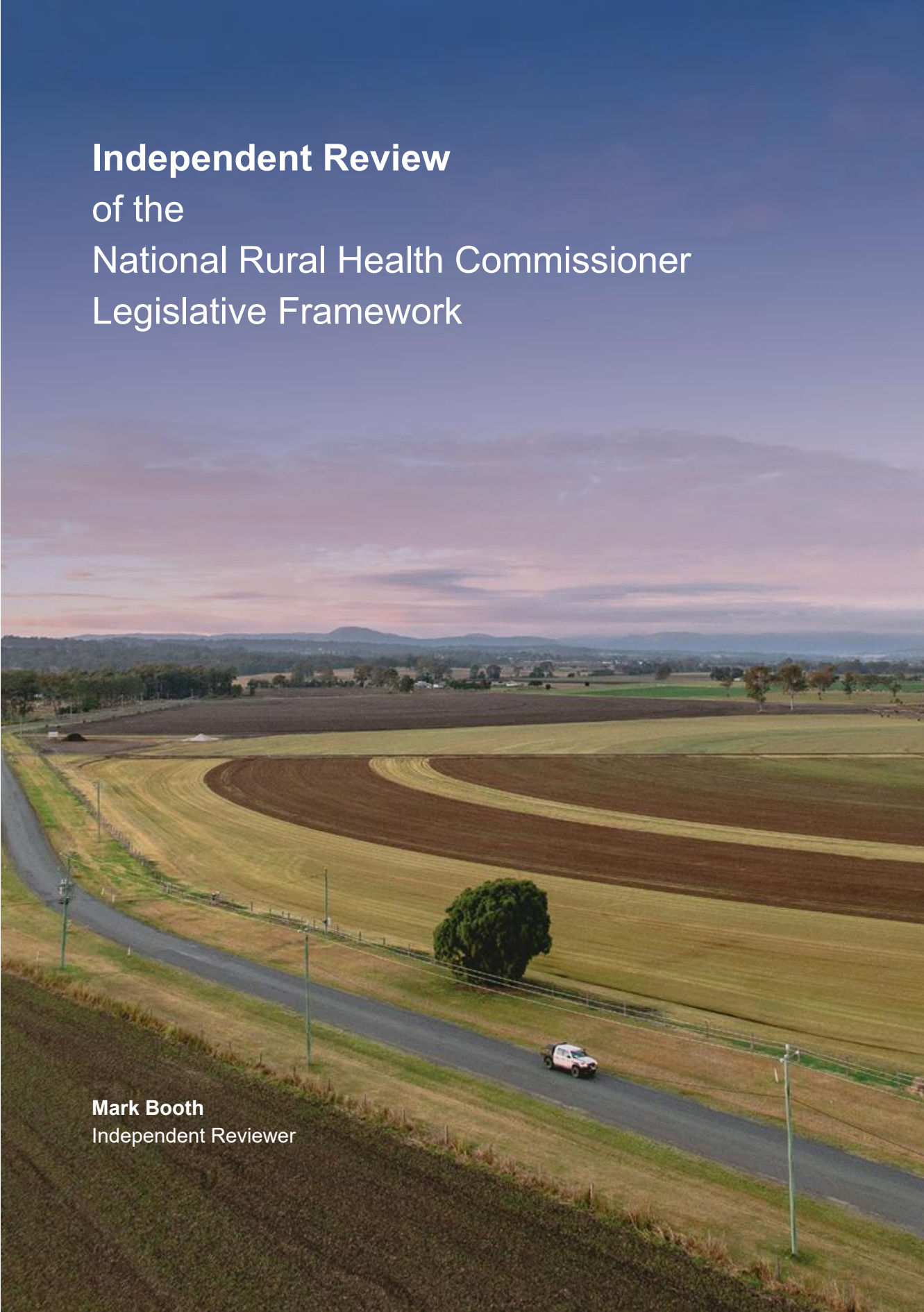
Independent Review
of the
National Rural Health Commissioner
Legislative Framework



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Independent Reviewer

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Acknowledgement of Country

The Reviewer acknowledges the Traditional Owners of Country throughout Australia. I pay respects to their ancestors and their descendants, who continue cultural and spiritual connections to Country. I recognise their contributions to Australian and global society.

The Hon Emma McBride MP
Assistant Minister for Rural and Regional Health
Assistant Minister for Mental Health and Suicide Prevention
PO Box 6022
House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Assistant Minister

Independent Review of the National Rural Health Commissioner (NRHC) Legislative Framework

On 27 October 2025, I was appointed to undertake the Independent Review of the National Rural Health Commissioner (NRHC) Legislative Framework. The review is required under Part VA, section 79AB of the *Health Insurance Act 1973*, which states that you must cause an independent review to be conducted within 6 months of the fifth anniversary of that Part.

It is my pleasure to present to you my review.

Yours sincerely

Mark Booth
Independent Reviewer

1 May 2026

Foreword

As Independent Reviewer I am pleased to introduce the report of the Independent Review of the National Rural Health Commissioner (the Review). At the core of this Review is an ongoing commitment to the almost one-third of Australians who live outside of urban centres in regional, rural and remote areas of the country. For these Australians, access to high-quality health care at both an individual and a population level is essential but can be challenging. Many of the issues faced by communities in these areas are impacted by geography, workforce distribution issues and access issues. Despite these challenges, healthcare professionals continue to deliver high-quality, holistic, team-based care that aims to keep people healthy in their communities.

The National Rural Health Commissioner (NRHC) was initially established in legislation in 2017 – subsequently amended in 2020 – to provide an independent, impartial and evidence-based voice to government on health workforce initiatives that could positively impact on the health outcomes of regional, rural and remote populations. The 2020 legislative amendments mandated that a review of the effectiveness of the role be carried out after 5 years, and this report presents the results of that exercise.

The Review explicitly looks at the role of the NRHC under its legislative framework. It has not looked at the performance of individuals who have held the office of Commissioner or at any staff who have worked within the office.

I would like to acknowledge the assistance of the current Commissioner, Professor Jenny May AM, and her staff, as well as the staff of the Rural Policy Section of the Rural and First Nations Workforce Branch at the Department of Health, Disability and Ageing in the completion of this review.

Mark Booth
Independent Reviewer

A note on terminology

The legislation being examined is specifically related to the activities of the Commissioner. The Commissioner is supported by staff within the Office of the National Rural Health Commissioner. Within this report the acronym ‘NRHC’ is used to cover both the National Rural Health Commissioner and the Office of the National Rural Health Commissioner. Where these need to be separated, this is made clear in the text by use of the acronym ‘ONRHC’ or ‘the Office’.

The term ‘rural’ has been used to cover regional, rural and remote unless otherwise identified.

Executive summary

This report provides the results of an independent review of the effectiveness, relevance and impact of the legislative framework governing the operations of the National Rural Health Commissioner (NRHC). It provides recommendations for future amendments to the legislative framework governing the role and function of the NRHC, the Deputy Commissioners and the Office of the NRHC (ONHRC). The Review is a formal requirement of the revised legislation that established a permanent NRHC in 2020.

The legislative framework looked at in this Review encompasses underlying legislation that permanently established the NRHC, as well as other formal accountability mechanisms such as the Statement of Expectations and ministerial directions. The Review has been informed by extensive stakeholder consultation, an online survey, detailed document analysis and assessment of available qualitative and quantitative datasets.

The NRHC was established as an independent statutory position in 2017 for a period of 3 years, with the role being made permanent through a legislative amendment in 2020. The NRHC exists to provide independent and impartial evidence-based advice to the federal Minister with responsibility for rural health issues. The Commissioner is assisted in this task by 2 Deputy Commissioners and a small core staff.

Since its establishment, the work of the NRHC has concentrated upon rural workforce issues, as this is the area that has been deemed to have the greatest impact upon access to health services for rural populations. This work has covered a variety of areas, including rural generalism, which was initially for general practitioners (GPs) but has subsequently covered nursing and allied health professions, rural maternity services and integrated models of care. In addition, the NRHC provides policy input into and advice on areas of health policy that impact upon rural populations. In carrying out its work the NRHC invests heavily in stakeholder consultation to inform its views and advice as mandated within legislation.

The NRHC is purely advisory, with no formal powers to direct or enforce, and relies upon evidence, knowledge and experience in informing its advice to government. This is unusual in the federal government, in which most statutory offices are regulatory with enforcement powers or are standard setters. This arrangement does have advantages in that it encourages a more open dialogue with stakeholders, who do not associate the NRHC with any regulatory or coercive functions.

The Review has found that the NRHC commands a high degree of respect and is perceived as a truly independent voice that can ‘funnel’ the views of many stakeholder organisations. Consensus among stakeholders is not always possible, but the high standing of the office ensures that stakeholders feel that their views are heard and that consultation processes are fair. A small number of stakeholders felt that the NRHC should expand its activities with more formal investigation powers and a mechanism for formal government responses. The Review believes that this is not an appropriate role for the

NRHC and would weaken the advantages that come from its existing way of operation. As such, it is recommended that the NRHC continue in its current format with its existing organisational form and placement. Given this, the Review finds that there is no requirement for large-scale changes to the legislation that would fundamentally affect its mode of operation or role.

Despite there being no statutory investigation role for the NRHC, the Review makes some recommendations aimed at improving the influence of the NRHC. The main vehicle suggested for this is a biennial overview of key issues in rural health. This is not intended to be a 'rural health strategy' (although some stakeholders support the development of such a strategy); rather, it is a document that would highlight the key issues that the NRHC is seeing in the performance of its activities and the key areas of both concern and good practice. This report would provide an evidence base to identify priority areas for work and could help align research and innovation in rural health issues. Such a report could be required within legislation or through a mechanism such as the Statement of Expectations. The document would also form a key piece of evidence to inform future Statements of Expectations as well as wider policy development.

The Review has found that the NRHC performs its tasks in an efficient and effective manner. It has addressed all the priority areas of the relevant Minister through actions highlighted in the Statement of Expectations and reported within annual reports and activity work plans. All actions have been achieved within current budget with no overspends, and all legislatively required outputs (such as the annual report) have been produced in a timely manner.

The Review has assessed the current placement of the ONRHC within the federal Department of Health, Disability and Ageing (the Department). While acknowledging that there could be tensions with ONRHC staff being employed by the Department but answering to an independent statutory office holder, the Review finds that, on balance, this is the best placement.

The Review found that the legislative framework for the NRHC is fundamentally sound. There are a small number of amendments suggested to core legislation, including to emphasise the importance of Aboriginal and Torres Strait Islander peoples' input to the activities of the NRHC, as they are not separately identified as being a stakeholder within the legislation. The inclusion of Aboriginal and Torres Strait Islander people would be consistent with Priority Reform One in the National Agreement on Closing the Gap.[1] Consumers are also absent as a separately identified stakeholder, which is not in line with contemporary approaches that emphasise consumer-centred approaches and involvement in health care.

[1] Department of the Prime Minister and Cabinet, 'Closing the Gap', Closing the Gap website, Australian Government, n.d., www.closingthegap.gov.au/national-agreement.

Another recommended legislative amendment is around the tenure of the Commissioner. The Review specifically looked at the current 2-year length of tenure and compared it with other statutory appointments. The 2-year appointment appears to reflect the pre-2020 legislation. The Review recommends that the appointment be amended in the legislation to a 4-year appointment for purposes of efficiency, certainty to the office holder, and ability to pursue multi-year projects. The extension of appointment term would also support the independence of the office and would bring it in line with other statutory appointments.

Although not mentioned in legislation, many stakeholders commented upon the importance of the role of the Deputy Commissioners in providing specific areas of advice and support to the Commissioner. There was a strongly held view that the current 0.3 full time equivalent (FTE) roles were not sufficient given the size of the task. It is not the role of this Review to impinge upon the managerial decisions of the Commissioner, but, given the crucial nature of the roles, a recommendation to increase the roles to a minimum of 0.5 FTE is included.

Several stakeholders commented upon the lack of a cross-jurisdictionally agreed strategic direction focused on rural health. Stakeholders provided comments regarding the impact of new technologies on service delivery, the importance of funding models that address the needs of rural services, and the risks that arise if states and territories are not coordinated in their approaches. In addition, many stakeholders reflected on the reality of service provision in rural areas, where care needs are considered holistically through multipurpose services that combine health, aged care and disability services. This Review believes that there is merit in and support for tasking the NRHC with coordinating a forum of state and territory representatives that could provide advice to the Health Ministers' Meeting. Such a forum would not be intended to duplicate the work of the current Health Workforce Taskforce[2] but would complement it.

A significant issue raised by many stakeholders reflects the sharp differences that exist between regional and rural areas (Modified Monash Model (MMM) 2–5) and remote areas (MMM 6–7). Many stakeholders reflected on the severe issues that affect health delivery in remote and very remote areas of the country. The differentiation of approaches between rural and remote areas is complex and there is merit in investigating how policy levers and approaches may be more nuanced in developing local solutions. This is reflected in the recommendations. It is also a reality that many impacts and determinants of an individual's or a population's health status are outside of the influence of the health sector. Considering this, the Review considers that the Statement of Expectations could be used to highlight (within budget constraints) work that will allow the NRHC to look at determinants of health and cross-portfolio areas. This is particularly important when

[2] Department of Health, Disability and Ageing, Australian Government, 'Health Workforce Taskforce', Department of Health, disability and Ageing website, n.d., www.health.gov.au/committees-and-groups/health-workforce-taskforce-hwt.

considering health impacts on population groups with significantly higher levels of health need.

It is recognised that some of these recommendations will have funding implications and, should they be accepted, will require an increase in FTE staffing of the ONRHC.

This Review concludes that the NRHC is a respected and effective advocate for rural health, operating efficiently within its advisory remit. While the current legislative framework is robust, targeted amendments and increased resourcing will strengthen the NRHC's ability to address evolving rural health challenges and ensure its continued impact.

Recommendations

Recommendation 1: The NRHC performs a key role in seeking to improve health outcomes in regional, rural and remote Australia and it should continue this role under its current operational and legislative settings.

Recommendation 2: The NRHC should be tasked with producing a biennial report that provides a strategic overview of key issues within the rural health sector and highlights areas of both good practice and concern.

Recommendation 3: The biennial report should be presented to Parliament, as is the case with the annual report of the NRHC.

Recommendation 4: The Minister should consider the issues highlighted in the biennial report when developing the Statement of Expectations for the NRHC.

Recommendation 5: Future appointments to Deputy Commissioner roles should be extended from the current 0.3 FTE to a minimum of 0.5 FTE.

Recommendation 6: The appointment term for the NRHC should be extended to 4 years.

Recommendation 7: The NRHC, in collaboration with the Department of Health, Disability and Ageing, should consider the establishment of a multi-jurisdictional rural health advisory body to consider rural health policies across states and territories, and identify areas for collaboration and improved health outcomes.

Recommendation 8: The NRHC, in collaboration with the Department of Health, Disability and Ageing, should consider a mechanism to effectively coordinate approaches to service delivery in rural and remote areas, acknowledging the interdependence of health, disability and aged care service provision.

Recommendation 9: Section 79AD(f) of the legislation should be revised to explicitly identify Aboriginal and Torres Strait Islander people, and consumers. The listing of stakeholders should be in alphabetical order.

Recommendation 10: The NRHC, in collaboration with the Department of Health, Disability and Ageing, should consider a mechanism to investigate more fully innovative approaches to funding and delivery of services in rural areas (MMM 2–5) and remote areas (MMM 6–7) separately.

