The National Rural Health Alliance (NRHA) is pleased to present its Position Papers for 2000-2001.

The Alliance is the peak non-government rural and remote health organisation working for good health and well-being in rural and remote Australia. It is comprised of twenty-two Member Bodies representing consumer and health provider organisations. Each Member is a national organisation in its own right and its affiliation to the Alliance is regularly accredited. A list of the current Member Bodies is at the end of this document.

The Position Papers represent the agreed position of the twenty-two Member Bodies of the National Rural Health Alliance but not necessarily the entire view of all individual Member Bodies.

These Position Papers should be seen in the context of the Alliance’s general priorities, which are family issues, political empowerment, workforce and infrastructure. There are many other specific issues within the general framework to which the Alliance is committed and on which it is working.

The Papers in this document reflect the comments and concern of a large number of stakeholders. Working drafts were circulated to Member Bodies and also to over 500 members of the friends of the Alliance, a grass roots organisation in the Alliance representing a broad range of individuals and organisations with an interest in rural and remote health.

There are many uses to which the agreed Position Papers can be put. It is hoped that they will inform the decisions of rural health policy makers, managers, researchers, consumers and professional bodies. They will also be used in the Alliance’s advocacy work.

Position Papers are dynamic documents that reflect changes in community values and priorities. These Position Papers will be reviewed every twelve months in an effort to reflect the changing environment in which they are used.

If you would like to make comments, we would be pleased to receive them.

Position Papers are also available on the NRHA website - http://www.ruralhealth.org.au

We hope that you find the papers useful and informative.

Gordon Gregory  
Executive Director

Nigel Stewart  
Chairperson

January 2001  
January 2001
These Position Papers were adopted by the Council of the National Rural Health Alliance (NRHA) between November, 2000 and January 2001. They are published as part of the Alliance’s core work to promote good health and well-being in rural and remote Australia.

The Vision of the National Rural Health Alliance, as the peak non-government rural and remote health organisation, is good health and well-being in rural and remote Australia.

The National Rural Health Alliance (NRHA) is a collective of national organisations which represent the consumers and/or providers of health services in rural and remote Australia. The NRHA is comprised of such organisations as are admitted as Member Bodies from time to time.

Friends of the Alliance support the work of the NRHA through their special input into Position Papers. Membership is open to all individuals and organisations with an interest in improving the health and well-being of those in rural and remote Australia. For enquiries about joining, please contact the friends Manager at the address below.

National Rural Health Alliance

PO Box 280
Deakin West ACT 2600

Ph: 02 6285 4660
Fax: 02 6285 4670
Email: nrha@ruralhealth.org.au
Website: www.ruralhealth.org.au
Contents

Rural Health - 30% Fair Share  Section 1
Suicide Prevention  Section 2
Oral Health  Section 3
Allied Health Professionals in Rural and Remote Australia  Section 4
Section 1

RURAL HEALTH - 30% FAIR SHARE
RURAL HEALTH - A 30% FAIR SHARE

As at December 2000

The National Rural Health Alliance, the peak non-government rural and remote health organisation, notes that:

1. The health status of people in rural and remote areas is generally poorer than that of people in metropolitan areas, with higher incidences of cardio-vascular disease, preventable accidents, mental illness, cancer and diabetes. Health status declines along a continuum as one moves away from metropolitan centres to rural and remote locations.

   Death rates in the remote zone are the highest with rates among males and females in ‘other remote areas’ 22% and 32% higher respectively than males and females in capital cities (AIHW 1998).1

2. Key factors contributing to this poorer status include lower socio-economic and employment levels, risky behaviours, occupational and environmental hazards, and a lack of access to health services.

   Thirty three of the poorest electorates in Australia are rural electorates, with the average weekly earnings of families and individuals in these areas considerably lower than the national average.2

   Critical shortages of health professionals combined with the lack of public transport networks in rural and regional areas make access to health services very difficult for the financially disadvantaged, the aged, disabled and people who do not drive.

   The Australian Consumers’Association (1998) states that people in rural and remote areas, including those on Health Cards, have considerably less access than urban dwellers to General Practitioners (GPs) who bulk-bill.

3. Australia's Aboriginal Peoples and Torres Strait Islanders continue to experience poorer health than the general Australian population. The life expectancy for indigenous people is 20% lower than for the general community. Life expectancy for indigenous males is 56.9 years compared to 75.2 years for the total male population and 61.7 years for indigenous females compared to 81.1 years for the total female population.4

4. The profile of Australia's rural population is ageing, placing increasing demands on the health and community services in rural and remote areas. The older population of rural communities is not homogeneous but includes people on farms, properties, stations, mines, fishing and tourism areas, retired manual and farm workers, people from different cultural and linguistic backgrounds, retirees from urban areas and Aboriginal Peoples and Torres Strait Islanders.

   Evidence presented at the National Rural Public Health Forum in 1997 showed that rural older people use health services more frequently than younger people, with twice as many General Practitioner consultations and three times more hospital admissions.

5. The National Rural Health Alliance defines ‘rural’ as all areas of Australia except the capital cities and Townsville, the Gold Coast, Newcastle, Gosford-Wyong, Wollongong and Geelong. Based on the 1996 Census figures, 69.63% or 13,028,900 people live in these areas. The remaining 30.37% of Australia’s 18.7m people live in rural, regional or remote areas.

6. Lack of access to GP services is a major risk factor for the health of people in rural and remote communities. Even though 30% of the Australian population lives in rural areas as defined, only 22% of male GPs and 17% of female GPs practise there. The result is a rural GP shortage of 500-750, with critical shortages in the specialties of psychiatry, obstetrics and anaesthesia.

   A lack of other health professionals is also undermining the delivery of health services to people in rural and remote areas. These include nurses and midwives, dentists and members of the allied health professions.

7. Cost-shifting and buck-passing between the Federal and State/Territory governments on health responsibility compromise the development and operation of appropriate services in rural and remote areas.

   In addition, policies of economic rationalism and the centralisation of health services in the name of efficiency and deficit reduction have impacted most heavily on small rural and remote communities.

   The closure or partial closure of smaller rural hospitals has meant that rural people must travel considerable distances for minor procedures and routine operations as well as the delivery of their babies.
8. The Commonwealth provides funding for medical services provided by private practitioners through the Medical Benefits Schedule (MBS) and for medicines provided by privately owned community pharmacies through the Pharmaceutical Benefits Scheme (PBS). Together, these programs account for 48% of the Commonwealth's health budget. The table below outlines the financial contribution of the main players in the healthcare system.

