



NATIONAL RURAL
HEALTH
ALLIANCE INC.

Election Charter 2004

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National Rural Health Alliance

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Recent advances in rural health

Governments, health organisations and community leaders have given some priority to rural and remote health in recent years, with the Australian Government taking the lead on many matters. Rural and remote health issues have from time to time been prominent on the national agenda and this has resulted in some good outcomes for people in rural and remote areas. They include the following:

- re-financing of the Rural Health Strategy in the 2004 Australian Government Budget at the level of \$830 million over four years (some of the specifics in the list below are funded through that Rural Health Strategy);
- further development of the national network of Rural Clinical Schools and University Departments of Rural Health;
- extension of the Medical Specialist Outreach And Support program to existing specialist outreach services;
- increased accessibility for rural communities to a range of allied health services through the More Allied Health Services Program;
- re-funding of Rural Workforce Agencies;
- renewed support for the Divisions of General Practice;
- increased numbers of Registrar places for rural areas and greater numbers of hours of rural exposure in medical undergraduate courses;
- several other health professional training initiatives, including the Rural Australia Medical Undergraduate Scholarship scheme, some nursing and allied health scholarships, and bonded medical undergraduate scholarships and places;
- a major review of medical indemnity arrangements including supports for retired and disabled doctors, part-time practitioners and procedural GPs;
- streamlining and supporting the recruitment of overseas-trained doctors; and
- the extension of Medicare to a small number of dental and allied health consultations.

The biennial National Rural Health Conferences have received support from governments at all levels, including through the Alliance's core support from the Department of Health and Ageing and the attendance and participation of significant numbers of State and Northern Territory officers and researchers. These conferences have become key events for the rural and remote health community and would not be successful without the support of government.

The NRHA has continued to lead a range of activity and brings together an increasing number and diversity of rural and remote voices. The Alliance's Member Bodies, both

within the Alliance and of their own accord, have been strong advocates for various aspects of rural and remote health.

Progress in rural and remote health can be measured against the standards and principles set in *Healthy Horizons: Outlook 2003–2007*. This has been signed off by Health Ministers and the NRHA.

The Alliance is pleased to have been involved in many of the above initiatives and this Election Charter provides constructive proposals for adding to them. The Alliance looks forward to continuing its work with the Australian Government and the States and the Northern Territory in the interest of people in rural, regional and remote parts of Australia.

A Key issues

The social determinants of health

Health does not simply mean the physical well-being of the individual. It refers to the social, emotional, environmental and cultural well-being of the whole community. Health is a fundamental resource for individuals, the community and society as a whole. It is a basic human right. It requires investments in living conditions and networks of care that create and maintain health regardless of geographic location.

The determinants of health tell us that the important distal ('at a distance') causes of ill-health are living conditions; education (particularly in the early years of life); social, health and political systems; economic development and employment; culture and environment; addiction; food insecurity; social exclusion; and transport to enable access to services and participation in social life. The more proximal ('immediately related') determinants of behaviour and lifestyle are commonly targeted by health programs, despite the relatively limited success of such an approach. There is a clustering of known proximal risk factors amongst populations who are marginalised or disenfranchised socially and economically. To improve health status effectively, fairly and speedily there needs to be a focus on both distal and proximal determinants.

The Alliance's work is based on principles of social justice, equity and improved access to the range of goods, services and entitlements that impact on health status. These goods and services include housing, employment, transport, community services, recreation, aged care, affordable fresh food, telecommunications and broadcasting, and 'citizenship services' such as those that enable participation in social, political and economic decision making.

The Alliance will therefore continue to advocate to government and other bodies on this wide range of services and activities — as well as on 'health services' more narrowly defined.

The Alliance's approach to primary health care recognises a continuum of care from primary care (provided at the first point of contact) to community-based programs of primary health care that build the capacity of communities to provide environments that enhance health and well-being and mitigate against inequities. Primary health care is an inter-sectoral approach designed to address a wide range of determinants of health and to produce sustainable systems that lead to healthy communities and equitable services. Partnerships between local government, rural health services, education and social support services are integral for effective primary health care, particularly for children, youth and older population groups.

The Alliance is committed to the concept of general practice as a central and co-ordinating focus for the provision of primary care services, working in collaboration with other health professionals. Given the special circumstances of rural and remote areas, the smaller numbers of people and the higher costs of providing

service, the Alliance believes that all health professions need special training, support and allowances to work effectively, safely and happily in such areas.

The Alliance's proposals

1. The incoming Government should recognise the relationship between regional development, socio-economic disadvantage and health — and the particular needs in these respects of people in rural and remote Australia. Socio-economic disadvantage is the number one cause of poor health. Rural development should therefore be seen as a pre-requisite to better health outcomes, as well as to other economic and social objectives.
2. The Alliance calls on the incoming Government to recognise the need for improved public health infrastructure in remote Aboriginal communities, and the proven role of community-based approaches to address public health and related problems in them.
3. The Government should consider means by which a more equitable geographic distribution of private sector health services could be achieved. Possible actions include differential tax treatments, IT support, and program subsidies.
4. The Alliance will ask the incoming Government to ensure that there is a comprehensive package of support for the aged care sector in rural and remote areas so that as many people as possible in those areas have the option to pass through various stages of growing old without leaving their home area.
5. The incoming Government will be asked to commit to continued support for the extension and further development of quality telehealth networks and the provision of leadership and infrastructure for telehealth applications in rural and remote areas.
6. The Australian Government will be asked to retain the current ownership structure of Telstra and to fund further initiatives to improve the quality of rural and remote telephone lines and services. These initiatives should include an explicit plan for progressive upgrading of the quality of lines, on a 'worst first' basis, against measurable and enforceable targets. Priorities in this area include upgrading data transmission rates to enable all households to engage in the information economy, the provision of broadband services to communities with a physical health facility to enable telehealth and other applications, and mobile telephony services to all defined communities and along major transport corridors.
7. The Alliance will call on the incoming Government to work with States and Territories to review the PATS/IPTAAS scheme, particularly in relation to eligibility criteria, escorts, return travel, cross-border issues, pre-payment, and access to allied health and other non-medical professions. Health transport services should receive higher priority in health funding arrangements, including discharge arrangements for people returning home. There is a heavy burden on the community in States where ambulance services are run as private enterprises with a large commitment of volunteer labour (compounded by indemnity issues) and private donations.

