National Rural Health Alliance

... healthy and sustainable rural, regional and remote communities

28 January 2022

The Hon Josh Frydenberg MP
Treasurer
Parliament House
CANBERRA ACT 2600

Dear Treasurer

National Rural Health Alliance—2022–23 Pre-Budget Submission

The National Rural Health Alliance (the Alliance) is pleased to provide a submission for consideration in the 2022–23 Federal Budget. The Alliance is the peak body for rural and remote health in Australia. We represent 43 member bodies (see Appendix 1), and our vision is for healthy and sustainable rural, regional and remote (rural) communities.

Rural, regional and remote Australia is not only home to more than seven million Australians, it is also the source of the majority of the nation's economic contribution, with around two thirds of Australia's export earnings coming from regional industries such as agriculture, tourism, retail, services and manufacturing.[1]

The Australians who live in rural, regional and remote Australia enjoy the benefits of living in smaller communities with a strong sense of community spirit, less congestion and, depending on location, more affordable housing. The Household, Income and Labour Dynamics in Australia (HILDA) survey found that Australians living in towns with fewer than 1,000 people generally experienced higher levels of life satisfaction than those in urban areas and major cities.[2]

However, people living in rural Australia have poorer access to health services than other Australians, with the number of health professionals (including nurses and midwives, allied health practitioners, general practitioners, medical specialists and other health providers) decreasing as geographic isolation increases. Per capita, rural areas have up to 50 per cent fewer health providers than major cities. As a result, Australians living in rural, regional and remote areas have, on average, shorter lives, higher levels of disease and injury, and poorer access to and use of health services, compared with people living in metropolitan areas.[3]

Despite there being a high level of awareness of the often significant disparities in health outcomes between urban and rural Australia, health outcomes for rural Australians have not been consistently improving over time, but rather are stagnating or, in some instances, declining.

The National Rural Health Alliance believes that all Australians, wherever they live, should have access to comprehensive, high-quality, accessible and appropriate health services, and the

opportunity for equitable health outcomes. The Alliance does not consider that poor health or premature death should be an accepted outcome of living in rural, regional and remote Australia.

The Alliance has two 2022-23 Pre-Budget proposals which support strategies and initiatives to expand access to healthcare and improve the health outcomes for rural Australian communities:

- Rural Area Community Controlled Health Organisations (RACCHOs)
- a new National Rural Health Strategy and Implementation Plan.

Further information on these proposals and detailed costings are provided below.

Yours sincerely

Dr Gabrielle O'Kane
Chief Executive Officer

NATIONAL RURAL HEALTH ALLIANCE PRIORITIES FOR BUDGET 2022-23

Proposal 1 – Rural Area Community Controlled Health Organisations (RACCHOs)

The Case for RACCHOs

There are a range of government programs and initiatives aimed at addressing the maldistribution of the health workforce across Australia. The Stronger Rural Health Strategy is currently being evaluated and the Alliance looks forward to the outcomes of this evaluation. It is apparent however, that these initiatives are inconsistently targeted (focussed primarily on general practitioners and nurses and extremely limited recognition of the role of allied health), fragmented, and have not had a significant impact on the workforce challenges and poor health outcomes in rural Australia over many decades.

There are a range of factors driving the poor health outcomes of rural communities:

- Difficulty attracting and retaining health professionals in rural areas
- Lack of access to services due to distance, lack of transport, low income, poor health literacy and attitudinal barriers
- Higher rates of overweight and obesity, smoking, risky alcohol consumption and poor diet, and reduced levels of physical activity
- Social determinants of health including: lower socio-economic status; lower educational outcomes; higher levels of disability and chronic disease; and an older population.

The shortage of health professionals in rural areas means that people cannot access health services or claim Medicare benefits at the same rate as people in major cities. This results in an underspend on health services in rural Australia. The National Rural Health Alliance estimates that this rural health expenditure deficit is $4 billion every year.

A different approach is required to address the maldistribution of the health workforce, rural health expenditure deficit and resultant poorer health outcomes experienced by rural communities. A new model of rural health care is needed to overcome the barriers to attracting and retaining a rural health workforce which are:

- Professional – perceptions of limited networking opportunities, clinical experiences and supervision; professional isolation and lack of support from peers; and work-life balance issues
- Financial – financial viability of practices, the need to work across multiple settings, multiple sources of both government and private funding, administrative burden and business acumen requirements.
- Social – lack of family and friendship networks, social isolation, cultural and recreational limitations, and partner concerns including career and children's educational opportunities.

