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Submission to the Senate Community Affairs Committee

Inquiry into Palliative Care in Australia

June 2012

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.

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The National Rural Health Alliance is comprised of 33 Member Bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health (see Attachment). The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia, with the particular goal of equal health for all Australians by 2020.

Palliative care is an approach which improves the quality of life of patients and their families facing life-threatening illness, through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems.[1] It is often associated with older people with terminal age-related conditions, but it can be applicable for people at any age, including young adults, teenagers and children who may also need palliative care for cancer and neurodegenerative conditions.

This submission addresses the terms of reference for the Senate Inquiry into Palliative Care in Australia, with a particular focus on rural and remote communities.

Approximately seven million people (nearly one third of Australia's population) live outside Major Cities. Mortality rates increase with remoteness, ranging from 1.1 times as high as Major Cities in Inner and Outer Regional areas to 1.8 times as high in Very Remote areas.[2] The higher proportions of Aboriginal and Torres Strait Islander people who live in more remote areas tend to have higher death rates and contribute to, but do not account for, these differences. Supporting quality of life for people near the end of their life ought to be a significant part of health service provision in rural and remote communities, as elsewhere.

General palliative care for the patient with low to moderate complexity of palliative care need, provided as part of routine clinical practice by their usual professional carers, should be available in rural and remote communities. The following principles underpin such care:

- it has a focus on quality of life, which includes good symptom control;
- there is a 'whole person' approach, taking into account the person's past life experience and current situation;
- it will be directed at both the person with life-threatening illness and those who matter to them;
- it will show respect for patient autonomy and choice (e.g. over place of care, treatment options); and
- it will have an emphasis on open and sensitive communication, which extends to patients, informal carers and professional colleagues.[3]

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[1] World Health Organisation definition of palliative care. Downloaded June 2012. http://www.who.int/hiv/topics/palliative/PalliativeCare/en/print html

[2] Australian Institute of Health and Welfare, 2010. Australia's Health 2010. AIHW, Canberra.

[3] after Watson M, Lucas C, Hoy A, Wells J, 2010. Oxford Handbook of Palliative Care. 2nd edition. Oxford University Press, 2010. http://ohpallve.oxfordmedicine.com/

a) Access to and choice of appropriate palliative care in rural and remote communities

Rural people generally have less access to health services and health professionals at all stages of their lives. In addition, they are likely to be more socially disadvantaged, as reflected by the greater proportion of concession card holders in regional areas (45 per cent compared with 30 per cent in Major Cities). [4] Although specific data are in short supply and the evidence is not clear, the available information suggests that rural access to palliative care is no exception.

Rural people less likely to access in-hospital palliative care

An AIHW analysis of admitted hospital patient data in 2011 found that a substantially higher proportion of cancer patients who lived in a *Major City* (73 per cent) were palliative care patients during the hospitalisation that ended with their death, compared with only 52 per cent of those whose usual residence was a *Remote* or *Very Remote* area.[5] A straightforward estimate of the annual palliative care separations by remoteness[3] as a proportion of average annual deaths by remoteness[6] yields a much lower figure for people whose usual address is outside the Major Cities (34 compared with 44 palliative care separations per 100 deaths respectively).[7]

Rural people's access to community palliative care is not known

The data on hospital separations discussed above may reflect an element of choice by country people about where they want to spend the final stage of their life. Tertiary hospitals or specialised hospices are most likely to be located in the city. Country patients may choose to spend the final stage of their life in their own community, perhaps at home with their loved ones around them or in a small rural hospital or Multi-Purpose Service, or in an aged care facility. It is also possible that what eventuates may not be the result of choice, but rather due to a lack of options. It is not possible to establish from the AIHW's 2011 report whether these situations result from people's expressed preferences or not.

The relative balance between the provision of palliative care services in the admitted patient setting and other settings is unknown and is likely to vary across jurisdictions. A comprehensive national data collection on community based palliative care services does not currently exist. Data relating to palliative care services for children and young people are likely to be even more deficient than the data for adults.

