


Patient and carer experiences of hospital-based hybrid virtual medical care: a qualitative study

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The known: Virtual medical care is widely accepted by those who receive it, but most evidence on virtual medical care comes from non-acute outpatient settings.

The new: Patients who had received medical care from the Virtual Rural Generalist Service in a rural or remote hospital, and their carers, felt that the care was acceptable and that the service provided good quality medical care.

The implications: In the context of current workforce shortages, virtual care has an important role to play in providing continuous medical coverage to rural and remote hospitals. Patients and carers accept that it increases their access to a doctor and can provide equivalent medical care.

The Virtual Rural Generalist Service (VRGS) is a hybrid virtual medical model that provides medical support to 31 multipurpose services and small rural hospitals in the Western NSW Local Health District when local doctors are unavailable or need relief.^{1,2} Most VRGS care is delivered via video consultation to people who present to an emergency department (ED) and to admitted patients, with on-site nurses providing in-person care. Most of the medical support that the VRGS provides is for lower acuity ED presentations (Australasian Triage Scale categories 3 to 5).² VRGS doctors also work in-person shifts in the Western NSW Local Health District to cover workforce gaps.

Since the coronavirus disease 2019 (COVID-19) pandemic began, telehealth services have proliferated, as have evaluations of whether they deliver outcomes and experiences that matter to patients (value-based health care³). Despite some perceptions that telehealth will have challenges for specific populations, such as older patients and children,^{4,5} there is broad evidence that, on the whole, patients accept and respond well to comprehensive, supportive care that is delivered virtually.^{6,7} Virtual models can actually increase patient and carer satisfaction.⁸ For patients in rural areas, telehealth also has the perceived benefits of convenience, increased access to care, and reduced cost.^{9,10}

Most of the evidence regarding the acceptability of telehealth by consumers, including patients of virtual hospitals, relates to non-acute outpatient telehealth services.¹¹ In this study, we sought to understand consumer and carer perceptions of virtual care in rural and remote hospital settings. Our key questions were:

- Can hospital-based virtual care deliver the outcomes and experiences that matter to patients and carers?
- To what extent do patients and carers in rural and remote Australia see hospital-based virtual care as acceptable, effective and safe?
- Is hospital-based virtual care acceptable for specific patient groups, such as older patients and children?

Abstract

Objectives: To understand patients' and carers' experiences of virtual medical care delivered into rural and remote hospitals.

Study design: Qualitative study using semi-structured interviews.

Setting, participants: Interviews were conducted between 7 June 2022 and 21 February 2023. Participants were people who had received a virtual medical service from the Virtual Rural Generalist Service (VRGS), and their carers, in rural and remote hospitals within the Western NSW Local Health District.

Main outcome measures: Acceptability of, access to, quality of and appropriateness of care provided by the VRGS.

Results: We interviewed 43 patients and carers about their experiences of VRGS services received in an emergency department or inpatient setting. About half of our participants thought that virtual medical care (supported by in-person nursing staff) was highly acceptable and equivalent to in-person care. For the remaining participants, virtual care was seen as being an acceptable alternative if in-person care was not available. Patients reported that the model met their immediate needs, even if the virtual delivery mode was not their preference. VRGS doctors were generally seen as skilled and personable, and acceptability of virtual care increased with more experience of it. A key perceived benefit of virtual care was increased access to medical care without the need to travel long distances. Hospital-based virtual care was not considered less appropriate for older adults or children.

Conclusions: Virtual care in a rural hospital setting, such as that delivered by the VRGS, is broadly acceptable to patients and carers. While most would prefer to have a doctor physically present, patients and carers are accepting of the need for virtual care to supplement in-person care in rural and remote areas. Patients and carers who experience hospital-based virtual care perceive that it can provide good quality medical care and meet many of their needs.

Methods

Study design and setting

We conducted a qualitative study using semi-structured interviews within rural and remote hospitals in the Western NSW Local Health District. Eligible hospital sites were those serviced by the VRGS during the study period (June 2022 to February 2023). Sites were purposively sampled from across the geographic area of the Western NSW Local Health District. Convenience sampling was then used to determine which sites could be visited by the interviewer at the time of VRGS coverage. Sites with very low patient numbers were excluded due to low recruitment potential.