9. Recurrent health Expenditure, 1997-98

<table>
<thead>
<tr>
<th>Area of Health</th>
<th>Government sector</th>
<th>Non-Government sector</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commonwealth</td>
<td>State &amp; Local</td>
</tr>
<tr>
<td></td>
<td>[$m]</td>
<td>[$m]</td>
</tr>
<tr>
<td>Medical</td>
<td>6970</td>
<td>-</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>2785</td>
<td>16</td>
</tr>
<tr>
<td>Public hospitals(^3)</td>
<td>5793</td>
<td>6437</td>
</tr>
<tr>
<td>Private hospitals</td>
<td>550</td>
<td>-</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>2575</td>
<td>1437</td>
</tr>
<tr>
<td>Administration, public health, dental services</td>
<td>1380</td>
<td>2086</td>
</tr>
<tr>
<td>Research</td>
<td>427</td>
<td>96</td>
</tr>
<tr>
<td>Other professionals</td>
<td>219</td>
<td>-</td>
</tr>
<tr>
<td>Other(^4)</td>
<td>438</td>
<td>281</td>
</tr>
<tr>
<td><strong>Total each sector</strong></td>
<td><strong>21137</strong></td>
<td><strong>9053</strong></td>
</tr>
<tr>
<td><strong>% each sector</strong></td>
<td><strong>47.8</strong></td>
<td><strong>20.5</strong></td>
</tr>
</tbody>
</table>

Source: 6, p 13

1. Not adjusted for personal income tax rebate for net medical expenses

2. Includes Workers' Compensation and Motor Vehicle Third Party insurers

3. Includes acute, repatriation and psychiatric hospitals

4. Includes ambulances, aids and appliances and other institutional expenditure

10. The backbone of the Australian health system is the publicly funded Medicare program. While eligibility for Medicare is unaffected by location of residency, difficulty recruiting a full range of health professions, in combination with long distances, means that access to the services provided through Medicare can sometimes be more difficult in rural and remote areas.

11. On average, people in rural communities receive only $92 per year in Medicare services compared with $145 in urban areas. The difference is even starker in remote areas. According to the AIHW (1998) the rate of GP consultations in ‘other remote areas’ was less than 50% of the rate in ‘capital cities’. For example, in NSW, the average person has access to $363 of Medicare benefits per year, whereas someone in the Kimberley or Pilbara, is accessing only $66 per year.

Some of this gap may be offset by the increased use of other services in rural and remote areas, such as hospital services, salaried community medical services (including the Aboriginal Medical Services) and other primary care providers such as Aboriginal Health Workers and remote area nurses. However, the use and availability of non-Medicare services does not fully compensate for the discrepancy between rural/remote and urban benefits from Medicare.

12. Based on the 92:145 ratio, rural people are $250m worse off in terms of Medicare rebates for GP services. Lack of access to a GP is the most significant factor explaining this difference.

Rural people receive $460m (19.6%) of the total $2.3b of Medicare rebates for non-referred consultations. $250m in additional Medicare funds would achieve the “30% fair share” for rural people on this measure alone.

13. Low income and lack of access to or choice of medical practitioner or hospital in rural and remote areas are also major reasons for the low take-up of private health insurance. There is a major debate about the rebate to private health insurance. Whatever the view on this debate it is certain that rural and remote people have less to gain from the rebate, and from the private health system, than people in the major cities.

14. The changed administrative arrangements within the Department of Health and Aged Care provide for the better co-ordination of rural health issues. In particular, the establishment of the Office of Rural Health and the significant new allocation to rural general practice in budget 2000 is welcomed by the Alliance.
The **National Rural Health Alliance affirms** that:

15. Access to affordable health care is a basic human right that should not depend on a person's socio-economic status, religion, gender, sexual preference, ethnic background or geographical location.

16. Health status is closely linked to socio-economic and employment status, social and geographic location and education level. It is therefore impossible to consider health in isolation from other social and economic factors. Rural and remote areas need their 30% fair share of allocations to physical and human infrastructure, as well as a loading to reflect the higher cost of infrastructure development and its poorer status. The most important parts of this infrastructure are education, transport and telecommunications.

17. The poor health status of our Indigenous population is a national disgrace. The principle of ‘worst first’ should therefore be pursued in addressing the health problems of rural and remote areas. This requires a commitment to increase health resources to Indigenous communities. Currently only 23 cents per head is spent on Indigenous health for every one dollar per head spent on non-Indigenous health.

18. The loss of a range of health, social welfare, retail and other services from small rural communities has impacted negatively on the physical and mental well-being of people in these communities.

19. The maintenance of a publicly funded universal health insurance scheme is critical to the provision of affordable and accessible health care to all Australians.

20. Member Bodies support the principles of Healthy Horizons and work by the Commonwealth States and Territories to implement them. The Member Bodies themselves will continue to monitor their own developments with the goals of Healthy Horizons.

21. The lack of health and medical services in rural and remote communities is a critical risk factor affecting the health status of rural and remote people.

22. There is a need for more funding to address the shortages of health professionals in rural and remote locations. In addition to its initiatives to improve the recruitment and retention of GPs and pharmacists to rural and remote areas, the Federal Government should accept greater responsibility for providing incentives and support for Aboriginal Health Workers, nurses and allied health professionals working in rural and remote areas. These could include scholarships and other support for undergraduate and post-graduate training as well as support for existing workforce.

23. Member Bodies will seek from governments across the board a commitment to a ‘30% fair share’ of the overall health dollar for the 30% of the Australian population that lives in rural and remote areas. The funding for rural and remote people should be spent in rural and remote areas.

24. The development of integrated and flexible regional public transport networks is critical to improving access to health services in rural areas.

25. Community consultation must be an integral part of the planning, development and organisational phases for a Regional Health Services facility. The process of community consultation must not be hurried but allow for all stakeholders to have their views, both positive and negative, considered in a non-threatening manner. The termination of acute care service should not be seen as a trade-off for the development of a Regional Health Services facility.

The **National Rural Health Alliance resolves** to:

26. Work with the Federal and State and Territory Health Departments for implementation and evaluation of the principles and actions of ‘Healthy Horizons’.

27. Strongly support initiatives and funding to improve the health status of Australia’s Indigenous population.

28. Continue to lobby Federal and State Governments for flexible health and aged care services that suit rural and remote communities.

29. Continue to lobby Federal and State Governments for funding of integrated and flexible regional public transport networks to improve access to health services in rural areas.

