



NATIONAL RURAL
HEALTH
ALLIANCE INC.

The National Rural Health Alliance (NRHA) is the peak organisation working for good health and well-being in rural, regional and remote Australia. It is comprised of twenty-three Member Bodies representing the consumers and providers of health services. The Members are national organisations and they are listed at the end of this document.

These Position Papers represent the agreed views of the Alliance but not necessarily the full or particular views of all 23 Member Bodies. Working drafts were circulated to Member Bodies and to members of *friends of the Alliance*, comprised of individuals and organisations with an interest in rural and remote health. The Papers were adopted by Council of the Alliance at meetings between November 2003 and May 2004.

These Position Papers are published to help inform the discussions and decisions of policy makers, managers, researchers, consumers and professional bodies.

Position Papers are dynamic documents that change from time to time in order to reflect altered views and priorities. If you would like to make comments, we would be pleased to receive them. NRHA Position Papers, Policy Portions, submissions and Media Releases are all available on our website at www.ruralhealth.org.au

We hope you find the Papers useful and informative.

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Position Paper

Current issues for Australia's rural and remote health workforce

May 2004

This Position Paper represents the agreed views of the National Rural Health Alliance but not necessarily the full or particular views of all Member Bodies.

Current issues for Australia's rural and remote health workforce

This paper outlines some of the key health workforce issues currently of concern to the National Rural Health Alliance. For the purposes of this paper the term 'health professionals' includes doctors (general practitioners and specialists), Aboriginal and Torres Strait Islander Health Workers, nurses, allied health professionals¹, health service managers, pharmacists and dentists.

The Alliance advocates for people in rural and remote Australia and is therefore primarily concerned with the supply of health professionals and their distribution in those areas. However its work is based on principles of social justice and the right to have affordable access to high quality health services, so it recognises that there are also serious shortages of health professionals in some outer metropolitan areas. In aggregate, however, the health of people in rural and remote areas is worse and their income lower than in the capital cities, so that the Alliance does not apologise for asserting that the most serious workforce shortages are those in country areas.

The shortages in rural and remote Australia need to be seen within the context of the **global situation**. They also have to be dealt with in that context. There is a global shortage of health professionals, and non-metropolitan Australia is well-off compared with poorer nations. The Alliance therefore advocates strongly for Australia not to solve its own problems by making the situation worse in poorer countries. More than this, the Alliance believes firmly that Australia has an ethical responsibility to make a net contribution to the world supply of health professionals. This means at least two things for Australia: not actively recruiting health professionals from poorer nations; and training more than enough health professionals for its own needs.

The Alliance and its Member Bodies support the ethical approach to recruitment of health professionals outlined in *The Melbourne Manifesto*² and will continue to promote the document as a valuable framework for international action.

Global considerations of supply and demand for health professionals raise two important issues not canvassed in this paper. The first is just how much health care is warranted for any particular individual, given competing demands for resource allocation. The second is how an agreed amount of health care should be provided and by which professionals. These questions are important and answers to them will help determine the numbers required in any professional group (doctor, nurse, podiatrist). If podiatrists were to do 'all the foot work' there would be the need for a greater number of them, and less doctors, than if the foot work were to be shared between podiatrists and doctors. Answers to the second question (who does the work) will also determine the boundary issues relating to individual professions. These in turn will impact on multi-skilling, the nature of multi-disciplinary teams, and the work of professionals whose work might in the old days have been seen as 'crossing boundaries', such as advanced practice nurses.

Given the importance of **overseas-trained doctors** (OTDs) to rural and remote Australia, the Alliance has an ongoing interest in matters related to OTDs. Some of the Alliance's concerns have been expressed in the Policy Portion recently published³ and by Media Release⁴. The Alliance's overall view is that overseas-trained doctors should be sought for Australia only from developed countries, should be carefully assessed for clinical and cultural competence so that there is no reduction in the quality of service provided, and should be well supported and highly valued. The Alliance welcomes the activity under way at national level as part of the MedicarePlus package, and expects continued adherence to the principles relating to assessment and support for OTDs.

The matter is so complex that, in order for sustainable solutions to be found, there will need to be a high level of ongoing collaboration between the health and immigration agencies of the Australian Government, the States and Territories, the Health Insurance Commission, the Australian Medical Council, the State Medical Registration Boards, Medical Colleges and other professional bodies.

There will always be overseas-trained doctors working in a country like Australia, and the unique opportunities and challenges of rural and remote practice will mean that many of them will be in those areas. The Alliance's long-term hope is that, as a nation, we will soon be able to make a net contribution to the world supply of doctors. This means that at any given time there would be more Australian-trained doctors working overseas than overseas-trained doctors working in Australia.

There have been a number of significant developments in **rural and remote medical education** in recent years and the Alliance is on the record as welcoming these. The regionalisation of medical education has been a great boon to the health sector currently and will underpin a better distribution of doctors between city and country areas in the medium term. The health sector has arguably set a new standard for useful regionalisation of resources through the Rural Clinical Schools, the University Departments of Rural Health and the work of General Practice Education and Training Ltd (GPET). These have made health the envy of other sectors in which so many of the key resources and decisions are still tied to the capital cities.

The Alliance has had a long-term interest in measures to provide a larger, better-trained and safer **nursing workforce** for rural and remote areas. It is co-ordinating a rural and remote nursing project led by the three nursing organisations within the Alliance and involving a further five national nursing bodies.

The shortage of nurses in rural and remote Australia is already very serious. At any given moment, a significant proportion of those trained within Australia as nurses are not in the nursing workforce. This attests to relatively poor rates of pay in nursing, the difficulties and conditions of the work, and probably the perceived low status of the profession.

At the time of writing, the United States has initiated action to obtain up to one million extra nurses and the UK government has also embarked on a large recruiting exercise. The pressure on supply in Australia is going to become even worse.

The most important recommendations being promoted in the rural and remote nursing project are:

- to develop access for rural and remote nurses to information technology;
- to encourage nursing employers in rural and remote areas (Area Health Services, hospitals, nursing homes) to make available special incentives, in recognition of the special circumstances and costs associated with work in those areas;
- to find ways to help potential employees prepare for rural and remote practice;
- to support the rural and remote aspects of the follow-up work from the National Review of Nursing and Nursing Education;
- to seek the means for promoting rural and remote nursing as a rewarding and safe profession; and
- to encourage curriculum changes that will lead to better preparation of nursing students for clinical and cultural practice in rural and remote areas.

There is a maldistribution of **allied health professionals** and shortages in rural and remote areas. Despite increased activity at national, state and territory level, rural and remote Australia is losing allied health positions and clinicians. This has adverse consequences for patients and the remaining workforce. The Alliance has called for Area Health Services (or their equivalent) and public hospitals in non-metropolitan areas to increase the priority they give to allied health positions.

Allied health professional 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. They work in both the public and private sectors, and provide services to people in rural and remote communities.

Australian Bureau of Statistics data indicate critical shortages across all allied health professions⁵. Many of the issues impacting on the recruitment and retention of GPs and nurses impact similarly on allied health professionals.

Health practice in rural and remote areas provides great rewards as well as some well-known challenges. The Alliance works hard to present a balanced picture of the circumstances faced by practitioners in country areas. Evidence shows that having a **rural placement** while training or retraining increases the likelihood of a health professional working in rural or remote areas. However such placements must be well-supported, planned and safe, and this makes demands on existing rural practitioners who are the mentors of those on placement. There are currently insufficient practitioners with the time and skills to support the placements of all health undergraduates in training. The Alliance has therefore called for a quality rural health placement system that gives priority to those who indicate an intention to practise in country areas.⁶

There is a special workforce program funded by the Australian Government for **rural pharmacists**. It was initially established in 1999 and now includes an emergency locum service, undergraduate scholarship schemes, including one for Indigenous students, assistance for placements, funding to allow a pharmacist academic to be located in each of the existing University Departments of Rural Health, continuing professional education support, and an infrastructure and support scheme to help link rural and remote pharmacists with each other and with other health practitioners and clients.

The training and retention of **Aboriginal and Torres Strait Islander Health Workers** is also a matter of great importance to health outcomes, particularly in more remote areas and for Aboriginal and Torres Strait Islander peoples. There is a National Strategic Framework for the training of Aboriginal and Torres Strait Islander Health Workers, and Community Services and Health Training Australia Ltd (CSHTA) is leading work to produce a revised set of competency standards for such workers, to replace the set agreed in 1996⁷. The Alliance has to date had a low-level of activity in relation to Aboriginal and Torres Strait Islander Health Workers — through recommendations at its biennial Conferences, for instance. In consultation with NACCHO and ATSIC, which are Member Bodies, and others, the Alliance will increase the priority it gives to this matter.

There is as yet no rural **dental** organisation in the Alliance. This is arguably a serious deficiency. Nevertheless, the Alliance has an agreed Position Paper on Oral and Dental Health⁸. The Alliance has continually pushed for national leadership and funding, with the States and Territories, of additional public oral and dental health services⁹. This will be of most value to people on low income and, potentially, to school children and elderly people. This is a serious issue because of the current poor state of oral and dental health and because oral and dental problems are largely preventable. The Alliance does not see this merely as a time-limited intervention by the Australian Government in order to reduce waiting times at existing public services. Rather it sees this as an area where there should be joint Commonwealth/State action on an ongoing basis.

