Submission to the Senate Community Affairs Committee Inquiry

Prevalence of different types of speech, language and communication disorders and speech pathology services in Australia

28 February 2014

This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.
Introduction

The National Rural Health Alliance (NRHA) is the peak national organisation for rural and remote health and wellbeing. The Alliance comprises 37 Member Bodies including consumer groups (such as the Country Women’s Association of Australia), representation from the Aboriginal and Torres Strait Islander health sector, organisations representing rural health professionals (doctors, nurses, allied health professionals including speech pathologists, dentists, pharmacists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service and Frontier Services of the Uniting Church in Australia). A complete list of Member Bodies is attached.

The NRHA welcomes this inquiry into the different types of speech, language and communication disorders and the assistance and support that speech pathology services could provide. We are concerned that awareness of speech pathology services, and the situations in which they can assist, is quite low outside the major cities. This lack of awareness, coupled with poor availability of speech pathology services, contributes to under-diagnosis and to underestimates of the prevalence of speech, language and communication disorders. The result is less than optimal treatment of many of these disorders for people in rural and remote areas.

In this submission, the NRHA summarises information relevant to the Terms of Reference of the Inquiry (Appendix 1) from the perspective of the more than 6.7 million people in rural and remote areas.

Addressing the Terms of Reference

a) **Prevalence of conditions treated by speech pathologists in rural and remote Australia.**

b) **Incidence of these disorders by demographic group (paediatric, Aboriginal and Torres Strait Islander people, people with disabilities and people from culturally and linguistically diverse communities).**

Speech pathologists study, diagnose and treat communication disorders, including difficulties with speech, language, fluency and voice. Speech pathologists can also help people (adults and children) who experience difficulties swallowing food and drinking safely (for example, from neurodegenerative disorders such as Parkinson’s, dementia or stroke).

The difficulties in speech and language that are treated by speech pathologists include those caused by:

- developmental delays – including autism;
- stroke;
- brain injuries;
- learning disability;
- intellectual disability;
- cerebral palsy;
- dementia; and
- hearing loss.

Data by remoteness\(^1\) are available for some but not all of these conditions, as summarised below.

**Developmental delays**
No information.

**Stroke**
Although stroke rates appear to be similar in regional areas and major cities, in the former they result in higher rates of hospitalisation. Admission to a hospital is presumably an indicator of more severe stroke outcomes where distance is a factor, and/or that community options for treatment and support are more limited.

**Brain injuries**
NRHA work in 2012 showed the rate of hospital separation for traumatic brain injury was substantially higher outside Major cities as a result of motor vehicle accident and assault as well as for stroke and 'other' causes. Up to 40 per cent of separations in Australia for these reasons involve people living outside Major cities.\(^2\)

**Disability**
People in regional and remote areas are 1.04, 1.14 and 1.31 times more likely than those in Major cities to have, respectively, an intellectual or learning difficulty, a sensory or speech disability, and acquired brain injury.

They are 1.07, 1.15 and 1.16 times more likely than those in Major cities to have severe/profound core activity limitation as a result of, respectively, an intellectual or learning difficulty, a sensory or speech disability, and acquired brain injury.

Females have similar rates of disability across remoteness areas, but for males living in rural and remote areas, rates of these forms of disability tend to be 20 per cent to 40 per cent higher than in Major cities.\(^3\)

**Cerebral palsy**
Rates of cerebral palsy appear to be similar in urban and rural parts of Australia. However, the Australian Institute of Health and Welfare (AIHW) reports that access to therapy appears to be particularly difficult in rural and remote areas, as over 300 clients were on a 16-month waiting list for services in rural and remote New South Wales, while therapy is unavailable for adult clients in non-metropolitan areas of Western Australia.\(^4\)

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\(^1\) Using ASGC-RA: Major cities, Inner regional, Outer regional, Remote, Very remote.