30. Seek a commitment from the Federal, State and Territory Governments to a “30% Fair Share” of the overall health dollar for the 30% of Australians that live outside the metropolitan centres.
31. Maintain the close working relationship with the Office of the Minister for Health and Aged Care, the Office of Rural Health and other Departmental staff to highlight the issues of concern for rural and remote people and health practitioners in rural and remote locations.

32. Support widespread consultation in implementation of the Regional Health Service program to ensure that the services provided are flexible and suit local conditions.

33. Seek additional funding from the Federal Government to provide incentives and support for the recruitment, retention and support of nurses and allied health professionals to rural and remote areas.

34. Continue its support for the development and application of models of service delivery that include outreach, mobile teams, and hub and spoke approaches.

35. Push for further consideration of the relative costs of general practice and its complexity as between metropolitan and rural/remote areas. Among other things, the results of such further study would inform the debate about whether Medicare in rural and remote areas should provide differential rebates for different areas or different types of practice. The argument for a higher rebate in rural and remote areas includes the assertion that it would result in the attraction of more general practitioners and that it would lead to a higher rate of bulk billing.

36. The bilateral Medicare agreements between Commonwealth and States must provide that at least 30% of State’s health budget is expended in rural and remote areas of the States and mandate the measurement and monitoring of this principle.

References:
4. ABS & AIHW, 1999, The health and welfare Australia’s Aboriginal and Torres Strait Islander peoples, ABS Cat No. 4704.0, AIHW Cat No. IHW 3, ABS & AIHW, Canberra.
6. DH&AC & NRHA, 2000, Health Financing in Rural and Remote Australia- a background paper, Canberra.

Adopted at the National Rural Health Alliance Council Meeting on 27 November, 2000
Section 2

SUICIDE PREVENTION IN RURAL AREAS
SUICIDE PREVENTION IN RURAL AREAS

As at December 2000

The National Rural Health Alliance, the peak non-government rural and remote health organisation, notes that:

1. According to the Australian Institute of Health and Welfare (2000), suicide was the seventh leading cause of premature death in Australia in 1998, following various cancers, heart disease and stroke. Suicide rates have remained relatively stable since the 1920s, however rates have fluctuated within age groups in the population.

2. Men are four times more likely than women to die from suicide, often adopting more violent means which result in a greater number of deaths. However, females have higher rates of hospital admissions for suicide and self-harm attempts. Hospitalisation due to self-harm between 1996-1997 peaked in the 15-19 year old age group for women.


Australian Bureau of Statistics (1998) figures indicate that the suicide rates for men aged between 20-39 are significantly higher than for young men aged between 15 and 19 years. However, over the period 1979-1998, the suicide rates for 12-24 year olds rose 40%.

3. Rates of suicide are consistently higher in remote areas and rural towns than in metropolitan and regional areas. In communities with a population of less than 5000, the male suicide rate is one-and-a-half times the capital cities rate, and the suicide rate of males aged 15-24 is almost twice that of their city counterparts. Here the impact of structural adjustment in agriculture and the withdrawal of government and other services, such as banks, has been most dramatic.

3. Rates of suicide are consistently higher in remote areas and rural towns than in metropolitan and regional areas. In communities with a population of less than 5000, the male suicide rate is one-and-a-half times the capital cities rate, and the suicide rate of males aged 15-24 is almost twice that of their city counterparts. Here the impact of structural adjustment in agriculture and the withdrawal of government and other services, such as banks, has been most dramatic.

3. Rates of suicide are consistently higher in remote areas and rural towns than in metropolitan and regional areas. In communities with a population of less than 5000, the male suicide rate is one-and-a-half times the capital cities rate, and the suicide rate of males aged 15-24 is almost twice that of their city counterparts. Here the impact of structural adjustment in agriculture and the withdrawal of government and other services, such as banks, has been most dramatic.

4. Factors associated with a greater risk of suicide include mental illness, unemployment, socio-economic disadvantage, loss of parent through separation or divorce, family and inter-personal problems, physical and/or sexual abuse, issues of sexuality, homelessness and substance abuse. Access to means (eg firearms) and previous suicide attempts are other key factors.

Research indicates that the downward trend in firearm suicides nationally conceals the significant increases that have occurred in firearm suicides in small rural communities over the last 30 years, and particularly between 1989 and 1993.

5. Suicide rates for young indigenous males are up to 40% higher than the national average. Suicide rates for all young males have increased significantly over the past 30 years. According to the report “Bringing Them Home”, cultural and family dislocation are factors to be considered in indigenous suicide.

Same Sex Attracted young males aged between 18-24 years are 3.7 times more likely to attempt suicide than males in the general population. Most of these attempts occurred after the person had self identified as being gay.

6. Shortages of GPs, mental health nurses, psychiatrists and psychologists in rural and remote communities undermine the development of intervention strategies for people at risk.

The current shortfall of GPs in rural and remote areas is estimated to be in the range 500-750 practitioners. Many rural GPs lack specific training in mental health or suicide prevention and/or lack the time that needs to be spent with a depressed or mentally ill person. Options for referral are all but non-existent in many rural and remote areas.

There is a critical shortage of psychiatrists, psychologists and outreach mental health teams in rural and remote areas. Only 7.5% of psychiatrists are located in rural or remote locations with more than 90% of those in non-metropolitan areas being in major regional centres.
Shortages of clinical psychologists are also evident in rural and remote areas. The situation has been exacerbated by the rationalisation of public services in rural areas that employed psychologists. Lack of access to training, professional isolation, heavy workloads and limited resources affect the recruitment and retention of psychologists to rural and remote areas.

Few local hospitals have the resources to deal with people in the acute phases of mental illness who often require hospitalisation.

7. The incidence of suicide is higher amongst health professionals than other professional groups. Stress and burnout are frequently cited problems for health professionals in rural and remote communities, particularly where there is a lack of professional support, combined with excessively long hours of work and social and cultural isolation.

The Bush Crisis Line (1800 805 391) established in 1997 provides a valuable 24 hour telephone counselling and debriefing service for remote area health professionals and their families.

8. Healthy Horizons (1999-2003), the strategic framework for rural, remote and regional health, identifies mental health as a key issue. Mental health is also one of the six National Health Priority Areas, along with cardiovascular disease, cancer control, injury prevention and control, asthma and diabetes mellitus.

In 1993, the National Mental Health Strategy (NMHS) was re-affirmed by Health Ministers with a five-year Second National Mental Health Plan in 1998. In the 1996-97 Budget, the Federal Government announced an additional $18m funding to support the National Youth Suicide Prevention Strategy to 1999-2000. $48 million dollars over five years has been allocated for the National Suicide Prevention Strategy (NSPS) Project called “LIFE- Living Is For Everyone”. Issues which impact on the risk of suicide in rural and indigenous communities are identified as two of the four priority areas under LIFE.