Recommendation 11: Subject to budget constraints, the activities of the NRHC should be expanded to allow it to take a more holistic view of rural health issues, reflecting the importance of determinants of health as well as impacts outside of health service settings. This should include impacts on groups that have disproportionate levels of health needs.

Recommendation 12: The ONRHC should continue its current organisational model with staff being employed as Australian public servants within the Department of Health, Disability and Ageing.

Independent Review of the National Rural Health Commissioner Legislative Framework – approach and context

This section of the report provides details on the approach taken to the Review. It also provides information on rural populations and the policy and legislative environment within which the NRHC exists.

1. Methodology

The Review has adopted a mixed methods approach utilising various techniques, including:

- desk-based research of relevant legislation, reports, academic literature and media articles
- stakeholder consultation (in person or virtual) with key stakeholders from across the rural health sector as well as staff of the NRHC and the Department
- qualitative and quantitative assessment of the activities of the NRHC compared with expectations
- an online survey circulated to interested stakeholders and open to the public
- comparisons with comparable independent office holders and their enabling legislation.

A total of 38 stakeholder interviews were held, and 27 survey responses were received. A listing of the organisations included in stakeholder interviews is provided in Appendix 2. Although submissions were not invited, 4 submissions were received.

One of the key issues in the Review has been how to effectively measure the impact of the activities of the NRHC on the wider rural and regional sector. Attribution is difficult, as the NRHC does not have measurable activities in the same way that a regulator or a standard setter would. The activities of the NRHC are mainly advisory and are often carried out by providing expert input into policy development and advice on policy issues that will impact on rural and remote populations. As such, the Review has relied much more on qualitative data than on quantitative data.

Appendix 3 provides further detail on the methodology used.

2. Rural health in Australia

The legislation that covers the activities of the NRHC has a clear focus upon improving the health status of people who live in rural and remote areas of Australia. Appendix 4 to this report gives an overview of the characteristics of populations that live in rural areas, the workforce that is available and some aspects of the policy context.

In summary, approximately 30% of the Australian population live outside of major cities. It is acknowledged that there are significant benefits of living outside of major cities, and the positive economic contribution of the rural economy is significant. From a health perspective, however, individual and population health measures decline with increased levels of rurality. This reflects several issues, including the following:

- Determinants and impacts on health status tend to be more pronounced in rural and remote areas – for example, the population profile tends to be older, with lower educational levels, higher levels of unemployment and lower income levels, all of which are strong predictors of poorer health status.
- Access to services can be difficult due to low population density across wide geographic areas and high infrastructure costs. Associated with this are persistent workforce shortages across all areas of the health workforce, including the medical, nursing and allied health sector.
- A higher proportion of population groups that are particularly impacted by poorer health outcomes live in rural and remote areas. Aboriginal and Torres Strait Islander people tend to have poorer health outcomes than non-Indigenous Australians, as do Australians from culturally and linguistically diverse (CALD) backgrounds. Around 15% of Aboriginal and Torres Strait Islanders live in very remote areas, compared with 1.4% of the non-Indigenous population.[3]

Key to addressing disparities in health has been an emphasis on recruiting and retaining a highly qualified workforce that is able to provide appropriate and timely care to rural populations. Federal, state and territory governments have put in place a significant number of rural incentive programs aimed at improving health outcomes via workforce programs, as well as enabling contemporary multidisciplinary team-based approaches to the provision of primary care.

The information provided in Appendix 4 shows that significant workforce recruitment, retention and distribution issues remain a challenge. Although the number of GPs has increased across all areas, the FTE increase has been lower, with a marked reduction of FTE in MMM 6. Nursing and midwifery numbers have increased markedly in both actual and FTE numbers, reflecting a reliance upon the nursing workforce in many rural areas.

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[3] Australian Institute of Health and Welfare, Australian Government, 'First Nations people', AIHW website, 20 October 2025, www.aihw.gov.au/reports-data/population-groups/indigenous-australians/overview.

3. The legislative framework of the National Rural Health Commissioner

3.1. Core legislation

The NRHC was established in 2017 to help support reforms in rural health that would positively impact health outcomes for Australians living in rural and remote areas of Australia. The position of the NRHC was formalised in the *Health Insurance Amendment (National Rural Health Commissioner) Act 2017*, which passed both houses of Parliament on 22 June 2017.

The initial intent of the NRHC was to be 'The champion of regional and rural health reform',[4] although the initial activities were circumscribed. The revised Explanatory Memorandum for the legislation indicated that:

> The Commissioner will be responsible for:
>
> – the development of a new National Rural Generalist Pathway to increase access to training for doctors in rural, regional and remote Australia;
> – working with Government and the health sector to enhance policy and promote opportunities of a career in rural health; and
> – developing options for increased access to training and appropriate remuneration for rural generalists.[5]

This shows that the focus was very much on the development of a National Rural Generalist Pathway. This provided the key focus of activities for the first NRHC, Professor Paul Worley, who commenced in November 2017.

It was also noted that:

> The National Rural Health Commissioner position will terminate on 1 July 2020 with completion of functions at that time.[6]

The legislation indicated that the Minister should consider a year in advance of this termination date whether the NRHC should continue.

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[4] L O'Brien, Federal Member for Wide Bay, *Australia's first National Rural Health Commissioner – the champion of regional and rural health reform* [media release], 8 February 2017, https://llewobrien.com.au/australia-s-first-national-rural-health-commissioner-the-champion-of-regional-and-rural-health-reform/.

[5] Parliament of Australia, 'Health Insurance Amendment (National Rural Health Commissioner) Bill 2017', Parliament of Australia website, n.d., https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22legislation%2Fems%2Fr5796_ems_a1d16841-74bc-4bfa-b37e-8308e76a80e9%22.

[6] Ibid.

The establishment of the NRHC was welcomed by rural health stakeholders, with the Rural Doctors Association of Australia noting that they had long advocated for such a commissioner.[7] A 2017 editorial in the *Australian Journal of Rural Health* noted that:

> The federal government's announcement of the introduction of a Rural Health Commissioner is welcomed. It presents a great opportunity to systematically address key rural health issues and enhance the health care of rural Australians.[8]

It also highlighted 5 conditions for success: 'independence, rural credibility, rural accountability, broad political support and longevity'.[9]

As the 2017 legislation indicated the termination of the office in 2020, it was determined that legislation should be introduced to continue the role of the NRHC. This legislation was introduced in June 2020 with the Health Insurance Amendment (Continuing The Office Of The National Rural Health Commissioner) Bill 2020. This legislation was passed through both houses on 18 June 2020, receiving assent on 25 June 2020. In the Explanatory Memorandum for the Bill, it was noted that:

> It is essential that the Office continues to function to give rural communities confidence that the enduring challenges of health workforce shortages, higher burden of disease, and the ever-present threat of external shocks such as droughts and bushfires, are central to health policy formulation and implementation.[10]

The Bill further envisaged a wider role for the NRHC:

> The new Office will be able to take a broader perspective in providing advice and support to Government. It will consider the entire health workforce – medical, nursing, allied health and all other health workforce members – in its work. The Office will have a key role in strengthening the rural training pathway, considering innovations to achieve a sustainable and accessible workforce, and will have patient needs at the heart of its work.[11]

The 2020 legislation amended the *Health Insurance Act 1973*.[12] The core legislation for the NRHC is in Part VA of this Act. The Act highlights the key functions of the

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[7] P Rutherford, 'The National Rural Health Commissioner: a champion for rural healthcare', *Partyline*, 22 September 2017, www.ruralhealth.org.au/partyline/article/national-rural-health-commissioner-champion-rural-healthcare.html.

[8] R Roberts , 'A health commission for regional, rural and remote Australia', *Australian Journal of Rural Health*, 2017, 25:76, https://doi.org/10.1111/ajr.12356.

[9] Ibid.

[10] Parliament of Australia, 'Health Insurance Amendment (Continuing the Office of the National Rural Health Commissioner) Bill 2020 Explanatory Memorandum', Parliament of Australia website, n.d., https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22legislation%2Fems%2Fr6565_ems_1325749f-ef2d-40bc-966b-96327ed880ff%22.

[11] Ibid.

[12] *Health Insurance Act 1973* (Cth), www.legislation.gov.au/C2004A00101/latest/text.

Commissioner, which are wide ranging, and in summary require the Commissioner to provide advice to the Minister for Rural Health relating to:

(i) developing, aligning and implementing Commonwealth strategies, priorities or measures so as to improve health outcomes in those areas; and
(ii) developing and promoting innovative and integrated approaches to the delivery of health services in those areas so as to improve the quality and sustainability of, and access to, health services in those areas; and
(iii) identifying opportunities to strengthen and align health workforce training in those areas; and
(iv) strengthening and promoting regionally-based, patient-centred approaches to the delivery of health services in those areas that take into account the needs of the communities, families and individuals in those areas[.][13]

The legislation requires that the activities of the NRHC should be underpinned by wide-ranging stakeholder consultation and that advice must be given in an independent and impartial manner. It states that the period of appointment for the NRHC is 2 years, with the possibility of reappointment.

It is important to recognise that, although the Commissioner is a statutory appointment enshrined in legislation, their powers are limited. Many other statutory appointments have associated regulatory or coercive powers that they exercise on behalf of government in particular areas – in the health sector this includes, for example, the Aged Care Quality and Safety Commissioner, who has specific powers to regulate in the aged care sector. The statutory powers of the NRHC are advisory and consultative and exist to facilitate the independent advice to the Rural Health Minister[14] on issues related to rural health. The implications of this are discussed later in this report.

Following the amendments to the legislation in 2020, Professor Ruth Stewart was appointed as Commissioner in July 2020 and was in the position until June 2024, when the current Commissioner, Professor Jenny May AM, was appointed. The Commissioner is assisted by 2 Deputy Commissioners, with the most recent being appointed in October 2025. The Deputy Commissioner roles are not mandated in legislation. The ONRHC has a small contingent of permanent staff employed to assist the Commissioner and Deputy Commissioners in carrying out their roles. These staff, including the Deputy Commissioners,[15] are public servants employed by the Department.

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[13] *Health Insurance Act 1973* (Cth) Part VA, s 79AD.

[14] Although the legislation refers to the Rural Health Minister, in practice this title can change, and the current responsible authority is the Assistant Minister for Rural and Regional Health. Legal advice from the Department has indicated that the Rural Health Minister's powers under the legislation can be exercised by any Minister or Assistant Minister appointed to administer the Department of Health, Disability and Ageing.

[15] This is the case for the current Deputy Commissioners. The previous Deputy Commissioners were engaged as contractors under secondment.

3.2. The wider authorising framework

The previous section highlighted the legislation that governs the activities of the NRHC. Other documents also direct the NRHC's activities, most notably the Rural Health Minister's Statement of Expectations and the corresponding NRHC's Statement of Intent. A Statement of Expectations is developed by the Minister and highlights key activities and deliverables to guide the work of the agency. A Statement of Intent is produced by the NRHC in response and highlights how they will meet the expectations. These documents are publicly available. In the lifetime of the NRHC there have been 3 Statements of Expectations, each covering a 2-year period to tie in with the appointment term of the Commissioner.

4. The status of the National Rural Health Commissioner

The NRHC is established within legislation as a statutory appointment. The Commissioner is appointed by the Rural Health Minister, with formal appointment being approved by the Prime Minister or Cabinet. The NRHC is classified as a secondary statutory structure[16] within the Australian Government, meaning that it is established within a primary body by legislation. In this case the primary body is the Department, with the legislation being part of core federal health legislation. This is different from primary bodies that have their own legislation and exist as separate entities, although they may be part of an overarching departmental portfolio. Within the health sector, examples of primary bodies are the Aged Care Quality and Safety Commission, the Australian Digital Health Agency, and Food Standards Australia New Zealand.

While the Commissioner is a statutory appointment, the staff of the ONRHC are public servants who fall under the *Public Service Act 1999* and are required to adhere to all standards of the public service. It also means that the staff are employed under public service terms and conditions. This is the standard situation for Australian federal statutory agencies. The NRHC is funded through the Department and does not have a separate appropriation.

Another way of considering the status of the NRHC is contained in work by the Australia and New Zealand School of Government, which has highlighted 3 main types of statutory agency:[17]

- standalone agency – an agency with its own organisational structure and administration and support staff
- integrated agency – an agency within a Department of State; its head and staff are departmental employees, but it has its own statutory powers
- secretariat – a statutory office or board outside a Department of State which is supported by a team of public servants.

Under this typology the NRHC would be a secretariat in which the Commissioner is independent, but the secretariat consists of public servants provided by the Department.

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[16] Australian Government Directory, 'Office of the National Rural Health Commissioner', Australian Government Directory, n.d., www.directory.gov.au/portfolios/health-disability-and-ageing/department-health-disability-and-ageing/national-rural-health-commissioner.

[17] A Bushnell and P Brownlee, *The purpose of small statutory agencies: insights on the functions, form, and practices from public sector leaders*, ANZSOG Research Insights No. 30, Australia and New Zealand School of Government, Melbourne, 2023.

Review of the National Rural Health Commissioner Legislative Framework – assessment of the performance and operation of the National Rural Health Commissioner

This section of the report first considers 7 lines of enquiry[18] based on the focus areas identified in the Terms of Reference for the Review, which are given in Appendix 1 and are also available online.[19] This is followed by a comparison with other agencies.

5. Review of the performance and operation of the National Rural Health Commissioner

5.1. System effectiveness: the extent to which the activities of the Commissioner have had a wider policy impact

This section focuses on:

- influence on rural health policy and strategy
- responsiveness to emerging rural health issues.

Section 3.1 of this report notes that the role of the NRHC as a statutory appointment is unusual in that it has an advisory role with no powers available to direct or directly implement actions. Instead, the NRHC must use what several stakeholders have referred to as ‘soft power’. This is a term normally associated with international relations and refers to the ability to influence actions via persuasion as opposed to coercion.

[18] Further information is given in Appendix 3 – Methodology.

[19] Department of Health, Disability and Ageing, ‘Terms of Reference – Independent Review of Part VA – *Health Insurance Act 1973* – National Rural Health Commissioner’, Department website, Australian Government, 14 November 2025, www.health.gov.au/resources/publications/terms-of-reference-independent-review-of-part-va-health-insurance-act-1973-national-rural-health-commissioner.

> ‘I think it would be devastating to lose that role because it’s giving a voice to people on Regional Health issues that they otherwise don’t have, certainly with a level of clarity of where to go to and who to raise issues with.’
>
> Government stakeholder interview

This section of the report explicitly looks at influence in the context of the absence of coercion powers and in the enabling framework of the current legislation.

There is a clear threshold question that can be addressed at the outset – do stakeholders feel that the NRHC is a valuable part of the health system that should be retained? When stakeholders were asked this question there was clear and strong support for the NRHC and its role as an independent advisor. This stakeholder support came from organisations both within government bureaucracy and outside of it.

Many interviewees reflected upon the situation before the establishment of the NRHC as one where it was more difficult to have a voice to the responsible Minister or to be able to be effectively consulted on decision making. The Review confirmed that the NRHC performs a valuable role within the health sector and this role should continue.

> **Recommendation 1:** The NRHC performs a key role in seeking to improve health outcomes in regional, rural and remote Australia and it should continue this role under its current operational and legislative settings.