8. The Alliance will continue to push for a Rural Development Commission or its equivalent, to take the lead in developing policies to stimulate rural development in conjunction with the three levels of government and local communities.

Further details of the Alliance's views on telecommunications, regional development and National Competition Policy are available at www.ruralhealth.org.au

Reform of the health system

A redirection of health funds from administration to services is possible with a more rational allocation of health responsibilities between governments. It would also provide clarity and reduce dysfunctional aspects of the current system that allow blame and cost to be continually shifted back and forth between the Commonwealth and the States/Territories. Jurisdictional inefficiencies contribute to the system's failure to be patient-focused and to provide integrated care. Integrated care requires close collaboration between hospital, community and primary care systems, and is not being delivered consistently enough by the present system.

The Alliance is generally opposed to further moves towards a user-pays system in health. The *Strengthening Medicare* program is reinforcing a two-tiered health system through its limited incentive for doctors to bulk bill some patients but not others. Access to health services should be determined by health need, not ability to pay. Health financing through the tax system is equitable and progressive. It is unacceptable that poorer Australians and those with less access to services are up to five times more likely to die of a preventable disease than their wealthier compatriots.

The Australian HealthCare Reform Alliance is promoting the case for a unitary source of funding for health and aged care, through a joint Commonwealth/State Commission. The NRHA supports the notion of a defined package of services and access standards being provided to all Australians. The means to and the cost of such a set standard will vary between different geographic areas. The stream of funds must be sufficient to ensure that access standards can be met for special need groups such as those with mental illness, dental problems or a disability, Indigenous people, and people in more remote areas.

There needs to be further analysis of different health funding options and their capacity to support the promotion of health and well-being and the prevention of ill-health. National reform of the health system is a major challenge, but all Australians have a right to access a quality health service in a timely fashion on the basis only of need.

The Alliance's proposals

1. The incoming Government will be asked to confirm the view that access to necessary health services is a social good and that governments' role in health is to maximise the health of all Australians, regardless of income, geographic location or origins.
2. The Australian and State/Territory Governments will be asked to work together to put in place new ways of managing and funding Australia's health system that will make it more effective in addressing health inequalities and ensuring that access to services is on the basis of relative health need only. A key first step is an informed national debate to establish the people's key values and priorities for an Australian healthcare system.
3. The incoming Government will be asked to commit to the target of raising the health status of people in rural and remote areas to that of their urban counterparts by 2020.
4. Until people in rural and remote areas have equivalent health status and access to services, the Alliance will continue to advocate for compensatory health programs for them.

Background to these proposals is in documents from the Australian HealthCare Reform Alliance and the National Healthcare Alliance, available through www.ruralhealth.org.au

Medicare

The Alliance believes that the key principle of Medicare is its universality, which underpins its ability to deliver on other principles such as access, equity, efficiency and simplicity. Medicare reduces cost barriers to primary care and can help ensure that health funds flow to areas of health need.

Its commitment in Medicare to universal access to necessary health services means that the Australian Government should provide funding for alternative first-point-of-contact assessment and treatment services in areas where there is limited access to doctors. The Alliance opposes proposals for the introduction of geographic provider numbers for doctors which incorporate reduced opportunities to practise in urban areas.

Reform of Medicare is part of the overall reform of the health system and its financing that is required. Recognising that people in rural and remote areas are currently poorly served, the Commonwealth and States/Territories should implement innovative approaches to health financing that would result in health care resources being more closely targeted to health need.

The Alliance's proposals

1. If people have no access to a doctor they have no access to Medicare. For areas where there is little chance of attracting sufficient private GPs, the incoming Australian Government should accept responsibility for funding necessary primary care services regardless of which suitably qualified health care professionals provide them. This is the contract between the national Government and the people that underpins Medicare.
2. The incoming Government should recognise that in its present form the private health insurance rebate is of limited value to rural and remote area residents and has increased the imbalance between urban and rural areas in the per capita distribution of government health funding. It should therefore re-direct some of the funds the rebate absorbs to measures to improve healthcare services in country Australia.
3. The Australian Government should routinely publish Medicare statistics that enable geographic comparisons of access to private medical services and patients' out-of-pocket costs. This could be done by aggregating the figures for Electorates now published annually.
4. The incoming Government should commission research on the total health costs to consumers of ambulatory care over episodes of illness or over a 12-month period and whether these are linked to billing practices of general practitioners. For example, there may be a relationship between the percentage of services bulk billed by a General Practitioner and the add-on costs incurred by patients through scripts, pathology and diagnostic imaging tests and specialist referrals.
5. In its program funding decisions, the Government should recognise the higher costs of providing health services in rural and remote areas, including for medical practitioners.
6. The incoming Government should support efforts to protect local access to procedural medical services when this can be demonstrated to be in the local community's best interests.

Further background to these proposals is in the Alliance's Position Paper, *A More Effective Medicare for Country Australians*, available at www.ruralhealth.org.au

Health promotion and illness prevention

Health promotion is the process of enabling people to increase control over the determinants of their lives in order to improve their health. Health promotion is most effective when actions are taken collaboratively between disciplines and inter-sectorally.

The Alliance would like to see explicit efforts by all governments and health agencies to ensure that the trend of health expenditures in the immediate future will favour health promotion and illness prevention activity. This will require political courage, as there are strong and effective vested interests in both some of the key lifestyle areas and in support of more and more illness treatment, including through high tech and expensive means — and including measures to extend life in the end stages. The Alliance will continue to contribute to national programs and activity related to health promotion, particularly for its rural and remote constituents.

Behavioural intervention strategies alone usually prove to be less successful with socially and economically disadvantaged groups than with those that are better-off. More comprehensive approaches to health promotion are those that build social capital in communities, address the relative lack of resources and education while also tackling behavioural and lifestyle risk factors.