The Alliance, in collaboration with the National Aboriginal Community Controlled Health Organisation (NACCHO) is pushing for a substantial proportion of the effort on dental services through MedicarePlus to be for Indigenous patients. Oral and dental health is getting even worse among Indigenous peoples, including for pre-schoolers, who have a rate of dental caries three times as bad as for Australian pre-schoolers overall.

Like Aboriginal and Torres Strait Islander Health Workers, **health service managers** are sometimes forgotten in discussions about the health workforce. This is a serious oversight because no matter what the health service is, or where it is, or which professions it includes, it needs to be well managed. The Alliance intends in future to focus more of its effort on measures that will improve recruitment, retention and support of health service managers. It will be led in this endeavour by the rural sub-group of the Australian College of Health Service Executives, a Member Body of the Alliance.

For some years the Alliance has been interested in the role of **nurse practitioners** (or **advanced practice nursing**). In recent years there have been significant developments across the country with nurse practitioners. Currently the Australian Nursing Council is working with its New Zealand counterpart on educational standards and competencies for nurse practitioners. Nurse practitioners obviously have a great deal to offer to people in more remote areas where fee-for-service general practice is difficult to sustain. Issues related to nurse practitioners raise some of the puzzles referred to above about boundaries between health professions.

For many years people in small country towns and more remote areas have been concerned about their continuing ability to have local **birthing services**. There has been a gradual loss in country areas of general practitioner proceduralists delivering babies. The recent difficulties with indemnity (still not solved to everyone's satisfaction) have exacerbated the service losses. As far as birthing services and the workforce are concerned, there are unresolved issues relating to access to GPs and/or midwives. The Alliance has been approached by national bodies involved with **midwifery** to develop a position on the matter.

Practice nurses are trained nurses who work for a GP, often in the general practice but sometimes in the community. They have a mix of nursing and administrative duties. They are part of the general practice team and MedicarePlus allows certain services provided by a practice nurse — eg immunisations and wound dressing — to be charged to Medicare even if a doctor is not present. *Good Health to Rural Communities — A Collaborative Policy Document*¹⁰ calls for this system to be extended to other services like Pap smears, home visits and aspects of geriatric, antenatal and infant care “to allow doctors to spend more time providing services at the level for which they are appropriately qualified and so reduce patient waiting times. In some places, it would also give consumers a much appreciated choice of male or female service provider.”

Notes

- 1 The Alliance uses the term ‘allied health’ to refer to health professions other than nursing and midwifery, medicine, dentistry and pharmacy. The larger groupings of allied health professionals, according to this definition, are in physiotherapy, psychology, social work, medical imaging, occupational therapy, speech pathology, optometry, dietetics, podiatry, and audiology.
- 2 *The Melbourne Manifesto*, A Code of Practice for the International Recruitment of Health Care Professionals; Adopted at 5th Wonca World Rural Health Conference Melbourne, Australia, May 2002.
- 3 Policy Portion 2003/3, November 2003, available at www.ruralhealth.org.au/nrhpublic/PublicDocs
- 4 See the Media Releases of 5 November 2003 and 27 February 2004.

- 5 National, State and Northern Territory Allied Health Workforce Reports, Ann O’Kane and Shelagh Lowe, Services for Australian Rural and Remote Allied Health, March 2004.
- 6 *A Quality Rural Placement System for Health Students*, NRHA Position Paper, March 2004; available at www.ruralhealth.org.au
- 7 *Aboriginal Health Worker and Torres Strait Islander Health Worker Competency Standards and Qualifications Project*, Community Services and Health Training Australia Ltd; accessed from www.cshata.com.au
- 8 Position Papers 2000–2001, NRHA, Canberra; available at www.ruralhealth.org.au
- 9 See for example the second report from the Senate Select Committee into Medicare (chapter 5):
http://www.aph.gov.au/senate/committee/medicare_ctte/medicareplus/report/index.htm
- 10 *Good Health to Rural Communities — A Collaborative Policy Document*, ALGA, RDAA, CWAA, NFF and HCRRA, March 2004.



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Position Paper

Bonded medical scholarships and university places

November 2003

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Bonded medical scholarships and university places

Introduction

There is a global shortage of health professionals, including doctors, nurses and allied health professionals. Australia is relatively well-off and has a good overall health system but there is, nevertheless, a recognised shortage of health professionals in the nation. The shortages are worst in rural and remote areas and some outer-metropolitan suburbs.

The shortage and maldistribution of general practitioners is particularly prominent in people's understanding of this issue. Governments over the years have made a number of efforts to rectify this, recognising that in Australia (as elsewhere) GPs play a central role in providing primary health care. Workforce shortages result in poor access for patients, unmet health need, overworked doctors and expensive strategies for governments.¹ Because the shortages contribute to a lack of primary care and illness prevention, they also result in higher public and personal costs as patients move unnecessarily or more quickly to acute and tertiary care.

It is accepted that the reduction of this maldistribution of GPs is a key health workforce issue for Australia. A number of programs are in place to try to meet the challenge, building on various determinants of doctors' decisions and attitudes: personal factors like family ties; where they were raised and trained; the scope of practice to which they aspire; and remuneration and the sustainability of their practice.

A number of government programs intervene in what might be seen as free market approaches to the training of GPs and their choice of training and practice locations. Universities have been asked to achieve targets for the proportion of their medical student intake that comes from rural areas. Many GPs who choose to work in rural and remote areas have access to differential remuneration loadings in programs such as the Practice Incentive Program, and some of them are eligible for retention payments. Governments and registration bodies collaborate to expedite the placement of overseas-trained doctors and temporary resident doctors in areas of need.

Despite all such efforts to redress the shortage, altered expectations about the pattern of work, and other personal preferences related to family, social and professional goals have resulted in the persistence of this adverse situation. Currently the situation is seriously worsened by costs and uncertainties related to indemnity insurance.

It is therefore important that a suite of integrated policy approaches remains in place to improve the recruitment and retention of rural GPs in Australia and to

help assure people in rural areas of access to a GP. Despite some evaluation activities there is not yet strong empirical evidence of the greater effectiveness of any particular policy approach. Nationally co-ordinated, adequately funded, long-term research and evaluation programs on workforce recruitment and retention must continue.²

This Position Paper describes some of the Alliance's views on two quite different forms of bonding currently being applied to medical education. They are the established rural bonded scholarships and the proposed bonding of students to future rural or urban areas of workforce need in return for additional places in Australia's Medical Schools.

Market intervention

Services in rural areas are still declining on a number of fronts, such as in essential services like banking, transport and retailing. Market forces have failed to bring about an equitable distribution of medical practitioners as well, so that governments have intervened in a number of ways. The Commonwealth's interventions have included incentive schemes and support services, active recruitment of temporary resident doctors, outreach programs, support for technology, rural training programs and differential support for rural students. State, Territory and local governments have also contributed to efforts to attract GPs to rural areas, with packaged incentives such as housing, a surgery, salary under-writing and spouse support, and co-operation with other agencies on efforts related to overseas-trained doctors.

Market intervention is also revealed in some of the activities of the Australian Medical Schools. They have modified their undergraduate selection processes to encourage rural and remote student applications and admissions. They have developed rural curricula that are reinforced with a program of rural clinical placements. The establishment of Regional Clinical Schools and University Departments of Rural Health has offered supportive infrastructure for rural medical training.³

One particular form of government intervention in market processes is the provision of scholarships for medical training. Several examples exist and some are bonded, some are not. The most extensive are those provided by the Commonwealth Government, while some of the longest standing are those provided by State Governments and bodies such as the Country Women's Association.

In the context of recruiting to the rural and remote health workforce, many of the scholarships in existence are targeted at students who come from rural or remote areas. This is based on some evidence that, all other things being equal, an important determinant of willingness to practise in rural areas is that an individual was raised and went to primary school there. There is evidence now that another factor predisposing an individual to settle and practise in the country is rurality of the spouse.

Bonded scholarships are those which provide incentives (normally financial) in return for a commitment to serve for a particular time in a particular area. Many people in Australia are familiar with the concept because of the existence of large numbers of such scholarships in the 60s and 70s for teaching. There were also bonded scholarships offered by organisations such as State Railways and, to this day, they are still available from a range of private and public sector organisations. Indigenous Graduate Assistants are put through University by organisations such as Land Councils and expected to serve the sponsoring body when they graduate. Such bonded scholarships have generally had a positive reputation, being sought after and providing supported access to vocational education and some early career certainty.

The Australian Government announced the Medical Rural Bonded Scholarship scheme in 2000.

In mid 2003, another 'workforce-based' scheme was announced in which an additional 234 HECS-funded medical places in Australian universities are being offered to students willing to be 'bonded' to areas of medical workforce shortage.

Current Commonwealth medical undergraduate initiatives

The Australian Government's medical scholarships and bonding initiatives fall into three categories: scholarship programs without bonds, bonded scholarship programs and bonded university places.

Scholarship programs without bonds

The first of the contemporary Australian Government undergraduate health scholarship schemes announced was the John Flynn Scholarship Scheme. This is an experiential program that places selected medical students under the mentorship of rural general practitioners for two weeks for four consecutive years. The aim is to expose the students to rural health practice in order to encourage them to consider rural practice after graduation. This scheme is not bonded.