**Dementia**

The prevalence of dementia appears to be similar across remoteness areas\(^5\) but access to aged care and dementia services – one of the avenues for referral to speech pathology services – decreases by remoteness.\(^6\)

**Hearing loss**

No information has been identified on hearing loss by remoteness for the general population. It is known that Aboriginal children have substantial hearing loss, resulting in significant disadvantage at school and in later life. Over 50 per cent of Aboriginal and Torres Strait Islander children in the Northern Territory have some form of hearing loss, with about 10 per cent having moderate to severe hearing loss.\(^7\)

**Other problems that can affect speech and language**

Speech pathologists play an important role in assisting elderly patients with swallowing issues. This is very important for the taking of medications – many of which should not be crushed – as well as for nutrition. Since the proportion of older people increases by remoteness, except for Very remote areas, the prevalence of such difficulties outside the Major cities is likely to be relatively high.

Residential and community aged care services are important avenues for identifying swallowing issues and referring older people to speech pathologists. Because the prevalence of such services is lower, it is likely that there is substantial unidentified need in rural and remote regions.

c) **Availability and adequacy of speech pathology services provided by all levels of Government across health, aged care, education, disability and correctional services**

d) **Provision and adequacy of private speech pathology services in Australia**

Issues contributing to the adequacy of speech pathology services include:

- the availability, accessibility and affordability of speech pathologists;
- the effectiveness and reach of speech pathology services through a range of programs and multidisciplinary team based care
  - for children; and
  - for other groups; and
- technological and other means for providing speech therapy support through local health professionals or directly to clients, to complement (not replace) face-to-face speech pathology services and to improve access to services overall.

Each of these points is discussed below.


Availability, accessibility and affordability of speech pathologists

According to the 2006 Australian Bureau of Statistics (ABS) Census, there were 3,867 speech pathologists and 1,076 audiologists in Australia, but no breakdown by remoteness. The AIHW does not collect or publish separate data on speech pathologists.

At the 2011 ABS Census there were 7,048 people who identified as either speech pathologists or audiologists. Extrapolating the apparent workforce growth from 2006 to 2011, it seems likely that in 2011 there were about 1,500 audiologists and some 5,550 speech pathologists in Australia, consistent with Speech Pathology Australia’s estimate of over 5,500 speech pathologists.

Table 1 provides an indication of the number of speech pathologists in regional and remote Australia. The pattern is similar to that for other allied health professionals, eg podiatrists, with high prevalence in Major cities, decreasing with remoteness.

Based on the estimated numbers of speech pathologists in regional and remote areas and the higher prevalence there of people with disabilities, brain injury and likely hearing loss, it is reasonable to conclude that the supply of speech pathologists in those areas is insufficient to meet need. This conclusion is corroborated by anecdotal evidence set out below.

Table 1: Estimates of prevalence of speech pathologists, by remoteness, (for where they live), 2011

<table>
<thead>
<tr>
<th>Remoteness area</th>
<th>Reported rate of speech pathologists and audiologists per 10,000 population</th>
<th>2011 population</th>
<th>Inferred number of audiologists and speech pathologists</th>
<th>Inferred number of speech pathologists</th>
<th>Inferred prevalence of speech pathologists per 100,000 population</th>
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<tr>
<td>MC</td>
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<td>192,374</td>
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Note: Column 5 assumes that about 4 in 5 are speech pathologists rather than audiologists (based on the relative numbers in 2006). The remoteness area relates to the area where the speech pathologist lived, which may not necessarily be where they work. The numbers in this table are indicative rather than specific given a number of assumptions made. Comparison with HWA figures confirm that Table 1 does indeed provide a reasonable approximation of the number and distribution of speech pathologists across remoteness areas of Australia.

Remoteness is defined according to the Australian Standard Geographical Classification – Remoteness Areas (ASGC-RA) system: Major Cities (MC), Inner Regional (IR), Outer Regional (OR), Remote (R) or Very Remote (VR) areas.

Source: NRHA derived from ABS Census 2006 and ABS Census 2011 (provided by Joanna Wood from Speech Pathology Australia).