Funding has been provided under the National Youth Suicide Prevention Strategy, to the telecounselling, information and referral services with Kids Help Line (a 24 hr, centrally located free service for young people who need support with life skills and resiliency), Lifeline (a national, 24 hr telecounselling service for all ages) and Reachout! (an Internet-based information service providing a map-based search system for people to self refer).

Early intervention programs targeting school age children have been funded by a number of State governments. These programs aim at improving self-esteem, developing resilience and coping strategies, and reducing violent and anti-social behaviour such as bullying.

9. A lack of resources and commitment by both Federal and State Governments is evident in relation to the issue of suicide and adult Australians - particularly men.

Threatened or actual loss of the family farm, declining off-farm employment opportunities, the dominance of traditional male norms, community decline, family breakdown, alcohol abuse, lack of education and a lack of appropriate services are all factors implicated in the rising rate of suicides by rural men in the middle years.

10. Information technologies such as telepsychiatry and video-conferencing provide important adjuncts to the services provided by health professionals in rural and remote locations. It can also improve the support and training of local health professionals who provide service to this population.

Consultations using telepsychiatry or video-conferencing facilities can reduce the need for a person in a rural area to travel to the capital city for assessment and treatment.

The Royal Flying Doctor Service (RFDS) plays a vital role in the assessment and evacuation of people with a mental illness. The RFDS has released an educational and interactive CD-Rom for health professionals, aimed at improving the knowledge and awareness of the issues of mental health.

11. There are 6 priority mental health targets for rural and remote communities outlined in the National Action Plan for Mental Health Promotion, Prevention and Early Intervention 1998-2003. These priority targets are:

- promote family and community cohesion;
- promote protective factors that impact on the effects of unemployment, environmental hazards, geographical isolation, alienation and loss, building on particular strengths of people in rural and remote communities;
- reduce the prevalence of risk factors for depression, anxiety, stress and suicide;
- capacity building of infrastructure and communication technologies to assist improve mental health outcomes for rural and remote communities eg. telehealth/telemedicine;
- develop and support initiatives as determined by the local community; and
- increase access to mental health promotion and prevention services.
12. Member Bodies of the Alliance strongly support the Commonwealth Government’s stricter gun control laws introduced following the Port Arthur tragedy. Given the high incidence of suicide by firearms in rural communities, the Alliance considers the stricter ownership and storage control measures are important to reducing access to the means of suicide in rural areas.

The National Rural Health Alliance affirms that:

13. It is important to focus on early intervention and school programs aimed at providing positive role models and improving the self-esteem, resilience and coping strategies of young people. Member Bodies of the Alliance support the introduction of a national school based package which is specifically targeted to rural students and long term strategies for maintaining, valuing and enhancing the family.

14. Member Bodies of the Alliance strongly support the inclusion of mental health as a national population health priority.

15. Member Bodies support the service provided by the Bush Crisis Line (1800 805 391) designed to assist remote area health professionals through telephone counselling, debriefing and stress management after critical incidents or traumatic stress situations.

16. Member Bodies of the Alliance support the funding of the National Suicide Prevention Strategy by the Federal Government and the actions identified under LIFE- Living Is For Everyone.

17. Member Bodies of the Alliance support initiatives that support the provision of mental health information to consumers, including the Commonwealth’s telecounselling and internet information service.

The National Rural Health Alliance resolves to:

18. Lobby for funding from the Federal Government to undertake further research to assist with the development of effective suicide prevention programs for men in rural and remote areas and for Aboriginal Peoples and Torres Strait Islanders.

19. Form a working relationship with Suicide Prevention Australia to address the issues of suicide in rural and remote areas.

20. Maintain close links with Mental Health Branch of the Department of Health and Aged Care in order to provide support to the National Rural Health Alliance’s resolutions on mental health and suicide.

21. Support incentives to recruit, retain and support rural mental health workers and counsellors, including GPs to small rural communities, and to increase the skills of others, such as teachers, sports coaches and youth workers involved with young people at risk.

22. Support, as a priority, initiatives to improve mental health training for GPs, nurses, allied health professionals and Aboriginal Health Workers.

23. Support the expansion of funded telepsychiatry and video-conferencing services as an adjunct to, not a replacement for, face-to-face services in rural and remote communities.


References:


Adopted at the National Rural Health Alliance Council Meeting on 27 November, 2000
Section 3

ORAL HEALTH IN RURAL COMMUNITIES
ORAL HEALTH IN RURAL COMMUNITIES

As at January 2001

The National Rural Health Alliance, the peak non-government rural and remote health organisation, notes that:

1. Oral disease, in particular dental caries and periodontal disease, is a significant and costly burden for Australians even though it is mostly preventable. Dental decay is the most costly disease related to diet ahead of coronary heart disease, hypertension and diabetes. Aboriginal and Torres Strait Islander communities are at significant risk, experiencing dental decay at twice the rate of non-indigenous populations. Sustainable and comprehensive health promotion and population oral health initiatives could address the significant financial and social burden.

2. There is growing evidence of the links between oral health and systemic health including links to pre-term birth, diabetes and cardiovascular disease. Oral health promotion within a primary health care context is a priority policy area.

3. The Commonwealth Dental Health Program (CDHP) was started in 1994 to provide services to low income people who had been waiting up to three years for dental treatment. In the August 1996 Budget, the Federal Government abolished the CDHP. People on low incomes in rural and remote areas were among the main beneficiaries of the Program. Queensland has maintained funding of public dental services after the cessation of the CDHP. Since the cessation of the CDHP, the Victorian Government has provided an additional $1.5m for basic dental care in rural and regional communities as well as $1.1m for an 8 chair dental clinic in Bendigo. State Government funding now maintains the mobile van that takes dental care to rural areas.

4. The dental health needs of young adults, the aged, nursing home residents, rural and remote dwellers and those in lower socio-economic groups are not adequately met through either public or private dental practice and their treatment is less comprehensive. An extraction, for example, is more likely if the patient is young and of low socioeconomic status. According to the AIHW (2000) the highest rates of decayed teeth were for rural patients aged between 25 and 34 years. Rural and remote hospital separations for the removal and restoration of teeth for 0-14 year olds in the Far West Area Health Service of NSW are almost 6 times those in central Sydney.

5. Rural people have limited access to routine dental treatment and are often only able to access emergency care and may have to travel long distances to specialist services.

