Compendium to the Rural Health Action Plan

2025 – 2027

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Australasian College for Emergency Medicine

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Contents

Driving equity in regional, rural and remote emergency care

This compendium supports the *Rural Health Action Plan 2025–2027* (*RuHAP*) by consolidating data, analysis and context to highlight the challenges and opportunities facing regional, rural and remote emergency medicine. It is designed to inform stakeholders, guide implementation and support coordinated efforts to strengthen emergency care and improve health equity across Australia and Aotearoa New Zealand.

Implementing this second *RuHAP* demonstrates the Australasian College for Emergency Medicine's (ACEM, the College) ongoing commitment to advancing rural emergency medicine. The plan prioritises building relationships, engaging members, trainees and stakeholders, and piloting innovative strategies to expand and upskill the workforce. These actions are essential to improving emergency care, supporting sustainable workforce development and addressing persistent health inequities in regional, rural and remote communities.

Context for action

Public health systems in both Australia and Aotearoa New Zealand are funded and delivered based on universal access to healthcare. In practice, however, this principle has not consistently ensured equity in either availability or access. People living in rural areas experience shorter life expectancies and higher rates of injury, illness and disease risk factors compared to those in major cities.

According to the latest census, more than eight million Australians – roughly one-third of the population – live outside capital cities and major urban centres.[1] In Aotearoa New Zealand, over half of the five million people live outside major population centres such as Auckland, Canterbury and Wellington.[2]

Our goal

All patients presenting to emergency departments in Australia and Aotearoa New Zealand, regardless of location, have equitable access to timely, safe and high-quality care.

Our vision

ACEM recognises best-practice approaches in rural emergency medicine, including:

- A sustainable and permanent emergency medicine workforce supported by robust and effective networks.
- Equitable access to emergency medicine physicians, or physicians with advanced emergency medicine skills, for communities in regional, rural and remote areas of Australia and Aotearoa New Zealand, ensuring high-quality care for all.
- An enhanced understanding of health and emergency care practices specific to regional, rural and remote settings.

ACEM's role

ACEM plays a central role in improving health equity and access to emergency care across regional, rural and remote areas in Australia and Aotearoa New Zealand. As the peak professional organisation for emergency medicine, ACEM influences emergency care through standards development, training, policy, advocacy, accreditation and continuing education for its members. The *Rural Health Action Plan* 2025–2027 defines the College's strategic role in addressing gaps and coordinating efforts across the organisation to maximise impact on health equity.

ACEM's approach focuses on three key areas to advance equity in regional, rural and remote emergency care:

- Leadership in emergency care

  Building on the foundations established in the first *RuHAP* (*June 2021*), this iteration aims to remove barriers to equitable emergency care, ensuring all patients receive timely, safe and high-quality treatment.

- Collaboration and partnerships

  ACEM works with governments, hospital executives, health departments, other medical colleges, community and cultural representatives, and regional, rural and remote health organisations. These partnerships are essential to address gaps and improve equity in emergency care for all communities.

- Workforce and system strengthening

  Specialist emergency medicine physicians operate across hospitals and healthcare systems, bringing unique local, national, and bi-national perspectives that shape strategies to improve access to safe, high-quality and timely emergency care. Piloting innovative workforce strategies is key to achieving these objectives and sustaining future *RuHAP* initiatives.

Regional, rural and remote emergency medicine workforce

ACEM recognises that emergency departments are staffed by a diverse range of health practitioners. The emergency medicine workforce in regional, rural and remote areas includes the following roles:

- Fellow of the Australasian College for Emergency Medicine (FACEM)
- FACEM trainees
- ACEM Foundational, Intermediate and Advanced Associateships
- ACEM Associateship in Pre-Hospital Retrieval trainees
- Trainees and specialists of other colleges, such as Fellows of the Australian College of Rural and Remote Medicine (ACRRM), Fellows of the Royal Australian College of General Practitioners (RACGP) and Fellows of the Division of Rural Hospital Medicine in Aotearoa New Zealand of the Royal New Zealand College of General Practitioners (RNZCGP)
- Career medical officers and other medical officers working in hospital emergency departments and other emergency care settings
- Nursing staff, including emergency nurse practitioners
- Allied health practitioners
- Other hospital support and administrative staff.