The Alliance's proposals

1. The incoming Government should adopt a strong and explicit overall approach to health programs and policies that favours health promotion and illness prevention by:
 - giving greater attention to child and maternal health, and the health aspects of pre-school and child care;
 - giving higher priority to public health measures relating to smoking, weight control and obesity, alcohol and other drugs, safety on the roads and in workplaces (including on farms), gambling, interpersonal violence of all forms, and self-care;
 - taking on strong vested interests in the tobacco, alcohol and advertising industries, in order to put in place health-promoting advertising, taxation and pricing regimes;
 - devoting more leadership, inter-governmental and inter-agency activity, and resources to the urgent matter of improving health and life expectancy among Australia's Aboriginal and Torres Strait Islander peoples;
 - building communities through their full participation in decision making about how to tackle the issues that affect them; and
 - addressing mental health promotion using evidence-based approaches.

2. The incoming Government should give specific attention to the rural and remote aspects of these critical health areas, most importantly:
 - the Indigenous health challenge, which has some particular rural and remote aspects and which is a particularly rural and remote issue because the proportion of people who are Indigenous is higher in country areas — and much higher in remote areas;
 - advocating for children in rural and remote areas, who are often without a voice;
 - occupational health and safety in all industries in rural and remote areas, including especially agriculture, forestry, mining and the health sector itself; and
 - a comprehensive public health and health promotion approach to injury, accidents and self-harm which, in terms of statistical significance, account for the greatest amounts of excess morbidity and mortality in rural/remote over metropolitan areas.

Background to these proposals is in various of the Alliance's Position Papers and Submissions, available at www.ruralhealth.org.au

Recovery from drought and other natural disasters

Drought and natural disaster are key determinants of the health and well-being of country communities and their people. Large parts of the nation are suffering the effects of a widespread drought that is still not broken in many areas. The Alliance was asked by participants at the 7th National Rural Health Conference to pursue the links between drought and health, and ways in which recovery from the present situation could be supported.

It is important that government agencies do not see the temporary loss of population and economic activity caused by drought as the rationale for closure of local services. Once closed, the services may be hard to re-establish. In general it will be helpful to recognise that community recovery from a prolonged drought is quite a different challenge compared with the aftermath of a sudden and one-off event.

The Alliance's proposals

1. Because of the significant lack of agreement between its providers and recipients about the purposes of Exceptional Circumstances assistance, there needs to be further clarification of the program structure and more information about it. There needs to be further examination of the capacity of the Exceptional Circumstances arrangements to support individual and community recovery.

2. Governments should evaluate the application of community recovery strategies to all types of Exceptional Circumstances events.
3. Disaster management and recovery arrangements must ensure that all aspects of the health system are able to withstand the effects of potential hazards and are prepared to function at increased capacity following the impact of a disaster. Outreach arrangements to help people recovering from both natural disasters and Exceptional Circumstances events must deliver needed health and medical services as part of an overall support package. The ability of the health system to do these things is one of the benchmarks for evaluation of local and regional health service systems, including public health systems.
4. Arrangements for enabling recovery from Exceptional Circumstances should pay more attention to the positive role that adequate psychological support can play in enabling individuals and communities to recover. The provision of psychological help to support recovery from natural disasters should be reviewed to identify possible improvements.
5. Arrangements for developing and maintaining the disaster recovery skills of the rural and remote medical workforce, particularly rural and remote nurses, should be upgraded.
6. During periods of low income rural people often delay or do not seek medical treatment for pre-existing conditions or for conditions they develop as a result of disaster and disaster recovery. Disaster recovery and Exceptional Circumstances arrangements should be reformulated so that people are able to obtain the health (including medical) services they need when their income is reduced or interrupted.

Background to these proposals will soon be available in the Alliance's Position Paper *Rural Communities and Disaster Recovery* at www.ruralhealth.org.au

B Special need groups

Indigenous health

Improving the health of Aboriginal and Torres Strait Islander people should be the nation's number one social priority. A bipartisan national commitment is needed. Work and agreement across a number of policy areas is also needed.

The Alliance welcomed the additional \$40 million allocated in Budget 2004–05 to Indigenous health through the Primary Health Care Access Program (PHCAP). However evidence shows that, as a nation, we are still failing to address the real health issues facing Aboriginal and Torres Strait Islanders in Australia.

The Alliance will join with other bodies and individuals to call on the incoming Government to make improving Aboriginal health its first health priority. On average the life expectancy of Australia's Indigenous people falls behind that of Nigeria, Nepal and Bangladesh. A recent Canadian study ranks the quality of life for Australia's Aboriginal people as the second worst on the planet.

Oral and dental health is one of the most serious parts of the challenge. Indigenous children are much worse off in terms of dental disease and have a high level of untreated decayed teeth. An Aboriginal and Torres Strait Islander Oral Health Action Plan was produced at a Workshop in September 2002 and action on it is urgently needed. The National Strategic Framework for Aboriginal and Torres Strait Islander Health also recognises the impact of poor oral health on chronic disease and self-esteem. The inclusion of selected dental care in Medicare provides a major opportunity to make some progress on this.

The Alliance's proposals

1. The incoming Government should explicitly declare that it will make Aboriginal health and well-being the number one national social priority. This will require it to provide ongoing leadership through every agency (eg employment, community services, housing, reconciliation).
2. The incoming Government should commit immediately to acting on the new National Strategic Framework for Aboriginal and Torres Strait Islander Health (2003–2013) and funding its component parts such as the Framework for Social and Emotional Well-being.
3. The incoming Government should make a commitment that the new dental initiative in MedicarePlus will give priority attention to Indigenous patients. A major part of the program should be delivered through the referrals of medical officers employed by Aboriginal community controlled health services.

4. The Government should work urgently on a suite of policies and programs that will increase the number of Aboriginal and Torres Strait Islanders in all health professions, and provide additional support to Aboriginal and Torres Strait Islander Health Workers.

Aged care

There are two key principles which should guide consideration of the issues facing aged care in rural, regional and remote communities:

- aged care services should be available locally for all Australians; and
- Governments should recognise the higher costs of providing rural and remote aged care services, and the fact that such services cannot benefit from economies of scale.

There is a range of services and aspects of our nation's infrastructure and life that will enhance and extend the well-being of the healthy aged.¹

The Alliance's proposals

1. The incoming Government will be asked to commit to providing alternative models of aged care planning and service delivery in rural, regional and remote Australia — models that account for the needs and characteristics of communities in such areas.
2. The Alliance believes that governments should fund and manage rural and remote aged care services as Flexible Care, with funding and quality regimes designed for the specific circumstances of each local community and service. The Viability Supplement should be extended to community aged care services in rural and regional areas, and adequate capital grants provided to rural and other disadvantaged areas so that facilities are built and maintained to meet appropriate certification requirements.
3. The Government should introduce a funded staff support scheme for rural, regional and remote aged care services. It would potentially include e-learning and other forms of distance education and give access to training for staff, support the recruitment and induction of qualified staff, and provide staff and family benefits. There also needs to be a management and volunteer support scheme to help improve the performance of committees of management of aged care facilities and services.
4. Training and support in geriatric work should be provided for health professionals who intend to work in rural and remote communities.

