NATIONAL RURAL HEALTH ALLIANCE INC.

ABN: 68 480 848 412

PO Box 280 Deakin West ACT 2600
Phone: (02) 6285 4660 • Fax: (02) 6285 4670
Web: www.ruralhealth.org.au • Email: nrha@ruralhealth.org.au

Budget Submission

January 2012

Introduction

The National Rural Health Alliance (NRHA) is comprised of 32 Member Bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health organisations (see Attachment 1).

The vision of the Alliance is good health and wellbeing in rural and remote Australia. Its particular goal is equal health for all people in Australia by 2020.

In pursuing this particular goal, the Alliance promotes the importance of person-centred care as an underlying principle of its work.

In response to the Treasurer's general invitation, the Alliance is pleased to submit its views about the specific New Policy Proposals it believes should be included in the 2012-13 Budget. This submission also includes reference to priority areas in which the Alliance will be pleased to see continued spending.

The Alliance's proposals focus on some of the areas of greatest current need in rural and remote health, and build on the strengths of existing health services wherever practicable. Particularly at a time of fiscal restraint, all health initiatives in the Budget should pass the tests of **improving equity** in access to services and **targeting those most in need**.

Overview

In a prosperous nation such as Australia, it is unacceptable that the seven million people of rural and remote Australia live with poorer health outcomes and significantly less access to health services than those in the major cities.

Given the current national focus on rural and regional affairs, there is now a special opportunity to correct this inequity. This focus has had some pleasing outcomes to date, such as the new public service and political entities focusing on rural and regional affairs, and the differential regional allocations in some national infrastructure funding rounds.

Where the Federal Government is concerned, this work can continue with the May Budget. Notwithstanding the arbitrary fiscal target set, the people of rural and remote Australia need and deserve additional health-related investments. A 'royalties for regions' approach has the capacity both to provide greater equity and to be in the longer-term interest of the nation's economic development.

Good health may be seen as a human right and provides the basis for a productive economy. Budget savings accrue from health promotion and primary care that keeps people out of hospital. Significantly, in rural and remote areas where health is poorer and savings potential greater, there is currently an annual underspend on primary care of over $2 billion.

Following the progress made with hospital reform, including improvements relating to accountability, the next priority should be ensuring that the people in rural and remote Australia achieve their overdue expectation of better health.

The administrative centrepiece of this effort will be the new body in DoHA, *Rural and Regional Health Australia.* The Alliance expects it to lead the Government's work across relevant Departments and play a leading role, in consultation with organisations like the NRHA, in developing a national rural health plan that is agreed by all health jurisdictions. The plan will serve as the roadmap for national development in rural health services and, just as government at all levels now have increased accountability for their work on public hospitals, it is hoped the plan will lift governments' accountability for their work on rural and remote health.

In the health sector narrowly defined, the Alliance believes the Budget priorities are as follows.

1. Action on better **oral and dental health**, including through workforce initiatives.
2. A stronger system for **aged care**.
3. **Greater equivalence of support** for professionals in all health disciplines.
4. Strong financial support for **rural Medicare Locals**.
5. Specific **rural mental health** measures.
6. **'Broadband for all'** - including the hard-to-connect 3 per cent.
7. Re-investing in rural **maternity services**.
8. Rural and remote **health research**.

1. Oral and dental health

The Alliance strongly supports the Government's current commitment to improved oral and dental health services. Immediate changes should focus on the people in greatest need, who include those living in rural and remote Australia, who have had limited access to dental health services for a very long time.

The annual cost to the economy of untreated dental conditions is estimated at between $1.3 and $2 billion, with the brunt being borne by families on low incomes. Aboriginal and Torres Strait Islander people - 70 per cent of whom live outside the capital cities - are twice as likely as non-Indigenous people to have untreated decay.

This means that people in rural and remote areas are among those who stand to benefit most from government investment in better dental health services. However, for this to be realised, there will need to be particular attention to increasing the availability of dentists and other oral health professionals in country Australia.

