

A U S T R A L I A N

Medicine

The national news publication of the Australian Medical Association

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Managing Editor: John Flannery
Editor: Chris Johnson
Contributors: Maria Hawthorne
Simon Tatz
Graphic Design: Streamline Creative, Canberra

Advertising enquiries

Streamline Creative
Tel: (02) 6260 5100

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42 Macquarie St, Barton ACT 2600
Telephone: (02) 6270 5400
Facsimile: (02) 6270 5499
Web: www.ama.com.au
Email: ausmed@ama.com.au

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AMA LEADERSHIP TEAM



President
Dr Tony Bartone



Vice President
Dr Chris Zappala

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New publishing approach from *Australian Medicine*

Australian Medicine will increase its online presence in 2019 by reducing the number of its print editions. The journal will still be published online fortnightly with more content. Four bumper print editions will be produced and distributed over the next 12 months – one each quarter. This is a change from one print edition each month. All editions will be published online.

Federal Budget needs detailed vision



The AMA has lodged its Pre-Budget Submission with Treasury, calling on the Federal Government to provide a detailed and funded vision for the Australian health system.

With this year's Budget day being brought forward to April 2, ahead of an expected Federal election in May, AMA President Dr Tony Bartone said the date offered an ideal opportunity for a health vision to be articulated.

But he said that vision must be based on the reality that all parts of the health system are linked, and depend on each other to meet patient and community demand effectively.

"You cannot concentrate on one or two parts of the system and

neglect the others – they must all be properly resourced and funded to ensure a quality patient journey," Dr Bartone said.

"The key to successful long-term health reform is to properly fund and invest in primary care, especially general practice.

"General practice is the beating heart of the health system, and it must be supported."

Dr Bartone said there was plenty of time for the Government to roll out a series of fully-funded policies designed to meet the increasing health care demands of a growing and ageing population.



Federal Budget needs detailed vision

“The conditions are ripe for a new round of significant and meaningful health reforms, underpinned by secure, stable, and adequate long-term funding, to ensure the best possible health outcomes for the Australian population,” Dr Bartone said.

The 2019 Budget and the election come as the Government finalises significant reviews, most notably the Medicare Benefits Schedule (MBS) Review and the implementation of the review of the private health insurance (PHI) sector.

“We also believe that all governments – Commonwealth, State, and Territory – need to commit their fair share, and work cooperatively to build efficiencies in the system.”

The AMA and the medical profession will watch closely to see which MBS Review recommendations become Government policy.

“It has been our view from the start that the MBS Review must not be a cost saving exercise – it needs to be a credible clinical process to produce a strong contemporary MBS,” Dr Bartone said.

“The private health insurance reforms – the Gold, Silver, Bronze, and Basic policies – are already being introduced. But we are yet to see how they will be accepted by the public and the health professions.

“At the same time, the Government will be navigating the implementation of vital public hospital funding negotiations with the States and Territories via the Council of Australian Governments (COAG) processes.

“The AMA is adamant that more funding is needed to ensure hospital capacity to meet rapidly growing patient demand.

“We also believe that all governments – Commonwealth, State, and Territory – need to commit their fair share, and work cooperatively to build efficiencies in the system.

“The Government, led by Health Minister Greg Hunt, has shown strong commitment to the Pharmaceutical Benefits Scheme (PBS), and we expect this ongoing commitment to be reflected in the Budget.

“The Aged Care Royal Commission will have impacts across the health system, which the next Government will have to manage.

“The key to successful health reform is keeping all the important and disparate sections of the health system linked – and the key to keeping everything working to a common goal is general practice and the local GP.”

The AMA stresses that this Budget and the imminent election policies from all parties must contain a significant, long-term funding commitment to primary health care, led by general practice.

“This will be one of the key factors by which we will judge the Budget and the election policies,” Dr Bartone said.

“The Government acknowledged the importance of general practice in the Mid-Year Economic and Fiscal Outlook (MYEFO) statement in December, but the funding commitment was inadequate. More is needed.

“This AMA Pre-Budget Submission sets out a range of policies and recommendations that are practical, achievable, and affordable. They will make a difference. We urge the Government to adopt them in the Budget process.

“We have stuck mainly to the major pillars of the health system – public hospitals, the private health sector, the PBS, and primary care – in this submission.

“We have also highlighted emerging policy priority areas such as aged care, mental health, and medical research.

“The AMA will release a broader policy agenda – encompassing Indigenous health, public health, prevention, and other issues – ahead of the election.

“Health should never be considered an expensive line item in the Budget. It is an investment in the welfare, wellbeing, and productivity of the Australian people.

“Health is the best investment that governments can make.”

CHRIS JOHNSON

The AMA Budget Submission 2019-20, is available at https://ama.com.au/sites/default/files/budget-submission/AMA_Budget_Submission_2019_20.pdf

Key points of the AMA Pre-Budget Submission 2019-20

The AMA calls on the Government to:

General practice and primary care

- implement a program for patients with chronic disease who are most at risk of unplanned hospitalisation (including readmission), providing a quarterly 'care coordination' payment to GPs to support a more proactive and team-based approach to care. This would supplement existing Medicare funding arrangements and operate in a similar way to the Department of Veterans' Affairs Coordinated Veterans' Care program;
- provide additional funding for the Practice Incentive Program (PIP) to properly support the May 2019 introduction of the PIP Quality Improvement Incentive (PIPQII) and avoid the loss of other key PIP incentives. A well-funded PIPQII represents a significant opportunity to promote improved patient care and better target population health planning;
- retain the Aged Care Access Incentive (ACAI), which is scheduled for abolition from 1 May 2019;
- increase support for longer GP consultations through the introduction of an 'extended' Level B MBS consultation item that recognises the extra work involved for those GPs who spend more time with their patients;
- improve access to after-hours GP services for patients by bringing forward the Medicare definition of after-hours in-rooms consultation items so that they commence at 6.00pm on weeknights and 12 noon on a Saturday;
- introduce specific MBS rebates for GP telehealth consultations provided by a patient's usual GP for: + after-hours services, + patients with a GP Management Plan, + patients with mobility problems, and + patients in residential aged care facilities;
- support patients with hard-to-heal wounds by funding the costs of dressings for patients who: + have a diabetic foot ulcer or diabetic leg ulcer; or + have a venous or arterial leg ulcer; or + are 65 years of age and over; and

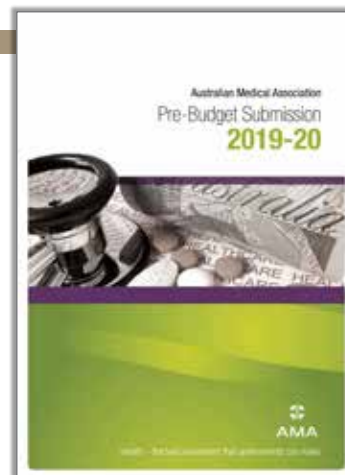
- support enhanced access to GP-led team-based care for patients by lifting the caps on subsidies available through the incoming Workforce Incentive Program, better supporting the employment of nurses, pharmacists, and allied health professionals in general practice.

Public hospitals:

- boost funding for public hospital services beyond levels set out in the 2020-2025 agreement, and lift public hospitals out of their current funding crisis, which is putting doctors and patients at risk;
- stop penalising hospitals for adverse patient safety events, and fully fund hospitals so they can improve patient safety and build their internal capacity to deliver high value care in the medium to long term;
- include an explicit ongoing Commonwealth contribution above and beyond the activity-based formula, to fund the obligations on jurisdictions to deliver integrated care post discharge to prevent avoidable re-admissions; and
- include an explicit ongoing Commonwealth contribution above and beyond the activity-based formula, to fund the obligations on jurisdictions to reduce potentially avoidable admissions for patients with complex and chronic disease as specified in the 2020-25 agreement.

Medicare

- establish a Medicare Reinvestment Fund – one that ensures every cent taken out of the MBS Reviews is reinvested in new and improved items recommended by the Committees, and kept separate from the funding needed to fund indexation and increased volume; and
- ensure there is a robust and transparent implementation process, with appropriate time to ensure decisions taken in the MBS Review do not have unintended consequences for patients, and that the MBS Review does not become a mechanism for shaping the scope of practice.