The Rural Australia Medical Undergraduate Scholarship Scheme (RAMUS) was the second of these scholarship initiatives. RAMUS offers \$10 000 a year to selected applicants in recognition of the higher costs that rural and remote people face in studying medicine at metropolitan medical schools. There are a total of 500 RAMUS scholarships available. This scholarship is not bonded.

Bonded scholarship programs

The third in this suite of scholarships is the Medical Rural Bonded Scholarship Scheme. Announced in 2000 as part of the Regional Health Strategy and operational from 2001, the scheme offers bonded scholarships to 100 undergraduate medical students annually. Scholars receive \$20 000 a year indexed

and, following graduation and postgraduate training, are bonded to take up rural practice for 6 years. At the time of writing there is a cohort of 300 Medical Rural Bonded Scholars studying in Australian universities. Each cohort of 100 will graduate at varying times because their courses run for 4, 5 or 6 years.

The package also contained the HECS (Higher Education Contribution Scheme) Reimbursement Scheme. This Scheme wipes off 20% of a student's HECS debt for each year they spend in a designated rural area.

Bonded university places

The fifth initiative, announced in the 2003 Federal Budget, makes available 234 additional fully funded undergraduate medical places (a 16% increase in HECS places), with the students accepting them to be bonded to work in areas of workforce shortage. There is no income support for students in these places.

The draft Deed of Agreement for these places is available from the Department of Health and Ageing.⁴

In the case of graduates from these additional places who become GPs (cf specialists) these areas of need will be any that are not in an Inner Metropolitan Area⁵ and that have a ratio of GPs to population less than the national average at the time. They will therefore be in outer-metropolitan, regional, rural or remote areas.

For the purpose of medical specialties, a District of Workforce Shortage is all of RRMA 2–7 plus RRMA 1 places in which the specialist:population ratio is less than the national average for that specialty, or any other area deemed appropriate by the Minister. Professional service of GPs and specialists may be undertaken in an Aboriginal Medical Service or After-Hours-Only Medical Service anywhere in Australia.

As there are no financial or support incentives associated with these places, they are in effect bonded university places rather than bonded scholarships. Those who accept a place under this scheme will be required to start work in a "District of Workforce Shortage" within 12 months of obtaining a Fellowship. They will be required to work in a District of Workforce Shortage in Australia for 6 years, for a minimum of 20 hours a week for not less than 9 months a year. These extra places "will be integrated with existing medical school places in such a way that total bonded medical school places (available under this measure and the existing Medical Rural Bonded Scholarship Scheme) are appropriately distributed across universities. Periods of up to three years of postgraduate training undertaken by doctors in rural areas will count towards meeting the bonding requirement" (from the Government's MedicarePlus package information).

Students with these bonded places will be liable for HECS fees and other course expenses in the normal way. They cannot "render a Professional Service outside a District of Workforce Shortage" while they are completing their "Work Period".

If the contract is breached the recipient must repay the real (indexed) “aggregate of the amounts paid by the Commonwealth to the University” for the medical course.

Discussion

It is now widely accepted that the notion of ‘sustainable general practice’, particularly for non-metropolitan areas, be considered in a flexible and integrated way. The days are long gone when rural and, especially, remote areas are provided with effective medical services by a handful of committed individuals who give a lifetime of service in such areas. Sustainable practice in rural areas these days is more likely to involve a shorter period of practice from a range of individuals, many of whom will also spend part of their professional life in cities. The contemporary structure of sustainable rural general practice also needs to accommodate the needs of an increased proportion of female GPs, new attitudes to work-life balance, the opportunities provided by information and communication technology, and the desirability of having a complete primary health care team practising collaboratively within a geographic area.

Programs for the recruitment of GPs need to accommodate these new realities.

The bonded scholarships

There is obviously much public support for efforts to source more GPs for practice in country areas. The community’s general approach to bonded scholarships is therefore that if they can succeed without adversely affecting either the student doctors concerned or the communities they serve, then they should be supported. Anecdotally, some rural people feel that the students are well enough looked after and they wonder why they are not getting more doctors.

Nevertheless some of the Alliance’s Member Bodies are strongly opposed to bonding of any sort, believing it to be coercive and discriminatory. Some in the Country Women’s Association argue that bonding is “a retrograde step — a band-aid solution to a long-term problem”. The main concerns with bonding as an approach come from medical undergraduates themselves, doctors who understand their predicament, and consumers who fear that they may have to put up with an unwilling conscript fulfilling a bond and so, potentially, a second-class service.

There is also strong opposition to the bonding of any Indigenous health students, including medical students, on the grounds that they are already committed to their local country and community.

Where the bonded scholarships are concerned, the Alliance believes that the critical issues are the conditions and requirements placed on the students who elect to take them up. If the conditions are fair and reasonable, and information on them is openly available, the bonding contract should be acceptable. In these circumstances students will be able to make the informed life choices that will impact on them for many years into the future.

With bonding an established part of efforts to recruit and retain medical practitioners for rural and remote areas, the focus of attention needs to be directed to the conditions that are imposed on students. These conditions must be fair, fully and openly described up-front, and not varied over the (lengthy) period for which the bonding will apply to individual students.

A case can be made for the period of bonding to be no longer than the length of the course and some of the Alliance's correspondents believe that one year's service for every two years funding would be fair.

Although bonded scholars complete the same course as other medical students, it is possible that the commitment they have made may impact on the quality of their undergraduate experience. For instance, the bonded scholars with \$20 000 (indexed) a year are likely not to face the same imperative to obtain casual or part-time work as some others. This may make them better students, but there may be a countervailing loss of workplace and social experiences.

The current medical undergraduate bonding system is being compared by some to the historical bonding arrangements for professionals such as teachers. The efficacy of the new bonded scholarship program has not been tested because recipients have not yet graduated. What is clear is that the bonded medical scholars will be assured of a provider number, but only to work in a prescribed geographical area — RRMA 4–7 if they are in general practice, or 3–7 if they have a specialty. The majority of them are likely to be in private practice in which they may have control over the development of a business. In sum, therefore, the bonded medical scholars are likely to be faced with greater professional and commercial risks, as well as opportunities, than people who (like teachers “in the old days”) were bonded to guaranteed positions in the public service.

The precise legal situation with respect to bonding is also unclear. There has been some unfounded speculation that bonding of GPs may be unconstitutional.

In summary, the Alliance provides conditional support for the bonded scholarships as fair contracts based on full disclosure by both parties, with a genuine benefit being provided by one, in return for services made available by the other. Students and the public are likely to support them if — and only if — the terms and conditions are fair, openly explained and do not result in any lessening of quality or safety in the services provided. In this matter, as with so much else, the devil is in the detail.

The bonded university places

The Alliance overall is not supportive of the bonding associated with the extra 234 places in university Medical Schools.

Certainly these extra places will provide opportunities for people to study medicine who would otherwise not be able to do so. They will be bonded to ‘districts of workforce shortage’ for six years following completion of vocational education. For the universities, these additional places pose difficulties associated

with extra numbers of students without extra infrastructure and other facilities. Worst of all, the proposal seems to have been implemented with indecent haste and without proper consultation with students, the universities or professional bodies.

A very broad definition of ‘district of workforce shortage’ is currently proposed. There is the possibility that such a definition could be changed, potentially in response to ‘base political motive’. This is another argument in favour of development of robust and commonly agreed definitions of health needs and of service accessibility, which might include measures of staff turnover. Ideally areas of need should be forecast so that schemes with designated areas of activity can be part of useful workforce planning.

There are also ethical questions relating to this policy. As Professor Nick Saunders summarises, in essence they mean:

- large numbers of commencing students — one in five — in every Australian medical school will now be bonded in one way or another;
- in return for a place in medical school — but no financial incentive — eighteen year olds will be asked to make major decisions about their lives ten to fifteen years hence;
- as there are no incentives to take up a bonded place apart from the place itself, these students will be admitted in a second phase, once all unencumbered places are filled. It is likely that the ‘second phase’ will become ‘second tier’ or ‘second class’, however worthy the students; and
- if the proposed Nelson Higher Education reforms are passed by the Federal Parliament, domestic fee-paying places will also be available in Australian medical schools from 2005. The mechanics of University admissions processes will require these fee-paying places to be offered once unencumbered HECS places are filled, so that fee-paying places and bonded places will be on offer at the same time. This introduces a number of ethical issues around equity and access with regard to places in Australian medical schools.⁶

In comparison with full-fee places, the bonded places will seem like a cheap alternative. However it is very hard to justify bonding without some immediate material incentive being provided. One of the Alliance’s correspondents has described it as “indentured servitude — horrible”. The incentive could be financial (eg they could receive \$20 000 a year or be made automatically eligible for the HECS Reimbursement Scheme) or in-kind (eg support with career pathways and planning, which the Regional Clinical Schools and Regional Training Providers could undertake). Carrots are better than sticks.

It has been suggested that some of those who take a place among the additional 234 will do so because they are very highly motivated to get into medicine by any means, but with the intention of buying their way out of their commitment rather than serving an area of workforce need. On the other hand if the debts for students increase to be “of house mortgage proportions” — as for some in North America

— students may well be forced to agree that they “would rather pay back time than money”.

