NATIONAL RURAL HEALTH ALLIANCE INC.

Submission to the Senate Economics References Committee into the Inquiry into Personal Choice and Community Impacts

September 2015

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.

Good health and wellbeing for rural and remote Australia

Introduction

The National Rural Health Alliance (the Alliance) is comprised of 37 national organisations. We are committed to improving the health and wellbeing of the more than 6.7 million people in rural and remote Australia. Our members include consumer groups (such as the Country Women's Association of Australia), representation from the Aboriginal and Torres Strait Islander health sector, health professional organisations (representing doctors, nurses and midwives, allied health professionals, dentists, pharmacists, optometrists, paramedics, health students, chiropractors and health service managers) and service providers (such as the Royal Flying Doctor Service).

The Alliance notes the wide range of issues that are included for consideration through this Inquiry.

The issue of personal choice can be vexed when it applies to issues that fall within or impinge upon the health sector – particularly in situations where the exercise of personal choice by one individual has consequences, which may include potentially fatal consequences, for others. Many health-related issues fall within such parameters – for example smoking, alcohol use, vaccination, drug use and even selection of the food we eat and the building products used in our homes.

Overwhelming scientific and epidemiological evidence on deleterious health impacts has seen governments legislate or regulate to protect the public from severe unintended consequences of such actions and products, but the lag time between emergence of an issue – for example, mesothelioma from the use of asbestos based fluff used in home insulation, and asthma and lung diseases from exposure to cigarette smoking – means that it is never possible to completely safeguard the population from the consequences stemming from choices others have made.

While some people may decry the loss of their personal choices in situations where the greater public health good has been seen as the most important issue, the difficult question is the extent to which governments can and should safeguard the general population from unintended and severe consequences of personal choices exercised by others.

Where the exercise of personal choice has potentially deleterious effects on others, and may result in significant calls on the health and social welfare budget, governments argue that it is important to limit those personal freedoms for the protection of others, and for the protection of scarce health resources. The Alliance argues that in such situations, where there is substantial to overwhelming scientific and epidemiologic evidence of the hazard, it is vital that governments act to safeguard public health.

To what extent some issues can be put down to choice may also be questionable. If it is cheaper to go to McDonalds and purchase food for five than it is to go to the local shop and purchase food to make a nutritious meal for five, how can we be critical of the unhealthy outcome?

At the heart of the raison d'être of this submission is the concept of addressing rural health inequalities and the most effective way in which to do so. The health of people living in rural and remote Australia is poor when compared with the health of people living in major urban centres (1)(2)(3). Addressing such significant health inequalities requires effort from multiple layers of government, local communities and the wide range of health, social, economic and educational workers who contribute to the support systems that are needed to bolster the interwoven program responses that can effect change.

The determinants of health are those underlying features of society and community that affect an individual's ability to achieve good health and wellbeing. When they are present, they empower individuals to exercise choices that hopefully result in good health and wellbeing. Their absence, however, makes the exercise of healthy personal choice difficult, possibly even impossible.

The Alliance argues that unless this Committee also examines the socio-economic and cultural context within which individuals seek to exercise personal choice, any discussion of how choice may be exercised is vapid. In a situation where an individual has poor access to housing, is locked in the poverty cycle, unemployed and with low self-esteem, they are not in a position to exercise personal choice in any meaningful way.

Throughout this submission references to remoteness areas are based on ASGC-RA, in which category 1 is Major cities, 2 is Inner regional areas, 3 Outer regional, 4 Remote and 5 Very remote. For methodological reasons (eg small numbers) Remote and Very remote are often reported jointly. In the submission, references to "regional areas" mean Inner plus Outer regional; and references to "remote areas" mean Remote plus Very remote.

The Alliance notes that the committee has listed several specific areas of interest, and will use those headings to address issues of particular concern for rural and remote health.

The sale and use of tobacco, tobacco products, nicotine products, and e-cigarettes, including any impact on the health, enjoyment and finances of users and non-users.

The link between smoking and health was clearly established in the report Smoking and Health (4), delivered to the US Surgeon General in 1964. Since then, additional research has only strengthened evidence that there is a causal link between smoking and a wide range of health conditions. In 1991, Glantz and Parmley published their findings that passive or secondary smoking was the then third greatest cause of death in the USA behind active smoking and alcohol (5).

Since the publication of these landmark studies, there has been further evidence in support of their findings, resulting in the rapid growth in preventive health strategies and a wide range of measures by governments of all levels to reduce the health sequelae of smoking in the population.

