Australian College of Rural & Remote Medicine
WORLD LEADERS IN RURAL PRACTICE

COLLEGE SUBMISSION

National Medicines Policy

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College Details

Organisation	Australian College of Rural and Remote Medicine (ACRRM)
Name	Marita Cowie AM
Position	Chief Executive Officer
Location	Level 1, 324 Queen St, PO Box 2507 Brisbane Qld 4001
Email	m.cowie@acrrm.org.au
Phone	07 3105 8200

Initial Comments

ACCRM welcomes the opportunity to comment on the draft of Australia's revised National Medicines Policy (NMP). Equitable, safe, timely and affordable access to medicines can lead to improved health outcomes, and the College is pleased to note that the Policy specifically notes that ***all*** communities in Australia, no matter their location, should have timely access to safe and affordable medicines and related services required to meet their health and/or wellbeing.

However, the current reality is that many of our rural and remote and Aboriginal and Torres Strait Islander communities are grossly underserved by the healthcare system, and this underservice occurs in tandem with this sector of the population recording greater disadvantage by health, mortality, and morbidity measures as well as by most measures of social determinants of health. This equity gap is spiralling as rural health workforce shortages are exacerbated by diminishing funding for rurally based practice and services.

Urgent action is required in relation to several the listed key enablers, particularly health workforce, leadership and culture, data and information and technology if the NMP is to succeed in meeting its aims across rural and remote Australia.

We have only responded to the survey questions pertinent to the work of the College.

Response to Survey Questions

Aim, Scope, principles, and enablers

Question 10 : The Policy's aim is to create the environment in which appropriate structures, processes and accountabilities enable medicines and medicines-related services to be accessible in an equitable, safe, timely and affordable way and to be used optimally according to the principles of person-centred care and the quality use of medicines so that improved health, social and economic outcomes are secured for individuals and the broader community. Please indicate your level of agreement with the Policy's aim.

The aim of the Policy is ambitious, and whilst the statement "the location of care delivery should not affect access to medicines" is welcomed, it is unclear how the Policy will lead to this being implemented across rural and remote communities. The Policy appears to assume that all communities across Australia have access to full range of healthcare services which is not the case for people living in rural and remote areas of Australia.

ACRRM agrees that all communities in Australia should have timely access to safe and affordable medicines and related services required to maintain their health and wellbeing, however, the reality for many of our most remote and vulnerable communities is that they are grossly underserved

Whilst the Policy's aim is commendable, it is unclear how it can or will succeed in its objectives without substantive change across the wider health system, particularly in relation to the health workforce. It would be of benefit both to this Policy and other health system reform proposals to note this need for change and coordination between a range of policy areas.

Question 12: The Policy includes key principles that should be evident in planning, design and implementation of all policies, strategies, programs, and initiatives related to the Policy. Please indicate your level of agreement with the inclusion of each of the Policy's Principles and their descriptions

The College welcomes a person-centred approach which focuses on delivering positive health outcomes that matter most to people and their communities, and the commitment to strive to eliminate health inequities, particularly for those living in rural and remote areas, Aboriginal and Torres Strait Islander groups, and people from culturally and linguistically diverse backgrounds.

The College would stress the importance of the Policy recognising that access to medicines and medicines-related services in rural and remote areas requires a broad, outcomes-focused definition which incorporates the Rural Generalist scope of practice. This will often involve provision of services extending from general practice clinic-based care to contribution to, and facilitation of as much as safe and practicable of people's secondary and tertiary needs in the most accessible possible way.

This involves coordination between private and public health services, hospital, and private clinics, and between the traditional roles of medical, nursing, allied health professionals and pharmacists, using a team-based approach where possible.

Our members report that there is no equity of access to medicines in Australia. Some items are not easy to obtain, and rural and remote areas can be adversely impacted by stock shortages. Specialist ordered medications can cause particular difficulties with members reporting for example, that they have been refused access to immunotherapy on the basis that it must be administered in specialised centres hundreds of kilometres away.

"*Other medications require specialist assessment and approval. This creates big hurdles in rural and prohibits their use in remote. More recently rural and remote had difficulties with other*

specialist ordered medications during lockdown, with intransigence by the Oncology sector over allowing any immunotherapy or chemotherapy to be given other than in specialised centres, despite the obvious difficulties of travelling when the community transport option is withdrawn. In another case I was refused access to immunotherapy although immunotherapy is prescribed by Rheumatology and I am able to give in people's own homes. I used to give chemotherapy in hospitals in the 1990s, and just note the hurdles placed in the road by various specialist silos".

