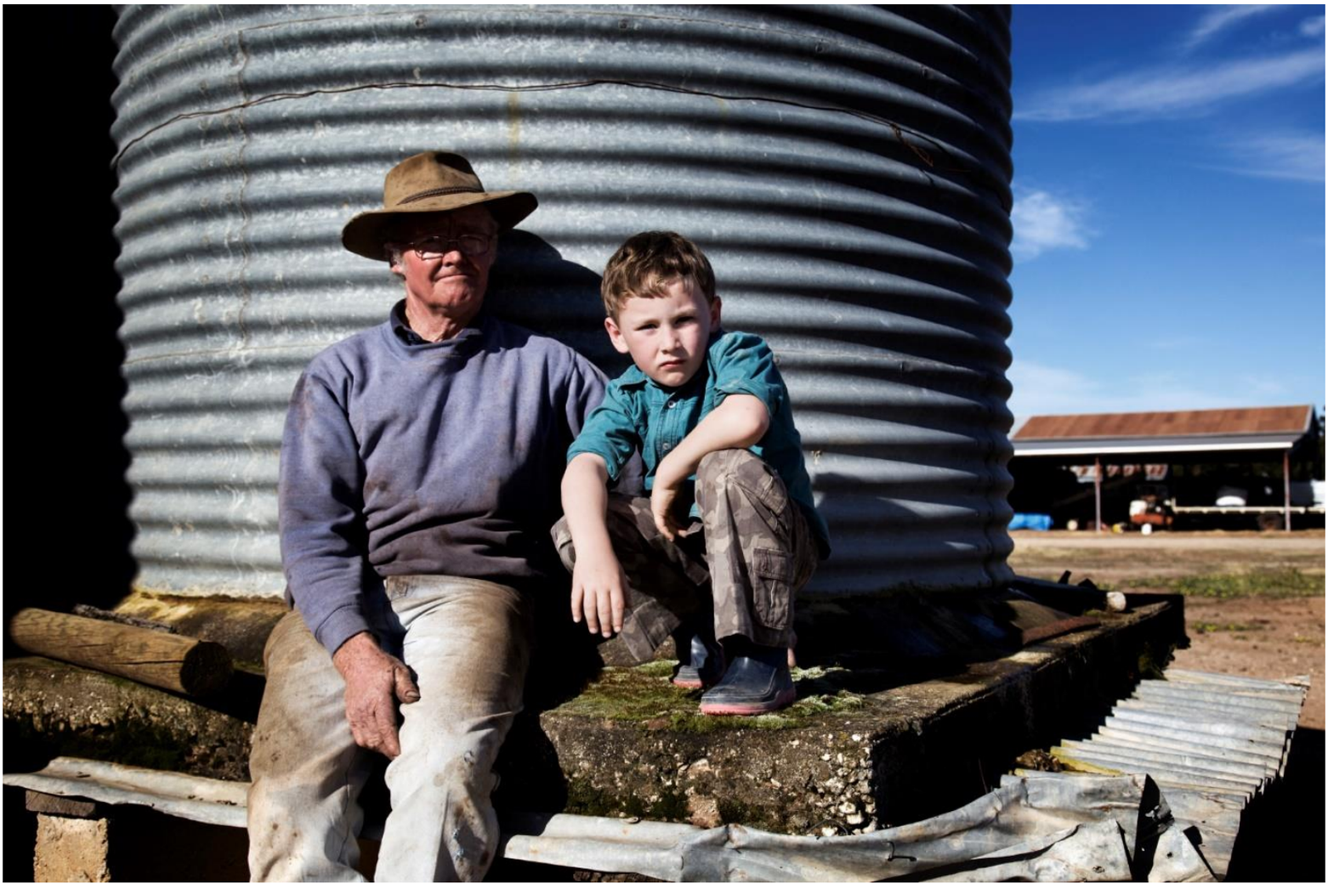
National Rural Health Alliance

2024–25 Pre-Budget Submission

25 January 2024



Healthy and sustainable rural, regional and remote communities across Australia

National Rural Health Alliance

Postal address: PO Box 280 Deakin West ACT 2600
Address: 10 Campion St Deakin ACT 2600
Phone: 02 6285 4660
Email: nrha@ruralhealth.org.au

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Healthy and sustainable rural, regional and remote communities across Australia.