Key points of the AMA Pre-Budget Submission 2019-20

Medical care for older Australians

- take responsibility to ensure quality of, and timely access to, specialist support and allied health in all aged care settings. This includes palliative care, mental health care, physiotherapy, audiometry, dentistry, optometry, and occupational therapy;
- introduce a mandatory minimum staff to resident ratio that reflects the level of care needs and ensures 24 hour registered nurse availability;
- provide better funding support for services being delivered on site (such as mobile radiology services), which can save on costly hospital transfers; and • introduce specific MBS rebates for GP telehealth consultations provided by a patient's usual GP.

Private health

- ensure that any move to establish a fee transparency website is helpful to patients. Patients want to know what their out of pocket cost will be for a health procedure. A website that only shows doctors' fees will not deliver this. To determine an out of pocket cost, patients need to know what rebates they will receive from their health insurers – some are certainly far better than others;
- fully fund an extensive consumer education campaign on the Private Health Insurance Reforms, and provide further funding to the Private Health Insurance Ombudsman (PHIO) to monitor the rollout and transition to protect patients;
- increase the lead time it provides before new MBS items take effect; and
- provide the methodology and logic behind the changes, to give the funds the chance to consider and make appropriate changes, and to guard against funding reductions.

Diagnostic imaging

- ensure that Medicare rebates for diagnostic imaging services are adequately funded so that patients receive quality medical services;
- introduce new MBS rebates for clinically appropriate, evidence-based diagnostic imaging services, reflecting current practice;

- introduce a billing system to allow patients to pay just the gap up front;
- scrap the MRI licensing system; and
- fund referral arrangements that support better access to high quality, timely, and affordable services in regional and remote Australia.

Pathology

- ensuring that Medicare rebates for pathology services are adequately funded so that patients receive quality services;
- investing in a sustainable, diverse pathology workforce, including in regional areas; and
- increasing investment in the development of genomics, which has the potential to revolutionise medicine.

Health and medical research

- immediately restore the funding removed from MYEFO to the Research Block Grants program;
- increase funding to the NHMRC for investment in fundamental health and medical research; and
- bring investment in research and development in Australia to the OECD average of 2.36 percent of GDP (currently, Australia has fallen to 1.88 per cent).

Mental health

- ensure that the National Disability Insurance Scheme (NDIS) is properly and adequately resourced so that patients are not left without support or care for their mental health issues;
- fund and resource an appropriately sized, skilled, and resourced mental health workforce – addressing workforce gaps should be a priority;
- ensure workforce and services for the delivery of mental health care for those living in regional and remote areas;
- commit to a level of funding that allows for a mix in the range and level of mental health care available for all Australians, regardless of their geographical location, level of income, and ethnic background; and
- provide increased access to e-health and telemedicine for service delivery.

Australia Day Honours for AMA members



Associate Professor Beverley Rowbotham AO.

AMA members from all walks of medicine have been recognised into the Australia Day Honours list.

More than 40 members, including the chair of the AMA Federal Council, are among those inducted into the Order of Australia.

The doctor who literally wrote the book for general practice – Emeritus Professor John Murtagh – has been made an Officer (AO) in the General Division of the Order of Australia, for his services to medicine and medical education.

John Murtagh's General Practice, now in its seventh edition, has been the pre-eminent reference textbook for general practitioners, medical students, and registrars since it was first published in 1994, and has been translated into 13 languages.

Emeritus Professor Murtagh was last year recognised with the AMA Gold Medal for his outstanding service to the practice of medicine.

Emeritus Professor Richard Larkins, of Melbourne, received the highest honour and was made a Companion of the Order of Australia (AC) for his service to medicine, medical research and education, to public health care, and to the community.

Emeritus Professor Larkins is the Chancellor of La Trobe University, and is a former President of the National Stroke Foundation and former chair of the Victorian Comprehensive Cancer Centre.

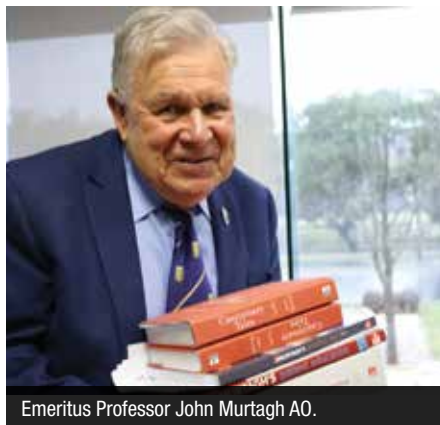
Chair of the AMA Federal Council and distinguished pathologist, Associate Professor Beverley Rowbotham, was made an Officer



Australia Day honours for AMA members... from p7



Emeritus Professor Richard Larkins AC.



Emeritus Professor John Murtagh AO.



Dr Andrew Miller AM.

in the General Division of the Order of Australia (AO) for her service to medicine, and to professional bodies including the AMA.

AMA Federal Councillor, Dr Andrew Miller, from the ACT, was made a Member in the General Division of the Order of Australia (AM) for his service to medicine as a dermatologist, and to professional organisations.

“AMA members have a long and proud history of public service across all fields of medicine,” AMA President, Dr Tony Bartone, said.

“On behalf of the AMA, I congratulate all members recognised in today’s awards, and thank all the hard-working and dedicated members of the medical profession who are working to keep us all healthy and safe over this long weekend.”

Other AMA members to be recognised include:

- Professor David Ball AO
- Professor Sharon Lewin AO
- Dr Bronte Ayres AM
- Dr Penelope Briscoe AM
- Associate Professor Andrew Brooks AM
- Dr David Burke AM
- Dr Anne Chang AM
- Dr Michael Davies AM
- Professor Paul Haber AM
- Group Captain Gregory Hampson AM
- Professor Jennifer Hoy AM
- Dr William Johnson AM
- Professor Matthew Kiernan AM
- Dr Donald McTaggart AM
- Mr Randall Sach AM
- Dr Bryan Walpole AM
- Dr Roger Wilkinson AM
- Captain Ian Young AM
- Dr Ian Airey OAM
- Dr Adrian Allen OAM
- Dr Michael Bourke OAM
- Dr Alexander Campbell OAM
- Dr Eleanor Chew OAM
- Dr Steven Coverdale OAM
- Dr Peter Davidson OAM
- Dr Christopher Dodds OAM
- Dr Francis Harvey OAM
- Dr Bernard Jenner OAM
- Dr Christopher Lowry OAM
- Dr Peter Marendy OAM
- Dr Robert Marr OAM
- Dr Jennifer McArthur (Chambers) OAM
- Dr Stanley Menzies OAM
- Dr Dinesh Palipana OAM
- Dr Sujon Purkayastha (OAM)
- Dr Jaswinder Samra (OAM)
- Dr Gregory Thompson (OAM)
- Dr Richard Tooth (OAM)
- Dr Robert Wight (OAM)

MARIA HAWTHORNE

My Health Record still a hot topic

The My Health Record opt-out deadline came and went on January 31, with calls for it to be further extended. But the Government has moved to assure Australians that even after their record has been created, they can cancel it at any time (see Health on the Hill p22).

With reports that some doctors are seeking legal advice over liability for potential incorrect patient data on MHR, the AMA has urged Australians to move forward with the system.

“... Australians can be assured that it’s as good as possible, and it is going to aid in the clinical outcomes of a vast number of Australians, and prevent unnecessary medication errors, unnecessary hospital re-admissions.”

AMA President Dr Tony Bartone said the Government and all parties across both Houses of Federal Parliament have worked together to increase and improve the legislation and the security around the MHR.

“I feel that what we’ve now ended up with is a far better product than what we started the year with,” Dr Bartone said.

“And really, Australians can be assured that it’s as good as possible, and it is going to aid in the clinical outcomes of a vast number of Australians, and prevent unnecessary medication errors, unnecessary hospital re-admissions.