Models of care that work for metropolitan areas do not work in rural Australia. Developing a model of care for rural Australia requires all levels of government - Federal, state and local - to commit to a new, rural specific model of care rather than short-term, ad hoc and piecemeal approaches. Rural Area Community Controlled Health Organisations (RACCHOs) are a new model of care specifically designed to address the challenges of delivering primary healthcare in rural settings.

What are RACCHOs?

RACCHOs are community-based organisations that offer a comprehensive and affordable range of primary health care services. They are not-for-profit organisations funded by government, designed and established by local communities to meet their primary healthcare needs in flexible and responsive ways.

RACCHOs will employ a range of primary healthcare providers including – general practitioners, nurses and midwives, dentists, allied health professionals (such as physiotherapists, podiatrists and psychologists), paramedics and pharmacists. The mix of practitioners employed will depend on the needs and circumstances of individual communities, with consideration of existing healthcare providers. Health practitioners will be supported by administrative staff (including practice managers), to ensure that clinical staff can focus on clinical practice. The RACCHO paradigm supports medical and allied health rural generalist models and pathways, including opportunities for structured supervision and support.

RACCHOs would only be established at the request of communities.

RACCHOs overcome the barriers to attracting and retaining a rural health workforce outlined above by providing secure, ongoing employment with a single or primary employer, attractive conditions - including leave provisions (holiday, personal, parental and long service leave), and certainty of employment and income.

RACCHOs do not rely on health practitioners committing to establish their own practice, with the attendant responsibilities of operating a financially viable, standalone business (managing staff, administration and compliance), in what are generally thin markets. This employment model makes it easier for health practitioners to take up a rural position, knowing they can focus on their professional practice without the stress of establishing, purchasing or running a practice. They can also easily change their minds if their circumstances change.

RACCHOs support work-life balance, minimising social and professional isolation through peer support from a multidisciplinary team and overcoming related negative perceptions of rural practice. Employment conditions recognise and support continuous professional development and specific accreditation requirements, and can provide the opportunity for training and research collaborations. RACCHOs provide ready connection to the local community, with support and advice available regarding accommodation, employment opportunities for partners, education options for children, and social and recreational activities.

The health workforce shortages in rural Australia often mean that older people or people with disabilities cannot access the support and interventions they need and are eligible for, including medical, nursing, allied health, dental and pharmacy, across a range of settings: residential aged care facilities (RACF); National Disability Insurance Scheme (NDIS) benefits; and support through the Department of Veteran's Affairs (DVA). RACCHOs have the potential to provide in-reach services for RACF, NDIS and DVA recipients, as well as for rural people with chronic disease, including those with chronic disease management or other similar care plans.

RACCHOs are not intended to compete with Aboriginal Community Controlled Health Organisations (ACCHOs). Where appropriate, RACCHOs will work collaboratively to ensure that all primary health care services, serving the full spectrum of community members, can thrive. RACCHOs acknowledge the holistic, comprehensive and culturally appropriate health services provided by these distinct organisations.

RACCHOs are also not intended to compete with existing health professionals in a community or threaten the viability of existing services. RACCHOs are aimed at supporting communities where there is a lack of primary health care and would be implemented to ensure existing services are enhanced. Hence, RACCHOS will be co-designed with local health consumers, providers and organisations to address local needs, offering a range of services that are better integrated across all sectors.

RACCHOs comprehensively address the ambitions outlined in the 2020-2025 Addendum to the National Health Reform Agreement, including joint planning and funding, identifying rural and remote areas where there is limited access to healthcare, re-orienting health systems around individuals and communities and addressing workforce issues.

Funding and Budget

The RACCHOs model draws on the successful ACCHO model. RACCHOs will require government funding from dedicated, additional and ongoing mechanisms to ensure their sustainability in thin rural markets, serving on average older, sicker and more disadvantaged communities.

Rural hospitals receive block funding in acknowledgement that activity-based funding is not sufficient to support sustainable services in rural areas. The funding of primary healthcare should be no different. The issues with lack of sustainability in primary care are the same as in secondary and tertiary care.

The current funding streams for rural practice are fragmented, complex and narrowly focussed, and act as a disincentive to rural practice and the establishment of multi-disciplinary teams. These teams should include an appropriate mix of medical, nursing and midwifery, allied and other health practitioners.