5.1.1. Influence on rural health policy and strategy

This Review is not a formal evaluation, primarily due to the unusual nature of the role and the lack of detailed quantitative measures, and a detailed policy impact assessment has not been carried out. It has been possible to look at policy impact through 2 specific lenses:

- stakeholder perspectives on influence
- assessment of the take-up or adoption of specific reports or processes that have been undertaken.

5.1.1.1. Stakeholder perspectives

Stakeholders who participated in one-on-one interviews were largely of the opinion that the NRHC does have a positive influence on policy and strategy. Around 85% of survey responses said that the NRHC had been moderately or very effective in providing impartial advice.

> ‘It is critical to have rural representation to the Government and the Department.’
>
> Professional group stakeholder interview

This view was echoed within the federal bureaucracy and was evidenced by the Commissioner being seen as the de facto expert on rural health policy and strategy. Numerous examples were given of ONRHC staff being consulted to provide specific rural

input into policy development exercises, including the assessment of unintended consequences.

Among non-government stakeholders, there was a belief that the NRHC was effective and influential due to the ‘voice’ that it gave to a large and disparate group of stakeholders tied to the strong stakeholder engagement activities that the NRHC carries out. There was, however, a minority view that the current legislative settings do not give it enough scope to be as effective as it could be. Several stakeholders talked about the need to give the NRHC more ‘teeth’ to be able to influence policy but did not define what that influence may be.

In the survey a more nuanced story emerged in this area. When asked if the current legislation supports the NRHC to have a meaningful impact on rural health policy, 18 respondents (67%) felt that it did but 9 respondents (33%) said no or were unsure. When asked whether respondents had noticed improvements in service delivery due to NRHC activities, a similar split was evidenced.

5.1.1.2. Key reports and initiatives

There have been several key reports and initiatives that have been led by the NRHC over the last 5 years. A sample of these is highlighted in Table 1.

Table 1: Sample of National Rural Health Commissioner initiatives and reports[20]

Report/activity	Comments
Rural generalism	The NRHC played a role in leading, advising and collaborating with others on the adoption of rural generalism in Australia. Specific policy outcomes have included: • formal recognition of rural generalism as a specific specialty within general practice in September 2025[21] • leading development of the National Rural Generalist Pathway[22] • leading initiatives in rural generalism for medical, nursing and allied health groups.
National Rural and Remote Nursing Generalist Framework 2023–2027 (2023)[23]	This framework defines the core capabilities that are required for registered nurses working in rural and remote areas. The framework has: • been incorporated into nursing and education training frameworks such as the Queensland Remote Area Nurse Model of Consultation • been supported by key nursing stakeholders across the sector and incorporated into university training courses • achieved international reach, including incorporation into training programs into the United Kingdom.

[20] Note: The Report for the Minister for Regional Health, Regional Communications and Local Government on the improvement of access, quality and distribution of allied health services in regional, rural and remote Australia (June 2020) is outside of the timeframe for this Review and is not included in the table.

[21] The Hon Mark Butler MP, Minister for Health and Ageing, *Rural generalists recognised as medical specialists* [media release], Australian Government, 21 September 2025, www.health.gov.au/ministers/the-hon-mark-butler-mp/media/rural-generalists-recognised-as-medical-specialists.

[22] Department of Health, Disability and Ageing, 'National Rural Generalist Pathway', Department website, Australian Government, 24 October 2025, www.health.gov.au/our-work/national-rural-generalist-pathway.

[23] Department of Health, Disability and Ageing, 'The National Rural and Remote Nursing Generalist Framework 2023–2027', Department website, Australian Government, 24 March 2023, www.health.gov.au/resources/publications/the-national-rural-and-remote-nursing-generalist-framework-2023-2027.

Report/activity	Comments
Ngayubah Gadan (Coming Together) Consensus Statement: rural and remote multidisciplinary health teams (2023)[24]	This consensus statement establishes a nationally recognised definition of a multidisciplinary team, including its core elements and enablers. This statement: • fitted strongly into the national discourse on team-based multidisciplinary primary care practice • was endorsed by several leading stakeholder groups, including the Australian Medical Association.[25]
Implementing rural selection: a guide for medical colleges (2025)[26]	This guide was produced in partnership with the Council of Presidents of Medical Colleges and provides evidence-based guidance on embedding rural criteria into selection processes for specialist training programs. It is too early to assess impact, but this guide does provide a way for different professional colleges to standardise their assessment processes.
Second edition National Consensus Framework for Rural Maternity Services (2025)[27]	This framework replaced one originally completed in 2008 and was coordinated and facilitated by the ONRHC. It is too early to assess the impact of the framework, but it received strong endorsement from key stakeholder groups [28] and key primary care professional bodies, including the Australian College of Rural and Remote Medicine[29] and the Australian College of Midwives.[30]

[24] Department of Health, Disability and Ageing, 'The Ngayubah Gadan Consensus Statement – Rural and Remote Multidisciplinary Health Teams', Department website, Australian Government, 19 June 2023, www.health.gov.au/resources/publications/the-ngayubah-gadan-consensus-statement-rural-and-remote-multidisciplinary-health-teams.

[25] Australian Medical Association (AMA), 'AMA submission supports "coming together" in GP-led rural team care', AMA website, 20 April 2023, www.ama.com.au/ama-rounds/21-april-2023/articles/ama-submission-supports-coming-together-gp-led-rural-team-care.

[26] Department of Health, Disability and Ageing, 'Implementing rural selection: a guide for medical colleges', Department website, Australian Government, 3 July 2025, www.health.gov.au/resources/publications/implementing-rural-selection-a-guide-for-medical-colleges.

[27] Australian College of Midwives, Australian College of Rural and Remote Medicine, Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, Maternity Consumer Network, National Association of Aboriginal and Torres Strait Islander Health Workers and Health Practitioners, National Rural Health Alliance, Office of the National Rural Health Commissioner, Royal Australian College of General Practitioners, Royal Australian and New Zealand College of Obstetricians and Gynaecologists, Rural Doctors' Association of Australia, Rural Workforce Agency Network, *Second edition National Consensus Framework for Rural Maternity Services*, Australian College of Midwives website, 2025, www.midwives.org.au/common/Uploaded%20files/New%20Doc/FINAL%202025_2nd%20Ed%20National%20Consensus%20Framework%20Rural%20Maternity%20Services%20DIGITAL.pdf.

[28] National Rural Health Alliance (NRHA), 'The future of rural and remote maternity; a framework for success', NRHA website, 24 June 2025, https://www.ruralhealth.org.au/media-release/the-future-of-rural-and-remote-maternity-a-framework-for-success/.

[29] Australian College of Rural and Remote Medicine (ACCRM), 'ACRRM welcomes updated framework supporting rural maternity services', ACRRM website, 23 June 2025, https://www.acrrm.org.au/about-us/news-events/news/article/2025/06/23/acrrm-welcomes-updated-framework-supporting-rural-maternity-services.

[30] Australian College of Midwives (ACM), *National Consensus Framework for Rural Maternity Services* [media release], ACM website, 23 June 2025, https://midwives.org.au/Web/Web/News-media-releases/Articles/2025/23_June/Rural_Maternity_Framework.aspx.

The work of the NRHC is important and its impact has been noted above. Its impact is constrained, however, by the advisory nature of its activities and the lack of funding that it can make available to support implementation of any of its recommendations – a point made by several stakeholders regarding the Ngayubah Gadan (Coming Together) Consensus Statement in particular.

The Review found a tension between a desire among some stakeholders for the NRHC to exert a greater level of impact and produce actionable findings where it can; and a competing desire not to give the NRHC a coercive or regulatory function that would negatively impact upon stakeholder relationships. In considering this tension, the report highlights some changes which would increase the evidence base and profile of issues in the rural health sector and strengthen the role of the NRHC.

The recommendation is for the NRHC to produce a biennial rural health system report that would provide an overview of the provision of health services in regional, rural and remote areas as well as highlighting issues that are impacting upon the delivery and accessibility of services. This is explicitly not a 'rural health strategy'[31] but, rather, a document that would highlight the key issues that the NRHC is seeing in the performance of its activities and emphasise key areas of both concern and good practice. The biennial nature of such a report reflects the fact that change often takes a significant amount of time and is often not reflected in yearly timeframes.

This report could be required within legislation or through a mechanism such as the Statement of Expectations. To maximise its impact, it should be completed as a standalone report, although it could be produced in conjunction with the annual report. The document would also form a key piece of evidence to inform future Statements of Expectations, as well as wider policy development activities both within the Department and across the wider sector.

It is also recommended that the biennial report should be presented to Parliament in the same manner as the annual reports of the NRHC. This will improve visibility of the biennial report across portfolios and reinforce the independence of the NRHC.

Recommendation 2: The NRHC should be tasked with producing a biennial report that provides a strategic overview of key issues within the rural health sector and highlights areas of both good practice and concern.

Recommendation 3: The biennial report should be presented to Parliament, as is the case with the annual report of the NRHC.

Recommendation 4: The Minister should consider the issues highlighted in the biennial report when developing the Statement of Expectations for the NRHC.

[31] Several stakeholders highlighted the lack of a rural health strategy as an issue.

5.1.2. Responsiveness to emerging rural health issues

The previous section highlighted several initiatives carried out by the NRHC that have resulted in published documentation in response to issues that emerged in rural health. It is noted that many of these issues have been longstanding in the sector. The NRHC's documents and activities mainly relate to workforce issues and addressing the need to improve rural health outcomes by increasing the number of primary care professionals working in rural and remote areas. They have also focused on the best ways to encourage team-based multidisciplinary approaches to primary care that are crucial in rural and remote areas.

Within the legislation, the relevant Minister can direct the NRHC to investigate specific areas and issues. In the 5 years covered by this Review, no Minister has used this directing power. There have been emerging issues that the NRHC has been tasked with providing advice or input on through the Statement of Expectations. Appendix 7 lists several examples of these areas. Two specific examples are:

- advice on the COVID-19 pandemic. The 2022–23 Annual Report highlighted several areas of activity and leadership during the pandemic. Specific examples included working with Rural General Practice Respiratory Clinics on appropriate vaccine access and chairing groups aimed at ensuring access to primary care for rural and remote populations during the pandemic
- linking in with the National Emergency Management Agency (NEMA) to coordinate advice during bushfires. This role was set up following a catastrophic bushfire season and allows the NRHC to provide advice to NEMA on access issues in bushfire-affected areas.

Based on evidence provided in the Statements of Intent, annual reports and other publications, the Review's conclusion on responsiveness to emerging issues is that, within its budgetary constraints, the NRHC has responded appropriately.

5.2. Administrative effectiveness: the extent to which the Commissioner's functions have been fulfilled as per the legislative framework

This section focuses on:

- achievement of statutory functions and objectives
- performance against the NRHC Statement of Expectations and Statement of Intent
- performance against the annual activity work plan prepared by the NRHC.

The legislative framework was briefly discussed in Section 3.2 and includes the core legislation, the Statement of Expectations, and the Statement of Intent. Each of these documents is publicly available.

The NRHC also produces an activity work plan. This is a more detailed work program that highlights specific work areas and timescales. This plan is updated on a 6-monthly basis.

Evidence to inform the analysis in this section has been taken from:

- examinations of literature, including annual reports and related documents
- structured interviews with external stakeholders and staff of the NRHC
- feedback from a survey of stakeholders.

5.2.1. Achievement of statutory functions

The statutory functions of the NRHC are contained within section 79AB of the *Health Insurance Act 1973*. This section of the report concentrates on activities relating to section 79AB(a)–(e) and (h), with section 79AB(f) and (g) discussed in Section 5.4. Table 2 below provides commentary on each of these areas.

Table 2: Responses to statutory functions[32]

Function	Comments
(a) to provide advice to the Rural Health Minister about matters relating to health in rural, regional and remote areas	Evidence provided in Appendix 7 to this report supports a conclusion that the NRHC provides appropriate levels of advice to the relevant Minister in carrying out their duties. The NRHC meets regularly with the Assistant Minister for Rural and Regional Health to provide updates on the activities of the NRHC and key issues that are emerging within the sector; and to respond to any issues raised by the Assistant Minister. Stakeholder feedback indicates that this is a very effective mechanism. In addition, the NRHC provides written advice on specific areas as requested. The NRHC also provides advice to the Minister in the form of its annual reports as well as through other processes and documents.
(b) to undertake specified projects about those matters	Since the establishment of the NRHC in 2017 there have been work programs that have focused upon the key matters highlighted in advice provided to the relevant Minister. These programs have particularly focused on workforce issues and has been evidenced through literature reviews and key stakeholder interviews.
(c) to inquire into and report on specified aspects of those matters	Table 1 in this report together with Appendix 7 provide examples of the activities required under this section of the legislation. Examples include: • Ngayubah Gadan Consensus Statement • National Rural and Remote Nursing Generalist Framework 2023–2027 • Improvement of Access, Quality and Distribution of Allied Health Services in Regional, Rural and Remote Australia.

[32] The functions in Table 2 have been taken from the section 79AB simplified outline.

Function	Comments
(d) to support the implementation of Commonwealth strategies, priorities and measures about those matters	A good example of the way the NRHC supports implementation of policy is the adoption of rural generalism. This has progressed through the adoption of a definition for rural generalism, which was agreed between professional bodies and formalised in the Collingrove Agreement.[33] It was also progressed through the development of generalist pathways and the recent recognition of rural generalism as a specialty within general practice in Australia. In addition, there is a significant amount of work that the NRHC performs in terms of input into other areas of policy that will impact on rural and remote areas. It is difficult to quantify these areas, but stakeholder feedback has noted: • the significant number of consultative committees of which the Commissioner is a member • the position of the Commissioner as the de facto source of advice within the Department on the impact of policy measures on rural and remote populations • the role of the NRHC as a conduit for the views of stakeholders across the rural health sector.
(e) to undertake research, and to collect, analyse, interpret and share information, about approaches to those matters	The ONRHC consists of experts within the field of rural health whose job it is to support the Commissioner in their role. As a part of this activity, the ONRHC produces background evidence-based research to underpin its activities. Much of this research is shared within reports and other documentation produced by the ONRHC.
(h) to perform functions conferred on the Commissioner by a Commonwealth law about those matters.	This section of the legislation is a standard provision within Commonwealth legislation and is intended to 'futureproof' legislation. It allows the Commissioner to carry out other functions in rural health through other laws without having to amend the original legislation each time.

The legislation also contains the power for the Minister to direct the NRHC to investigate specific areas. This is in section 79AD(4) of the legislation. It is understood that this has never been used.

The conclusion of this section is that the NRHC has undertaken the statutory activities that are laid out in the legislation. The evidence provided by stakeholders and the review of documentation indicates that this has been done effectively and that the involvement of the NRHC in wider policy development, as well as in specific areas such as the development of rural generalism, has been positive.

[33] Australian College of Rural and Remote Medicine (ACCRM), 'The Collingrove Agreement', ACCRM website, February 2018, www.acrrm.org.au/rsrc/documents/misc/the-collingrove-agreement.pdf.