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9 personal communication Joanna Wood, Speech Pathology Australia

Effectiveness and reach of speech pathology services

For children

Representatives of Member Bodies of the Alliance across several health professional and consumer groups reported experiences with various programs for providing speech pathology services, mainly for children.

The long wait for service due to shortages of speech pathologists in rural and remote areas was a common theme. Speech pathologists are employed across a range of sectors, including in mainstream public education and the special school sector as well as health and social services. In country areas, speech pathologists should be able to move more freely between salaried public roles and private practice. Greater flexibility would allow them to better meet the range of needs in the rural and remote communities where they live and work and allow them to practise in areas where a sparser population makes private practice hard to sustain. Providing outreach services and visits to outlying rural areas should be part of the mix.

Rural members of the Australian Psychological Society reported that funding models may have an impact on the provision of speech pathology services through unequal distribution of resources. For example, in Queensland’s Mount Isa region, children in more remote areas have better access to a speech pathologist than those living in town – even though the outreach service is infrequent. In the larger regional centre, the high population has resulted in long wait lists and infrequent access, resulting in poorer outcomes than for children living in remote communities. Further, children aged over 8 years have no access to speech pathology services unless they meet the criteria for intake to a school speech therapist, where they again face long waiting lists. There is also a lack of speech pathologists in private practice in Mount Isa, placing further pressure on those working in the public sector.

Other health professional groups’ reports also highlighted concerns about programs for school-age children. Programs funded by the Department of Social Services which provide speech pathology for pre-school children with autism spectrum disorders, cerebral palsy and Down’s syndrome, are highly valued. Apparently there is very limited access to speech pathology programs for school-age children who would obviously benefit from speech pathology services when learning to socialise and read. Medicare-funded Enhanced Primary Care plans established in consultation with general practitioners provide for limited numbers of speech pathology sessions if a private speech pathologist is available, but paediatricians and other members of the multidisciplinary team do not have direct referral pathways for these plans.

Mental health plans are a potential avenue that could be extended to include funding for speech pathology for school-age children, given the impact of poor communication on mental health and wellbeing. At present, while allied health referral pathways in mental health include occupational therapists and psychologists, speech pathologists are not covered.

Speech Pathology Australia (SPA) comments that Australian research with parents of children with communication disorders demonstrates that lack of availability of speech pathology services and long distances for travel are frequently cited barriers to access in rural and remote parts of Australia (O’Callaghan et al, 2005). O’Callaghan concludes that:

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Consumers living in rural and remote areas experience a number of barriers that affected their ability to access speech pathology services. These barriers include the lack, and limited choice, of speech pathologists in rural areas; long distances to travel to access services, expensive travel costs, lack of public transport; poor awareness of speech pathology services; and delays in treatment due to waiting lists.

A recent study showed that around one-third of people living in areas classified as ‘non metropolitan’ in NSW and Victoria were more than 50km from a public paediatric speech pathology service (Verdon et al, 2011). “People living in almost one third of rural localities in rural New South Wales and Victoria lie beyond what is considered by rural speech-language pathologists to be a reasonable travel distance to weekly speech-language pathology services.”

Having had little or no exposure to such services, many people in rural and remote areas may not realise the value of speech pathology, making it impossible to assess unmet need. In such situations and without understanding of and advocacy for such vital services, people will simply ‘make do’. Parents may not think to present to a general practitioner for assessment of their child’s speech-related issues. And when they do present, with no local options or only limited access via long waiting lists, early-intervention opportunities are missed with concomitant impacts on developmental outcomes for the child.

To achieve positive outcomes for some clients, the vital links between speech pathology and psychology must be recognised. A psychologist working in rural and remote Western Australia has provided the Alliance with a comment on the high correlation between intellectual disability/impairment and speech disability/impairment. This relationship necessitates working collaboratively with speech therapists as part of a team. He reported that the majority of his referrals in this context are from speech therapists who recognise the complexity of a presentation potentially involving other psychological and developmental issues more broadly (eg intellectual disability, autism spectrum disorder, congenital syndromes). These children often benefit from psychological assessment that can inform the treatment strategies of both the speech pathologist and paediatrician.