Dedicated, ongoing, RACCHO funding will recognise the increased costs of delivering health services in rural and remote areas, the lack of economies of scale inherent in thin markets, and the on average older, lower socio-economic status and poorer health of rural communities.

A detailed costing for the introduction of the RACCHO model over the forward estimates is provided below. It should be noted that the costing does not include possible offsets such as MBS rebates, aged care and NDIS funding, nor the potential reduction in spending in the acute care sector due to improved utilisation of primary care.

A single RACCHO is estimated to cost $2.5 million for one year, or $10.5 million over the forward estimates. Given the significant unmet need in primary health care in rural areas, the Alliance believes that the government should commit to the rollout of a significant number of RACCHOs in order to make a real impact on the lives and wellbeing of rural Australians. The costing therefore includes a figure for the rollout of 30 RACCHOs, estimated at $75 million for one year, or $313.8 million over the forward estimates.

RACCHO Estimated* Costings

1 RACCHO					
	2022-23	2023-24	2024-25	2025-26	Total
	$	$	$	$	$
Salaries and on costs	2,119,600	2,183,188	2,248,684	2,316,144	8,867,616
Administration	160,500	165,315	170,274	175,383	671,472
Rent and Accommodation	86,500	89,095	91,768	94,521	361,884
Insurance, legal and audit - accounting	33,400	34,402	35,434	36,497	139,733
IT operational costs/software	40,000	41,200	42,436	43,709	167,345
Board expenses	10,000	10,300	10,609	10,927	41,836
Contingency fund	50,000	51,500	53,045	54,636	209,181
TOTAL	2,500,000	2,575,000	2,652,250	2,731,818	10,459,068

30 RACCHOs					
	2022-23	2023-24	2024-25	2025-26	Total
	$	$	$	$	$
Salaries and on costs	63,588,000	65,495,640	67,460,509	69,484,324	266,028,474
Administration	4,815,000	4,959,450	5,108,234	5,261,481	20,144,164
Rent and Accommodation	2,595,000	2,672,850	2,753,036	2,835,627	10,856,512
Insurance, legal and audit - accounting	1,002,000	1,032,060	1,063,022	1,094,912	4,191,994
IT operational costs/software	1,200,000	1,236,000	1,273,080	1,311,272	5,020,352
Board expenses	300,000	309,000	318,270	327,818	1,255,088
Contingency fund	1,500,000	1,545,000	1,591,350	1,639,091	6,275,441
TOTAL	75,000,000	77,250,000	79,567,500	81,954,525	313,772,025

* Does not include possible offsets for example MBS and NDIS payments

Proposal 2 - National Rural Health Strategy

The Alliance supports the development of a new National Rural Health Strategy and Implementation Plan. The Strategy should build on previous strategies and frameworks for rural health, include outcomes measures and targets, and a requirement for annual reviews and reporting. A critical element missing from previous strategies has been an implementation plan that includes specific targets and an evaluation schedule at five and ten year intervals. Consideration could also be given to the development of minimum service access standards for rural and remote Australia as part of the Strategy.

We propose that the Australian Government engage with state and territory governments, local government and key rural health stakeholders, including the National Rural Health Alliance, to develop the Strategy and Implementation Plan over the 2022-23 financial year, with completion at the end of 2023. The Australian Government Department of Health would also be responsible for annual reporting against the Strategy and Implementation Plan over the forward estimates and into the future, along with five and ten yearly evaluations beyond the scope of the forward estimates.

A commitment from all levels of government to support a National Rural Health Strategy will be critical to the success of the Strategy and its capacity to drive reform and structural change. Support for the objectives of the strategy and collaboration and action across governments will be key drivers required to achieve the aims of improved accessibility, equity and rural health outcomes. In particular, a commitment from governments to additional funding to support rural access to the full spectrum of health professionals, including medical, nursing, allied health, dental, paramedicine and pharmacy.

It will be important that there is close engagement with the National Rural Health Commissioner, the Aboriginal and Torres Strait Islander health sector, rural health stakeholder bodies and peak bodies, health professionals and professional bodies, educators, funders, researchers and consumers.

The outcomes of the Stronger Rural Health Strategy Evaluation which is currently being conducted by the Department of Health will also provide critical input to the development of a new National Rural Health Strategy.

Full details of the imperative for and key issues to be addressed in the Strategy and Plan are outlined further in this submission. A fully costed budget would be dependent on the timeframe and the agreed scope, frequency, and location of consultations. The National Rural Health Alliance estimates that the cost of development of the Strategy and Implementation Plan would be in the vicinity of $2.5 million.