25 January 2024

The Hon Dr Jim Chalmers MP, Treasurer
The Hon Mark Butler MP, Minister for Health and Aged Care
The Hon Emma McBride MP, Assistant Minister for Rural and Regional Health
The Hon Ged Kearney MP, Assistant Minister for Health and Aged Care

House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Treasurer, Minister and Assistant Ministers,

National Rural Health Alliance – 2024-25 Pre-Budget Submission

The National Rural Health Alliance (the Alliance) is pleased to provide a submission for consideration in the 2024–25 Federal Budget. The Alliance is the peak body for rural, remote and regional (rural) health for the 30% of people who live in these regions in Australia. We represent 50 National Members, and our vision is for healthy and sustainable rural communities across Australia.

The solutions we provide below will demonstrate your commitment to rural communities that are crucial to Australia's social, cultural and economic livelihood, indeed for urban Australia.

The three key priorities we put forward in this Budget cycle are complimentary, integrate and strengthen findings and solutions from this Government's reforms, reviews and enquiries. They add to other priorities the Alliance works on with its members and communities. They are strategic and support and augment Government's strategies. They are as follows:

1. **Community led Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) in targeted communities, supported with block funding where the market is thin:** a community-led and governed workforce intervention designed to improve access to high-quality, culturally safe, multidisciplinary primary care where markets have failed in rural Australia **- block funding of between $13.53 million and $16.65 million over five years.**

2. A **National Rural Health Strategy**, to bring together state and federal rural health priorities and strategies and drive tangible and sustainable improvements in rural health outcomes over time **– investment of $3.37 million over four years (of which $1.37 million would be Departmental staff costs).**

3. **RuralHealthConnect Network: Bridging Evidence and Action:** an evidence-based innovation via a community of practice, a Journal and web based intelligent Practice Hub. Its purpose is to improve the access, effectiveness, and translation of Government investment in rural programs, innovative models and workforce strategies, and share outcomes of innovative rural health initiatives in Australia. This community of practice would collate, collaboratively synthesise, and generate evidence-based resources through raising awareness, as well as bridging funding, delivery and findings via an online hub. It ensures ALL rural Australian communities and healthcare stakeholders can learn from each other, as well as adopt and adapt from current Government investment and research. – **investment of $6.850 million over five years**.

Further information on these proposals is provided below. I can be contacted for further information and to clarify and elaborate on any aspect of this pre-budget submission.

Yours sincerely,

Susanne Tegen
Chief Executive

T 02 6285 4660 F 02 6285 4670 E nrha@ruralhealth.org.au W ruralhealth.org.au NRHAlliance
PO Box 280 Deakin West ACT 2600 10 Campion Street Deakin ACT 2600
ABN 68 480 848 412 ACN 620 779 606 ARBN 620 779 606

NATIONAL RURAL HEALTH ALLI ANCE PRIORITIES FOR BUDGET 2024–25

Proposal 1: Community-led Primary care Rural Integrated Multidisciplinary Health Services (PRIM-HS) in targeted communities are supported with block funding where the market is thin or failed.

Problem

The almost 30 per cent of the population residing in rural, remote and regional (hereafter rural) Australia contribute proportionately more to the Australian economy than their metropolitan counterparts, generating at least 80 per cent of export revenue, nearly 50 per cent of tourism revenue and producing 90 per cent of the food we consume.[1] The income derived from rural Australia is largely made up of industries such as agriculture, fisheries, forestry and resources, with exports from these industries valued at almost $500 billion per year.[2]

Yet rural people and communities are exposed to **poorer social determinants of health**, have **higher rates of health risk factors**, increased rates of **multi-comorbidity,** experience **reduced access to primary healthcare services**, and experience **poorer health outcomes** and **reduced life expectancy**.[3] They are also missing out on $6.55 billion in spending on health care annually, equating to an **underspend of almost $850 per person, per year.**[4]