There is some possibility that the students who take up the 234 special places may regard themselves, or may be regarded, as the poor cousins of other medical undergraduates. They do not have the financial benefits of the Medical Rural Bonded Scholars or the practice options of the other unassisted students. RAMUS students have both some financial incentive and unconstrained options. There will also be up to ten per cent who are full-fee-paying students. It might be useful for universities to manage these different groups differentially, eg by providing special positive support as needed. However confidentiality issues and the feasibility of such a task will probably mean that this is not possible. For example at the University of Queensland the Bachelor of Medicine/Bachelor of Surgery (MBBS) Program is likely to have an intake over 300, making special treatment of particular groups an administrative challenge requiring real commitment.

Currently there is concern within the student body and medical practitioner representative groups about whether the current system provides adequate peer support and mentor support services for students. These networks will need additional support in order to cater for the 234 new undergraduate places (16% extra) and the demands they will make on the system as they progress through it.

General

The Alliance is concerned to protect and evaluate the incentives to rural general practice, and to see them extended to other rural health professions. The relative lack of similar schemes for allied health, nursing, and other health team practitioners could mean that doctors end up working in areas of need without the support of health care team members from other disciplines — or indeed refusing to do this. In practice, it will be difficult for doctors to provide effective and comprehensive care in such circumstances. “Doctors cannot work in a vacuum; they cannot do it all alone.”

Support is required for all rural scholars, whether bonded or not. Queensland has a long history of State-bonded scholarships but the Alliance has been informed they are becoming less popular due to a perceived lack of support and poor access to vocational training and appropriate career paths. This emphasises the importance of the work currently being done by the Rural Clinical Schools, the professional Colleges, General Practice Education and Training Ltd., and Regional Training Providers to adjust their activity and support medical training. The rural student clubs and Rural Workforce Agencies are other key players in the provision of such support.

Overall, people feel anxiety and uncertainty about a system that locks young people into a commitment for periods of ten to sixteen years down the track. One of the consequences of this is that there needs to be careful consideration of the arrangements in place for students to opt out of the system should they need to: the penalties and other conditions that will apply. The amount re-payable will

apparently be about one quarter of the new full-fee equivalent. Non-financial penalties could also be considered, eg repayment of service in other tightly defined areas of need in addition to Aboriginal Medical Services (eg selected public hospitals or an alcohol and drug service).

The attitudes of other stakeholders to bonded scholarships vary. The Australian Government and Opposition and some State Governments support the initiative with the Opposition keen to extend these bonded scholarships to nurses and the placement of nurses in rural general practice.

If bonding helps locate additional new practitioners for needy areas, the idea is viable. Overall, rural communities are likely to support any initiative that provides them with more doctors, particularly if they are confident that they are appropriately trained, motivated and supported.

Suggested alternatives to bonding include an increase in the number of unbonded HECS places for medicine, increasing the numbers of RAMUS and John Flynn scholarships, increasing funding for Rural Clinical Schools, that bonding be mixed with other initiatives such as the extension of coverage of the HECS reimbursement initiative to newly graduated rural practitioners, and the ongoing development of incentives to encourage doctors to enter rural practice. One particular proposal is for the additional university places to be delivered through the Rural Clinical Schools. This would enhance the universities' moves to produce the right generalist medical competencies for rural and remote areas, including through further curriculum changes within the Clinical Schools.

The public should be encouraged to think of bonded scholars as those willing to accept slightly reduced 'future options' in return for slightly greater 'future certainty'. They may therefore become a group of doctors characterised by a different average approach to risk, but not by any differences in terms of the quality and safety of their service. Experience in Queensland suggests that the rural bonded doctors offer a superior service, mainly due to their increased amount of procedural work and the training required for rural general practice.

No suggestion of second-rate service should be allowed to develop — in reality or in the public's mind — from application of the principle of bonding. Rural people will naturally express apprehension if rural programs come to be seen in negative terms.

It will not be possible to evaluate fully the effectiveness of these two bonding schemes until fifteen or even twenty years have passed. It will therefore be important to maintain ongoing evaluation of them.

Recommendations

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 Alliance does not support the ‘bonding’ of additional places in Medical Schools that are provided without an associated incentive to either the students or the universities involved.
3. Any program designed to increase the exposure of medical students to rural areas must allow for the impact of greater numbers of rural and remote placements on communities, mentors, teachers in the field, and students themselves.⁷
4. There must be continued longitudinal studies to evaluate the impact of bonded scholarships, in particular on the students at medical schools, the schools themselves, their mentors and, most significantly, on the supply of GPs to rural and remote areas. Long-term decisions on the two approaches will be determined on the evidence from such research.
5. Ideally, university authorities should continue their efforts to monitor the various groups of medical undergraduates in order to see that no particular cohort is disadvantaged or marginalised.
6. The Alliance recommends that all medical undergraduate scholarships be brought into line and standardised as much as possible in terms of the benefits offered to the scholars. This would equalise the opportunities and make it easier for universities and training providers to administer the programs and minimise the risks of different cohorts of students developing.
7. The Alliance will encourage the public, the press and students to regard bonded scholarships as a positive approach to an important health workforce issue, helping to ensure that there will be a positive cycle associated with bonded scholarships.

Appendix 1—GP:population ratios in Australia and some of the characteristics of rural practice

Rural general practice:

- 123 GPs per 100 000 population in capital cities
- 108 GPs per 100 000 population in outer metropolitan areas
- 111 GPs per 100 000 population in large rural centres
- 94 GPs per 100 000 population in small rural centres
- 77 GPs per 100 000 population in other rural areas
- 66 GPs per 100 000 population in remote centres and other remote areas

While the reasons for patient presentation are generally similar between metropolitan and rural areas, the characteristics of rural practice differ in a number of ways:

- there is more procedural work undertaken
- the rural general practitioners are associated with their local hospitals
- the average hours worked per week by rural practitioners is higher
- the proportion of general practitioners on call, and the number of hours on call, is much higher
- there is a lower proportion of female general practitioners in rural areas
- there is a higher proportion of general practices in rural areas, and
- the turnover of general practitioners is higher in rural areas.⁸

Notes

- 1 Australian Medical Workforce Advisory Committee and Australian Institute of Health and Welfare (1998), *Medical Workforce Supply and Demand in Australia: A Discussion Paper*, AMWAC Report 1998.8, AIHW Cat. No HWL 12, Sydney; October 1998.
- 2 McDonald J (2003), "Recruiting and retaining rural general practitioners: a mismatch between the research evidence and current initiatives?" in papers to the 7th National Rural Health Conference, Hobart, March 2003.
www.ruralhealth.org.au
- 3 Evidence from Japan and Norway supports the value of a decentralised medical school approach with training opportunities in rural and community-based settings. Canadian research also shows that the combination of a rural background and a decentralised training program encourages individuals into rural practice. See for instance Dunbabin JS and Levitt L (2003), "Rural origin and rural medical exposure: their impact on the rural and remote medical workforce in Australia", *Rural and Remote Health* 3 (online), 2003: 212. <http://rrh.deakin.edu.au>
- 4 <http://www.health.gov.au/workforce/> Note: Guidelines for the Bonded Medical Placement scheme were released at the end of October 2003. Some of those connected with the Medical Schools expressed concerns about apparent restrictions on the ways in which people with these places could usefully serve as doctors. The contract apparently would not allow for doctors to continue to work in the public health system, despite public hospitals seeking a greater number of career medical officers or 'hospitalists'. Such doctors choose not to complete a fellowship but continue to practise medicine in a public hospital in a variety of roles, including administration.

Also, a doctor who chose to take on a role in politics rather than obtain a fellowship would also break his/her contract. Such opinions suggest that section 3.1 of the proposed guidelines needs re-working. Not all graduates enter and complete clinical postgraduate training — or even want to. Some of them work in industry, research and hospitals. The guidelines ask all of those in the scheme to practise relatively isolated, responsible clinical medicine. They do not allow for the graduate who finds a useful future in a pharmaceutical company or in the public service.

Also there seems to be no allowance made for graduates who are unable to gain entry into a Fellowship training program, particularly one of their choice or who, having got into such a program, fail to pass the qualifying exams and are then excluded from the program. The FRACGP is no longer a default option as the College of GPs has its own selection criteria. Doctors working outside the jurisdiction of Fellowship training (Other Medical Practitioners or OMPs) are not mentioned in the guidelines, yet this is where most non-trainees exist. It is understood that there are around 5000 OMPs in Australia, many working in rural areas. The guidelines need to take this category into consideration rather than assuming completion of Fellowship — unless the Government decides to guarantee every graduate a place in Fellowship training.

- 5 This is the class in the ASGC Remoteness classification system with an ARIA index value of 0.0–0.2; see <http://www.abs.gov.au/websitedbs/D3110122.NSF/0/f9c96fb635cce780ca256d420005dc02?OpenDocument>
- 6 Nick Saunders, “Future Challenges in Postgraduate Vocational Education in Medicine”, National General Practice Education Convention, 15 August 2003, Melbourne.
- 7 The Alliance is developing a separate Position Paper on an integrated rural placement system for all health disciplines.
- 8 Department of Education and Training, Higher Education Funding Amendment Bill (No. 1) 2000.



NATIONAL RURAL
HEALTH
ALLIANCE INC.

Position Paper

A quality rural placement system for health students

April 2004

This Position Paper represents the agreed views of the National Rural Health Alliance but not necessarily the full or particular views of all 23 Member Bodies.

