A definition of a rural model of health service delivery: A ‘hub and spoke’ (service partner) model

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1. Executive summary

The *Infrastructure Renewal Project for Rural and Remote Areas* aims to define a rural model of health service delivery for Queensland, outline service profiles for a selection of rural health service sites and engage architect consultants to audit and review the related infrastructure.

In the absence of a strategic statewide policy for rural health services (but in anticipation of this work) it is proposed that this paper would underpin the future rural and remote policy development by describing a ‘hub and spoke’ (service partner) model of service delivery for rural and remote areas. This paper identifies Queensland rural hub sites and their associated spoke sites. The ‘hub and spoke’ model of rural service delivery aims to assist in ameliorating some of the many issues faced by the rural sector through improvements to organisation, governance, management and leadership and the development of formalised service networks.

There will be three papers written for the *Infrastructure Renewal Project for Rural and Remote Areas*. This first paper describes a ‘hub and spoke’ model of service delivery for rural and remote areas. It also outlines the minimum services that hub sites will be required to provide, based on the draft, and about to be endorsed, *Clinical Services Capability Framework V3* (2010) (hereafter, referred to as the *Clinical Services Capability Framework V3*) (Planning and Coordination Branch 2010). The second paper, *Service Profile*, will describe service mix and level for each of the ten prioritised hub sites. This profile will then be compared against the minimum suite of services and service gaps identified. The third paper will outline options for addressing a range of infrastructure requirements at the ten hub sites in relation to the provision of the minimum suite of core acute health services.

Project objectives are:

- define a ‘hub and spoke’ (service partner) model of health service delivery to support the provision of safe, high quality and sustainable health services in rural and remote Queensland (paper 1)
- Queensland rural hub sites identified (paper 1)
- describe a minimum set of core acute services to be provided by Queensland rural hubs based on the *Clinical Services Capability Framework V3* (paper 1)
- prioritisation of ten Queensland rural hub sites for infrastructure assessment (paper 2)
- service profiling of the ten prioritised hub sites (paper 2)
- develop an infrastructure renewal program that provides a comprehensive and prioritised list of health infrastructure improvements for selected hub sites. This will assist the department to identify and respond in a coordinated manner when and if resources become available (paper 3).


2. Planning context

This rural and remote definition paper is supported by the *Statewide Health Services Plan 2007-2012* (Queensland Government 2006, 2007) government commitment to improving access to safe and sustainable services and better meeting people’s needs across the continuum. The *Statewide Health Services Plan 2007-2012* provides a framework for the effective and efficient delivery of health services to Queenslanders and the strategic direction for planning and delivery of health services. The *Statewide Health Services Plan 2007-2012* focuses on two key reform areas:

1. Improving access to safe and sustainable services
2. Better meeting people’s needs across the health continuum.

The two key reform areas will be assisted by establishing service networks between health sectors and developing a ‘hub and spoke’ service model for rural and remote Queensland. They are also highlighted as key platforms for supporting a rural health system that is safe and sustainable. Defining hospital roles based on the *Clinical Capability Service Framework V3* (Queensland Government 2010) will support the development of a rural health system that allows small health services to be networked with rural hub hospitals where the level and mix of core services are similar.

*Blue Print for the Bush* (Queensland Government 2006) recognised that there was no one-size fits all plan for rural and remote Queensland and only by developing partnerships across organisations, communities and individuals can dynamic and innovative service solutions be achieved. The *Toward Q2-Tomorrow’s Queensland* plan communicated governments’ long term vision to make Queensland stronger, greener, smarter, healthier and fairer by 2020 (Queensland Government 2008).

The impact of the National Health and Hospitals Reform agenda on rural health services is also acknowledged in this paper. Establishing an integrated rural and remote health system in Queensland will allow the sector to be well placed to take advantage opportunities that may present as a result of this agenda.

2.1. Background

Rural and remote Queensland is characterised by geographical and social diversity and has one of the most regionalised health services in Australia. As a result, Queensland’s decentralised population presents some significant challenges for the planning and delivery of health services. Over the last ten years a number of rural communities have seen a significant decline in the population resulting in a reduction of services provided by banks, post offices and small business for many. As a result this has often meant that the public hospital and health services have become one of the major employers in the town and seen as critical to the ongoing viability of the community. In contrast, other communities have seen population growth as a result of investment in the resource sector. These communities experience similar problems particularly with the recruitment and retention of workforce.