6. One of the reasons for the waiting lists is the under-supply of dentists in rural and remote areas. In 1994, there were 28.7 practising dentists per 100,000 people in regional and rural areas compared with 51.2 per 100,000 in capital cities. A major barrier to dental services is the cost of private dental treatment. 88% of dental services are provided by the private sector through dental surgeries and denture clinics. The remainder is provided through public dental services like the school dental service, hospital dental services and community dental health services. Capital cities are more likely to receive diagnostic services. Rural locations have a higher number of patients with prostheses and fewer dentists. Rural men and women are 23% less likely to visit a dentist.

7. The reasons why dentists do not take up the option of practice in rural or regional areas are very similar to those for General Practitioners and other health professionals. These include lower earning capacities, lack of professional support, lack of continuing education and lack of employment, health and educational opportunities for their spouse or children. Professional isolation is a major problem for dentists, who mostly work as sole practitioners. There is also a relative lack of professional organisation by rural dentists. The level of private health insurance and the average levels of income in rural areas are lower than in metropolitan areas, impacting on the number of visits made by rural people to the dentist. This, in turn, affects dentists’ earning capacity.
8. Queensland is currently targeting financial assistance at dentists in an attempt to overcome the disincentives of rural dental practice.

Since 1996 Queensland Health has paid an allowance of up to $20,000 per year to individual dentists to attract them to rural and regional areas. Rural dentists are also eligible to receive seniority payments of up to $7,000 per year. This program has been successful in attracting dentists to rural practice.

9. A few attempts have been made to meet the demands of the rural dental workforce for professional development.

For example, in Victoria, a professional development program has been designed and established by Dental Health Services Victoria (DHSV) to support all dental professionals, support staff and their managers involved in public dental programs across the State.

Since 1996, the Victorian Government has also placed more than half of their dental interns in rural areas, all with experienced mentors.

However, there is still the need for the rural dental workforce to be provided with the kind of training that some other rural health professionals receive.

10. In October 1997, the issue of the Provision of Public Dental Services in Australia was referred to the Senate Community Affairs References Committee. Reference to the Committee resulted primarily from the cessation of the CDHP from 1 January 1997.

137 individuals and organisations made submissions to the Inquiry, many from rural and regional areas.

11. The Committee handed down its Report in May 1998 making 9 recommendations, the key ones being:

Recommendation 5: That the Commonwealth Government assist the States and Territories to establish, conduct and evaluate highly targeted pilot programs to address the priority oral health needs of the following specific disadvantaged groups: pre school-age children (1 - 5 years), young adult Health Card holders (18 - 25 years), aged adult Health Card holders (65+ years), the homebound, rural and remote communities and indigenous Australians.

Recommendation 6: That the Commonwealth Government adopt a leadership role in introducing a national oral health policy, and give consideration to the possibility of using the National Public Health Partnership as the vehicle for developing and implementing that policy in partnership with the States and Territories.

The latter recommendation embraces the concept of a National Reform Agenda for Oral Health including a National Oral Health Partnership, put forward in the Queensland Health submission.

12. The responses received from the various State Health Departments in relation to the NRHA's discussion paper “Fighting Rural Decay-Dental Health in Rural Communities” were critical of the termination of the CDHP.

13. Access to affordable and nutritious foods is essential for oral health. Rural and remote communities have less access to quality fresh foods.

14. Fluoridation of the water supply has been one of the most effective public health programs in Australia, resulting in a significantly lower number of dental caries. Most rural and remote communities do not have a fluoridated water supply, often due to the high infrastructure costs. Alternate strategies need to be investigated for those areas, including subsidised fluoridated toothpaste and fluoride supplements.

The National Rural Health Alliance affirms that:

15. Member Bodies of the Alliance support the 9 recommendations outlined in the Senate Report on Public Dental Services (see Attachment A).

16. Poor dental and oral health is a major public health issue affecting the general health and social well-being of the person. The dental profession plays an important role not only in maintaining sound teeth and gums, but also in the early diagnosis of certain cancers eg. tongue and salivary glands. Yet little communication occurs between the dental profession and general practitioners. This is more marked in rural areas where there is limited access to dental specialists. There is a need for improved lines of communication between urban dental professionals and rural general practitioners. Improved communication between these health professionals will lead to improved health outcomes.
17. Lack of access to dental services, fluoridated water and affordable fresh produce are major issues. There is a marked inequity in access to dental services between metropolitan and rural and regional areas.

18. There is a need for a Rural Dental Practice Incentive Program with similar financial and training incentives to the GP Rural Incentives Program to attract and retain dentists in rural and remote communities. However initially the lack of access to an appropriate diet, fluoridated water and socio-economic factors must be addressed. Locums, professional development and continuing education in oral health promotion are supporting mechanisms for a broad-based oral health incentive program.

19. There is a need for the Commonwealth and the States to work together to put in place a subsidised and targeted oral health program for low income people and others with poor access to dental health care. People in rural and remote areas, particularly if they are on low incomes or social welfare benefits, should be prime beneficiaries of such a program.

20. The fluoridation of water supplies is recognised as one of the most successful public health strategies in Australia. Fluoridation is one of the most effective and safe methods of prevention of dental caries with levels recommended by the NHMRC.

The National Rural Health Alliance resolves to:

**Political issues**

21. Continue to lobby the Commonwealth for the implementation of the recommendations of the Senate Report on Public Dental Services, particularly those relating to improved service delivery to meet the specific needs of rural and remote communities and Indigenous populations.

22. Lobby for the Commonwealth to exercise leadership on public dental services for people with limited means, especially in rural and remote areas.

23. In partnership with the Indigenous organisations, including the National Aboriginal Community Controlled Health Organisation (NACCHO), lobby the Commonwealth for more oral health resources for the Aboriginal community controlled health sector.

**Workforce issues**

24. Lobby State and Territory governments to provide incentives to private dentists to take up the option of practice in rural or remote locations.

25. Support the need to meet the professional development needs of dental health workers through collaborative action between governments, the profession and consumers.

26. Support the role of the Rural Health Support, Education and Training Program in developing collaborative approaches to improving access to dental and oral hygiene workers in rural areas.

**Population oral health**

27. Support the development of public health strategies for dental and oral health, including recognition of the need for oral health promotion initiatives through the National Public Health Partnership Taskforce on Health Promotion for Oral Health.