It is difficult to recruit and retain the required health workforce in many parts of rural Australia and there is an **ongoing, significant maldistribution of health professionals** at the expense (in particular) of small rural towns and remote areas, across most health professions.[5]

The provision of healthcare in rural Australia is generally more costly than in major cities.[6] The population is smaller and dispersed over vast distances. Rural communities also tend to have lower incomes and be of lower socioeconomic status, on average. Together, these factors make it **difficult for primary healthcare businesses to be financially viable in the context of predominantly fee-for-service funding mechanisms,** such as Medicare. When these businesses are not viable, they are often lost from communities, making it even harder to access the right care at the right time, close to home, with flow-on effects for the acute hospital system.

The demographics of our population as a nation, which is ageing and accumulating higher rates of chronic disease over time, mean that people all over the country need access to comprehensive care in the community to help manage illness and keep them well, functioning and contributing to society. Australian government policy has recognised these facts in its recent and ongoing work on the *Strengthening Medicare Taskforce* and the *Scope of Practice Review*. These pieces of policy work assert the **need for all Australians to have equitable access to comprehensive, multidisciplinary primary healthcare services**.

Enabling health professionals to work to their full depth and breadth of scope of practice is a core component of this. Yet **fee-for-service funding mechanisms, while important, have a limited ability to fund (or adequately subsidise), comprehensive, multidisciplinary primary healthcare**. Funding for the work of nurse practitioners, practice nurses, midwives and most allied health professionals is very limited. Additional funding of services streams, for example private health insurance, are less accessible outside of major cities.[7]

Small grants and non-ongoing and innovative funds, while welcome, are not the solution for the lack of core and sustainable funding which is needed to guarantee that primary health care services can continue to provide essential care in the future.

Solution

The Alliance has been working collaboratively with its members, rural communities and other key stakeholders over several years to find a solution to this "wicked" problem. We have developed ongoing relationships with several primary healthcare businesses and communities in rural and remote areas, who are keen to sustain and not lose the services they deliver for their communities, in the context of socially disadvantaged and geographically isolated communities, financial difficulty and workforce challenges.

The Alliance developed the Primary care Rural Integrated Multidisciplinary Health Services (**PRIM-HS) model as a solution** to this problem.

PRIM-HS is a model of comprehensive primary healthcare developed locally, according to population health need, considering existing services and the perspectives of local stakeholders, most importantly consumers. As no two communities are the same and there are often no alternative services, rural stakeholders work together to develop a model tailored to their needs. Ideally, the governance mechanism brings key stakeholders together and includes an independent chair.

The PRIM-HS model centres on core principles of **local co-design and governance**; provision of **comprehensive, multi-disciplinary primary healthcare**; **flexible employment models** for the health and associated workforce; and a **component of block funding** to enable financial sustainability in the context of market failure.

While the specifics of each of the rural primary healthcare businesses we have been working with differ, they are all convinced of the validity of the PRIM-HS model and are working towards any elements of this model they do not currently encompass.

A key hurdle to the ongoing sustainability and further development of these PRIM-HS exemplars in rural communities is the model of funding. Despite careful practice and financial management, attempts to trial innovative methodology and persistent effort to build and maintain relationships with key local stakeholders, these businesses are **making a financial loss which is being subsidized via community fundraising, local government rates paid by community and other community and industry provided grants**. This is not sustainable, nor equitable. Rural people's healthcare should not be subsidised by community, business or by rates paid to local governments when it is funded by government in major cities and consumers have paid taxes and their Medicare levy.

Innovative ways of funding primary healthcare are required that do not rely solely on the fee-for-service model and adequately fund comprehensive, multidisciplinary care in the context of low average incomes and elevated rates of chronic disease. Hence, block funding is needed where markets fail or are failing, and the provision of this funding is long overdue.

Case Studies

1. **Bogan Shire Medical Centre**: Multidisciplinary general practice, local government owned, after emergency take-over when doctor and team retired.