¹ Some of the factors of greatest importance to the healthy aged are summarised in the joint ACSA/NRHA paper (2004) and the Alliance's Submission to the Senate Inquiry (February 2003); see at www.ruralhealth.org.au

5. There need to be ongoing nursing scholarships for those who intend to work in the aged care sector in rural and remote Australia. To succeed in attracting nurses and other health professionals to rural and remote areas, the scholarships need to make provision for flexible distance learning models and support.
6. The incoming Government should work on a range of policies and program funding for improved transport services and facilities for older people in country areas, including for helping them to access services. This should include assisted transport for the elderly.

Background to these proposals is in the joint ACSA/NRHA Discussion Paper, *Older People and Aged Care in Rural, Regional and Remote Australia*, available at www.ruralhealth.org.au

Child and adolescent health

The voice of rural and remote children is often unheard and the Alliance is one of the organisations advocating for programs and approaches that will meet their needs. This is not only a social justice issue for the child but one of the best possible investments in the future health of Australia.

‘Failure to thrive’ among Indigenous babies is still a major challenge. Indigenous children suffer high rates of ear infection that affect their learning as well as their immediate health.

The Alliance's proposals

1. The incoming Government should commit to the key action areas outlined in the Consultation Paper on *Developing a National Public Health Action Plan for Children 2005–2008*.
2. Aboriginal and Torres Strait Islander children must be the highest priority for the Government’s programs and general leadership on the issue.
3. The Australian Government should lead work to develop inter-sectoral approaches to the health impacts on children of physical, social, environmental and economic factors.
4. The Alliance calls for a significant increase in the national effort on early intervention in child and adolescent health and for healthy parents, particularly through Healthy Mothers: Healthy Babies programs, family services for rural areas and community development. Early intervention for adolescents with a mental illness should be a particular priority.

5. The Alliance seeks the institution of a National Children's Rights Commissioner.
6. The Alliance supports the status quo as far as the confidentiality of doctors' records for young patients is concerned.

Background to these proposals is in the Alliance's agreed Position Paper entitled *Child and Adolescent Health in Rural and Remote Australia* and a poster on the Rights of the Rural Child, available at www.ruralhealth.org.au

Oral and dental health

Poor oral and dental health is preventable and has adverse consequences for a person's overall health status and esteem. It is particularly prevalent among people on low incomes and those in rural and remote areas who have limited access to the services of oral and dental health professionals. The state of oral and dental health is poorest among Aboriginal and Torres Strait Islander people.

This is a blight on Australia's health that is largely avoidable and Governments need to collaborate on the solutions. There is clear evidence that programs like the Commonwealth Dental Health Program (1994–96) can bring significant improvements to the situation.

The Alliance's proposal

The incoming Government will be asked as a matter of urgency to increase its spending on public dental services in rural and remote areas and for people on low incomes in all areas. They should also work with relevant professional organisations on workforce initiatives for oral and dental health.

Background to this issue is in the Alliance's Submission to the Senate Inquiries into Medicare (2003 and 2004), the Hansard records relating to the Hearings of those Inquiries, and in *Position Papers 2000–2001* at www.ruralhealth.org.au

Mental health

Total health cannot be achieved without mental health. Mental health initiatives are therefore fundamental to primary health care. There needs to be a collaborative approach to mental health across all relevant agencies and existing initiatives such as those in health, education, employment, housing, disability and community services.

The costs of mental health in welfare payments, lost tax revenues and through carers has been estimated to be three to five times what is spent on mental health care.

There are a number of factors which exacerbate mental health problems in rural and remote Australia. People in rural areas are poorer, face higher rates of unemployment, and face additional challenges such as isolation, stigma as a result of less anonymity, exposure to environmental hazards, lack of appropriate services and service providers, and the effects of economic restructuring. They also face the challenge and consequences of dealing directly with drought and other natural disasters.

There is a shortage of mental health nurses, psychiatrists and psychologists in rural and remote communities. Lack of access to training, professional isolation, heavy workloads and limited resources affect the recruitment and retention of mental health personnel. As a consequence, non-mental health professionals in rural areas are more likely to be treating people with a mental illness. This prejudices the treatment and development of intervention and prevention strategies for people at risk in those areas.

In rural and remote areas there are particularly serious challenges in relation to the mental health of young people. Suicide is a major cause of death among 15–24 year old males, particularly in rural and remote areas, and many can be attributed to untreated depression and related drug and alcohol problems. An emphasis on mental health in young people, including measures to return a higher proportion of them to the workforce, would be most valuable.

The Alliance's proposals

1. The incoming Government will be asked to provide increased support for mental health programs focusing on young people, including those in rural, regional and remote areas.
2. The Mental Health Council of Australia should be supported to undertake an independent annual report on the status of mental health in Australia.
3. Government should expand the *Better Outcomes in Mental Health* program so that it can provide reasonable access to non-pharmacological treatment services, including in non-metropolitan areas.
4. Government should put in place specialised schemes to encourage and enable people with mental health problems who are on the Disability Support Pension to return to work.

5. National programs are required for early intervention for psychosis and for expanded research into early intervention models for mood-disorders and related substance abuse problems.
6. Greater attention should be given nationally, and in rural and remote areas in particular, to the needs of the carers of those with a mental illness. This includes children of parents with a mental illness. They are especially vulnerable and in rural and remote areas are likely to be very isolated both geographically and socially.
7. The managers of mental health services should ensure they have mechanisms in place for participation by consumers and carers.

Background to these proposals is in *Position Papers 2002–2003*, available at www.ruralhealth.org.au

C Health care professionals in rural and remote areas

Australia's international responsibility

Australia has a high dependence on overseas-trained doctors and other health professionals from overseas. This is particularly the case in rural, regional and remote areas.