**References:**

1. Lester 1H, Australia's food and nutrition, Canberra, AGPS, 1994.


3. National Aboriginal Community Controlled Health Organisation Inc. (NACCHO), Canberra

4. Patterson, Dr A, NSW Public Health Bulletin, VOL 10, No. 3, Sydney, 1993


**Adopted at the National Rural Health Alliance Council Meeting on 27 November, 2000**
Recommendation 1: That the Commonwealth, in consultation with the States and Territories and other key stakeholders in the public and private dental sectors, support the development of programs to improve the promotion of oral health throughout Australia.

Recommendation 2: That the Commonwealth Government support the introduction of a vocation training program for new dental graduates, especially to assist in the delivery of oral health services to people in rural and remote areas.

Recommendation 3: That the use of dental auxiliaries such as therapists and hygienists be expanded, particularly to cater for the needs of specific disadvantaged groups and that, to this end, the States and Territories be encouraged to review legislation restricting the employment of such auxiliaries.

Recommendation 4: That support be given to a national oral health training strategy for health workers and careers, specifically including those working in the fields of aged care and Aboriginal health.

Recommendation 5: That the Commonwealth assist the States and Territories to establish, conduct and evaluate highly targeted pilot programs to address the priority oral health needs of the following specific disadvantaged groups: preschool-age children (1 to 5 years), young adult Health Card Holders (18 to 25 years), aged adults Health Card holders (65+ years), the homebound, rural and remote communities and indigenous Australians. Such programs should include a capacity for the individual beneficiary to make a contribution to the treatment costs.

Recommendation 6: That the Commonwealth Government adopt a leadership role in introducing a national oral health policy, and give consideration to the possibility of using the National Public Health Partnerships as the vehicle for developing and implementing the policy in partnership with the States and Territories.

Recommendation 7: That the national oral health policy include the:
- setting of national oral health goals;
- establishment of national standards for the provision of, and access to, oral health care and the quality of services;
- establishment of a national strategies and priorities for oral health care reform, with an emphasis on preventative dentistry;
- setting of minimum service targets; and
- monitoring national oral health goals through the maintenance of a national data collection and evaluation centre and undertaking research into the current and projected needs.

Recommendation 8: That the Commonwealth allocate resources for a national oral health survey, to be conducted as a priority, to establish data on the oral health status and oral health needs of the Australian community.

Recommendation 9: That the Commonwealth Department of Health and Family Services create a dedicated section or appoint an appropriately qualified senior officer with responsibilities for oral health matters, and that the necessary resources to fulfil the role and responsibilities of such an office be provided.
Section 4

ALLIED HEALTH PROFESSIONALS IN RURAL AND REMOTE AUSTRALIA

This Position Paper represents the agreed position of the twenty-two Member Bodies of the National Rural Health Alliance but not necessarily the entire view of all individual Member Bodies.
ALLIED HEALTH PROFESSIONALS IN RURAL AND REMOTE AUSTRALIA

As at January 2001

The National Rural Health Alliance, the peak non-government rural and remote health organisation, notes that:

1. Allied Health Professionals (AHPs) as defined by the Department of Health and Family Services (1997) “are health professionals, with a degree from a tertiary institution, from one of several individual professions who have, for the purpose of presenting a collaborative position, come together to work towards a common goal. Professions represented in any allied health professional group vary depending on the goal of the collaborative exercise.” Professions usually included under the umbrella of allied health include audiologists, dieticians and nutritionists, hospital pharmacists, occupational therapists, optometrists, orthotists and prosthetists, orthoptists, physiotherapists, podiatrists, psychologists, radiographers, social workers and speech pathologists. Dentistry, pharmacy and optometry, although defined as allied health, are generally classified individually due to the size and structure of their profession.

2. AHPs strongly support the unique and specific nature of each discipline, and are keen to work in co-operative roles to promote the health outcomes of all Australians.

3. AHPs provide a diverse range of services in a variety of settings in the health sector (including acute hospital care, rehabilitation, children, women and men’s health and aged care, community health, indigenous health, veterans’ affairs, health promotion and participation in research). They also provide a range of services in other sectors, including education, aged care, public health, industry, disability, and welfare.

4. AHPs work in both the public and private sectors providing services to people in rural and remote communities.

WORKFORCE ISSUES

5. Anecdotal information indicates critical shortages across all allied health professions. Many of the issues impacting on the recruitment and retention of GPs to rural and remote communities impact similarly on AHPs. These include professional, social and cultural isolation. Lack of training and professional support, career pathways, shortages of locums/back-filling of positions, lack of educational and employment opportunities for their children and partners, levels of income, on-call obligations and personal safety, in the region where the AHP is practising, all impact on recruitment and retention.

6. Lack of access to a range of AHPs in rural and remote communities is now being recognised as a major inhibiting factor to the development of a truly multi-disciplinary approach to primary care in rural and remote areas. Lack of access to AHPs in rural and remote communities contributes to the decrease in sustainability of health services generally in these communities and to the lack of sustainability of GP services more specifically. It is easier to attract a GP to a rural community with access to a range of allied health services.

7. Overseas recruitment of Australian graduate AHPs by international agencies exacerbates the difficulties of attracting graduates to rural and remote locations.

8. A leakage of allied health graduates to the Graduate Medical Program is also affecting the recruitment of AHPs to rural and remote areas.

9. The lack of formal allied health representation at the senior management level in the Commonwealth or State Departments of Health has been a long-standing concern of AHPs in both rural and metropolitan areas. Such a lack of representation places AHPs at a disadvantage, vis-à-vis medical practitioners and nurses, in the development of coordinated policies and programs to effect improvements in the delivery of health services and/or conditions of service for their professional group. Furthermore, in relation to rural and remote AHPs, this lack of representation undermines the development of multi-professional rural health workforce strategies.

10. Little research has been commissioned into the workforce distribution of AHPs across rural and remote Australia. Significant gaps exist in the data and information on AHPs in rural and remote locations; on the shortages across the various professions and geographical regions; on their training and other support needs; and on what the optimum professional to population ratio should be. In his Rural Health Stocktake, Dr Jack Best also reported on the lack of data about the workforce distribution of AHPs in rural and remote areas, stating “it is clear that there is a dearth of workforce information, which should be rectified as soon as possible”.

Section 4 Allied Health Professionals in Rural and Remote Australia
A recommendation from the 5th National Rural Health Conference was “that innovative data collection be devised and implemented to capture allied health professional workforce data. Allied health is recognised as working across many sectors - not only health, but also education, welfare, disability services, private practice, veterans’ affairs, mining and farming. Due to the complexity of professionals grouped under the banner of allied health, and the complexity of work sectors, workforce data is difficult to collect and requires innovative collection methods”.4

11. The Australian Institute of Health and Welfare has undertaken some quantitative analyses of selected allied health professions. This can be done when the profession concerned has Registration Boards in each State and Territory, and when the Boards are willing to organise the collection of information.