The ABS Census of Population and Housing 2006 reported the distribution of oral and dental health workers as follows:

Table 1: Oral and dental workers employed, per 100,000 people, by remoteness, 2006

Major cities	Inner regional	Outer regional	Remote	Very remote
159	119	100	60	21

When it comes to dentists, rather than oral and dental health workers as a whole, there were 60 per 100,000 in the major cities in 2006, compared with 18 per 100,000 in remote areas. And whereas between 2003 and 2006 there were modest increases in dentist numbers in the major cities, the number in remote and very remote areas fell slightly.

The oral health outcomes of people in rural and remote Australia are substantially worse than those of urban people, with surveys showing that rural people aged 25-44 were only half as likely to visit a dentist as city dwellers in the same age group. About 40 per cent of Aboriginal and Torres Strait Islander people reported avoiding some foods because of dental problems, and child dental health was significantly worse with increasing remoteness from Major cities, with the lack of access to fluoridated water being a contributing factor.

This pattern of greater need shows that any oral health plan must have clear and effective distributional measures. People in rural and remote areas should be at the head of the queue for better dental services. The Alliance is agnostic about the specific new policies to be announced in the Budget, assuming that they will be some of (or some mix of) improved child and school dental services, a modified chronic disease dental program, and enhanced public dental schemes.

What the Alliance is not uncertain about is the need for immediate investments in oral labour force measures to ensure that the benefits are experienced by those in rural and remote areas. The first improvements should be directed to those people in greatest need, with the medium-term target of good and fair access for all Australians, irrespective of income and location, as soon as possible.

There should be annual reporting on the distribution of services across geographic regions, including for people in high need groups. While an improved national system is being built, special arrangements for service provision may be necessary, such as visiting dentist and other oral health worker services, and contracting of public service provision to existing private providers in rural and remote areas, coupled with a greater emphasis on oral health in rural health infrastructure programs.

Supports that have been in place for the rural medical workforce should be available to dentists, therapists and hygienists, including scholarships for rural students, HECS relief for rural practice, and locum relief services. If incentives and training are appropriate, the expanding oral health therapist and dental hygienist workforce will help improve access in the bush.

2. A stronger system for aged care

Ageing and elderly people in rural and remote areas should have a range of options for later life as similar as possible to those of their city cousins. The Productivity Commission's August 2011 report, *Caring for Older Australians*, makes recommendations and suggests approaches that will provide these wider options to country people as they grow older.

Notwithstanding the fiscal environment in which the Government finds itself, the Alliance believes that Budget 2012-13 should make further investments in both residential aged care and aged care at home for people in rural and remote areas.

The Alliance welcomes the Productivity Commission's recommendation for flexible funding to provide a range of choices in rural communities. Like people everywhere, very many country folk want to stay at home and close to their friends as they age. For this to be practicable, there needs to be significant new investment in both aged care services in the home and in residential aged care facilities in medium to small country towns. These investments need to recognise the higher costs faced by both domiciliary care and residential facilities in country areas, as well as the specific staff recruitment and retention challenges faced by people managing aged care services in the bush.

Most rural communities do not have the full range of professionals that are available in the major cities to care for elderly people. The best use therefore has to be made of the available professionals

in each location to provide both health and aged care. This will include support for local workers to upgrade their training which may require travel to a regional centre; and for local professionals to adopt new technology and meet new standards of safety and quality. In rural areas there may well be insufficient capital available for establishing video-conferencing facilities to better link local aged care professionals and their clients with multidisciplinary care teams in regional centres, for example through the roll-out of new telehealth initiatives. Managers in rural and remote areas also struggle to keep their services on a par with urban services with such things as the purchase and installation of infrastructure for new technology and the associated costs of staff training and technical support.

As they age, people in rural communities want the flexibility to choose services to help them stay home if they are able. For example, support with cleaning, shopping and personal care at home may be easier to provide in a small community if resources are shared by service providers, be they residential aged care or outreach from a health and community service. The Productivity Commission has recommended additional support for local service managers as well as improved education and training opportunities for nurses and personal carers in rural and remote communities.

The Productivity Commission has also made the point that where populations are sparse and there are unavoidable and significant variations in needs for aged care beds, supplementary block funding and capital grants may be necessary to keep the services open, on top of mainstream funding. The successful approach adopted with Multi-Purpose Services should be built upon.

The proposed Aged Care Commission would need to account for rural and remote differences in setting the efficient prices for services generally, and when recommending to the Government the appropriate subsidies for providing sustainable aged care services in the community and in residential care.