5.2.2. Performance against the National Rural Health Commissioner NRHC Statement of Expectations and Statement of Intent

For the purposes of this report there have been 3 Statements of Expectations covering the following time periods:

- 1 July 2020 to 30 June 2022[34]
- 1 July 2022 to 30 June 2024[35]
- 2 September 2024 to 30 June 2026.[36]

Each of these has a very similar layout and highlights the vision for the NRHC, the role of the Commissioner, specific areas of delivery and stakeholder consultation. Appendix 7 summarises the activities that have been highlighted in each of the Statements of Expectations and provides an assessment of whether these activities have been completed and the source of evidence to assess this. The analysis has not included the Statements of Intent, which are formal responses to the Minister confirming acceptance of the activities outlined in the Statements of Expectations.

The information provided in Appendix 7 indicates that, since its commencement, the NRHC has met the expectations that have been highlighted within each of the Statements of Expectations.

5.2.3. Performance against annual activity work plans prepared by the National Rural Health Commissioner

Since June 2023, the NRHC has produced 6-monthly activity work plans which map the requirements of the Statements of Expectations against the work activities of the NRHC to track progress. The plans are provided to the Assistant Minister. This process ensures that the requirements of the Statement of Expectations are reflected in the activities of the NRHC and its work program and that ongoing progress is captured and updated. Assessment of the ongoing activity work plans has shown that they are maintained and updated regularly so that performance can be monitored.

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[34] Department of Health, Disability and Ageing, '1 July 2020 to 30 June 2022 Statement of Expectations for the National Rural Health Commissioner', Department website, Australian Government, 1 July 2020, www.health.gov.au/resources/publications/1-july-2020-to-30-june-2022-statement-of-expectations-for-the-national-rural-health-commissioner.

[35] Department of Health, Disability and Ageing, '1 July 2022 to 30 June 2024 Statement of Expectations for the National Rural Health Commissioner', Department website, Australian Government, 24 March 2023, www.health.gov.au/resources/publications/1-july-2022-to-30-june-2024-statement-of-expectations-for-the-national-rural-health-commissioner.

[36] Department of Health, Disability and Ageing, 'Statement of Expectations for the National Rural Health Commissioner – 2 September 2024 to 30 June 2026', Department website, Australian Government, 26 September 2024, www.health.gov.au/resources/publications/statement-of-expectations.

5.2.4. Summary

This section of the report has demonstrated that the NRHC has met its legislative and associated requirements. The Review found that these activities have been carried out to a high standard and the reputation of the NRHC among all stakeholders is high.

It is inevitable, however, that the activities will be limited by the advisory nature of the role and the resourcing available, and this has led to much of the work focusing on workforce issues, where the need for expert policy input is highest.

5.3. Efficiency: the ability of the Commission to deliver its functions within available budget and operational settings

This section focuses on:

- adequacy of NRHC resourcing for delivering functions
- efficacy of the Deputy Commissioner roles and responsibilities
- timeliness and quality of outputs (e.g. reports, advice)
- capability in managing funding appropriation to deliver expected outcomes
- adequacy of the legislated 2-year appointment term for supporting efficient delivery of the NRHC functions.

5.3.1. Adequacy of National Rural Health Commissioner resourcing for delivering functions

The resourcing for the ONRHC is $1.892 million for the current financial year (2025–26), which is $97,000 less than in the previous financial year. Most of the budget is used on salary costs, which account for $1.634 million of the budget. The next largest component of expenditure is on travel, followed by rent for the Cairns office and IT costs. Travel expenses take up a larger portion of the budget than for other organisations due to the need to link with stakeholders across a very wide geographical area. The location of the NRHC within the Department provides benefits, as they do not have to separately procure items and services – for example, costs associated with buildings and maintenance for Canberra-based staff; access to specialist resources such as HR, payroll, IT advice etc; and, importantly, access to departmental resources and advice.

The ONRHC currently has 10 staff consisting of:

- Commissioner
- 2 Deputy Commissioners
- 1 Executive Level 2
- 4 Executive Level 1
- 2 APS Level 5.

Not all positions are full time – the 2 current Deputy Commissioner roles are 0.3 FTE each, and some of the office staff also work less than full time.

The funding that the NRHC receives is adequate to meet its needs, because the activities are done to meet the budget of the agency. This Review makes some recommendations that would deliver additional functions to its workload, and these would not be able to be carried out within the existing funding envelope. Several survey responses highlighted a need to increase the funding to the NRHC for it to expand its activities.

5.3.2. Efficacy of the Deputy Commissioner roles and responsibilities

The NRHC has 2 Deputy Commissioners. These roles are not established in legislation and are not statutory appointments. Since the establishment of the NRHC, there have been 4 Deputy Commissioners. Two Deputy Commissioners were appointed in 2021 to advise the Commissioner on areas related to their specific expertise, with one Deputy Commissioner providing advice on allied health workforce issues and the other providing advice on nursing and First Nations health. These 2 Deputy Commissioner positions were employed on a secondment basis. In 2025 the original 2 Deputy Commissioners came to the end of their terms and were replaced by 2 new Deputy Commissioners who have expertise in allied health and nursing and midwifery. The current Deputy Commissioners are employed as departmental staff on a 0.3 FTE basis. All Deputy Commissioners have had experience in living and working in rural areas.

> ‘1.5 days per week is not adequate for the range and amount of work required.’
>
> Professional body stakeholder interview

There was significant comment from stakeholders relating to the Deputy Commissioner roles. These included the following:

- The Deputy Commissioners are seen as crucial in providing advice in their areas of expertise and in supporting the Commissioner in their work.
- Many stakeholders, while aware of the roles of the Deputy Commissioners, reported that they had little visibility of them.
- There was a strong perspective that a 0.3 FTE role was not sufficient to enable the Deputy Commissioners to adequately carry out their roles and effectively support the Commissioner.

Given the importance of the roles of the Deputy Commissioners in providing advice on nursing and allied health, complementing the expertise and experience of the current Commissioner, the Review recommends that the roles be expanded in terms of time. It is acknowledged that there is merit in appointing for less than a full-time role, if the incumbent is a health professional, to allow them to maintain their accreditation and bring practical experience to bear on their advice. Several stakeholders supported the notion of Deputy Commissioners bringing lived experience of rural service provision. The final make-up of the time is an operational decision for the Commissioner.

> **Recommendation 5:** Future appointments to Deputy Commissioner roles should be expanded from the current 0.3 FTE to a minimum of 0.5 FTE.

When discussing the role of the Deputy Commissioners with stakeholders, many commented upon the fact that each Commissioner has been a GP, while Deputy Commissioners have been nurses and allied health professionals. Several stakeholders queried why this was the case and whether the Commissioner had to be a GP, as this arrangement was not necessarily consistent with team-based primary care models that are particularly important in rural and remote areas.

In considering this issue it is noted that the legislation appointing the Commissioner does not specify that the role must be filled by a GP. Under section 79AFI, the only eligibility requirement is that the appointee must have experience in rural health.

The Department has advised that recruitment processes for the Commissioner are specifically developed to be an open and merit-based process which appoints the best person for the role, irrespective of professional background and consistent with the legislative requirement.

5.3.3. Timeliness and quality of outputs (such as reports and advice)

The analysis and information provided in Appendix 7, along with discussions with key officials, have indicated that the outputs of the NRHC in terms of specific reports have been of high quality and delivered on time. See Section 5.1.1 and Appendix 7 for examples of the reports or other products that have been issued.

Specific stakeholder feedback was sought from officials who interact with the NRHC on policy issues, and it is apparent that the NRHC is a valued and trusted source of advice on rural health issues.

5.3.4. Capability in managing funding appropriation to deliver expected outcomes

Annual reports and discussions with ONRHC staff indicate that there have been no overspends and the ongoing activity work plan monitors performance to ensure outcomes are being met. All activities have been carried out within budget.

5.3.5. Two-year appointment term

Under section 79AF(2), the Commissioner is appointed for the period specified in the instrument of appointment, with a maximum term of 2 years. The Commissioner may be reappointed, with the legislation silent on the number of reappointment terms.

A 2-year appointment period is on the shorter side of appointment terms for statutory office holders, which are typically between 3 and 5 years. The rationale for a 2-year appointment is not clear, but internal departmental documentation would suggest that the 2-year period was contained in the 2017 legislation and was simply carried across into the new legislation in 2020.

The 2-year appointment term has some clear disadvantages:

- It produces uncertainty for both the incumbent and the sector.
- It militates against longer term projects.

- It is costly in terms of process, as a merit-based appointment takes a significant amount of time to progress and frequent reappointments are administratively intensive.

The shorter timeframe may also militate against the perceived independence of the role – an issue discussed further in Section 5.6.2.

In stakeholder interviews and survey responses there was strong support for increasing the appointment term. It is noted that within the current legislation there are termination provisions that can be used if needed.

Recommendation 6: The appointment term for the NRHC should be extended to 4 years.

5.4. Stakeholder engagement: the effectiveness of the Commissioner's engagement with stakeholders

This section focuses on:

- breadth and depth of engagement with rural communities, health professionals and government bodies
- stakeholder satisfaction and perceived value.

Stakeholder consultation is a key part of the activities of the NRHC and is specifically mandated within legislation. Section 79AB highlights the requirements:

(f) to consult with a broad range of rural, regional and remote stakeholders about those matters; and
(g) to build and maintain effective working relationships with those stakeholders.

5.4.1. Breadth and depth of engagement with rural communities, health professionals and government bodies

Like many groups and organisations in the rural health sector, the NRHC faces significant challenges in connecting with a population of over 9 million people spread across geographically diverse areas. These challenges include travel time and financial costs required to visit areas, the diversity of health needs of communities across the country, and the range of health services delivered in often unique and isolated settings. This is a particular problem for an organisation that has only 10 staff and places significant pressures on the Commissioner and Deputy Commissioners in particular.

To address this issue the NRHC has 3 formal engagement structures to allow it to engage with stakeholders from across the sector. These groups are:

- Advisory Network of the National Rural Health Commissioner (ANNRHC). This group exists to provide advice to the NRHC and allows the NRHC to test ideas in particular topic areas with the group. The ANNRHC has 37 members drawn from the following organisations:
  - all state and territory health departments

  - the federal Department of Health, Disability and Ageing
  - peak professional bodies.

- National Rural Health Commissioner's Consumer Advisory Group (CAG). The CAG exists to provide specific advice to the NRHC on consumer perspectives and experiences of care in rural and remote settings. It currently has 13 members.
- First Nations Roundtable. This is a roundtable set up to discuss key issues and challenges from a First Nations perspective and provide advice to the NRHC.

In addition, there are project-specific groups that provide advice to the NRHC on specific areas of activity. The longest lasting group is the National Rural Generalist Pathway Strategic Council. This council exists to provide strategic advice on the development of a National Rural Generalist Pathway. The council currently has 13 members from across jurisdictions, professional bodies and the Department.

In addition to the formal advisory mechanisms, the Commissioner and Deputy Commissioners are members of other advisory groups, which provides an opportunity to link in with other policy issues that can inform the work of the NRHC. The 2024–25 Annual Report indicates that the Commissioner and Deputy Commissioners sat on 21 such groups.

The NRHC also has a commitment to attend conferences, seminars and other meetings where possible. These are avenues for informal consultation, as well as linking with people participating at these events across the country. The 2024–25 Annual Report indicates a total of 62 appearances, mainly as speaker or panellist, at such meetings during the year. This is a significant commitment for a small organisation.

Overall stakeholder feedback has been very positive about the way that the NRHC carries out its engagement activities. The survey responses showed that 96% were very or moderately satisfied with the engagement activities. When asked if this stakeholder input had resulted in influence on policy or program decisions, 37% of survey respondents were unsure. One interpretation here is that, while almost all stakeholders feel engaged, a sizeable group cannot see what has changed because of this engagement.

Some additional comments regarding opportunities for improvement or change have been raised and discussed:

- The ANNRHC is a large group that consists of stakeholders who have fundamentally different perspectives – namely, professional bodies and representative groups that have a focus upon advocacy, as opposed to state and territory health departments, which have a policy perspective. Given these comments, it would be appropriate for the NRHC to revisit the make-up of the advisory committees.
- There is a lack of a mechanism for states and territories to get together separately to consider both advice to the NRHC and consideration of national approaches to issues. This is particularly important given the importance of states and territories in service provision in rural areas; and the reality of service provision where

multipurpose services provide a mixture of primary care, secondary care, aged care and disability support in a variety of different models.

This Review believes that there is merit and support from stakeholders for tasking the NRHC with coordinating a forum of state and territory representatives that could provide advice to the Health Ministers' Meeting. Such a forum would not be intended to duplicate the work of the current Health Workforce Taskforce but would complement it.

Recommendation 7: The NRHC, in collaboration with the Department of Health, Disability and Ageing, should consider the establishment of a multi-jurisdictional rural health advisory body to consider rural health policies across states and territories, and identify areas for collaboration and improved health outcomes.

Many stakeholders reflected on models of service provision in rural areas where multidisciplinary working is essential. Many innovative models of care have emerged from service provision in rural areas, including hub and spoke models of service provision,[37] nurse-led services,[38] and multipurpose services that combine primary and secondary care services. In addition, many services work across boundary areas that are often more circumscribed in urban areas, and staff often work across the areas of health, aged care and disability services to provide holistic care. The Review believes there is merit in further considering coordination of services across the medical, aged care and disability sectors. This reflects recent moves to incorporate these 3 areas within a single department at the federal level.

Recommendation 8: The NRHC, in collaboration with the Department of Health, Disability and Ageing, should consider a mechanism to effectively coordinate approaches to service delivery in rural and remote areas, acknowledging the interdependence of health, disability and aged care service provision.

Section 79AD(f) identifies the stakeholders that the NRHC should be engaged with – namely:

- health professionals
- state and territory governmental bodies
- industry, non-profit and other community groups
- other health stakeholders.

This listing is not consistent with contemporary policy directions that emphasise the importance of Aboriginal and Torres Strait Islander peoples' input into policy-making processes. It does not align with the Priority Reform One of the Closing the Gap around

[37] D van Gaans, 'Evidence of hub-and-spoke health service models improving accessibility to health services in Australia', *LinkedIn*, 21 November 2025, www.linkedin.com/pulse/evidence-hub-and-spoke-health-service-models-services-van-gaans-tsvbc/.

[38] H Beks, S Clayden, A Wong Shee et al., 'Evaluated nurse-led models of care implemented in regional, rural and remote Australia: a scoping review', *Collegian*, 2023, 30(6):769–778, www.sciencedirect.com/science/article/pii/S1322769623000513.

formal partnerships and shared decision making. It is acknowledged that the NRHC has made significant efforts to incorporate Aboriginal and Torres Strait Islander peoples' perspectives in its work and advice and has recently changed the way that this work is carried out, moving from this being a specific responsibility of one Deputy Commissioner to a joint responsibility across all ONRHC staff.

Consumer perspectives and input are also notable in their absence from this list. Recent policy processes (e.g. the Royal Commission into Aged Care Quality and Safety) highlighted the need for consumers to be at the centre of decision making around the services they receive.

The listing of stakeholders should be in alphabetical order so that no hierarchy or ranking can be implied.

Recommendation 9: Section 79AD(f) of the legislation should be revised to explicitly identify Aboriginal and Torres Strait Islander people, and consumers. The listing of stakeholders should be in alphabetical order.

5.5. Impact: the impact of the Commission's advice and projects on rural health outcomes

This section focuses on:

- NRHC contribution to tangible improvements in rural health infrastructure and services
- NRHC contribution to systemic change or innovation in rural health.