The challenges relating to population changes, workforce recruitment and retention and technological advancements have meant that current service models have become increasingly difficult to maintain and require government to investigate alternative ways in which health services are delivered in rural and remote communities.

Health service provision in rural and remote Queensland communities are serviced by a range of providers including Queensland Health, the Commonwealth Government, General Practitioners, local government, non government organisations and private providers. The mix and breadth of providers is often dependent upon the type, size and location of the service.
While larger rural communities are generally able to support local hospitals and specialised services, increasing remoteness and diminishing population size and density constrain service models options. Formal links between lower and higher levels of service should enable the development of more integrated and comprehensive health services. These services should be provided using a ‘hub and spoke’ (service partner) service and arranged so that there is integration across the continuum. Reorganising the current familiar ‘hub and spoke’ (service partner) model of service may involve the need to consolidate services, reorientate existing services and to explore opportunities to create partnerships between private and government service providers.

A further challenge for the delivery of health services in rural and remote areas is the overall age of the infrastructure portfolio and the associated condition of the assets. The majority of buildings are over 60 years old and many have significant infrastructure issues. These issues impact on service delivery in a number of ways including:

- inefficient and outdated layouts
- lack of compliance with current building codes, accreditation and safety standards
- workplace health and safety issues
- recruitment and retention issues compounded by poor quality workforce accommodation
- an inability to provide the minimum level of health services required by the community because of the age and quality of for example operating theatres, medical imaging and procedural rooms.

2.2. Scope

For this paper, rural and remote refers to Mt Isa, Central West, South West, Torres Strait and Northern Peninsula Area and Cape York Health Service Districts, and to the rural areas (RA2 - RA5 (Commonwealth Government 2004)) of Townsville, Sunshine Coast and Wide Bay, Cairns Hinterland, Central Queensland, Mackay and Darling Downs-West Moreton Health Service Districts.

This ‘hub and spoke’ (service partner) model of service delivery already exists in an informal manner in many Health Service Districts across Queensland. However the current model is not consistently applied. This paper aims to define the informal tiered ‘hub and spoke’ (service partner) model and describe a health service delivery for rural and remote Queensland. It will include an outline of the required level of clinical level of service capability for hub services.

Sites designated as hubs will be developed over time to provide a minimum suite of acute health services based on the on the Clinical Services Capability Framework definitions of Level 3 services (Clinical Services Capability Framework V3 2010). A minimum suite of primary health care services will also be identified.

The map of Queensland below has 19 hub sites highlighted in red. The hub sites are numbered in descending order by emergency department presentations from Queensland Admitted Patient Data Collection (2007-2008) detail in Appendix B).
Map 1: Hub sites in Queensland

3. Objectives
Queensland Health aims is to ensure that there is a sustained quality of service provision based on the “right service, right place, in the right time” (Queensland Government 2006). The Blueprint for the Bush also emphasises the need for providing dependable, safe and sustainable health services that meet rural community needs. Despite this, rural and remote populations often experience great difficulties in accessing health services when they are needed.

Establishing a tiered ‘hub and spoke’ (service partner) model of health service delivery for rural and remote Queensland will support the following objectives:

1. The capability of hub sites will be defined and core minimum services identified against the draft Clinical Services Capability Framework V3.
2. The capability of spoke services will be defined locally guided by the Clinical Services Capability Framework V3.
3. Defining the capability for rural and remote services using the Clinical Services Capability Framework V3 will emphasise improvement of services rather than service restrictions clinical senate recommendations (Queensland Government 2009)
4. The introduction of a common language to describe the Queensland hub and spoke service model.
5. Facilities are developed to be fit for purpose to meet the minimum requirements as outlined in the Clinical Services Capability Framework V3.
6. Service provision at rural hub and spoke sites will evolve over time recognising the changing community needs.

This paper aims to assist in describing the hub and spoke service model in Queensland it does not aim to be prescriptive and should not be seen to replace the need for local planning and consultation regarding the suite of services provided at a local level.

Effective governance will be critical to facilitate the collaboration between health services.

4. Definition of the hub and spoke rural model of health service delivery

The tiered hub and spoke model of service delivery requires that formal links are established between the providers of lower level capability services and the providers of higher level capability services. This means that formal service networks and escalation policies to manage emergency care and care outside the capability of the lower level service are required. To facilitate this and integrate patient management at each level of service, formal links are required that should be underpinned by documented processes. The development of service networks and the formalisation of links between lower and higher level services aims to ensure that smaller rural services are supported and that the sustainability of all networked services is potentiated.

