Submission to the Joint Standing Committee on Northern Australia

Inquiry into Preparing for Emerging Industries Across Northern Australia

Submitted by: Remote Australians Matter (RAM)
| Date: December 2025

About Remote Australians Matter (RAM)

Remote Australians Matter (RAM) is a national not for profit organisation committed to advancing health equity, essential service access, and long-term wellbeing for individuals and families living in remote and very remote Australia. RAM serves as a non-partisan, independent conduit for the voices of remote communities, ensuring that the lived experience of residents of all remote and very remote communities, shapes policy decisions at all levels of government. Our organisation engages directly with community leaders, Aboriginal Community Controlled Organisations (ACCOs), health practitioners, families, and remote service providers to capture the realities of life in the bush. These perspectives are essential for creating effective, sustainable, and culturally appropriate responses to the rapid industrial and economic developments occurring across Northern Australia.

Table of Contents

Executive Summary

Remote communities in Northern Australia continue to face profound inequities across health, access to essential services, digital connectivity, nutritious food availability, and workforce access. Without purposeful effort to include these communities, emerging industries, including renewable energy, critical minerals, export development, defence, and decommissioning, will exacerbate existing inequalities rather than reduce them. Remote Australians Matter (RAM) argues that emerging industries must be planned and implemented through the lens of health equity and community wellbeing, supported by infrastructure investment, equitable workforce pathways, genuine community participation in governance, and place-based decision-making. Health outcomes in remote Australia are inextricably linked to infrastructure, workforce stability, and economic opportunity. When roads become impassable, barge landings fail, or power systems are unreliable, communities lose access to emergency medical care, fresh food, essential medications, and ongoing primary healthcare. When workforce accommodation is inadequate, health services become dependent on costly and inconsistent fly-in fly-out models that undermine continuity of care, fragment chronic disease management, and erode community trust. When industries develop without consideration for community capacity, local health services become overwhelmed, housing shortages intensify, and the social determinants of health deteriorate further.

This submission demonstrates that addressing these interconnected challenges requires coordinated action across multiple domains. Renewable energy transitions must be approached as public health interventions ensuring reliable power for clinics, medication refrigeration, and safe drinking water systems, with community-owned microgrids prioritized. Critical minerals development must include mandatory co-investment in health infrastructure and workforce expansion, with realistic local employment pathways created through in-community training. Export infrastructure including barge landings, roads, cold storage, and telecommunications must be classified as dual-purpose critical health infrastructure, recognizing that systems enabling commercial activity also to determine whether communities can access healthcare, nutritious food, and emergency services. Defence expansion must assess implications for local housing and health services while favouring remote and Indigenous-owned businesses in procurement. Central to all recommendations is recognition that remote service delivery costs significantly more than metropolitan equivalents due to distance, logistics, cross-jurisdictional complexity, and workforce constraints. Current funding models that impose metropolitan cost structures, rely on short-term project cycles, and separate health from other essential services systematically undermine remote communities' capacity to thrive. A substantial proportion of funding is consumed by logistics and administration before services reach communities, this is not inefficiency but geographic reality requiring multi-year, flexible funding frameworks that reflect true delivery costs.

First Nations leadership must be embedded throughout policy, planning, and implementation, with Aboriginal Community Controlled Organisations positioned as central partners in governance, service delivery, and economic participation. Simultaneously, all remote communities, Indigenous and non-Indigenous, require workforce pathways, quality housing, reliable infrastructure, and access to integrated health services that address environmental, biosecurity, and human health challenges together. Remote Australians Matter urges the Committee to adopt a health equity lens across all recommendations, mandating health impact assessments for major projects, requiring industry co-investment in health infrastructure as conditions of approval, upgrading marine and road infrastructure as critical health assets, establishing long-term funding partnerships that recognize true delivery costs, and ensuring community-controlled research drives innovation in remote health service models. Northern Australia's economic future depends on healthy, connected, empowered communities, and achieving this requires policy frameworks that place remote wellbeing at the centre of economic development planning.