All Australians irrespective of their location, should have ease of access to a regular medical practitioner and a pharmacist and this should be a minimum accepted standard. A positive team-work approach can ensure access to medicines for our most remote Australians. Supporting linkages (collaboration or a teams-based approach) between rural and remote pharmacists, as the experts in medicines, and general practitioners, who are responsible for providing continuous and coordinated patient care, will be key.

This collaboration should occur within the context of maintaining safety and quality, with all team members working to a full but appropriate scope of practice, and supporting local facilities, services, and practitioners wherever possible.

Question 13: The NMP influences and is also influenced by related policies, programs, and initiatives of the wider health system. Seven enablers are identified in the Policy as being critical to the Policy's success. Indicate your level of agreement with the inclusion of each of the Enablers and their descriptions

The College agrees with the listed seven enablers, but stresses that the Policy must ensure that each enabler is considered with a "rural-proofing" lens which takes cognisance of the current challenges facing healthcare services in rural and remote Australia.

Health Literacy - The Policy should recognise that health literacy initiatives must be designed to ensure they can be easily adapted to the rural and remote context. Activities need to be tailored to the specific needs of each community, particularly high-risk communities, and need to be culturally responsive and safe for those from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds. The role of rural General Practitioners and Rural Generalists as leaders in rural and remote communities should be leveraged to ensure effective engagement.

Health workforce – the pervasive failures to provide enough doctors with appropriate skills to rural areas have reached crisis levels for many rural, remote, and Aboriginal and Torres Strait Islander communities. These communities face growing difficulties in accessing a doctor, have diminishing local hospital services, and where doctors are available these are increasingly provided on a FIFO basis the national commitment to improving rural health is acknowledged, but too often, positive rural health policies are undermined in their implementation, and rural health funding does not invest in healthcare staff and resources located in rural communities. The Policy needs to recognise the service gaps in rural and remote areas and acknowledge that until such time as there is a reset in long-term strategic thinking about rural health, the system will remain in crisis.

Technology – there are still areas of Australia where limited access to adequate internet bandwidth and mobile phone coverage are significant impairments to the use of digital services. These deficiencies need to be addressed urgently as part of the broader digital health policy agenda.

Question 14: Please indicate your level of agreement with the proposed governance

ACRRM welcomes the commitment to mechanisms that support collaborative action and timely application of the efforts and expertise of relevant partners in setting shared priorities and agrees these are vital to the Policy's success.

However, as has been evidenced across wider health system planning there can be a lack of overarching authority at the jurisdictions level to translate state and territory-level strategic commitments to on-the-ground operational outcomes. Over time this sees the erosion of rural services.

The division of service responsibilities which is based on an essentially urban model, enables blame shifting, and a situation where no tier of government accepts accountability for ensuring small and isolated communities have adequate service provision. The NMP could potentially face similar challenges in meeting its aims, particularly where the concept of "collective responsibility" rather than a single point of accountability is utilised to implement and evaluate the Policy.

The Policy should consider a commitment to establishing benchmarks for minimum standards of access to medicines and medicine-related services, and it will be important to obtain rural and remote input from practitioners and communities in all aspects of the proposed governance structure.

CENTRAL PILLARS – Indicate your level of agreement with each Pillar including its intended outcome, description, and key responsible partners

Question 15: Pillar 1 – "Timely, equitable and reliable access to needed medicines at a cost that individuals and the community can afford"

The College agrees with Pillar 1, however, the deficiencies in several of the key enablers across rural and remote Australia (which we have addressed in Question 13) must be noted. In addition, the Policy needs to address the following:

Aboriginal and Torres Strait Islander Peoples Health – the Policy needs to have a clearer vision for addressing access barriers for Aboriginal and Torres Strait Islander peoples.

Vulnerable groups – the gap in the health and wellbeing of vulnerable members of our communities is well-documented. This includes older people, people living with mental illness, people from culturally and linguistically diverse backgrounds, migrants, and refugees. Again, the Policy needs to define how challenges for these groups can be met.

Chronic conditions - people are living longer and have more chronic health conditions. The increasing role of preventive and self-care in the management of chronic conditions and the delivery of non-pharmalogical care by medical and allied health professionals should be acknowledged.

Out of pocket costs – these can be a barrier to access for many patients and especially rural and remote patients who typically record a lower socio-economic status than their urban counterparts, and there should be equitable access to expensive and off-label medicines between jurisdictions. Current medicines funding mechanisms need to be reviewed to address this nationally.