Nyngan, New South Wales – Bogan Shire (MM6)

- Population of 2467, lower than average socioeconomic status and 17.8% First Nations peoples
- More than 3600 active patients
- 1 FTE of medical practitioner, working 6 weeks on and 2 weeks off
- Various practitioners and other workforce employed, and additional visiting allied health and other services are run out of the centre
- Outreach to local aged care facility with Multipurpose Service

PRIM-HS Principles:

✓	Local governance (local government)
✓	Local co-design (to some degree)
✓	Multi-disciplinary care
✓	Component of block funding (local government funded)
✓	Flexible employment models

Current funding: Medicare, Council funds and in-kind support, rate payer contributions, various grants. 100% bulk-billing practice, though there are gap fees for some allied health services.

The current business model is not viable and is at risk**. Annual losses** by the business, subsided by Bogan Shire Council, are anticipated to continue at **$700,000 per year in 2024-25**. The infrastructure the business operates out of is owned by Bogan Shire Council.

2. St George Medical Centre: Multidisciplinary general practice, currently privately owned, need to leave practice and management.

St George, Queensland – Balonne Shire (MMM6)

- Population of 4320, lower than average socioeconomic status and 20.5% First Nations peoples
- 2700 active patients
- 4FTE medical practitioners, including 1.5FTE medical support to the local health service, 2 of whom are leaving March 24
- Various practitioners and other workforce employed, and numerous allied health and other services visit the centre
- Outreach services to an additional community, aged care facility and secondary school

Current funding: Medicare, some PHN funds, private business contribution. Mixed billing but high proportion of population bulk billed, some gap fees for allied health services.

PRIM-HS Principles:

×	Local, community-led governance (private business)
×	Local co-design
✓	Multi-disciplinary care
✓	Component of block funding (private business funded)
✓	Flexible employment models

The current business model is not viable and is at risk. **Annual losses** by the business, subsided by the private business owners, community, are anticipated to continue at **$560,000 per year in 2024-25**. The infrastructure the business operates out of is owned by private business owners.

Proposal

The Alliance requests block funding to enable the ongoing financial sustainability of service provision via four PRIM-HS exemplar sites like the cases presented, over five years. This funding would be in addition to existing Australian government funding streams and Medicare. It would allow these communities to receive the funding to support their current reduced healthcare access, despite failed/failing rural healthcare markets, and continue to provide essential services to their communities.

We can learn from rural hospitals and Aboriginal Community Controlled Health Organisations (ACCHOs), which receive block funding in acknowledgement that activity-based funding is not sufficient nor fit for purpose to support sustainable services in rural areas. Funding of primary health care should be no different. Importantly, many of the primary health care entities we work with provide services to Aboriginal and Torres Strait Islander people where there is no local ACCHO.

Dedicated, ongoing PRIM-HS funding will recognise the increased costs of delivering health services in rural areas, the lack of economies of scale inherent in thin markets and, on average, the lower socioeconomic status, the current underspend of $844 per person in rural health services, and poorer health of rural communities.

Funding must be able to support employment of health practitioners (including packages equal to Department of Health employees so not to lose practitioners, relocation costs and housing), as well as rent of capital infrastructure where needed, and practice improvement activities that increase alignment with the PRIM-HS model. This will still be well below the cost of not having any services, or the continuous revolving door of flying in locums at great expense for care (as opposed for holidays and professional development).

The two case studies presented illustrate the nature of the existing funding shortfall in two primary healthcare businesses with similar contexts, but different business models. Costing estimates have been provided based on the range generated by these two case examples and annual reports.

Actual funding will differ in each site, depending on specific context and need. Government will need to develop guidelines regarding this, and communities will present their individual budgets to Government, based on local context and need.

It is essential that funding be directed to local entities. Government should support local businesspeople, organisations and health practitioners who have a proven track record and commitment to their rural communities and have put in the work to develop tailored solutions to meet local needs. An independent chair at each site, will ensure all stakeholders around the table have an equal voice in developing local solutions and share resources and workforce. The best return on investment will be generated if local strengths and capacity are built on, with a focus on community-led and driven initiatives.