“It’s going to help with the mapping out the journey that is very complex through the whole health system, and hopefully become that backbone that improves the communications and connectivity that is sadly lacking in our health system at the moment.”

Health Minister Greg Hunt compared the MHR to people having their banking details online, which they have been able to do for many years.

“The My Health Record is simply giving people access to their



own health records,” Mr Hunt said.

“We can all access if we chose our banking details online, but historically people haven’t been able to access something even more important than that – their own health records.

“From the outset we predicted that there would be about a 90 per cent participation rate. My latest advice ... is we are on track to have a 90 per cent participation rate.

“Now I have to say I am quietly very pleased if that is the case... I was speaking to representatives from international health bodies and they said if a country has a 90 per cent participation rate that would be extraordinary internationally.

But Shadow Health Minister Catherine King said there were still too many unresolved uncertainties in the system and the Government should further extend the opt-out period.

“We had hoped the Government would have used the two-and-half-month extension to address other outstanding privacy issues – particularly around minors, default settings and automatic uploads. But they have failed to do so,” Ms King said.

“We maintain there should have been a longer extension of the opt-out period to ensure these issues were sorted out. And we maintain the Government should commission an independent Privacy Commissioner review of the system.”

CHRIS JOHNSON

Productivity Commission report shows need for improved investment in general practice

Australia's 37,000 GPs are providing more services than ever before, with patient satisfaction ratings of more than 90 per cent, the latest Productivity Commission report shows.

The annual Report on Government Services (ROGS) found that GPs provided around 160.3 million Medicare services to patients around Australia in 2017-18.

However, it also found a rise in the number of avoidable presentations to public hospital emergency departments, giving weight to the AMA's Pre-Budget Submission call for greater investment in general practice.

About 2.9 million people – an increase of 20,000 – presented at EDs for ailments that could have been more easily and cost-effectively treated by a GP, the report said.

AMA Federal Councillor, Dr Chris Moy, said it was important not to blame the patient.

"It's not the patient's fault if they're sick, they need medical care, but unfortunately it is the result of long-term, short-sighted funding, where the funding has really not tended to be going to general practice," Dr Moy told ABC TV.

"You have situations, particularly in aged care for example, where the patient is actually very unwell with a urinary tract infection, and there may not be a GP available, and so the patient will therefore have to be transferred to hospital.

"A general practice visit is funded to the tune of about just under \$40 – the same amount as a men's haircut – whereas the cost that the community bears when someone goes to hospital is about \$600 a visit, before the ambulance callout.

"It is a result of short-sighted long-term funding from both governments, I'm afraid, in terms of freezes to Medicare. We've ended up in a really distorted situation – we don't have a situation where prevention is the best cure."

AMA President, Dr Tony Bartone, said it was imperative that both major parties spelled out their long-term vision for the Australian health system, with general practice front and centre, ahead of the upcoming Federal Election.

"GPs are working harder but are feeling the squeeze from underinvestment in Medicare rebates for patients and general practice across the board," Dr Bartone said.

"With over a third of GPs aged over 55, we need to do more to resource and encourage a career in general practice so the

community can continue to access the high quality care they need and deserve.

"Government spending on GP services is currently about 8 per cent of total Government spending on health. The AMA is calling for this to be lifted over time to about 10 per cent of total Government health spending.

"This will lead to long-term savings to the health system, and improved health outcomes by keeping patients out of hospital."

The AMA Pre-Budget Submission is at https://ama.com.au/sites/default/files/budget-submission/AMA_Budget_Submission_2019_20.pdf

MARIA HAWTHORNE

Key findings of the Productivity Commission Report on Government Services 2019:

- In 2017-18, Australia had 36,938 GPs working full-time and part-time, equating to 25,149 on a Full Service Equivalent (FSE) basis;
- Rates of service used per annum remained steady at 6.5 per annum per head of population;
- 4 per cent of the population reported that they delayed or did not visit a GP in the previous 12 months due to cost, down from 4.1 per cent in 2016-17;
- 7 per cent reported that they had delayed or did not purchase prescribed medicines in the previous 12 months due to cost;
- Around 73 per cent of patients could get a GP appointment within 24 hours;
- 91.8 per cent said the GP always or often listened to them;
- 94.1 per cent said that the GP always or often showed them respect;
- 90.7 per cent said the GP always spent enough time with them.

Pill testing trial must be controlled and scientific

AMA President Dr Tony Bartone has repeated the call for a controlled pill testing trial for music festivals, following the worst season for drug-related deaths at such events.

Six young people have died in as many months from drugs taken during music festivals in some Australian States.

The issue of pill testing has been thrust to the top of political debate, while at the same time arrests have been made of suspected suppliers.

Dr Bartone told ABC Radio that action was required, and a pill testing trial should be considered as one component.

“What we’ve said for a good while now is that we are in favour of a controlled, multi-party research and supervised test or trial of a clinical approach to this position,” he said.

“So, it’s not about pill testing as a panacea, but understanding that we need to get both the clinical evidence, both the research behind it and both the outcomes and interventions required to come to a considered position.

“Everyone says where’s the proof that it works? Well, if all the authorities – regulatory, parliamentary, judiciary, the police, as well as the medical profession and lab technicians and indeed toxicologists – all get together, supervise the testing under really close controlled circumstances, we can then come to the position that it works.

“Overseas, it has been shown to be quite effective in certain parts of European countries, in particular. But I’m talking about, just to really completely ram home one way or another in our own backyard, the evidence to show that we believe it has a role to play in harm minimisation.

“We’re talking very selectively and with the proper supervision and the proper controls; but also, to test out the premise. It’s an opportunity to intervene at the point of taking the so-called illicit substances.

“Supply reduction strategy is not working at the moment. Trying to control it and remove it from the streets is not working. It’s there in ever-larger quantities as ever and only to be replaced by the next option. So, we can’t stick our heads in the sand and say ‘it’s illegal and that’s all that should be done and, you know, if you take risks with your health so be it, you suffer the consequences’.

“We’ve got to be innovative and look at a harm minimisation strategy ... and understand that the circuitry in the people taking the substances – in as still yet developing brains – is really looking for that addiction hit.

“They’ll push the envelope. They will do things that we’re told not to do, and we need to understand that the supply is there, the messaging is there. They’re not hearing the right messages about the harm that it can do, and we’ve got to get one step ahead if we really want to try and help and save and prevent serious outcomes to a number of our young Australians.”

Dr Bartone also pointed out that pill tests needed integrity and analysis in order to be productive.

“We know that the simple colour tests that say: yes, no, or good or pure; safe, not safe, are really of very little value,” he said.

“We need the analysis, the chemical toxicology-type assessments. That’s what we need. We’ve read reports where importers are bringing in those colour-metric testing kits that sort of give an on-the-spot yes or no.

“That’s not what we want to see because they’re of dubious reliability and accuracy, and we need to be very clear about how precise both the purity indication are, but also how strong are their concentration. So, it’s about getting all the information and being very, very clear about what the shortcomings, if any, are there to be understood.

“It’s about sending a message to the person, especially the first-time taker or the casual experimenter – that really this is quite dangerous, very dangerous, and could potentially kill you. And you know what? If you need help, we’ve got some programs that we can help refer you to. We can put you in touch with some really clever programs and clever strategies that will help you.

“If you’re much more further along the line, we’ll basically look at what are the other options. Who are the other specialists that we can bring in to help try and assist you in the process? It’s about the messaging at the time of intake. It’s about trying to medicalise the issue rather than criminalise it, and trying to give them the information about the harm that it’s doing to their body – there and then, and in the future.”

CHRIS JOHNSON

Medical students talk pill testing

Following the spate of recent deaths at music festivals across the country, Australia's medical students are highlighting the need for a new approach to prevent harm from recreational substance use.

ABC Radio National recently hosted a panel discussing pill testing with Australian Medical Students' Association (AMSA) President, Jessica Yang, alongside former Australian Federal Police commissioner Mick Palmer, and ACT Liberal MLA Jeremy Hanson.