Attribution and cause and effect are difficult to establish in relation to the impact of the NRHC's advice and projects on rural health outcomes. The NRHC has a policy advisory role with no powers to direct activities or resources, meaning that there are few direct linkages between activity and outcomes. In addition, the areas that the NRHC works in (e.g. rural generalism) have been long-term, with impacts yet to be measured. What can be measured are intermediate outcomes and specific areas of impact.

5.5.1. NRHC contribution to tangible improvements in rural health infrastructure and services

This section concentrates upon the key areas of activity that the NRHC has carried out and assesses whether these have led to tangible improvements. While these examples show clear attribution between the work of the NRHC and the activities and outputs, detailed evaluations are limited. A listing of reports and other documents produced by the NRHC is contained in Table 1, while a wider description of activities highlighted in the Statement of Expectations is given in Appendix 7. Two specific examples of NRHC activities that have led to tangible improvements are given below.

5.5.1.1. Establishment and expansion of the rural generalist model

The NRHC has been the key driver of the development of rural generalism in Australia – it was the main area of work given to the inaugural Commissioner, Professor Paul Worley, when the ONRHC was established under previous legislation in 2017. The activities of the

NRHC have led to the adoption of the agreed definition of rural generalist medicine, development of agreed training principles, national coordination mechanisms and the adoption of rural generalism as a separate specialty under general practice.

As a result of this work, rural generalist coordination units exist in all states and the Northern Territory to support doctors on the pathway.[39] This work helps services in smaller hospitals and multipurpose centres to maintain emergency, obstetric, anaesthetic and other advanced skills onsite, which is crucial for service provision in smaller communities.

Significant work has also been undertaken on rural generalism models as they apply to nursing and midwifery and allied health professionals.

Appendix 4 of this report describes the ongoing workforce shortages across rural areas. It is still too early to determine whether the work on rural generalism will have a significant impact on workforce shortages.

5.5.1.2. Second edition National Consensus Framework for Rural Maternity Services

The NRHC led the revision and national endorsement of the National Consensus Framework for Rural Maternity Services, which provided guidance on rural maternity services across jurisdictional boundaries. Much of this work provided evidence around the need to sustain rural birthing units in rural and remote areas and gave providers and funders the guidance to justify increased investments in these services.

In addition to these areas, the NRHC has provided significant input into policy development of a series of Commonwealth workforce incentive programs, resulting in better targeted activities to provide improvements to service provision. Examples include advice on:

- Workforce Incentive Program
- Bonded Medical Program and rural streams
- distribution priority areas aligned with MMM.

In general, as noted above in Section 5.1, stakeholders who participated in interviews felt that the activities of the NRHC did have an impact. The survey specifically asked questions on whether the legislation supported the NRHC to have a meaningful impact upon rural health. The responses were divided, with 56% saying yes, 26% saying no and the remaining 19% unsure. For those who said no or were unsure, several different areas were highlighted, including:

- a lack of power to ensure recommendations are acted upon
- a lack of a feedback loop to illustrate what impact the activities were having
- a lack of funding and resources.

[39] Department of Health, Disability and Ageing, 'National Rural Generalist Pathway', Department website, Australian Government, 24 October 2025, www.health.gov.au/our-work/national-rural-generalist-pathway?language=en.

The responses highlight one issue that is also explored in Section 5.6.1 below – namely, that, due to the advisory nature of the work of the NRHC, many of its activities are not visible; and (except for the annual report) there is no public-facing 'feedback mechanism'.

> 'The Commissioner appears to have no powers or authority. They can just provide advice that can be dismissed or ignored.'
>
> State/territory government survey response

5.5.2. National Rural Health Commissioner contribution to systemic change or innovation in rural health

The NRHC's main systemic and innovative contributions have been new national frameworks, pathways and models that change how rural health workforce and services are designed, trained and governed. The previous section highlighted how the NRHC has worked to progress rural generalism, which is a systemic response to medical workforce maldistribution, creating a nationally consistent concept and training framework across jurisdictions. This work has also been extended to other professions. For example, the National Rural and Remote Nursing Generalist Framework 2023–2027 extends the generalist model to nursing, positioning rural and remote nurses within a structured national scope-of-practice and capability framework linked to broader reforms such as the Stronger Rural Health Strategy and Closing the Gap.

In compiling this report, it has become clear that there are some significant policy and service delivery issues that will impact differentially upon rural communities. The first of these is the rapidly changing impact of new technologies upon service delivery. The use of tele-medicine has been well established in Australia for several years, but the advances in AI highlight that significant change will continue. Work needs to consider how these changes will impact upon rural service delivery and should focus in particular on the impact on rural and remote communities that may lack basic infrastructure to take advantage of such changes. The second area is funding reform. There has been an acceptance that funding mechanisms based upon casemix and efficient price are not appropriate in settings that have low throughput and high fixed costs – in these settings block funding is more appropriate. These are examples of areas where the NRHC could be involved under their innovation remit.

There has also been significant comment from stakeholders that 'one size fits all' solutions are not always appropriate. This is particularly so when considering health needs of residents in remote and very remote areas, where service delivery issues are often of a different magnitude to those faced in other areas. In this context there is merit in considering innovations for these areas separately.

> **Recommendation 10:** The NRHC, in collaboration with the Department of Health, Disability and Ageing, should consider a mechanism to investigate more fully innovative approaches to funding and delivery of services in rural areas (MMM2–5) and remote areas (MMM6–7) separately.

The Review recognises the importance that many impacts upon an individual's or population's health status are outside of the influence of the health sector. Considering this, the Review considers that the Statement of Expectations should be used to highlight (within budget constraints) work that will allow the NRHC to consider determinants of health and impacts across other portfolio areas, allowing a more holistic view to be taken. This is particularly important when considering health impacts on population groups with significantly higher levels of health need.

Recommendation 11: Subject to budget constraints, the activities of the NRHC should be expanded to allow it to take a more holistic view of rural health issues, reflecting the importance of determinants of health as well as impacts outside of health service settings. This should include impacts on groups that have disproportionate levels of health needs.

5.6. Legislative adequacy: the adequacy of legislative provisions in supporting the Commissioner's functions, including independence and impartiality

This section focuses on:

- clarity and sufficiency of legislative provisions
- support for independence, transparency and accountability.

5.6.1. Clarity and sufficiency of legislative provisions

This section of the report examines the legislation to see if it adequately gives the Commissioner adequate guidance to undertake the functions of the office and meet expectations. In undertaking this review it has become apparent that, overall, the legislation is sufficient to provide clear legislative authority and purpose for its current roles. In other words, the legislation is well defined but limits the activities and functions of the NRHC by design.

In looking at **clarity** the following points can be made:

- The purpose is unambiguous and specifically relates to rural and remote health systems and workforce.
- The role of the NRHC is clearly identified as advisory, not regulatory or executive.
- The scope is broad but coherent, allowing the Commissioner to:
  - address workforce, training, service models, and infrastructure issues.
  - engage across portfolios and jurisdictions.

In considering the legislation, there is little ambiguity regarding:

- what the Commissioner may advise on
- who the Commissioner advises (the Minister)
- the non-operational nature of the role.

Given these points it can be concluded that the legislation is clear, internally consistent, and low risk from a statutory interpretation perspective.

In comparing the NRHC with other statutory agencies, there are several areas that the legislation omits. While these omissions are in line with the NRHCs advisory role, it is instructive to consider them. Some of these are:

- The NRHC has no Statement of Expectations framework embedded in legislation.
- The NRHC has no power to make directions.
- There is no formal obligation for the Minister or Department to respond to any recommendations or suggestions that the NRHC may make.

The practical impact of this is that the legislation clearly delineates the activities and responsibilities of the NRHC but, because these are circumscribed, it creates limited accountability, does not provide a formal feedback mechanism and makes it difficult to assess the impact of the activities of the NRHC. This issue is reflected in some of the comments received in the survey and discussed in Section 5.5.1.

In terms of **sufficiency**, a similar argument can be made as for clarity. With the intent for the NRHC to be a purely advisory voice with no formal powers and no ability to direct, the legislation is sufficient. If at some future date a wider role was considered, the legislation would not be sufficient and would need to be revisited.

One area that is worth highlighting is that the NRHC is expected to *assist in improving health outcomes in rural, regional and remote areas.* Delivery of improved outcomes could be seen as difficult when, as noted previously, the impact of the NRHC is difficult to measure. One way around this issue is to ensure that the Statement of Expectations is worded in such a manner that appropriate outputs can be defined and impacts measured and assessed.

5.6.2. Support for independence, transparency and accountability

The legislation is very clear in terms of independence, stating the requirement for the NRHC to perform functions in *an independent and impartial manner.* A key issue is the degree to which the supporting legislative framework allows the NRHC to effectively operate in an independent and impartial manner. For the purposes of this Review several markers of independence have been identified against which the independence of the NRHC can be assessed. These are shown in Table 3.

Table 3: Assessment of independence

Area	Strength of independence	Comment
Statutory status	High	The role of the NRHC is created by statute and not by administrative arrangement, with functions defined in legislation. The NRHC is not a departmental officer.
Appointment and Removal	Medium	The 2-year appointment of the role is very short in comparison with other office holders and militates against independence. Termination powers are defined in legislation and are similar to other statutory officers.
Operational independence	Medium/high	The NRHC sets its own work program within the parameters of its legislation and the Statement of Expectations. The reports and annual reports it produces are independent, with annual reports required to be presented to Parliament. It does not have any directions power, which means there is no formal requirement for recommendations to be responded to.
Financial independence	Low	The NRHC does not have its own appropriation, and its budget is controlled by the Department and ultimately government. ONRHC staff are all departmental employees. The Commissioner is employed on separate conditions determined by the Remuneration Tribunal.

Table 3 shows that independence varies across the different domains. This accords with the description of the NRHC in Section 4 as a secretariat. In summary it can be seen to be largely independent in the provision of its advice but with limited financial autonomy and the 2-year appointment term of the Commissioner being potentially problematic. Adopting Recommendation 6 would assist in rectifying this issue.

The legislative framework of the NRHC as discussed in Section 3 is comprehensive, with the requirements to produce an annual report and respond formally to the Minister's Statement of Expectations providing clear levels of accountability.

In terms of transparency of operations, this is primarily performed through the stakeholder engagement actions of the ONRHC as examined in Section 5.4.1. Further discussion on transparency is in Section 5.7.2.

5.7. Governance and reporting: the level of compliance with and accessibility of the reporting obligations of the office

This section focuses on:

- compliance with reporting obligations
- transparency and accessibility of outputs.

5.7.1. Compliance with reporting obligations

The legislation governing the NRHC includes specific reporting obligations. These are outlined in Table 4.

Table 4: Reporting obligations

Obligation	Detail	Comment
Producing an annual report to Parliament (section 79AP(1))	*The National Rural Health Commissioner must prepare and give to the Rural Health Minister, for presentation to the Parliament, an annual report about the Commissioner's activities during the previous financial year (the **reporting period**).* This report must include an account of the activities of the NRHC and any other matters highlighted by the Minister.	Annual reports have been produced by the NRHC since its inception. These reports have been consistent with the reporting requirements of the legislation. The reports have increased in length over time and staff of the ONRHC have reported that they impose a significant administrative burden on a small agency.
Keeping the Minister informed (section 79AE(1)(a))	The legislation notes that the Commissioner should *keep the Rural Health Minister informed of the activities of the Commissioner.*	Key stakeholder consultation has indicated that this obligation has been met, with both regular and ad-hoc reporting to the relevant Minister.
Disclosure of interests (section 79AN)	The Commissioner has an obligation to *disclose to the Rural Health Minister details of any direct or indirect pecuniary interests that the Commissioner has or acquires and that conflict or could conflict with the proper performance of the Commissioner's functions.*	Such disclosures would be confidential and have not been looked at as part of this Review.

5.7.2. Transparency and accessibility of outputs

The annual reports that are required under Part VA of the legislation are published on the Department's NRHC resources page[40] as standalone publications.

The NRHC resources page provides Statements of Expectations, Statements of Intent, specific thematic reports, and occasional webinar recordings, providing a single public entry point for most formal outputs.

While formal reports, expectations/intent documents and some thematic outputs are published, not all day-to-day advice, briefings and correspondence with Ministers, the Department or other areas of government are made public. This inevitably limits visibility

[40] Department of Health, Disability and Ageing, 'Office of the National Rural Health Commissioner resources', Department website, Australian Government, 6 June 2023, www.health.gov.au/our-work/onrhc/resources.

of the Commissioner's activities and policy influence – an issue that was commented on by several stakeholders. Balanced against this, however, is the significant number of public engagements that the Commissioner and staff of the ONRHC make to discuss issues and help inform work programs and advice.

6. Comparison with other agencies

As a part of this Review, a comparison with several other statutory office holders and heads of agencies was undertaken. There are very few statutory positions that exist that are purely advisory like the NRHC. The closest agency is Jobs and Skills Australia, which exists under secondary legislation and has an advisory mandate. The Regional Education Commissioner has a similar role to the NRHC in providing advice specific to government on regional, rural and remote education issues, but this role is not legislated. The Department has several advisory positions, such as the Chief Allied Health Officer and the Chief Nursing and Midwifery Officer, which provide advice and undertake extensive consultation but again are not statutory roles. The Department also has several statutory roles that differ from the NRHC in that they have regulatory powers. A brief description of each of these agencies is provided in Appendix 5, with Table 5 providing an overall summary.

Table 5: Summary of different agencies

Agency	Type	Comments
Jobs and Skills Australia	Independent agency with no statutory regulation or other powers. Headed by a statutory officer, with staff employed as public servants within the Department of Education	This agency is the most like the NRHC, although it is a much larger organisation, with 200 FTE. Jobs and Skills Australia has a Ministerial Advisory Board to guide its strategy and performance.
Regional Education Commissioner	Non-statutory position but appointed by government and independent	The Regional Education Commissioner has a similar remit to the NRHC, with a focus on regional and rural Australia. It differs in that it is not a statutory appointment.
Chief Allied Health Officer	Non-statutory leadership position within the Department. No statutory powers.	This senior leadership position provides a focal point for advice to the Department and Minister on allied health issues. It is not a statutory appointment and covers urban as well as rural areas.
Chief Nursing and Midwifery Officer	Non-statutory leadership position within the Department. No statutory powers.	This senior leadership position provides a focal point for advice to the Department and Minister on nursing and midwifery issues. It is not a statutory appointment and covers urban as well as rural areas.

Agency	Type	Comments
Australian Industrial Chemicals Introduction Scheme (AICIS)	Regulator with its own legislation. Headed by independent statutory officer, with staff employed as public servants.	AICIS is a regulator and is considerably larger than the NRHC but is similar in that it is a portfolio agency within the Department where the executive director is independent, but staff are departmental employees.
Gene Technology Regulator	Regulator with its own legislation. Headed by independent statutory officer, with staff employed as public servants.	As with AICIS, the Office of the Gene Technology Regulator is a regulator and is considerably larger than the NRHC but is similar in that it is a portfolio agency within the Department where the regulator is independent but staff are departmental employees.

Each of the organisations in Table 5 has developed its organisational type to reflect the requirements, context and circumstances of the areas it works within and the issues that it is seeking to influence. The models reflect 2 main operating options for the NRHC:

- Remain as it is, characterised by limited powers and a need to base independent advice upon research and stakeholder engagement.
- Move towards a more regulatory model. This could give the NRHC 'powers' which may include investigating issues, directing other agencies to investigate issues and requiring a formal government response to any recommendations.

