NATIONAL RURAL HEALTH ALLIANCE

YEARBOOK *includes* ANNUAL REPORT

2000 ▪ 2001

NATIONAL RURAL HEALTH ALLIANCE INC.

YEARBOOK

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2000 - 2001 ANNUAL REPORT

National Rural Health Alliance 2001

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PART ONE – THE YEAR'S ACTIVITY

2 October 2001

Ms Joanna Davidson
Head of the Office of Rural Health
Department of Health and Aged Care
GPO Box 9848
CANBERRA ACT 2601

Dear Ms Davidson,

Formal Report to the Office of Rural Health for 2000-2001

I am writing formally to discharge the requirement for the Alliance to report each year on the work it has done with the funds provided by the Office of Rural Health.

Enclosed is a copy of the Financial Statements for 2000-2001.

The attached Summary Report deals with each of the outcomes and strategic activities listed in the Agreement dated August 1999 between the NRHA and RHSET.

The financial year 2000-2001 included the following highlights.

CHAIRPERSONS' REPORTS

Steve Clark, Chairperson from July to October 2000

It is a pleasure to present my report as Chairperson of the National Rural Health Alliance for the period until the AGM in October 2000. It was a challenging period. We spent considerable time reflecting on our Constitution, particularly our shared values and rules governing statements on policy. Like other organisations we were also faced with the challenge of implementing the GST. These administrative issues provided significant 'background noise' to the Alliance's normal busy round of activity.

The most significant changes were consequent upon our success in being awarded tenders for the administration of the John Flynn Scholarship Scheme and the Rural Australia Medical Undergraduate Scholarship Scheme. These provide the Alliance with functional reasons for close contact with rural communities, medical undergraduates, their Medical Schools and their mentors in rural and remote areas.

The 6th National Rural Health Conference was beginning to demand our attention even before the AGM in October. The decision was made to merge the Infront Outback Conference associated with Toowoomba with the National Rural Health Conference. This has important implications for the rural health community, as well as for policy and research, and it will be important to monitor the outcomes of this decision.

It is clear that the Alliance can exert considerable influence on government policy. The critical question right now is how to continue to present a united front to government on key issues while also acknowledging our diverse views and opinions and the various charters of each of our Member Bodies.

We all know there is room for improvement in our health system and if we work hard on all the elements of a shared vision we will exert the type of influence on government policy we desire. This means Council has to take more responsibility for the development of policy. The Office has been missing a dedicated policy position for some time and there simply is not the capacity within the present staffing structure to stretch anyone any further.

I want to thank all Members of Council and staff for their work. Special thanks to Margaret Smith, Immediate Past National President of the Country Women's Association of Australia, who has been a stalwart and high profile delegate from that organisation.

Finally, I want to thank the Executive and our Executive Director for their support to me as Chairperson. I left the position at the AGM with mixed feelings but with great confidence in the future of this organisation. ■

Nigel Stewart, Chairperson from October 2000

Staff continue to do wonderful work for the National Rural Health Alliance. Some have left and we regret their going, and some have come and we welcome them. The Conference staff organised an excellent and well-received National Rural Health Conference in March. They also assist other organisations with their conferences. It is probably timely that we re-evaluate this model of conference organisation and review all of our conferences, their size, accessibility and purpose.

We continue to administer the John Flynn Scholarship Scheme (JFSS) and Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme and I believe we do this well and efficiently due to the excellent input of Alison Miles and other team members. A major issue for all our programs will be to have the appropriate business structures for them.

A recognised need within the organisation has been to have further policy generating capacity within the staff. Despite this, an excellent amount of policy has been developed this year, both from the Conference and by Executive and full Council. It would appear that we are well-placed to continue to promote rural health and rural issues in general.

A Governance Committee of Council has been formed. There is a commitment from all of Council to education about this vital area, which has achieved even higher prominence in Australia in the last year. We are putting in place structures, we are becoming more knowledgeable about governance and the responsibilities that this means to staff and Council, and we are putting in place the appropriate procedures that flow on from this. We are looking at aspects of accreditation, both with its relevance to program management and also to overall good functioning. Governance in the long-term underpins our solidity as an organisation. It also codifies our relationship as Council with the Executive Director and staff, and also codifies appropriate relations between Council members and also between Council members and the bodies they are representing.

The last few years have been a watershed for the National Rural Health Alliance and its Council, as some of the original members have retired and new people have come on board. This is a difficult stage for any organisation, but the National Rural Health Alliance appears to have weathered this quite well. It is my perception as Chairperson that we have (with the usual shortages of time and energy that busy people have) acquitted ourselves well in developing new directions for the National Rural Health Alliance in the last year. Council members have dealt with issues in an open, collegial and consultative manner.

Our Treasurer Mark Dunn has (along with the professional staff) brought our finances a long way. They are now on an excellent footing with appropriate professional accounting practices. This is an important aspect of governance. Each and every Council member needs to be aware (to an appropriate level) of the financial issues and structures.

As a child health specialist I make no apologies for bringing child health to the table. I very much appreciate the support of my colleagues with this issue.

We may have had a role to play in the development of the new rural nursing scholarships and we continue to advocate strongly the issues of rural nursing and allied health professionals. We have of course maintained our commitment to medical practitioners and pharmacists. The issue of oral health has resulted in some policy documents and is one that is starting to be discussed and advanced.

We enjoy good access to politicians and also to relevant sections of the Department of Health and Aged Care, hopefully reflecting a very real credibility.

The future however is unpredictable, as ever, with the need to re-tender for the administration of scholarships, and with a Federal election this year. There will be a strong need to manage communications, media, and to keep in touch with our Member organisations.

I believe strongly in a unified and focused Alliance challenging rural people, ourselves and the government process. This is a balancing act: to challenge but not annoy fruitlessly. We need to talk to government but not become seduced. I believe in working as committed colleagues in an open manner with issues on the table. If they are not on the table they are interesting background but not too high in my priorities. We need to tidy up the good work on structure, governance and staff support as quickly as possible to pursue the big issues.

I value the staff as our greatest asset. They need to be looked after and given clear direction. They also need operational freedom. I value corporate memory and see this as vital on the Executive.

At a personal level I have thoroughly enjoyed the year. It has been great to work with Council and an extremely knowledgeable Executive Director and a very professional staff. There have been some reasonable challenges and I have received excellent support from everyone. I would particularly acknowledge the wisdom and support of John Lawrence as Deputy Chair, the directness and passion of Lesley Fitzpatrick and the financial acumen and quiet contemplation of Mark Dunn. I must also thank Steve Clark for his advice and knowledge of the political process. Mark Cormack has contributed a lot to the advancement of governance. I thank all of you for the support and the opportunity to have grown as a person in the role of Chair. ■

The 6th National Rural Health Conference was held in March 2001 and was well-attended and successful.

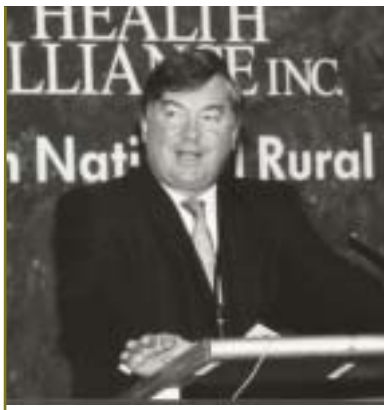
6TH NATIONAL RURAL HEALTH CONFERENCE

4 – 7 March 2001
National Convention Centre, Canberra, ACT

Integrating Research and Policy

(The following is an edited version of extracts from a paper in the Australian Journal of Rural Health written by Lesley Fitzpatrick, Gordon Gregory and Bruce Harris, and published in Volume 8 (3), June 2000.)

The National Rural Health Alliance (NRHA), the Toowoomba Hospital Foundation (THF) and the Cunningham Centre have agreed on a merger of the two biennial conferences for rural and remote health that have been running in alternate years since 1991. This means that, in March 2001, the National Rural Health Conference will, for the first time, incorporate Infront Outback, the Australian Rural and Remote Health Scientific Conference.



Michael Wooldridge speaking at the conference

There will therefore be one major biennial rural heath conference, dealing coherently with health scientific research and policy development. The recommendations to governments and national bodies that result should be even stronger and more highly regarded than has been the case to date.

A strong argument in support of the merger is the proper relationship that ought to exist between health research and policy development, and the contribution that a joint conference can make. Given the tremendous pressure on public resources, including those allocated to health, it is now more important than ever to have changes in policies and programs underpinned by evidence.

To some commentators it seems curious that we place much store in the health domain on 'evidence-based' decisions in clinical practice, but that the evidence-based approach does not inform choices about policies and programs. There is now some evidence about what programs work under what conditions, and what policy approaches are and are not appropriate. Good research papers should therefore be the main basis upon which governments, communities, institutions and professional bodies make their decisions about practice and approach.

It is therefore not appropriate to separate scientific research on health from policy decisions, even if that was possible.

Internally at its Council meetings and at similar events, the Alliance has been considering the possibility of formalising or structuring an evidence-based approach to policy development and change. It would have to be said that the discussions have been somewhat desultory and inconclusive, reflecting perhaps the complexity of the challenge.

Meg Lees and Nigel Stewart

(Alternatively it may be that this reflects the fact that, all too often, policy changes are determined by political will, expediency, 'rent seekers' and accident - all of which are less susceptible to ready analysis than 'evidence'.)

Some have gone so far as to suggest the idea of a database for policies and programs that is styled on the Cochrane Collaboration for evidence on clinical interventions. The supporters of this notion have been encouraged by the fact that there is a history in Australia and elsewhere of needing to have flexible models of health service for rural and remote areas that are based on models that already exist and that are known to be working.

Healthy Horizons puts it this way:

> " Governments have recognised that metropolitan solutions and rigid program guidelines cannot always be successfully applied in rural, regional and remote communities. Therefore health providers and communities must be able to develop solutions and service models that reflect their need and circumstances " (p16).

Kim Beazley speaking at the conference

Perhaps a database approach to existing models of service delivery, and to the characteristics of successful and unsuccessful models, could help in the uptake of new approaches and in understanding the reasons for success or failure.

The name 'Archie Cochrane' is the one most people recognise as starting the whole 'evidence-based' debate by asking the medical profession to examine research in an orderly fashion. In 1979 A.L. Cochrane wrote 'A critical review with particular reference to the medical profession' for the Office of Health Economics, London. It was one of those forward-looking articles titled 'Medicine for the Year 2000' which has now caught up with us. The point he made was that clinical practice was not - and could not be - supported by scientific evaluation. It was not that practice wasn't being researched, but that the research evidence could not be reliably accessed or compared. Apart from anything else, there was too much of it.

Sabina Knight Infront; Louis Ariotti Outback

In 1991 when the first National Rural Health Conference was held in Toowoomba there was a sustained call for much more appropriate research on rural health. Those who convened the first Infront Outback knew that there was some good work happening but that there was no easy way to spread the good news. Since that time the AJRH has helped and the energies called for have continued to drive successive governments to take note and, to their credit, they have responded. Infront Outback at Toowoomba became both a showcase for Australian rural health research and a meeting place for the committed.

In 1999 the National Rural Health Alliance produced its first CD - 'Rural and Remote Health Papers 1991-1999' - packing many of the relevant papers and articles onto a searchable database. This was both sophisticated technology and an astonishing task and was, incidentally, achieved just before the time was up for Archie Cochrane's call for accessible data by 2000.

So where to now? The Alliance believes that policy - which is 'government practice' - must, like clinical practice, be firmly based on available 'evidence'. If there is not enough of such evidence then it must be found; and the process of finding it must follow reputable processes. Ideally, when reliable evidence shows policy to be right or wrong then scarce resources can be suitably shifted without too much dispute.

There is of course also the opportunity for policy to lead research, rather than follow it. This is what makes strategic research priority setting such an important venture.

Australia's efforts in rural health are now acknowledged internationally. The Cochrane message of an accessible critical summary, organised and adapted periodically, can be usefully adapted to guiding this and other countries toward a healthier policy for rural and remote communities.

Outcomes of the 6th Conference

(The following is from the Alliance's e-forum at www.ruralhealth.org.au)

The National Rural Health Conference is over for another two years and now the most important work associated with it begins. The Conference has established itself as a most significant event on at least two counts. First, it is an unequalled opportunity for networking among people interested in rural and remote health. Second, it is a forum in which recommendations are produced that can have a direct impact on policies and programs for rural and remote health.

Neil, Colleen and Henry at the Conference

It is to be hoped that there can be the same high level of success with the recommendations produced. This will require concerted action from all of those organisations involved with the Conference, including the Alliance.

A good set of priority recommendations has already been circulated. They are 'good' in the sense that they address a number of the most urgent issues identified at the Conference and, in some cases, they are specific enough to be the responsibility of an individual government or agency.