ACEM is responsible for training emergency physicians and advancing professional standards in emergency medicine across Aotearoa New Zealand and Australia. In recognition of these roles and responsibilities, and to best direct its influence, the *RuHAP* focuses on:

- ACEM members, including FACEMs, Associateships in Foundational Emergency Medicine, Associateships in Intermediate Emergency Medicine, and Associateships in Advanced Emergency Medicine;
- ACEM trainees; and
- The relationships between ACEM members and its trainee workforce, as well as the broader emergency medicine workforce.

Regional, rural and remote classification

As noted in ACEM's *Position Statement on Rural Emergency Care*, multiple classification systems exist for defining hospitals, emergency departments, and geographic locations, both within ACEM and by Australian and Aotearoa New Zealand governments. These definitions are context-specific (for example, training and education, accreditation, emergency department delineation) and consider various factors such as geographic distance, population, and access to tertiary hospitals.

For the purposes of this *RuHAP*, the term 'regional, rural and remote' includes:

- **Within Australia:** All locations outside capital cities without access to a tertiary hospital; and
- **Within Aotearoa New Zealand:** All locations outside greater Auckland, Christchurch, Hamilton or Wellington. All emergency departments within these metropolitan areas are classified as metropolitan.

The definition is not intended to be exclusive but rather to broadly capture non-metropolitan areas with reduced access to emergency care. It should be interpreted within the context of the *RuHAP*'s purpose to increase equitable access to healthcare in regional, rural and remote areas. It is important to note that some large regional centres have experienced significant growth and may now function as small urban centres, with increased access to FACEM-led emergency care. As equity improves in these regions, the *RuHAP* will continue to shift its focus to areas of greatest need, regardless of geographic classification.

Regional, rural and remote policy, advocacy and strategic partnerships

ACEM has a longstanding commitment to advancing rural health across Australia and Aotearoa New Zealand. The initial dedicated entity tasked with overseeing this important work was established in 2010, reflecting the College's recognition of the unique challenges faced by regional, rural and remote communities. Over time, this oversight body has evolved in structure and scope to more effectively address the complex and changing healthcare needs of these populations. The current iteration, the Regional, Rural and Remote Advisory Committee (RRRAC), serves as the principal advisory group guiding the College's strategic initiatives and policies aimed at improving health equity, workforce distribution, and access to quality emergency care in rural and remote areas.

The RRRAC plays a key role in shaping ACEM policies and guidelines to improve rural health and workforce distribution in Australia and Aotearoa New Zealand. It leads the development and implementation of the *RuHAP*, collaborates with College departments to enhance training for rural trainees, and supports workforce planning and governance through representation on key committees. The RRRAC also oversees the National Program's alignment with rural priorities and advocates for rural health equity externally through partnerships and alliances.

Overall, the RRRAC plays a pivotal role in advancing equitable emergency care across regional, rural and remote communities. Its functions and responsibilities are detailed in its terms of reference, which guide the committee's efforts to address disparities and promote improved health outcomes in these areas.

ACEM's *Position Statement on Rural Emergency Care* was first published in 2012 and is regularly reviewed. It outlines ACEM's policy positions and key principles for achieving timely, safe and quality emergency care in rural areas.

ACEM's advocacy is strengthened through its membership in organisations focused on regional, rural and remote healthcare, including:

- Australia's National Rural Health Alliance
- Hauora Taiwhenua Rural Health Network, Aotearoa New Zealand
- The Joint Consultative Committee, in collaboration with the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM), regarding ACEM's Foundational, Intermediate and Advanced training programs.

ACEM also collaborates and consults with a range of medical colleges, government bodies, health authorities and other organisations involved in regional, rural and remote healthcare.