12. In 1998, the Rural Health Support Education and Training (RHSET) Program funded SARRAH to undertake a qualitative research project “to develop a framework for improving support, education and training for allied health professionals in rural and remote areas, and for those allied health professionals who wish to practice their skills in these settings”.2

Key findings from the project include:

a. Rural and remote allied health professionals work across a range of sectors including:
   • Federal Government (aged care, disability, veterans’ affairs, defence, tertiary education and Indigenous services);
   • State/territory Government (hospitals, community health, schools);
   • Private industry (private practice);
   • Local Government; and
   • Not-for-profit community/charity organisations.

b. The majority of allied health professionals were in public employment with 16.7% in private practice; 4.6% were employed in the aged care sector and 2.9% in education;

c. Allied health professionals working in rural and remote Australia span all age groups and have varying degrees of experience. 30% of respondents (n=1652) were under 30 years of age;

d. The majority (93%) were Australian graduates with 33.5% of the respondents possessing a post-graduate qualification and 15% currently enrolled in post-graduate study;

e. 65% indicated that they were in full-time employment. 20.9% were in part-time work. 12.4% were self-employed. 20% of all respondents indicated that they worked more than 40 hours per week. 36% of all respondents were sole practitioners. About 75% of allied health professionals have no access to locum services while on leave, and

f. 51% of the respondents were located in a provincial city or regional centre although more than half (56%) routinely practise in more than one geographical location (ie provide outreach services), and over half of these are provided at least weekly to other communities.

NATIONAL HEALTH PROGRAMS

13. 1999 saw the launch of Healthy Horizons, the strategic plan for rural health until 2003.5 The national health budget now includes new medical initiatives including Medicare items for the Enhanced Primary Health Care Packages and Chronic Disease Self Management Programs to enable GPs to co-ordinate multidisciplinary team management across a range of client conditions. In all these areas, AHPs in rural and remote areas provide a range of crucial services to assist in the achievement of the health goals and targets for these priority areas including:
   • The reduction in mortality and morbidity;
   • The reduction in health risk factors;
   • Improvements in health literacy; and
   • The creation of environments that promote good health.

14. At the Federal level, the training and recruitment of AHPs is considered to be a State/Territory responsibility, despite the fact that the Federal Government has prime responsibility for aged care and Veterans’ Affairs. With the announcement of the More Allied Health Services (MAHS) program in the Federal 2000-2001 budget, links with the Federal Government have been strengthened.
RECRUITMENT AND RETENTION ISSUES

15. Access to and cost of maintaining and updating skills through professional development, (including issues of time away from work, locum relief, loss of income, transport, accommodation, family support) remain major issues for AHPs in rural and remote areas. Rural Health Training Units (where they are still funded) and University Departments of Rural Health throughout rural and remote Australia play a very important role in providing education, training and support. Lack of access to information and communication technology for many rural and remote AHPs undermines education and training strategies as well as more general support initiatives. Internet and email access, particularly in remote areas, remains very expensive.

16. At the 5th National Rural Health Conference in Adelaide in March 1999, the major issue to emerge was the need for all sections of the rural and remote health workforce to be given the same level of incentives and support as those currently offered to doctors. Specific recommendation from the Conference included:

- That the Federal Government provides a national framework for allied health services, recognising that, through aged care, Aboriginal Health, Veterans' Affairs and the Enhanced Primary Health Care and Chronic Disease Self Management Programs, Allied Health Services are not solely a state responsibility;
- That University Departments of Rural and Remote Health include allied health professionals on their advisory and steering committees;
- That University Departments of Rural and Remote Health actively engage with existing support structures and services for rural AHPs eg. Services for Australian Rural and Remote Allied Health (SARRAH) and the Australian Rural and Remote Allied Health Taskforce (ARRAHT) of the Health Professions Council of Australia; and
- That the Commonwealth, States and the Northern Territory continue to support the recruitment and retention of AHPs in rural and remote Australia by maintaining and improving support to currently established Rural Health Training Units.

UNDERGRADUATE ALLIED HEALTH STUDENT ISSUES

17. A positive experience on a rural placement is recognised as an important recruitment and retention strategy for health professionals in rural and remote areas. This is evidenced by federal funding of initiatives to improve recruitment and retention of GPs in rural and remote areas. A number of States have recognised the importance of the allied health professions to the delivery of health services and improved health outcomes in rural and remote areas, and are now providing rural Allied Health scholarships to students to enable them to undertake a rural clinical placement. The Rural Student Clubs at the universities also play an important role in supporting allied health students interested in a career in rural or remote locations.

The National Rural Health Alliance affirms that:

18. AHPs have an essential role to play in public health and health promotion initiatives in rural and remote areas. AHPs have a wide variety of roles. Dieticians have key roles to play in the prevention and management of diabetes, reducing the risk of complications in people with this condition, and with cardiovascular disease. Podiatrists also have an essential role in the management of diabetes, reducing the incidence of amputation. Social workers and psychologists can play an important role in assisting people cope with stressful situations or depression, often identified as key factors contributing to the increasing incidence of suicide in rural and remote locations. Similarly, physiotherapists and occupational therapists assist in the prevention of workplace accidents and are an essential part of post-injury rehabilitation and return to work. Audiologists and Speech Pathologists, working within the education area, have a key role to play in the management of hearing, language and communication problems resulting in poor literacy and numeracy skills. Orthoptists and optometrists have key roles to play in the identification and management of eye problems associated with conditions such as diabetes, as well as within the education area, as vision problems also can result in learning difficulties.

19. AHPs have key roles to play in the education sector. For example speech pathologists and occupational therapists undertake vital work in relation to reading and learning skills, including for young people and adults with learning difficulties. The work of podiatrists and physiotherapists can help lay the basis for sound development of gait and other movement, and for a range of other physical capacities. A range of AHPs are involved in screening and early intervention work with young children which has the capacity to lay the basis for lifelong development. Where these early interventions services are not available the costs to individuals, families and society at large will be substantial. This early intervention and prevention activity can take place in school environments and, better still, in home and community settings in which children can be assessed in their earliest formative years.
WORKFORCE ISSUES

20. Member Bodies of the Alliance strongly support further research being undertaken to address the gaps in data and knowledge about the allied health workforce, its training and support needs.