Evaluation of the community-led PRIM-HS approach will ensure the effectiveness and efficiency of use of funds is measured to enable continuous improvement and learning from the experience. Evaluation would measure return on funding investment in terms of service provision, cost, workforce, change in alignment with PRIM-HS principles, consumer and community experience and health outcomes. Evaluation costing has not been included in the budget below.

Cost

The Alliance estimates Government block funding of between $13.53 million and $16.65 million will be required to sustain four, “shovel-ready”, PRIM-HS aligned rural primary healthcare businesses over the next five years and ensure they do not close down.

- This value is based on the lower and upper limit values from the case studies above, which provide an inclusive indication of financial deficit.
- Rent for infrastructure (where needed).
- Block funding of a single PRIM-HS over five years is estimated at between $3.38 million and $4.16 million.

Additional details are available on request.

Proposal 2: National Rural Health Strategy

Problem

People living in rural, remote and regional parts of Australia, who contribute significantly to the economic prosperity of the nation, and are integral to our social and cultural fabric, face notable disadvantage when it comes to maintaining healthy lifestyles, accessing health services and as a result, achieving equitable health outcomes to their metropolitan counterparts. This is something governments and health practitioners have known for many years, yet little has changed. Rural populations must be made a priority to close the gap in population health status and healthcare access.

The first ***National Rural Health Strategy*** was released in 1994. There have been various updates and revisions of the document over the ensuing years, with the last being the *National Strategic Framework for Rural and Remote Health*, endorsed by Health Ministers in November 2011. The 30 per cent of the population that comprise rural Australia is not covered by a current rural health strategy at the national level. Yet, New South Wales, Queensland and Western Australia have dedicated rural, remote and/or regional health strategies, indeed, as does New Zealand. Meanwhile, the whole health system in the Northern Territory and Tasmania serves people who live in rural, remote or regional areas and is therefore focused on the specific needs of these populations. New Zealand released its first *Rural Health Strategy* in 2023. Without an active Rural Health Strategy rural Australia's health and wellbeing outcomes have become worse, as has access.

While the 2011 Framework can still be accessed through the Department of Health and Aged Care website, it is not being utilised as a strategic driver of health policy. No reporting has been undertaken against the goals of the original strategy, nor has there been an evaluation of the effectiveness of the Framework in addressing its goals. The Framework has not been actioned in a consistent or comprehensive way. There are no national reports on progress against the Framework, nor attempts to update it.

There are also currently a range of programs and incentives grouped under the banner of the *Stronger Rural Health Strategy*. This strategy focuses on the rural health workforce which, while critical, is only one element of addressing rural health outcomes. Further, this strategy seeks to meet some workforce needs but is not a comprehensive or integrated policy approach. Rather, it demonstrates gaps and inconsistencies in addressing rural health workforce needs.

The Stronger Rural Health Strategy evaluation, which was completed and reported on at the end of 2022, has not been publicly released. The Government has had the report for twelve months and has not responded to it. This was a fabulous opportunity to learn, in depth, about the strengths and weaknesses of the Stronger Rural Health Strategy and improve the national approach to enhancing rural health outcomes into the future. We call on the government to release this report and utilise its recommendations in the development of a contemporary national strategy.

The Government has an obligation, social and economic contract to rural communities to support the full spectrum of primary healthcare services throughout the country and the need for a multidisciplinary approach which utilises the full skillset of the variety of health practitioners is acknowledged in its work as part of the *Strengthening Medicare Taskforce* and *Scope of Practice review*.

Australia's first *National Health and Climate Strategy* was released in December 2023 and addresses the health and wellbeing impacts of climate change, in addition to describing priorities to reduce emission generation within the health system. The disproportionate impact of climate change on rural populations is noted in the strategy, along with its status as a multiplier of inequity. A new strategy should align with the Health and Climate Strategy, providing specific actions that address the burden of climate change on rural health outcomes.