1. Global Transition to Net Zero, Renewable Energy & Decarbonisation

The transition to net zero represents a critical opportunity to address longstanding energy inequities in remote areas. Many remote communities rely on diesel-powered generators that are expensive to operate and vulnerable to supply chain disruptions. However, they are the only source of energy that these communities can access reliably. For many communities there are no other options to access power, and this means there is sole reliance on fossil fuels with little market competition and prices are often very high. Many homes in remote communities do not have access to cooling or heating and so people often congregate to public offices to access air-conditioning rather than the required services. This slows down service delivery and creates frustration with both providers and the community. There has been extensive research into the impacts of climate variability and the social impacts on remote communities. Quilty et. al (2023) documented the severity of health implications from interrupted power supplies in remote Australian communities in their *Climate, housing, energy and Indigenous health: a call to action*. However, any switches to green energy sources such as Solar, must consider the required supporting infrastructure. Boretti (2024) found that often solar power is not a complete answer, as the need for suitable power storage and batteries is often not considered when switching from diesel power. These interruptions in power supply have huge impacts in remote communities, which can lead to life threatening circumstances.

Renewable energy development must therefore be approached not only as an economic opportunity but as a public health intervention. It is essential that government planning embeds formal health equity impact assessments to evaluate how energy changes will affect access to healthcare, refrigeration of medications, safe drinking water systems, and the viability of remote clinics. Further, community-owned renewable energy microgrids should be prioritised to ensure local energy independence, support essential services such as schools and health centres, and reduce long-term operational costs. Remote communities can be positioned as early adopters and leaders in renewable energy, with investment focused on place-based capability, governance participation, and long-term asset ownership.

2. Developing the Critical Minerals Industry

Growth in the critical minerals sector presents significant risks and opportunities for remote communities. While new projects may generate employment and economic activity, they also place pressure on already-stretched local health services, housing availability, emergency response systems, and essential community infrastructure. Mining companies operating in remote regions must therefore be required to co-invest in health infrastructure and service expansion, recognising that population increases, whether permanent or FIFO, directly impact community capacity. In addition, First Nations communities must be central to planning and benefit-sharing arrangements,

with mandatory cultural, social, and health wellbeing agreements built into project approvals.

Realistic local workforce pathways must be created through accessible VET and technical training delivered in-community, ensuring that residents can obtain qualifications without relocating. Relocating often creates social disruption and reduces long-term participation of local human resources. Culturally First Nations people are reluctant to move from their "country" and have strong links to their homelands for ceremonies and belonging. By supporting local people to be actively involved in the industry's growth is a win-win situation for all stakeholders. This is already done well in parts of the NT and North QLD where there are good community engagement and collaborative approaches to development.

Sustainable development of the critical minerals sector can only occur when community wellbeing and local service capability are integrated into industry planning from the earliest stages. From a remote health perspective, the investment from the minerals sector would help with the large financial challenges that remote delivery of health and services often face.

3. Supporting the Development of Export Industries

Remote export industries rely on highly fragile supply chains, where disruptions have direct consequences for both economic activity and community health. The same infrastructure used for exporting goods, such as barge landings, roads, airstrips, cold storage facilities, and telecommunications connectivity also underpins the delivery of healthcare supplies, fresh food, emergency evacuations, and essential medication transport. Treating export infrastructure in isolation from health determinants creates systemic vulnerability.

Agriculture alone is responsible for 33% of Australia's export earnings, Kashem et al (2024). Most of this produce (especially sheep and beef cattle) is produced in MM6 and MM7 regions. The communities that maintain this industry require support to live and thrive in these environments and therefore ensure the longevity of the industry. By placing an emphasis on community health and resilience when enhancing export capabilities in these regions there is an opportunity to build robust social infrastructure to provide an ongoing workforce.

Government should therefore classify freight and export infrastructure as dual-purpose critical health infrastructure, ensuring it is funded, maintained, and designed to support community resilience. Investment in cold chain systems will benefit both commercial enterprises and local food security, enabling affordable and nutritious foods to reach remote households consistently. Export development must be linked to capacity building for remote owned businesses, ensuring that economic opportunities increase

local prosperity rather than bypass communities through externalised or FIFO business models.