As a nation we have an international obligation to ensure that we are producing sufficient health care professionals for our own current and future needs, that we are retaining them, and that we are planning for both rural and urban areas. Producing more health professionals than we need, in conjunction with activities and programs which encourage some Australian health professionals to spend time working in needy countries, would be a significant contribution to global health care.

The corollary of this is that Australia must certainly not actively recruit health care professionals from less well-off nations. The Melbourne Manifesto is a protocol on this matter and one the Alliance supports and promotes.

The Alliance's proposals

1. To help meet local and international demands for health care professionals, the incoming Australian Government must commit to increasing the number of training places for health care professionals in Australia.
2. Australia should develop a Memorandum of Understanding (MOU) with countries from which it wishes to recruit health care professionals. The MOU should include the issues listed in the Melbourne Manifesto.
3. Australia's systems for the recruitment of health professionals trained overseas should be regularly monitored. We must ensure that the working conditions and educational opportunities available here for overseas-trained health care professionals are supportive and at least equivalent to that provided to other health care professionals.
4. Australia should facilitate international exchanges of health care professionals and continue to work on educational links with universities and medical schools in less developed countries in order to contribute to the education and training of their health care professionals. We must continue to provide for further training within Australia for health care professionals from developing countries, and in such a way as to encourage them to return to their home countries after training

5. Australia must explicitly consider the effect its domestic workforce policies and overseas recruitment practices are having on less developed countries. For example it must ensure that the number and distribution of undergraduate and postgraduate training posts are adequate to meet its own workforce needs.
6. Another way to ensure the supply of adequate numbers of health professionals is to be creative about how they work together and about individuals' scope of practice. Australia must continue to consider alternative and innovative ways of providing care in areas of need such as the development of multidisciplinary teams and intersectoral collaboration.
7. Australia should help less developed countries recruit health professionals from developed countries. This support could include providing short-term opportunities for Australian health care professionals with clinical, educational, management, research and other skills to assist in the development of health care services in resource-poor countries.
8. Australia should push for an international process to ensure the evaluation and monitoring of international migration of health care professionals.

Background to these proposals is in the Position Paper, *An Ethical Approach to the Training and Supply of Health Care Professionals: in support of the Melbourne Manifesto*, available at www.ruralhealth.org.au

Strategic health workforce reform

In recent years the major health workforce focus in Australia has been on increasing numbers, for example by increasing training places, making greater use of overseas-trained health professionals or by programs to encourage a redistribution of the workforce to areas of relative undersupply. There have also been some programs to attract qualified health professionals, especially nurses, back into the health workforce and some attempts to introduce innovation in workforce structures and practices, for example nurse practitioners and a greater use of nurses in private general practice.

Despite these programs, dire predictions are still being made about actual and emerging severe shortages in most health professions. Rural and especially remote areas are particularly vulnerable as health workforce shortages increase because, in the absence of special supports, such areas are seen by many health professionals as less attractive than urban areas as places in which to live and work.

It is now clear that attracting and retaining health professionals, including health service managers, in rural and remote areas requires attention to a broad range of issues. Many of these issues are common to all groups, including:

- attracting students with country backgrounds into the professions;

- providing positive experiences in rural and remote areas to undergraduates and trainees;
- ensuring appropriate initial and ongoing education and skills development linked to future roles in rural and remote area practice;
- providing ongoing peer support and mentoring;
- providing locum relief;
- providing financial and other incentives such as flexible employment, enhanced leave and attention to future career prospects;
- paying attention to family and social needs; and
- ensuring appropriate resources for the health services in which or in conjunction with which they will work.

The Alliance's papers on specific professional groups outline priority issues for each of these groups. The health workforce overall seems so far to have missed out on many of the broader workforce reforms that have been adopted in other industries and which have led to increased productivity in them. John Menadue² has referred to the 'antiquated workforce structure' and highlighted the following items as potential areas for improvement, foreshadowing major productivity gains from implementing national workforce reforms:

- there are too many occupational groups and no plan to draw them together into a cohesive workforce;
- greater use of teamwork;
- greater integration of training and work;
- reduce demarcations and restrictive work practices;
- improve career prospects for some groups;
- reduce over-reliance on specialists for management of some conditions;
- closer linkages between service plans and workforce planning;
- redesign roles and re-engineer work processes; and
- national registration for all health professions.

To the extent that Menadue is correct, some health workforce shortages can be dealt with through increased productivity. This will require national leadership and a national strategy to identify and pursue workforce restructuring. Rural and remote areas are well placed to take a lead here as they already face a critical shortage of many health professions and already have a substantial focus on interdisciplinary teamwork and innovative scopes of practice.

² Menadue, J., *Curing Sick Hospitals*, Griffith Review, March 2004, pp 186–194.

The Alliance's Proposals

1. The incoming Australian Government will be asked to take the lead in encouraging all Governments to collaborate on developing and implementing a broad agenda for health workforce reform in Australia directed at improving workforce productivity within a safe and high quality health care system.
2. As part of this process, the Government will be asked to give priority to actions that are part of a strategic long-term plan to improve the availability of an appropriately skilled health workforce in rural and remote areas.

Rural placements for health undergraduates

Rural placements for health undergraduates are an important part of their preparation for rural or remote practice. Thanks to GP organisations and government, there is a high quality system in place for medical undergraduates. There is an urgent need for State and Territory investment in infrastructure and facilities to provide a placement system with equality for students of medicine, nursing, allied health, health management, pharmacy and dentistry.

Rural placements are invaluable opportunities for students to work in unique clinical environments and they must not be regarded as 'extra' or optional placements when sufficient places cannot be found in the cities.

The Alliance's proposals

1. The Alliance will ask the incoming Government to collaborate with the States/Territories, student bodies, rural communities, universities and professional bodies on a set of standards for rural placements for health students, to be implemented regionally through Government programs and those of the universities and professional associations. The standards would relate to teaching and supervision, travel, accommodation, financial commitments, community support, evaluation, information and reporting requirements.
2. These same standards should be the basis of funding and other support provided to the rural placement system. Governments should provide financial support for students, mentors, supervisors and preceptors for rural placements in all health professions. Resources for student support should be provided through the universities. Resources for mentors, supervisors and preceptors should follow the student and be provided as specific grants or allocations to the States, quarantined for student teaching in rural sites.
3. Consideration should be given by governments to the creation of a national database of student accommodation in rural, regional and remote areas to facilitate priority setting and systematic approaches to meeting gaps at a national, State and regional level. The database would be developed through joint collaborative action of health agencies, local authorities and universities.