As part of a service network, rural hub services will in turn be supported by larger or higher level regional and metropolitan specialist services. The model supports the governments aim to ensure the safe delivery of services in Queensland rural health facilities, and that the facilities are fit for the purpose they are intended for. This will ultimately ensure the timely provision of services where people most need them.

4.1. The Queensland tiered rural hub and spoke model

As identified earlier in this paper, rural and remote services across Queensland already operate via an informal hub and spoke service model. Given this, Policy, Planning and Asset Services initiated a desk top mapping exercise. The desk top exercise analysed data on the measures identified below:

• presence of a birthing service (2008) (Queensland Health 2007/08a)

• presence of spoke sites (services supported by a hub site) (Appendix B)

• the population catchment (greater than immediate town area)

• accessibility/ remoteness scores (Commonwealth Government 2004)

As a result of this desktop mapping exercise rural services were able to be grouped into a tiered hub and spoke model with tiers being:

• Primary hub

• Secondary Hub

• Spoke (service partner)

The mapping exercise identified 19 hub sites in Queensland of which 14 were primary hub sites and five were secondary hub sites. There were hub sites in most of the rural health service districts including:

• Darling Downs West Moreton has four primary hub sites and 2 secondary hub sites,

• South West has one primary hub site and two secondary hub sites,

• Central Queensland has one primary and secondary hub,

• Mackay has one primary hub site

• Townsville has two primary hub sites

• Central West has one primary hub site

• Cairns and Hinterland has three primary hub sites

• Torres Strait and Northern Peninsula has one primary hub site

• Mt Isa, Cape York, Sunshine Coast Wide Bay and Metro North and South health service districts do not have any rural hub services.

The results of this exercise were supported by work completed at a rural health services forum held in February 2010 and consultation with the Office of Rural and Remote Health.
5. Primary hub

Primary hubs generally serve catchments with larger population numbers. Larger population numbers ensure there is sufficient critical mass to sustain a higher capability of health services (Humphreys 2008). In this context critical mass refers to workforce and population and the resultant ability to be able to both provide a service to a population and have a population that requires a set of services.

Primary hub sites provide services at the Clinical Services Capability Framework V3 Level 3 with the ability to support some higher level services when medical specialist outreach services are required. Primary Hub services will also support various spoke services and in some instances, smaller secondary hub sites with service delivery and workforce assistance.

Services provided at a hub site would generally consolidate the provision of higher level services in one place such as specialist outreach services, procedural and birthing services. Where procedural outreach services require workforce and administrative support, these services would generally be provided and supported at the hub site. A primary hub site may also support higher level outreach services at a spoke site.

Primary hubs will in turn be part of a larger service network including regional specialist services and metropolitan specialist services provided at Clinical Services Capability Framework (V3) Level 4, 5 and 6. (refer to Appendix A for generic descriptors of levels 1-6)

Patients that require transfer to a higher level service from a spoke or secondary hub site must consider whether the condition could be managed appropriately at the primary hub site. Regional or metropolitan transfer options should be determined based on patient care needs.
5.1. Core acute and support services

Primary hub sites will provide a common core suite of acute services that will be complemented by a range of primary health care services. The minimum suite of Level 3 health services to be provided at all designated hub sites include procedural services, maternity services, emergency services and general medical services. To provide these services it is mandatory that each hub also provide a suite of support services enabling the core services to be provided.

The minimum service requirements for each of the common core services will be guided by the Clinical Services Capability Framework V3. The core services will include:

- Level 3 emergency services including retrieval services for adults and children
- Level 3 medical services for adults and children
- Level 3 surgical services for adults and specific aged children
- Level 3 peri operative services including recovery, endoscopies and theatres
- Level 3 anaesthetics services for adults and specific aged children
- Level 3 maternity services for low risk pregnancies, birthing and postnatal care (planned birthing of ≥ 37/40 weeks gestation)
- Level 3 neonatal services – well baby care (≥ 37/40 planned delivery) may manage infants with minor feeding and oxygen requirements and infants back transferred from regional and metropolitan centres
- Level 2 inpatient mental health services
- Level 3 pathology services – a limited range of approved tests and the ability to manage emergency specimens to transfer out (this may include point of care testing), lab scientist on duty / available
- Level 3 medication services- on site pharmacy available during business hours
- Level 3 medical imaging services
5.2. Primary Health Care services

The National Health and Hospitals Reform Committee recommends that establishing networks of primary health care services in rural and remote locations is necessary either by local service delivery or by an outreach mechanism. There has also been a increased interest on reducing demand for inpatient services by implementing models of care that are based on outsourcing, implementing chronic disease programs and substituting hospital services with community based services. The tiered hub and spoke service model will ensure rural and remote health services are well placed to support these directions.