4. Supporting the Decommissioning Industry

As legacy mining, defence, and energy assets reach the end of their operational life, Northern Australia requires a structured and safe approach to decommissioning. Poorly executed decommissioning can result in environmental contamination, unsafe sites, and long-term health risks for nearby communities. A formal requirement for remote health risk assessments, including soil, water, and air quality monitoring, should accompany all decommissioning plans to ensure that communities are protected during and after closure. Furthermore, local ranger groups and community-based environmental organisations should be funded and trained to play central roles in site rehabilitation, environmental monitoring, cultural heritage protection, and reporting. Involving local people strengthens community oversight, supports employment, and ensures that rehabilitation activities respect cultural values and local ecological knowledge. Building a specialised decommissioning workforce in remote regions will also contribute to long-term economic resilience and reduce reliance on external contractors.

5. Supporting the Defence Industry

Defence expansion across the North has the potential to contribute economic activity and regional capability, but without careful planning, military growth can exacerbate local housing shortages, place pressure on health services, and alter community dynamics. Defence investment must therefore include an assessment of its implications for remote health services, emergency response capacity, and essential worker accommodation. For many communities the support from defence families has significant positive impact, however the transient nature of defence resources across Australia leads to some instability for smaller communities who may find themselves in a feast and famine business model. Overall though the Defence community offers excellent opportunities for stronger remote communities. Much of Australia's borders and assets lie in MM6 & MM7 regions, therefore remote Australians with local knowledge are also an asset to the Defence community. Defence procurement policies should actively favour remote and Indigenous-owned businesses, particularly in construction, facilities management, environmental services, transport, and logistics. These people have deep local knowledge and create a framework for growth around remote locations. By supporting people who know the area and are already addressing the challenges of remote logistics, there are both financial and environmental benefits to be had. Additionally, defence-related training in cybersecurity, drone operations, logistics management, and technical trades should be made available within remote communities, providing long-term pathways into a stable and high-skilled workforce. Meaningful collaboration between Defence, local governments, and community-

controlled organisations will ensure that defence presence strengthens, not undermines, remote community resilience

6. Supporting Infrastructure

Infrastructure in remote communities is fundamentally linked to health outcomes and service access. Barge landings, roads, airstrips, telecommunications systems, and water supply infrastructure are not merely economic assets; they directly determine whether communities can access emergency medical retrieval, safe drinking water, fresh food, medications, and ongoing healthcare. Many remote regions rely on ageing barge landings and unsealed roads that become impassable during wet seasons, isolating residents for extended periods. Investment must therefore prioritise climate-resilient, all-weather infrastructure, including upgrades to marine access points and the expansion of reliable digital connectivity capable of supporting telehealth, remote training, and emergency alerts.

Northern Australia continues to experience a significant infrastructure deficit, particularly across remote regions where both Indigenous and non-Indigenous communities, pastoral and agricultural enterprises, mining operations, and service providers rely on basic transport, telecommunications, and energy networks to function. While investment has traditionally been directed toward regional centres, the lack of all-weather, climate-resilient infrastructure in remote areas has now become a national economic, social, and health issue.

Reliable infrastructure in the North is not simply a matter of convenience, it is fundamental to equitable service delivery, industry growth, food security, emergency response capability, and the health and wellbeing of thousands of Australians who live and work in remote regions. When roads, bridges, telecommunications, and supply routes fail, the consequences are widespread and costly for households, businesses, and government.

To illustrate the broader national challenge, the Central Arnhem Road in the NT provides a clear and instructive case study.

Case Study: Central Arnhem Road

The Central Arnhem Road is a 675 km route linking Katherine to Nhulunbuy and numerous communities, pastoral properties, mining operations, and agricultural activities in between. Despite its strategic importance, the road remains mostly unsealed, poorly maintained, and dangerous. Seasonal flooding, deep corrugations, washouts, and damaged river crossings make it impassable for extended periods every year.