Some of the priority issues are still likely to be grounds for cost-shifting and blame-shifting between governments. These include recruitment and retention support for non-medical health professionals (see below); oral health; funding for health consumer involvement in consultation, policy development and governance; and the pervasive challenge of rural community transport. The Conference has taken the sensible way forward by directing these requests to the Ministers and governments which are jointly responsible.

Rural and remote people are saying that these issues are critical and must be fixed, and it is up to the Ministers responsible to decide how the costs, responsibilities and credits are shared between them. Uncertainty about how the responsibility will be shared will not be accepted as an excuse for a lack of action. Having said that, the Alliance and other organisations must take up Michael Wooldridge's oft-repeated challenge (repeated again in his address to the Conference) to work with the States and the Territory to see that they are doing their proper share in these important areas.

Extension of workforce support to all health professionals in rural and remote areas was the strongest single theme to emerge at the Conference.

One hundred and forty-nine recommendations arose out of the Conference Recommendations Process. The fifteen priority recommendations (all, of course, with a rural and remote emphasis) included those on:

- a social model of health driven by a whole-of-government, whole-of-body, whole-of-life approach;
- primary health care, including general practice;
- some population health issues, including men's health, oral health care, and mental health;
- transport and health, including patients' transport, community transport;
- support for consumer participation in health consultation and policy development;

Matilda House at the Smoking Ceremony, 6th Conference

- education and training for the rural and remote health professions, including undergraduate scholarships and other incentives;
- the role of arts in health and how to fund it;
- resources for all Aboriginal and Torres Strait Islander health issues;
- other general practice, nursing and allied health workforce issues;
- the inclusion of health promotion, primary health care, population health and cultural safety components in the undergraduate curricula for all health disciplines;
- a holistic approach to the health of children and adolescents;
- resources for adequate information technology and telecommunications infrastructure, including affordable access to the Internet; and
- separate national summits for rural and remote nursing and allied health.

There were 930 delegates at the Conference - the same number, coincidentally, as attended the 5th in Adelaide. The Alliance is pleased to acknowledge again the support of the Major Sponsor in Canberra: Telstra Country Wide.

We are also pleased to acknowledge the other sponsors and supporters of the 6th National Rural Health Conference:

- The Arts in Health Stream at the Conference was sponsored by the Community Cultural Development Fund of the Australia Council.
- Conference sponsorship was provided by the Chief Minister's Department of the ACT and the ACT Department of Community and Health Services.
- The Rural Industries Research and Development Corporation.
- The Toowoomba Hospital Foundation.
- The Cunningham Centre and Infront Outback.

The Office of Rural Health of the Commonwealth Department of Health and Aged Care provides the core operational grant to the National Rural Health Alliance and this grant includes an allocation for administration of the biennial Conference.

Lesley Fitzpatrick was Convenor of the Infront Outback stream, and managedthe referee process for Infront Outback papers. Lesley also convened the Conference Drafting Group which worked on the recommendations.

We would also like to acknowledge the contributions made to specific sessions of the Conference by:

- Matilda House and Ngambra Sunfire;
- The Woden Valley Youth Choir;
- Integrated Vision;
- Picture-tel Ltd;
- The National Gallery of Australia;
- Screensound Australia;
- The Australian War Memorial;
- The National Multi-cultural Festival; and
- The International Year of Volunteers.

Many thanks to the staff of the National Convention Centre.

Thanks to all of the speakers. Finally, thanks to the delegates for making it all worthwhile. ■

OTHER CONFERENCES

National Workshop on Advanced Nursing Practice

(The following overview was prepared by Lesley Fitzpatrick, Convenor of NARHERO.)

The National Association of Rural Health Education and Research Organisations (NARHERO) is one of the Alliance's Member Bodies.

NARHERO's first initiative in addressing workforce issues from Healthy Horizons was to convene a National Workshop on advanced nursing practice. As advanced nursing practice involves medical practitioners, nurses, and Indigenous Health Workers, it is an area in which the professions need to work together to discuss and resolve issues in order to move forward.

The National Workshop, 'Advanced Nursing Practice: Charting a future for rural and remote area practice', was held in Canberra in October 2000.

Invited participants included representatives from professional organisations (nursing, general practice, allied health, pharmacy etc), State and Federal Health Departments, Indigenous groups, Member Bodies of the National Rural Health Alliance, regulatory authorities, University Departments of Rural Health and Rural Health Training Units. Also invited were representatives of the rural sub-committee of AHMAC, Chief Nursing Officers, researchers, academics and consumers.

The Workshop considered progress towards, and barriers to, advanced nursing practice in rural and remote areas, and canvassed common ground in order to advance the issue through the development of a discussion paper.

The goals of the Workshop were:

- to contextualise the collective problems of recruitment and retention of nurses and consider the better use of nursing skills in rural and remote areas in order to overcome inequalities in access to health care experienced by Australians living in rural and remote areas;
- to encourage support for, and an understanding of, collaborative health care practice in rural and remote areas, and to expand understanding of this concept among health professionals, policy makers, and consumers;
- to clarify what is happening with regard to advanced nursing practice in organisations, in the States, the Northern Territory and nationally, and to identify strategies to progress the issue;
- to identify and discuss the barriers and concerns of all parties interested in the future development and composition of the rural and remote health workforce; and
- to advance the view that there is a legitimate leadership role for the Federal Government on this issue as the structure and preparedness of the nursing workforce is a national concern.

It became clear during the Workshop that a planned and strategic approach to the development of nurse practitioners was critical in order to ensure that the potential of this workforce development for rural and remote communities is realised. It was apparent that agendas and industrial issues driven by metropolitan interests and circumstances are clouding the goals, needs and service provision issues related to the development of nurse practitioners for rural and remote Australia.

NARHERO will continue to work with interested organisations and individuals on the blockages and the possible solutions and strategies required to progress the issue.

Chronic Disease Self-Management

The Alliance was involved in ensuring that the increased emphasis on the management of chronic disease has an appropriate focus on people in rural and remote areas. Dr Steve Clark, Chairperson of the Alliance, presented to the National Chronic Disease Self-Management Conference in Sydney at the end of July and Gordon Gregory was on a discussion panel. The proceedings of the panel discussion were recorded and later broadcast by the Rural Health Education Foundation.

General information on the Government's chronic disease initiatives can be found at www.chronicdisease.health.gov.au/ ■

The Alliance continued with its core information and policy development work.

ESTABLISHING RESEARCH PRIORITIES FOR HEALTHY RURAL COMMUNITIES

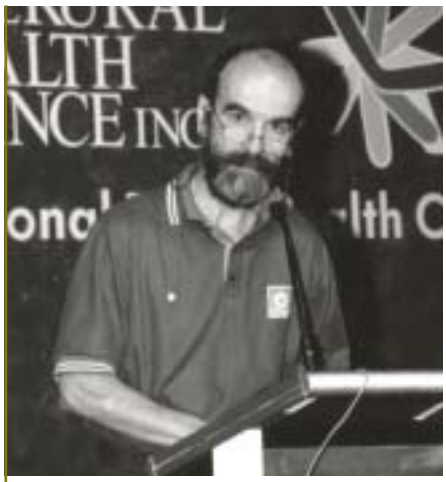
(In July 2000 the Alliance helped the ANU's National Centre for Epidemiology and Population Health (NCEPH) mount a workshop on rural and remote health research. The following is an extract from the paper prepared as background for the workshop by Dr Fran Rolley of the University of New England. The extract is reproduced here with Dr Rolley's permission.)

The past two decades have seen a growing concern over the existence of continuing, and in some cases widening, health inequalities, not only between national populations but also within populations. In an attempt to reduce health inequalities, many governments have sought to identify the determinants of health, focusing particularly on why health outcomes are unevenly distributed across the social spectrum.

In Australia, the very significant and unequal burden of disease and illness caused by social and economic disparities has been recognised for some time as a major health challenge (National Health Strategy, 1992; Mathers et al., 1999). In particular, despite population-wide health gains, persistent health differentials remain for Indigenous Australians and Australians living in rural and remote communities (Health Inequalities Research Collaboration (HIRC), 1999). Recent research has highlighted the nature and extent of inequalities in health, providing evidence that Australia's rural and remote populations have poorer health than their metropolitan counterparts with respect to many health outcomes (National Rural Health Policy Forum (NRHPF), 1999). Rural and remote Australians have higher mortality rates and consequently lower life expectancy than those living in capital cities and other metropolitan areas (Australian Institute of Health and Welfare (AIHW), 1998a, 2000). They experience higher hospitalisation rates for many causes of ill-health and experience significantly more illness for some disorders than do urban people (Fragar et al., 1997; AIHW, 1998b). Mortality and morbidity statistics demonstrate the ubiquitous existence of these health inequalities both among men and women and for virtually all age brackets (Titulaer et al., 1997).

Australia's Aboriginal and Torres Strait Islander peoples continue to experience much poorer health than the general population. Indigenous Australians suffer a higher burden of illness with twice as many hospital separations as would be expected if they experienced rates similar to the total population, and life expectancy at birth of up to 20 years lower than the Australian population as a whole (Donovan, 1995; Australian Bureau of Statistic (ABS) & AIHW, 1997; AIHW, 1998a; ABS, 2000). Regardless of the health status indicator chosen, the health inequality faced by Indigenous Australians is evident (Sidoti, 1999).

Given increasing concern over rural-urban differences in health status, health care need and the factors that contribute to rural health and wellbeing, this discussion paper seeks to canvas current research themes which describe and explain the differential health experience of rural residents as a basis for establishing research priorities.



NRHA's Executive Director, Gordon Gregory

Key questions to be addressed include:

- What is the nature and extent of the health differentials that exist between rural and metropolitan regions and within rural and remote areas of Australia?
- What factors help to account for the health inequalities experienced by residents of rural and remote areas?
- How are the determinants of health status in rural areas affected by locational disadvantage?
- What are the potential opportunities for, and threats to, reducing health inequalities in rural and remote areas?

The paper concludes by highlighting the strengths and weaknesses in current research activity and suggesting opportunities for future research with a view to reducing the health inequalities experienced by rural Australians.

The paper does not, however, attempt to provide an exhaustive review of Australian rural health literature. One early review to examine health status and health care needs in rural Australia was published by Humphreys and Rolley in 1991, and Britt et al. (1993) also provide a useful country dimension to the data set created by the survey 'Morbidity and treatment in general practice in Australia'.

In addition, Fragar et al. (1997) present a detailed report which outlines the health of country Australians, while the landmark report Health in rural and remote Australia (AIHW, 1998b) is devoted entirely to documenting the health of rural and remote Australians. More recently, an extensive audit and inventory of rural health research in Australia has been undertaken by the National Health and Medical Research Committee's Rural Health Research Committee (NHMRC - RHRC). A report to the Australian Health Ministers' Advisory Committee (June 2000) documents that NHMRC project's progress to date.

The program for NCEPH's "Social origins of health and well-being" conference is at www.health.gov.au/hfs/pubhlth/hirc/pdfs/conference.pdf ■

A NEW GROUPING OF KEY ISSUES

(The following is from the in-house report of the Council's face-to-face meeting in October 2000.)

Council agreed on the following group of key issues:

- Family Issues: child health, men's and women's health, domestic violence, aged care, isolation of the aged, mental health, suicide, education, dental health, access to services, including to the Medicare Benefits Schedule (MBS).
- 'Political Empowerment': including such issues as rural capacity buiding, the problems with access to home loans in remote areas, business development, tax arrangements, banking, education, rural voice, fuel tax, and transport.
- Workforce Issues: including with respect to allied health and nursing, retention equity, incentives, education and training, regionalisation of training, declining number of nurses, a 30% fair share, recruitment and retention.
- Infrastructure: including health data, equitable financing, housing, water, infrastructure for Indigenous people, food security, employment, health hardware, the proposal for an MBS rural item number, a 30% fair share, fuel tax, bulk billing and telehealth. ■

SOME ALLIED HEALTH ISSUES

(The following comprises edited extracts from the paper produced jointly by SARRAH and ARRAHT, the two allied health organisations within the Alliance.)

Professions usually included under the umbrella of allied health include audiologists, dieticians, hospital pharmacists, occupational therapists, optometrists, orthotists, orthoptists, physiotherapists, podiatrists, psychologists, radiographers, social workers and speech pathologists. Dentistry, pharmacy and optometry, although defined as allied health, are generally classified individually due to the size and structure of their profession.

Allied health professionals as defined by the Department of Health and Family Services (1997) "are health professionals from one of several individual professions who have, for the purpose of presenting a collaborative position, come together to work towards a common goal. Professions represented in any allied health professional group vary depending on the goal of the collaborative exercise."

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

Allied health professionals (AHPs) provide a diverse range of services in a variety of settings in the health sector, including acute hospital care, rehabilitation, children, women and men's health, community health, Indigenous health, veterans' affairs, health promotion and participation in research. A range of services is also provided to other sectors, including education, public health, industry, disability, welfare and aged care.

The redoubtable Jean, Sabina and Fiona at the Conference

AHPs work in both the public and private sectors.