It is recognised that a range primary health care services should be available at each primary hub site, although the type of services at each site will be based on community need. It is also recognised that primary and community health services may be provided by a range of public and private service providers. Examples of primary health care services that could typically be available are:

- Aboriginal and Torres Strait Islander Services- as designated by the Indigenous Health Outcomes Unit framework making tracks recommendations
- allied health and rehabilitation services
- Level 3 ambulatory mental health services
- Alcohol Tobacco and Other Drugs
- Population Health
- chronic disease management services
- child health services
- maternity care may be delivered in the primary health care environment
- dental / oral health services
- community nursing - including palliative care
- Level 2 Renal chairs (self managed) and support for home dialysis

5.3. Role of primary hub in supporting spokes (service partners)

The most significant factor identifying a primary rural hub was that the service would have larger population catchment than the immediate local town area and would provide support and services to a variable number of spoke (service partner) services. Where a site only provided services to its immediate catchment population they were categorised as a spoke (service partner) regardless of the size of service.

6. Secondary hub

In mapping the ‘hub and spoke’ (service partner) services across the state it became apparent that some districts had a number of sites that provide a similar breadth of services to that of a primary hub but at a lower level of activity. In addition to a hub supporting a number of spokes (service partners), designation as a hub depends on the range of services provided, the size of the service and workforce availability. It was evident when assessing the data that there was a relationship between the volume of activity in rural emergency departments and the size of the proposed hub sites. It was also acknowledged that the districts that have secondary hubs rely on these services to provide acute services together with supporting a range of spoke (service partner) services. However sustainability of some of these services over time will rely on developing strong service networks with the primary hub.

Secondary hubs were defined on the same criteria as a primary hub but with a lower level of activity based on 2007/08 data from the Queensland Health Admitted Patient Data Collection and the Perinatal Data Collection:
• emergency department presentations (approximately less than 5500 per annum)
• number of births (less than 100 per annum)
• Health Service District had more then one site providing the common core services

Where a health service district had only one rural hub it was designated a primary hub regardless of level of activity (Central West Health Service District).

7. Spoke (service partner)

Spoke sites can be identified as those services which only cater to their local populations and usually provide lower Clinical Services Capability Framework V3 levels of service (for example Level 1 and 2) than a hub site. Health services provided by spokes (service partners) are generally characterised by small populations dispersed over vast areas with a limited range of services. Rural spoke (service partner) sites may be of variable size and service profile. The spoke service will usually depend on the hub services to provide some level of support dependant on local need as part of their core service provision. The services provided by spoke sites have similar issues to those at hub sites such as poor infrastructure, workforce recruitment problems, small populations and additionally the distance to a regional hub service.

Spoke services are essential to ensuring rural and remote communities have access to primary, community and emergency support services. They should not function in isolation or be required to compete for resources from larger providers. The tiered hub and spoke service model provides an integrated service system where spoke services are supported by a larger service rural hub service, a regional specialist centre and or a metropolitan specialist centre. Hub services will support each spoke differently based on community need. Common examples of the types of services provided on an outreach basis to spoke sites are:

• allied health services
• general practitioner medical clinics
• mental health services
• antenatal and postnatal maternity services

Spoke (service partner) services may operate under a variety of service models service such as a Multi Purpose Health Service, a Primary Health Care service, Aboriginal and Torres Strait Islander services, local out patient departments and/or small hospitals.
Reference List


10. Queensland Health Admitted Patient Data Collection, Queensland Health, Queensland Health (vendor).
Attachment A: Clinical Services Capability Framework (V3)

Levels of service

**Level 1 service:** A Level 1 service will provide a low risk ambulatory care service only, predominantly delivered by health providers (registered nurse and/or health worker) other than a general practitioner. A visiting general practitioner may intermittently provide a medical service and patients requiring a higher level of care can be managed for short periods before transfer to a higher level service.