- The viability of aged care services for people in rural and remote communities is affected by the higher cost of goods and services, due both to their freight component and the relatively small volumes.

- Smaller rural populations do not provide opportunities for the economies of scale in services that are available to major city services. For example, building or upgrading treatment and training rooms that would enable the facilities to accommodate allied health and medical specialist outreach visits may well be impossible.

- Rural services will generally have higher costs for attraction and retention of staff, with the need in some communities to provide suitable accommodation.

Any co-contribution scheme for aged care in rural and remote communities must be adjusted for the capacity of clients to pay.

Local aged care services are not only good for the people receiving them, but also contribute to the local economic base and so can be critical to local businesses and to the general sustainability of communities in rural, regional and remote Australia.

The Alliance supports the proposal for an Australian Gateway Agency. It should help people find their way to the mix of care each person will need to enable them to stay at home, including support for their carers, or to choose residential care.

Specific proposals

- Improved reporting by remoteness classification on the delivery of aged care services, taking account of the Aboriginal population aged 50-69 years of age, and through Medicare Locals' Healthy Community reports.

- 'Catch-up' aged care places and packages: rural and regional Australia should get priority in further allocations of aged care places and packages to allow catch-up to Major city rates of service provision.

- Further refinement of the aged care Viability Supplement to offset the higher cost of providing both community and residential aged care places in rural and remote communities.

- Further expansion of the Multi-Purpose Service (MPS) program.

- A National Rural and Remote Aged Care Infrastructure Grant round, to expand and upgrade the services that aged care facilities offer to rural and remote communities and to improve the safety and quality of caring for older people.

3. Greater equivalence of support for professionals in all health disciplines

Doctors alone cannot provide comprehensive primary health care; they need the support of allied health professionals, dentists, nurses, Aboriginal and Torres Strait Islander Health Workers, paramedics and health service managers.

The 2012-13 Budget should announce additional investment in programs to improve the health workforce distribution so that rural and remote consumers have more equitable access to health services. Strategies similar to those in place for doctors should be implemented for other health professions, especially in light of the greater number of nursing, dental and allied health students now in training.

The programs would include rural clinical training and placements, scholarships for rural people to study health sciences, and HECS reimbursement for rural or remote service. There should be financial incentives to existing rural and remote practitioners for providing mentoring and support to nursing and allied health students, and further investments in the careers of Indigenous health science students.

It is well documented that rural background, rural education and training experiences, and rural scholarships are predictors of rural work location[1] [2]. A package of measures should be made available to students and graduates. Implementation of the package would find support from the network of University Departments of Rural Health (UDRHs) which assist education and clinical supervision across the range of professions. Students of all professions should have equal access to the accommodation made available through UDRHs and Rural Clinical Schools.

The package could include the following elements.

Increased numbers of undergraduate scholarships for students of rural origin

The number of undergraduate scholarships available for dental, allied health and nursing students should be doubled and should include arrangements for a rural mentor for each scholarship holder

[1] *Choosing general practice as a career – the influences of education and training,* Bunker and Shadbolt, Australian Family Physician 38:5, May 2009

[2] *Nature of association between rural background and practice location: A comparison of general practitioners and specialists,* Matthew R McGrail, John S Humphreys, and Catherine m Joyce, BMS Health Services Research 2011 http://www.biomedicacentral.com/a472-6963/11/63

(as the Rural Australian Medical Undergraduate Scholarship (RAMUS) provides for medical undergraduates).

Currently, the Nursing and Allied Health Scholarship and Support Scheme (NAHSSS) is shared amongst nurses and 19 allied health professions in five streams and includes undergraduate, postgraduate, continuing professional development and clinical placements. The funding available under this scheme, the number of professions competing for scholarships and the range of scholarship types make the success rate for applicants relatively low. Between 2006 and 2011 it had an applicant success rate of 15 per cent, compared with 28 per cent for RAMUS.

Rural scholarships such as these would help the universities' health science schools to achieve the target of at least 30 per cent of their student intake being of rural or remote origin. These institutions should be required to report on such targets, as well as for the proportion of their student intake with Aboriginal or Torres Strait Islander heritage.