Regional, rural and remote education and training

ACEM is one of several medical colleges that allow trainees to be based in regional areas, requiring them to rotate to a metropolitan centre only for their six-month Major Referral training. The College's introduction of a six-month Regional, Rural and Remote Training Requirement, commencing in 2027, ensures that all trainees gain experience in regional, rural and remote emergency departments. This initiative necessitates accrediting additional sites to provide sufficient training placements for all trainees. Not only will this requirement offer a more comprehensive training experience, but it will also benefit regional, rural and remote patients by increasing their access to FACEMs and trainee-provided emergency care.

ACEM manages the following projects and initiatives under its National Program, funded by Australian Government grants, which aim to develop, strengthen and support a skilled and confident workforce of emergency medicine physicians in regional, rural and remote areas.

- Associateship Training Programs in Emergency Medicine (Foundational, Intermediate and Advanced)
- Special Skills Placement
- Emergency Medicine Education and Training Program (EMET Program)
- Integrated Rural Training Pipeline (IRTP)
- Specialist Training Placements and Support Program (STPS Program)
- Blended Supervision Pilot Project
- Accredited Training Networks Project

Inequitable access to emergency care in regional, rural and remote areas

The sustainability of the emergency medicine workforce across Australia and Aotearoa New Zealand is influenced by factors such as increasing workloads, workplace culture, health system pressures, emergency physician burnout and employment status issues.

ACEM's *Guidelines on Constructing a Sustainable Emergency Department Medical Workforce* (G23 Guidelines) recommend minimum staffing levels necessary to provide quality patient care. Compared with metropolitan emergency departments, an even smaller proportion of emergency departments in regional, rural and remote areas meet these benchmarks for FACEMs and senior decision-makers, resulting in inequitable access to local specialist emergency care.

Geographic maldistribution of FACEMs and trainees

In 2023, across Australia and Aotearoa New Zealand, the majority of FACEMs working in hospital settings (70.1 per cent in Australia and 68.2 per cent in Aotearoa New Zealand) were employed in metropolitan public hospitals as their primary workplaces. Just under one-quarter (24.2 per cent) of all FACEMs worked in a regional or rural area, with 23.2 per cent in Australia and 31.8 per cent in Aotearoa New Zealand based in these locations as their primary workplaces (**Figure 1**).[3]

More than half (55 per cent) of new FACEMs (six to twelve months post-Fellowship) worked exclusively in metropolitan areas, 22 per cent worked only in regional, rural or remote areas, and 16 per cent worked across both metropolitan and regional, rural or remote settings.[4] This represents an increase from 2014, when only 12.9 per cent of new FACEMs were working in regional or rural areas. The main factors influencing new FACEMs to work in regional, rural or remote areas were an appreciation for the rural lifestyle and greater job availability and security.

In 2023, only 18.2 per cent of trainees in Australia were based in regional or rural localities as their permanent workplaces, a figure similar to that in Aotearoa New Zealand (17.8 per cent) (**Figure 2**).[5]

Figure 1. Distribution of FACEMs' primary workplace, by region and remoteness (n = 3470)