Question 16: Pillar 2 – "Medicines meet appropriate standards of quality, safety and efficacy"

It is vital that the Policy takes cognisance of these distinctions of rural and remote practice. The Policy needs to recognise that alternative treatment or management options might be appropriate in rural and remote areas to deliver the safest and highest quality care in their context. What might

be considered appropriate in the urban context may not fit a rural situation. For example, the appropriate standards around prescription of medicines for dementia patients in areas with minimal prospect of accessing gerontologist services are likely to be different to those for patients in major cities.

Question 17: Pillar 3 – "Quality use of medicines and medicines safety"

The Role of the Rural Generalist - the Policy needs to take cognisance of the fact that rural and remote general practitioners work under unique circumstances and with a scope of practice and working environment which can be very different to urban practice.

These doctors are often the only readily available health care practitioners and as such, they may need to take on a range of roles which would ordinarily fall to specialists, allied health professionals, or health care teams in larger areas.

These practitioners are critical to the delivery of healthcare services in rural and remote areas, as they provide continuity of care for patients at all stages and have the necessary skills and training to provide intervention to those in need. In many cases, best practice for these rural GPs may take a form that is distinctive and not especially applicable to general practice outside of rural and remote settings. They require an enhanced training and knowledge of quality guidelines for medicines and medical technologies.

Health literacy - ACRRM acknowledges that better health literacy better enables people to actively participate in shared decision making processed. However, the Policy should recognise that health literacy initiatives must be designed to ensure they can be easily adapted to the rural and remote context. Health promotion and education activities need to be tailored to the specific needs of each community, particularly high-risk communities, and need to be culturally responsive and safe for those from Aboriginal and Torres Strait Islander or culturally and linguistically diverse backgrounds.

Question 18: Pillar 4 – "Responsive and sustainable medicines industry and research sector with the capability, capacity and expertise to meet current and future health challenges"

Research priorities should ensure that access to medicines and medicines related services also considers the rural and remote context. There is urgent need to develop better, nationally consistent health service data in the provision of healthcare services in rural and remote Australia, and the Policy needs to recognise that the development of evidence-based policy appropriate to community needs is not possible with an evidence base.

IMPLEMENTATION

Question 19: Please indicate your level of agreement with the proposed implementation approach

Whilst it is accepted that implementation of the Policy's aims is the collective responsibility of all partners, a single point of accountability would ensure provision of those minimum acceptable standards. The Policy does not clearly articulate how each partner's "mapping" of the areas where they can deliver and/or influence actions according to their remit, will be coordinated to achieve the collective understanding or outcomes outlined.

There should be a commitment to benchmarking minimum standards of access to medicines and medicines-related services for every Australian.

EVALUATION

Question 20: Please indicate your level of agreement with the proposed evaluation approach

It is noted that each partner will be obliged to make publicly available the results of monitoring and evaluation activities associated with their NMP aligned programs, and that specific committees and working groups may be established to monitor the achievement of the intended outcomes against the Pillars of the NMP including reporting on how the NMP's principles have been put into action.

Again, a single point of accountability and uniform reporting structures and requirements would ensure that implementation outcomes can be properly monitored against benchmarked standards.

There is urgent need to develop better, nationally consistent health service data on the provision of healthcare services in rural and remote Australia. The development of evidence-based policy appropriate to rural community needs is not possible without an evidence base. Appropriate national datasets should include establishment of benchmarks for minimum standards of access to medicines and medicines-related services for every Australian, including those living in our most vulnerable and remote communities, which could be used as a proactive planning tool to ensure the Policy's aims are met across rural and remote Australia.

GENERAL COMMENTS

Question 21: Please provide any additional comments you may have on the draft Policy

Overall, the Policy would benefit from being clearer in its language in places, and from taking a more realistic approach to the current state of each of the listed key enablers. The assumptions which the Policy makes about health workforce, leadership and culture, data and information and technology are unhelpful in that they fail to take account of current limitations within each system, particularly in the rural and remote context.

About the Australian College of Rural and Remote Medicine (ACRRM)

ACRRM's vision is *the right doctors, in the right places, with the right skills, providing rural and remote people with excellent health care.* It progresses this through the provision of quality vocational training; professional development education programs; setting and upholding practice standards; and through the provision of support and advocacy services for rural doctors and the communities they serve.

ACRRM is accredited by the Australian Medical Council to set standards for the specialty of general practice. The College's programs are specifically designed to provide Fellows with the extended skills required to deliver the highest quality Rural Generalist model of care in rural and remote communities, which often experience a shortage of face-to-face specialist and allied health services.

ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the traditional owners of lands across Australia in which our members and staff work and live and pay respect to their elders past present and future.