Health care pathways leading to palliative care for rural people are not clear

The different pathways that city and country people follow between primary and hospital care across local, regional and urban services may affect the critical access points for information about choices and access to palliative care. For example, cancer survival rates remain much higher for people in Major Cities and Inner Regional areas than for those in Outer Regional areas. The five year survival rates for people with cancer in Remote and Very Remote areas

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[4] National Rural Health Alliance, 2011. Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas. http://nrha ruralhealth.org.au/cms/uploads/publications/nrha-final-full-complementary-report.pdf

[5] Australian Institute of Health and Welfare, 2011. Trends in palliative care in Australian hospitals. AIHW, Canberra.

[6] Australian Institute of Health and Welfare 2007. Rural, regional and remote health: a study on mortality (2nd edition). Rural health series no. 8. Cat. no. PHE 95. Canberra: AIHW. (Estimate is calculated using average annual deaths 2002-04, see Table 3.1, p 23) http://aihw.gov.au/publication-detail/?id=6442468054

[7] The AIHW, 2011 report on Trends in palliative care in Australian hospitals analysed palliative care separations as a proportion of overall hospital separations. This data is difficult to interpret, given rate of hospital separations increases with remoteness and lack of access to primary care.

combined were lower than for all other areas.[8] These differences reflect on access to primary care and preventive health as well as hospital care, and are due at least in part to later stage at diagnosis and poorer access to treatment services.

b) The funding arrangements for palliative care provision, including the manner in which sub-acute funding is provided and spent

Hospitals are an essential part of the fabric of many small rural towns, providing a centre for the delivery of primary, community care and basic hospital care and hosting various outreach services (including specialist medical, nursing and allied health services). Many also provide a mix of community and residential aged care services. Yet the role of rural hospitals in providing palliative care as close to home as possible for people in rural and remote communities does not appear to be adequately recognised in the current funding of sub-acute care.

Sub-acute care includes hospitalisations for rehabilitation, palliative care, geriatric evaluation and management and psychogeriatric care. Rehabilitation and sub-acute services are important in assisting older people to maintain functional ability as they age – and assisting people with terminal illnesses to maintain quality of life as the end of life approaches. Health professionals who provide support for rehabilitation (eg physiotherapy and occupational therapy) are often simply unavailable outside metropolitan or large regional locations. The COAG Reform Council found that the rate of separations for older Australians receiving sub-acute care increased in 2008-09, but the rate at which services are used in Major Cities has increased more than in other areas, suggesting that current investment may be increasing inequality in access to sub-acute services outside major cities.[9]

The Independent Hospital Pricing Authority (IHPA), established to improve transparency around hospital funding arrangements, should recognise the specific and irreplaceable functions small hospitals and similar facilities such as Multi-Purpose Services provide in rural and remote areas. Small rural hospitals need to be funded for 'capacity', not just throughput; and the true costs associated with providing health and aged care outside the major cities, including palliative care, need to be recognised. Effective Multi-Purpose Service models allow for pooling of funds for health, aged care and community care in consultation with the community to maintain viability of a range of local services. In general, the smaller the community, the more the boundaries between hospital care and aged care are blurred. This is particularly relevant to palliative care in rural and remote communities.

Some of the elements raised in the Alliance submission to the IHPA consultations are directly relevant to palliative care, including:

- the essential need for block funding (cf ABF) in order to maintain the capacity of the hospital to deliver the services necessary during times of high demand by supporting the core functions of the hospital, through staffing, operating and facility costs;
- core funding must cover emergency services and the capacity to provide essential care such as maternity and mental health services and a palliative approach to end of life care;

[8] COAG Reform Council, 2012. Healthcare 2010-11: comparing outcomes by remoteness. Supplement to the Report to the Council of Australian Governments. www.coagreformcouncil.gov.au/reports/index.cfm
[9] COAG Reform Council, 2012. Healthcare 2010-11: comparing outcomes by remoteness. Supplement to the Report to the Council of Australian Governments. www.coagreformcouncil.gov.au/reports/index.cfm

- a remoteness loading that recognises the scope of practice of hospitals in rural and remote areas and the important roles they play in small rural towns, and also the need to fund visiting professionals and carers;
- funding for small rural hospitals providing basic levels of care must cover the costs of securing and hosting outreach services from other hospitals, Medical Specialist Outreach Assistance Program (MSOAP) and similar allied health programs, as well as private practitioners; so that a more comprehensive range of services, including a palliative approach through primary care, is available in small communities. Professions in high demand include geriatric specialists, physiotherapists, occupational therapists and those dealing with pain management and mental health;
- funding must be adequate to provide clinical facilities, access to IT and telecommunications, and temporary accommodation for visiting service providers;
- funding must also meet the additional costs of ambulance services and transporting patients to and from larger, distant hospitals when an individual's needs cannot be met locally. These small hospitals also have to undertake additional long distance liaison and coordination to achieve continuity of care for the patient, which must also be funded;
- over time, small rural hospitals and Multi-Purpose Services must continue to be block funded, with growth funding built into the pricing framework to address inequities, including poor access to sub-acute services and expected increases in demand, as well as flexibility to respond to changes in population health needs.