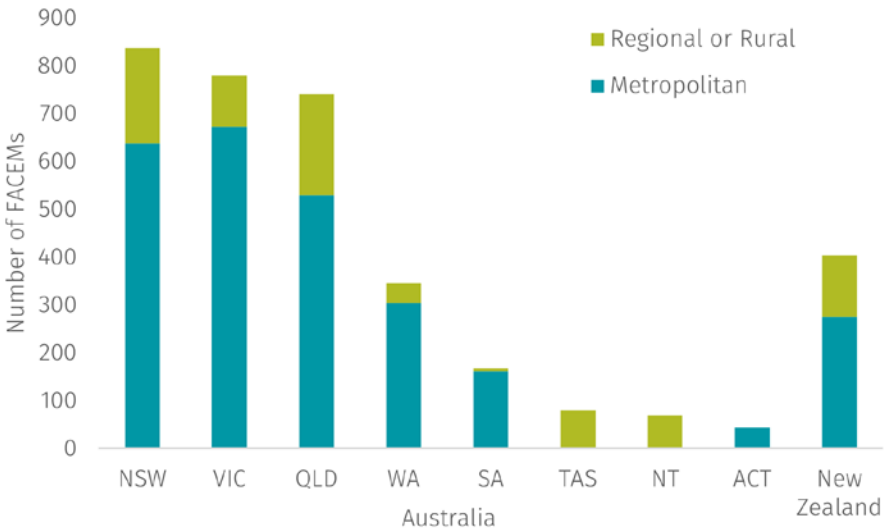
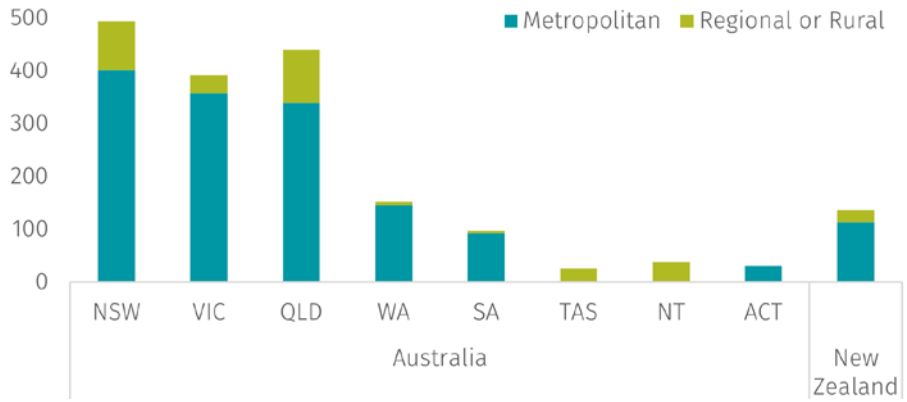


Figure 2. Distribution of FACEM trainees' placement workplace, by region and remoteness (n = 1805)



Inequitable emergency department staffing levels/ratios

In 2024, only 5.3 per cent of emergency departments in Aotearoa New Zealand and 18.9 per cent of emergency departments in Australia met the minimum FACEM staffing levels recommended in ACEM's G23 Guidelines.

At the time of reporting, just over one-third (40.7 per cent) of ACEM-accredited major hospital emergency departments in metropolitan Australia met the G23 Guidelines. In contrast, none (zero per cent) of the metropolitan (Urban 1) hospital emergency departments in Aotearoa New Zealand met the recommended minimum staffing levels.

No emergency departments in the Australian Capital Territory or the Northern Territory met the G23 Guidelines. In regional hospitals in Australia, two emergency departments (13.3 per cent) met the G23 Guidelines, but no rural or remote hospitals in Australia, nor Urban 2 hospitals in Aotearoa New Zealand, met the minimum FACEM requirements.[6]

In addition:

- ACEM-accredited rural and remote (1:0.5) and private (1:0.3) hospitals in Australia had the lowest ratio of emergency medicine specialists to FACEM trainees compared with larger hospital peer groups.
- Regionally located ACEM-accredited emergency departments in Australia and Aotearoa New Zealand were more likely to report unfilled FACEM FTE positions. In Australia, 60 per cent of regional and 66.7 per cent of rural and remote hospitals reported unfilled FACEM FTE, compared with 29.6 per cent of major referral hospitals and 45.8 per cent of non-major referral metropolitan hospitals. In Aotearoa New Zealand, 55.6 per cent of Urban 2 hospitals reported unfilled FTE, compared with 36.4 per cent of Urban 1/specialist hospitals.