Many communities, both Aboriginal homelands and non-Indigenous remote settlements, experience severe isolation when the road becomes unsafe. Residents

must then rely on small charter planes or own 4WD transport for access to food, fuel, healthcare, freight, and other essentials. This dramatically increases the cost of living, reduces the availability of fresh and healthy food, and undermines community wellbeing.

During medical emergencies, road closures delay access to healthcare facilities, often forcing expensive aeromedical evacuations. This increases avoidable hospitalisations and contributes to poorer long-term health outcomes.

The Central Arnhem Road is a critical artery for cattle and buffalo transport, mining logistics, freight movement, and workforce mobility. Poor conditions create:

- Significant delays in livestock transport, affecting animal welfare and market timing.
- Higher operating costs for pastoral stations, including feed, maintenance, and fuel.
- Reduced production certainty for mining operations that rely on road access for equipment and workforce movement.
- Increased wear and tear on vehicles and machinery, burdening small businesses and contractors.
- Difficulty attracting and retaining skilled workers in all sectors due to unreliable access.

The road's condition directly affects national export industries, energy security, and Northern Australia's contribution to the Australian economy.

National Health Implications

The Central Arnhem Road demonstrates how infrastructure is a determinant of health. Key issues include:

- Delayed emergency care due to impassable roads, leading to preventable complications. Also restricted police access leads to an increase in social issues (DV) that impact on community health
- Reduced access to visiting GPs, allied health, maternal and child health, and mental health services, as clinicians cannot safely travel.
- Food insecurity and rising chronic disease from expensive or limited freight capacity.
- Increased stress, isolation, and community safety risks during long periods of disconnection.

Workforce accommodation is a critical determinant of how remote health services are delivered across Northern Australia. In many regions, the lack of suitable, long-term housing for health professionals has forced health providers to rely heavily on Fly-In Fly-Out (FIFO) and short-term locum staffing models. While intended as temporary solutions, these models have become the default because permanent staff simply cannot be accommodated locally.

This shift toward FIFO has created significant challenges for communities. FIFO staff, by definition, are present only intermittently. Their schedules are shaped by flight availability, contract periods, and accommodation constraints, not by community need. As a result, essential health services are often delivered in short, irregular blocks, leaving long gaps where no clinician is available.

The absence of permanent accommodation leads directly to:

- Limited and inconsistent service availability, with clinics sometimes staffed for only a few days each fortnight.
- Reduced continuity of care, particularly for chronic disease management, maternal health, and mental health—areas that rely on trust and stable relationships.
- Fragmented record-keeping and clinical follow-up, as each FIFO staff member has only a brief window to understand patient needs.
- Increased pressure on Aboriginal Health Practitioners, who must shoulder ongoing care without consistent support.
- Higher reliance on emergency retrievals due to delayed or sporadic treatment opportunities.

The FIFO model also undermines preventive health efforts. Health promotion, home visits, community outreach, and school-based programs are difficult sometimes impossible when staff are in community for only a few days at a time. Timing becomes reactive, not proactive, with community members often missing out on routine screening or follow-up simply because a clinician is not present when they need care.

Additionally, FIFO models weaken the relationship-building that is essential in remote health. Trust, cultural safety, and patient engagement cannot be developed effectively when staff turnover is constant, and workers are unfamiliar with local families, language, and context.

In contrast, when secure, adequate accommodation is available, remote clinics can recruit and retain permanent staff, stabilising service delivery and improving health outcomes. Accommodation is therefore not a peripheral issue it is central to reducing

dependence on FIFO, restoring continuity of care, and ensuring that remote communities have reliable, timely access to essential health services.

7. Managing Biosecurity Risks

The cross-jurisdictional nature of remote health in Australia creates additional complexity, with responsibilities fragmented across Commonwealth, state, and territory governments. Biosecurity responses require coordination between federal agriculture departments, state animal health authorities, Western Australia, Northern Territory and Queensland health services, and local Indigenous-controlled health organizations. Strengthening collaboration across these jurisdictions and with neighbouring nations is essential for regional disease surveillance and rapid response to transboundary threats.