The aged care reform process must also be considered. Aged care data show a higher proportion of people in rural and remote areas use community-based rather than residential aged care. However, the overall rate of use of aged care places (community-based and residential places combined) is much lower outside the Major Cities.[10] Thus, the welcome resourcing for palliative care through residential aged care facilities or community aged care services will not necessarily reach rural people.

c) The efficient use of palliative, health and aged care resources

Primary and aged care services with the capacity to provide some general palliative care as part of their usual practice are critical for rural people, to provide them with the choice of spending the end of their life in their local communities. Specialised palliative care services are less likely to be available locally.

Health services and health professionals in rural and remote areas provide many examples of good multidisciplinary care across health and aged care. These provide a strong platform for local primary care settings to adopt a palliative approach to end of life care, with support from specialised palliative care services when more complex needs arise.

The commonest and best service models in rural areas include:

- Multi-Purpose Services that combine primary, aged and acute care;
- GPs with multiple roles in aged and acute care in local hospitals as well as in primary care;
- rural hospitals with elements of community care, aged care, health promotion such as immunisations and diabetes education, primary care and various allied health services; and
- a mix of health and community professionals available locally who may foster and support the development and sustainability of innovative services (eg outreach services such as the

[10] COAG Reform Council, 2012. Healthcare 2010-11: comparing outcomes by remoteness. Supplement to the Report to the Council of Australian Governments. www.coagreformcouncil.gov.au/reports/index.cfm

Royal Flying Doctor Service, Medical Specialist Outreach Assistance Program, telehealth support for local health professionals and patients; and many others).[11]

However the planning and support framework necessary to underpin a palliative approach through primary care in rural and remote communities is different from the cities and is considered below.

The establishment of Medicare Locals and Local Hospital Networks provides important opportunities for ensuring that the health needs of the local population are planned for and met. This should include local choices for palliative care for people who live in rural and remote communities, and advice, support and tertiary referral options for more complex situations should they arise.

The contribution of rural communities themselves to fundraising and building local hospitals and aged care facilities, and through the work of local volunteers, hospital auxiliaries and health initiatives of local service clubs, should also be considered when decisions are made about reconfiguring local services. Such community good will and passion extend to palliative care services as well, with associated concerns about how best to honour these local efforts and ensure that investments in small facilities or equipment for palliative care can contribute to sustainable services over time.

d) The effectiveness of a range of palliative care arrangements including hospital care, residential or community care and aged care facilities

It is likely that a needs-based primary care approach will provide the most effective range of choices for first line care in many rural and remote communities, across the range of different service models discussed above. The effectiveness of palliative care arrangements will depend less on the model of care and more on the support available to the local primary care professionals.

For example, Cumming reported on a mail survey and follow up interviews with Community Primary Health Care nurses in rural and remote settings who are required to provide palliative care as part of their generalist role.[12] She found that they have limited access to specialist medical and nursing support and sometimes there are no resident GPs. Most were registered nurses experienced in nursing in rural and remote communities who juggled multiple generalist roles. They had occasional palliative care patients and more than half had provided palliative care for a close friend or family member. Some nurses found palliative care rewarding, but even those who preferred not to do it would go beyond the call of duty to support a patient at home if that was what the patient wanted. Three quarters had attended palliative care education in the last two years, but 88 per cent wanted more education. Barriers to education included competing work roles, workload, geographic isolation and lack of back fill. They

[11] For example, see National Rural Health Alliance, 2011. Use of 'fly-in, fly-out' (FIFO) workforce practices in regional Australia Submission to the Standing Committee on Regional Australia.
http://nrha ruralhealth.org.au/cms/uploads/publications/fifo_submission_final_11_october_2011.pdf
NRHA, 2012 Opening statement to a public hearing of the Standing Committee on Regional Australia on the use of 'fly-in, fly-out' workforce practices in rural and remote Australia. 15 February 2012.
http://nrha ruralhealth.org.au/cms/uploads/publications/fifo_opening_statement_feb_2012_final.pdf

[12] Cumming M, Boreland F, Perkins D. Do rural Primary Health Care nurses feel equipped for palliative care? Australian Journal of Primary Health (accepted for publication)
http://www.publish.csiro.au/view/journals/dsp_journals_pip_abstract_Scholar1.cfm?nid=261&pip=PY11150

considered support from managers and peers to be important, as well as access to timely and relevant clinical support.