Regionally located emergency departments are more likely to employ locums. In Australia, 76.2 per cent of emergency departments in rural and remote areas and 53.3 per cent of emergency departments in regional areas employ locums, compared with eight per cent of major and non-major referral emergency departments in metropolitan areas. In Aotearoa New Zealand, the opposite trend is observed: only 22.2 per cent of Urban 2 emergency departments reported employing locums, compared with 45.5 per cent of departments in Urban 1 areas.[7]

Impact on health outcomes for patients in regional, rural and remote areas

Geographic maldistribution of the emergency department workforce has an amplified impact on Māori in Aotearoa New Zealand, as a greater proportion of Māori attend emergency departments located outside metropolitan areas compared with non-Māori. In 2017–2018, 69 per cent of Māori emergency department patients attended regional hospitals, compared with 51 per cent of non-Māori patients.[8] As of August 2025, these figures have not been updated by the New Zealand Ministry of Health.

This maldistribution also has a distinct impact on Aboriginal and Torres Strait Islander peoples in Australia, as a higher proportion of this population resides in regional, rural and remote areas compared with metropolitan areas. Aboriginal and Torres Strait Islander people represent 1.9 per cent of the population in major cities, increasing to 32 per cent in remote and very remote areas.[9]

In 2024, Aboriginal and Torres Strait Islander peoples accounted for a higher proportion of emergency department presentations in regional (15.2 per cent) and rural and remote (17.7 per cent) hospitals, compared with 5.2 per cent in major referral hospitals.[10] Across all ACEM-accredited emergency departments, Aboriginal and Torres Strait Islander patients were over-represented relative to their proportion of the general population.[11]

Inequitable access to ACEM-trained emergency care reflects the broader challenge of unequal access to healthcare services. Individuals residing in regional, rural and remote areas frequently encounter barriers such as extended waiting times for treatment, limited choice of healthcare providers, and reduced availability of specialist services. For patients, this may manifest as:

- Not having a regular general practitioner (GP) or usual place of care.[12]
- Needing to present to an emergency department due to the unavailability of a GP when required.[13]
- Travelling long distances and experiencing extended stays away from home to access health services.[14]
- Experiencing delays in diagnosis, transfer and treatment.[15]
- Encountering difficulties in self-managing chronic conditions.[16]
- Compromised ongoing recovery after returning home, contributing to a ‘vicious cycle’ of worsening health.[17]

The effects of inequitable access to healthcare are reflected in the poorer health outcomes of people living in regional, rural and remote areas compared with those in metropolitan areas. For example:

- In Australia in 2023, 48 per cent of deaths of people aged under 75 were potentially avoidable. For both males and females, the rate increased with remoteness. The rate of potentially avoidable deaths in very remote areas was 2.8 times higher than in major cities.[18]
- In Australia in 2018, the burden of disease in remote and very remote areas was 1.4 times higher than in major cities.[19]
- In 2023, Australians living in very remote areas were more than twice as likely to die by suicide compared with Australians in major cities.[20] In Aotearoa New Zealand, the suicide rate is also higher for those living in rural areas than in urban areas.[21]
- In Aotearoa New Zealand, people living in rural towns have a lower life expectancy than those living in cities or surrounding rural areas.[22]

Inequitable health outcomes for Māori may be worse in regional, rural and remote areas

In general, Māori experience significantly worse health outcomes than non-Māori across Aotearoa New Zealand. Although progress has been made over the past 30 years to improve Māori health, substantial disparities persist. These include poorer outcomes across a range of measures, greater exposure to the determinants of ill-health, limited health system responsiveness, and under-representation of Māori in the health workforce. Māori have higher rates than non-Māori for many health conditions and chronic diseases, including cancer, diabetes, cardiovascular disease and asthma. They also experience higher disability rates, shorter life expectancy, higher suicide rates (particularly among young Māori), and higher smoking rates.[23]

Māori are over-represented among those accessing mental health and addiction services, comprising 27.7 per cent of users compared with 15.4 per cent of their proportion in the general population.[24] Similarly, Māori account for 20-21 per cent of presentations to emergency departments.[25] However, there is a gap in data regarding how many of these emergency department presentations by Māori are related to mental health.