A quality rural placement system for health students

The rationale for rural placements

This Position Paper is about developing a better rural placement system in Australia for students (mainly undergraduate) in the health professions. Such a system would help with the recruitment and retention of graduate Australian health professionals to rural and remote areas. (We use the term ‘rural’ as an abbreviation for ‘rural, regional and remote’, to connote all parts of the nation outside the main cities.)

There has been good progress in recent years with the regionalisation of health education, particularly for medical students. Governments and professional bodies are to be congratulated for the resources and support they have given to such regionalisation. One of the next steps required along the road to recruiting and retaining more health professionals for country areas is to give all students access to good rural placements, irrespective of the main location of their training.

A ‘rural placement’ is a period of experience (usually including clinical training experience) provided to a health undergraduate¹ in one or more health settings in a rural area.

There is a growing body of evidence, largely based on studies in the US and Australia, that the key determinants that make rural practice more likely for a health care professional are rural origin, rural spouse and rural placements, and that these predictors are stronger when they occur in combination.^{2 3 4} There is also some evidence that length of exposure to rural and remote practice during training can predict future rural practice.⁵

The National Rural Health Policy Forum has identified clinical experience in rural health services as a key element of the educational preparation of health care students for rural practice⁶. It would be valuable to expose all health students — irrespective of rural practice intentions — to the challenges of rural practice but the system cannot accommodate that yet.

There are compulsory placements and elective ones. Both are elements of the whole university curriculum and both have clearly specified learning outcomes. There are also placements outside the curriculum, such as John Flynn Scholarships that are taken during University holidays.

There are two types of rural placement within curricula for undergraduate health professional training. They are generic ones that just happen to be undertaken in a rural or remote area, and specific rural placements (ie targeted at rural exposure and having to be in a rural area).

Forcing students to undertake a rural experience by making it a compulsory part of their course or program requirements is not a sensible option. There is already a risk that the sheer numbers on rural placement will overwhelm the institutions and individuals charged with the responsibility of providing and supporting them. In addition, compulsory placement systems risk creating antipathy.

A more suitable approach is to have a graded exposure to rural health and clinical practice, with all undergraduate health science students required to complete a rural health subject that contains a mix of theoretical and practical content, and encouragement for those students with an interest in rural clinical practice to have quality learning experiences in rural areas.

To be successful, rural placements need to be accessible, well co-ordinated and well-supported. A well-supported rural placement is one in which dislocation is minimised, instructional content is maximised, and costs are covered. If it is a good experience, the student is more likely to look favourably on rural practice when they are trained.

Even if graduates do not end up practising in a rural or remote area, rural placements will sensitise them to both general rural issues and to the issues affecting rural health services. This would help health professionals to take an appropriate approach when working in a metropolitan hospital, for example, and to understand and address the issues involved with such things as discharging a patient home to a rural area.

Overall then, rural placements are important as part of a strategy to increase recruitment and retention of health professionals to rural areas. If planned and supported properly, the mentoring of those on rural placements can contribute to the training and job satisfaction of existing practitioners.

The ultimate goal is to help to ensure that people in rural and remote areas have reasonable access to an appropriate number and mix of health care professionals.

The current situation

The Health Reform Summit in August 2003 highlighted the concerns of the States and Territories about the increasing demands placed on them in the delivery of health services. Many of the placements in nursing and allied health occur within the hospital and area health service systems. In some States and Territories the Area Health Services (or equivalent) receive funding for teaching and research as part of their total resource allocation. In recent times the demands placed on acute services (particularly in rural areas) have increased the pressure on practising health professionals to prioritise acute clinical care over teaching or research activity.

For **Registered Nurse** education, clinical placements in rural areas vary widely across the tertiary institutions. Some Schools of Nursing in the capital cities have no compulsory rural placements throughout the whole curriculum, whereas others

do. Overall there is increasing pressure on Schools of Nursing to find placement positions, which means that there is increased demand on rural nursing settings to provide them.

No two undergraduate nursing courses in Australia have identical curriculums, so there is great variation between Schools regarding the use of elective rural placements. Given the current lack of formal support, many nursing placements rely on the voluntary commitment of all involved, including members of the rural community.

I invite nursing students to stay with us on our dairy farm as it is cheaper for them and they get to see life in the country rather than in a motel or hotel — but they don't get their own bathroom, and the internet could be a little slow. (personal communication from a farmer)

I had to go out of town for this placement because I had not been out previously. I asked for X, but got placed in Y instead. I inquired about the possibility of travel assistance because it is about 9 hours by road from the University. I drove here on my own and paid my own petrol costs. Unfortunately there was no assistance available. I'm lucky to be staying in the quarters at the hospital, which is free. I'm the only nursing student at the quarters at present, but there are a couple of agency nurses from New Zealand staying there as well, which is good company. I'm having an excellent placement, and plan to go rural when I graduate. I grew up in the bush, and hadn't really considered working in the city. (personal communication from a student nurse)

I had no support getting to A. I got a lift with another student to R and then caught the bus to A, which is about 11 hours by road from the University, and involved an overnight stay in R. I'll be paying the bus fare to get back to Uni. from here. This is my first placement in a rural area and it's hard being away from my family for 6 weeks. I'm staying in the quarters at the Hospital and I hope it's free, but I haven't actually asked. We have to pay for all our own meals. We are able to use the local library for the Internet. It's been an excellent placement, the staff are very welcoming and supportive. (personal communication from a student nurse)

Undergraduate **allied health** courses also vary across Australia as to their requirements for rural placements. For many years rural practitioners and Base Hospitals have taken students on placements for either community or clinical training. Because health professionals in rural settings are frequently sole practitioners and new graduates, the opportunities they provide for rural placements are less than in the better-resourced metropolitan centres with large departments of staff experienced in student supervision, often a designated clinical supervisor and infrastructure like a medical library and good IT access. For staff at the Base Hospital, supervising students may be that one final burden too many.

The resource bases of Universities also vary. Some universities pay for health services to take their students and for other support of student placements, while other more established Universities have a history of placing students with major teaching hospitals in metropolitan centres and have limited need for rural placements. In general, allied health teaching resources are still concentrated in the

metropolitan areas. For many rural placements there are no incentives from universities for the training of undergraduate student placements.

The establishment of University Departments of Rural Health (UDRHs) has seen an improvement in student accommodation and access to resources for students on placement — particularly within the UDRHs' regions of influence. For example, for allied health disciplines, universities in Western Australia support the regional travel of Placement Co-ordinators to ensure the preparedness of their rural sites. UDRHs are closely linked to programs in their parent universities and also offer support to students from other universities.

The UDRH student housing was greatly appreciated. The four-bedroom house was fully furnished and equipped with four computers with broadband internet connection. The accommodation allowed me to meet other students, therefore developing my network with other future health professionals. The supportive study environment provided an excellent environment for data analysis and report writing.

It would be great if all students had that same experience and opportunities provided by their rural placements. The project became tedious in the final week, with a move into the caravan park as the UDRH student accommodation was not available. (personal communication from a student on a 6-week community placement in a rural regional centre in Victoria)

Currently not all nursing and allied health students have placements that meet these UDRH standards, particularly where accommodation and IT and staff support are concerned. Additional resources are needed to ensure that quality placement options are available to all undergraduate health students in all locations, so that their rural placement is a positive incentive to practise in a rural or remote area after graduation.

For **medical** students, placements are planned, scheduled and recurring during the undergraduate years and integrated between components of the universities (including but not limited to their Rural Clinical Schools and their Departments of Rural Health). Many placements are based on personal networks. Qualified medical practitioners, approved by the universities, tutor the students through learning outcomes that must be achieved and reported upon. These placements are supported through university resources and facilities and are covered by indemnity insurance. GPs are usually paid for taking students, although there is still a significant reliance on volunteers and concessions, such as the altruism that has traditionally been displayed by hospital and home.

It is pleasing to note ... that support for the concept of rural and community terms [in medicine] is almost universal among stakeholder groups. The features of high quality terms have been well articulated, and include appropriate attention to training and supervision requirements, clear role definitions and orientation programs, ready access to advice from senior colleagues, consistent and constructive feedback and adequate accommodation and other resources. (personal communication from a medical workforce administrator)

A fourth general group in the health system is comprised of **health service management** students. Quality health service management is an important requirement for any health facility, particularly in rural areas where similar recruitment issues exist as for clinical workers.

In Australia there are limited opportunities for formal health service management placements in rural settings. The schemes in existence are specific to particular professions and industries, and individually funded according to the vision and commitment of particular health services. Furthermore there is very little specific rural or remote health management training. The issues of adequate training for supervisors of rural health service management students, and support for students in accommodation, are similar to those for other health professional groups, except that some of the health service management students are postgraduate.

A formal placement is not usually part of a University health service management course. If such opportunities exist they occur at a postgraduate level and few postgraduate health service management learning experiences are provided in rural settings. Exceptions include the Flinders University Remote Health Management program run by the Centre for Remote Health, and the program conducted through the NSW Branch of the Australian College of Health Service Executives (ACHSE). There is also a scheme in NSW funded by the Commonwealth and State governments co-ordinated by the NSW Aboriginal Health and Medical Research Council and the NSW Branch of ACHSE for the training of Indigenous health service managers, usually for periods of twelve months or two years. The benefits of rural placements in this scheme have been considerable for both mainstream and community controlled health services. It is important that the funding for such schemes is continued at State and Commonwealth levels.