Other improvements will come from greater support for Patients' Assisted Travel Schemes and further developments in telehealth services. For palliative care there is a particular need for Patients' Assisted Travel Schemes to provide for patients as well as their families and carers who need to travel to be involved in care decisions and support. Telehealth will link people in more remote areas with specialist palliative care services and advice at a distance, and may help keep family members in touch. However, a video consultation with a palliative care specialist at a distance through telehealth must not be seen as a replacement for the many circumstances in which patients and their families in rural and remote communities may prefer a face-to-face consultation with a local physician or other health professional.

In rural and remote communities, especially for complex cases, ready and timely access to specialised advice for health professionals as well as for patients and their families is critical if the palliative care approach is to be effective. Finding patient pathways from the local base hospital to the tertiary referral hospital can be difficult and much could be done to clarify and improve the care pathways offered in a Local Hospital Network or Medicare Local.

e) The composition of the palliative care workforce, including its ability to meet the needs of the ageing population, and the adequacy of workforce education and training arrangements

A substantial proportion of palliative care provided in Australia occurs within the admitted patient setting; 49 per cent of all palliative care separations across Australia (with some variations between jurisdictions) are from principal referral hospitals that are almost exclusively located in capital cities, compared with 63.9 per cent of all hospital separations. [13]

The picture is quite different for palliative care provided in rural and remote settings, where primary care professionals provide a palliative approach as part of their general work. The composition of this rural palliative care workforce includes remote area nurses, Aboriginal health workers, primary care nurses and allied health professionals who may be working without immediate medical support on hand. Even pharmacy advice can be limited in more remote areas and dental health workers are in short supply. Paramedics, ambulance services and the Royal Flying Doctor Service play vital roles in primary care service delivery and they interface with both acute and aged care as remoteness increases. All of the health professionals, including doctors, are likely to be juggling a range of different responsibilities as part of the more generalist roles that characterise rural and remote practice. Their time may already be stretched given the workforce shortages in rural and remote communities summarised in Table 1 below.[14]

[13] Palliative Care Outcomes Collaboration (PCOC) 2010. PCOC national report on palliative care in Australia: January to June 2010. Wollongong: University of Wollongong

[14] Improved and updated health workforce data is expected to be available with the establishment of the Australian Health Professional Registration Authority and Health Workforce Australia

Table 1: Persons employed in health occupations, per 100,000 population, by Remoteness Areas, 2006

Occupation	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Medical practitioners	324	184	148	136	70	275
Medical imaging workers	58	40	28	15	5	51
Dental workers	159	119	100	60	21	143
Nursing workers	1,058	1,177	1,016	857	665	1,073
Registered nurses	978	1,056	886	748	589	979
Enrolled nurses	80	121	129	109	76	94
Pharmacists	84	57	49	33	15	74
Allied health workers	354	256	201	161	64	315
Complementary therapists	82	82	62	40	11	79
Aboriginal and Torres Strait Islander health workers	1	4	10	50	190	5
Other health workers	624	584	524	447	320	602
Other health services managers	32	33	28	28	18	31
Total health workers	2,777	2,536	2,166	1,827	1,379	2,649

Source: ABS, Census of Population and Housing, 2006.

The Alliance has recently released a 20-Point Plan to reduce the poorer health status experienced by people in rural and remote areas.[15] This Plan is relevant to strengthening the generalist primary care workforce in rural and remote communities to better provide a palliative approach to end of life care.