Some of the required actions to improve health outcomes in rural and regional areas are:

- prepare a map of all available practitioners by profession and discipline;
- utilising the available information resources, prepare a profile of need by geographic regions for allied health professions;
- gather data where feasible and cost effective to develop a profile of rural allied health workers including factors such as age, gender, qualifications, employer (public, private, self) specialty areas, seniority/classification level, and social factors eg marital status, parental status; and
- identify priority regions, based on an analysis of supply and demand data and infrastructure data.

The National Rural Health Alliance affirms that:

- Allied Health Professionals have a critical role to play in public health and health promotion initiatives in rural and remote areas.

  For example, dieticians have key roles to play in the prevention and management of diabetes, reducing the risk of complications in people with this condition, and cardiovascular disease. Podiatrists also have an essential role in the management of diabetes, including reducing the incidence of amputation. Social workers and psychologists can play an important role in assisting people cope with stressful situations or depression, often identified as key factors contributing to the increasing incidence of suicide in rural and remote locations. Similarly, physiotherapists and occupational therapists assist in the prevention of workplace accidents and are an essential part of post injury rehabilitation and return to work. Audiologists and Speech Pathologists, working within the education area, have a key role to play in the management of hearing, language and communication problems resulting in poor literacy and numeracy skills. Orthoptists and Optometrists have key roles to play in the identification and management of eye problems associated with conditions such as diabetes, as well as within the education area as visual problems also can result in learning difficulties.
- Overseas recruitment of Australian graduate AHPs by international agencies exacerbates the difficulties of attracting graduates to rural and remote locations.
- A leakage of allied health graduates to the Graduate Medical Program is also affecting the recruitment of AHPs to rural and remote areas.

Chris Ward and Shelagh Lowe discuss allied health with the Minister

- A number of States have recognised the importance of the allied health professions to the delivery of health services and improved health outcomes in rural and remote areas, and are now providing rural allied health scholarships to students to enable them to undertake a rural clinical placement.
- The Rural Student Clubs at the universities also play an important role in supporting allied health students interested in a career in rural or remote locations.

The National Rural Health Alliance resolves that:

- There is a need to raise the awareness of people in rural and remote communities of the roles of AHPs in terms of their skills in rehabilitation, aged care, palliative care, mental health and health promotion. The AHP needs to be considered not just as an "extra" but as an integral member of rural and remote multi-disciplinary health care teams.

The Alliance continued to provide input to the Health Inequalities Research Collaboration at the ANU.

THE SOCIAL DETERMINANTS OF HEALTH

(The following is an edited extract from the Keynote address by Jane Dixon to the joint Infront Outback and AARN Conference in early 2000, a later version of which was published in the Australian Journal of Rural Health Volume 8 (5), October 2000.)

Two major indicators of societal progress are increasing life expectancy and improved well-being. In the last decade, increasingly sophisticated data sets and monitoring systems have revealed negligible improvements in mortality and morbidity for some groups in Australia. In particular, the health gains by people living in inland small towns and rural areas and male manual workers relative to the general population have not been maintained in relation to heart disease (Burnley 1998). Furthermore, the health gains by Indigenous Australians are inconsistent and there appears little improvement in death rates, which are rising for diabetes (ABS 1997). Australia, like other OECD countries, has arrived at the year 2000 without having achieved the goal, Health For All by the Year 2000. This commitment undertaken by all signatories to the Declaration for Alma Ata in 1978 was always going to be difficult to achieve. I am not sure, however, that anyone in the health field expected statistics indicating a widening difference in health status in that period.

As well as better data for monitoring national health, another part of the health sciences has been flourishing. Indeed, some are suggesting a new research field or a paradigm shift is emerging from the combined efforts of epidemiologists and social scientists (Evans et al. 1994). Called "the social determinants of health", a respectable number of researchers are dedicating themselves to generating knowledge about the complex interactions which produce health. To do this they are focusing on why health inequalities persist in even the most affluent societies, why health inequalities vary across societies and why health outcomes are unevenly distributed across the social spectrum, not simply between the rich and the rest: what is referred to as "the gradient story" or the social gradient.

Members of Council in Meg Lees' Office

Very briefly, the term 'social determinants of health' refers to the economic, social and environmental factors that influence both individual and population health. This field of research departs from explanations of genetic inheritance, biomedical processes and behaviours to address the context in which individuals live, work and play. The social determinants of health enlarges dramatically the risk factors for disease. If the Health Targets and Implementation (Health for All) Committee were writing about risk factors today, those nominated in 1988 - nutrition, physical inactivity, licit and illicit drugs, high blood pressure and cholesterol, occupational and environmental health hazards - would be joined by factors such as socioeconomic status, social capital and social support.

A combination of evidence of intransigent health inequalities and the emerging literature on the social determinants of health led the Population Health Division of the Department of Health and

Aged Care (DHAC) to sponsor a new research and development effort focussing on health inequalities. In September 1998 the Health Inequalities Research Collaboration (HIRC) began at the National Centre for Epidemiology and Population Health (NCEPH) and it has been my job to coordinate the feasibility and establishment phases for the collaboration. In the first year, the literature reviews which were commissioned concentrated on the relationship between socio-economic status and health. More recently the DHAC and others closely involved with HIRC have encouraged an exploration of why health differences persist between rural and remote Australia and metropolitan Australia.

One category of social determinant is called psycho-social factors. Among the many psycho-social factors which have been implicated in health and illness are social support and social status.

Note: The HIRC website is at www.hirc.health.gov.au ■

The Alliance engaged in media activity from time to time related to its information and policy work.

FEDERAL BUDGET 2001

"For many rural people the most exciting breakthrough in Budget 2001 was the decision of the Commonwealth to begin providing scholarships for undergraduate nursing students from rural areas. This initiative, which it seems will result in 350 such scholarships being available in 2004/05 after the initial 110 next year, was a major step towards meeting one of the NRHA's longstanding priorities.

More money was allocated to the Primary Health Care Access Program for 2003/04 and 2004/05. Views on this program vary, with some arguing that it is still not successful on the ground. But it is a cutting edge program in terms of its regional focus and its capacity to cash up health entitlements and pool them - rather than cashing out the lower levels of health payments being received in remote areas, where costs are higher and health is poorer. One of the interesting questions about this program is when it will be seen as part of the mainstream rather than something which applies mainly to Indigenous communities. (The same could be asked of the principle of 'community control', which has much to offer all communities.)

The Budget also announced some welcome changes to the taxation and payment regimes for retired people, including both self-funded retirees and full and part pensioners. The wisdom and fairness of providing greater assistance to the 0.3 million self-funded retirees than to the 1.6 million pensioners is debatable. Tax changes continue to be regressive. (www.acoss.org.au)

The special attention of rural and remote people will have been drawn to the substantial allocation to roads. This will no doubt be welcome by all those who depend on road transport. For other regional developments one has to look either to existing programs or to future announcements that may be made in the context of a Federal election. A small but vital exception is the additional funding for the Australian Broadcasting Commisions's rural services. The existing programs in place of the greatest importance are: Networking the Nation, Roads to Recovery, Regional Solutions, Rural Transaction Centres, Agriculture - Advancing Australia, the National Heritage Trust and the National Action Plan for Salinity and Water Quality. (www.dotrs.gov.au/regional/index.htm) Announcements and program funding in these areas have been rolling out at various rates over several years. The question for people who live and work in rural and remote areas is what impact they are having on your life, your income and your work on the ground.

A clear example is telecommunications. There have been numerous announcements in an area which is complex both technically and from a policy point of view. It is now asserted that wherever you live you can access the internet at the same price at an equivalent level of effectiveness. The National Rural Health Alliance, for which communications and information exchange is core business, would be interested in testing the reality of this.

Given the long list of programs referred to above it may seem churlish to complain. But the most important questions to be asked for the long-term are:

- How are the programs actually working on the ground?
- Are the programs sufficiently well co-ordinated?
- What is their impact on the sustainability of rural communities and ecologies?
- What is being done for the rural economic base and for jobs?

The NRHA has been arguing for years for a 'blueprint approach' to rural and regional development. (www.ruralhealth.org.au/rhip5.htm) There have been signs over the past year of an increasing recognition of the need to intervene in the fundamentals affecting the place of rural communities in Australia. Organisations such as the Institute of Chartered Accountants and the National Farmers' Federation (NFF) have joined the NRHA in arguing for incentives to create the economic climate necessary to rejuvenate regional Australia. A taskforce of the NFF has proposed changes to the personal income tax and company tax zone schemes. (www.nff.org.au) The Australian Conservation Foundation and the NFF have called for a decade of land care. The Institution of Engineers is leading an impressive consortium of interests in a bid for major investments in Australia's physical infrastructure, including roads, electricity, water and other utilities in rural and regional areas." ■

The Alliance continued to meet formally with the Rural Sub-Committee of the Australian Health Ministers' Advisory Council (AHMAC), a relationship that the Alliance values very highly.

RURAL HEALTH POLICY SUB-COMMITTEE

"New Government Structure Will Help in the National Rural and Remote Health Effort.

The decision made last week by all Health Ministers in Australia to establish a new National Rural Health Policy Sub-committee is strongly supported by the NRHA, Australia's peak non-government rural and remote health body.

The new structure will be a Sub-committee of the Australian Health Ministers' Advisory Council and so will have a strong and continuing relationship with Health Ministers and their Departments at Commonwealth, State and Territory levels. This has the capacity to strengthen the overall national effort to improve health in non-metropolitan areas.

The States, Northern Territory and the Commonwealth have agreed that the new Committee will continue to meet regularly with the NRHA, as did its predecessor." ■

RURAL SUB-COMMITTEE OF AHMAC

(The following is an extract from an internal Alliance report from one of those regular meetings.)

"Some members of the Committee expressed the view that there would need to be still closer focus if the Alliance was to make a difference. Others welcomed the new clustering of issues, partly because it would enable the Alliance to deal with some issues that are important for health outcomes but not within the strict area of interest of Health Departments. There was a brief discussion of some regional development issues, including of the impact on smaller towns of growth of regional centres.

Some members of the Committee expressed the view that there were now 'diminishing returns' to financial incentives to rural general practice and that the suite of programs in place should be evaluated before additional ones were put in place. It was suggested that the programs for recruitment and retention of rural General Practitioners (GPs) had had more impact on the distribution of rural GPs and on recruitment from overseas than on movements from the cities to rural areas. It was suggested that it was better to focus on long-term programs such as scholarships and university recruitment practices. It was agreed that there are great benefits to be had from health professionals training together at undergraduate and postgraduate levels.

It was suggested that some of the challenges related to work on nurse practitioners would be overcome if the words 'rural and remote' were used in conjunction with the term Advanced Nursing Practice." ■

Those associated with the Alliance, including its Chairperson, Executive Director and Manager (Scholarships), represented the organisation at a number of meetings and inquiries, and provided rural and remote input into numerous activities run by other bodies.

THE ALLIANCE'S INVOLVEMENT IN COLLABORATIVE WORK

A number of the Alliance's Member Bodies held their annual meetings in Canberra and this provided the opportunity for some closer liaison between them and the Office and its staff. The Country Women's Association of Australia and the National Rural Health Network both met in Canberra during July 2000. Health Consumers of Rural and Remote Australia worked there on their policy initiatives and organisational matters during October.

In April 2001 the Isolated Children's Parents' Association, in conjunction with the National Farmers' Federation, held their first Rural Education Roundtable. Work continues on this potentially valuable initiative relating to one of the issues that underpins the health and well-being of people in country areas. The Royal Flying Doctor Service held its annual meeting in Canberra in May.

The Executive Director continued to serve as a Deputy President of the Australian Council of Social Service (ACOSS). The agendas of ACOSS and the Alliance have much in common and from time to time both organisations work together on particular activities. This was the case during 2000/2001 with the National Oral Health Alliance and the consortium led by the Royal Australian Planning Institute. This latter exercise led to a National Summit on Cities and Regional Development, involving twelve national organisations including the Australian Conservation Foundation, the Australian Local Government Association and the Institution of Engineers - Australia. The work for ACOSS involved delegations to the Prime Minister, other senior Ministers and the Leader of the Opposition.

In August 2000 the Chairperson and two members of staff attended the Annual Conference of the Isolated Children's Parents' Association at Griffith in New South Wales.

Carmel Brophy attended a meeting in Melbourne in May run by the National Health and Medical Research Council to agree on guidelines for awards to volunteers in the health industry in rural and remote Australia. The chair and the secretariat spent time explaining the basis for its definition of 'rural' and 'metropolitan'. The Alliance helped by providing information about the RRMA definitions.