While some stakeholder feedback indicated support for the second option, most of the feedback supported the first option. The key rationale was that the adoption of coercive powers would fundamentally impact on the relationship that the NRHC has with stakeholders, result in the NRHC being perceived as a potential investigative organisation, and add to the number of health regulatory agencies. There would also be legislative issues relating to what appropriate powers may be permitted or relevant.

The different agencies present some alternative models for the NRHC, including the following:

- Have the NRHC as an independent position with staff located outside of the Department. This may increase perceptions of independence but would curtail the advantages of being within a large department.[41]
- Have the NRHC as an independent position within its own independent agency. Again, this may improve perceptions of independence but would require major legislative change and would be costly and time-consuming for minimal gain.

[41] Examples include access to other policy areas, use of data sources and involvement in wider policy initiatives.

- Have the NRHC as an independent advisor within the Department (similar to the Regional Education Commissioner or the Chief Allied Health Officer). This arrangement would impact perceptions of independence, affect stakeholder relations and be costly and timely to undertake.

The Review believes that the current operational settings are correct and recommends that the NRHC retain its current advisory focus, as reflected in Recommendation 1.

One issue with the current model highlighted by stakeholders is that staff who work in statutory agencies can face tensions relating to the dual associations of their work:

- Very often staff in specialist agencies can strongly align with the mission and activities of the agency. It can often be the case that staff with specialist areas of interest and expertise gravitate towards agencies that reflect this expertise. In the case of the NRHC section 79AR(2) of the legislation specifies that 'When performing services for the National Rural Health Commissioner under this section, a person is subject to the directions of the Commissioner'.
- At the same time, the staff of the agency are part of the wider Australian Public Service and share the values and ways of working of the public service. For staff in an agency such as the NRHC who are physically located in a department, they also gain benefit from departmental resources and linking in with the activities of the wider department.

The Review found that the current placement of the ONRHC with the Department has contributed positively to the ability of the NRHC to carry out their duties and responsibilities. In considering the pros and cons of this arrangement, the Review considers that the benefits strongly outweigh the costs and that the current arrangements should be maintained.

Recommendation 12: The ONRHC should continue its current organisational model with staff being employed as Australian public servants within the Department of Health, Disability and Ageing.

7. Concluding remarks

This Review finds that the NRHC is a respected and effective independent adviser, providing credible, evidence-based leadership on issues affecting rural, regional and remote health. The current legislative framework is fundamentally sound and has enabled the NRHC to influence policy, strengthen stakeholder engagement and contribute to system-level reforms, particularly in rural workforce development and models of care.

While the advisory nature of the role limits direct authority, it is also a key strength, supporting trust, collaboration and national coherence across jurisdictions and sectors. Targeted refinements, including extending the Commissioner's term, strengthening Deputy Commissioner capacity, enhancing strategic visibility, and updating legislative recognition of key stakeholders, would further strengthen the NRHC's effectiveness.

In conclusion, the Review affirms the ongoing value of the NRHC as a central pillar of Australia's rural health policy architecture. With modest refinements to its legislative settings and resourcing, the NRHC is well positioned to continue providing trusted leadership, independent advice and national coherence in addressing the evolving health needs of rural, regional and remote communities.

Appendix 1: Terms of Reference

Independent Review of Part VA – Health Insurance Act 1973 National Rural Health Commissioner

Background

Establishment of the NRHC

The National Rural Health Commissioner (NRHC) plays a pivotal role in enhancing health outcomes across rural, regional, and remote communities in Australia. The position was established under the *Health Insurance Act 1973* (the Act), with Part VA of the Act outlining the Commissioner's responsibilities and functions.

Under this legislation, the NRHC is responsible for advising the Assistant Minister for Rural and Regional Health, undertaking projects, conducting inquiries, supporting Commonwealth strategies, performing research, and engaging with stakeholders in rural, regional, and remote health.

Additionally, s79AB of the Act requires an independent review of the NRHC's functions, governance and reporting arrangements to ensure accountability and effectiveness.

Purpose

The purpose of this review is to assess the effectiveness, relevance, and impact of the legislative framework governing the NRHC, and to provide recommendations for future improvements.

Scope

The review will examine:

- The extent to which the Commissioner's functions have been fulfilled as per s79AB
- The effectiveness of the role and function of the Commissioner and Deputy Commissioners
- The impact of the Commissioner's advice and projects on rural health outcomes
- The effectiveness of the Commissioner's engagement with stakeholders
- The adequacy of legislative provisions in supporting the Commissioner's independence and impartiality
- Opportunities to strengthen the legislative framework to better support rural health policy and delivery.

Out of scope

- Review of rural health policy implementation outcomes. Implementing health policy is the responsibility of the department.
- Individual personnel performance. The review should not assess the personal performance of individuals within the NRHC office, including Commissioners and Deputy Commissioners.

Guiding Principles

The review of the NRHC should be guided by principles that reflect the role's statutory purpose, and aligned with the aims of the NRHC. More details on the aims of the NRHC are available at: http://www.health.gov.au/our-work/onrhc/about.

Methodology

The review will include:

- Analysis of relevant legislation and documentation
- Stakeholder consultations including with rural health professionals, rural health stakeholder organisations, community representatives, and government agencies
- Review of reports, projects and outcomes
- Comparative analysis with similar statutory roles.

Evaluation Criteria

The review will assess the Commissioner's performance and legislative framework against the following criteria:

(1) Effectiveness

- Achievement of statutory functions and objectives.
- Performance against the NRHC Statement of Expectations and Statement of Intent.
- Performance against the annual Activity Work Plan prepared by the NRHC.
- Influence on rural health policy and strategy.
- Responsiveness to emerging rural health issues.

(2) Efficiency

- Adequacy of NRHC resourcing for delivering functions.
- Efficacy of the Deputy Commissioner roles and responsibilities.
- Timeliness and quality of outputs (e.g. reports, advice).
- Capability in managing funding appropriation to deliver expected outcomes.
- Adequacy of the legislated 2-year appointment term for supporting efficient delivery of the NRHC functions.

(3) Stakeholder Engagement

- Breadth and depth of engagement with rural communities, health professionals, and government bodies.
- Stakeholder satisfaction and perceived value.

(4) Impact

- NRHC contribution to tangible improvements in rural health infrastructure and services.
- NRHC contribution to systemic change or innovation in rural health.

(5) Legislative Adequacy

- Clarity and sufficiency of legislative provisions.
- Support for independence, transparency and accountability.

(6) Governance and Reporting

- Compliance with reporting obligations.
- Transparency and accessibility of outputs.

Review Lead and consultation

The review will be conducted by an independent reviewer(s) appointed by the Department of Health, Disability and Ageing. The reviewer(s) must have expertise in rural health policy, legislation, and stakeholder engagement.

Report

The final report will be provided to the Assistant Minister for Rural and Regional Health and will be tabled in Parliament and made publicly available.

Appendix 2: Stakeholders consulted

Organisation consulted
Australian College of Nursing
Australian College of Rural and Remote Medicine
Australian Industrial Chemicals Introduction Scheme
Australian Medical Association
Consumers Health Forum of Australia
CRANAPlus
Department of Health, Disability and Ageing
Department of Health, Western Australia
Jobs and Skills Australia
National Aboriginal Community Controlled Health Organisation
National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
National Rural Health Alliance
New South Wales Health
Office of the Assistant Minister for Rural and Regional Health
Office of the Gene Technology Regulator
Office of the National Rural Health Commissioner
Regional Education Commissioner
Remote Australians Matter
Rural Workforce Agencies
Royal Australian College of General Practitioners
Rural Doctors Association of Australia
Rural Workforce Agencies
Services for Australian Rural and Remote Allied Health

Appendix 3: Methodology

The Review has used a conceptual framework which adopts a simple measure of attribution considering:

- functions described in legislation
- the level of policy influence
- degree of system change
- changes in rural health outcomes.

This attribution has been developed through a theory of change which provides a practical method of assessing and measuring attribution. The theory of change that has underpinned the approach to the Review highlights the following:

- **Context:** the key activities, functions and expected impacts highlighted in core legislation and other guiding documentation.
- **Inputs**: the inputs of the office – resources, including staffing and funding, access to other resources, stakeholder activities.
- **Activities**: the main activities of the NRHC in terms of, for example, input into policy development activities, provision of written and oral advice to the government, leadership activities.
- **Outputs**: production of reports, frameworks and other formal documentation.
- **Intermediate outcomes**: the degree to which the advice and outputs produced by the NRHC are incorporated into wider health policies, programs, funding allocations and so on, and the improved visibility of rural health issues across the policy spectrum.
- **Longer term outcomes**: progressive improvements in rural health system performance in terms of, for example, better workforce distribution, reduced health disparities and so on.

Beneath this high-level theory of change the organisational framework for the Review is based on a series of lines of enquiry (LE). The LE are derived from the Terms of Reference for the Review, shown in Appendix 1, and 7 have been identified:

- LE1: System Effectiveness – the extent to which the activities of the Commissioner have had a wider policy impact.
- LE2: Administrative Effectiveness – the extent to which the Commissioner's functions have been fulfilled as per the legislative framework.
- LE3: Efficiency – the ability of the Commission to deliver its functions with available budget and operational settings.
- LE4: Stakeholder Engagement – the effectiveness of the Commissioner's engagement with stakeholders.
- LE5: Impact – the impact of the Commissioner's advice and projects on rural health outcomes.
- LE6: Legislative Adequacy – the adequacy of legislative provisions in supporting the Commissioner's functions, including independence and impartiality.

- LE7: Governance and Reporting – the level of compliance with and accessibility of the obligations of the office.

Appendix 4: Contextual information

Population health status in rural Australia

Just under 30% of the Australian population live in regional, rural and remote areas of the country. Given the large geography of Australia, it is necessary to classify different locations to reflect the degree of rurality. Within the health sector, the main classification model used is the Modified Monash Model (MMM), which underpins many of the workforce distribution programs overseen by the Department. The MMM utilises a measure of remoteness as well as distance to nearest town and town size in its calculation. The classification has 7 categories, from MMM1, representing populations in major cities, to MMM7, which has populations in very remote areas. Table 6 below shows population numbers for each MMM estimated in 2024.

Table 6: Population distribution[42]

MMM category	Population	Percentage of total population
MMM1 – Metropolitan areas	19,618,406	72.1
MMM2 – Regional centres	2,518,676	9.3
MMM3 – Large rural towns	1,686,533	6.2
MMM4 – Medium rural towns	1,008,571	3.7
MMM5 – Small rural towns	1,850,437	6.8
MMM6 – Remote communities	297,850	1.1
MMM7 – Very remote communities	213,896	0.8

Residents who live outside of major cities report very positive attributes of living away from large cities. These include:

- greater levels of social cohesion and community connection
- higher levels of wellbeing and life satisfaction associated with lifestyle factors and less stressful environments
- more affordable housing with larger homes (although this is not necessarily the case in more remote locations)
- for health practitioners, the ability to work to a higher scope of practice.

In addition, rural industries – in particular, resources, agriculture and tourism – are very significant contributors to the economic wellbeing of Australia.

From a health perspective, however, research has consistently indicated that populations that live in these areas have poorer health outcomes than Australians living in urban environments. These poorer health outcomes manifest in higher rates of morbidity and

[42] Data provided by Department of Health, Disability and Ageing – ABS Estimated Resident Population.

mortality and increase with increased remoteness.[43] Figure 1 illustrates the number of premature deaths per 100,000 population on an age standardised basis.

Figure 1: Premature deaths (under 75) 2023 age standardised [44]

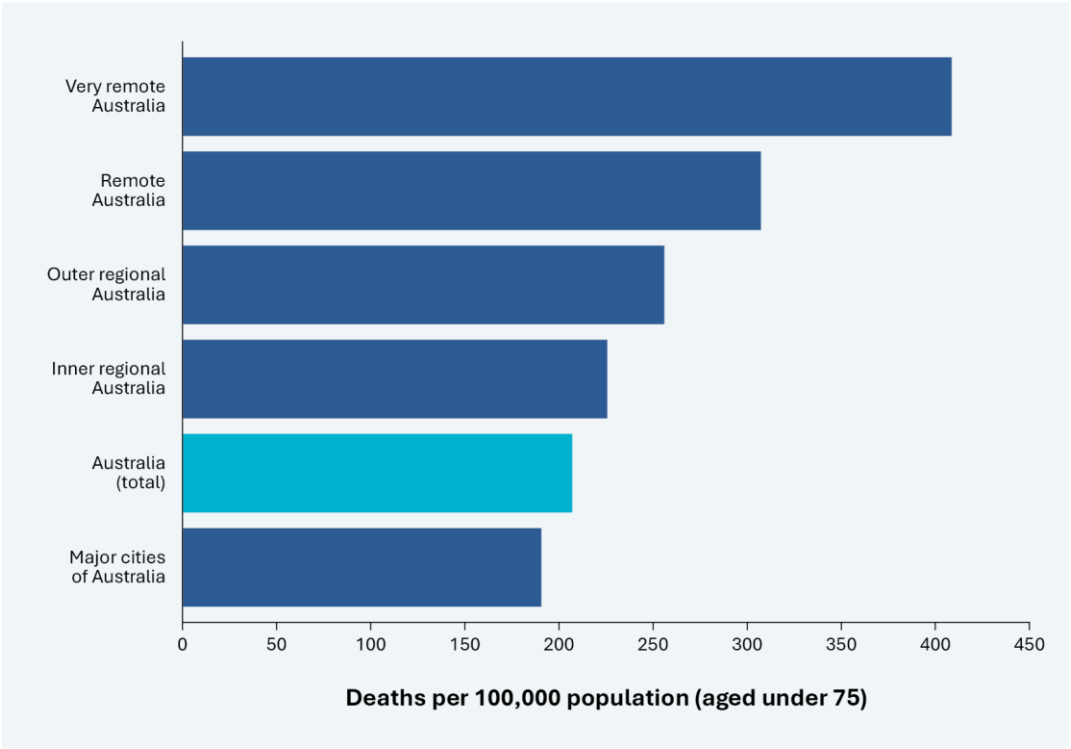
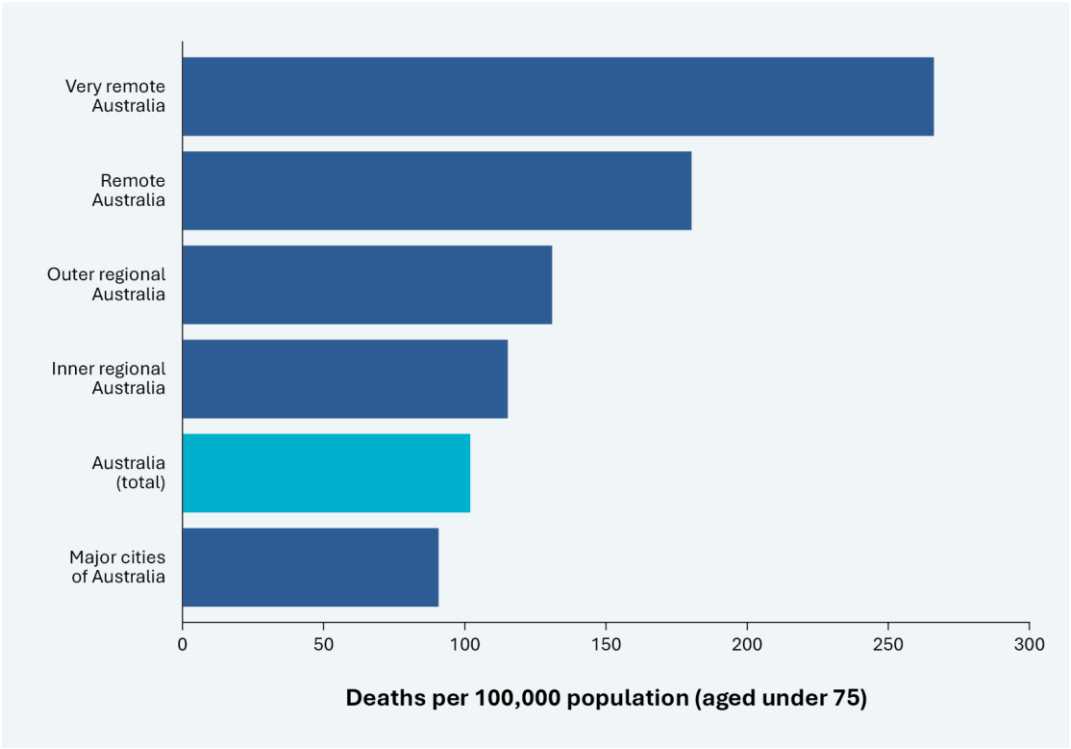


Figure 2 shows the number of potentially avoidable deaths per 100,000 population on an age standardised basis. Potentially avoidable deaths are deaths that could have potentially been avoided through the provision of appropriate primary and/or hospital-based care.