In summary, the limited access to speech pathology services in regional, rural and remote Australia is creating a significant gap in best practice multidisciplinary approaches to managing a range of childhood problems, including mental health and behavioural issues. Current approaches to address this issue appear to leave gaps and problems which need resolution in terms of equity of access to care and increased demand on other health professionals.

For adults
The Alliance has received little information from rural and remote networks about speech pathology services for older people, people with chronic conditions and people with acquired brain injury and stroke. The prevalence of all of these conditions is higher outside the Major cities and should be associated with higher levels of demand for speech therapy – but this is not the case.

In many rural areas with historically poor access to speech pathology, community members are not fully aware that they are missing out on such services. The higher rates of

hospitalisation for stroke outside the cities may well reflect such service deficits. For example, patients and their clinicians may well be reluctant to have the patient return home if they have not re-learned how to swallow food and medicines, especially given the possibility that such patients have no support for such learning at home.

The following proposals from a speech pathologist in a central Queensland town about what would make a difference to speech pathology in a primary care setting are instructive:

- Enticements to establish rural private speech pathology (SP) practice.
- Internet connection speeds to support Telehealth SP services.
- Financial assistance to access professional development resources such as the Speech Pathology Australia lending library in rural areas.
- Establish network of specialist clinicians from whom rural clinicians can request advice and clinical guidance (eg. Fluency specialist).
- Support to purchase clinical resources in rural areas. Generalist caseloads require a broad resource set that organisations seldom provide.
- Improve collaboration between existing speech pathology services.
- Promote community awareness in rural and remote areas.

**Technological and other means for providing speech therapy support**

Several submissions to the Alliance have confirmed the potentially critical role of telehealth to improve access to speech pathology services for country people. These telehealth services should include support and advice from specialised speech pathologists to those providing a wider range of general services in rural and remote areas, or to local health professionals, parents or other carers to support them in assisting the client. Current cohorts of rural health students are keen to be sure that the technology is available in more isolated areas to support telehealth services.

The Rural and Remote Interest Group (RRIG) of the Australian Psychological Society is concerned that one approach to addressing the limited access to speech pathologists in rural areas has been to train other professions, such as psychologists, to administer a specialised assessment instrument (e.g. CELF 4) which is usually administered by speech pathologists.

They point out that the strategy is problematic for a number of reasons. Other professions, such as psychologists, require additional training and development to administer these specialised assessments. Such training takes time and money and in rural areas those other professionals – like speech pathologists – have limited access to such training. While other professions may be willing to attend training and administer the test, there are likely to be limited referral pathways for follow-up interventions with a speech pathologist if a problem is identified, raising questions such as: Where does the patient go? How does the other health professional, who may have limited competence working with a very specific presentation, continue working with the patient? In other words, there will be very little to offer unless the patient travels to another geographic location and pays for private services.

It was also noted that the time taken to administer specialised speech pathology assessments reduces psychologists’ time where their psychological expertise (such as cognitive assessments) is required.
Although allied health professionals are positive about opportunities to train and work across disciplines with speech pathologists, this does not solve the problem of equitable access to services in the bush. Shortages of one professional group cannot be solved by co-opting people from another.

e) **Evidence of the social and economic cost of failing to meet communication and swallowing disorders**

Speech pathology is absolutely essential for the early identification of speech and communication issues in early childhood. Without early intervention the child’s development may be compromised for a lifetime. Infants and young children in more remote communities are almost certainly missing out on these fronts because of an under-supply of speech pathologists.

For example, until recently there were no paediatric speech services (and other early intervention services) on Kangaroo Island in South Australia, until the child reached school age. At that time, he or she would be placed on a waiting list for up to eight years for a visiting service team, who only attended twice during a school term. Children with severe difficulties (such as feeding difficulties) were directed to the mainland. The consequence of this delay is that problems are not picked up early enough, leading to poor educational and health outcomes. Similarly, demand for speech therapy in the midwest of Western Australia is reported to be significant, with a large number of children missing out altogether or very limited services.