This requires sustained investment in shared surveillance infrastructure, harmonized reporting systems that function across Commonwealth and state boundaries, and collaborative training programs. Indigenous communities with traditional connections that span state borders and international boundaries should be recognized as vital partners in cross-border monitoring networks.

Current funding models that separate animal health, environmental management, and human health services across different government portfolios create silos undermining coordinated responses. Flexible funding frameworks supporting holistic community-led approaches, alongside sustained workforce development and infrastructure investment, are essential to building resilient remote health systems.

8. Training, Attracting and Retaining a Skilled Workforce

Remote workforce shortages remain a severe and persistent barrier to health equity, service delivery, and economic development across regional and remote Australia. Health services, schools, local government, infrastructure providers, biosecurity networks, and emerging industries all report chronic difficulty attracting and retaining qualified staff. This challenge affects both Aboriginal and non-Aboriginal remote communities, creating cascading impacts on community wellbeing, economic opportunity, and essential service continuity. In remote health specifically, workforce instability undermines continuity of care, disrupts chronic disease management, delays emergency responses, and prevents the establishment of integrated primary healthcare models that address interconnected environmental, biosecurity, and human health challenges. Health professionals face additional pressures including broad scope of practice requirements, limited specialist support, on-call responsibilities, and the emotional demands of working in under-resourced settings with complex needs, compounded by geographic isolation, housing scarcity, cultural adjustment challenges, and distance from family and professional networks.

Governments should develop remote-specific workforce incentive programs that include substantial salary loadings reflecting actual cost of living and professional demands, guaranteed quality housing meeting contemporary standards and comprehensive relocation support including family considerations. Clearly defined career progression pathways, regular relief and professional supervision arrangements, and structured professional development will maintain clinical currency and prevent professional isolation.

Training must be delivered in ways that do not require residents to leave their communities for extended periods, supporting local workforce development while maintaining community connections. Mobile training units blended digital delivery with hands-on components, micro-credential pathways building toward formal qualifications, and place-based partnerships between educational institutions and remote employers can build capability across health, education, infrastructure, biosecurity, and emerging industry sectors. For Aboriginal community members, training pathways should recognize and build upon cultural knowledge, particularly in environmental health monitoring, biosecurity surveillance through Ranger programs, and community health worker roles bridging Western and traditional health approaches. Remote health services should establish formal training partnerships with universities and vocational providers, creating supervised clinical placement capacity that builds the workforce pipeline while exposing students to remote practice.

The cross-jurisdictional nature of remote workforce challenges requires coordinated Commonwealth, state, and territory responses aligning incentive programs, qualification recognition, and service standards across health, education, local government, agriculture, biosecurity, and infrastructure sectors. Aboriginal community-controlled organizations should be central partners in workforce development strategies as major employers and holders of cultural knowledge essential to effective service delivery. Retention strategies must extend beyond initial attraction through mentorship programs, peer support networks, clinical supervision, realistic workload management, and recognition that remote practice requires specialized skills deserving appropriate recognition and sustained resourcing.

9. Empowering and Upskilling First Nations People

First Nations leadership is essential for ensuring that emerging industries and health systems are culturally safe, equitable, and sustainable. Empowerment must extend beyond employment to include meaningful participation in governance, decision-making, economic ownership, and control over service design and delivery. Training and development initiatives should be co-designed with local Traditional Owner groups, Aboriginal Community Controlled Organisations, and Indigenous businesses to ensure they reflect community priorities, cultural protocols, language needs, and existing knowledge systems. This approach strengthens self-determination and ensures that

economic and health service development aligns with cultural obligations and community aspirations. For remote health specifically, Aboriginal community control of primary healthcare has consistently demonstrated superior outcomes yet remains chronically underfunded relative to mainstream services. Empowerment in health contexts means supporting Aboriginal Community Controlled Health Organisations to employ, train, and retain local workforce; to integrate traditional healing practices with Western medicine; and to address the social, cultural, and environmental determinants of health through holistic, community-defined approaches.