Discipline-specific differences in placements are likely to persist since the opportunities, rights and obligations are determined by the profession and closely governed by university curriculum committees with a responsibility to professional and accreditation bodies.

Deficiencies of the current system

The deficiencies of the current rural placement system can be summarised as follows.

- There are no agreed standards or benchmarks across States and Territories, between universities, and among the different health professions; therefore there is no equity between individuals and professions as far as rural placements are concerned.
- Currently the system gives insufficient attention to the needs of the communities, teachers and mentors of the students on placement. The number of undergraduate students on rural placement and the rural placement facilities available are out of proportion. Given that mentors are mostly volunteers who

can “pause when they are weary”, it is critical to recognise their contribution to a system with supported clinical placements for all professions.

- There is inequitable access for the different professions to fully funded placements; there should be parity for students from all health disciplines, so that access and conditions for all students is brought up to the hard-won standard applying to medical students.
- In particular there is currently insufficient support for all students’ travel, accommodation and access to information technology.
- There is a need to cater for the needs of greater numbers of mature age students, many with partners and children.
- The access, cost and quality of accommodation for students on placement are extremely variable. There is a strong perception that medical students are given preference over other students for accommodation, thus limiting the opportunities for others and, at worst, encouraging rivalry between professions. (We should be encouraged by the knowledge that things can change so much: people recall how hard it was originally for medical students to be given access to country hospitals’ nursing home accommodation.)
- The use of hospital quarters in regional centres for undergraduate students has, in some cases, displaced rural practitioners undertaking refresher courses or updates in the regional centre. This is common where Rural Clinical Schools have been established in regional hospitals and students are now accommodated in the old nursing quarters. This means that rural practitioners may have to pay for alternative lodgings during periods of professional development and training.
- Generally, the current system is poorly co-ordinated; some placements are not well-timed for the parties involved, and very little advantage is taken of the possibility of using rural placements to build inter-disciplinary collaboration and health teams for the future.
- Understaffed health facilities in rural areas lead to overworked clinicians who may not have the capacity or the time to mentor students. This can lead to poor learning opportunities, colouring the views of the student about the placement, and the views of the clinician about students and placements.
- There are insufficient data to ascertain the long-term effect of rural placements. There needs to be a national system of longitudinal tracking of health science students and graduates, to ascertain the impact of rural and remote education and training programs, including placement programs.
- Students on placement often incur additional living expenses as they may be required to maintain rent or lease payments at their normal home. They also find it hard to keep regular part-time or casual work when they have to go on placement.

- Despite some major improvements in information technology services to rural areas⁷, good IT is still spasmodic and not universal. Poor access to information technology still limits the learning experiences students have on clinical placements.
- There is concern about the lack of social support networks, particularly where the student is on placement on their own, and particularly on longer term placements.

Accommodation and other infrastructure

Infrastructure is an important area requiring attention. An audit is needed of supply and unmet demand across Australia with regard to infrastructure for student placements in rural and remote areas, particularly student accommodation. This would provide the initial evidence base for an ongoing, adequately funded and rational approach to the provision of infrastructure and accommodation based on need, rather than the short term and *ad hoc* initiatives that have been the pattern to date.

Preceptor training and support

There are some schemes that provide funding for medical preceptors (eg RRAPP, JFSS), and specialists in hospitals are likely to be paid for their work with registrars. Overall, however, there is no uniform funding approach to health services taking students. In some States there is no allocation to the Area Health Services for teaching, so that health service dollars have to be used to support the education of students. Clinical staff provide supervision and clinical teaching, and are expected to clear their backlog of patients after the students have left. There needs to be proper recognition of the fact that if a practitioner has a student they will be able to see fewer patients.

Most rural and remote health professionals value opportunities to supervise students and to be involved in teaching. In fact, contributing to student placements can renew and maintain a professional's commitment to rural and remote practice. A reflection of this interest is the demand for seminars, workshops, and short study programs to provide clinicians with skills and knowledge to enable them to be more effective clinical teachers, mentors and supervisors.

Designing a quality placement system

A quality rural placement system would have the following characteristics:

- it would have agreed national standards or benchmarks, and be of a uniformly high standard across the nation;
- the national standards would be applied to fit regional needs and be co-ordinated at a regional level;

- it would treat all professionals in training equally: whether you are studying Medicine at Monash, Nursing at Newcastle, Dentistry at Darwin, or Podiatry at Perth, the same opportunities, rights and obligations would apply to your rural placement; the system will meet the changing needs of the student population, with more of them now being mature age people with partners and a family;
- it would be ‘information-rich’: communities and mentors would know who was coming to the town when, communities would have placements when they wanted them, information on vacancies could be advertised nationally, etc;
- there would be perfect communication between and among the key agencies involved: the university schools of health, medicine, nursing, etc; the professional organisations; the individual mentors; and the communities⁸;
- it would be well-resourced and equitable for all health professionals — medicine, nursing, allied health, pharmacy, health service managers, dentists; the students’ travel, accommodation and IT needs would be covered, as would the mentors’ and communities’ costs, and remuneration for time spent by the teachers and mentors;
- it would be stimulating and enjoyable for rural health practitioners and not seen as an additional burden of practice;
- there would be systems for ongoing monitoring and evaluation of the regional and national impact of placements in all health professions;
- communities would benefit from the additional resources provided by regular student placements, and from having current evidence-based practice being taught within their health service facilities; and
- flexible models would be offered that were appropriate to the size of the community and that contributed to the infrastructure and well-being of the host families or communities.

The concept of Rural Centres of Health Education could be advanced where there are rich clinical, social and community experiences available and sufficient resources to manage larger numbers of students over extended periods of time. There also needs to be increased support for clinical teachers — perhaps through dedicated clinical units where students from several disciplines work under direct and indirect supervision with a defined group of clients/patients.

The benefits on the ground of this quality system would be far reaching. Health professionals would have happy rural experiences and be looking forward to returning to a rural area. They would develop relationships with other health professionals that would last them a lifetime and stand them in good stead in clinical and personal terms. The teachers and mentors in rural and remote areas would have reasonable and happy placement loads, for which they would be recompensed and recognised. The universities would turn out better practitioners for the richness of the practice experience which necessarily comes from rural and remote clinical experience. Governments would get good returns on their ‘placement dollar’.

Because rural and remote areas need ‘whole health teams’, the Alliance is interested in the possibility of **joint placements**: medical, nursing and allied health professionals sharing placements together as a learning and working team.⁹ Multi-disciplinary experience is a neglected aspect of student placements. Multi-disciplinary practice and new forms of practice (such as nurse practitioners) are a reality, especially in remote Australia. These make ideal learning settings for students. There are existing examples of innovation in this area. The UDRHs are among those agencies developing and implementing inter-professional education (or “multi-professional learning”) programs for health students in rural and remote Australia.

Special attention and additional resources are needed to develop the quality placement system outlined here. While there is recognition of the need for better structures and support for rural clinical experiences in undergraduate education, the tight and competitive economic environment of the universities and the health sector reduce their capacity to provide them. Staff cuts affecting health services in rural areas, and the general maldistribution of health professionals, reduce capacity to provide teaching and supervised learning. The Alliance has called elsewhere for government initiatives to increase the number of university places for health undergraduates.¹⁰ This will help increase the number of rural practitioners, but it will also further increase the demand for rural placements and put further pressure on the parties involved.

In considering the quality and number of rural placements, proper account must be taken of the role of the communities, the health facilities, and the rural health professionals who will be looking after the students. Being properly looked after is an important part of a positive experience. Rural health services and their staff are already stretched and busy, as are rural health providers in private practice, like GPs and allied health professionals. For them to see the placements as positive experiences, they need to be fully informed about timings and expectations, reimbursed for the reasonable direct costs involved, and given credit for their efforts.

Good mentors are critical for all health students on placement. Financial support for mentors is currently different for different disciplines. For instance in north-western Queensland the medical mentors are remunerated while the nurses are not. Yet according to one correspondent:

The students placed on single nurse posts or with nurses in larger places consistently report greater learning opportunities and maintain ongoing contact with their mentors post-placement. I would like to see equitable remuneration for all mentors ie, if they are mentoring a student through a rural placement, they receive recognition of that work to the same value, regardless of what professional group they and the student come from.
(personal communication from a nurse academic)

It is clear from first principles that the keys to a successful rural placement system are information and resources. Everyone involved needs to know what’s happening and when, and what are the expected activities, reports and acquittal requirements. Good information will ensure that those on placement arrive and stay at times that are not locally difficult. Resources are needed to support travel,

accommodation, remuneration and IT services. There must also be work and resources to ensure that the placements are safe for the students involved.