Further, since the development of previous strategies and frameworks, the impact of the COVID-19 pandemic has exposed the vulnerability of rural Australians due to the lack of capacity in the rural health system. Workforce shortages, the lack of appropriate facilities, and a higher proportion of vulnerable people all contribute to this risk. The way forward is a comprehensive and integrated National Rural Health Strategy and Implementation Plan to drive necessary policy change and reform.

Solution

The Alliance is seeking an integrated **National Rural Health Strategy and Implementation Plan,** to address enduring service access, healthcare workforce, scope of practice and affordability issues. It should also include the rural health sector in responding to the impact of climate on health, local disaster and emergency response goals and processes.

Such a plan would send a very clear message to the 7+million people loving in rural, remote and regional Australia that their economic and social contribution and well-being is important to Australia.

A new Strategy and Implementation Plan should acknowledge that rural communities are different to metropolitan communities and that each rural community has a unique context and needs. It must address the lack of progress in improving the health outcomes for those living in rural Australia and the lack of access to services. It would consider how to incentivise and provide greater investment in preventive health and primary healthcare as well as acute and subacute care, how to fund and administer models of care that are multidisciplinary, flexible and responsive to local needs, how to best embrace the current and future potential of technology to enhance healthcare delivery and healthy lifestyles in rural Australia, how to facilitate coordinated responses in partnership with jurisdictional governments and local communities and how we can increase health care, health system and digital access literacy.

The report of the *National Health Reform Agreement (NHRA) Mid-term Review*, released in October 2023, emphases the need for collaboration, coordination and shared responsibility for rural health outcomes by both the Australian and jurisdictional governments. Indeed, it proposes a specific Schedule in a new Agreement relating to rural and remote health, as a mechanism to drive a “shared plan of action focused on equity of access in rural and remote areas”.[8,p3] A new agreement would need to align with the new Strategy and Implementation Plan and would be an important tool to drive key activities and achieve positive outcomes.

Developing a new Strategy and Implementation Plan requires a consultative process that includes significant input from the Alliance and its many members and friends, grassroot consumer Friends of the Alliance and other rural health stakeholders including University Departments of rural health and medicine. It will be important that there is close engagement with the National Rural Health Commissioner, the Aboriginal and Torres Strait Islander health sector, state and territory Governments (several of which already have rural health strategies), rural health stakeholders and peak bodies, local governments, health practitioners and professional bodies, educators, funders, researchers and consumers.

We welcome the opportunity to work with the Australian Government, as well as state and territory governments, ministers of health and rural/regional/remote health, local governments, and, importantly, local communities experiencing great health access distress and low health outcomes.

A commitment from all levels of government to support a National Rural Health Strategy and Implementation Plan will be critical to its success and capacity to drive reform and structural change.

It will demonstrate a real commitment to communities across Australia. As fellow Australians, we have a social and economic contract to do so.

Support for the objectives of the Strategy, as well as collaboration and action across governments, will be key drivers required to achieve the aims of improved healthcare accessibility, affordability, equity of workforce distribution and ultimately, improved health outcomes.

Proposal

The Australian Government Department of Health and Aged Care works with the Alliance, state and territory departments of health and rural/regional/remote health ministers, key rural health stakeholders, and rural communities, to develop a contemporary, comprehensive, action-oriented and measurable National Rural Health Strategy and Implementation Plan.

This plan will link with the National Health Reform Agreement – Addendum and any future agreements, align with other strategies related to rural health, such as the National Health and Climate Strategy and various health practitioner workforce strategies of the Government, to drive action and sustainable change across the sector and around the nation.

Cost

The Alliance estimates that the cost of development of the Strategy and Implementation Plan would be $3.37 million over four years, of which $1.37 million would be Departmental staff costs.

Additional details are available on request.

Proposal 3: RuralHealthConnect Network: Bridging Evidence and Action

Problem

The Federal Government has invested many millions of dollars on addressing the rural health sector and rural communities' health service access by funding programs such as IMOC, PRIMM, MRFF research and various workforce programs, innovation models of delivery and care.

While the funding may impact a particular community or individual, there is currently little sharing of what is learnt, what works and what may be a challenge. Other rural communities which may have similar problems do not have access to findings and trends, to cross-pollinate ideas to build capacity, adopt or learn from others for maximum utility and impact on health outcomes.