The Department of Health has recently updated its Tobacco Facts and Figures page. It begins with the stark statement that, every year, tobacco kills over 15,000 Australians and costs the economy $31.5 billion in social and economic costs (6).

A range of health promotion, regulatory and fiscal measures has reduced the overall rate of smoking in Australia. Some current programs, particularly those targeting smoking and its uptake among Aboriginal and Torres Strait Islander people, have shown early signs of success. These programs should be further supported, with successful models extended to target additional areas and population groups.

Health promotion and primary care intervention appear to be less effective in rural areas. This is particularly marked in the lag in the downturn in smoking rates in rural areas compared with major cities (unpublished NRHA/ABS data).

While smoking rates in Major Cities have fallen steadily over the past 15 years, communities in Outer Regional and Remote areas have not seen a significant decline in the number of current daily smokers. Data also show an inverse relationship between smoking rates and socio-economic status (7).

Based on ABS National Health Survey data, a significantly higher proportion of adults in rural areas are smokers: 22.4 per cent in Outer regional/Remote areas and 18.4 per cent in Inner regional areas, compared with 14.7 per cent in Major cities.

AIHW National Drug Strategy Household Survey data show that people older than 14 years living in Remote and Very remote areas are around twice as likely to be daily smokers as those in Major Cities.

Tobacco use by ASGS remoteness areas, people aged 14 years or older, 2013 (age-standardised percentage)

Behaviour	Major cities	Inner regional	Outer regional	Remote/Very remote	Australia
Daily	11.0	16.2	20.0	22.1	12.9
Weekly	1.4	1.3	1.5	1.2	1.4
Less than weekly	1.8	1.1	2.1	1.1	1.7
Ex-smoker	23.0	24.2	25.7	25.9	23.5
Never smoked	62.8	57.2	50.8	49.7	60.5

Source: National Drug Strategy Household Survey 2013

Tobacco use by Indigenous status, people aged 14 years or older, 2013 (age-standardised percentage)

Drug/behaviour	Aboriginal and/or Torres Strait Islander^	Non-Indigenous	Australia
Daily	32.2	12.5	12.9
Weekly	2.3	1.4	1.4
Less than weekly	0.7	1.7	1.7
Ex-smoker	17.4	23.7	23.5
Never smoked	47.4	60.7	60.5

Source: National Drug Strategy Household Survey 2013

That such levels of smoking persist despite the significant effort by public health workers and governments to reduce the levels of smoking is perverse. The people who can least afford the price increases put in place as part of the broad-based public health measures are those who are resisting public health measures most strongly. Personal choices are being made to reduce spending elsewhere to sustain their smoking habit, despite the health risks to the individual and those around them.

Department of Health data suggest that plain paper packaging is having an effect, with a three percent decline in expenditure over 14 months (6). This represents a greater decline in smoking rates due to two price indexations over that period of 12.5 percent each (6). This is accompanied

by a Treasury estimated drop in tobacco clearances – that is the amount of tobacco imported into Australia – of 10.8 percent (6). Data on the actual reduction in smoking and the distribution of that reduction will not be available until after the next National Drug Strategy Household Survey has reported.

It is well established that people with lower incomes and/or lower levels of completed education are more likely to smoke. In 2010, 25 per cent of people living in the lowest socioeconomic areas smoked tobacco, twice the rate of people living in the highest socioeconomic areas. This is particularly relevant to rural areas where:

- incomes are lower (~15 per cent lower than average incomes in major cities) (8), which limits people's capacity to afford basic goods and services, such as health care;
- education levels are lower; over 75 per cent of children in metropolitan areas complete year 12, compared with just under 70 per cent of children in rural and remote areas, and only 40 per cent of children in very remote areas (9); this tends to translate into lower levels of health literacy (10);
- employment opportunities are fewer and employment is a key factor that helps individuals take control over their life; and
- people are more likely to be living in poorer housing, overcrowded homes and to experience homelessness (11).

There is also evidence that women with a lower socioeconomic profile more commonly smoke before, during and after pregnancy than those who are socio-economically advantaged (7)(12).

There is insufficient understanding of the reasons why people continue to smoke in situations where they are aware of the negative impact on their own health and the health of those around them. However the long term health and welfare system costs incurred through their persistence can be calculated.