Recommendations

1. National and State Governments should collaborate with student bodies, rural communities, universities and professional bodies to agree 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 travel, accommodation, financial commitments, community support, evaluation, information and reporting requirements. The standards should be widely publicised so that all parties are aware of them.
2. These same standards should be the basis of funding and other support provided to the rural placement system. The Department of Health and Ageing should work to ensure that financial support is available for students, mentors, supervisors and preceptors for rural placements — in nursing, health service management, allied health and medicine. The resources for student support should be provided through the universities. The resources for mentors, supervisors and preceptors should ideally follow the student and be provided as Commonwealth specific grants or budgetary allocations to the States quarantined only for student teaching in rural sites.
3. A specific paper on placement accommodation should be developed by the National Rural Health Network, circulated to stakeholders for endorsement and presented to the Minister for Health and Ageing for attention. It would include consideration of accommodation available for students across all health professions on rural placement.
4. The NRHA will collate information from its Member Bodies about the preceptoring and career development resources they hold or are developing and, assuming copyright permissions, will make a list of them available.
5. The UDRH network will continue to provide high quality student accommodation that is not discipline-specific, and will work with Rural Clinical Schools and others to maximise access by all students to good accommodation and other infrastructure.
6. Consideration should be given to creation of a national database of student rural accommodation to facilitate priority setting and systematic approaches to meeting gaps at a national, State and regional level. The database would be developed and maintained through joint collaborative action of health agencies, local authorities and universities. It would list details of student accommodation available in rural, regional and remote areas. Funding for the database would be provided jointly by the Australian and State/Territory Governments.

7. 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.
8. There should be a protocol prepared relating to IT services and support for students on placement in rural, regional and remote areas. Such a protocol would seek greater uniformity between the Universities and other health training institutions in relation to information technology services provided for students on placement.
9. 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 Councils and practitioners needs to be recognised and rewarded.
10. As part of the overall evaluation of workforce recruitment and retention initiatives, the Australian Government should support data collection to track students undertaking rural placements.

Acknowledgments

Thanks to all of those who contributed to this Position Paper, in particular our 23 Member Bodies and their delegates to Council, and a number of other special friends.

Notes

- 1 The term ‘undergraduate’ is used here to mean the first degree for a health professional in a particular discipline. For convenience it includes those who are in ‘graduate programs’ — particularly in Medicine.
- 2 Simmons D, Bolitho LE, Phelps GJ, et al. Dispelling the myths about rural consultant physician practice: the Victorian Physicians Survey. *Med J Aust* 2002; 176: 477–481.
- 3 Brooks RG, Walsh M, Mardon RE, et al. The roles of nature and nurture in recruitment and retention of primary care physicians in rural areas: a review of the literature. *Acad Med* 2002; 77: 790–798.
- 4 Laven GA, Beilby JJ, Wilkinson D, McElroy HJ. Factors associated with rural practice among Australian-trained general practitioners. *Med J Aust* 2003; 179: 75–79.
- 5 Wilkinson D, Laven G, Pratt N, Beilby J. Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice among Australian general practitioners: national study of 2414 GPs. *Med Educ* 2003; 37: 809–814.
- 6 National Rural Health Policy Forum 1999.
- 7 see for example *Rural Telecommunications — Current Status*, A paper for the National Rural Health Alliance, July 2003 — available at www.ruralhealth.org.au
- 8 Baker PG, Dalton L, Walker J. Rural general practitioner preceptors — how can effective undergraduate teaching be supported or improved? *Rural and Remote Health* 3 (online), 2003: 107. Available from: <http://rrh.deakin.edu.au>
- 9 One correspondent writes: “I support fully the principle of inter-professional collaboration. However, it involves deliberate planning and resultant action well before any clinical placement. It does not just ‘happen’ when on placement. Nursing students attend placement with specific nursing competencies and psychomotor skills that must be achieved, as do other professions with respect to the requirements of their placements and their Course I am sure. The question needs to be asked: What makes rural placement different, so that inter-professional collaboration is more important in those settings than at any other placement? How have students from the different disciplines been socialised to collaborate prior to attending their placement? What outcomes are sought from such collaborative processes? How do these relate to improvements in client care, for example? How is the potential synergy that may result from inter-professional collaboration evidenced — ie in clinical decision making, research activities, organisational models of care and clinical governance, and so on? There are many other issues to discuss re team collaboration and it is important to separate the idyllic rhetoric from the reality. The concept has much to offer, yet I think it has to be presented realistically and in an informed way.”
- 10 *Australia and the global supply of health professionals*, Policy Portion 2004(2), NRHA, Canberra, 2004.



NATIONAL RURAL
HEALTH
ALLIANCE INC.

Position Paper

An ethical approach to the training and supply of health care professionals: in support of the *Melbourne Manifesto*

May 2004

This Position Paper represents the agreed views of the National Rural Health Alliance but not necessarily the full or particular views of all 23 Member Bodies.

An ethical approach to the training and supply of health care professionals: in support of the *Melbourne Manifesto*

The global demand for health care professionals

There is a global shortage of health care professionals. The world's failure to effectively combat poverty and disease, and to minimise the impact of natural disasters, war and corrupt Governments, underpins the continuing urgent need for health and emergency personnel in less developed countries.

In other parts of the world, people's expectations of health services have increased significantly. Technical possibilities, especially in the areas of reproductive technologies and end-of-life treatments, have also multiplied.

Factors like these have combined to produce an increased global demand for the services of health care professionals. The world supply of health graduates willing and able to work in the sector for which they trained has failed to keep pace.

There are also major problems with the worldwide distribution of trained health care professionals, as distinct from the supply.

The World Health Organization has noted that the most critical issue facing health care systems is the shortage of the people who make them work. Australia currently makes a net call on the world supply, thereby contributing to the problem. Some health professionals trained in Australia work in disadvantaged parts of the world, but Australia takes doctors, nurses and others from less developed countries in greater number. This is an irresponsible and unethical situation.

A number of wealthy nations, including Australia, provide at least tacit support for the recruitment of health care professionals from resource-poor nations. There are some benefits to the nations concerned, such as family remittances and the skills learned by the individuals concerned. Overall, however, the loss of their trained health staff has a damaging effect on the people of such nations, most of which have inferior health status and seriously under-resourced health systems.

There are a number of obvious responses. Wealthy nations should discourage or prohibit their domestic agencies from recruiting in poorer nations. Such nations (including Australia) must train a greater number of health care professionals — enough to meet their own needs and to compensate for the loss of those who, for one reason or another, go overseas. Wealthy nations should also do what they can to secure the return from overseas of their own health professionals — unless they have gone to work in less developed countries. Finally developed countries like

Australia can be active in their support for the health sectors of less wealthy nations.

There is a significant amount of unfinished business for Australia on these matters and the document that is the subject of this paper provides a valuable checklist of the required actions.

The Melbourne Manifesto

By limiting their call on health care professionals from developing nations and contributing to world supply, it is quite feasible for developed nations such as Australia to contribute to the pool of health care professionals who practise in places of greatest need.

These issues have been canvassed at the Conferences of the World Organisation of National Colleges and Academies (Wonca — also known as the World Organisation of Family Doctors), including the one in Melbourne in 2002.

That Conference produced *The Melbourne Manifesto, A Code of Practice for the International Recruitment of Health Care Professionals*¹. The Manifesto briefly describes the obligations of countries like Australia with respect to the international supply of such professionals. It requires a Memorandum of Understanding to be signed before one country recruits health care professionals from another. It can help to ensure that wealthier countries do not recruit from resource-poor ones.

The Alliance advocates for people in rural and remote Australia and is therefore primarily concerned with the supply of health professionals and their distribution in those areas. However its work is based on principles of social justice and the right of all to have affordable access to high quality health services. It therefore recognises that the most serious and urgent shortages of health care professionals are in less affluent nations.²

So the rural shortages of health professionals and their mal-distribution in Australia are seen by the Alliance in the context of the global situation. Non-metropolitan Australia is relatively well-off compared with many developing nations, except for the average status of health of its Indigenous people. This exception is a very serious one: life expectancy for Indigenous people is currently 20–21 years lower than for the total Australian population.

The Alliance advocates strongly for Australia not to solve its own problems by making the situation worse in poorer countries. More than this, the Alliance believes firmly that Australia has a responsibility to make a net contribution to the world supply of health care professionals, particularly in our own region of the South Pacific. Regional considerations are increasingly seen as important issues in global health activity.

This means at least three things for Australia: not actively recruiting health professionals from poorer nations; training more than enough for its own needs; and supporting developing countries with their health workforce needs.

The Alliance has called on the Australian Government to commit extra resources to the training of health graduates in Australia, for practice both within Australia and overseas.

The Alliance and its Member Bodies will also continue to promote *The Melbourne Manifesto* as a valuable framework for international action and for attention within Australia. A copy of the Manifesto is attached as an Appendix 1 to this paper. It can also be read on the Alliance website — www.ruralhealth.org.au

The changing work of health professionals

Global considerations of the demand for health care professionals raise some issues for their scope of practice. The first is just how much health care is warranted for any particular individual, given competing demands for resource allocation. The second is how an agreed amount of health care should be provided and by which professionals. Answers to these questions will help determine the numbers required overall and within any particular health professional group.

Changes are already occurring in the distribution of health care work between different professions. Multidisciplinary teams are a good way to provide services in rural and remote Australia and they encourage close collaboration between their various members, notwithstanding different professional backgrounds. Happily, less attention is now being paid to what may be called ‘the boundary issues’ relating to individual professions. There is greater acceptance of professionals whose work might previously have been seen as ‘crossing boundaries’, such as advanced practice nurses.

The further development of multidisciplinary health teams will mean situations in which necessary tasks are shared between a greater number of professional and semi-professional groupings.

International medical graduates

International medical graduates (otherwise known in Australia as overseas-trained doctors) are of great importance to rural and remote Australia. The Alliance therefore has an ongoing interest in matters related to IMGs.