To optimise enrolments and completion rates, extensive support programs should be funded as part of 'an educational pathway' for Indigenous and rural students.

Support for rural placements

There should be significant new investments in clinical placements for non-medical health students, including to help cover the costs of travel and accommodation. The Integrated Regional Training Networks being established by Health Workforce Australia would be responsible for the provision of structured rural placements for students of all health professions.

HECS reimbursement

The HECS reimbursement scheme is a highly motivating incentive for young professionals to choose to work in a rural or remote area. For doctors this is an uncapped scheme that is administered through Medicare. A similar program should be implemented for other health professions to take advantage of the increased numbers likely to graduate over the next few years. The program could be funded through Health Workforce Australia.

Orientation and transition support for young professionals commencing rural practice.

A package of orientation and transition support for young professionals commencing rural practice should be funded to assist them establish themselves in a rural community and practice. The supports offered should be comparable to those offered to doctors under the Workforce Support for Rural General Practitioners program and the Rural and Remote General Practice Program.

A current Health Workforce Australia project is developing a range of settlement and retention supports to assist allied health and nursing professionals integrate and remain in a community for up to two years. The suite of supports has been developed in consultation with the Rural Workforce Agencies and various other stakeholders. The package developed through this process should be funded for national implementation.

A marketing campaign

Establishment of a pathway to rural practice will be ineffective if it is not clearly defined and well publicised to everyone who influences career choices, applications for scholarships or financial assistance, decision making about clinical placements and practice location. It would be essential to develop and implement an effective marketing campaign targeted at high schools; university schools of health; students and their families; and rural health professionals.

The marketing campaign should also promote the advantages of rural practice and rural life. The National Rural Health Students' Network reports that some teaching staff at Universities display a

negative attitude towards rural practice. This is clearly inappropriate and dysfunctional. At all levels and in all possible ways, universities need to encourage students to consider a career path in rural and remote settings. A strong marketing campaign would help overcome these attitudes and so encourage students and young professionals to pursue rural placements and careers.

4. Support for rural Medicare Locals

Medicare Locals will now have the primary role in the identification of the health needs of local areas, in the development of services to meet them, and in providing support to clinicians and other service providers. These activities will improve the patient journey and develop more integrated and coordinated services. People in rural and remote areas will value Medicare Locals when they see that they are filling gaps in primary care services.

Such responsibilities are much greater for rural Medicare Locals than for those in urban areas. In rural areas there are greater health needs, fewer primary care providers per capita, more pressures upon them, larger distances to travel for giving and receiving service, more gaps in services and greater complexity in integrating care because of the lack of local specialists, allied health professionals and many acute services.
The resourcing of Medicare Locals based in rural and remote areas must be commensurate with these greater responsibilities, and take account of the serious deficiencies in health workforce, Medicare funding, public transport and health infrastructure, as well as recruitment and retention challenges. The Alliance believes that Medicare Locals with rural/remote coverage should be allocated substantially more than the average funding provision, and should have some flexible funding to provide additional services that target locally-identified priority service gaps. Consideration will also need to be given to Medicare Locals that have both city and rural coverage for their work in rural areas.

Rural and remote Medicare Locals must also be funded and developed in such a way as to contribute to Closing the Gap in health for Aboriginal people, including through the new agencies' relationships with Aboriginal Community Controlled Health Organisations.

5. Specific rural mental health measures

The prevalence of mental illness in rural and remote Australia is estimated to be broadly equivalent to the levels in Australia's major cities. However the AIHW estimates that rates of completed suicide in regional and remote areas are 1.2 to 2.4 times higher than those in Major cities. Natural disasters, which have greater impacts in rural areas, also contribute to mental illnesses and have a direct impact on income and wellbeing for rural Australians. There are known 'mental health hotspots' in some more remote areas, including in some Aboriginal communities.

Despite these needs and risks, people in rural and remote areas have lower levels of access to specialised mental health services. One thing agreed by all parties about the Better Outcomes and ATAPS programs is that their reach in rural and remote areas has been limited.

Local access to psychiatrists is very poor for people in rural and remote areas, with 91 per cent of psychiatrists having their main practice in metropolitan areas.

A package of mental health measures that can be well-distributed throughout Australia and provide locally for the needs of people in smaller towns and communities could include the following.