Policy Background

The first National Rural Health Strategy was released in 1994. There have been various updates and revisions of the Strategy over the ensuing years, with the last being the National Strategic Framework for Rural and Remote Health, endorsed by Health Ministers in November 2011. The Framework was developed through a consultative process that included significant input from the Alliance and other rural and remote health stakeholders.

While the Framework can still be accessed through the Department of Health website, it is not being utilised as a strategic driver of health policy. No reporting has been undertaken against the goals of the Strategy nor has an evaluation of the effectiveness of the Framework in addressing its goals been undertaken. At the time, the Alliance called for a National Rural and Remote Health Plan to be developed to operationalise the goals set out in the Framework, but this key driver for outcomes was not implemented. Therefore, the 2011 Framework has not been actioned in a consistent or comprehensive way. Nor are there any national reports on progress against the Framework, and no action has been taken to update it. The current Framework is also principally focused on the medical workforce and there is a pressing need to invest in and support the nursing, allied health workforce and other non-medical health professions.

There are also currently a range of programs and incentives grouped under the banner of the Stronger Rural Health Strategy. The Strategy focuses on the rural health workforce, which while critical, is only one element of addressing rural health outcomes. Further, this Strategy, while seeking to meet some workforce needs, is not a comprehensive or integrated policy approach, but rather demonstrates gaps and inconsistencies in addressing rural and remote workforce needs. The Stronger Rural Health Strategy is currently being evaluated.

The Case for a National Rural Health Strategy

Health outcomes

As noted in proposal 1, on average, Australians living in rural and remote areas have shorter lives, higher levels of disease and injury, and poorer access to and use of health services compared with people living in metropolitan areas.[3] The Alliance analysed the health data for Australians living in rural, regional and remote Australia twenty years ago and today for evidence of significant improvement in health outcomes over time when developing the case for a new National Rural Health Strategy. The Australian Institute of Health and Welfare (AIHW) produces annual reports on Australia's health. While the data was often not directly comparable, an examination of the AIHW *Australia's Health 2000*[4] and AIHW *Australia's Health 2020*[5] reports showed a consistent pattern in health outcomes for rural and remote Australians.

Rural Australians are consistently overrepresented in data on health risk factors, including having higher levels of alcohol consumption, higher rates of smoking, poorer diet choices, lower levels of physical activity and higher rates of overweight and obesity. Likewise mortality, including from chronic diseases, remains higher in rural communities, increasing with remoteness.

Despite the release of the first National Rural Health Strategy in 1994, there are still troubling and unacceptable health outcomes for rural, regional and remote Australians in 2020:

- Potentially Preventable Hospitalisations (PPH) - hospital admissions that could have been prevented by timely and adequate health care in the community - increase with remoteness and socioeconomic disadvantage, and the gaps may be widening.[6]
- After adjusting for age, the total burden of disease increases with remoteness, with the total burden rate in remote and very remote areas 1.4 times as high as major cities.[3]
- For most disease groups, total burden rates increase with remoteness.[3] While there is some variation by disease, a clear trend of greater burden of disease with remoteness is seen for coronary heart disease, chronic kidney disease, chronic obstructive pulmonary disease, lung cancer, stroke, suicide and self-inflicted injuries and type 2 diabetes.

- People living in rural and remote areas are more likely to die at a younger age than their counterparts in major cities.[3] They have higher mortality rates, higher rates of potentially avoidable deaths, and lower life expectancy than those living in major cities.

The very poor health outcomes of Aboriginal and Torres Strait Islander Australians in remote and very remote Australia contributes to the poor health profile of these communities as a whole.[7] Indigenous Australians have lower life expectancies, higher rates of chronic and preventable illnesses, poorer self-reported health, and a higher likelihood of being hospitalised than non-Indigenous Australians.[8] Any Strategy will need to consider the particular needs of Aboriginal and Torres Strait Islander Australians, including addressing the broader determinants of health such as social, commercial and cultural determinants.