The Alliance’s view is that IMGs should be sought for Australia only from developed countries, should be carefully assessed for clinical and cultural competence so that there is no reduction in the quality of service provided, and should be well supported and highly valued members of the communities in which

they work. They should be assessed for competence in a multidisciplinary and team approach to health care delivery, and on their communication skills.

The Alliance and its Member Bodies are pleased to be involved in the activity relating to IMGs under way as part of the MedicarePlus package. The Alliance has sought and obtained assurances that the work to recruit IMGs within the MedicarePlus package will meet such ethical standards. Over and above such officially endorsed recruitment is the *ad hoc* activity of the private sector and of individual health agencies. These too need to be monitored and managed to ensure they are not putting further at risk the health of people in less well-off countries. In this work and at other opportunities the Alliance will continue to expect national adherence to the principles of *The Melbourne Manifesto*.

For sustainable and ethical solutions to be found on IMGs, there will need to be a high level of ongoing collaboration between the health and immigration agencies of the Australian Government, the states and territories, the Health Insurance Commission, the Australian Medical Council, the State Medical Registration Boards, medical colleges and other professional bodies.

Australia is an attractive country in which to work and, given supportive legal and administrative structures, there will always be IMGs here, both as temporary visitors and as new settlers. The unique opportunities and challenges of rural and remote practice will mean that a number of them will work in non-metropolitan areas. Overall though it is the Alliance's hope that, as a nation, we will soon be able to make a net contribution to the world supply of doctors. This means that at any given time there would be more Australian-trained doctors working overseas than overseas-trained doctors working in Australia.

Unfinished business for Australia

There are a number of policy areas in which Australia needs to work if it is to meet the standards and principles enunciated in the Melbourne Manifesto within its own jurisdiction and make a contribution to international developments on the matter.

- 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 such professionals than we need would be a significant a contribution to global health care.
- Australia's systems for the recruitment of health professionals trained overseas should be regularly monitored and must be informed by integrity, transparency and collaboration with overseas countries and the professionals from them.
- Australia should facilitate international exchanges of health care professionals as a contribution to international health care development.
- Australia should explicitly consider the effect its domestic workforce policies and overseas recruitment practices are having on less developed countries.

- Australia must ensure that the number and distribution of undergraduate and postgraduate training posts it has are adequate to meet its own workforce needs.
- Australia 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) and enable them to work as appropriate in our health sector.
- Australia should 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.
- Australia must continue to consider alternative and innovative ways of providing care in areas of need such as the development of multidisciplinary teams, extended primary health care models of service delivery, intersectoral collaboration and new types of health professionals.
- Australia should develop a Memorandum of Understanding (MOU) with countries from which they wish to recruit. This MOU should outline the issues listed in the Melbourne Manifesto.
- Australia should help less developed countries recruit 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.
- Australia must continue to provide for further training within our country of health care professionals from developing countries, and in such a way as to encourage them to return to their home countries after training.
- Australia should push for an international process to ensure the evaluation and monitoring of international migration of health care professionals.

Appendix 1—A Code of Practice for the International Recruitment of Health Care Professionals: The Melbourne Manifesto

Adopted at 5th Wonca World Rural Health Conference, Melbourne, Australia. 3 May 2002

Preamble

Many countries in both the developing and developed world are experiencing shortages of skilled Health Care Professionals (HCPs), particularly in rural and socially deprived areas. One of the responses of wealthier countries is to recruit HCPs from resource-poor countries, rather than training sufficient numbers of their own. This leads to a flow of highly trained professionals away from the countries that can least afford to lose them. The effect is to impact negatively on already seriously under-resourced health systems and therefore on the health status of developing countries. Development of an ethical code should balance the rights of individuals to travel against the needs of communities.

Principles

We assert that:

1. It is the responsibility of each country to ensure that it is producing sufficient HCPs for its own current and future needs; is retaining them; and is planning for both rural and urban areas.
2. International recruitment is related to an inability on the part of individual countries to satisfy their own workforce needs.
3. The principles of social justice and global equity, the autonomy and freedom of the individual, and the rights of nation states, all need to be balanced.
4. Integrity, transparency and collaboration should characterise any recruitment of HCPs.
5. International exchanges of HCPs are an important part of international health care development.
6. Countries that produce more HCPs than they need, may continue this contribution to global health care.

Purpose

This code of practice aims to:

- promote the best possible standards of health care around the world;
- encourage rational workforce planning by all countries in order to meet their own needs; and
- discourage activities which could harm any country's health care system.

The code

1. Countries considering and benefiting from recruitment from other countries must:
 - a) examine their own national circumstances and
 - i. consider the effect that their existing recruitment policies and practices are having on lesser developed countries
 - ii. develop and implement their own ethical recruitment policies
 - iii. ensure that the number and distribution of undergraduate and postgraduate training posts available within the country are adequate to meet their own workforce needs
 - iv. ensure that the working conditions and educational opportunities in their own countries are sufficient to encourage HCPs to work in areas of need
 - v. develop and resource active educational links with universities and medical schools in lesser developed countries that contribute to the education and training of their HCPs
 - vi. consider alternative and innovative ways of providing care in areas of need such as the development of multidisciplinary teams and intersectoral collaboration.
 - vii. explore using the skills of HCPs who have migrated for personal reasons living in these countries but unable to work.
 - b) review their recruitment strategies to ensure that they:
 - i. acknowledge the principles outlined in the 1997 Wonca Durban Declaration, "Health for all Rural People", together with the principles outlined above.
 - ii. develop a Memorandum of Understanding (MOU) with countries from which they wish to recruit. This MOU should outline issues such as:

- how this recruitment will be done
 - the benefits to each country
 - the nature and degree of compensation that should be paid to contribute to the support and training of HCPs in their country of origin
 - the steps required to ensure that any recruitment by agencies or government is conducted and monitored according to this Code of Practice
 - the inclusion of HCPs recruited from abroad under the receiving country's employment laws
 - the provision of full and accurate information to potential recruits regarding the nature of the job, selection procedures and their contractual rights and obligations
 - the support, further education, training and continuing professional development available to recruited HCPs that is equivalent to that provided to other HCPs
 - the support and encouragement of nationals to return to work in their country of origin.
- iii. only recruit and advertise (including national journals) from another country when a MOU exists.
2. Countries experiencing damaging loss of HCPs should explore the reasons why HCPs are leaving and address these by:
- a) evaluating their own training programs to ensure that they equip their graduates with the knowledge, skills and attitudes that are most appropriate for their national needs;
 - b) ensuring that the working conditions, incentives and educational opportunities in their own countries are sufficient to encourage HCPs to work in areas of need; and
 - c) considering alternative and innovative ways of providing care in areas of need such as the development of multidisciplinary teams and intersectoral collaboration.
3. Developing countries should be supported to recruit from developed countries, given that they will not be able to compete in terms of financial incentive packages. Such recruitment would focus on providing short-term opportunities for HCPs with clinical, educational, management, research and other skills to assist in the development of health care services in these countries.

4. Countries should develop transparent processes for the limited registration or licensing of HCPs trained abroad which allows for:
 - a) short term exchanges, fellowships, and sabbaticals, which can:
 - i. offer opportunities for enhanced practice and experience over a specified period of time
 - ii. allow trained staff from the recruiting countries to benefit from exchange experience abroad.
 - b) further training of HCPs from developing countries in more developed countries. This can make a positive contribution if it is structured in a way that ensures that HCPs return to their home countries after training for at least the equivalent period of the duration of such training.
 - c) international mobility of HCPs prepared to work in areas of great need.

We believe there should be an international process to ensure the evaluation and monitoring of international migration of HCPs to inform this code.

Participants at this 5th World Conference on Rural Health in Melbourne hereby call on all countries to adopt this Code of Practice for the International Recruitment of Health Care Professionals.

Notes

- 1 *The Melbourne Manifesto, A Code of Practice for the International Recruitment of Health Care Professionals*; Adopted at 5th Wonca World Rural Health Conference, Melbourne, Australia, May 2002.
- 2 In Australia there are also serious shortages of health professionals in some outer metropolitan areas. Within Australia overall, however, the health of people in rural and remote areas is worse and their income lower than in the capital cities, so the Alliance does not apologise for asserting that the most serious workforce shortages within our nation are those in country areas.

Member bodies

AARN	Association for Australian Rural Nurses Inc
ACHSE	Australian College of Health Service Executives (rural members)
ACRRM	Australian College of Rural and Remote Medicine
ADGP	Rural Sub-committee of the Australian Divisions of General Practice
AHA	Rural Policy Group of the Australian Healthcare Association
ANF	Australian Nursing Federation
ARHEN	Australian Rural Health Education Network Ltd
ARRAHT	Australian Rural and Remote Allied Health Taskforce of the Health Professions Council of Australia
ATSIC	Aboriginal and Torres Strait Islander Commission
CRANA	Council of Remote Area Nurses of Australia Inc
CRHF of CHA	Catholic Rural Hospitals Forum of Catholic Health Australia
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association of Australia Inc
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHN	National Rural Health Network
RDAA	Rural Doctors' Association of Australia
RACGP	Rural Faculty of Royal Australian College of GPs
RFDS	The Australian Council of the Royal Flying Doctor Service of Australia
RGPS	Regional and General Paediatric Society
RPA	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
SARRAH	Services for Australian Rural and Remote Allied Health

nrha



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