"The Australian Medical Students' Association supports public health policy around illicit drug use which is evidence-based, including research into the efficacy of novel harm minimisation techniques, such as pill testing," Ms Yang said.

"The current system clearly isn't working. Medical students advocate for reframing recreational drug use as a health issue, rather than a criminal one. Use of illicit substances and the associated consequences is an issue we see on medical

placements, in the community, and in emergency departments.

"There needs to be ongoing, meaningful support for national drug prevention programs and relevant education. This includes facilitating the distribution of resources to best minimise the harm we are currently seeing."

AMSA, the peak representative body for Australia's 17,000 medical students, stands with the Australian Medical Association, the Royal Australian College of Physicians, the National Australian Pharmacy Students' Association (NAPSA), and numerous other student health organisations in advocating for new approaches to an ongoing problem.

"As future health professionals, this is an issue that is already affecting our future patients," Ms Yang said.

NAPSA President, Jess Hsiao said: "NAPSA strongly urges the national government to take action on pill testing by approving trials as an approach to harm minimisation."

Home Affairs top medic visits AMA House



AMA President Dr Tony Bartone has held discussions at AMA House, Canberra with the Chief Medical Officer and Surgeon General of the Home Affairs Department, Dr Parbodh Gogna.

Both doctors described the meeting as productive. The health and wellbeing of detained asylum seekers was one subject canvassed by the pair.

Record organ donations



Australia has recorded a major increase in lifesaving and life changing organ donations and transplants, following an unprecedented rise in donor consent rates over the past year.

The Minister responsible for the Organ and Tissue Authority, Ken Wyatt said with the greatest number of people donating their organs, a record 1,544 Australians received transplants in 2018, which was 144 more than the previous year.

“We salute from the bottom of our hearts the 554 selfless and generous Australians who have given the gift of life in the past year, especially their families, who play a crucial role by confirming their loved one wanted to be a donor,” Mr Wyatt said.

“This means that in the ten years since the national program started, organ donation has more than doubled, saving almost twice the number of people through transplantation.”

The 2018 performance data released by the Organ and Tissue Authority shows increases in national donation and transplant rates.

The Federal Government introduced fast online organ donor registrations in July 2017 and supported promotional programs across popular sporting codes including the AFL, the NRL and the FFA.

“One of the key factors driving the increase in donations is a significant rise in the consent rate, from 59 per cent in 2017 to 64 per cent in 2018, the highest rate ever recorded,” Mr Wyatt said.

“I am confident outcomes will continue to rise as consent rates increase. Organ and tissue donation is now firmly embedded in our hospitals with over 275 donation specialist nurses, doctors and support staff covering 96 hospitals across Australia.

“Records show that 75 per cent of families say ‘yes’ to donation when a donation specialist is involved in providing support and information to family members in the hospital.”

The consent rate is an international benchmark indicating the number of times donation specialists have donor conversations with next of kin, compared with the proportion of next of kin who agree to donation proceeding.

The 2018 results will place Australia in the top 15 countries in the world for organ donation, with a national donation rate of 22.2 donors per million population (dpmp), a seven per cent increase on 2017 (20.7 dpmp).

“Increasing our consent rate to 70 per cent would place Australia in the world’s top ten performing countries and we are now within six per cent of achieving this goal,” Mr Wyatt said.

“Clearly there has been significant progress but there is more we can and must do to increase donation.

“With around 1,400 Australians currently wait listed for a transplant, and around 12,000 people on kidney dialysis, it is crucial that everyone thinks about donation, talks to their families and registers on the Australian Organ Donor Register.”

The Organ and Tissue Authority is responsible for the national organ donation program and works with each State and Territory to maximise transplant rates and raise community awareness of organ and tissue donation.

People can register at www.donatelife.gov.au in less than a minute on mobile phone, tablet or computer, to one day give someone a second chance at life.

CHRIS JOHNSON



ECG INTERPRETATION IN ATHLETES

The Center for Sports Cardiology at the University of Washington in collaboration with the Australasian College of Sport and Exercise Physicians are extremely excited to offer open access worldwide to a new collection of six online ECG training modules. These are based on the 'International criteria' and the latest consensus recommendations for ECG interpretation in athletes.

ECG increases the detection of cardiac disorders predisposing to sudden cardiac death, the leading cause of athlete fatalities during sports participation. After completing the training modules, clinicians should have a foundation to interpret an athlete's ECG in clinical practice using the International criteria. The complete training course includes:

1. Basic ECG interpretation in athletes (post-test 1)
2. Normal ECG findings in athletes
3. ECG abnormalities in cardiomyopathy
4. ECG abnormalities in primary electrical disease
5. ECG interpretation challenges and common pitfalls
6. Advanced ECG interpretation in athletes (post-test 6)



Rural health conference is better together



The 15th National Rural Health Conference is a biennial event being held in Hobart from 24 to 27 March 2019. With a theme of 'Better Together!' the conference program highlights how we can work better together to improve the health and wellbeing for everyone living in country areas.

The four-day event provides learning and networking opportunities to public and private healthcare professionals, health consumer advocates and carers, students and researchers, and interested people from sectors such as education, transport and housing.

The conference will feature a number of prominent Keynote speakers presenting on a range of topics, including:

- **Isabelle Skinner**, CEO of the International Council of Nurses, on how addressing the United Nation's Sustainable Development Gals will lead to healthy people in a healthy world;
- **James Buchan**, World Health Organization Collaborating Centre, will provide a global view of the rural health workforce;
- **Sir Harry Burns**, Professor of Global Public Health at the University of Strathclyde, Scotland, on early childhood trauma, social determinants of health and an anticipatory care approach;
- **Bo Remenyi**, Paediatric Cardiologist and NT 2018 Australian of the Year talking about her work tackling Rheumatic Hear Disease in the NT;
- **Kelvin Kong**, an otolaryngology head and neck surgeon and Fellow of the Royal Australasian College of Surgeons on hearing loss and poor educational outcomes for rural children;
- **Saul Eslake**, economist and Vice Chancellor's Fellow, University of Tasmania, on a Tasmania case study for education, employment participation and health outcomes;
- **Sandro Demaio** from ABC's Ask the Doctor, Chief Executive Officer of EAT; and founder of the Sandro Demaio Foundation;
- **Cassandra Goldie**, Chief Executive Officer of the Australian Council of Social Services will join **Richard Di Natalie**, Leader of the Australian Greens, and **Kalinda Griffiths** from the Centre for Big Data Research, University of NSW to discuss managing health into the future; and
- **James Ward**, Head Aboriginal and Aboriginal Health Infectious Disease, South Australian Health and Medical Research Institute will be addressing sexually transmitted infections in remote Australia.

The full list of keynote presenters and the conference program can be found on the Rural Health Alliances conference website at www.ruralhealth.org.au/15nrhc where online registration is also available.

Should we minister to the lonely?



Loneliness is such a serious social, mental and physical health problem that the UK Conservative Government appointed a Minister for Loneliness.

Tracey Crouch was anointed as the first ever Minister for Loneliness following a report from the Jo Cox Commission on Loneliness. The Commission found that more than nine million people in Britain (about 14 per cent of the population) often or always feel lonely.

Jo Cox is tragically remembered as the MP who was assassinated in June 2016 by a far-right extremist. As an MP, she raised the issue of loneliness, and in her honour a cross-party commission was established.

The Jo Cox Commission on Loneliness called for the Government to initiate wide ranging reforms, including:

- National leadership
- A UK wide Strategy for Loneliness across all ages
- A nominated lead Minister
- A Family and Relationships Test for new policy
- A national indicator on loneliness across all ages
- Measures of loneliness included in major national studies
- Annual reporting on loneliness
- A program to develop the evidence around 'what works' in

tackling loneliness

- Easy-to-understand messages to help individuals connect with others and avoid loneliness.

The findings of the Jo Cox Commission were echoed in the United States, where Vivek Murthy, the former United States Surgeon General, called loneliness a “health epidemic.”