The Alliance provided support to Professor Jenny Watson in her work as Convenor of the Continuum of Care Conference held in Darwin in August 2000. The Conference provided a great opportunity for health care and professional issues related particularly to more remote areas to be addressed in detail. The Executive Director spoke at the Conference. The Senate engaged in an important piece of work relating to the funding of public hospitals. Two roundtables were held and the Alliance was invited as an observer to the first in August and as a contributor to the second (November). Council Member Judith Adams travelled from Western Australia to attend one of the meetings. The Senate's report is available at www.aph.gov.au/senate/committee/clac_ctte/pubhosp/contents.htm

Tony Gleeson is one of Australia's most creative thinkers about policies affecting Australia's rural people, industries and regions. He was the instigator and Convenor of a symposium held in late August 2000. It brought together over a hundred thinkers and planners with a special interest in policies for rural and remote areas. Details of the Kingma Symposium (as it became known) are at www.synapseconsulting.com.au/symposium/program.htm

In September the National Stroke Foundation held a special forum in Toowoomba on 'Rural and Remote Issues in Stroke Care'. The Executive Director gave a presentation. The Stroke Care Australia homepage is at www.strokecare.com.au

In September the Alliance contributed to a Conference in Perth on home and community care, run by the WA Community Service Association.

The Royal Australian College of General Practitioners initiated a project into the role of GPs in reducing health inequalities. The Alliance is pleased to be involved with this ongoing work.

Preliminary meetings were held with the National Farmers' Federation, the Australian Medical Association and the Australian Local Government Association with a view to resuscitating the so-called 'mega-Alliance' in the lead-up to the Federal Election. The Alliance also attended a planning day on rural research convened by its friends in the Rural Industries Research and Development Corporation, who have been supporters of the Alliance's CD ROM.

During the year a most significant new relationship was developed with the Australian Broadcasting Corporation, particularly Rural ABC Radio. Regional ABC has for many years been a valuable supporter of the Alliance's work through its interest in broadcasting news stories on developments in health and regional development. During 2000/2001 meetings were held with senior staff of Rural Radio, including Shane Mahony and Lucy Broad. One of the results was even closer involvement of regional radio in work to improve the health and well-being of people in country areas, including through their on-site presence at the 6th National Rural Health Conference.

The Alliance continued to build its relationship with Family Planning Australia and with FPA - Health. Open Learning Australia is another organisation with which close contact was made during the year. The Executive Director spoke about rural issues to the Board of the Alcohol and other Drugs Council of Australia (ADCA) and, later in the year, ADCA led work of a group of non-government organisations interested in substance misuse and mental health.

Visiting the Federal Member for Ryan

A welcome development on the data front was new work at the Australian Institute of Health and Welfare (AIHW). After the lengthy period since the AIHW's release of 'Health in Rural and Remote Australia' in 1998, in mid-2001 the Institute again received funding for some specific work on rural and remote health indicators. The Alliance is represented on the Rural Health Information Advisory Committee of this project. ■

A NEW ZEALAND RURAL HEALTH ALLIANCE?

(One of the most interesting meetings in 2000-2001 was a planning meeting in Christchurch for a proposed New Zealand Rural Health Alliance.Thanks to Martin London for permission to reproduce this extract.)

Rural health in New Zealand, in its broadest sense, may include equity of access to health services for rural people, the recruitment and retention of rural health care professionals, the maintenance of a culture of rurality within New Zealand society and affirmative action to stimulate the rural economy and awareness of its importance nationally.

The time has come in New Zealand for an organisation to be formed to unify the efforts of the many groups around the country which are working towards improving rural health - a New Zealand Rural Health Alliance. The Alliance is not intended to act as a dictatorial or superior organisation over its member groups but will allow collaboration between the groups, coordination of efforts and avoidance of costly competition, in support of rural health.

The sharing of expertise through the Alliance, the achievement of national consensus on important issues, and the presence of an organisation which can work with government agencies to produce effective outcomes for rural New Zealand should be of interest to all groups, including government and rural communities. Above all, the Alliance will work across its sector groups with the clear aim of ensuring that rural New Zealand gets a fair share of resources reflecting the value New Zealanders give to their rural areas.

The gains for members or contributors to the Alliance will be at both a local and a national level.

- Groups will have ready access to information, ideas and people who might support their local initiatives.
- They will derive an understanding of how their work relates to activities and policies in other sectors.
- They will find ways of saving on resources through avoiding duplication of effort and parallel lobbying.
- They will be able to forge cooperative alliances with other member groups for specific project work.
- They will have input into policy development at a national level, be kept in the information loop and know what is going on.
- A strong national body will move the issues of rural development forward more effectively and thus relieve the pressure on local groups.
- Being part of a nationally collaborative organisation will reap the benefits of unity for member groups.

The operations of a New Zealand Rural Health Alliance will be related to achieving regular communication between all members on issues affecting rural health and the preparation of submissions on these issues to government agencies. Communication is likely to be mainly through electronic media and teleconferences with a minimum of face-to-face meetings.

To achieve these aims the Alliance would need a secretariat and need to be run by an executive or a board (depending on the nature of its legal entity) which would be composed of representatives from the member organisations.

The Alliance would in no way be attempting to take over the work or interests of existing national and regional organisations. In particular, it would not be duplicating the work of such groups as the New Zealand Rural GP Network, Rural Women New Zealand or Local Government New Zealand. Its task would be to enhance communication between these and other bodies so that each might work more effectively in relation to the other and within their independent organisations.

Postscript: Work is continuing on the proposal. Collaborative work on the Implementation of the Primary Health Care Strategy in Rural New Zealand is being undertaken by the Ministry of Health with the assistance of a rural expert advisory group with broad representation. The proposed Alliance is being considered as part of the overall rural health plan. In the meantime, according to Martin London, "rural activism boxes on regardless".

Martin is at the National Centre for Rural Health based in Christchurch. ■

The NRHA was formally represented by Members of its Council or staff on the Mental Health Council of Australia, the Rural, Remote and Indigenous Advisory Group of the National Heart Foundation, the Board of Management of the Australian Journal of Rural Health, the Rural and Remote Nursing Scholarship Committee and the National Dental Health Alliance.

MENTAL HEALTH COUNCIL OF AUSTRALIA

(A report from the NRHA Representative: John Lawrence.)

It has been estimated that at any particular point in time, three to four per cent of Australians experience severe mental disorders which will significantly interfere with their mental well-being, and reduce their capacity to participate fully in community life.

The Mental Health Council of Australia (MHCA) was established in 1996 as the peak, independent national body for mental health. There are thirty members of the MHCA, and the organisation has many similarities to the National Rural Health Alliance, particularly in the areas of governance, constitution, representation and funding.

The NRHA delegate to the MHCA is elected each year.

The MHCA Board meets four times each year - two face to face meetings and two teleconferences. The Executive is comprised of five members, and they meet monthly, generally by teleconference. There are three sub committees - legal and membership, finance, and research, policy and projects.

The MHCA made a number of submissions to parliamentary committees in 2000-2001 (such as the Stolen Generation Senate review); is organising World Mental Health Day (in Australia) on October 10, where the theme is mental health and work; and has a number of projects under tender, such as Enhancing Relationships (between Mental Health Professionals and clients and carers). The Chairperson, John McGrath, has been a major player in the establishment of the National Depression Initiative in Melbourne.

Networking and liaison between organisations in the mental health field in Australia have been challenging for MHCA as the recently-funded peak body.

MHCA has developed a sponsorship policy, and will seek corporate sponsorship to diversify its funding base, which at the moment is three year Federal funding for core activity, with additional short-term project funding. ■

CHRONIC DISEASE ALLIANCES

A potentially important new organisation on chronic disease sprang from the Townsville workshop held in 1999 by the National Heart Foundation (NHF), the National Aboriginal Community Controlled Health Organisation (NACCHO), James Cook University, the Department of Health and Aged Care and the NRHA. It is an alliance of non-government organisations with an interest in chronic disease facing Aboriginal Peoples and Torres Strait Islanders. It is led by NACCHO. The purpose is to help develop a chronic disease strategy that would bring to bear an integrated focus rather than a 'body parts' approach.

Work proceeded during the year to secure agreement from its potential members about what they expected from such an alliance, what contribution the particular organisations could make to it and how it should be run. Thanks to a grant from the Office of Aboriginal and Torres Strait Islander Health and the support of the NHF a meeting was held in Sydney in October 2000.

There will be further work to progress this initiative, which owes much to the energy and leadership of the National Heart Foundation's (NHF) Pat Field as well as to the members of the NHF's Rural, Remote, Aboriginal and Torres Strait Islander Advisory Committee. The parties involved in the Townsville Conference in 1999 are also continuing to monitor progress with the other recommendations made at that original meeting. ■

NATIONAL ORAL HEALTH ALLIANCE

(The following is a compilation from the working documents of the National Oral Health Alliance (NOHA).)

The deep inequalities in access to dental care for adult Australians are well-documented: people living on low incomes visit dentists less frequently than the rest of the community, are likely to have teeth extracted rather than filled, and are less likely to get preventive care (National Health Strategy 1992; Roberts-Thomson 1998; Spencer 1998; Schofield 1999). Waiting lists and waiting times for public dental health services have increased dramatically over the last few years. Research by the Brotherhood of St Laurence has shown that some people who have all their teeth removed during emergency treatment may wait up to a year to receive dentures (Leveratt and Gilley 1998).

A forum auspiced by the Australian Council of Social Service (ACOSS) and the Brotherhood of St Laurence met in May this year to consider the difficulties which many low-income people face in getting treatment for oral health problems. At the forum, around 20 organisations agreed to establish a national alliance to work together over the next 6-12 months, and a working party was established. The Alliance will attempt to keep the issue of oral health on the public agenda in the lead-up to the next Federal election and will lobby all major parties regarding the need for better-funded public dental services.

With Jenny Macklin

The NOHA calls on the Commonwealth Government to provide leadership and ongoing funding for the development of a Joint State/Commonwealth National Oral Health Strategy which:

- addresses the current crisis in the provision of dental services for Australians living on low incomes and other disadvantaged groups by providing appropriate, affordable (no co-payments) services;
- includes comprehensive and ongoing oral health education and promotion;
- includes a strategy to address current and future shortages of dental health professionals; and
- is evidence-based and independently evaluated.

The cost of a checkup at a private dentist is around $100 with another $40 for x-rays and $95 for each filling. Most people on low incomes cannot afford such fees and turn to the public sector. Only those on health care cards and pensions can access public dental services.

Public dental health services for people with concession cards are provided at community health centres, dental hospitals, some Aboriginal Community Controlled Health Services, general hospitals (in rural areas) and by private dentists. These services are funded generally by State governments at around $215m per year, including treatment for school-age children (Spencer 2001).

However, restrictions in funding for public dental services mean that waiting lists and waiting times are unacceptably long. About 500 000 people are on waiting lists around Australia (Spencer 2001) and only about 11% of those eligible for treatment receive it each year.

Oral health also has well-established links to general health. For example there is a strong link between diabetes and oral disease:

> "I have developed diabetes and I am steadily losing weight (over 9kg so far) and my dentures no longer fit my mouth but I can't afford to have new ones made."

There are high rates of diabetes in Aboriginal communities yet they are one of the most marginalised groups in terms of access to oral health services. ■

Council of the NRHA met face-to-face in October 2000. There were two face-to-face meetings in calendar year 2000 and, including the meetings during the 6th Conference, two in 2001 as well.

OPERATIONAL CHANGES AT THE NRHA

During the financial year a number of important changes occurred to the Alliance's structure and operation.

They included:

- establishment of a larger Executive, comprising the four Office Bearers, the Immediate Past Chairperson, three Ordinary Executive Members and two Moderators - ten in all;
- less frequent Council meetings and more Executive meetings;
- the Executive of the Alliance met face-to-face in Melbourne on 17-18 January 2001, and on six other occasions by teleconference.
- moves towards re-accreditation of all Member Bodies;
- the term of office for Executive members will be limited to 5 consecutive years;
- explicit definitions adopted in the Constitution of 'primary health care' and 'primary care';
- explicit statement about the place of general practice in health care; and
- explicit process on reporting only consensus and referring differences to individual Member Bodies. ■

Throughout the financial year the Alliance worked very closely with your colleagues in the General Practice Branch in respect of the administration of the John Flynn Scholarship Scheme (JFSS) and the Rural Australia Medical Undergraduate Scholarship Scheme (RAMUS); with the Health Financing Division on the Rural and Remote Health Financing Project; and with your colleagues in the Mental Health Branch, the Office of Aboriginal and Torres Strait Islander Health, the Population Health Division and the National Health Priority Areas group. (At the time of writing the report from the Health Financing Project is in the final stages of negotiation.)

RURAL AND REMOTE HEALTH FINANCING

(This is a reprint of the report to Council prepared by Joan Lipscombe, Consultant.)

This project was established between the NRHA and the Commonwealth Department of Health and Aged Care in August 1999.

Its objectives are:

> To develop options for consideration by Governments for effective and sustainable policy change in health financing structures that will improve access to appropriate health services and health outcomes in rural and remote areas within existing funding levels.