The twenty elements of the Plan cover the lifetime path of an individual who might train, work, mentor and then transition to retirement – all within the rural and remote health sector. The proposal begins its chronological path with action to attract more students from rural and remote areas into health science courses, and ends with initiatives to make better use of mature aged and retired rural practitioners who are willing to provide support and mentoring on a part-time basis to students and junior health professionals on placement or training in rural areas. Intermediary elements include active recruitment of more Aboriginal and Torres Strait Islander people to health professions; positive representation of rural practice by teachers at university; and a campaign to ensure students and new health practitioners are aware of the professional and family benefits of rural practice and the financial support that is available to assist them in making their professional contribution in rural areas.

[15] National Rural Health Alliance, 2012. Twenty steps to equal health by 2020. The NRHA's 20-Point Plan for improving health services and health workforce in rural and remote areas http://nrha ruralhealth.org.au/cms/uploads/publications/twenty_steps_to_equal_health_for_website_11may2012.pdf

For health professionals who are working in rural and remote areas, a palliative approach to end of life care should be a part of basic training and continuing professional development. Additional training and support may well be needed in the event that a health professional is required to provide ongoing clinical and emotional support to people well known to them in their communities. These people are likely to roll up their sleeves and do what needs to be done; but palliative care is time consuming and may be draining, and they are likely to be already working across a wide scope of practice. In these situations, there may not be back-up available to allow the professional to take leave for education purposes, or to cover the additional workload involved in providing palliative care when it is needed, or even to take some time off after a patient has died.

In response to shortages of registered nurses in Australia, overseas trained nurses are granted visas and encouraged to come and work in unfamiliar work conditions in rural locations and aged care. A pilot palliative care orientation and training program for overseas trained registered nurses is being undertaken in the Wimmera region of Victoria to upskill these nurses in cultural issues, palliative care and pain management in the Australian context. No palliative care education has previously been conducted as part of overseas trained nurses' orientation to Australia.[16]

Families and carers will often rely on their local health professionals for information and understanding about their loved one's condition and the likely support needs as death approaches. Cultural awareness with respect to dying and end of life needs and care can also be of great significance, given the mix of cultural backgrounds and the higher proportion of Aboriginal and Torres Strait Islander people in rural and remote communities.

f) The adequacy of standards that apply to the provision of palliative care and the application of the Standards for Providing Quality Palliative Care for all Australians

The Alliance supports Palliative Care Australia's formal position:

> "Standards should underpin the provision of palliative care in Australia. It is important that they are relevant, reflecting the day to day practice of the way palliative care is provided to patients, their families and carers, and relevant to the whole Australian population. There is a need to ensure that the Standards can be implemented across all levels of service provision in Australia, not just limited to specialist palliative care."[17]

The greatest risk to safety and quality of health care for many rural and remote residents across the stages of their lives is the risk of not receiving necessary health care at all – and this applies to palliative care as well. There are risks associated with travelling large distances over poor roads or in difficult conditions to receive care; or travelling when injured or in ill-health; receiving care a long way from home without the support of family and friends; or not travelling and therefore not receiving care because of frailty, age, or the inability to meet travel and accommodation costs.

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[16] Wimmera Health Care Group, 2012. Palliative Care in Australia: an orientation manual and self-directed learning package for overseas trained nurses working in the Wimmera region of Western Victoria, Wimmera Hospice Care. The pilot was funded by the Rural Health Continuing Education Stream 2 program in 2011-12; the manual will be published online later in 2012.

[17] Palliative Care Australia, 2012. Submission to the Australian Senate Standing committee on Community Affairs Inquiry into Palliative Care in Australia. Submission 45. http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=clac_ctte/palliative_care/submissions.htm

Standards for palliative care must be designed and implemented in ways that address these challenges and ensure that rural and remote health services are supported and empowered to provide a palliative approach to end of life care as close to home as possible, no matter where people live.

g) Advance care planning, including: avenues for individuals and carers to communicate with health care professionals about end-of-life care, national consistency in law and policy supporting advance care plans, and scope for including advance care plans in personal electronic health records

The Alliance is supportive of quality end of life care that addresses a patient's needs and acknowledges their care preferences.

Giving patients the opportunity to consider and identify care preferences through advance care planning is one mechanism for informing and supporting choices about achieving quality end of life care. For people who live in rural and remote communities, these conversations may need to occur at various stages along the care pathway and in various locations. It will be important for people to know what can and cannot be achieved locally and what supports are available to them in different settings. The inclusion of information about advance care plans in the eHealth record should provide a useful reminder for people navigating complex care pathways between the city and the country that the conversation needs to be had, as well as informing the health care professionals with whom they share their eHealth record.