4. Funding should continue to be provided to support the training of Indigenous and non-Indigenous health service managers for placements in rural areas within both mainstream and non-government health services.
5. Consideration should be given to ways in which the taxation system could be used to produce incentives to individuals, local authorities and health professionals involved in the rural placement system. Local investment by local government Councils and practitioners needs to be recognised and rewarded.
6. The Australian Government should provide ongoing support for data collection to track career patterns of students undertaking rural placements.

Background to these proposals is in *A Quality Rural Placement System for Health Students and Current Issues for Australia's Rural and Remote Health Workforce*, available at www.ruralhealth.org.au

General practitioners (OTDs, bonding)

As a nation there is still much to be done to improve the supply and distribution of general practitioners. The Alliance will continue to be involved in action on this fundamental issue.

The Alliance is committed to the concept of general practice as a central and co-ordinating focus for the provision of primary health care services, working in collaboration with other health professionals. It is a strong supporter of the range of special programs for rural general practice, given the poor distribution and availability of GPs in rural and remote areas, and the particular scope of practice and costs in rural general practice. Rural proceduralists (those GPs who do surgery, deliver babies and give anaesthesia) are of particular value and significance and the Alliance is concerned at their loss of numbers in country Australia.

Overseas-trained doctors are particularly important to rural, regional and remote areas. There is a fear that the *Strengthening Medicare* program will result in losing rural OTDs to urban Districts of Workforce Shortage (those with permanent residency and FRACGP can move regardless of the length of their original contract of service), and that it may also attract new OTDs to urban rather than rural areas.³

Despite all the best endeavours, the training and recruitment incentives to date have left rural, regional and remote areas still struggling to recruit and retain doctors. Other approaches need to be re-evaluated and the Alliance will be taking a lead in this.

³ There is evidence to show that even when OTDs have no choice but to move to rural areas, only 30% say they want to be in rural areas.

OTDs – the Alliance's proposals

1. The incoming Government will be asked to build on the initiatives for overseas-trained doctors in *Strengthening Medicare*. There needs to be a more intensive case-management approach to supporting OTDs and their families, to help ensure that they are successfully placed in fully equivalent medical practice. This will require additional resources for community, cultural, language and practice orientation and mentoring for work in rural and remote Australia. If this is done there will be more certainty that OTDs are accepted by the community and establish good working relationships with their practice, employer, peers and other health practitioners.
2. Consideration should be given to a new regulation under which only those OTDs who have not worked in Australia in the previous twelve months are allowed to choose urban (cf rural/remote) Districts of Workforce Shortage under *Strengthening Medicare*.
3. Further attention needs to be given to assisting doctors who have trained overseas to prepare for and pass the Australian Medical Council examination and the Fellowship exams of the specialist Colleges. This can be done by various means, including through support from the AMC and the Colleges, GPET-funded Regional Training Providers in rural areas, Rural Workforce Agencies, and Divisions of General Practice.
4. The incoming Government must continue efforts to provide overseas-trained doctors with accurate and comprehensive information about available opportunities for practice, particularly in rural and remote areas, including through the new Government websites.
5. Additional resources are required to support doctors trained overseas in their collaboration with other members of inter-disciplinary health teams, such as allied health workers, clinical nurses, dentists and practice managers.
6. The Government should support communities to increase their capacity to provide local programs which support cultural integration of overseas-trained doctors.

Bonding – the Alliance's proposals

1. The Alliance accepts bonded scholarships as one of a suite of policies to increase recruitment and retention of GPs for country areas as long as there is reward (financial and/or other) and understanding for the students, and the conditions imposed upon them are fair, open and fixed. This will require continual appraisal of the terms and conditions that apply from time to time, with due attention being given to the views of students themselves.
2. The Government must accept that any program designed to increase the exposure of medical students to rural and/or remote areas must allow for its impact on communities, mentors, teachers in the field, and students themselves.

3. There must be continued longitudinal studies to evaluate the impact of bonded scholarships on the students at medical schools, the schools themselves, their mentors and, most significantly, on the supply of GPs to rural and remote areas.
4. The Alliance will ask Governments to consider bringing all medical undergraduate scholarships into line in terms of the terms and conditions for scholars. This would equalise opportunities, make it easier for universities and training providers to administer the programs, and minimise the risks of rivalries and tensions between different cohorts of students.

Background to these proposals may be found in the Alliance's Papers *Support for Overseas-Trained Doctors and Bonded Medical Scholarships and University Places*, available at www.ruralhealth.org.au

Allied health

The Alliance is concerned about the continuing shortage of allied health services in country areas and calls on State and Territory Governments, through their Area Health Services and public hospitals, to increase the priority given to allied health positions in rural and remote areas.

The Alliance's proposals

1. The incoming Government will be asked to play a lead role in raising awareness among both consumers and GPs in rural and remote communities of the wide range of services that allied health professionals provide, including in rehabilitation, acute care, continuing care for chronic illnesses, aged care, palliative care, mental health and health promotion. Such action should be part of a strategic approach to the allied health workforce in rural and remote areas — otherwise increased awareness is likely simply to raise unrealistic expectations about service availability. Allied health professionals need to be considered as integral members of rural and remote multi-disciplinary health care teams.
2. The incoming Government will be asked to commission a national analysis of supply and demand for allied health professionals across rural and remote areas, and of their training and support needs.
3. The Australian Government should provide funding for a national scholarship system for rural and remote undergraduate allied health students, similar to that which already exists for medical, nursing and pharmacy students. There should also be support for rural and remote allied health placements.
4. Governments should increase the number of joint academic/clinical allied health positions in rural and remote areas, to provide high quality professional support to allied health students, new graduates and local practitioners.

5. The Government should introduce a HECS reimbursement scheme for graduate allied health professionals going to rural and remote employment.
6. The Australian Government should ensure that all University Departments of Rural and Remote Health have a strong multi-professional focus across all of their education and training programs, including where possible the promotion of joint placements of medical, nursing and allied health students.
7. The Australian Department of Health and Ageing should appoint a senior National Allied Health Adviser to foster co-ordination and co-operation on allied health issues with State and Territory Governments, as part of the development of a broad health workforce strategy for allied health professionals in rural and remote areas.
8. The Australian Government should ensure that allied health professionals are involved in policy and program development for the National Health Priority Areas and other relevant national initiatives.