The project has been guided by a large Steering Committee comprising representatives of the Alliance, the Department and a range of other key stakeholders.

The Committee's report is close to finalisation. By the time of the CouncilFest it should be with Steering Committee members for final comments.

The issues considered in the project have been wide-ranging and complex. There has been substantial agreement within the Steering Committee on what the health financing issues are for remote and rural communities.

Despite this, it has not been possible to reach consensus within the Steering Committee on all areas of potential action to change the health financing arrangements to enable improved access to services and better health outcomes.

The report concludes that future health financing approaches for supporting health services in remote and rural areas should encourage four essential features, namely:

- community and stakeholder participation;
- primary health care focus;
- integrated and flexible services; and
- needs-based resource allocation.

The report includes some suggested actions based on the areas of agreement. These include:

- develop a national plan to implement 'Healthy Horizons';
- review of transport assistance programs in the broader context of a comprehensive approach to improving access to the full range of services;
- consider developing bilateral agreement between each State/Territory and the Commonwealth on remote and rural health;
- a trial of a rural health planning model;
- make Indigenous people a specific key target group for all mainstream health initiatives;
- governments to work cooperatively to achieve health resource allocation more in line with relative need; and
- improve data collection and publication including the development of regional health expenditure systems.

Gordon, Chris and James

The main areas where consensus was not possible are:

- that the Commonwealth should accept responsibility for funding acute primary care for all Australian residents including funding for alternative service models where there is no or limited access to medical practitioners and community pharmacists;
- some matters relating to redistribution of resources including the development and use of resource allocation formulae applying to Commonwealth and State health funding at the regional level and shift in the balance over time between acute hospital care and primary health care;

- the introduction of special items in the Medicare Benefits Schedule for rural/remote consultation at higher Schedule fees than those currently applying to the generic consultation items; and
- the potential for extensions of funds pooling beyond those currently applying (eg Co-ordinated Care Trials, Multipurpose Services/Regional Health Services) to deal with many of the identified problems in remote and rural health financing.

Once it has been circulated again, the Department of Health and Aged Care and the Alliance will provide the report to the Commonwealth Minister for Health and Aged Care with advice on how to progress the suggested actions.

It is anticipated that the Minister will refer the report to his State and Territory counterparts as well as making it widely available to relevant peak bodies and other key stakeholders, both from the health sector and more broadly.

For the Alliance itself the next steps include action to progress issues on which there is agreement and perhaps to continue to discuss issues on which there is not. There is valuable role to be played in advancing the discourse and progressing the agenda. The structure and operation of the health financing system overall are fundamental to health outcomes in rural and remote areas. ■

The Alliance undertook the administration for the 5th National Undergraduate Rural Health Conference held in Toowoomba in September 2000. This saw further close co-operation between the Alliance and your colleagues in the General Practice Branch.

5TH NATIONAL UNDERGRADUATE RURAL HEALTH CONFERENCE

(This report was prepared for the NRHN by Rod Martin, Convenor of the Conference.)

"The National Undergraduate Rural Health Conference is the annual conference of the National Rural Health Network (NRHN), the peak organisation representing the interests of undergraduate students in all health disciplines. It is concerned with rural health issues and education in rural, remote and Aboriginal Torres Strait Islander health at undergraduate and postgraduate level. NRHN is a member of the National Rural Health Alliance. The 2000 Conference was convened by Towards Rural and Outback Health Professionals in Queensland (TROHPIQ), Queensland's Rural Health Organisation for students. The location for the 2000 Conference was the University of Southern Queensland at Toowoomba and it was held between 9 and 13 September 2000. The Conference was attended by approximately 200 student and 40 academic and profession delegates.

The conference theme "Bringing it all Together" represented the need to draw together the diverse aspects of rural health care and to act on them through taking stock, looking ahead, and moving forward. Through the hard work of the delegates and the quality of the presentations of the speakers at the conference, some of the objectives are currently well progressed.

All of the Conference Proceedings can be found at www.nrhn.org/reports/5th_NURHC/default.htm

NURHC 2000 followed on from the 1999 conference in that the progress of action arising out of the 1999 'Discussion Topics' had been reviewed prior to 2000. After reviewing the action on the fourteen 1999 topics, it was agreed that the following six topics would be the focus for this Conference:

- Aboriginal and Torres Strait Islander Curriculum
- Rural Curriculum
- Rural Placement Coordination
- Scholarship Discussion Group 1
- Scholarship Discussion Group 2
- Rural Streaming.

A forum was provided for discussion of any issues of relevance to academics in rural health and also administrators of the rural health clubs in attendance.

A continuing aim of Conferences of the NRHN is to provide a forum for discussion of all matters relating to education of professionals so important to the future of rural health provision to Australia. In doing so, it gives the Network short to medium term direction which flows through to individual Rural Health Clubs and their students. These Conferences also aim to provide some direction to Universities, State Health Departments and importantly the Commonwealth Department of Health and Aged Care as the funds provider, as to the perceived needs for the future of rural health provision in Australia." ■

During the year a considerable amount of effort was put into 'governance issues' and the Alliance's Constitution was further revised. The Annual General Meeting (AGM) was held on 31 October 2000. Two applications were received but no new Member Bodies were admitted to the NRHA at that AGM.

MEMBER BODIES OF THE ALLIANCE

At the end of the 2000/2001 financial year, there were twenty-two Member Bodies of the National Rural Health Alliance, as follows:

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

ALSO AT THE NRHA'S ADDRESS

- The Secretariat for Health Consumers of Rural and Remote Australia (HCRRA), one of the Alliance's Member Bodies.
- The Secretariat for the Remote and Isolated Pharmacists' Association of Australia (RIPAA).

NRHA'S WEBSITE

(Report to Council from, Jim Groves, Webmaster.)

The NRHA website (www.ruralhealth.org.au) currently consists of over 700 files (including graphics). Major sections of the site include:

- Alliance announcements and press statements;
- a site for the 6th National Rural Health Conference;
- almost all the papers from the 4th and 5th National Rural Health Conferences;
- other Alliance publications, submissions etc;
- 'Healthy Horizons';
- information and application forms for the JFSS and RAMUS scholarships;
- information on the organisation of the Alliance;
- information on Member Bodies of the Alliance;
- links to a wide range of other websites of relevance to rural health concerns, including a page publicising forthcoming conferences; and
- homepages for the student undergraduate conference, SARRAH, NARHERO and HCRRA.

The website is hosted by TrueNorth, and maintained on a part-time basis by Jim Groves. The site is designed to download quickly and to be search engine friendly. The site contains a site-specific search engine provided by FreeFind, and its availability is checked automatically every hour by NetWhistle.

In a typical month, Netwhistle reports around 99.7% availability. In two months over the past two years, however, availability fell below 95%.

TrueNorth provides some statistics on usage of the site. There have frequently been problems in accessing these statistics. This along with the part-time nature of the webmaster's role has limited the extent to which usage statistics have been incorporated into site management. Some comments from users have been received, and these are always acted upon.

In general, the statistics showed that whereas the site was receiving around 100 visitors per day during most of 1999 (somewhat more - around 150 - at the time of the 5th National Rural Health Conference), this has increased to around 200 per day more recently. These figures would include some robotic visitors (Netwhistle and the search engines), and usage in the NRHA Office, but most would be "real people". A small proportion of users to the site are from countries other than Australia.

Only around one quarter of visitors come from search engines or links from other sites. Only around one third of visitors start at the front page of the site.

FreeFind provides statistics of the searches people are conducting on the site. For August 2000, FreeFind reported 329 searches conducted at the site, with the most popular search terms being rural (76), health (62), national (25), transport (19), suicide (15), training (11), aboriginal (10), Wagga (10), and youth (10). Unfortunately, these reports do not indicate what combinations of keywords are used.

The eforum has been issued almost every fortnight. It currently has around 750 subscribers. The eforum includes NRHA statements, contributions and announcements from subscribers, and some additional material of relevance to rural health interests compiled by the moderator, Jim Groves. There has been little user feedback, but after an initial problem over balance, most feedback received was positive.

Four member organisations use the site for their own websites (NRHN, SARRAH, NARHERO and HCRRA). It is understood that others are considering doing the same.

Council is urged to consider whether the current status of the website is adequate and whether there are attractive options for more effective use of the site. Options include:

- a password-protected section ("Intranet") for Council Members and NRHA staff for, eg, minutes, internal communications;
- usage of the site for more consultative purposes, eg, posting of draft papers with comments sought; and
- more dynamic uses of the site, eg, for webcasting. ■

The Alliance held a 'national rural health associations' networking day' in October 2000 at which the focus was on follow-up to the Regional Summit of October 1999. Outcomes from the Summit remained a focus for some of the Alliance's attention.

MOVING FROM THE REGIONAL AUSTRALIA SUMMIT TO ELECTION 2001

Full Council meets once each year in Canberra at CouncilFest. This provides the opportunity for a networking seminar. It provides an occasion for national associations represented in Canberra and interested in any way in the future of rural Australia to meet with each other and with people with similar interests from the public service, as well as with representatives from the media and the private sector. The meeting is given added substance by the presence of representatives of the 22 national organisations which make up the Alliance. Most of those 22 are not themselves represented in Canberra so they too benefit from the contacts made at this networking meeting.

In October 2000 the meeting focused on the follow-up to the Regional Summit. It was addressed by John Chudleigh, Chair of the Summit Implementation Committee, and Ian Sinclair who chaired the Summit itself and is now on the Board of the Foundation for Rural and Regional Renewal.

John Chudleigh discussed the health sections of his committee's final report. He encouraged the people of regional Australia to keep a focus on what needs to be done and to keep reminding the Government of the key issues that had not yet been dealt with. He emphasised the continuing importance of rural health workforce initiatives and the general importance of education and training in country areas.

Ian Sinclair drew on his experience as Chair of the Ministerial Advisory Committee on Rural Hospitals in New South Wales, on the work of the NSW Salinity Summit, and his work on the Regional Summit. He emphasised the links between the environment and the health and well-being of country people and their communities. He suggested that one of the real problems is trying to get the States and the Commonwealth "to look through the same coloured glasses and the same dimension". He also referred to three areas on which there had been recent reports: depression, population decline, and 'the aged-care time bomb'.

Mr Sinclair ended by emphasising that regional renewal requires looking at the whole problem and not just health or employment or transport separately. ■

A great deal of effort was put into administration of the John Flynn Scholarship Scheme (JFSS) and the Rural Australia Medical Undergraduate Scholarship Scheme (RAMUS). This work was fully funded by a separate allocation from the General Practice Branch. There are significant synergies between this administrative work and the Alliance's core policy and advocacy work, including the new functional relationships between the Alliance and a significant number of rural and remote doctors, students and educational bodies; and the close view the Alliance is given of 'live' policy issues through its involvement in general practice and other educational issues affecting rural and remote health outcomes.

(The two reports that follow are from Ms Alison Miles, Scholarships Project Manager.)

JOHN FLYNN SCHOLARSHIP SCHEME

On 18 May 2000 the NRHA assumed responsibility for national administration of the John Flynn Scholarship Scheme (JFSS).

In calendar year 2000 the Scheme reached its full complement of 600 recipients: 150 in each of four calendar years. The scholars in the first group under the JFSS have now completed their four years' placement.

There are several benefits from national administration of the Scheme and from the NRHA's inclusive model of practice. They include improved coordination and consistency, the greater availability of interstate placements and better coordination of placements. Before development of this national system, there were ten individual databases - one at each Medical School - collecting a range of data concerning mentors and scholarship recipients. There was little similarity between the ten subsystems.

The students allocated scholarships under the new national regime in the year 2000 were most appreciative of the placement matching processes and logistical arrangements for travel and accommodation being organised in consultation with them. Asking each student for the characteristics of the placement they would like, rather than focusing only on its geographic location, means students consider a variety of issues eg health issues, population sizes, different settings and social activity as distinct from only the destination. Under the new system, mentors welcomed the accommodation payment in addition to the mentoring payment. Some of the existing mentors had not been aware of the mentor payment.

The NRHA JFSS Project Team comprises Alison Miles (Manager), Toni Alexandrow, Ali Coleman and Gordon Gregory, with technical support from Barry Cameron and ongoing support from other members of the NRHA staff. Regular consultation by members of the core project team with Departmental Project Officers is routine practice. Form letters approved during 2000 were amended for use in 2001. Scholarship recipients continue to communicate effectively and cheaply using the toll-free phone line and e-mail.

The national scholarship database is held in MS Access and is meeting the needs of both JFSS and RAMUS. The reporting capacity meets the needs of the Medical Schools and the information requested by the Rural Workforce Agencies (RWAs). It has the capacity to collect placement dates, mentor details, payment status and details, travel and accommodation, host families, scholar agreements and reports by scholars and mentors.