Here in Australia, a Lifeline survey in 2016 found that more than 80 per cent of Australians believe society is becoming a lonelier place. Swinburne University research showed that loneliness is a risk factor for all causes of early death and that feelings of loneliness can increase the likelihood of earlier death by 26 per cent – which they say is greater than the risk for obesity.

Loneliness is experienced across all age groups, but more often it is older people, those who have lost or are separated from their partner or relative, people with a disability and their carers, those who are new to a local area, including migrants and refugees, and people who struggle to make social connections. A report by the Commissioner for Senior Victorians found that 185,000 older people in Victoria will experience loneliness by 2031.

The AMA’s Public Health secretariat recently met with *Friends for Good*, an organisation raising awareness of loneliness as a significant issue and trying to fill gaps in services to foster a greater sense of connection and wellbeing for individuals and communities. They describe loneliness as having nobody to talk



AMA advocacy breakthroughs in MBS Review

AMA lobbying has proved fruitful in the continuing Medicare Benefits Schedule (MBS) Review, with some wins achieved over changes being considered.

The AMA has pushed for reports from MBS Review Taskforce Clinical Committee to be made publicly available.

Late last year the AMA wrote to the Taskforce and lobbied the Health Department for that Committee's reports to be made publicly available in order to improve transparency and boost the medical profession's engagement with the MBS Review process.

In response to AMA's request, the Department quietly published all the MBS Review Clinical Committee reports dating back to the commencement of the Review in 2015. These were published unannounced just before Christmas.

The AMA urges members to review the MBS Review Clinical Committee reports for recommendations relevant to their specialty and to engage directly with their relevant medical Colleges, Associations and Societies to provide responses to the MBS Review Taskforce.

Another success was related to the MBS Review Anaesthesia

Clinical Committee recommendations.

In 2017, the AMA supported the Australian Society of Anaesthetists (ASA) concerns with that Committee's recommendations. The AMA facilitated meetings with relevant members of the Government, as well with the MBS Review Taskforce and the Health Department.

In November 2018, the AMA also wrote to the MBS Review Taskforce to represent ASA's continuing concerns.

This advocacy, along with that of the Colleges, Associations and Societies, proved influential. Just prior to Christmas, Health Minister Greg Hunt was reported to have rejected the Committee's recommendations that sought to change Medicare rebate and leave patients significantly out of pocket.

MBS Review Taskforce Clinical Committee Reports are available at: <http://www.health.gov.au/internet/main/publishing.nsf/Content/MBSReviewTaskforce>

CHRIS JOHNSON

Should we minister to the lonely? ... from p16

to or share experiences with, not having someone to confide in and not finding a connection with people, places or things. Loneliness is experienced on-line as well, with people reporting feeling lonely on social media.

The impact of loneliness on health and wellbeing is serious.

A 2015 research report from Brigham Young University found: "actual and perceived social isolation are both associated with increased risk for early mortality." The *Journal of Neurology, Neurosurgery and Psychiatry* reported a study showing older people who report feelings of loneliness and social isolation are more likely to develop Alzheimer's disease and other forms of dementia, and is also associated with depression, increased blood pressure and higher cholesterol levels.

A significant problem in addressing loneliness is that often the people we try to reach are isolated in every respect. They may live alone, without internet or mobile phone services, and they may rarely be seen or connect with others. Surveys and data

collection may not capture the most isolated members of society.

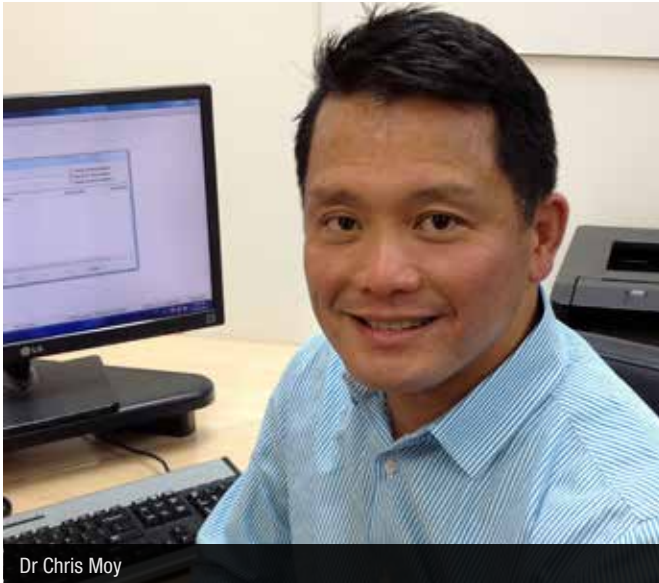
It is the GP or health worker who is most likely to come into contact with lonely and socially isolated people. In the UK, three out of four GPs report that they see between one and five people a day who have come in because they experience loneliness. We do not know what the data is here in Australia. But we should know. This is an issue that warrants further investigation.

Federally, leadership in addressing loneliness and socially isolation is needed. The current Government has instigated initiatives in the aged care sector, however a much more comprehensive community focus is needed.

While some may scoff at the idea of a Minister for Loneliness or a Minister for Social Inclusion, it certainly has merit.

SIMON TATZ
AMA DIRECTOR, PUBLIC HEALTH

Consent when prescribing to dementia patients



Dr Chris Moy

Responsibility rests with doctors to obtain family consent before giving anti-psychotics to dementia patients in nursing homes, but administrators in the aged care facilities have the responsibility to administer them correctly.

Chair of the AMA Ethics and Medico-Legal Committee, Dr Chris Moy explained where the onus falls when it comes prescribing such medications in an aged care facility.

“At the end of the day the right to prescribe is inextricably linked to the responsibility to prescribe,” Dr Moy told ABC News.

“So, at the end of the day ... if I have to sign a medication order or prescription, I’m responsible for that, and so therefore responsibility to obtain consent for that rests with me, ultimately.

“Obviously (nursing home administrators) need to ensure that the order that I’ve written is administered in the correct way and under the right circumstances, but that’s a separate issue to the actual prescribing and writing of the order.”

Dr Moy explained that there is a reasonably good framework in most jurisdictions for maintaining order in prescriptions.

“It’s pretty straightforward. At the end of the day, it is a matter of consent,” he said.

“So, firstly, as a doctor, before I actually provide treatment to

anybody, I need to obtain consent from them, I need to say ‘will you accept if I do this to you?’ and this also applies to an individual who’s lost decision-making capacity, for example, someone’s who got severe dementia.

“Now, in that situation, somebody should be representing them, which is why we really advocate for people to have advanced care directives or appoint decision-makers for them, so that we can ask them on the patient’s behalf.

“And their job – the job of that individual – is to do what that patient would have wanted. And so, my job is to say ‘look, what would your loved one have wanted in these circumstances?’ and, knowing the information, ‘this is what’s happening, and maybe there may be issues of behaviour or violence that may be happening or confusion, or they may be shouting things that may be very distressing. In those circumstances, knowing that information, would your loved one ... want this this to be prescribed to them?’

“I think one of the issues is that, unfortunately, there is a chronic underfunding of aged care and, unfortunately, situations like the Oakden situation probably give us a bit of an insight into that. And I think that’s what we found.

“For example, as a GP, I actually have to provide a lot more time to a patient. I have to go down and see a patient but also have to take the calls out of hours, which is not remunerated, contact the decision-maker to try and get consent for that, and that may not always be possible.

“And so, those sorts of things have to be factored in. So, in amongst the issue of the prescribing and obtaining consent is the need for proper funding, not only of the doctors providing the care but also of the facilities themselves, so that the patients get appropriate care, and appropriate supervision and appropriate administration of their medications...

“Ultimately, you’re looking at medications as a last resort, and then going through the proper consent process so that the doctor first-up ensures that they get consent from the right person, and that person giving consent is the legally appropriate individual but is also acting for the patient and doing what the patient would have wanted.”

CHRIS JOHNSON

End of Life Law for Clinicians: A new training program about end of life law in medicine

“If I give my terminally ill patient medication for pain relief and she dies, will I have assisted her death?”

“If my patient is close to death and his family demands treatment, do I have to give it?”