The online resource, Tobacco in Australia, includes comprehensive data on the financial costs of smoking to the health and broader economic systems in Australia. It brings together data from the AIHW and from health economists, including the cost benefit derived to the economy from the sale of tobacco items and from non-use of health and welfare due to earlier death offset against the cost of health care, taxes foregone through a shorter working life, and other health and economic system deficits. What is not included in this detailed examination is the effect on rural and remote life due to higher smoking rates.

The sale and service of alcohol, including any impact on crime and the health, enjoyment and finances of drinkers and non-drinkers

Perhaps the saddest indictment of the drinking culture that pervades rural youth culture in Australia is the quotation used by Allen et al – "You're less complete if you haven't got a can in your hand" (13). Their study reports the way in which alcohol consumption has become ubiquitous in rural Australia, with payment for goods and services often being made in alcohol, rather than in currency.

In rural areas, alcohol consumption and its associated harms are consistently higher than in urban areas. The 2013 AIHW National Drug Strategy Household Survey shows that the proportion of people older than 14 years drinking at risky levels increases with increasing remoteness, with 17 per cent, 20 per cent, 23 per cent and 36 per cent of people consuming alcohol at risky levels for

lifetime risk, and 25 per cent, 29 per cent, 34 per cent and 43 per cent at risky levels for single occasion risk[1] in, respectively, Major cities, Inner regional, Outer Regional and remote/very remote areas.

Alcohol use by ASGS remoteness areas, people aged 14 years or older, 2013 (age-standardised percentage)

Behaviour	Major cities	Inner regional	Outer regional	Remote/Very remote	Australia
Abstainers/ex-drinkers	23.3	17.9	19.6	17.5	22.0
Lifetime risk: Low risk	60.0	62.6	57.4	46.8	59.8
Lifetime risk: Risky	16.6	19.5	23.0	35.7	18.2
Single occasion: Low risk	40.1	39.7	35.9	30.8	39.4
Single occasion: At least yearly but not monthly	11.6	13.2	10.8	9.1	11.7
Single occasion: At least monthly	25.0	29.2	33.8	42.6	26.9

Source: National Drug Strategy Household Survey 2013

Alcohol use by Indigenous status, people aged 14 years or older, 2013 (age-standardised percentage)

Behaviour	Aboriginal and/or Torres Strait Islander^	Non-Indigenous	Australia
Abstainers/ex-drinkers	27.8	21.8	22.0
Lifetime risk: Low risk	48.6	60.0	59.8
Lifetime risk: Risky	23.5	18.1	18.2
Single occasion: Low risk	25.8	39.7	39.4
Single occasion: At least yearly but not monthly	11.0	11.7	11.7
Single occasion: At least monthly	35.4	26.7	26.9

Source: National Drug Strategy Household Survey 2013

In their detailed examination of alcohol and crime in rural Australia, the Australian Institute of Criminology found that young people (aged 14-24) in rural Australia were more likely to verbally abuse someone, more likely to drive and more likely to damage property while drunk (14). The same study found that two thirds of those who verbally abused someone when affected by alcohol had been verbally abused previously by others.

[1] At least monthly

The higher rate, and social acceptability, of drinking and drink driving results in higher rates of hospitalisation due to alcohol-related harm and injury – with 24.7 per cent of men living in rural Australia being hospitalised for those reasons, compared with 17.6 per cent of men in major cities (15). In 2008, 54 per cent of accidents in which alcohol was a factor occurred in rural and remote locations (15) where about one-third of the population live.

There is a diverse range of alcohol treatment services in Australia, including mainstream publicly-funded alcohol and other drug treatment services, Indigenous-specific drug and alcohol treatment services, sobering up shelters, alcohol treatment services provided in correctional institutions, and alcohol treatment services provided to inpatients of acute care or psychiatric hospitals.

The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) provides data about all mainstream publicly-funded alcohol and other drug treatment services. Of the 635 treatment agencies reporting the AODTS NMDS in 2004–05, 96 (15 per cent) were located in Outer regional or remote areas of Australia (compared with 13 per cent of the population). Of the 142,144 closed treatment episodes (completed episodes of care) provided during 2004–05, only 10 per cent were provided in Outer regional and remote locations (16).

Through the AODTS NMDS, detailed information is collected about people who receive closed treatment episodes. This information includes the clients' sex, age, Indigenous status, source of referral, whether they are attending treatment for their own or another's use, treatment type and treatment delivery setting.