An allied health professional with many years’ experience working in remote communities across the Top End of the Northern Territory reported that he came to appreciate the importance of providing full access to these remote area residents to the whole range of health professionals encompassing allied health professionals such as speech pathologists. The consequences of denying this access were often significant, resulting in unnecessary hardship and disability for clients and their family and carers.

In practice as a physiotherapist in these remote communities, the vast majority of his patients were Aboriginal people and residents with major health and independent living issues, including children with disabilities, adults with chronic illness and injury, and the frail elderly with various disabling conditions. For such people, having good access to allied health services can mean the difference between living meaningful, functional and independent lives versus ongoing handicap with high dependence on others. Without responsive and expert services, people from these remote areas would often be forced to take up institutional care far from home in Darwin, or be forced to live difficult lives with minimal support. In some cases related but preventable illnesses would occur leading to hospitalisation and premature death.

The outreach health team did not include a speech pathologist, so that speech therapy services were very limited for the district’s remote area people. Many clients would have greatly benefited from a speech pathologist’s clinical advice and help, and people’s ongoing lives would have been of a much better quality. As one example, an 18-month-old boy who had

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13 For example, under the Rural Health Continuing Education Program Stream 2 (see http://www.ruralhealth.org.au/rhce) three allied health private practitioners (Speech Pathologist, Occupational Therapist, Clinical Psychologist) working in Inverell, Moree, Glen Innes and Tenterfield attended a specialist workshop on the SCERTS® method, and visited Aspect and Cerebral Palsy Alliance in Sydney, and the Sensory Clinic in Maitland to learn about trans-disciplinary team approaches to the provision of services for children with a range of disabilities including Cerebral Palsy and Autism.
recently returned from hospital after a devastating meningitis infection received a range of therapy inputs during his recovery phase in hospital in Darwin. No such services were available in his home community on his return. Six-weekly visits to the community provided physiotherapist input to assist his mobility recovery but this input was too limited for the child’s needs and efforts to get more intensive input were frustrated. The little boy was suffering speech and vocalisation delay as another key consequence of the meningitis. He needed regular intensive speech input and there was little the outreach team or the local community medical officer, nurses and Aboriginal health workers could do. No one on the team had the special expertise of a speech pathologist.

The child suffered needless disability as a result of this service deficiency, and has likely gone on to experience learning, communication and vocational disability through childhood and into his adult years. It would be difficult to estimate the cost of the loss of potential for this child and the hardship for him and his family over many years.

This correspondent concluded with this:

In the case of speech pathology, it should not be beyond this country or our health system, to ensure an acceptable minimal level of service access for all Australians, remote people as well. This is not rocket science to work out. For example, remote areas could be broken into regions of similar population size, and then a minimum acceptable level and range of health services applied to this regional population. Services could be provided via a combination of publicly employed, not-for-profit or private sector professionals, as long as the minimum level of service access was ensured for all.

The Alliance is concerned that such stories are not being heard enough from rural and remote adults who would benefit from speech pathology. This is symptomatic of the poor awareness of the potential benefits of the service of speech pathologists referred to above. The level of unmet need is greater than has yet been understood and measured.

f) Projected demand for speech pathology services in Australia
As outlined above, the size of the current speech pathology workforce is not well known and its distribution has not been analysed by remoteness. It seems likely that more speech pathologists will be needed as understanding of the contribution they make to health and wellbeing increases – and as the population ages.

Workforce data, analysed by remoteness, are clearly needed to identify and articulate the areas of need and to inform planning and workforce incentives. Projections about speech pathology services in rural and remote areas also need to be considered, especially given the proven effectiveness of multidisciplinary teams in the health sector in achieving positive health outcomes. The effective use of a speech pathologist in a rural or remote setting may involve considerable coordination and support by and with local health professionals, including raising the awareness about their role in the local community and among professions, as part of training and ongoing professional development.

