their service context and priority safety and quality risks, while recognising the limitations associated with small population sizes and available data.

6. What changes would reduce compliance burden while maintaining safety and quality?

The initial draft's approach to proportionate implementation provides an appropriate basis for reducing unnecessary compliance burden without changing the standard of care expected in rural communities. It states that *implementation and assessment of the NSQHS Standards should reflect service size, scope, complexity, clinical risk profile, service model and digital maturity* and that assessment should *focus on the effectiveness of systems rather than uniform implementation models* (ACSQHC 2026a, p.7).

As outlined under Question 4, clearer links between related requirements would help avoid duplication of evidence. For smaller rural services, proportionate implementation should also allow effective regional, network and jurisdictional systems to be used without unnecessary duplication at individual facility level. This may include shared credentialling, clinical governance, specialist support, digital infrastructure and quality systems.

Requirements 1.19(c) and 1.20 should also support nationally consistent, portable or mutually recognised credentialling and scope of practice arrangements for clinicians who work across facilities and networks. Local oversight should remain where genuine facility-specific risks need to be managed, but repeated credentialling should not become a barrier to visiting, outreach or cross-service practice.

Existing models show how this can operate in practice. In Queensland, the Office of Rural and Remote Health supports credentialling and scope of clinical practice for health professionals working across four rural and remote Hospital and Health Services, as well as clinicians providing services through the Royal Flying Doctor Service, Queensland Country Practice and the Flying Specialist Service (Queensland Health 2024). Queensland Health's credentialling framework also provides statewide and regional scopes of clinical practice across multiple Hospital and Health Services, while maintaining responsibility for appropriate oversight and patient safety (Queensland Health 2024).

This provides a practical example of how shared governance systems can support consistent safety and quality across geographically dispersed services without requiring the same processes to be replicated at each facility.

The planned 2027 pilot will also provide an important opportunity to test how the third edition operates across different service contexts before its final release in 2028. The Alliance considers that the pilot should include a representative range of regional hospitals, small rural hospitals, multipurpose services, and remote and very remote services. Testing should consider not only whether the requirements can be implemented, but whether the implementation has unintended implications for workforce capacity, service sustainability or access to care. Rural consumers, clinicians, service providers, and Aboriginal and Torres Strait Islander organisations should continue to be involved as the Standards and supporting implementation resources are refined.

The Alliance recommends that:

- accreditation recognise effective regional, network and jurisdictional systems as evidence of compliance where these provide appropriate governance and assurance, rather than requiring unnecessary duplication at individual facility level.
- requirements 1.19(c) and 1.20, and associated implementation guidance, support portable or mutually recognised credentialling and scope-of-practice arrangements across networks, with proportionate local oversight of genuine facility-specific risks.
- the planned 2027 pilot deliberately include a representative range of rural and remote health services and assess unintended impacts on full-scope practice, visiting and outreach services, decentralised research models, workforce capacity, service sustainability and access to care closer to home.

Conclusion

The initial draft of the NSQHS Standards (third edition) represents a positive progression from the first stage of consultation, particularly through its stronger focus on equity, workforce sustainability, cultural safety, integrated care, consumer experience and continuous improvement. The Alliance also welcomes the recognition that nationally consistent safety and quality expectations do not require uniform implementation models.

The next iteration would be strengthened by carrying the initial draft's commitment to geographic equity more clearly through its individual requirements and implementation guidance. People living in rural Australia should expect the same standard of safe and high-quality care as people living in metropolitan Australia. Recognising these differences in workforce availability, service scale, distance, digital connectivity and access to care is necessary to ensure that the NSQHS Standards support equitable outcomes and operate effectively across the Australian health system.

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