The higher rates of drinking, particularly of harmful and hazardous drinking, in rural Australia suggest that there is a significant and urgent need for greater access to services and support and particularly for public health interventions that break down the ubiquitous nature of alcohol consumption.

There is evidence that provides suggestions on the way forward in addressing alcohol use, particularly amongst young people. Studies have found that young people with the highest levels of boredom in their leisure time are more likely to drink to excessive levels, and that young people who have the lowest levels of leisure-related boredom were less likely to participate in risk taking behaviour generally (17).

The sale and use of marijuana and associated products, including any impact on the health, enjoyment and finances of users and non-users

Cannabis use increases with remoteness. Compared with Major cities, cannabis use is higher in Remote/Very Remote areas: 8 per cent compared with 11 per cent respectively.[2] Its use is also higher among Aboriginal and Torres Strait Islander people (12.5 per cent) compared with other Australians (8.3 per cent).

[2] Table A8.1 NDSHS 2013

Cannabis use by ASGS remoteness areas, people aged 14 years or older, 2013 (age-standardised percentage)					
Behaviour	**Major cities**	**Inner regional**	**Outer regional**	**Remote/Very remote**	**Australia**
Never used	65.7	61.9	59.7	56.5	64.4
Ex-user	24.4	27.1	26.9	29.4	25.1
Recent user	8.0	8.6	10.4	11.0	8.4

Source: National Drug Strategy Household Survey 2013

Cannabis use by Indigenous status, people aged 14 years or older, 2013 (age-standardised percentage)			
Drug/behaviour	**Aboriginal and/or Torres Strait Islander^**	**Non-Indigenous**	**Australia**
Never used	54.4	64.5	64.4
Ex-user	28.4	25.2	25.1
Recent user	12.5	8.3	8.4

Source: National Drug Strategy Household Survey 2013

Cannabis use in rural communities produces a number of detrimental effects. These include harms to the individual, such as adverse physical and psychological effects, and harms to the community, including major financial losses (with money being used for cannabis and exiting the community).

A study of long term rural users of cannabis has found that 60 per cent use cannabis daily, with 94 per cent using it at least twice weekly (18). Over one third also combined regular cannabis use with consumption of alcohol at hazardous levels (18).

Scott et al, writing in *Crime in Rural Australia*, suggest that there is considerable scope to improve understanding of the nature of crime in rural settings in Australia (19). The literature relating to the sequelae of illicit drug use in rural settings in Australia is not extensive, but does include studies that report significant issues. Lee et al report levels of use of cannabis by over 90 per cent of residents in a number of isolated Indigenous communities (20) and that this level of use is associated with substantial health and social burdens in those communities. Use at this level goes beyond any suggestion that use is associated with enjoyment. Indeed, Lee suggests that use at the level described has resulted in the breakdown of community and family life.

Lee mentions reports that violence can occur when cannabis supply runs out in these communities and users become violent as a result of severe withdrawal (20). Violence can also occur where users attempt to obtain money from their family and friends for more cannabis. Cannabis use is considered to contribute to poverty, with money often being spent on cannabis rather than food or necessities for families.

National policy initiatives, such as the National Drug Strategy, provide context for addressing cannabis use, however it must also be recognised that each rural community has individual

concerns and local conditions that need to be assessed before specific interventions are implemented.

Bicycle helmet laws, including any impact on the health, enjoyment and finances of cyclists and non-cyclists

There is a body of evidence from Australia and overseas demonstrating that the implementation of mandatory bicycle helmets has resulted in a significant decrease in fatal head injuries (21).

Designated cycling paths and other bicycle-friendly road modifications (such as cycling lanes) are fewer in rural areas, meaning that cyclists are forced to compete with road traffic and challenging conditions.

Conversely, emerging evidence indicates that the mandatory use of helmets may have resulted in a reduction in the number of adults using cycling for physical activity (22). Barriers to the take up of physical activity are of significant health concern and no doubt this will be an issue being closely monitored by health professionals.

The Alliance has not been able to identify any specific studies that relate to bicycle use by remoteness, and so will not comment further on this issue.