It will also be particularly important to make sure that carers and family members and local health professionals are included appropriately in information sessions and discussions with rural patients, especially in conversations when the patient is far from home.

h) The availability and funding of research, information and data about palliative care needs in Australia

As discussed above, there are insufficient data about access to palliative care for people in rural and remote communities and the care pathways they follow. There are also insufficient data about the available and future health workforce in rural and remote communities. A recent Health Workforce Australia report[18] focused on the medical and nursing health workforce, but further data are needed for allied health and other professions.

Additional resources should be made available to the AIHW for specialised analysis by remoteness of health workforce data and care pathways that are relevant to people in rural and remote communities, including for palliative care. Such data will become even more important for population needs-based planning as Medicare Locals unfold and for performance monitoring and Healthy Communities reports through the National Health Performance Authority.

The Alliance would like to acknowledge the international contribution made by rural and remote health researchers in Australia to improving models of palliative care for people who live in rural and remote communities.[19] Ongoing work in the important field of rural and

[18] Health Workforce Australia, 2012. Health Workforce 2025. http://www.hwa.gov.au/health-workforce-2025
[19] Evans R, Stone D, Elwyn G. Organising palliative care for rural populations: a systematic review of the evidence. Family Practice 2003;20:304-310

remote health continues to be reported at the biennial National Rural Health Conferences,[20] as well as through the scientific literature.

The Alliance has recommended to the Strategic Review of Health and Medical Research (the McKeon review) that at least some test or lead implementation sites for major Commonwealth investments in health such as broadband applications, eHealth records, quality improvement collectives and the like should occur in challenging rural and remote situations.[21] This recommendation is particularly relevant to palliative care, where telehealth and eHealth are already seen as playing a significant role. Together, the settings should include a combination of challenges such as high turnover of health professionals; fluctuating populations due to work practices, seasonal industries, tourism; high proportions of Aboriginal and Torres Strait Islander people; and areas affected by disasters; and areas where there are not likely to be early adopters to win competitive funding rounds.

Rural and remote health researchers, with their experience in working with local health services, need to be involved in local planning and evaluation to ensure robust and credible methodology and reporting. Designing eHealth implementation programs and solutions that complement usual work practices in rural and remote settings will be fundamental to success. In this way, health services in areas of high need but with limited resources can effectively contribute good quality health data and improvements to end of life care.

Conclusion - a national rural health plan to include palliative care

Health Ministers from all jurisdictions recently joined together to launch the National Strategic Framework for Rural and Remote Health.[22] The Alliance unequivocally welcomed this new National Strategic Framework in the hope and expectation that it will lead to stronger and more coherent national action to improve health and wellbeing in rural and remote areas.

The major strengths of the new Framework are that it provides a succinct account of current health issues in rural and remote Australia and challenges the perception that success in the health care system nationally can be assessed solely on the quality and outcomes of services in urban areas. It also accepts the need for flexibility and for a focus on local ways of addressing local problems. The Framework emphasises consumer and community input and invites advocacy bodies, health service providers and communities to use it to identify and develop ways of addressing issues.

The major uncertainty associated with the Framework is that its effectiveness depends very much on how it is used by eight Governments operating in very different political, fiscal and geographic environments. The Alliance believes that significant progress for rural and remote health outcomes can be achieved through development and agreement of a national plan of action. Such a Rural Health Plan, complementary to the Strategic Framework for Rural and Remote Health, will help to focus progress towards greater equity in health outcomes and in the quality of health care, including palliative care, for people in major city and rural/remote areas.

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[20] For example, the concurrent session on Palliative Care at the 11th National Rural Health Conference, Perth, 2011. http://11nrhc.ruralhealth.org.au/

[21] National Rural Health Alliance, 2012. Submission to the Strategic Review of Health and Medical Research. http://nrha ruralhealth.org.au/cms/uploads/publications/nrha%20health%20and%20medical%20research%20review%20%28final%29%20april%202012.pdf

[22] Australian Health Ministers Council, Standing Council on Health. 2012. National Strategic Framework for Rural and Remote Health. Commonwealth of Australia, Canberra. http://www.ruralhealthaustralia.gov.au/

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
SARRAH	Services for Australian Rural and Remote Allied Health