[43] See Australian Institute of Health and Welfare (AIHW), 'Rural and remote health', AIHW website, 20 November 2025, www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health, for a wider discussion on rural health issues.

[44] Australian Institute of Health and Welfare (AIHW), 'Mortality over regions and time (MORT) books', AIHW website, 9 April 2025, www.aihw.gov.au/reports/life-expectancy-deaths/mort-books/contents/mort-books.

Figure 2: Potentially avoidable deaths (under 75) 2023, age standardised [45]



The 2 figures illustrate the significant disparities that exist between different MMM categories. There are many reasons for these differences, as outlined in Section 2 of the report.

The health workforce in rural and remote Australia

The assessment of workforce numbers in rural and remote Australia is complex, reflecting several factors including:

- the peripatetic nature of the workforce in rural and remote areas and the large reliance on locum workers, particularly in remote areas
- changing working habits which have seen older general practitioners (GPs) transitioning to reduced hours, the adoption of more 'family friendly' working hours and increases in part-time working.

There are 2 main methods of counting GPs (or other healthcare professionals):

- Headcount: this is a simple count of the number of GPs and does not consider hours worked. A GP would be counted in a region if they provided at least one service in that area during that period and may be counted to more than one region. Headcount

[45] Ibid.

is useful for looking at total numbers within the system but does not give an indication of the delivery of clinical services.

- Full time equivalent (FTE): this considers hours worked and gives a much more accurate indicator of services available.

It is possible for headcount and FTE to increase at different rates. As an example, between 2019 and 2024 the headcount of GPs providing services across the country increased from 37,530 to 40,375, or a 7.6% increase. However, in terms of FTE, the number increased from 26,609 to 29,976 – a 1.2% increase.[46]

Table 7 below provides details of the change in absolute numbers and the change in FTE for all MMM areas between 2019 and 2024.

Table 7: General practitioner numbers and full time equivalent change by Modified Monash Model category[47]

	Number			Full time equivalent		
	2019	2024	% Change	2019	2024	% Change
MM1	24,700	28,430	3.76	21,973	21,846	-0.58
MM2	4,203	5,077	20.79	2,542	2,817	10.82
MM3	3,584	4,276	19.31	2,044	2,172	6.26
MM4	2,706	2,950	9.02	1,280	1,293	1.02
MM5	3,394	3,748	10.43	1,394	1,492	7.03
MM6	947	1,091	15.21	225	201	-10.67
MM7	1,211	1,319	8.92	152	155	1.97

It can be seen from Table 7 that the actual headcount of GPs increased in all MMM areas over the time period. In terms of FTE, however, the increases were significantly smaller, and MMM1 showed a slight decline in FTE and MMM6 showing a significant fall. Table 7 also illustrates the relatively high total number of GPs relative to FTE in MMM6 and MMM7, showing the impact of temporary GP attendance – often through fly in, fly out or locum arrangements.

A similar calculation can be done for Nursing and Midwifery professionals, and this is shown in Table 8 below.

[46] Data provided by Department of Health, Disability and Ageing from National Health Workforce Dataset. Note that for headcount providers may provide services in multiple locations during the same period and would be counted towards each location, hence totals may not equal the column sum in Table 7. This non-additivity is not an issue for GP FTE, as the FTE is associated to the region itself and only counts the services provided in that region.

[47] Ibid.

Table 8: Nursing and midwifery number and full time equivalent change by Modified Monash Model category[48]

	Number			Full time equivalent		
	2019	2024	% Change	2019	2024	% Change
MM1	250,133	299,636	19.79	220,380	272,431	23.62
MM2	34,714	42,212	17.76	30,507	38,548	20.86
MM3	27,290	31,158	12.41	24,025	28,280	15.05
MM4	12,673	14,180	10.63	10,795	12,489	13.57
MM5	13,351	15,072	11.42	11,277	13,297	15.19
MM6	3,998	4,257	6.08	3,837	4,220	9.07
MM7	2,670	2,785	4.13	2,789	3,062	8.91

What is particularly interesting about Table 8 is that both absolute and FTE numbers have increased across all MMM categories. In MMM7, the FTE numbers are higher than the actual numbers for both years, indicating a high workload in those areas.

Rural health policy

An important aspect of the activities of the NRHC is the policy context within which rural health exists. An overarching rural health strategy that gives direction to policy does not currently exist. The most recent iteration is the Stronger Rural Health Strategy, developed in 2018, although this is not a strategy in the commonly accepted use of the term; rather, it is a collection of individual programs that were brought together under a single banner.

Instead of a single strategy, the focus of government over the life span of the NRHC has been primarily on workforce programs aimed at increasing the supply of health workers across the country through a variety of initiatives. This includes requirements for overseas trained doctors to work in rural areas for several years prior to obtaining a Medicare number as well as initiatives to encourage Australian graduates and doctors to work in rural areas. The Department website currently lists a total of 40 different workforce programs and initiatives to support this aim.

The figures presented in the previous section show that, in general, except for MMM6, GP numbers have increased in rural areas, as have nursing and midwifery numbers.

In addition, there are several recent initiatives that have an impact on rural health, although this is not their exclusive focus. These include:

- *Strengthening Medicare Taskforce report* (2022),[49] which includes recommendations to:

[48] Ibid.

[49] Department of Health, Disability and Ageing, 'Strengthening Medicare Taskforce report', Department website, December 2022, www.health.gov.au/resources/publications/strengthening-medicare-taskforce-report.

  - develop new funding models that are locally relevant for sustainable rural and remote practice in collaboration with people, providers and communities. The report notes that this needs to ensure new funding models do not disadvantage people who live in communities with little or no access to regular GP care and whose care is led by other healthcare providers
  - fast-track work to improve the supply and distribution of GPs, rural generalists, nurses, nurse practitioners and midwives, pharmacists, allied health, Aboriginal and Torres Strait Islander health workers and other primary care professionals
- *Independent review of health practitioner regulatory settings* (2023),[50] which examined regulatory settings for overseas health practitioners who wish to work in Australia. Such workers make up a key proportion of health practitioners working outside of MMM1 areas in Australia
- *Unleashing the potential of our health workforce – scope of practice review* (2023),[51] which looked at changes needed to enable primary care practitioners to work to their full scope of practice.

These reports all have a significant impact on policy settings, and it is understood that work is currently being undertaken by the Department to integrate findings from these reports. The extent to which this will identify rural and remote issues separately is not clear.[52]

[50] Department of Health, Disability and Ageing, *Independent review of the health practitioner regulatory settings*, 2023, www.health.gov.au/our-work/independent-review-of-health-practitioner-regulatory-settings.

[51] Department of Health, Disability and Ageing, *Unleashing the potential of our health workforce – scope of practice review*, 2023, www.health.gov.au/our-work/scope-of-practice-review.

[52] It is noted that discussions are continuing on the latest iteration of the National Health Reform Agreement which may have implications for this work.

Appendix 5: Comparator agencies

Jobs and Skills Australia

Jobs and Skills Australia (JSA) is an independent agency within the broader education and skills portfolio. The JSA Commissioner is the statutory head of JSA, empowered by the *Jobs and Skills Australia Act 2022* (as amended in 2023). The JSA Commissioner provides independent, evidence-based advice to government on workforce and skills needs, oversees national labour market reporting, leads strategic engagement across the skills system, and ensures JSA contributes to Australia's long-term workforce planning and economic development. The role does not have any regulatory or enforcement powers.

JSA is much larger than the NRHC, with over 200 staff who are all federal public servants. The role is very similar to the NRHC, but 2 aspects of the underlying legislation differ – namely:

- The legislation specifies that up to 2 (currently full-time) Deputy Commissioners support the JSA Commissioner.
- The legislation establishes a Ministerial Advisory Board to provide tripartite advice (government, industry, unions) on JSA's work program.

Regional Education Commissioner

The Regional Education Commissioner is a non-statutory, Cabinet-established national leadership role created to elevate and address the longstanding disparities in education outcomes for regional, rural and remote Australians. Early legislation was proposed in 2018 but was not passed, and the position now operates under a ministerial mandate with a broad advisory and advocacy remit. The Regional Education Commissioner works across all education sectors and tiers of government, providing independent advice and driving the national agenda on regional education improvement. The role is persuasive, not regulatory. There is a strong working relationship between the NRHC and the Regional Education Commissioner.

Chief Allied Health Officer

The Chief Allied Health Officer (CAHO) is a senior, non-statutory leadership role within the Department, providing high-level policy advice, strategic oversight and sector engagement for the nation's allied health workforce. The role is a recent one, with initial appointments being undertaken by deputy secretaries at the Department until the role existed as a single appointment in 2018. The current CAHO was appointed in June 2024. The role guides national reforms, strengthens workforce planning and ensures that allied health is embedded in broader health system strategies, even though it is not established by legislation.

Chief Nursing and Midwifery Officer

The Chief Nursing and Midwifery Officer (CNMO) was first appointed in 2008 and is the Australian Government's peak nursing and midwifery advisor, providing strategic leadership on workforce planning, professional standards, national reform agendas and system-wide policy. The position is an executive (non-statutory) leadership role within the Department, supported by specialised advisors and extensive national committee membership. The current CNMO was appointed in November 2019.

Australian Industrial Chemicals Introduction Scheme

The head of the Australian Industrial Chemicals Introduction Scheme (AICIS) (Executive Director) is a statutory office holder established under the *Industrial Chemicals Act 2019*, responsible for overseeing Australia's risk-based regulatory scheme for industrial chemicals. The role includes administering legislation, issuing guidelines, engaging with stakeholders, protecting human health and the environment and ensuring compliance across all industrial chemical introducers. The AICIS is administered by the Office of Chemical Safety within the Department. The role is regulatory.

Gene Technology Regulator

The Gene Technology Regulator is the central statutory authority responsible for regulating genetically modified organisms in Australia under the *Gene Technology Act 2000.* The Regulator operates within a coordinated national framework supported by advisory committees, state and territory legislation, and extensive consultation processes. The Regulator's primary role is ensuring that gene technology is used safely, through rigorous risk assessment, licensing, monitoring and public transparency. The Office of the Gene Technology Regulator (OGTR) supports the Regulator. The OGTR and its staff are part of the Department. The Gene Technology Regulator has regulatory powers.

Appendix 6: Key areas of feedback

In-person consultations

A total of 38 face-to-face stakeholder meetings were held. The key themes from the face-to-face meetings were as follows.

1. *The role is considered valuable*

Across stakeholders, there was strong agreement that the NRHC plays an essential role in the rural health landscape. The role was described as a national voice that brings visibility to rural and remote issues that would otherwise be lost within broader policy processes. Many stakeholders emphasised the importance of the coordination role that the NRHC played across a complex and multi-jurisdictional landscape.

2. *Independence was highlighted as a strength*

Stakeholders highlighted that the NRHC independence is fundamental to the role's effectiveness. It enables frank conversations, fosters trust from communities and peak bodies and allows the NRHC to represent rural concerns without being constrained by political or departmental pressures.

3. *Reliance on influence with no formal power*

A strong theme was that the NRHC influence relies almost entirely on persuasion, diplomacy, credibility and relationships. Many stakeholders felt this 'soft power' was effective for engagement and stakeholder coordination, as it elicited trust among stakeholders. A small number felt it was a limitation, particularly for addressing systemic issues such as workforce shortages, and limits the capability of the NRHC to drive change.

4. *Length of tenure*

There was strong agreement that the current 2-year term for the Commissioner and Deputy Commissioners is too short to be effective. Stakeholders noted that building relationships, understanding the complexity of rural health systems and progressing national initiatives all require more time than the current terms allow. Many recommended a 3- to 5-year appointment, more in line with other statutory roles, to support continuity, reduce churn and allow the ONRHC to pursue long-term work. Several stakeholders also observed the need to stagger appointment cycles so that knowledge and relationships are not lost when leadership transitions occur.

5. *Under-resourcing of the ONRHC*

Some stakeholders highlighted that they felt the ONRHC to be under-resourced relative to its national remit and the breadth and diversity of issues it is expected to cover. The small number of staff, combined with large geographic and population coverage, creates operational constraints that limit impact.

6. *Deputy Commissioners' capacity and visibility issues*

There was wide agreement that the 0.3 FTE allocation for Deputy Commissioners is unrealistic and undermines the ability of the office to support multidisciplinary rural health work. Many stakeholders felt that the Deputy Commissioners have limited visibility, limited influence and insufficient time to meaningfully engage with their stakeholders or progress their portfolios. Stakeholders strongly recommended expanding these roles and potentially embedding them in legislation.

7. *Need for clearer scope, priorities and expectations*

Many stakeholders highlighted the lack of clarity about the NRHC scope of work, especially beyond rural generalism. While workforce issues remain central to rural health, stakeholders emphasised that the agenda needs to encompass broader system challenges. These include service access, funding models, infrastructure, digital health capability, consumer perspectives, First Nations health, and place-based models of care.

8. *Strong stakeholder relationships and connectivity*

The building of strong relationships across sectors, regions and professional groups was seen as a major strength. Stakeholders frequently described the NRHC as approachable, credible and highly skilled in stakeholder engagement. This was felt to be a major contributor to the office's influence and legitimacy.

9. *Structural and location considerations*

Stakeholders discussed the current arrangement of the Commissioner as an independent statutory appointee supported by departmental staff. Some argued that being embedded in the Department enhances coordination and access to information, while others saw it as diluting perceived independence. Some commented on the use of the Cairns office, with some valuing the symbolism of a regional base, while others felt a Canberra location would be more efficient for engagement, coordination and access to decision makers.

10. *Gaps in engagement with some groups*

Some stakeholders felt that medical groups received more attention than other health groups. This was attributed to limited resources, the part-time Deputy Commissioner roles and the historical focus on rural generalism. There was also discussion on the need to differentiate remote from rural, noting that the 2 groups have very different needs and solutions will differ.