- Expanded funding for mental health nurses and the extensive Personal Helpers and Mentors Service program, with a particular focus on rural and remote Australia.

- Programs to build 'problem solving' capacity for people at high risk of suicide, including Aboriginal people and those exposed to natural disasters.

- Continuation of the various telephone help and counselling services.

- Expansion of the remits of centre-based initiatives (EPICC, Headspace) to ensure they have the capacity to reach out to the rural areas around the population centre in which they are based. The role of such 'centralised' services must include providing clinical support to rural generalists in their catchments. (The need to avoid too much reliance on single services in central places is illustrated by the fact that there are more than 1400 towns of 200 to 5000 people and about 140 in the range 5000-18,000 who will have the same need for these types of services as people in the major cities.)

- Specific tasking of Medicare Locals to work with Local Hospital and Health Networks on integrated patient pathways for people with mental illness, particularly critical clinical needs.

- Expansion of the visiting specialist scheme for psychiatrists to include the capacity to fund psychologists working with rural primary care teams, including in Aboriginal community controlled health organisations, in a mentoring and support role, as well as to provide direct client services.

- Similarly, the involvement of psychologists and social workers in primary mental health care through existing MBS telepsychiatry items should be updated in association with the new MBS telehealth initiative for online consultations with specialists, to include consultations with patients facilitated through the range of health professionals working in rural and remote communities (eg remote area nurses, nurse practitioners and Aboriginal Health Workers).

The National Mental Health Commission must give attention to how mental health services translate to areas where specialised mental health professionals are not available, and the National Report Card on Mental Health and Suicide Prevention should include a report by remoteness.

6. 'Broadband for all'

The Alliance sees the availability of 'fit for purpose' high-speed broadband across every part of rural Australia as a key facilitator of community sustainability, business and recreational opportunities, and the future health services in those areas. There should be a special grants program to ensure that 'difficult to access' homes, businesses and services can take advantage of the rollout of high speed broadband.

The Budget should target some of the resources earmarked for the National Broadband Network to a 'Broadband for all' initiative for those who are unlikely for technical and logistical reasons to be connected by fibre-to-the-home or business.

This was a key recommendation of the National Health and Hospitals Reform Commission and fundamental to improving access and safety and quality of health care in the most remote and disadvantaged communities in Australia. Internet access for patients could be provided as part of the attraction and benefit of attending the local health clinic.

Providing fast and upgradeable broadband for families and businesses in remote areas will require commercial grade satellite or other high speed connection capacity to be made available to them at an affordable price. This will involve a full assessment of the technological requirements and costs

of the alternatives to fibre, and specific plans to meet the electronic information and communication needs of Australians in more remote areas.

Improved connectivity will support health care and e-health as well as rural/remote commerce and lifestyles, with citizens and their health professionals having easier access to information held in different parts of the system, and to information available through the internet. Because of their capacity to deliver for people in rural and remote areas, the Alliance is a strong supporter of both the Personally Controlled Electronic Health Record and the MBS item numbers for telehealth. Both of these depend on access to high speed broadband for their effectiveness and it would be tragic (and ironic) if the people and services in hard-to-connect areas missed out on those critical new services.

7. Re-investing in maternity services

The National Maternity Services Plan was endorsed by Health Ministers in November 2010 and the first annual report on it has now been published. For the people of rural and remote Australia its success will be measured largely by one indicator: the extent to which it leads to *reinvestment* in maternity services in rural centres. The 2012-13 Budget should include allocations for this important purpose.

> "The Plan focuses on maintaining Australia's high standard of safety and quality in maternity care, while *seeking to improve access to services* and choice in models of care." (emphasis added)

The Plan identifies four major areas: patient access, service delivery, workforce and infrastructure.

Investment in maternity services yields high returns for individuals, families and the nation. Consistent with the Alliance's person-centred approach, we support the philosophy that women be assisted to feel 'in control' not only in pregnancy, but in childbirth and during the postnatal stage. Healthy pregnancy, a birth that is managed with appropriate care and an optimum beginning to life are key determinants of the long-term health of every individual. Poor prenatal and birthing experiences are likely to impose costs for life and involve health care greater than the costs of re-establishing and maintaining rural maternity services.