Background to these proposals is in the Alliance's Policy Portion, *Wanted: Allied Health Services in Country Areas*, and in a new paper on the allied health professionals soon to be available at www.ruralhealth.org.au

Nursing

The Alliance's proposals

The incoming Government should lead national action — that will necessarily involve other levels of Government, Schools of Nursing and other bodies — on the 7-Point Plan from the collaborative project being led by the Alliance on the rural and remote nursing workforce. The Plan is summarised below.

1. There should be pilot projects to establish national locum relief and mentoring programs, and additional incentives for rural and remote nurses in areas that have difficulty attracting and retaining staff. These additional incentives should include:
 - reimbursement of relocation costs;
 - an accommodation allowance;
 - appropriate housing;
 - financial recognition of qualifications and/or years of experience in remote settings;
 - annual airfares to nearest capital city for nurses and their families;

- study allowances, including leave to access courses and financial support to attend;
 - salary loading to reflect the degree of remoteness or isolation;
 - education on local cultural issues; and
 - regular isolation leave.
2. Governments should encourage health service providers to meet their duty of care obligations to nurses by adopting risk management strategies covering comprehensive preparation for practice relevant to the practice setting, including in relation to clinical skills, occupational health and safety, violence, cultural safety, and personal safety and coping skills.
 3. There should be a collaborative effort involving governments, nursing organisations, non-government organisations and the media, to market a positive image of nursing in rural and remote areas. The image should highlight the fact that nurses are valued and necessary for the continued health care of these communities.
 4. Schools of Nursing, including in the vocational education sector, should provide courses that prepare graduates for the realities of practice in rural and remote areas, including through curriculum content, placements and the needs of marginalised groups. To this end, all Schools of Nursing must ensure that:
 - their courses contain elements that cover all contexts in which nursing care is provided, including rural and remote areas;
 - Indigenous health and cultural safety education is incorporated as part of their core curriculum;
 - access to clinical placements in rural and remote areas is facilitated;
 - they establish regional learning centres to support local undergraduate students;
 - funding for nurse education programs in rural and remote areas is appropriate to the unique circumstances applying, such as high travel and accommodation costs; and
 - negotiations are undertaken between the Universities, rural and remote nursing organisations, and the Australian Government on the funding formulae for nursing education to achieve adequate financial support for both the administrative costs of clinical placements and the costs incurred by students.
 5. There must be action to ensure that health service providers in rural and remote areas provide workplace environments with adequate levels of human, financial and material resources, flexible employment models, reliable relief systems and professional support mechanisms.

6. There should be action to lobby for the provision to nurses in rural and remote areas of regular access to reliable information technology, including telephones and the internet, and training and support for its use.
7. Funding must be provided for postgraduate advanced practice training programs for rural and remote nurses that include context-specific advanced clinical nursing skills, public health, clinical supervision and co-ordination of trainee support and placements.

Background to these proposals is in the NRHA Submission to the Senate Community Affairs References Committee Inquiry into Nursing (June 2001), available at www.ruralhealth.org.au

Health service managers

Managers of health services in rural, regional and remote areas are sometimes the forgotten professionals where health policy considerations and support programs are concerned. They should be recognised as an important professional group within the multidisciplinary team, particularly in rural and remote areas, where they face some unique pressures and challenges. With skilled and experienced managers in place, it is possible to maximise high quality health care in rural, regional and remote communities.

The Alliance's proposals

1. Health service management positions in rural and remote areas should be regarded as a specialist area of management and be promoted as attractive positions with good career opportunities. Employers of health service managers, including Australian and State Governments, should resource the positions appropriately, and managers in rural areas should be remunerated on the same basis as those in metropolitan health services.
2. There should be a new national project to encourage and facilitate Indigenous people to become health service managers in mainstream and Indigenous fields. Once in such positions, Indigenous health service managers need targeted resources for support, ongoing professional development, mentoring and expanded career opportunities.
3. Opportunities should be provided for all career health managers to experience rural aspects of health management and a general rural orientation.
4. Consideration needs to be given to the provision of financial and other incentives for senior health service managers that take into account the unavoidable costs associated with relocation and re-establishing the family in a new place.

5. Health systems should recognise the importance of providing career progression opportunities for managers in country areas. A range of strategies could facilitate this, including rotation postings in larger organisations as part of an operational professional development process, acknowledging the equivalence (to their metropolitan counterparts) of experience and skill development gained in working in a rural organisational environment, and encouraging progression through more complex organisational environments (whether metropolitan or rural).
6. Health service managers in rural and remote areas should be provided with good access to management development, with support provided through video-conferencing, webstreaming and satellite broadcasts. Rural managers should have priority access to scholarships for postgraduate study and for self-help management development. Rural and remote managers could be given periods of work in city facilities — say 1–3 months at a time — as an extended mentoring system.
7. Health service managers in rural and remote areas should be provided with support to attend further education and professional development with other rural clinicians and in metropolitan areas. This could include Visiting Fellow programs in which leading health management proponents are funded to provide workshops in rural and remote areas, other management training programs in country areas, scholarships for further tertiary education, mentoring schemes and ongoing support for continuing professional development in the form of high grade IT access (eg for intranet contact with peers).
8. A scoping study should be undertaken to determine the major gaps in the rural health service management skill base, with a view to developing a strategic postgraduate program that targets these areas.
9. There is a need for further collection of workforce data on health service management, in particular in rural and remote areas.
10. There should be a network established of resources across rural communities that facilitates health service managers' peer support, CPD, locum replacement and/or training and career pathways.

Background to these proposals is in the Alliance's Position Paper *Supporting Rural Health Service Managers*, available at www.ruralhealth.org.au

D Other issues

Research

While Australia is now recognised as a world leader in rural and remote health education and training, rural and remote health research is still relatively piecemeal, and generally consists of short-term projects based on limited short-term funding.

Improved research infrastructure is likely to have significant benefits in recruitment and retention of clinicians to rural and remote Australia, allowing them to maintain and develop their skills and interests while working in such areas. It will also foster a culture of enquiry and continual improvement that will encourage rural health services to adopt new models of care.