The financial systems in place provide timely and efficient payments for scholarship recipients and mentors. Scholars continue to provide positive feedback on the effectiveness of this approach. More effort is required to streamline the process and reduce the number of steps in the payments process. Mentors are paid on invoice either electronically or by cheque. There has been some delay in mentor payment, due to uncertainties about the application of the Goods and Services Tax (GST); this has now been rectified.

Alison Miles with the RFDS's Barbara Ryan-Thomas

The investment by the Commonwealth Department of Health and Aged Care in joint administration for both JFSS and RAMUS is clearly demonstrated in the synergy of the two technical and financial systems and administrative processes.

In the first quarter of 2001 the NRHA Scholarships Manager visited the 11 Medical Schools calling for applications and conducting interviews. The briefing sessions were well supported by student services within each medical faculty and well attended by potential applicants. During the same visits, debriefing sessions were conducted for scholars appointed in 2000.

2001 JFSS interviews were held at each Medical School, with continuity of selection panels from 2000 being maintained wherever possible. Scholarships were subsequently awarded on the basis of written application and the interview.

Significant effort by NRHA has been put into the development and implementation of an on-line system for scholarship recipients and mentors. The ability to apply on-line for a John Flynn Scholarship provided a contemporary approach that was well supported by applicants. This approach has recently been extended to include updating of scholar contact details on-line with the ability for scholarship recipients to view their own information.

Last year's manual matching process has also been refined to include an on-line approach specifically for data capture. Placement matching is an intensive process with the sheer volume of numbers but one that NRHA is well equipped to operationalise. After 12 months of operation the manual system, while successful, is being refined. Electronic matching will, of course, always need to be supplemented with personal contact.

The JFSS continues to enjoy the support of many rural GPs. Approximately 85% of the new mentors required for 2001 responded within a very short timeframe to the expression of interest.

Eighteen months into the national administration, support continues to grow for the improved co-ordinated approach. With improved information dissemination enabled by the revised scholar agreement, NRHA is now in a position to better meet the needs of the Rural Workforce Agencies, Medical Schools and the units funded by the Rural Undergraduate Steering Committee - as well as of the students themselves.
The NRHA is pleased to be involved with the Department of Health and Aged Care in this valuable work. ■

RURAL AUSTRALIA MEDICAL UNDERGRADUATE SCHOLARSHIP SCHEME

The NRHA assumed administrative responsibility for the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme on 18 May 2000.

The NRHA RAMUS Project Team comprises Alison Miles (Manager), Toni Alexandrow, Ali Coleman and Gordon Gregory, with consultancy back-up from Barry Cameron. There is a strong, supportive working relationship between NRHA staff and departmental officers.

The allocation of RAMUS scholarships in 2000 was a smooth operation but one undertaken under pressure due to the very late start.

During the first year of the Project, administration systems were established by NRHA to manage the financial and communication components of RAMUS. This first phase was informed by the previous developmental work undertaken for the administration of the John Flynn Scholarship Scheme.

The investment made by the Department in allocating administrative responsibilities for both RAMUS and the JFSS to the one administrator has been of considerable benefit to students and other stakeholders. The second year of RAMUS has been timely and well-coordinated. NRHA's work on the algorithm required for ranking applicants has laid a strong basis for future systems which will benefit these Schemes and, potentially, other national initiatives.

As in the first year, significant effort during this second phase of the project was spent on the appeals process. This intensive task included being responsive to appellant issues, keeping them updated as to the status of their appeal, and coordinating review panel teleconferences. Many lessons have been learnt from this exercise in 2000.

There are regular contacts with existing scholarship recipients and potential applicants, mainly via email and the toll-free telephone number. There have been peak usage times, especially for the toll-free number, when some congestion may have been frustrating to a small number of callers. These periods were monitored by the NRHA.

During the second year of operation just over 50% of RAMUS recipients have nominated a rural doctor mentor from a RRMA 3-7 region in the first instance. Wherever possible the RAMUS Project Team have encouraged recipients to identify a mentor within RRMA 4-7. Again, there have been occasions when family members have been nominated. This has been strongly discouraged and this has not always been well received. The Rural Doctors Association of Australia (RDAA) continues to provide assistance with the identification of the remaining mentors required.

Mary Murray with Hayley and Ian, first recipients of the Des Murray Scholarship

There was complimentary feedback about the large and comprehensive number of state and regional newspapers in which RAMUS 2001 was advertised and promoted by the Department of Health and Aged Care. For 2001, NRHA received 394 applications for 116 scholarships. This brought the total number of RAMUS recipients to 512. NRHA facilitated the appeals process, in which there were over 100 appellants for 10 scholarships.

Some universities are disseminating information kits as interviews are being conducted with potential new undergraduates. These kits include the RAMUS brochure for promotion and marketing. The RAMUS Project Team has a specific communication strategy to RAMUS key stakeholders eg the Dean's Office within each Medical School, University academics and administrators, and the 22 Member Bodies of the Alliance.

The testing of an on-line application process for the JFSS earlier this year has paved the way for this approach to be adopted for RAMUS applications if and when approved by the Commonwealth Department of Health and Aged Care.

Administrative systems are operating smoothly. The National Rural Health Alliance continues to experience a positive working relationship with the Department, with clear lines of communication and a clear distinction between policy and administrative roles. ■

The Alliance worked on an update of the CD ROM, Rural and Remote Health Papers 1991-1999, completed just after the end of the financial year.

UPDATED CD ROM

The third edition of the CD ROM was published in June 2001. The updated CD ROM includes a video clip introduction, full proceedings from the 6th National Rural Health Alliance, full proceedings of the Infront Outback Rural Health Scientific Conferences, the Australian Journal of Rural Health, the Alliance's Rural Health Information Papers and the Alliance's Position Papers. This CD, which is keyword searchable, contains a complete record of most of the centrally important papers published on rural health since 1991.

The Alliance appreciated the support of the Cunningham Centre and the Rural Industries Research and Development Corporation (RIRDC) for the production of the new CD ROM. ■

The Australian Journal of Rural Health continued to grow and strengthen.

AUSTRALIAN JOURNAL OF RURAL HEALTH

The period since July 2000 saw some key strategic developments for the Australian Journal of Rural Health (AJRH).

The Journal has undergone substantial growth in 2000 from two sources: the increase from four to six issues a year, and the substantial growth in the number of subscribers, especially those through the Associations which have adopted the AJRH as their official journal. The latter growth has resulted mainly from the increase in ACRRM membership and from CRANA joining those Associations from 1 July 2000.

The number of subscribers to the Australian Journal of Rural Health is approaching 2,800, an increase of nearly 100% in just over a year. The Journal is now available electronically through the joint venture between Blackwell Science Asia (BSA) and Synergy and this is proving very popular.

However, a period of growth does not come without issues that need addressing. For the Journal these have included the financial and management structures. The structure of the Editorial Board is linked to the number of Associations which have adopted the Journal as their official journal; as the number has grown the Board structure has been reviewed.

Blackwell Science-Asia have been most positive, co-operative and generous in devising a new financial model for the Journal and for the payment of royalties which has provided a win/win situation for all concerned. It was a pleasure to meet formally with Mark Robinson, Managing Director of BSA in Australia, and his colleague Alma Ross.

It should be noted that the Journal operates on a very minimal budget. We acknowledge the time and work given voluntarily by the Editor, all members of the Editorial Board, the Assistant Editors and the reviewers.

Two face-to-face meetings of the Editorial Board were held, the first on 27-28 July 2000, the second immediately after the 6th National Rural Health Conference in March 2001.

The restructuring of the Journal's management, decided at the first of these, was implemented by the second. The Board of Management, which undertakes the administrative and strategic management of the Journal, consists of one representative from each of the owner associations (AARN, ACRRM, CRANA, NRHA and SARRAH), the Editor, the Journal Manager and a representative from Blackwell Science Asia. The five Assistant Editors are invited to attend all meetings of the Board. This structure reflects a management body that is reduced in size and will be more cost efficient. The new structure will also better meet the requirements for academic recognition of the Journal.

Representing consumers on Council: Marg, Megan and Marie

A recruitment process was developed for the appointment of a new Editor. In 2002 Professor Desley Hegney will have served for ten years as Editor of the Journal, and she has indicated her intention to retire from this position. The strategy is to have her replacement fully operational in the position of Editor by May 2002.

The Writing for Journal Publication Workshop project initiated by the AJRH is going well. It is normally held in conjunction with rural and remote health conferences whenever possible. Many thanks to Shirley Preston for taking the running on this. ■

The Alliance made a submission to the Senate Community Affairs References Committee Inquiry into Nursing.

SUBMISSION TO SENATE INQUIRY INTO NURSING (SUMMARY)

"There are major problems for Australia's nursing workforce. They are most simply illustrated by two facts. First, nurses comprise over 55% of Australia's total health workforce. Secondly, there has been quite a different pattern of change in the rate of growth of the nursing workforce since 1986 compared with other health professions. The nursing workforce grew by 3.2% between 1986 and 1991 compared with 32 % for speech pathologists and physiotherapists, 18% for medical practitioners, 12% for chiropractors and 9% for ambulance officers and paramedics. Between 1991 and 1996 the relative differences were even greater and the nursing workforce grew by only half of one per cent.

As a result, the ratio of nurses in a clinical role to population declined from 1,171 per 100,00 in 1989 to 1,033 per 100,000 in 1999. This decline occurred in a period of significant increase in the overall demand for health services.

Sabina's mum flanked by joint winners of the Louis Ariotti Award

For remote and rural nurses there are particular challenges, due mainly to isolation and the relative lack of support from other health professionals. What this means is that, in the context of a national shortage overall, the nursing workforce in remote and rural areas is under particular stress. This is so much the case that many are talking about "the impending crisis" in remote and rural nursing, as the existing workforce there continues to age and becomes more difficult to replace.

There are also particular challenges - and some say a looming crisis - for nursing in the aged care sector.

This pressure on the national nursing workforce, of which the remote and rural aspects comprise a particular part, poses real challenges for all concerned. For the public the challenge is to understand better and therefore place a higher value on the nursing workforce and nursing as a profession.
For education and training institutions the challenge is to make major contributions that will result in nurses who are better trained for what they will experience in the workplace and held in higher esteem - including by themselves.
For governments there are two classes of challenge: first, to set in place policies to enhance the situation; secondly, to the extent that they are direct employers or the funders of agencies which directly employ nurses, to provide adequate resources for nurses to be properly remunerated and supported. This last is also the challenge for private sector employers of nurses.

Nursing organisations themselves as well as other health bodies have major responsibilities with respect to these challenges. The National Rural Health Alliance, as one such organisation, is happy to commit itself to whatever collaborative work it might do to help the situation. We are pleased to be able to make this submission to the Senate Committee of Inquiry as a small contribution along the way.

Although we are an Alliance of rural and remote organisations, the premise of this submission is that our interests can only be met through actions to solve the overall national situation. There are a number of ways in which the total number of practising nurses in Australia

could be increased. Of these the Alliance does not first favour increasing the number of undergraduate nursing places. Instead, our emphasis is on increasing undergraduate completion rates, rates of transition to nursing work and the average length of time for which nurses remain in the profession. We also have a special interest in ways in which a greater number of nurses will spend time nursing in remote or rural areas at some stage in their career.

Some of the current problems are being met by an increased number of nurses coming to Australia temporarily; this is not a preferred or a sustainable answer to the problem.

We believe that steps to attract nurses into remote and rural nursing should begin even before prospective nurses enter undergraduate education. Employers have major responsibilities to put in place packages which more appropriately reflect the value and circumstances of nurses, particularly in remote and rural areas. This is especially the case in the aged care sector.

Australia needs some effective workforce planning for nursing (as well as for other health professions). This will require much better collaboration between the health policy and employment and training sectors. There is currently inadequate consultation on workforce supply and demand issues between employers, training institutions and departments for health and education

The Alliance argues for clearer and more collaborative arrangements between governments and other key parties. The Commonwealth should have a leadership role and through its responsibilities for higher education, migration and the aged care sector, take responsibility for national workforce planning to ensure a sufficient overall supply of nurses to provide for Australian's health care needs, wherever they are located. This role should also include identifying, promoting and, where appropriate, funding special measures to encourage increased numbers of young people from remote and rural areas to enter nursing as a career.

Through its leadership role in health policy and its interest in having a flexible and mobile health workforce, the Commonwealth should also encourage consistent approaches to terminology, role definitions, competencies and educational requirements for nursing in remote and rural areas. Policies on mutual recognition demand a cohesive approach across Australia to these issues.

Our recommendations in this submission include particular proposals to enable the Commonwealth to undertake these tasks.

State and Territory Governments should retain their responsibilities for the registration and regulation of nursing and for coordinating State nurse workforce planning and broader nursing policies across their jurisdictions. They must ensure that the legal and regulatory framework governing nurses working in rural and remote areas legitimises the actual roles of such nurses both as practised currently and emerging for the future; ensures protection for nurses providing such services; and ensures protection for communities from inadequately trained nurses being employed in such roles.