Participants

Eligible primary interviewees were adults (18 years or older) who had interacted virtually with the VRGS as a patient or carer, either during a presentation to an ED or during a hospital admission. Secondary interviewees were those who were present

when the primary interviewee was being interviewed and who chose to participate in the interview. This included patients younger than 18 years who were supported by their parent to offer their opinion.

Data collection

All semi-structured interviews were conducted by one of us (AT) during site visits, using an interview guide based on our key questions ([Supporting Information](#)). AT is a qualitative researcher and clinical psychologist with 20 years' experience engaging people in clinical settings. AT was introduced to potential participants as a researcher from the University of Sydney's School of Rural Health.

During each site visit, a senior clinical staff member identified eligible patients suitable for approach. These patients, and any carers present, were told about the project and invited to participate in an interview about their experience with the VRGS. If the patient could not be interviewed (due to being younger than 18 years or having a communication difficulty as determined by clinical staff) and a carer was present, the carer was invited to participate. The interview could take place at the time of their hospital visit or subsequently by telephone. Participation was voluntary. Participants were informed verbally and in writing that their decision about participation would not affect their health care.

For each primary interviewee, a multiple verbal consent process was employed, with initial consent at first contact after invitation, second consent before commencing the interview, and third consent audio-recorded at the beginning of the interview. For secondary interviewees, consent was implicit in their choice to contribute to the interview. This included

patients younger than 18 years if they were present when their carer was being interviewed.

A target of 30 patient and/or carer interviews was set, commensurate with project resources. Recruitment ceased after the site visit during which this target was exceeded. Interviews were digitally audio-recorded, transcribed, and de-identified for analysis. All data were stored securely in non-identifiable form.

Data analysis

Interview transcripts were coded manually by AT and analysed using an inductive thematic approach. We used researcher triangulation to corroborate the analysis: two of us who are experienced qualitative researchers (TS and ES) checked two randomly selected transcripts against the themes identified by AT.

Ethics approval and reporting

The study received ethics approval from the Greater Western Human Research Ethics Committee (project number 2022/ETH00718). We report this study in accordance with the Standards for Reporting Qualitative Research (SRQR).¹²

Results

Participant characteristics

A total of 32 interviews were conducted between 7 June 2022 and 21 February 2023; 26 were conducted in person and six were conducted by telephone ([Box 1](#)). Seven interviews involved input from both the patient and one carer and two interviews involved the patient and two carers, thus there were 43 participants in

1 Characteristics of study participants and interviews regarding the Virtual Rural Generalist Service (VRGS) conducted across Western NSW Local Health District

	Patients and/or carers	Sites represented	In-person interviews	Phone interviews
Patient and/or carer interviews	32	11	26	6
Total participants	43	11	36	7
Primary interviewee				
Patient	25	9	20	5
Carer	7	4	6	1
Patient status at time of most recent VRGS consultation				
Emergency department presentation	21	10	15	6
Admitted patient	11	5	11	0
Western NSW Local Health District sector				
Northern	8	4	7	1
Central	16	2	11	5
Southern	8	5	8	0
Patient age				
0–17 years	5	3	4	1
18–64 years	12	9	9	3
≥ 65 years	15	6	13	2

total, of whom 32 were primary interviewees and 11 were secondary interviewees. Of the primary interviewees, 25 were patients during the recent episode of care and seven were carers. In 21 of the interviews, the most recent episode of VRGS care for the identified patient was in the ED, and in the other 11 interviews the most recent episode of VRGS care occurred during a hospital admission. However, participants were asked to reflect on all their experiences with the VRGS, not just the most recent episode of care. The median duration of interviews was 16 minutes (range, 4–47 minutes).