**Level 2 service:** A Level 2 service will provide a low risk inpatient and ambulatory care service, delivered mainly by registered nurses and general practitioners with admitting rights to the local hospital. There will be some limited visiting/outreach allied health services provided. A Level 2 service will manage emergency care until transfer to a higher level service.

**Level 3 service:** A Level 3 service will provide a low-risk inpatient and ambulatory care service with access to limited support services. A Level 3 service will predominantly be delivered by general practitioners (available 24/7 but not necessarily on site) and registered nurses (including midwives and or nurses with speciality qualifications) with visiting day only specialist services. Day only specialist services may include low risk surgery, minor procedures and an education and training role (longer than day only may be arranged). A Level 3 service will manage emergency care until transfer to a higher level. A Level 3 service will have no access to an intensive care unit or high dependency unit although the service may have access to a monitored area.

**Level 4 service:** A Level 4 service will provide a low and moderate risk inpatient and ambulatory care service delivered by a variety of health professionals (medical, nursing, midwifery and allied health) including resident and visiting specialists. Medical staff will be on site 24/7 and an intensive care unit (may be combined with a cardiac care unit) with related support services will also be available on site (size to be determined with review of the intensive care unit module). If higher level or more complicated care is required, patients may need to be transferred to a Level 5 service. Some specialist diagnostic services will also be available. A Level 4 services will have a university affiliation including an education, teaching and research commitment.

**Level 5 service:** A Level 5 service will manage all but the most highly complex patients and procedures. It will act, as a referral service for all but the most complex service needs. This may therefore mean that highly complex high risk patients will require transfer or referral to a Level 6 service. A Level 5 service will have strong university affiliations and major teaching with some research commitments in both local and multi-centre research.

**Level 6 service:** A Level 6 service will be the ultimate high level service delivering complex care and acting as a referral service for all lower level services. A Level 6 service can also be a statewide Superspecialty service accepting referrals from across the state, health service districts and interstate where applicable. This level of service will generally be provided at a large metropolitan hospital. This level of service will have a strong university affiliations and major teaching and research commitments in both local and multi-centre research.

Source: Planning and Coordination Branch, Queensland Health, 2008
### Appendix B: Queensland primary and secondary rural health service hubs and service partners listed in descending order of Emergency department presentations