A widespread network of maternity services would help to sustain country hospitals as well as the rural, regional and remote communities that depend on their services. More midwives are needed in rural and regional areas.

Other things required for improved birthing in the bush include the replication of collaborative birthing services that have already been shown to work well, and greater support for the health professions involved in maternity services, antenatal and postnatal care. Investment in maternity service systems will also support electronic retention of routine data collected during pregnancy, birth and in the first five years of life.

A no-fault insurance scheme to reduce the cost to clinicians and taxpayers of adverse outcomes would be a major step forward. In this topic area, the Government's growing commitment to National Disability and Injury Insurance Schemes is very encouraging.

The National Partnership Agreement on Preventive Health has a focus, inter alia, on child care centres, pre-schools, children and family centres and breastfeeding support. These are important contributors to health for young children, and are programs which will yield positive returns on investments made.

8. Rural and remote health research

The results of high quality rural health research are needed to systematically identify best practice in rural health provision, and to guide policy and program development. Rather than competing in the research mainstream, there is a strong case for a separate program of research on rural and remote health in Australia.

The 2012-13 Budget should provide $500,000 per annum to the Australian Institute of Health and Welfare (AIHW) and an increased allocation to the NHMRC for a dedicated rural and remote stream within that body's work.

The new allocation to the AIHW is critical because it currently has no such dedicated resource base. The organisation did at an earlier time have limited but very valuable resources devoted to rural and remote issues and the current situation is the result of a retrograde step. Having dedicated rural capacity would permit a broader range of analysis of workforce issues, more timely results, and more detailed analysis to reveal particular rural areas where access, health risks, health status or health outcome measures are lower.

The Alliance supports a dedicated rural and remote stream in the NHMRC's work. Such a stream has many precedents, including the Primary Health Research, Evaluation and Development Strategy (PHRED), the 5 per cent allocation to Aboriginal Health of NHMRC funding, the NHMRC Partnership Projects, targeted to achieve a more effective integration of evidence into health policy and service delivery, and the Centres of Clinical Research Excellence. While all of these programs, as well as the mainstream NHMRC project grants, are in theory equally available for remote and rural research purposes, the outcomes do not show any reasonable allocation to rural and remote research. Part of the difficulty is that grants are awarded on the basis of past performance and in some cases require substantial resource contributions from the host and partner research bodies, all of which favours more established and resource-rich institutions, usually city-based.

A dedicated remote and rural research program is crucial to reverse this situation and enhance the evidence base and would comprise:

- research enabling grants, career development, research fellowship grants and infrastructure to build research capacity and the resource base in rural institutions in which research and evaluation are undertaken, including academic bodies and service providers;
- project grants to address the many clinical and service delivery challenges of particular relevance to remote and rural Australia;
- partnership grants to support collaborations between researchers and policy or practice agencies to facilitate the application of research into policy and service delivery; and
- a mechanism to provide support in the area of dissemination and knowledge-exchange, similar to the Primary Health Care Research and Information Service (PHCRIS) element of the Primary Health Care Research, Evaluation and Development (PHCRED) Strategy.

Conclusion

The 2012-13 Federal Budget provides an opportunity to continue to address the $2.1 billion rural health deficit recently confirmed by the NRHA. At a time of considerable fiscal constraint, the emphasis in funded new policy proposals should be on programs that will both meet the Government's current commitment to regional areas and result in reduced inequity in access to good health services and health outcomes.

Attachment

Member Bodies of the National Rural Health Alliance

ACHSM	Australasian College of Health Service Management
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare & Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANF	Australian Nursing Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRIG)	Australian Psychological Society (Rural and Remote Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group
PSA (RSIG)	Rural Special Interest Group of the Pharmaceutical Society of Australia
RACGP (NRF)	National Rural Faculty of the Royal Australian College of General Practitioners
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RHW	Rural Health Workforce
RFDS	Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
RNMF of RCNA	Rural Nursing and Midwifery Faculty of the Royal College of Nursing Australia
ROG of OAA	Rural Optometry Group of the Australian Optometrists Association
RPA	Rural Pharmacists Australia—Rural Interest Group of the Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the Society of Hospital Pharmacists of Australia
SARRAH	Services for Australian Rural and Remote Allied Health