Access to health care services

People living in rural Australia and particularly in remote and very remote areas have poorer access to health services than people in major cities. They may have to wait for long periods of time and travel long distances to access health professionals. Rural and remote Australians often incur additional financial costs associated with travelling to access health services, including the cost of travel and accommodation, as well as loss of income due to time away from work. This is reflected in data on Medicare benefits claims per person which are highest in major cities (6.4 per person), declining to around half that rate in very remote areas (3.6 per person).[5]

Health workforce

Despite a range of initiatives and programs being in place over the last two decades, there are still significant issues with attracting and retaining a health workforce for rural and remote Australia. For nearly all types of health professions there is a marked decline in the rate of clinical full-time equivalent (FTE) practitioners per 100,000 population once outside major cities. This includes health professionals such as dentists, pharmacists and allied health professionals, such as occupational therapists, optometrists, podiatrists and psychologists. As in 2000[4], the FTE rate per 100,000 population for nurses and midwives is higher in remote and very remote areas compared with major cities, inner regional and outer regional areas, reflecting the significant ongoing contribution this workforce makes to health service delivery in remote areas.[5]

The emergence of significant new health challenges in recent years gives added impetus for a new National Rural Health Strategy. The health effects of climate change, in particular the frequency and intensity of bushfires, drought, temperature extremes and other weather events, should be incorporated as a focus of any new health strategy. This is particularly relevant for rural and remote Australians who are disproportionately affected by these events.

Likewise, since the development of previous strategies and frameworks, the impact of the COVID-19 pandemic has exposed the potential vulnerability of rural and remote Australians due to a lack of capacity in the health system to respond to such events. Workforce shortages, the lack of appropriate facilities, and a higher proportion of older and vulnerable people contribute to this vulnerability.

National Rural Health Strategy and Implementation Plan

It is clear from examination of the trend data for rural health outcomes that there needs to be a renewed focus on addressing the gap in health outcomes for rural health. The current strategies and frameworks are not comprehensively fit for purpose. Robust accountability measures will be critical

to the success of a future strategy. These measures should include agreed targets, regular reporting against those targets, an implementation plan and an evaluation.

In an article published online by the Medical Journal of Australia, Professor John Wakerman, Associate Dean of Flinders Northern Territory and Emeritus Professor John Humphreys, from Monash University's School of Rural Health, wrote that the lack of progress in improving rural and remote health outcomes was largely due to a lack of an overarching strategy that draws on available evidence to guide its development, implementation and evaluation. They argue that while we know what works in rural and remote communities, the lack of a national strategic framework has led to a patchwork of responses without any evaluation of their effectiveness.[9]

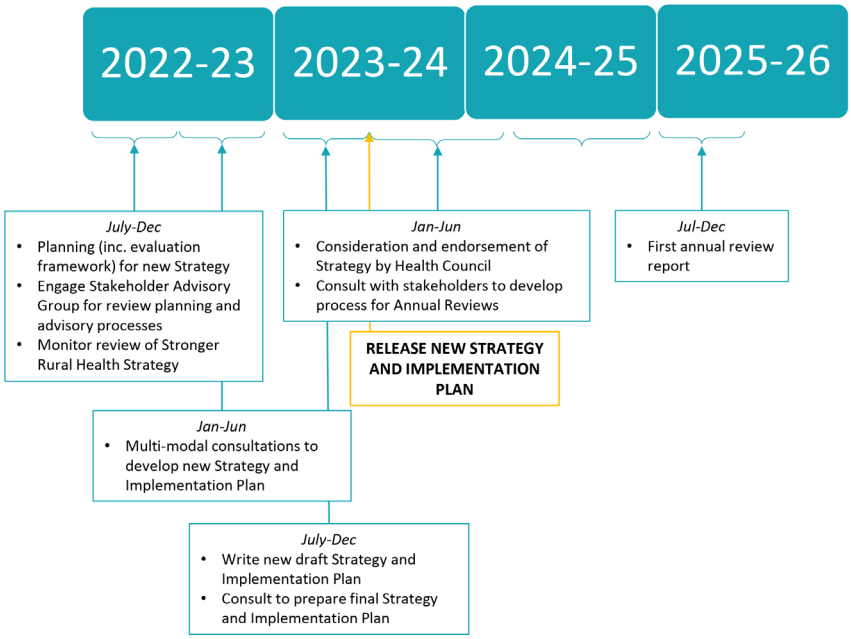
A new National Rural Health Strategy should acknowledge that rural and remote communities are different to metropolitan communities and that each rural or remote community has particular circumstances and needs. Any new Strategy must address the lack of progress in improving the health outcomes for Australians living in rural, regional and remote Australia. It should consider the barriers and incentives for attracting and retaining a rural health workforce, how to incentivise and provide greater investment in preventive health as well as acute care, and how to fund and administer models of care that are flexible and responsive to local needs.