“My elderly patient needs urgent treatment to save her life but refuses to go to hospital. What do I do?”

“My patient’s family is arguing about whether to consent to treatment. Who can make the decision?”

These are just some of the legal issues confronting clinicians who care for patients at the end of life. Often the answers are not clear cut, and knowing what to do, particularly in an urgent situation, can be challenging.

While research shows that doctors have significant knowledge gaps about end of life law, most doctors believe law has a place in clinical practice and decision-making, and want to learn more about the law.

To address this need, a team of researchers from the Queensland University of Technology recently launched End of Life Law for Clinicians (ELLC), a national training program for clinicians and medical students about the law at end of life. This freely available program, which is funded by the Commonwealth Department of Health, comprises ten 30-minute online modules.

Topics include capacity and consent to medical treatment, withholding and withdrawing treatment, Advance Care Directives, substitute decision-making, providing palliative medication, futile or non-beneficial treatment, emergency treatment, end-of-life decision-making for children, and managing disputes.

The training commences with a module about the role of law in end of life care, a topic more relevant to clinicians now than ever before. The past few years have seen significant legal reforms across Australia which have implications for the medical profession, including the Victorian Government’s reforms to laws on medical treatment decision-making. High profile cases like Charlie Gard in the UK have also renewed debate about futile or non-beneficial treatment, and where we should draw the line when it comes to providing treatment to critically ill patients. Legislators, the medical profession, and the broader community are grappling with some of the most complex ethical, moral and legal issues in modern medicine.

For some, law’s role in medicine may not be immediately apparent. Yet law provides the overarching framework for consent

to treatment and decision-making in end of life care, and clinicians are important legal actors in this. Caring for patients at the end of life necessarily involves clinicians applying the law in their practice: for example, when a doctor decides whether to follow a person’s Advance Care Directive; how much morphine to administer to a dying patient; or whether mechanical ventilation can be withheld or withdrawn. To do this effectively (and to understand what is lawful, and what is not) knowing end of life law, and where to go for information and advice to manage legal issues, can help.

ELLC comprehensively addresses these issues. It also explains the differences in the laws in all 8 Australian jurisdictions through End of Life Law in Australia, a complementary resource developed for health professionals and the broader community to find out more on end of life law.

In addition to the online modules, 22 workshops, focusing on clinical case studies will be rolled out in all States and Territories throughout 2019, in partnership with the medical and health sectors. CPD points may be claimed from professional Colleges for both modules and workshops, and certificates of completion are available.

ELLC aims to address current knowledge gaps and to help clinicians deliver high quality, appropriate care every day. It can also support management of legal issues in practice, and assist in improving communication with individuals and their families or substitute decision-makers.

Most importantly, applying the law in clinical practice can support individuals to receive care consistent with their goals and preferences, and to experience a ‘good death’. We hope this training program will provide a useful resource to enhance clinicians’ practice.

For more information and to register: <https://palliativecareeducation.com.au/course/index.php?categoryid=5>

Authors:

- **Prof Ben White:** Professor of Law, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology
- **Prof Lindy Willmott:** Professor of Law, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology
- **Prof Patsy Yates:** Director, Centre for Palliative Care Research and Education and Head of School of Nursing, Queensland University of Technology
- **Dr Shih-Ning Then:** Senior Lecturer, Australian Centre for Health Law Research, Faculty of Law, Queensland University of Technology
- **Penny Neller:** Project Coordinator, National Palliative Care Projects
- **Dr Rachel Feeney:** Senior Research Assistant, End of Life Law for Clinicians

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 Learning



TO THE EDITOR

Thank you letters from recipients of the AMA Indigenous Medical Scholarship

It has made a huge difference

I am writing to you today to inform you that I have officially completed my studies at the University of Newcastle in the Bachelor of Medicine program as of the 7th December 2018, and I would like to take this opportunity to say thank you to the Australian Medical Association for their support throughout my time at Newcastle University that made this endeavour possible with the Indigenous Peoples' Medical Scholarship 2016.

I can still remember the day I received the phone call that I had been awarded the scholarship. I was studying in the library, trying to finish off that week's 'Working Problem'. I saw it was a Canberra phone number, and instantly became nervous. I can still remember saying to myself 'is this real?' as I never expected to be even considered for such an award, but nonetheless, it has made a huge difference to where I am today.

As a mature aged student with a family, the scholarship took the pressure off the financial strain of attending university, and allowed me to focus more on my studies at the time when it was needed the most. Previous to the scholarship, my usual routine was to attend university Monday to Friday, then work Friday and Saturday night shifts in as a Registered Nurse in the Intensive Care Unit at the Newcastle Mater Hospital. This left me with one day to spend time with my family, and catch up on any extra reading. The scholarship enabled me to scale back work, spend more time studying, but it also allowed me to spend extra time with my boys.

I was fortunate enough to secure a position as a Junior Medical Officer in the Hunter New England Local Health District, commencing on the 21st January in 2019. This will keep me close to home at the present time, and I am looking forward to the challenge. Being an active member of the Wollotuka Institute at the University of Newcastle, I am also now looking forward to mentoring and tutoring Indigenous medical students in a new capacity so as to foster the next generation of Indigenous medical graduates.

Thank you once again to all the staff at the Australian Medical Association for making this dream possible.

Dr Darren Hartnett

Continues to be the source of support that facilitates my passion to pursue medicine

This year was my first clinical year of medicine, where I was placed in Wagga-Wagga NSW. I have always been sure about pursuing rural and remote medicine – but being immersed in clinical medicine in rural NSW has only reaffirmed this more and made me more motivated!

Reading about the UNSW medicine program before I even gained entry, I was always very keen to be placed in Wagga. I placed it as my first preference and was lucky enough to get it [Wagga is becoming very popular among students!].

The relocation to Wagga from Wollongong was always going to be an expensive exercise; however, it was very comforting knowing that the transition would be supported by the AMA Indigenous medical scholarship. Throughout various placements this year, both within the hospital and the community, I have been exposed to the spectrum of health – and in particular health issues common in rural Australia such as Indigenous health and mental health.

An interest of mine has always been obstetrics, and I have made sure that this year I have had as much exposure as possible. As part of the UNSW medicine program, students are required to complete a 30-week independent learning project in their 4th year of study. I have been fortunate enough to have my proposal approved and will also be completing my research project in Wagga during 2019.

My research has an obstetric focus and will be assessing Indigenous foetal-maternal outcomes. I have not had much exposure to research however I am excited to learn more about rural obstetric medicine and am looking forward to the challenge next year! This year has also seen the budget allocate funding of a new medical school in Wagga-Wagga.

I firmly believe this is a great opportunity to increase Indigenous medical student numbers as well as improving retention. As this has involved the current Wagga-Wagga rural clinical school I have been lucky enough to share my thoughts with the Dean of rural medicine.

This is something I have become quite passionate about as I truly believe that increasing the amount of Indigenous medical and allied health professionals will only aid in closing the gap between Indigenous and non-Indigenous health status. This is a passion which I will continue to lobby for.

The AMA Indigenous scholarship has, and continues to be, the source of support that facilitates my passion to pursue medicine. Medicine is a challenging experience and sometimes a little daunting and overwhelming. Being a recipient of the AMA Indigenous Medical scholarship is a constant source of motivation and an opportunity I am and will always be grateful for! Thank you again for your support and in assisting me throughout my medical studies and I look forward to 2019 as a proud recipient of the AMA Indigenous scholarship.

James Chapman

<https://ama.com.au/indigenous-medical-scholarship-2019>



Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

BY CHRIS JOHNSON

New permanent delete function for My Health Record

Australians can choose to have or cancel a My Health Record at any point in their life, according to new laws that came into place towards the end of January.

The laws aim to strengthen the privacy and security protections within My Health Record. A function has been activated in the My Health Record system that allows a person to permanently delete their record at any time, including any backups.

All records that have previously been cancelled will also be permanently deleted from the system.

If a person changes their mind, they can choose to register for a record to enjoy the benefits of controlling their health information securely in one place to support their health and care.