Researchers, policy makers in Government and entities which support communities are not able to synthesise what is learnt, amend and develop policy, approaches and funding to reflect trends and impact.

A fundamental challenge faced by Government is constraining the effectiveness and efficiency of innovative rural healthcare and education/training investment in Australia and beyond. Numerous entities and communities are funded to undertake initiatives, but information exchange to foster cross-pollination of ideas, adaptation, and capacity building in other communities, is severely lacking.

The potential lessons of many previous projects are not available to communities, not-for-profits, researchers, and other stakeholders.[9]

Exchange of ideas, learnings and outcomes fosters evidence-based learning, and is fundamental to translational efforts, including taking projects to scale, especially as initiatives are increasingly community-driven, place-based and participatory. Valuable lessons from service and education initiatives are not being adequately translated, not published in context into future rural health practice and education improvement.

This proposal is a collaboration of the National Rural Health Alliance (the Alliance) and the Australian Journal of Rural Health (AJRH), with the support and input from the Office of the National Rural Health Commissioner.

Solution

Bringing rural health care value to government, community and rural health stakeholders

Component 1

Establish real-time information exchange and build a community of practice to draw together the Innovative Models of Care (IMOC), Primary care Rural Integrated Multidisciplinary Models (PRIMM) and Medical Research Futures Fund (MRFF) grant recipients, rural workforce agencies (RWAs), primary health networks (PHNs), universities, training organisations, and the Alliance, around rural health service, health workforce and education models. The Alliance will establish and support this, and will promote information and learnings through workshops, the National Rural Health Conference, Scientific Symposia and media.

Component 2

Enhance methods for effective exchange, learning, collaboration and improvement. Identify and collate optimum models, research and evaluation methodologies and identify evidence-based principles that will support further strengthening and accessibility of rural community-based health service, workforce and education initiatives. This will be undertaken and supported by the Australian Journal of Rural Health (AJRH), initially through a special supplement on this topic in 2024, mid-2025 and in an ongoing fashion to disseminate findings and trends.

Component 3

Establish a "smart" RuralHealthConnect Network: Bridging Evidence and Action, accessible to anyone living in or interested in rural, remote and regional health service, workforce and education initiatives, that actively collates contact information, resources, evaluations, reports, and research publications regarding these models and initiatives. The hub will use collaborative methods to systematically synthesise and review this information as a foundation for evidence-based policy and practice. It will ensure efficient access to key information and resources for those wishing to learn about the barriers and enablers for rural models and initiatives in various contexts.

Proposal

The **RuralHealthConnect Hub** will be an **online resource**. It will **collate** relevant contact details, reports, resources, evaluations, research and materials across rural and remote health, workforce and education initiatives. However, the primary value-adding function of the Hub will be to **conduct collaborative syntheses** of the stored information and other resources, in an accessible and searchable manner.

This will involve:

- working with key stakeholders from the community of practice (Component 1), as well as academic partners and funders
- using peer reviewed methods for collaborative synthesis, as documented in the AJRH supplement (Component 2)
- Artificial Intelligence (AI) will be a key component of hub design and utility and will facilitate swift, accurate and intuitive data exploration by target users.

The Hub will **produce evidence-based resources** in various, accessible, contemporary formats, in alignment with the needs of key stakeholders and in a practical, timely fashion. These resources will be drawn from collated information and collaborative syntheses and incorporate focused follow-up with stakeholders. The aim is to produce contextually relevant data to improve models of healthcare delivery and workforce approaches in rural and remote areas of Australia, maximizing the utility of government funding in this area.

The Hub will also have a **training and mentoring dimension** to make optimal use of the stored data and its unique skills base.