A new National Rural Health Strategy will need to incorporate elements of previous strategies and frameworks addressing rural health, as well as relevant aspects of wider health Strategy documents with a focus on particular groups or health priorities, including the recent work developing the National Preventive Health Strategy and the Primary Health Care 10 Year Plan.

Due to the shared responsibility for health funding in Australia between the Australian Government, state/territory governments, consumers, private health insurers and non-government organisations, buy-in to the Strategy by these stakeholders will be important for its success.

A new National Rural Health Strategy would provide the structure and guidance for governments to align, prioritise and optimise future policies and investments in rural health.

Timeframe



The budget for the development of the Strategy and Implementation Plan will be dependent on a range of variables including:

- the nature and number of consultations i.e., whether consultation is conducted face-to-face or virtually and whether there are two rounds of consultation i.e., initial consultation and another round of consultation on a draft Strategy and Implementation Plan;
- the number of stakeholders consulted and whether the consultation costs of stakeholders or selected stakeholders would be met by government;
- additional Department of Health staffing would be required to develop the Strategy and Implementation Plan including organising consultations, drafting and editing, promotion and publicity and launch and ongoing monitoring and review,
- if there was an identified need to commission specific research or conduct surveys,
- costs incurred for any official launch.

The Alliance estimates that, subject to the caveats outlined above, the development of a National Rural Health Strategy and Implementation and Evaluation Plan would cost in the vicinity of $2.6 million.

A detailed costing is provided below.

Budget	2021-22	2022-23	2023-24	2024-25
Item	**Amount ($)**			
Development of Strategy and Implementation Plan				
Australian Government Department of Health staff	570 000	450 000		
University consultation regarding research and review methodology	10 000	10 000		
Round 1 consultation (incl. travel, facilitator, venue, catering)	300 000			
Round 2 consultation (incl. travel, accommodation, facilitator, venue, catering)		300 000		
Launch of Strategy and Implementation Plan				
Launch event (travel, accommodation, speakers, catering, venue, comms)		200 000		
Promotion of Strategy (comms material, printing)		80 000		
Ongoing review and evaluation				
Australian Government Department of Health staff			260 000	260 000
University consultation regarding research and evaluation methodology			10 000	10 000
Broad consultation informing review and evaluation			50 000	50 000
Total	**880 000**	**1 040 000**	**320 000**	**320 000**
Grand Total	**2 560 000**			

References

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National Rural Health Alliance Members (December 2021

Allied Health Professions Australia (Rural and Remote Committee)	Exercise & Sports Science Australia
Australasian College for Emergency Medicine (Rural, Regional and Remote Committee)	Federation of Rural Australian Medical Educators
Australasian College of Health Service Management (Regional, Rural and Remote Special Interest Group)	Isolated Children's Parents' Association
Australasian College of Paramedicine	National Aboriginal Community Controlled Health Organisation
Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine	National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners
Australian Chiropractors Association (Aboriginal and Torres Strait Islander Rural and Remote Practitioner Network)	National Rural Health Student Network
Australian College of Midwives (Rural and Remote Advisory Committee)	Optometry Australia (Rural Optometry Group)
Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)	Pharmaceutical Society of Australia (Rural Special Interest Group)
Australian College of Rural and Remote Medicine	Royal Australasian College of Medical Administrators
Australian Dental Association (Rural Dentists' Network)	Royal Australasian College of Surgeons (Rural Surgery Section)
Australian General Practice Accreditation Limited	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Australian Healthcare and Hospitals Association	Royal Australian and New Zealand College of Psychiatrists
Australian Indigenous Doctors' Association	Royal Australian College of General Practitioners (Rural Faculty)
Australian Nursing and Midwifery Federation (rural members)	Royal Far West
Australian Paediatric Society	Royal Flying Doctor Service
Australian Physiotherapy Association (Rural Advisory Council)	Rural Doctors Association of Australia
Australian Psychological Society (Rural and Remote Psychology Interest Group)	Rural Health Workforce Australia
Australian Rural Health Education Network	Rural Pharmacists Australia
Council of Ambulance Authorities	Services for Australian Rural and Remote Allied Health
Congress of Aboriginal and Torres Strait Islander Nurses and Midwives	Society of Hospital Pharmacists of Australia
CRANAplus	Speech Pathology Australia (Rural and Remote Member Community)