My Health Record is an online summary of a person's key health information. It allows them to share and control their health information with doctors, hospitals and other healthcare providers, from anywhere at any time.

Key facts and figures distributed by the Federal Health Department include:

- 6.45 million Australians currently have a My Health Record;
- Since July 2018, almost half a million Australians have decided not to wait for a My Health Record to be created for them, and have chosen to have a record created for them;
- 82 per cent of general practices are now connected to My Health Record;
- 84 per cent of community pharmacies are now connected to My Health Record. The increase in pharmacy connections has tripled in the past six months;
- 75 per cent of public hospitals are now connected to My Health Record.

New laws passed by Parliament last year strengthen the legislation prohibiting insurers and employers to access or use My Health Record information, or to ask a person to disclose the information, for insurance or employment purposes under any circumstance.

The new laws also legislate the Australian Digital Health Agency's existing policy around disclosure to law enforcement agencies – law enforcement agencies cannot access a person's My Health Record without a warrant or court order.

"Having a My Health Record places the control of a person's healthcare directly into their hands," said Professor Meredith Makeham, Chief Medical Advisor for the Australian Digital Health Agency.

"After 31 January 2019, a My Health Record system will be created for everyone who has not opted out of the system.

"However, January 31 is not a cut-off date for Australians to continue to have a choice about using My Health Record to manage their health and care.

"The new permanent delete functionality means Australians will always have the choice not to have a record and they can remove all of their data from the My Health Record system. At any time in their lives, they can delete their record – and no copy will be kept."

Grants to get ageing Aussies moving

The Government has allocated \$23 million to 27 organisations trying to help older Australians become more active.

The Move it Aus Better Ageing grants will be distributed over the next two years, with a focus on helping inactive people aged 65 and older to become more physically active and socially connected.

Sports Minister Bridget McKenzie said the Move It Aus Better Ageing program was an important step in helping older Australians to get the most out of their senior years.

"As outlined in the Government's National Sport Plan – Sport 2030 – no matter what your age and no matter what your stage, we're encouraging all Australians to embrace the philosophy of 'Movement for Life'. This is a really important step in that process," Senator McKenzie said.

"Physical activity for over 65s is not a one-size-fits-all proposition. The successful organisations will provide a wide range of opportunities, from simple exercise classes in our remote communities through to modified programs in traditional sports such as golf and netball."

Aged Care Minister Ken Wyatt said the new programs would benefit hundreds of thousands of senior Australians in coming years.

"These exciting and engaging activities are about giving us more choices for a longer life, as increasing numbers of Australians live to 100 and beyond," Mr Wyatt said.





Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

“Getting out and about through innovative new sports will help us score healthier, happier futures.

“Studies show sport is fun with serious benefits including better heart health and weight control, while it reduces the progression of chronic diseases and the risk of falls.

“Sport’s social connections mean it strengthens not only our bodies but our minds, and helps guard against loneliness in our later years.”

Australia’s population is ageing and, on current trends, the number of Australians aged 65-plus is expected to double in the next 40 years.

“This shift presents a challenge in broader health terms but provides a chance for sport and physical activity to make a positive difference to the lives of older Australians,” Senator McKenzie said.

Currently, only 25 per cent of Australians over 65 meet the Department of Health physical activity guidelines of 30 minutes activity per day.

Government lists new psoriasis medicines

Two new medicines for the treatment of the skin condition psoriasis have become more affordable, saving patients up to \$32,600 per year.

The Government has listed Tremfya® (Guselkumab) on the Pharmaceutical Benefits Scheme (PBS) from February 1 for the treatment of severe chronic plaque psoriasis.

The medicine would cost around \$30,200 per patient, per year without PBS subsidy. Under the PBS the price goes down to just \$40.30 per script, or \$6.50 for concessional patients.

Severe chronic plaque psoriasis is an inflammatory condition affecting the skin and nails.

The inflammatory autoimmune disease causes skin cells to grow too quickly. This can result in red, scaly lesions that can be painful, disfiguring and disabling.

Psoriasis, which is a lifelong condition without a cure, can impact the emotional and social wellbeing of affected people.

It can be associated with psychosocial issues including social isolation, poor self-image, depression and anxiety.

Treatment with Tremfya neutralises the activity of a protein called IL-23, and reduces proteins in the skin responsible for forming the plaques seen in psoriasis



This listing will help people who suffer the terrible effects of severe chronic plaque psoriasis and at the same time saving families more than \$30,000 a year.

The Government has also listed the medicine Ilumya® (Tildrakizumab) on the PBS from February 1. This medicine also treats severe chronic plaque psoriasis.

The medicine would cost around \$32,600 per patient, per year without PBS subsidy. Under the PBS the price goes down to just \$40.30 per script, or \$6.50 for concessional patients.

Treatment with Ilumya® reduces the inflammation and other symptoms of the disease and promotes skin clearance.

These two medicines are expected to benefit 3,600 Australian patients with this condition.

These PBS listing were recommended by the independent Pharmaceutical Benefits Advisory Committee (PBAC).

Health Minister Greg Hunt noted that the Committee is independent of Government by law and in practice. By law the Federal Government cannot list a new medicine without a positive recommendation from the PBAC.

“Our Government continues to provide PBS listing for every medicine approved by the PBAC to ensure that new, essential medicines are affordable for all Australians,” Mr Hunt said.

“The recent 2018–19 Mid-Year Economic and Fiscal Outlook (MYEFO) invests a further \$1.4 billion in new medicines, saving sick Australians hundreds or even thousands of dollars a year.

“We are now making on average one new or amended PBS listing every single day. Our commitment to the PBS is rock solid. Together with Medicare, it is a foundation of our world-class health care system.”



Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Sleep health hearings



The Australian Parliament's Health, Aged Care and Sport Committee will be holding public hearings in Sydney on Tuesday, February 5 and in Melbourne on Wednesday, February 6, as part of its *Inquiry into Sleep Health Awareness in Australia*.

The Committee Chair, Trent Zimmerman MP, said: "Sleep is a fundamental biological need, and along with a good diet and physical exercise, sleep is the third pillar of a healthy lifestyle.

"Increasingly, Australians are balancing their work, family, and social commitments by cutting back on sleep. We know as many as 40 per cent of Australian adults are not regularly getting enough sleep. And it is not just adults, for young people spending increased time on the internet, playing digital games, and social networking can come at the expense of sleep.

"In the short-term, the consequences of insufficient sleep include decreased work or school performance and an increased risk of road accidents. Over the longer term, insufficient sleep has wide ranging health effects, including increased risk of cardiovascular disease, obesity, diabetes, and dementia."

Further information about the inquiry is available on the Committee's website https://www.aph.gov.au/Parliamentary_Business/Committees/House/Health_Aged_Care_and_Sport/SleepHealthAwareness

More money for Parkinson's

The Federal Government is providing \$30 million over five years to the Garvan Institute of Medical Research to trial promising drugs to reduce the progression of Parkinson's disease and to allow people to live in their homes longer. It will support the Institute's Australian Parkinson's Mission.

Parkinson's disease is recognised as the second most common

neurodegenerative disorder in Australia. More than 100,000 Australians endure its progressive and debilitating symptoms – and without a medical breakthrough, this number is expected to double in 15 years.

Up to 1,000 Australians from Victoria, NSW and Queensland living with Parkinson's will test the effectiveness of four repurposed drugs, revolutionising our understanding of Parkinson's, identifying new treatment targets and discovering new drugs.

The \$30 million funding comes from the Medical Research Future Fund, which is giving support to the best and brightest minds from our research community.

The MRFF is an endowment fund, which will mature at \$20 billion, providing a sustainable source of funding for vital medical research.

A further \$6.8 million over four years will be provided to Primary Health Networks to improve access to specialised nursing care in the community for people living with movement disorders, including Parkinson's disease.

Specialist nurses would fill a range of roles, including providing clinical care to patients, coordinating timely access to community based care to manage acute and chronic health problems and delivery of education and information

Health Minister Greg Hunt said although it has been the subject of significant research since the 1960s, the cause of Parkinson's is largely unknown and current treatments only mask the symptoms.