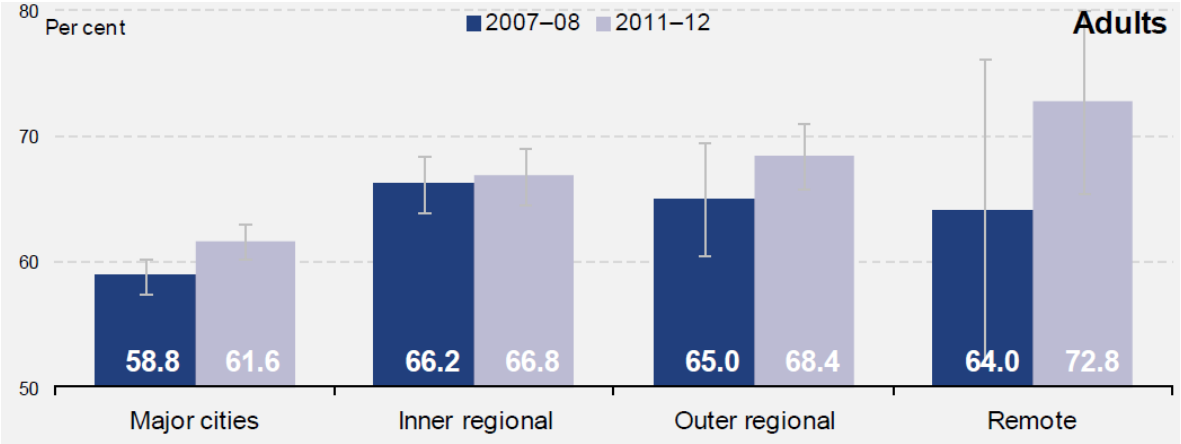
Other issues for consideration by the Committee

Obesity and personal choices

The Committee should be mindful of the increasing rate of adult overweight/obesity with remoteness. The Alliance believes that policies which remove barriers to physical activity are particularly important in rural areas.

In 2010-11 the rate of adult overweight and/or obesity increased with remoteness. The rate of overweight or obese adults was 61.6 per cent in major cities and increased to 66.8 per cent for inner regional areas, 68.4 per cent for outer regional areas and 72.8 per cent for remote areas (23).

Proportion of overweight or obese adults by remoteness, 2007-08 and 2011-12



Source: COAG Reform Council - Healthcare 2011–12: Comparing Outcomes by Remoteness

AIHW figures indicate that, compared with people in Major cities, and perhaps counter-intuitively, those living in regional and remote areas were 1.08 times more likely to be sedentary and 1.38 times as likely to be classified as inactive[3].

The Alliance raises the issue of obesity with the Committee because at one level it is possible to treat this issue as purely one of individuals exercising a personal choice to eat too much and not exercise enough. But the issue is not that simplistic.

Obesity rates in rural and remote Australia are leading to the higher prevalence of chronic diseases: diabetes, some cancers, cardiovascular disease, arthritis, and chronic kidney disease. People in rural and remote Australia also have poorer access to the primary care services through which these chronic diseases can be addressed.

The growing burden of chronic diseases in Australia, and particularly in rural and remote Australia, is of major concern to all governments and will be one of the leading drivers of health costs.

As obesity is a major contributor to the development of chronic disease, addressing obesity and promoting healthy lifestyle choice is a crucial element of any program to address this growing health risk. The aim is not to limit personal choice, but rather to ensure people are aware of the full range of choices and are able to exercise those choices.

But to make the choice to address obesity at the community and personal level requires:

- an understanding of what a healthy diet is;
- access to the components that make up a healthy diet;
- the ability to purchase the components of a healthy diet; and
- the willingness to make use of all three factors above.

A growing issue for many rural and remote communities is access to affordable, fresh, nutritious food. When the only lettuce in the local store costs over $9 and is fading fast, it is neither an attractive food choice nor an affordable one. When Coca-Cola Amatil and other suppliers are able to provide remote stores with manufactured food and drink at prices similar to major centres, but healthy food is double or triple the cost of major centres, if it is available at all, what choice can be exercised?

Road safety and personal choices

Every day, people throughout Australia exercise personal choice by driving a motor vehicle. The Alliance has recently undertaken work on road safety in rural areas. Our work suggests that those areas constitute a more dangerous transport environment.

- In Australia, the rate of serious road-related injury among those living outside major cities is nearly twice that of those living within them (24).
- Country people are also more than three times more likely to die as a result of a transport accident than their city counterparts (3).
- The death rate for transport-related accidents for young men aged 20-24 years living in the country is nearly four times higher than it is for those in the city (3).

[3] 2011-12 ABS Australian Health Survey updated results and physical activity results http://www.abs.gov.au/australianhealthsurvey

- Indigenous Australians, of whom around 70 per cent live outside the major cities, are nearly three times more likely to die as a result of a road accident than non-Indigenous Australians and 1.4 times more likely to be seriously injured (25).