NATIONAL HEALTH PRIORITIES AND PROGRAMS

21. The rural population is ageing and this will lead to increased demand for the services of AHPs. There is also an increasing incidence (over and above what results from better reporting) of workplace and other accidents, cardio-vascular disease, mental health problems, asthma, cancer and diabetes in rural and remote areas. These increases will also mean greater need for the skills of various AHPs. This means that State and Territory Governments, as well as other providers, will need to increase their resource allocations to allied health.

22. Member Bodies of the National Rural Health Alliance strongly support the individual allied health professional disciplines as partners in the delivery of health services to rural and remote Australia.

23. Given that significant numbers of AHPs are providing Commonwealth services, the Federal Government should assume greater responsibility for recruitment, training, incentives and other support required for the retention of AHPs in rural and remote areas.

24. Allied health personnel need to be involved at the local level in the development of the Regional Health Service Centres, and the implementation of the Enhanced Primary Health Care and Chronic Disease Self Management Programs.

RECRUITMENT AND RETENTION ISSUES

25. Member Bodies of the Alliance strongly support additional funding being made available by both the Federal and State/Territory governments to improve the recruitment and retention of AHPs in rural and remote communities.

26. Alternative methods of service delivery and education and training support need to be explored to reduce professional isolation and provide clearer career paths for allied health professionals in rural and remote locations. Access to information and communication technology is critical to the development of education, training and support strategies for rural and remote AHPs.

27. Member Bodies of the Alliance strongly support allied health being designated as a ‘strategic priority’ for RHSET funding in the future.

28. The University Departments of Rural and Remote Health and Rural Health Training Units need to have a strong allied health focus in their education and training programs.

UNDERGRADUATE ALLIED HEALTH STUDENT ISSUES

29. The opportunity for rural allied health undergraduates to experience placements in rural and remote areas is critical to the recruitment of AHPs to non-metropolitan areas in the future.

The National Rural Health Alliance resolves to:

30. Work to raise the awareness of people in rural and remote communities of their rights of access to a health service and the role of AHPs in terms of their skill in rehabilitation, aged care, palliative care, mental health and health promotion. The AHPs needs to be considered not just as an “extra” but as an integral member of rural and remote multi-disciplinary health care teams.

WORKFORCE ISSUES

31. Lobby the Federal and State Governments to co-ordinate AHP workforce planning at the national, state and local levels and to lobby both the Federal and State Governments to work together on recruitment and retention schemes for rural and remote AHPs.

NATIONAL HEALTH PROGRAMS

32. Initiate discussions with the Federal Department of Health and Aged Care to ensure the involvement and integration of allied health services in the development of the new Regional Health Service Centres, Enhanced Primary Health Care Packages and Chronic Disease Self Management Programs.
33. Work to ensure that in the bilateral Health Care Agreements between the Commonwealth and the States and Territories there is recognition of and commitment to appropriate levels of resources allocated to allied health services in rural and remote areas.

34. Contact the State and Territory Governments to ensure that the resources allocated in Federal Budget 2000 to the More Allied Health Services Program result in increased total effort on allied health.

35. Liaise with other national associations like the National Heart Foundation, Diabetes Australia, Arthritis Foundation and the Australian Cancer Society to highlight the important roles of the various allied health disciplines in caring for the rehabilitative, palliative and dietary needs of their constituents in rural and remote locations.

RECRUITMENT AND RETENTION ISSUES

36. Draw to the attention of the Minister for Health and Aged Care and the Office of Rural Health of the Department, those recommendations pertaining to allied health from the biennial National Rural Health Conferences.

37. Lobby the Federal Government to increase the amount of funding available for training and support initiatives for AHPs in rural and remote communities, given that many health service areas involving AHPs are a federal responsibility.

38. Seek ongoing funding through RHSET for allied health specific projects.

39. Support the inclusion of AHPs on the advisory and steering committees of the University Departments of Rural and Remote Health.

40. Lobby the Federal Government for a scholarship program, similar to that which exists for the nursing profession, for AHPs to undertake postgraduate education.

UNDERGRADUATE ALLIED HEALTH STUDENT ISSUES

41. Support initiatives to increase allied health student involvement in the Rural Health Clubs of the various universities and at the annual National Undergraduate Rural Health Undergraduate Conferences and in undertaking rural placements.

42. Lobby the Federal Government for the development of a scholarship system for undergraduate allied health students on a national level, similar to that which already exists for medical students.

43. Lobby the Federal Government to develop a system of HECS fees reimbursement for graduate AHPs undertaking rural and remote employment.

References:
1. Department of Health, 1997
2. Fitzgerald K, Hornsby D, Hudson L, 2000, A Study Of Allied Health Professional in Rural and Remote Australia, Services for Australian Rural and Remote Allied Health (SARRAH), Bathurst.

Adopted at the National Rural Health Alliance Council Meeting on 27 November, 2000
The National Rural Health Alliance currently has twenty two Member Bodies:

- Association for Australian Rural Nurses (AARN)
- Rural Interest Group of the Australian Community Health Association (ACHA)
- Australian College of Health Service Executives (rural members) (ACHSE)
- Australia College of Rural and Remote Medicine (ACRRM)
- Rural Policy Group of the Australian Hospital Association AHA (RPG)
- Australian Nursing Federation (rural members) (ANF)
- Australian Rural and Remote Allied Health Taskforce of the Health Professions Council of Australia (ARRAHT)
- Aboriginal and Torres Strait Islander Commission (ATSIC)
- Council of Remote Area Nurses of Australian Inc. (CRANA)
- Country Women’s Association of Australia (CWAA)
- Frontier Services (FS)
- Health Consumers of Rural and Remote Australia (HCRRA)
- Isolated Children’s Parents' Association of Australia Inc (ICPA)
- National Aboriginal Community Controlled Health Organisation (NACCHO)
- National Association of Rural Health Education and Research Organisations (NARHERO)
- National Rural Health Network (NRHN)
- Regional and General Paediatric Society (RGPS)
- Rural Doctors’ Association of Australia (RDAA)
- Rural Faculty of Royal Australian College of GPs (RF of RACGP)
- The Australian Council of the Royal Flying Doctor Service of Australia (RFDS)
- Rural Pharmacists Australia - Rural Interest Group of the Pharmacy Guild of Australia and the Pharmaceutical Society of Australia (RPA)
- Services for Australian Rural and Remote Allied Health (SARRAH)
contact details

4 Campion Street, Deakin  ACT  2600
PO Box 280, Deakin West  ACT  2600

phone  02 6285 4660
       02 6285 4850

fax   02 6285 4670

email nrha@ruralhealth.org.au

web  www.ruralhealth.org.au