11. *The importance of strong leadership*

Stakeholders repeatedly noted that the success of the NRHC heavily depends on the personal qualities of the individual appointed. Credibility in the rural health sector, strong networks, diplomacy, communication skills and deep lived experience were consistently cited as essential attributes. Many warned that, without the right person, the role could lose influence.

12. Absence of a national rural health strategy

A widely shared concern was the lack of a cohesive national rural and remote health strategy to guide policy direction. Stakeholders argued that the NRHC is ideally placed to lead or contribute to such a strategy, which they believe is essential to address fragmentation, clarify priorities and align Commonwealth, state and territory efforts.

13. Broader system challenges requiring national coordination

Stakeholders across the board raised structural issues that require national attention, including the rural health deficit, unsustainable funding models, inconsistent national standards, digital inequity, workforce shortages across all professions, and poor coordination between services. Many argued that the NRHC could play a critical role in identifying national priorities; surfacing system gaps; and pushing for policy coherence across health, education, housing, aged care, disability and other sectors.

14. Strong support for strengthening the role

Across all stakeholder groups, there was near-universal support for retaining and strengthening the Commissioner role. Stakeholders emphasised that the role provides essential national leadership, advocacy, visibility and coherence in a complex and fragmented rural health landscape. They called for improvements in resourcing, clarity of mandate, term length, Deputy Commissioner capacity, and possibly modest enhancements to powers, but they do not support removing or replacing the role.

Survey responses

A total of 27 surveys were completed. A summary of survey responses is given below.

Respondent profile:

- 27 respondents participated.
- Largest groups:
  - community organisations (33%),
  - professional organisations (22%)
  - state/territory governments (19%).

Engagement and familiarity:

- Engagement – 56% interact occasionally; 33% regularly.
- Familiarity – 59% very familiar; 33% moderately familiar with the role.

Respondent knowledge of NRHC and views on appropriateness of functions:

- 44% rate knowledge high; 41% moderate.
- 85% believe the legislated functions remain appropriate.

Respondent views on effectiveness and impact of the NRHC:

- 48% view the Commissioner as moderately effective; 37% very effective.
- 67% believe the legislation supports meaningful policy impact.

- 63% have noticed improvements in policy/services over the lifetime of the NRHC.

Respondent views on legislative and operational effectiveness:

- 56% feel the legislation enables effective performance.
- 67% were very satisfied with stakeholder engagement.

Respondent views on stakeholder influence and feedback:

- 63% believe stakeholder input influenced decisions.
- 48% rate feedback processes very effective; 37% rated them moderately effective.

Number of respondents who felt legislative change was needed:

- 44% think legislative changes are needed.
- 33% do not; 22% were unsure.

The survey allowed for free text responses, and these are summarised below.

1. *Appropriateness of NRHC functions*

- Most respondents agreed that the NRHC's legislated functions remain broadly appropriate and relevant, recognising the complexity of rural, regional and remote health. However, many suggested these functions could be broadened to better address sustainability, innovation and the needs of specific populations (e.g. Aboriginal and Torres Strait Islander communities, people with disabilities, LGBTIQ+ groups and rural women). In addition, a small number of stakeholders suggested expanding the NRHC's role to include regulatory oversight, system monitoring, and compliance enforcement, arguing that the current advisory-only function limits accountability and impact.

2. *Effectiveness and impact*

- The NRHC is widely regarded as an important and credible advocate for rural health, providing impartial and independent advice. Many respondents highlighted the NRHC's success in bringing together stakeholders and raising the profile of rural health issues.
- While the NRHC's advice is valued, its translation into concrete policy action and measurable improvements in rural health outcomes is uncertain. Some respondents noted that the NRHC's impact is often constrained by limited powers and resources and the advisory nature of the role. Some specific achievements cited include the development of frameworks for rural nursing, recognition of rural generalists, and contributions to policy discussions on workforce and service delivery.

3. *Legislative framework*

- The current legislation is generally viewed as providing a sound basis for the NRHC's work, with clear functions, reporting requirements and accountability mechanisms. However, some issues were raised:

- Short appointment terms: the 2-year term is widely seen as insufficient for strategic planning and continuity, with many recommending terms of 3 to 5 years.
- Lack of independence and authority: the NRHC's reliance on ministerial direction and departmental support is perceived as limiting true independence and the ability to drive long-term reform.

4. Stakeholder engagement

- Stakeholders recognised the significant work to engage a wide range of stakeholders, including regular forums and advisory groups. However, the effectiveness of these processes is sometimes limited by large meeting sizes, time constraints, and insufficient targeting of specific groups (e.g. culturally and linguistically diverse communities, people with disabilities, LGBTIQ+ organisations).

5. Recommendations for change

- Some suggestions for change were made, including:
  - extending appointment terms for the NRHC and Deputy Commissioners
  - embedding equity, inclusion and culturally responsive care in the NRHC's functions
  - formalising the role of advisory and consumer groups in guiding the NRHC's work
  - providing the NRHC with greater autonomy; regulatory powers; and resources to monitor, report and drive improvements in rural health
  - improving data collection and reporting, especially for marginalised groups, to inform targeted policy responses
  - strengthening mechanisms to ensure the NRHC's advice is systematically considered and acted on by government.

Appendix 7: Summary of activities highlighted in Statements of Expectations

High-level activity	Sub-activities	Complete	Source of evidence
Statement of Expectations 1 July 2020 – 30 June 2022			
1. Continue to support the Government's response to urgent and emerging priorities and communicate observations or potential risks for rural health workforce and service provision.	a. Supporting the sector in addressing the challenges and ongoing impacts of COVID-19.	Yes	**Annual Report 2021–22, ONRHC staff.** The Annual Report highlights input into the Primary Health Care COVID-19 Response and the National COVID-19 Health and Research Advisory Committee representing rural and remote voices.
2. Innovative models of care in regional and remote Australia.	a. Contribute to all aspects of this priority, with a focus on advising Government on future system-wide improvements.	Yes	**Annual Report 2020–21, Annual Report 2021–22, previous Commissioner, ONRHC staff, Department staff.**
	b. Design and manage a grant opportunity with the Department.	Yes	**Annual Report 2020–21, Annual Report 2021–2022, ONRHC staff, Department staff.** These note the allocation of $2.4 million for up to 6 grants under the Primary care Rural Innovative Models (PRIMM) Grant Opportunity.
	c. For innovative models being trialled, provide strategic oversight of data gathering and evaluation activities.	Yes	**Annual Report 2020–21.** The Annual Report provides information on visits and collaborations in several rural areas on innovative models of care. It notes the commencement of activities to evaluate trials and provide advice on data and evaluation.

High-level activity	Sub-activities	Complete	Source of evidence
3. Rural workforce training and primary care reform.	Provide evidence based rurally focussed advice on policy reforms including: a. National Rural Generalist Pathway b. National Medical Workforce Strategy c. Building the Rural Training Pipeline. d. Primary care reforms. e. Improving Access, Quality and Distribution of Allied Health Services Report.	Yes	**Annual Report 2020–21, Annual Report 2021–22, previous Commissioner, ONRHC staff, Department staff, external stakeholders.** Evidence indicates that comprehensive advice was provided in these areas as well as to additional areas, including the transition to College-led GP training and the Rural Health Multidisciplinary Training Program.
Statement of Expectations 1 July 2022 – 30 June 2024			
1. Support urgent and emerging priorities.	a. Advise of potential and actual rural health risks and provide practical options to mitigate these risks.	Yes	**Annual Report 2022–23.** This Annual Report included ongoing involvement in COVID-19 initiatives.
	b. Assist the design and implementation of response strategies on disaster and recovery advice for rural communities in consultation with NEMA.	Yes	**Annual Report 2022–23, ONRHC staff.** Ongoing regular meetings between ONRHC and the National Emergency Management Agency (NEMA) over 2022–2024. NRHC supported local rural primary care providers to be incorporated into emergency response, including communication with primary health networks on local capacity. Additional activity around medication supply and security and the key role of First Nations leaders within their communities. NRHC submissions to National Health and Climate Strategy.

High-level activity	Sub-activities	Complete	Source of evidence
	c. Provide lessons learned from the COVID-19 pandemic.	Yes	**ONRHC staff.** Report provided to Assistant Minister in June 2024, informed by Advisory Network meeting and chairing the Rural GP Respiratory Clinics forum. Separate submission responding to relevant issues was provided to the Department of the Prime Minister and Cabinet COVID-19 Inquiry in January 2024.
2. Innovative models of care in regional and remote Australia.	a. Advocate for approaches that maximise the health and care workforce through sustainable models of care and enable all health professionals to operate across the full scope of practice.	Yes	**Annual Report 2022–23, stakeholder consultation plus published report.** Development of the Ngayubah Gadan Consensus Statement providing a vision and framework for Rural and Remote Multidisciplinary Health Teams. Ongoing work on the PRIMM grant opportunity.
	b. Provide evidence-based advice to strengthen the health workforce program to reflect the needs of rural and regional communities.	Yes	**Annual Report 2022–23, stakeholder consultation plus published report.** Publication of the National Rural and Remote Nursing Generalist Framework 2023–2027.
	c. Provide written advice on future opportunities from interactions with the sector, evaluation findings and innovative solutions - including RACCHOs	Yes	**Annual Report 2022–23, ONRHC staff.** Primary Care Rural Innovative Multidisciplinary Models (PRIMM) and Innovative Models of Care (IMOC) grant rounds conducted in collaboration with the Department, which absorbed this function from 2021 onwards.

High-level activity	Sub-activities	Complete	Source of evidence
3. Support First Nations peoples' health and wellbeing	a. Contribute to the Government's commitments.	Yes	**Annual Report 2022–23, stakeholder consultation plus published report.** A key development here was the Ngayubah Gadan Consensus Statement, which was developed with significant input from First Nations partners.
	b. Ensure First Nations peoples' health is at the heart of decision making.	Yes	**Annual Report 2022–23, stakeholder consultation plus published report** – the Ngayubah Gadan Consensus Statement.
	c. Support preventive health strategies.	Yes	**Annual Report 2022–23, stakeholder consultation, ONRHC staff.** *Position statement: Impacts of racism on the health and wellbeing of Indigenous Australians* (March 2022) co-designed by ONRHC and National Aboriginal Community Controlled Health Organisation (NACCHO). Deputy Commissioner presented on 'Mental health research and training for regional Australians: a First Nations perspective' at the Manna Institute Leadership Program Launch (including focus on prevention of mental health issues).
4. Contribute to rural workforce, training and primary care reform.	a. Provide evidence-based advice to inform programs, policies and initiatives.	Yes	**Annual Report 2022–23, stakeholder consultation plus published report.**
	b. Support Australia's maternity care system.	Yes	**Annual Report 2022–23, stakeholder consultation and report production.** Rural maternity care was a key part of the work program.

High-level activity	Sub-activities	Complete	Source of evidence
	c. Provide ongoing advice and support for mental health and suicide prevention in rural and remote areas.	Yes	**ONRHC Staff.** PRIMM and IMOC grant rounds conducted in collaboration with the Department included a focus on mental health from 2021 onwards. Quarterly meetings with the Mental Health Commission.
	d. Provide advice on the support for the transition of the GP training program to a college led model.	Yes	**Annual Report 2022–23.** The Commissioner was a co-chair of the Transition to College Led Training Advisory Committee that advised the Australian Government on the transition.
Statement of Expectations 1 July 2024 to 30 June 2026			
1. Contribute to Strengthening Medicare through developing and promoting innovative, integrated and multidisciplinary approaches.	a. Advise on the Government's responses to key primary health care reviews and assist with implementation of rural and remote health measures.	Yes	**Annual Report 2024–25, Activity Work Plan updated December 2025, stakeholder consultation.** There has been a significant number of reviews and policy initiatives in the primary care area and the Commissioner and Deputy Commissioners are key informants or on advisory groups for most of the initiatives.
	b. Collaborate with Commonwealth, state and territory governments on evidence-based models of primary care and advocate for approaches that support sustainable and integrated health workforce development.	Yes	**Annual Report 2024–25, Activity Work Plan updated December 2025, stakeholder consultation.** The main area identified is the ongoing work on the implementation of the National Rural Generalist Pathway, including in nursing and allied health.
	c. Advise on opportunities to address inequities in access to health care in rural and regional settings, from a geographic and socioeconomic perspective.	Yes	**Annual Report 2024–25, Activity Work Plan updated December 2025.** Ongoing work on rural maternity services as well as providing advice on other initiatives, including telecommunications infrastructure.

High-level activity	Sub-activities	Complete	Source of evidence
2. Contribute to primary care, rural workforce, and training reforms.	a. Provide evidence-based advice on the development of strategies and initiatives aimed at improving access to all health services in rural and remote areas.	Yes	**Annual Report 2024–25, Activity Work Plan updated December 2025, stakeholder consultation.** Ongoing work across several areas – seen as core business for the NRHC.
	b. Collaborate with stakeholders to advise on strategies and frameworks that enable rural and remote service improvements in line with contemporary practice.	Yes	**Annual Report 2024–25, Activity Work Plan updated December 2025.**
3. Support First Nations peoples' health and wellbeing	a. Support workforce planning and solutions to ensure First Nations peoples' health and wellbeing is at the heart of decision making.	Yes	**Annual Report 2023–24, Annual Report 2024–25, Activity Work Plan updated December 2025, consultation with ONRHC staff and external stakeholders.** Deputy Commissioner sat on the Steering Group and Advisory Group for the National Allied Health Workforce Strategy and highlighted the importance of including recommendations for measures that will attract, retain and support the First Nations
	b. Support First Nations peoples to receive culturally safe care when and where they need it. This includes encouraging cultural awareness and competence among non-First Nations health professionals.	Yes	

High-level activity	Sub-activities	Complete	Source of evidence
	c. Support the increase of attraction, retention and career development for First Nations people in the health workforce.	Yes	allied health workforce. The ONRHC has also provided advice on strengthening culturally responsive environments for First Nations allied health students, allied health professionals and consumers (Annual Report 2024–25, page 36). While the NRHC has a very strong emphasis on First Nations peoples' health and wellbeing, recent changes in the ONRHC have led to a different approach to First Nations health issues, with a move away from this being the sole responsibility of a single Deputy Commissioner to a wider acceptance that this work should underpin the activities of all staff. Sector roundtables have been held, and work is progressing in these areas.
4. Support urgent and emerging priorities.	a. Advise of potential, and actual, rural health risks, and provide practical options.	Yes	**Annual Report 2023–24, Annual Report 2024–25, Activity Work Plan updated December 2025, consultation with ONRHC staff and external stakeholders**. This activity forms a core aspect of the work of the NRHC in advising on policy risks from new policy developments as well as highlighting emerging issues.
	b. Assist the independent review of the functions of the Office of the National Rural Health Commissioner in 2025 (Part VA of the *Health Insurance Act 1973*).	Yes	The independent review commenced in October 2025 with full cooperation from the NRHC.

High-level activity	Sub-activities	Complete	Source of evidence
	c. Assist with the design and implementation of response strategies on disaster and recovery advice for rural, remote and very remote communities in consultation with the National Emergency Management Agency.	Yes	**Annual Report 2023–24, Annual Report 2024–25, Activity Work Plan updated December 2025, consultation with NRHC staff**. The ONRHC has regular discussions with NEMA.