The 32 primary interviewees were considered a representative sample of VRGS patients and their carers. Participants were recruited from 11 of a possible 31 sites and all three Western NSW Local Health District geographic sectors. The median patient age was 63 years (mean, 56 years; range, 1–94 years), and this age distribution was commensurate with the large sample of VRGS patients from the quantitative component of the VRGS evaluation.¹³ Fifteen patients were older adults (65 years or older) and five parents were interviewed about care provided by the VRGS for their child aged younger than 18 years. Data about participants' Aboriginality were not collected as this was examined as a separate component of the VRGS evaluation.

Main themes

Acceptability of care

About half of our participants found the VRGS highly acceptable and equivalent to seeing a doctor in person.

I thought it was excellent. A wonderful innovation.
(P03, admitted patient)

It was just like talking to the doctor, like if he was here.
(P13, ED patient)

For the remaining participants, the VRGS was acceptable only if in-person care was not available.

If it's the only way to see a doctor you just have to deal with it.
(P11, ED patient)

However, across both groups, there was widespread acceptance that telehealth is needed to support medical services in rural and remote sites. Being able to access medical care and the quality of that care were more important for most participants than whether the care was delivered virtually or in person.

We live in the real world — doctors don't want to live in [my remote town]. I'm just glad to have a doctor. (P14, ED patient)

Several factors influenced acceptability of VRGS care. One of these was experience of virtual care — the more experience people had of virtual care delivered by the VRGS, the more acceptable they found it.

I would prefer to see doctor in the flesh, but I'm getting used to doctors on the screen. The first time I didn't like it at all. Just in my imagination, if they can't see you, they can't treat you. My opinion has changed 100% because the virtual doctors have fixed problems for me, sometimes better than a real doctor did. (P06, admitted patient)

Some participants commented that the virtual mode of consultation was acceptable for lower acuity issues but that they would prefer a doctor to be present in the case of a life-threatening medical emergency. Admitted patients expressed a preference for seeing a doctor who they had seen before, whether virtually or in person, for continuity of care and rapport. This was only sometimes possible with the VRGS.

I wish I would see the one doctor a few times on [screen], because then you feel comfortable. (P06, admitted patient)

A factor that limited the acceptability of care to patients was the unpredictable wait time for a VRGS consultation, especially in the ED. The VRGS wait list was not visible to local staff, so patients could not be given an estimated wait time as they might when a doctor is on site and the queue of patients is local. Participants were not unhappy with how long they had to wait, but they were dissatisfied with not knowing how long it was going to be.

If they could say 'There's four patients in front of you' or something like that, that would make a big difference. (Carer of P24, ED patient)

Access to care

The VRGS increased the accessibility of medical care and decreased the need to travel long distances to see a doctor.

I couldn't get in to [a local GP] until Thursday if I'd waited, and I'm in excruciating pain. So if I didn't have a virtual doctor, I would've had to have driven to [the nearest major town]. So yeah ... it's excellent as far as that goes for me today. (P23, ED patient)

Better than sitting in the car for 5 hours going to [the nearest major town]. (P12, admitted patient)

Participants valued being able to access a doctor within their local community and they unanimously considered a virtual doctor better than no doctor. Even in towns with a resident doctor, patients and carers saw that the VRGS supported sustainable access to medical care by providing fatigue relief to the local doctor.

It was good for me because I didn't want to drag our doctors out of bed, late as it was. The screen doctor was already on call. (P13, ED patient)

Quality of care

Patients and carers felt that the VRGS met their needs and provided high quality medical care in most cases. VRGS doctors were perceived to be skilled, thorough, and personable.

It was good. He was thorough, knew what he was talking about. Yeah, a lot better than the treatment I got in [the local base hospital] yesterday. (P02, ED patient)

Friendly, interested and concise with what he said. (P21, ED patient)

Even patients who did not like the virtual mode of consultation felt that they had received the care they needed.