The Alliance attributes these figures to a number of factors, including the following.

- Substantial differences in rates of risk-taking behaviour between city and country drivers, which might suggest lesser likelihood of adherence to bicycle helmet laws. In one study, researchers found that the ratio of fatal crashes in rural areas compared with urban areas in Queensland was:
    - 12.1 times higher for fatigue-related crashes;
    - 5.2 times higher for crashes where the victim was not wearing a seatbelt;
    - 4.7 times higher for speed-related crashes; and
    - 4.3 times higher for alcohol-related crashes (26).

- Less police presence because it is often unjustifiably costly and impractical on low traffic volume roads. There is therefore less likelihood of prosecution and less deterrent for people to partake in risk-taking behaviour. Bicycle helmet laws and introducing or toughening penalties for non-adherence have far less impact on country roads. There is a need to expand police presence in rural areas through State-funded provision of relocation benefits and retention incentives. The Police Federation of Australia has outlined a number of strategies to attract and retain police officers to rural areas in its Submission to the Productivity Commission's Geographic Labour Mobility Issues Paper.
- Road conditions are particularly varied in country areas. Compared with urban areas, there are more dirt roads, more hazardous roadsides, and generally more challenging road geometry. There is a greater likelihood of colliding with livestock and wildlife, and more heavy agriculture and mining vehicles on the road.

Designated cycling paths and other bicycle-friendly road modifications (such as cycling lanes) are presumably fewer in rural areas, meaning that cyclists are forced to compete with road traffic and challenging conditions.

In conclusion

At the heart of the questions to be considered by this Committee is the extent to which governments can and should be involved in the way in which individuals exercise personal choice.

The Alliance argues that this question is overly simplistic.

If it is the role of government in a democratic society to fulfil a social contract that government will support equality, freedom and the protection of human rights (27), addressing inequalities is an appropriate role of government. The issues raised in the Terms of Reference of the Committee are those in which significant health inequalities arise through the exercise of personal choices. And these significant health inequalities can have significant effects on those who have had no choice in the environment in which they are located.

If government is to fulfil its social contract to all, it must protect those who are being damaged by the exercise of personal choice by others, where there is appropriate evidence to document the harm and describe appropriate measures to address it.

Recommendations

The Alliance recommends that the Committee:

- Agrees that public health legislation to reduce the harm to others, based on solid evidence, has contributed to the general safety of life in Australia.
- Agrees that community discussion of the need to protect the public while maintaining appropriate levels of self determination is vital in the role of public health decision making and should continue to be actively discussed as further public health measures are contemplated.
- Supports the need for the examination of the reasons behind the relative ineffectiveness of anti-smoking health promotion and primary care intervention in rural areas in comparison with metropolitan centres.
- Acknowledges the differences in smoking, risky alcohol consumption and marijuana use rates across specific population groups and geographic locations; that changes in the regime of sale and service of these products will impact more heavily on some than others; and supports the role of government in addressing those impacts.
- Recognise that any strengthening of laws around the behaviours covered in this submission will only be effective if there is adequate enforcement and appropriate education and programmatic responses, including prioritised access to preventive health and treatment programs in areas of identified need.
- Support the growth of local community-based measures to address problem drinking and drug use – including improved access to appropriate treatment and intervention options in rural and remote communities, community-based arts/health programs and development of alcohol-free sport and leisure options for young people.

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ATTACHMENT

Member Bodies of the National Rural Health Alliance

ACEM (RRRC)	Australasian College of Emergency Medicine (Rural, Regional and Remote Committee)
ACHSM	Australasian College of Health Service Management
ACM (RRAC)	Australian College of Midwives (Rural and Remote Advisory Committee)
ACN (RNMCI)	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural members)
APA (RMN)	Australian Physiotherapy Association Rural Member Network
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CRANAplus	CRANAplus – the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (RRIG)	Exercise and Sports Science Australia (Rural and Remote Interest Group)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	National Rural Faculty of the Royal Australian College of General Practitioners
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
RDAA	Rural Doctors Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Royal Flying Doctor Service
RHWA	Rural Health Workforce Australia
RIHG of CAA	Rural Indigenous and Health-interest Group of the Chiropractors' Association of Australia
ROG of OA	Rural Optometry Group of Optometry Australia
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health
SPA (RRMC)	Speech Pathology Australia (Rural and Remote Member Community)