The Aotearoa New Zealand Health and Disability System Review found that, although data is limited, there are indications that poorer health outcomes for people living in rural towns are further accentuated for rural Māori.[26] A 2010 report by the National Health Committee found that life expectancy for rural Māori may be slightly lower than that for urban Māori.[27]

Appendix: Regional, rural and remote classifications

Multiple classification systems exist for defining hospitals, emergency departments, and geographic locations, both within ACEM and by the Australian and Aotearoa New Zealand governments. These definitions are context-specific (for example, training and education, accreditation and emergency department delineation) and take into account factors such as geographic distance, population and access to tertiary hospitals.

Australian government classifications

For programs funded under the Commonwealth Government's Specialist Training Program, the **Modified Monash Model** (MM) classification system[28] is used to determine rurality. The MM categorises metropolitan, regional, rural and remote areas based on both geographical remoteness and town size. It was developed to address the challenges of attracting health workers to smaller and more remote communities. The MM is based on the Australian Statistical Geography Standard – Remoteness Area[29] (ASGS RA) and further differentiates areas within Inner and Outer Regional Australia according to local town size.

Table 1. Modified Monash Model classifications

MM category	Inclusions	
MM 1	Metropolitan areas	Major cities accounting for 70 per cent of Australia's population. All areas categorised ASGS-RA 1.
MM 2	Regional centres	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are in, or within 20km road distance, of a town with a population greater than 50,000.
MM 3	Large rural towns	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 and are in, or within 15km road distance, of a town with a population between 15,000 and 50,000.
MM 4	Medium rural towns	Areas categorised ASGS-RA 2 and ASGS-RA 3 that are not in MM 2 or MM 3 and are in, or within 10km road distance, of a town with a population between 5,000 and 15,000.
MM 5	Small rural towns	All other areas in ASGS-RA 2 and 3.
MM 6	Remote communities	All areas categorised ASGS-RA 4 and islands that are separated from the mainland in the ABS geography and are less than 5km offshore. Islands that have an MM 5 classification with a population of less than 1,000 without bridges to the mainland (2019 Modified Monash Model classification only).
MM 7	Very remote communities	All other areas that are categorised ASGS-RA 5 and populated islands separated from the mainland in the ABS geography that are more than 5km offshore.

Aotearoa New Zealand government classifications

In Aotearoa New Zealand, rural and regional areas are classified using the **Functional Urban Area** (FUA) system.[30] The FUA framework identifies small urban areas and rural areas that are integrated with major, large, and medium urban centres to form FUAs. It uses the Urban Rural (UR) geography to define urban areas, Statistical Area 1 (SA1) units to delineate the surrounding commuting zone (hinterland) within FUAs, and rural or water areas outside FUAs.

Table 2. Functional Urban Area classifications

FUA category	Inclusions	
U1	Metropolitan area	More than 100,000 residents living in the urban core.
U2	Large regional centre	Urban core population 30,000–99,999.
R1	Medium regional centre	Urban core population 10,000–29,999.
R2	Small regional centre	Urban core population 5,000–9,999.
R3	Area outside functional urban area	

Application of regional, rural and remote classifications within ACEM

As a minimum requirement, a hospital must meet one of the delineation levels specified in ACEM's *Statement on the role delineation of emergency departments and other hospital-based emergency care services* (S12) to be considered for emergency department accreditation. For geographic location, sites accredited for FACEM training are classified as **Major Referral**, **Urban District**, or **Rural/Regional**, in accordance with relevant jurisdictional systems.

As previously noted, ACEM also manages several projects and initiatives under the National Program, funded by Australian Government grants. These projects primarily use the ASGS-RA classifications.

ACEM's Annual Site Census uses the following Australian Institute of Health and Welfare (AIHW) classifications:

- Major metropolitan
- Large metropolitan
- Medium metropolitan
- Major regional
- Large regional
- Medium regional
- Private hospital.

For ACEM's Aotearoa New Zealand hospital remoteness classification, emergency departments are considered metropolitan if they are located in greater Auckland, Christchurch, Hamilton or Wellington. All other emergency departments outside these cities are classified as regional.

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