I'm not happy with it. I want someone who can check me over in person, can touch me. But if you've got to see a doctor this way that's how it is. I still feel like I've been able to get the care I needed through VRGS. (P11, ED patient)

Several factors relating to how VRGS care was delivered influenced attitudes towards quality of care. Patients and carers could hear and see the VRGS doctor during the virtual consultation and felt the doctor could hear and see them. There was, however, a concern about privacy as volume settings on the telehealth cart were typically high and consultations could easily be overheard by others in the facility. Although some participants were concerned that the virtual examination was inadequate, for example to view a wound or rash, most considered the physical examination effective with the VRGS doctor working with on-site nursing staff and using the available technology.

They could examine my finger with a little machine like a scanner, so it didn't feel like inferior care. (P05, ED patient)

Also, the VRGS was perceived to be integrated with local systems in that the VRGS doctor had access to medical records and worked well with local staff.

They worked together. They knew what each other were talking about, didn't they? No question about that. And responsive both ways. (C05, carer of ED patient)

In addition, patients and carers recognised that VRGS supports quality of care by providing relief to local doctors.

If they work 24/7, they're going to get things wrong, aren't they?" (C01, carer of inpatient)

The presence of a nurse during VRGS consultations was important to patients; they felt that this contributed information, assisted with the examination, helped in terms of hearing what the doctor said (enabling follow-through with the plan and further explanation to the patient if necessary), and provided the human touch.

That was good because the nurse was here and could hear what he communicated too ... It's important to have that team there so everybody is on the same page. (P01, ED patient)

Appropriateness of care for specific patient groups

Appropriateness for children

Five parents were interviewed as carers of their children (these patients were aged 1–9 years). Four indicated that the VRGS was appropriate for their children and said that they were satisfied with the quality of care provided. One parent expressed that they had been dissatisfied with previous VRGS consultations for their children ("I left feeling like I wanted a second opinion ... something could have been missed"; C04, carer of ED patient), but were satisfied with the care and outcome from the VRGS interaction on the day of the interview. Three children

volunteered that they were happy with the VRGS and said it was much the same as seeing a doctor in person.

Appropriateness for older adults

Some participants aged 65 and older expressed initial scepticism about virtual care. They expected to have difficulties hearing or communicating with the doctor virtually. However, most were satisfied with the care they received when they reflected on their specific VRGS consultation.

I thought [the VRGS doctor] spoke very well ... I could quite easily hear him and I understood everything. (P22, aged 94, ED patient with self-identified hearing impairment)

Among older patients and their carers, the issue of a doctor (working virtually or in person) having a foreign language accent was more frequently raised as a barrier to communication than the virtual mode of consultation.

Benefits and challenges of the VRGS

Patients and carers expressed several clear benefits of the service, but also identified a range of challenges (Box 2). A benefit that was frequently noted was increased availability of medical care without the need to travel out of the local community. A challenge was the concern raised by some participants about whether a virtual examination was adequate.

Discussion

In our study, patients and carers felt that hospital-based virtual medical care met their needs and provided good quality care in most cases, sometimes better than that provided by an in-person doctor. Their perception of virtual care became more positive with more experience of it. The VRGS was perceived to increase access to medical care and reduce the need to travel. The quality of care provided and being able to access medical care without the need to travel were more important for most patients and carers than the mode of care. Virtual care is not only acceptable to outpatients who may choose it over in-person options, but it

2 Benefits and challenges of the Virtual Rural Generalist Service (VRGS) as perceived by patients and carers

Benefits

- Increases availability of medical care
- Reduces need to travel for medical care
- Provides good quality, thorough consultations
- Integrates with local team (has access to electronic health records, works in collaboration with nurses)
- Provides a second opinion for local medical and nursing staff
- Offers after-hours coverage to support local clinicians
- Streamlines access to specialists
- Provides timely care with shorter wait times (for some patients)
- Offers visual connection and direct patient-doctor communication (preferable to previous phone-based model)

Challenges

- Concern about the limitations of a virtual examination
- Desire to maintain the "human touch" in medical care
- Unpredictable wait times for VRGS consultations
- Continuity of clinician and accommodating patients' preferences for "a doctor who knows me"
- Concern about privacy when high volume settings are used on the telehealth cart during virtual consultations
- Reticence of some patients to engage virtually

is also acceptable to patients presenting to a hospital when this may be the only available option for medical care.