<table>
<thead>
<tr>
<th>No.</th>
<th>Primary rural health service hubs</th>
<th>Health Service District</th>
<th>Associated regional of Metropolitan Hubs Travel time - RACQ</th>
<th>2007/08 ED presentations</th>
<th>Births 2008</th>
<th>ASGC</th>
<th>Service partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mareeba-19.2 exemption</td>
<td>Cairns Hinter</td>
<td>Cairns- &lt;1 hour</td>
<td>19,182</td>
<td>139</td>
<td>RA3</td>
<td>Some communities in Cape York flow here rather than Cairns</td>
</tr>
<tr>
<td>2</td>
<td>Warwick</td>
<td>DDWM</td>
<td>Toowoomba- &gt; 1 hour</td>
<td>16,314</td>
<td>227</td>
<td>RA2</td>
<td>Stanthorpe, Inglewood, Tenterfield (NSW), Texas</td>
</tr>
<tr>
<td>3</td>
<td>Emerald</td>
<td>Central QLD</td>
<td>Rockhampton – 3 hours</td>
<td>14,705</td>
<td>304</td>
<td>RA3</td>
<td>Dysart, Clermont, Blackwater, Springsure, Gemfields, Rolleston Capella, Middlemount, Tieri,</td>
</tr>
<tr>
<td>4</td>
<td>Dalby</td>
<td>DDWM</td>
<td>Toowoomba 1 hour</td>
<td>14,333</td>
<td>233</td>
<td>RA2</td>
<td>Chinchilla, Miles, Jandowae, Tara, Wandoan, Taroom</td>
</tr>
<tr>
<td>5</td>
<td>Atherton</td>
<td>Cairns Hinter</td>
<td>Cairns – 75 min</td>
<td>13,068</td>
<td>230</td>
<td>RA3</td>
<td>Towns west of Atherton including Herberton</td>
</tr>
<tr>
<td>6</td>
<td>Proserpine</td>
<td>Mackay</td>
<td>Mackay 1 ½ hours Townsville 3 ½ hours</td>
<td>11,272</td>
<td>286</td>
<td>RA3</td>
<td>Bowen and Collinsville</td>
</tr>
<tr>
<td>7</td>
<td>Kingaroy</td>
<td>DDWM</td>
<td>Brisbane-2 hours</td>
<td>10,971</td>
<td>440</td>
<td>RA2</td>
<td>Cherbourg, Nanango, Murgon</td>
</tr>
<tr>
<td>8</td>
<td>Goondiwindi</td>
<td>DDWM</td>
<td>Toowoomba – 3 hours</td>
<td>10,548</td>
<td>120</td>
<td>RA3</td>
<td>Texas, Boggabilla (NSW) Tumela, Moree (NSW)</td>
</tr>
<tr>
<td>9</td>
<td>Innisfail</td>
<td>Cairns Hinter</td>
<td>Townsville 3 ½ , Cairns 75 min</td>
<td>10,492</td>
<td>303</td>
<td>RA3</td>
<td>Tully</td>
</tr>
<tr>
<td>10</td>
<td>Charters Towers</td>
<td>Townsville</td>
<td>Townsville 104 min</td>
<td>10,177</td>
<td>40</td>
<td>RA3</td>
<td>Hughenden, Richmond</td>
</tr>
<tr>
<td>11</td>
<td>Ayr</td>
<td>Townsville</td>
<td>Townsville – 1 hour</td>
<td>7,847</td>
<td>164</td>
<td>RA3</td>
<td>Burdekin LGA</td>
</tr>
<tr>
<td>12</td>
<td>Roma</td>
<td>South West</td>
<td>Brisbane – flight Toowoomba- 4 hours</td>
<td>7,703</td>
<td>127</td>
<td>RA3</td>
<td>Surat, Injune, Yuleba, Wallumbilla</td>
</tr>
<tr>
<td>13</td>
<td>Thursday Island</td>
<td>Torres Strait / Northern Pen</td>
<td>Cairns- flight</td>
<td>5836</td>
<td>188</td>
<td>RA5</td>
<td>Torres Strait Islands</td>
</tr>
<tr>
<td>14</td>
<td>Longreach</td>
<td>Central West</td>
<td>Brisbane/ Townsville flight</td>
<td>5,266</td>
<td>106</td>
<td>RA5</td>
<td>Barcaldine, Aramac, Alpha, Muttaburra (PHC), Winton, Windorah, Blackall</td>
</tr>
<tr>
<td>NO</td>
<td>Secondary rural health service hubs</td>
<td>Health Service District</td>
<td>Regional Hub Travel time RACQ</td>
<td>Emergency Department presentations 2007/08</td>
<td>Births 2008</td>
<td>ASGC</td>
<td>Service Partners</td>
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<td>-----------------</td>
</tr>
<tr>
<td>15</td>
<td>St George</td>
<td>South West</td>
<td>Toowoomba- 5 hours</td>
<td>5486</td>
<td>62</td>
<td>RA4</td>
<td>Dirranbandi, Mungindi, Cunnamulla</td>
</tr>
<tr>
<td>16</td>
<td>Stanthorpe</td>
<td>DDWM</td>
<td>Warwick 45 min, Toowoomba 2 hours</td>
<td>4,796</td>
<td>136</td>
<td>RA3</td>
<td>Texas/ Bonshaw (NSW), Inglewood primarily for birthing Wallangarra, Tenterfield, Northern NSW residents dependant on post code to access QLD health services</td>
</tr>
<tr>
<td>17</td>
<td>Biloela</td>
<td>Central QLD</td>
<td>Rockhampton 2 hours</td>
<td>3,777</td>
<td>120</td>
<td>RA3</td>
<td>Theodore, Moura, Taroom</td>
</tr>
<tr>
<td>18</td>
<td>Chinchilla</td>
<td>DDWM</td>
<td>Dalby 45 min, Toowoomba 2 hours</td>
<td>3,260</td>
<td>71</td>
<td>RA3</td>
<td>Jandowae, Wandoan, Miles</td>
</tr>
<tr>
<td>19</td>
<td>Charleville</td>
<td>South West</td>
<td>Brisbane, 9 hours Roma 3 hours Flight to Brisbane and Roma</td>
<td>2,860</td>
<td>47</td>
<td>RA5</td>
<td>Cunnamulla, Augathella, Quilpie, Morven OPD</td>
</tr>
</tbody>
</table>

ASGC remoteness Areas- RA1 Major cities, RA2 Inner regional, RA3 outer regional, RA4 remote, RA5 very remote