As with other allied health professions, an emerging issue from a health management perspective relates to the supervisory and ongoing professional needs of speech pathology. This can be challenging in rural and remote settings, often highlighted when relatively less-experienced speech pathologists take on more senior roles when attracting and retaining staff has been limited. There is a need for networking and leadership to be provided, often through
videoconferencing and led by centres with a critical mass for specialist resources. This does not replace the need for face-to-face interactions through conferences and opportunities for networking meetings, which are invaluable for health professionals working in more isolated settings.

The Alliance received input from the National Rural Health Students Network on the value of a rural speech pathology placement. Student placements in rural areas greatly inspire young health professionals to consider a career in rural and remote Australia. The generalist skills of the rural team were noted, including the willingness to share areas of expertise across the team. This expertise often came from professional development opportunities which were an important part of rural practice. However, opportunities for students to do speech pathology placements in rural and remote communities are currently quite limited. Short-term relocation for a placement entails a cost for the student and this needs to be considered in the future development of the speech therapy – and other allied health – workforce.

The development of speech pathology services in Australia should build in opportunities for professional development, including travel and other costs. Continuing professional development should not only be available to practitioners who can afford to pay their own way and short-handed rural services may need assistance to provide these opportunities for their staff.

Mentoring programs and cultural safety programs are essential for those who are starting work in rural and remote settings, where there are higher proportions of Aboriginal people and Torres Strait Islanders and people from other culturally and linguistically diverse backgrounds.

The Alliance is keen to emphasise the great experiences of working in rural and remote communities, which are quite different from metropolitan services. Local health professionals - including speech pathologists - value and benefit from a flexible approach and from support which is tailored to the specific needs of the community in which they are working.

**Conclusion**

Allied health has too often been 'the estranged cousin' in the rural and remote health family: relatively unseen, uncared for and poorly understood. For that reason alone the Alliance welcomes this inquiry and the opportunity to make a submission to it.

Speech pathology is not the largest of the professions under the rubric of 'allied health' but there can be no doubting its importance. Much of that importance is normally attributed to the tragedy of seeing infants and young children begin life without a diagnosis relating to their speech and other communication skills which should have been the basis for early intervention and management into a full life.

The Alliance believes there are other unmet critical needs for speech pathology, including in rehabilitation and in managing the onset of conditions normally associated with ageing.

Central to the Alliance's submission are two premises. First, we believe that a real measure of unmet need for the services of speech pathologists has to be based, first, on careful and effective explication of what speech pathology is and development of a wider understanding than currently exists of what it can do in various sectors and circumstances.
Second, from the little data and evidence available, we believe that the shortage of speech pathologists and their services is more acute in rural and remote areas than in the major cities. This of course has been and remains the rallying cry for almost all the work done by the Alliance but both the limited data available and extensive anecdotal evidence do nothing to disabuse us of that belief where speech pathology is concerned.

The Alliance recommends that an immediate outcome from this inquiry will be a push for better data and evidence relating to the services of speech pathologists. That would provide the basis for the action the Alliance believes is warranted for speech pathology and other allied health professions.
Appendix 1

Terms of Reference

a. the prevalence of different types of speech, language and communication disorders and swallowing difficulties in Australia;
b. the incidence of these disorders by demographic group (paediatric, Aboriginal and Torres Strait Islander people, people with disabilities and people from culturally and linguistically diverse communities);
c. the availability and adequacy of speech pathology services provided by the Commonwealth, state and local governments across health, aged care, education, disability and correctional services;
d. the provision and adequacy of private speech pathology services in Australia;
e. evidence of the social and economic cost of failing to treat communication and swallowing disorders; and
f. the projected demand for speech pathology services in Australia.
**Attachment**

**Member Bodies of the National Rural Health Alliance**

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<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>ACEM (RRAC)</td>
<td>Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)</td>
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<tr>
<td>ACM (RRAC)</td>
<td>Australian College of Midwives (Rural and Remote Advisory Committee)</td>
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