Sustained effort to develop rural and remote health research would produce health gains and economic benefits through an increased knowledge base and improved evidence-based practice. Such gains have the potential to benefit not only rural and remote populations, but the broader population as well. A flourishing research culture in rural and remote areas also provides opportunities for continuing education and professional development for health professionals in these areas, further assisting recruitment and retention strategies.

Priority areas for research include clinical and epidemiological work to identify and explore the conditions, population groups and locations for which rural and remote health status is significantly worse than the national average; applied research into innovative models of health service delivery; longitudinal studies of the effectiveness of a range of interventions on workforce recruitment and retention in rural and remote areas; and research into health issues affecting Aboriginal and Torres Strait Islander people, who are more significantly represented in remote and rural areas than in urban areas.

Rural and remote health research is an emerging area which needs strategic effort to build its capacity, and quarantined long-term funding.

The Alliance's proposal

The incoming Government must commit to a funded national strategic approach to rural and remote health research, building on the existing infrastructure located in rural, regional and remote areas. The approach should encompass all institutions in which research and evaluation is undertaken including academic bodies and service providers. The research should include participatory and action research as well as more theoretical inquiry.

Further details about this proposal can be found in the *Position paper on health research in rural and remote Australia*, Australian Rural Health Education Network, November 2002, available at www.arhen.org.au/research.htm

Healthy Horizons

The Alliance will ask the incoming Government to promote and act on the goals and principles of *Healthy Horizons*, the *de facto* national rural and remote health strategy. The strategy has been agreed by the Australian, State and Territory Ministers for Health and by the NRHA, and provides a useful framework for planning and management of rural and remote health issues.

The Government will be asked by the Alliance to promote the *Healthy Horizons* framework in the health sector, and to organisations in related sectors such as housing, employment, local government, environment, transport and community arts.

The principles of *Healthy Horizons* are a primary health care approach, public health, community capability, community participation, access, sustainability, partnerships and collaboration, and safety and quality. Its Goals are:

- Goal 1 Improve highest health priorities first.
- Goal 2 Improve the health of Aboriginal and Torres Strait Islander peoples living in rural, regional and remote Australia.
- Goal 3 Undertake research and provide better information to rural, regional and remote Australians.
- Goal 4 Develop flexible and co-ordinated services.
- Goal 5 Maintain a skilled and responsive health workforce.
- Goal 6 Develop a needs-based flexible funding arrangement for rural, regional and remote Australia.
- Goal 7 Achieve recognition of rural, regional and remote health as an important component of the Australian health system.

The vision of *Healthy Horizons* will be achieved when there is improvement in the health of rural, regional and remote Australians compared with other Australians; and areas of high need in rural, regional and remote Australia have access to adequate resources.

The Alliance's proposal

1. The incoming Government will be asked by the Alliance to continue to organise for reports on progress against *Healthy Horizons* to be provided to the public by national, State and Territory Governments and the Alliance itself, including a major progress report scheduled for 2005.
2. Governments will be asked to promote the principles and Goals of *Healthy Horizons* across their agencies so that the health consequences of actions in 'non-health' sectors can be recognised and considered.

***Healthy Horizons: Outlook 2003–2007* is available at www.ruralhealth.org.au**

Classification systems for rural and remote areas

The chief classification systems used in the rural and remote health sector are the Rural, Remote and Metropolitan Areas system (RRMA), the Australian Standard Geographical Classification system (ASGC) and the Accessibility/Remoteness Index for Australia (ARIA). There are a number of targeted or refined versions of ARIA, such as ARIA Plus and PHARIA.

These systems are based on geographical factors such as distance and do not incorporate a range of factors which are important in identifying areas of unmet need for health care, such as measures of health status, socio-economic disadvantage, health service availability or barriers to accessing health care. It is likely that these indices understate the extent of locational disadvantage in Australia.

All three systems are also challenged by geographic and local anomalies, and this can affect the eligibility of individuals for scholarships and other payments. For instance the classification of Darwin as a capital city may not be appropriate as a basis for allocating health resources. Some communities in Victoria which are not geographically 'very remote' are as disadvantaged as 'very remote' places in the larger States.

Delegates at the 7th National Rural Health Conference called for a review of these systems. Since then the Government has added the notion of 'Areas of Consideration' as a means of redressing specific anomalies with RRMA in particular. One of the purposes of a review would be to develop a classification system that would see the level of funding increased to areas of need. Having an effective, validated and widely accepted measure of relative access to health services would greatly facilitate advocacy work and equity in health services.

The Alliance's proposal

The incoming Government is asked to review the existing taxonomies used in rural and remote health (ARIA, RRMA, ASGC and Areas of Consideration), and in particular to assess them and alternatives to them as to their appropriateness as planning and resource allocation tools. This review should prepare recommendations which incorporate stakeholder feedback on the current systems and problems associated with their use, and review other systems used in rural and remote health service planning here and overseas.

Member Bodies of the National Rural Health Alliance

The National Rural Health Alliance currently has twenty-three Member Bodies:

- Association for Australian Rural Nurses Inc.
- Australian College of Health Service Executives (rural members)
- Australian College of Rural and Remote Medicine
- Rural Sub-committee of the Australian Divisions of General Practice
- Rural Policy Group of the Australian Healthcare Association
- Australian Nursing Federation (rural members)
- Australian Rural Health Education Network Ltd.
- Australian Rural and Remote Allied Health Taskforce of the Health Professions Council of Australia
- Aboriginal and Torres Strait Islander Commission
- Council of Remote Area Nurses of Australia Inc
- Catholic Rural Hospitals Forum of Catholic Health Australia
- Country Women's Association of Australia
- Frontier Services of the Uniting Church in Australia
- Health Consumers of Rural and Remote Australia
- Isolated Children's Parents' Association of Australia Inc
- National Aboriginal Community Controlled Health Organisation
- National Rural Health Network
- Rural Doctors' Association of Australia
- Rural Faculty of Royal Australian College of GPs
- The Australian Council of the Royal Flying Doctor Service of Australia
- Regional and General Paediatric Society
- Rural Pharmacists Australia — the Special Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia, and the Australian Society of Hospital Pharmacists
- Services for Australian Rural and Remote Allied Health



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