Universities and other organisations responsible for the education and training of nurses must ensure and, as necessary, enhance the continued relevance of their programs for nurses planning to work (or working) in remote and rural areas. This will involve cooperative arrangements with employers to ensure that programs are in tune with the demands on nurses from contemporary remote and rural health care practice. They should also strengthen their activities to encourage and support nursing students from remote and rural areas.

There are specific recommendations in this submission relating to these and other issues.

The Alliance is pleased to acknowledge the work of Ms Joan Lipscombe, Consultant to the NRHA for this submission.

We commend the submission to the Senate Committee and look forward to opportunities to promote our proposals." ■

The Alliance continued to provide planning input to the 5th World Conference on Rural Health (WONCA), to be held in Melbourne in 2002.

5TH WORLD CONFERENCE ON RURAL HEALTH (WONCA)

Australia will host the 5th WONCA World Conference on Rural Health in Melbourne, with the main program running from 30 April to 3 May 2002. (www.ruralhealth2002.net/)

The theme for the conference is *Working Together: Communities, Professionals and Services.*

The Conference will incorporate six conferences in one:

- rural medicine - education, training, research and policy.
- rural nursing - education, training, research and policy.
- rural allied health and pharmacy - education, training, research and policy.
- rural health service planning and administration - education, training, research and policy.
- rural health teams and integrated rural health services - cross-disciplinary/inter-disciplinary exploration of the issues.
- skills development/continuing education - clinical and IT sessions.

At a planning meeting in Melbourne, Bruce Chater outlined WONCA's expectations of the Conference in the following terms:

- "The Conference should be fun, educational and a means for swapping ideas, but WONCA also needs some definitive outcomes from it too, such as new policy ideas for international rural health practice.
- The WONCA Working Party is interested in Australia because in many ways Australia is seen as a world leader in rural health practice.
- The Conference needs to focus on issues that WONCA is dealing with, such as Indigenous health, sustainable services, communities, collaborative approaches, and how to garner political will for implementing rural health policies.
- WONCA views student participation as important.
- Including developing countries and their perspective on rural health is important.
- Continuity between the world rural health conferences is important.
- The output of the other conferences, such as the Durban Declaration, should be used to inform the 2002 Conference. We need to reflect on the documents produced so far and see how they can be modified (if necessary).
- The WONCA Executive will endeavour to be present at the Conference, which should help to confer a strategic advantage for rural health policy and practice in Australia.
- We need to identity and target particular issues for discussion at the Conference - both local ones and WONCA ones." ■

The friends of the Alliance continued to develop as a means for small health organizations and individuals to have a working relationship with the Alliance.

FRIENDS OF THE ALLIANCE

friends of the Alliance

Irene Mills

There are now seven new faces on the *friends* Advisory Committee. They include Irene Mills from Western Australia as Chairperson. Irene is no stranger to the work of the Alliance, having been a member of the *friends* Advisory Committee since its inception three years ago. Irene brings a wealth of experience and enthusiasm to the *friends* project. The others are as follows:

- Robyn Williams is the Northern Territory representative and works at the NT University in the Faculty of Aboriginal and Torres Strait Islander Studies and Centre for Remote Health. Joy Burch, the Executive Director of the Rural Workforce Agency in the NT, is Robyn's alternate.
- Meryl Brumpton is the alternate for Julie Watson in Queensland. Meryl is the Manager of the Office of Rural Health in Queensland, based in Roma.
- Chris Shoemaker is a community nurse in Bairnsdale and replaces Mandy Pusmucans as the Victorian representative.
- Richard Sager is an old friend and is the newly appointed New South Wales representative. Richard is working as a Health Council Co-ordinator for the Mid-Western Area Health Service based in Orange.
- Rosemary Jeffery is the new NRHA Council delegate.

These six join the existing committee members to make a very strong and enthusiastic team.

The Committee has been keen to extend the work of *friends* to the broader community. Committee members have been promoting the *friends* project to key contacts in their workplace.

Discussions have taken place with the Health Services Association of NSW to distribute PARTYline and other *friends* material to communities under the Health Council's umbrella. This will equate to some 100 extra copies being distributed. Students at universities have been encouraged to join *friends* to obtain a copy of the CD-Rom, which has been placed on the compulsory textbook list of some educational institutions. Others have displayed and distributed pamphlets and application forms in their places of work.

Other areas which are being investigated include targeted discussions of the Alliance's Position Papers through radio interviews and with representative forums in Universities.

The release of the latest version of the CD-ROM has been a valuable tool in attracting new members and encouraging existing members to renew.

There are approximately 550 current members of *friends*, 100 more than this time last year. ■

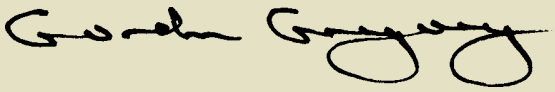
AUSTRALIAN NATIONAL FIELD DAYS 2000

The Alliance had a Display Booth at the Australian National Field Days 2000 held in Orange NSW from 19-21 October 2000. The Australian National Field Days is one of the largest field day events in Australia attracting approximately 30-40,000 visitors over a three-day period. In 2000 their particular focus was rural health. Some valuable contacts were made through attendance at the stand, and useful grass roots feedback was received. Visitors provided insights into the specific problems that people in rural and remote communities experience in health care delivery. ■

Council and staff of the Alliance took every opportunity in 2000-2001 to acknowledge the continued strong support of the Office of Rural Health, and it is a pleasure to thank you and your staff again here on behalf of all of our constituents.

Best wishes.

Yours sincerely



Gordon Gregory
Executive Director

Attachments:

Summary Report to Office of Rural Health for 2000-2001

NRHA-RHSET Agreement dated August 1999

Financial Statements for year ended 30 June 2001

Copies of the Australian Journal of Rural Health (for financial year 2000-2001)

Copies of PARTYline for financial year (2000-2001)

NRHA PUBLICATIONS

See www.ruralhealth.org.au/pubs.htm

NRHA STAFF & COUNCIL

NRHA Staff 2000 - 01

Toni Alexandrow
(Executive Assistant - until May 2001)

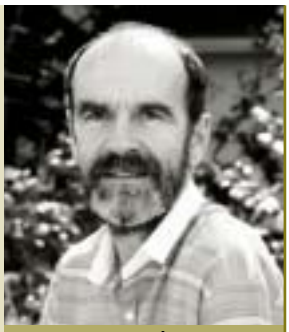
Nikki Allen
(Accounts Manager - from February 2001)

Alison Coleman
(Assistant Co-ordinator, Scholarships - from December 2000)

Leanne Coleman
(Office Manager)

Teresa Connor
(Policy Editor - from May 2001)

Lyn Eiszele
(Conference Project Manager)



Gordon Gregory
(Executive Director)

Kate Henley
(Executive Assistant)

Alison Miles
(Scholarships Project Manager)

David Petty
(Manager of AJRH and friends - until May 2001)

Michele Foley
(Manager, friends of the Alliance)

Kristin Ginnivan
(Administrative Assistant - from December 2000)

Lexia Smallwood
(Executive Assistant and, from May 2001, Manager, AJRH)

Carmel Brophy
(HCRRA - from December 1999 and RIPAA - from February 2000)

Members of Council 2000 - 01

Jodith Adams

Margaret Brown

Steve Clark


Mark Cormak


Ellen Downes


Mark Dunn


Lesley Fitzpatrick


Barbara Foggin


Jane Greacen


Bruce Harris


Rosemary Jeffery


Sabina Knight


Marie Lally


Louise Lawler


John Lawrence


Shelagh Lowe


Kris Malko-Nyhan


Nola Maxfield


Bruce McKay


Megan McNicholl


David Mildenhall


Irene Mills


Colleen Prideaux


Barbara Ryan-Thomas


Richard Sager


Lesley Siegloff


Margi Stewart


Nigel Stewart


Christine Thorne


Sue Wade


Christine Ward


John Ward


Libby Williams

Consultants to the NRHA in 2000-2001

Jim Groves (Webmaster)
Joan Lipscombe (Submission to the Senate Inquiry into Nursing)
Barry Cameron (NRHA and Scholarships Database)

PART TWO – FINANCIAL STATEMENT AND DIRECTORS' REPORT

NATIONAL RURAL HEALTH ALLIANCE INCORPORATED

Registered in New South Wales: Number Y17753-06

The Directors present their annual Financial Statement and Directors' Report covering operations of the NRHA for the year ended 30 June 2001. For further details please see the NRHA Annual Report for 1000-2001.

DIRECTORS

The Directors during the period of this report were:

Director	Period	Representing	Special Responsibilities
Stewart, Nigel	full year	RGPS	Chairperson (from Oct 2000)
Lawrence, John	full year	Rural Members, ACHSE	Deputy Chairperson (from Oct 2000); Immediate Past Chairperson (to Oct 2000)
Lowe, Shelagh	full year	ARRAHT	Hon Secretary (from Oct 2000)
Dunn, Mark	full year	RPA	Hon Treasurer
Clark, Steve	full year	co-opted	Immediate Past Chairperson (from Oct 2000); Chairperson (to Oct 2000)
Siegloff, Lesley	Jul00-Nov00	AARN	Deputy Chairperson (to Oct 2000)
Stewart, Margi	full year	ANF	Hon Secretary (to Oct 2000)
Greacen, Jane	full year	ACRRM	Executive Member (from Oct 2000)
McKay, Bruce	Mar01- Jun01	CRANA	Executive Member (from May 2001)
McNicholl, Megan	full year	ICPA	Executive Member (from Oct 2000)
Maxfield, Nola	Oct00- Jun01	RDAA	Moderator (from Nov 2000)
Wade, Sue	full year	ACHA	Moderator (from May 2001)
Lawler, Louise	Jul01-Mar01	NARHERO	Executive Member (Oct 2000 - Mar 2001)
Adams, Judith	Jul00-Feb01	AHA - Rural Policy Group	Co-opted Executive Member (Oct 2000 - Feb 2001); Moderator (to Oct 2000)
Harris, Bruce	Jul00-Mar01	Rural Faculty, RACGP	Moderator (to Oct 2000)
Knight, Sabina	Jul00-Mar01	CRANA	Moderator (Nov 2000 - Mar 2001)
Brown, Marg	Jul00-Mar01	HCRRA	
Cormack, Mark	Mar01- Jun01	AHA - Rural Policy Group	
Downes, Ellen	Jan01-Jun01	NRHN	
Fitzpatrick, Lesley	Mar01-Jun01	NARHERO	
Foggin, Barbara	Jul00-Feb01	Frontier Services	
Jeffery, Rosemary	Feb01-Jun01	Frontier Services	
Lally, Marie	full year	CWAA	

Directors continued on page 36 →

Director	Period	Representing	Special Responsibilities
Malko-Nyhan, Kris	Nov00- Jun01	AARN	
Mildenhall, David	Jul00-Oct00	RDAA	
Mills, Irene	Jun01-Jun01	co-opted, Chair of friends	
Prideaux, Colleen	full year	NACCHO	
Ryan-Thomas, Barbara	full year	RFDS	
Sager, Richard	Jul00-Dec00	NRHN	
Thorne, Christine	full year	ATSIC	
Ward, Christine	full year	SARRAH	
Ward, John	Jul00-Feb01	co-opted, Chair of friends	
Williams, Libby	Mar01- Jun01	HCRRA	

As the NRHA does not have any issued capital, no Director holds any shares in the NRHA.

During the financial year seven full meetings of the NRHA's Directors were held, in respect of which each Director attended the following number:

Name of Director	Number of meetings eligible to attend	Number of meetings attended
Adams, Judith	5	2
Brown, Marg	5	4
Clark, Steve	5	4
Cormack, Mark	3	3
Downes, Ellen	5	4
Dunn, Mark	7	6
Fitzpatrick, Lesley	2	1
Foggin, Barbara	5	2
Greacen, Jane	7	5
Harris, Bruce	5	4
Jeffery, Rosemary	2	2
Knight, Sabina	5	5
Lally, Marie	7	4
Lawler, Louise	5	4
Lawrence, John	7	6
Lowe, Shelagh	7	7
Malko-Nyhan, Kris	3	2
Maxfield, Nola	5	4
McKay, Bruce	2	2
McNicholl, Megan	7	5
Mildenhall, David	3	2
Mills, Irene	1	1
Prideaux, Colleen	7	1
Ryan-Thomas, Barbara	7	4
Sager, Richard	5	3
Siegloff, Lesley	4	4
Stewart, Margi	7	4

Meetings attended continued on page 37 →

Name of Director	Number of meetings eligible to attend	Number of meetings attended
Stewart, Nigel	7	3
Thorne, Christine	7	1
Wade, Sue	7	5
Ward, Christine	7	5
Ward, John	5	4
Williams, Libby	2	2

There were seven meetings held of the Directors in office, and the number attended by each was as follows:

Executive Member	Eligibility	Attendance
Stewart, Nigel	6	6
Lawrence, John	7	6
Lowe, Shelagh	6	5
Dunn, Mark	7	6
Clark, Steve	7	3
Siegloff, Lesley	1	1
Stewart, Margi	1	0
Greacen, Jane	6	6
McKay, Bruce	1	1
McNicholl, Megan	6	5
Maxfield, Nola	5	4
Wade, Sue	1	1
Lawler, Louise	4	3
Adams, Judith	5	1
Harris, Bruce	1	1
Knight, Sabina	5	3

Indemnification of Officers

The NRHA has not provided indemnification or insurance of its present or former officers or auditors of the NRHA.