Cultural safety standards, including Indigenous data sovereignty principles, must be embedded across all industry sectors to protect cultural knowledge and ensure that data derived from community contexts, whether health data, environmental monitoring, or biosecurity surveillance, benefits those communities directly and remains under their governance.

Current funding models severely constrain this potential. A substantial proportion of funding allocated to remote Indigenous services is consumed by logistics, administration, and coordination costs long before services reach communities. The tyranny of distance means that delivering equivalent services in remote contexts costs significantly more due to travel, accommodation, freight, communication infrastructure, and coordination across vast geographies and multiple jurisdictions. Staff recruitment, retention, supervision, and professional development all carry additional cost burdens in remote settings.

Funding frameworks must acknowledge these realities through longer-term, flexible funding arrangements that reflect actual delivery costs rather than imposing metropolitan cost structures on remote contexts. Short-term project-based funding creates instability, prevents strategic workforce development, undermines community trust, and wastes resources on repeated tendering and reporting cycles rather than service delivery. Multi-year funding commitments are essential to enable remote communities to employ stable workforces, invest in training pathways, develop local leadership, build infrastructure, and establish the trusted relationships upon which effective health and community services depend.

Funding must also recognize that remote service delivery inherently involves higher administrative and logistical costs this is not inefficiency but geographic reality. Loading factors that account for remoteness, community size, and jurisdictional complexity should be transparently applied, with funding adequate to both deliver frontline services and maintain the backbone systems that enable those services to function. Commonwealth, state, and territory governments must move beyond competitive short-term grants toward partnership-based funding models that support self-determination, recognize true costs, and enable Aboriginal communities and

organisations to build the sustained capacity required for genuine empowerment and long-term health equity.

10. Barge Landings and Marine Access for Remote Communities

Reliable marine access is indispensable for remote communities, influencing food security, healthcare delivery, construction timelines, fuel supply, and emergency response. Many barge landings across Northern Australia are outdated, cyclone-vulnerable, or unusable during certain tides or weather conditions, resulting in inconsistent freight schedules and prolonged community shortages. Government should establish a national Remote Marine Access Upgrade Program that prioritises safety, climate resilience, and reliability. Minimum service standards should be implemented for freight operators, ensuring timely delivery of essential goods, including medical supplies and perishable food. Emergency freight including medications, pathology samples, and life-saving equipment should receive priority during weather disruptions or supply chain delays. Investing in marine infrastructure is a direct investment in community health and wellbeing, reducing isolation and enabling the functioning of health and essential services.

11. Research and Development

Research in remote health must move beyond externally driven studies that extract data without delivering tangible community benefit, and instead prioritise community-led, culturally grounded methodologies that position remote communities as knowledge holders and research partners. Establishing remote-based health research hubs will enable place-based innovation, support local employment in research roles, build local research capacity, and create evidence tailored to regional health realities rather than imposing urban healthcare frameworks. Priority research areas should include integrated primary healthcare models addressing the interconnected environmental, biosecurity, and human health challenges remote communities face, telehealth delivery models suited to limited connectivity, chronic disease management approaches incorporating local food systems and cultural practices, mental health and suicide prevention strategies grounded in community strengths, workforce models supporting health professional recruitment and retention, and emergency response systems functioning across vast distances and jurisdictional boundaries. These hubs should be embedded within or closely partnered with community-controlled health organisations and local health services, ensuring research questions emerge from community-identified health priorities and processes respect local contexts and cultural protocols where relevant. Research governance structures must embed data sovereignty principles and community-controlled ethical oversight to protect local knowledge, ensure communities retain ownership of health data, and guarantee research benefits flow directly back through accessible findings, capacity building, and practical improvements in health service delivery and outcomes.