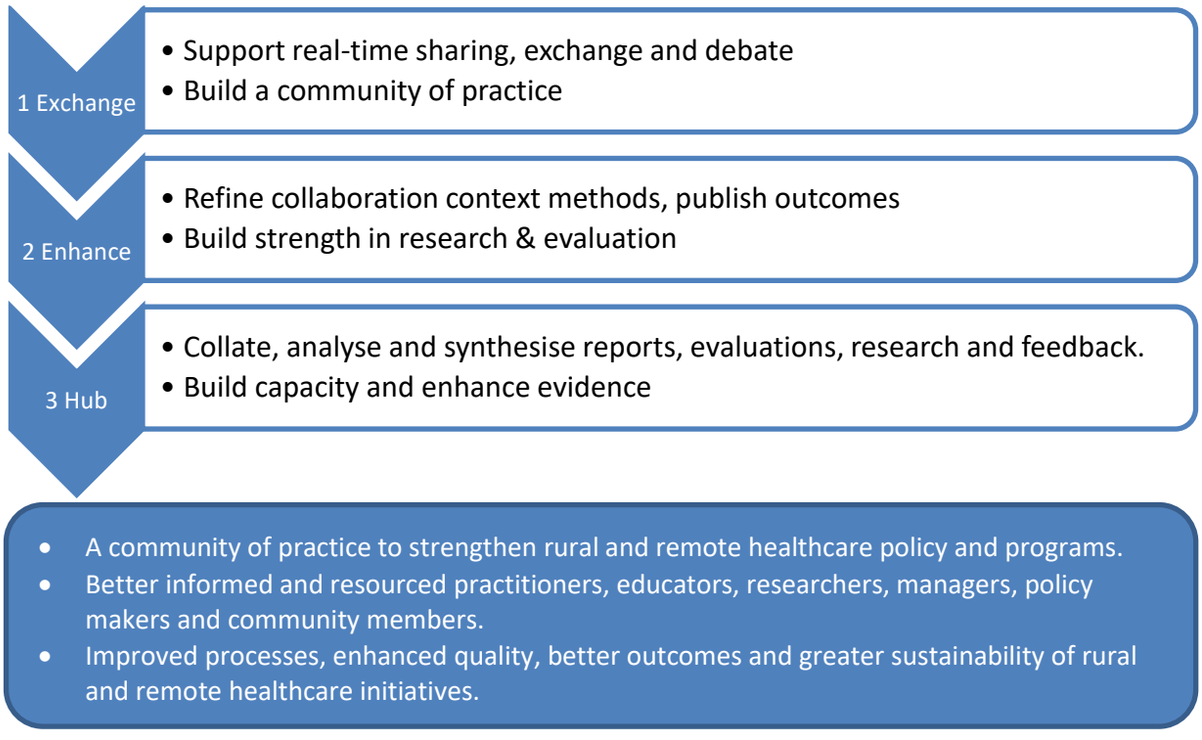
Key objectives

- Improve access to information regarding innovative rural health service, workforce and education/training initiatives, by relevant stakeholders.
- Increase utility of the information generated by these initiatives to relevant stakeholders.
- Increase effectiveness of future initiatives.
- Improve efficiency in the use of government funds.
- Improve access to high quality, culturally safe healthcare by rural and remote Australians.

Governance

- The Alliance will manage the implementation of this proposal in which the Australian Journal of Rural Health takes a key role, in conjunction with an advisory group. The project will fund a part-time director to provide project management, a librarian and administrative staff to collect, synthesise, catalogue data at the Alliance and AJRH and senior academic oversight, support by a full-time rural-origin PhD student, as core drivers of activity and the **RuralHealthConnect Network**.

- This plan will link with the National Health Reform Agreement – Addendum and any future agreements, align with other strategies related to rural health, such as the National Health and Climate Strategy and various health practitioner workforce strategies of the Government, to drive action and sustainable change across the sector and around the nation.



Cost

The NRHA requests the Department of Health and Aged Care provide funding for establishing, maintaining, and value-adding process and to an online Rural and Remote Health Evidence to Practice Hub (RuralHealthConnect) at a total cost of $6.85 million over five years. It is a process and Hub which would be difficult and costly for Government to deliver and run, however a necessary and useful way for expenditure and funding commitment outcomes to be shared and learnt from in one accessible site for the greater community.

Additional details are available on request.

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