PRINCIPAL ACTIVITIES

The principal activities of the NRHA during the financial year were policy development, communication, administration, and information activities to improve the health of people in rural and remote areas of Australia. There were no significant changes in the activities of the NRHA during the year.

Results of Operations

The operating surplus for the financial year was $57,544.

Dividends

The NRHA did not pay any dividends during the financial year as it is precluded from so doing by its Constitution.

Review of Operations

The NRHA's operational funds for the financial year were in the form of grants from the Commonwealth Department of Health and Family Services, membership fees, and fees-for-service. The expenditures of the NRHA were on its policy development, communication and information activities, including on the staffing and operation of its Office in Canberra and meetings of its Council of Directors.

Significant change in the state of affairs of the NRHA

There was no significant change in the state of affairs of the NRHA during the year ended 30 June 2001.

Significant post-balance date events

No matter or circumstances have arisen since the end of the financial year which significantly affected or may significantly affect the operations of the NRHA, the results of those operations, or the state of affairs of the NRHA in financial years subsequent to the financial year ended 30 June 2001.

DIRECTORS' BENEFITS

Neither since the financial year nor during the financial year has a Director received or become entitled to receive a benefit (other than a benefit included in the aggregate amount of emoluments received or due and receivable by Directors shown in the Accounts, or the fixed salary of employees of the NRHA) by reason of a contract made by the NRHA with the Director or with a firm of which the Director is a member, or a company in which the Director has a substantial financial interest.

Signed in accordance with a resolution of the Directors on 20 October 2001.

Nigel Stewart
Director
Chairperson

Mark Dunn
Director
Treasurer

FINANCIAL STATEMENTS

BALANCE SHEET

As at 30 June 2001

	NOTE	2001 ($)	2000 ($)
Current Assets			
Cash	2	67,633	2,196
Debtors	3	32,900	3,500
TOTAL CURRENT ASSETS		**100,533**	**5,696**
Non Current Assest			
Property Plant & Equipment	4	44,566	51,945
TOTAL NON CURRENT ASSETS		**44,566**	**51,945**
TOTAL ASSETS		**145,099**	**57,641**
Current Liabilities			
Provision for Annual Leave		44,002	30,949
Provision for Long Service Leave	5	19,968	11,634
Unexpended Grants	6	25,000	10,798
Grants Received in Advance		-	-
Creditors	7	19,918	25,593
TOTAL CURRENT LIABILITIES		**108,888**	**78,974**
TOTAL LIABILITIES		**108,888**	**78,974**
NET ASSETS		**36,211**	**(21,333)**
MEMBERS' EQUITY		**36,211**	**(21,333)**

STATEMENT OF INCOME & EXPENDITURE

FOR THE YEAR ENDED 30 JUNE 2001

	NOTE	2001 ($)	2000 ($)
Income			
Australian Journal of Rural Health	9	35,215	40,633
Conference	10	646,997	54,941
Friends of the Alliance	11	22,742	14,978
National Rural Health Alliance	12	645,198	595,371
Total Income		**1,350,152**	**705,923**
Expenditure			
Australian Journal of Rural Health	9	35,215	40,633
Conference	10	644,973	74,105
Friends of the National Rural Health Alliance	11	21,981	36,722
National Rural Health Alliance	12	590,439	512,842
Total Expenditure		**1,292,608**	**664,302**
OPERATING SURPLUS (DEFICIT)		**57,544**	**41,621**
OPENING ACCUMULATED FUNDS		**(21,333)**	**(62,953)**
CLOSING ACCUMULATED FUNDS		**36,211**	**(21,333)**

The accompanying notes form part of the accounts. To be read in conjunction with the attached Auditors Report

NOTES TO AND FORMING PART OF THE FINANCIAL STATEMENTS

For the Year ended 30 June 2001

NOTE 1- SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

The accounting policies adopted by the Alliance follow the accounting standards issued by the Australian Accounting Bodies.

a) BASIS OF ACCOUNTING
The statements have been prepared under the historical cost convention and accordingly do not reflect the changing value of money.

(b) INCOME TAX
The Councillors of the Association believe that the Association is exempt fromincome tax under Section 50-10 of the Income Tax Assessment Act 1997

(c) DEPRECIATION OF NON-CURRENT ASSETS
Depreciation is calculated on a straight line basis so as to write off each depreciable non-current asset during its expected useful life. Additions are depreciated for the number of months remaining in the year after the date of acquisition.

(d) STATEMENT OF CASH FLOWS
Accounting Standard AASB 1026 "Statement of Cash Flows" has not been adopted as in the opinion of Councillors, sufficient additional and materially useful information would not thereby be incorporated into the financial statements were such an Accounting Standard adopted in this year.

	2001 ($)	2000 ($)
NOTE 2 - CASH		
Westpac Conference	-3,914	1,763
AGC Money Market	38,039	-
Westpac Term Deposit	20,000	10,000
Westpac Curtin Cheque Account	13,508	-9,567
	67,633	**2,196**
Note 3 - DEBTORS		
Undeposited Funds	88	-
Owed by JFSS	19,481	-
Owed by RAMUS	8,277	-
Owed by HCRRA	282	-
Trade Debtors	772	-
NRHA 1999 Membership Fees	500	3,500
Deposit Paid for 7th NRHA Conference 2003	3,500	-
	32,900	**3,500**
NOTE 4- PROPERTY, PLANT & EQUIPMENT		
Property, Plant & Equipment (at cost)	119,402	104,885
Accumulated Depreciation	-74,836	-52,940
	44,566	**51,945**

NOTE 5 - PROVISION FOR LONG SERVICE LEAVE

This provision is taken up this year on a pro-rata basis for the Executive Director. He commenced service on 9 August 1993. After 7 years it is prudent to take up this provision, although it is not payable until after 10 years of service.

NOTE 6 - UNEXPENDED GRANTS

Australian Journal of Rural Health	25,000	10,798

The accompanying notes form part of the accounts. To be read in conjunction with the attached Auditors Report

	2001 ($)	2000 ($)

NOTE 7 - CREDITORS

Owed to NURHC	2,407	-
ATO - Net GST For June Quarter	8,816	762
ATO - PAYG For June	7,912	-
Superannuation	52	-
Various Operating Creditors	731	24,831
	19,918	**25,593**

NOTE 9 - AUSTRALIAN JOURNAL OF RURAL HEALTH

Income

Writing Workshop	1,455	-
Office of Rural Heath	25,298	40,633
Other Funding	8,462	-
Total Income	**35,215**	**40,633**

Expenditure

Communications	-	4,730
Depreciation	599	600
Personnel	25,307	29,412
Stationery	27	-
Travel and Council Meetings	9,282	5,891
Writing Workshop	-	-
Total Expenses	**35,215**	**40,633**
Surplus (Deficit)	**0**	**0**

NOTE 10 - CONFERENCE

Income

Arts Program		22,000		-
Bank Interest		362		13
Conference Proceedings		732		3,338
DHAC Grant		120,000		50,000
Registration Fees		330,518		1,590
Reimbursed Expenses		4,915		-
Satchel Inserts		1,455		-
Sponsorships		41,818		-
Tied Grants				
Indigeneous	20,000		-	
Students *	29,370	49,370	-	-
Trade Displays		75,827		-
Total Income		**64,6997**		**54,941**

Note 10 continued on page 42 →

The accompanying notes form part of the accounts. To be read in conjunction with the attached Auditors Report

		2001 ($)		2000 ($)
Expenditure				
Advertising and Promotion		491		5,000
Arts Program		30,531		-
Bank Fees		3,102		667
Catering		99,606		-
Conference Dinner		55,740		-
Council Attendance		8,812		-
Depreciation		610		611
Des Murray Scholarship		3,542		-
Entertainment		4,991		-
Exhibition		16,121		-
Freight		856		88
Interpreter Service		1,627		-
Management Fee		20,000		-
Media		2,009		-
Office Setup		3,483		3,222
Personnel		80,138		31,601
Photocopying		6,352		-
Photographer		4,501		-
Postage		5,432		3,991
Printing		38,935		25,343
Satchels		18,611		-
Signage		3,216		-
Speakers		27,095		-
Stationery		422		1,449
Telephones		17,739		671
Tied Grants				
Consumers	2,326		-	
Indigenous	22,685		-	
Students	26,386	51,397	-	-
Travel		2,127		1,462
Venue		137,487		-
Total Expenses		**644,973**		**74,105**
Surplus (Deficit)		**2,024**		**(19,164)**

The 6th National Rural Health Conference was held in March 2001.

* Student Tied Grant includes grant of $9090.90 plus contributions from Students and Universities.

NOTE 11 - FRIENDS OF THE ALLIANCE

Income

Membership	22,742	14,905
Sales	-	73
Total Income	**22,742**	**14,978**

Expenditure

Advertising & Promotion	-	113
Bank Fees	-	-
Depreciation	112	112
Operational	3,769	-
Personnel	18,100	19,985
Postage	-	2,968
Printing	-	13,322
Travel	-	222
Total Expenses	**21,981**	**36,722**
Surplus (Deficit)	**761**	**(21,744)**

The accompanying notes form part of the accounts. To be read in conjunction with the attached Auditors Report

	2001 ($)	2000 ($)

NOTE 12 - NATIONAL RURAL HEALTH ALLIANCE

Income

Bank Interest	2,624	914
Fee-for-service	69,065	82,442
Health Financing	8,020	25,000
Membership Fees	9,977	11,450
NRHA Publications	2,437	9,570
Reimbursements	133,075	45,995
DHAC Grant - Operating	420,000	420,000
Total Income	**645,198**	**595,371**

Expenditure

Audit & Accounting	9,448	5,796
Bank fees	4,451	2,261
CD Rom Update	22,142	17,522
Cleaning	1,736	1,560
Communications (Partyline)	13,192	-
Depreciation	20,575	16,427
Electricity	3,428	2,888
Email, Internet & Website	18,353	15,486
Equipment - minor items	984	-
Health Financing Project	7,955	36,530
Insurance/Legal	2,818	2,292
Media Services	3,789	4,837
Memberships	2,100	549
Miscellaneous	974	806
Motor Vehicle	13,359	13,188
Official Hospitality	290	536
Photocopying	1,319	398
Postage	29,128	9,550
Printing	24,541	28,271
Publications	1,942	200
Publicity and Promotion	1,349	726
Rent	28,761	27,287
Stationery	15,894	8,154
Telephones	16,173	22,567
Personnel	308,909	233,442
Travel & Council Meetings	36,829	61,570
Total Expenses	**590,439**	**512,842**
Surplus (Deficit)	**54,759**	**82,529**

The accompanying notes form part of the accounts. To be read in conjunction with the attached Auditors Report

LETTER FROM GORRELL & CO

Gorrell Long & Co
(Pty Ltd ABN: 87 088 416 522)
Chartered Accountants
Tax & Business Advisors
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INDEPENDENT AUDIT REPORT
TO THE MEMBERS OF
National Rural Health Alliance

Scope

We have audited the financial statements of National Rural Health Alliance, being the Income & Expenditure Statement and Balance Sheet for the year ended 30 June 2001. The Committee is responsible for the preparation and presentation of the financial statements and the information they contain. We have conducted an independent audit of these financial statements in order to express an opinion on them to the members.

Our audit has been conducted in accordance with Australian Auditing Standards to provide reasonable assurance as to whether the financial statements are free of material misstatement. Our procedures included examination, on a test basis, of evidence supporting the amounts and other disclosures in the financial statements, and evaluation of accounting policies and significant accounting estimates. These procedures have been undertaken to form an opinion as to whether, in all material respects, the financial statements are presented fairly in accordance with applicable Australian Accounting Standards (and relevant statutory and other requirements) so as to present a view of the entity which is consistent with our understanding of its financial position and the results of its operations and cash flows.

JFSS & RAMUS

As JFSS and RAMUS are funded separately to the Alliance, and the funding body requires a calendar year audit conducted, I feel it is appropriate to exclude them from these accounts. To include the figures would not be a true reflection of the financial situation of the Alliance. Separate audited accounts are prepared at the end of the Calendar year for JFSS & RAMUS.

Audit Opinion

In our opinion, the financial statements present a true and fair view of the financial position of National Rural Health Alliance as at 30 June 2001 and the results of its operations for the year then ended.

Bryce Gorrell
Chartered Accountant

25 September, 2001

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