Other researchers have suggested that patients can perceive virtual consultations as distant and lacking in personal touch.¹⁴ The experiences of patients and carers with the VRGS show it is possible to deliver virtual care personally, although the interpersonal skills of the clinician who delivers care virtually are critical.¹⁵ The VRGS model also relies on in-person nursing care, which is valued by patients and carers. Many said that having a doctor present on site would be preferable in acute or life-threatening situations, but they accepted that virtual services are needed to support medical care in rural and remote areas. The preferences of both patients and clinicians for in-person care for acute or life-threatening presentations have previously been reported¹⁶ and need to be considered when developing models of virtual hospital care. The VRGS model of care² incorporates this preference by focusing virtual services on lower acuity presentations. If available, a local doctor is called in for triage categories 1 and 2, but in cases when there is no doctor on site, either VRGS or vCare (a specialist emergency service)¹⁷ is used to support patient care. As with in-person care, when a patient's condition cannot be managed locally, the patient is transferred.

Contrary to public perception, there was little evidence that virtual care was less acceptable for older patients or children. While older patients and their carers expressed more initial reticence about virtual care, their actual experiences did not differ from those of other patients. In hospital, digital equipment is supplied and operated by staff, thus hospital-based virtual care avoids the two primary challenges of outpatient virtual care delivered to older people at home: limited access to technology and low digital literacy.^{18,19} This also highlights the value of having a nurse present to facilitate the virtual interaction, interpret information to and from the patient, and facilitate continuity of care, especially for older patients.^{20,21} The reliance of the virtual model of care on the skill and availability of local nursing staff was a theme also expressed by clinicians participating in the VRGS evaluation.²¹

Our findings suggest that the patient and carer experiences of hospital-based virtual care could be improved in three ways. Firstly, the virtual waitlist could be made visible to local staff so that predicted wait times could be communicated to patients. Secondly, supporting nursing staff could be present for all VRGS consultations; in Western NSW Local Health District, this may require a review of staff workloads in relation to virtual care.²¹ Thirdly, doctors providing virtual care could be rostered for a "run" of shifts to accommodate patients' preferences for continuity of care provider, and this has been implemented by the VRGS since the evaluation.

Our study had some limitations. Firstly, we only included people who received virtual care from the VRGS, so we did not capture the perspectives of people who leave the hospital or go elsewhere to avoid receiving care via a virtual service. Further study of this possible phenomenon might identify pathways that could increase access to care. Secondly, we only interviewed people about their experience of the virtual component of the VRGS model of care, not the in-person component. Anecdotal evidence suggests that rural communities would be more accepting of the VRGS if they knew the service also involved in-person support of rural sites. Thirdly, in the interviews with admitted patients, we cannot be certain that the VRGS was accurately identified from among other hospital-based virtual services, such as allied health and clinical pharmacy services. Although attempts were made in each interview to isolate experience of the VRGS service, interactions with other virtual services may have contaminated participants' recall. However, the feedback obtained still pertains to hospital-based virtual care, even if not specific to the VRGS. Finally, given the high proportion of Aboriginal people living in the Western NSW Local Health District,²² it is important to understand the cultural acceptability and appropriateness of hospital-based virtual care for this population. While Aboriginal patients were included in the general patient sample of this study, a separate component of the VRGS evaluation specifically sought to understand the experiences of Aboriginal patients and carers and will be reported elsewhere.

In conclusion, virtual medical care that is delivered in a rural hospital setting, like that provided by the VRGS, is broadly acceptable to patients and carers. While most patients and carers would prefer to have a doctor physically present, they are accepting of the need for virtual care to supplement in-person care in rural areas. Patients and carers who experience hospital-based virtual care perceive that it can provide good quality medical care and, with more experience, they view it more favourably.

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Competing interests: This study included VRGS operations and governance. Shannon Nott was not involved in data collection or analysis for this study.

Data sharing: The data for this study will not be shared, as we do not have permission from the participants or ethics approval to do so. ■

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Supporting Information

Additional Supporting Information is included with the online version of this article.