Investment in health research and development should focus on practical solutions addressing the unique challenges of distance, workforce constraints, infrastructure limitations, and the complexity of delivering equitable healthcare in remote settings. This includes evaluating integrated models that link primary care with biosecurity surveillance, environmental health monitoring, and chronic disease management; testing telehealth technologies and clinical decision-support tools that function effectively with limited bandwidth; examining workforce accommodation, supervision, and professional development models that improve retention; assessing the health impacts of housing quality, water security, and food access; and identifying effective approaches to cross-jurisdictional coordination between Commonwealth, state, and territory health systems. Research must examine health funding models themselves, generating evidence on the true cost of remote health service delivery, the impact of short-term versus sustained funding on health outcomes and workforce stability, and the effectiveness of different governance and partnership structures in achieving health equity. Current research funding favours metropolitan institutions, creating barriers for remote-based and community-led health research. Funding bodies should establish dedicated streams for community-controlled health research, provide capacity-building support for emerging remote research capacity, value diverse evidence forms including local knowledge and lived experience of health service delivery, and require all remote health research to demonstrate genuine community partnership and practical benefit to health outcomes as funding conditions. Supporting community-led health research ensures that emerging health innovations, service models, and policy directions align with local needs, incorporate both Indigenous and non-Indigenous community knowledge, and enhance the sustainability and effectiveness of remote health systems.

Conclusion

Emerging industries across Northern Australia present a critical juncture for remote communities. Without deliberate, equity-focused policy interventions, economic development will deepen existing disparities in health outcomes, service access, and community wellbeing. The evidence presented throughout this submission demonstrates that health, infrastructure, workforce, and economic development are inseparable in remote contexts. Investment in renewable energy, critical minerals, export industries, defence, and decommissioning must be accompanied by parallel investment in health services, workforce accommodation, climate-resilient infrastructure, reliable marine access, and community-controlled governance.

Central to achieving equitable outcomes is the recognition that remote service delivery costs significantly more than metropolitan equivalents due to distance, logistics, cross-jurisdictional complexity, and workforce constraints. Current funding models that impose metropolitan cost structures, rely on short-term project cycles, and separate health from other essential services systematically undermine remote communities'

capacity to thrive. Multi-year, flexible funding frameworks that reflect true delivery costs, support community-led governance, and enable integrated service models are essential.

First Nations leadership must be embedded throughout policy, planning, and implementation processes, with Aboriginal Community Controlled Organisations positioned as central partners, while simultaneously all remote communities, Indigenous and non-Indigenous, require workforce pathways, housing security, reliable infrastructure, and access to health services that enable people to live, work, and raise families in remote Australia.

Remote Australians Matter urges the Committee to adopt a health equity lens across all recommendations related to emerging industries, mandating health impact assessments for major projects, requiring co-investment in health infrastructure and workforce as conditions of project approval, prioritizing community-controlled research and local employment pathways, upgrading marine and road infrastructure as critical health assets, and establishing long-term funding partnerships that recognize the true cost and complexity of remote service delivery.

Northern Australia's economic future depends on healthy, connected, empowered communities, and achieving this requires governments, industry, and communities to work in genuine partnership with policy frameworks that place remote wellbeing at the centre of economic development planning.

References

Boretti, A., 2024. Investigating the correlation between extreme temperature events and the increasing frequency of power outages in the Northern Territory of Australia. *International Journal of Electrical Power & Energy Systems*, *155*, p.109608.

Kashem, M.A., Rahman, M.M. and Khanam, R., 2024. Impact of climate change on the australian agricultural export. *Environmental Processes*, *11*(2), p.20.

Quilty, S., Jupurrurla, N.F., Lal, A., Matthews, V., Gasparrini, A., Hope, P., Brearley, M. and Ebi, K.L., 2023. The relative value of sociocultural and infrastructural adaptations to heat in a very hot climate in northern Australia: a case time series of heat-associated mortality. *The Lancet Planetary Health*, *7*(8), pp.e684-e693.

Contact:

E: admin@remoteaustraliansmatter.org

W: www.remoteaustraliansmatter.org