"No drugs exist to slow or stop the disease progressing – and there is no cure. There is an urgent need to identify drugs that will slow or halt the disease," Mr Hunt said.

"Many of us have watched Parkinson's disease wreak its havoc on our loved ones. We know first-hand how critical the search for a breakthrough cure or treatment is and that's why research is so important.

A successful Australian Parkinson's Mission will mean that Australian patients and their families will be the first to benefit from the future of precision medicine for Parkinson's.

"The mission will be rolled out nationally through leading capital city centres and extended into regional Australia, where possible, via a hub and spoke model."

The Australian Parkinson's Mission is an international research collaboration between the Garvan Institute of Medical Research, Shake it Up Australia Foundation, the Cure Parkinson's Trust, Michael J Fox Foundation and Parkinson's Australia.



Research

BY CHRIS JOHNSON

Asthma flare-ups in children returning to school



Studies in Australia and the UK have shown asthma hospitalisations surge during the first month of the school year, with cases in Australia rising as much as threefold in children aged 5 to 14 years and doubling in pre-schoolers.

For the one in nine Australian children living with asthma, going back to school can increase the likelihood of an asthma attack.

While increased risks have also been recorded at the start of subsequent school terms, the February spike is by far the most significant.

In Australia, about 20 per cent to 25 per cent of children's hospital admissions for asthma occur in February.

Childhood asthma peaks in primary school aged kids and affects mainly boys, however the group at highest risk from asthma death in childhood is adolescent boys.

Dr Louisa Owens, Respiratory Paediatrician and National Asthma Council Australia spokeswoman, said that in the lead up to the new school year, parents and carers should identify contributing factors to children's asthma flare-ups and take steps to help prevent them.

"Possible causes for flare-ups in February include not taking

medication as prescribed during the summer holidays; the stress of returning to school; allergic triggers at school such as mould and dust and close quarters with new classmates who can bring a new batch of cold and flu bugs," Dr Owens said.

"For parents and carers, if you see your child is using more of their blue reliever (e.g. Ventolin or Asmol), make sure you take them to the GP to have their asthma reviewed.

"When at school, you may be less aware about how often your children are using the puffer, so you need to ask them to keep you updated as well as keeping an eye on how often you are needing to buy new medications for them.

"Following a GP prescribed treatment plan and properly managing a child's air quality and environment, such as help them avoid smoke, can truly transform a child's life, allowing them to perform better in school, build confidence in sports and simply get outside and play."

By following this checklist parents can help increase the likelihood of children with asthma having a symptom-free return to school:

- Schedule an asthma check-up with your health provider;
- Share a copy of your child's up-to-date written Asthma Action Plan with school staff and after school carers;
- Ask your child to let school staff know when their asthma is flaring up;
- If your child has exercise induced asthma, ensure they take their reliever before sport;
- Explain to your child their asthma triggers and why it's important to avoid them;
- Make sure your child is taking asthma prevention medicine, as prescribed;
- Check that your child knows how to effectively use their puffer by themselves (if old enough), or with help; and
- Get the seasonal flu shot every year for your child and family members.

The National Asthma Council has useful resources available on its website www.nationalasthma.org.au to help parents navigate a healthy and safe return to school for their children. This includes video tutorials demonstrating the proper use of asthma medications.





Research

BY CHRIS JOHNSON

New blood screening device developed



Scientists have developed a new device that can rapidly screen the blood in just minutes to detect a range of pathogens that cause disease, in a breakthrough that could fast-track the way disease or infection is diagnosed and treated.

From a sample of blood, or other body fluids, it has the potential to diagnose serious diseases within an hour, including bacterial or fungal infection, HIV, hepatitis and diabetes. It can also create a full blood profile giving the overall health status of a patient simultaneously.

The technology is a small spectrometer that uses infrared light to analyse disease-causing pathogens in the blood. Each pathogen has a unique chemical fingerprint and it's from this fingerprint a diagnosis can be done. The portable device weighs about seven kilograms and is powered by a small battery.

Monash University biospectroscopists have been issued a US patent for the diagnostic technology they hope will one day help doctors to diagnose and treat patients much faster than current pathology methods.

A US patent was issued for the technology last year for its ability to detect malaria, but the multi-disease diagnostic has since been expanded with this second patent to detect all pathogens in blood. The patents, which have been licensed to Biotech Resources (Aust) Pty. Ltd. (BTR), are the first of a kind to utilise spectroscopy to quantify pathogens in blood. BTR will commercialise the product.

The diagnostic technique is the brainchild of co-inventors Dr

Philip Heraud, Professor Bayden Wood and Dr David Perez-Guaita, of the Monash University Centre for Biospectroscopy in Melbourne, Australia.

The team is currently trialling patients in the detection of bacterial and fungal pathogens in the blood that cause the deadly bacterial infection sepsis.

“This technology represents a paradigm shift for disease diagnostics and has such been recognised with patent rights,” Professor Wood said.

“It means doctors could triage a patient faster than ever before – right at the point of care. Current techniques can take days to return a diagnosis – but this technique can provide initial diagnoses within an hour, allowing patients with life-threatening infections or illness to be treated without delay.”

The next step is to commercialise and refine the technology. Researchers hope the device could be approved for used in hospitals and field settings in the next three to four years.

More bowel cancer cases for under 50s

A recent study by Cancer Council NSW has found that the incidence of bowel cancer (colon and rectal) is increasing in Australians under the age of 50. Bowel cancer is the third most commonly diagnosed cancer in Australia, with about 17,000 new diagnoses estimated in 2018.

The study found that for people under 50 years, colon cancer incidence rates have increased by up to 9.3 per cent a year from the mid-2000s, while rectal cancer incidence rates have risen by up to 7.1 per cent a year since the early 1990s.

“There are a number of risk factors that could be associated with this rise in new cases of bowel cancer in people under 50, including obesity, alcohol consumption and red and processed meat intake,” said Dr Eleonora Feletto, Research Fellow at Cancer Council NSW.

“To reduce overall cancer risk, but especially for bowel cancer, we encourage all Australians to reduce their intake of alcohol and red and processed meat and maintain a healthy weight.

“Our research also found that bowel cancer incidence is decreasing in Australians aged 50 or over.

“This is partially due to our National Bowel Cancer Screening Program (NBCSP) and reinforces how important it is that people





who can access the NBCSP use it.”

By 2020, the NBCSP will invite all eligible people aged 50 to 74 to screen for bowel cancer every two years using a free, simple stool test kit which they can complete at home.

Another recent, complementary Cancer Council study found that screening people 50 to 74 is still the best approach to reducing the impact of bowel cancer. This second study explored extending the NBCSP to people in their forties, late 70s and early 80s, compared with the current age group.

It concluded that though there might be incremental benefits of screening people under 50 and over 74, they did not outweigh the associated harms.

“We appreciate that the NBCSP’s current age bracket may seem at odds with the rise in bowel cancer incidence rates in under 50s,” said Professor Karen Canfell, Director of Cancer Research Division at Cancer Council NSW.

“However, our research shows that this is still the best approach to bowel cancer screening for average risk Australians.

“We found that extending the NBCSP to people in the older age group is unlikely to be cost-effective at the moment. At the other end of the scale, inviting people in their 40s as part of the program leads to a substantial increase in the number of unnecessary colonoscopies required – increasing burden on the health system and colonoscopy waiting times for those most in need.

“We know from a previous study that 83,800 lives could be saved between now and 2040 if we could increase the current participation from 40 per cent to 60 per cent.

“It’s vital that we focus on increasing participation in the program. We encourage all Australians aged 50-74 years to take part in the NBCSP when they are sent the test kit, as approximately 90 per cent of bowel cancers can be cured if detected early.”

Cancer Council encourages concerned individuals, possibly with a family history of bowel cancer, symptoms such as rectal bleeding or questions relating to other bowel cancer risk factors, to visit their GP. GPs can recommend the appropriate screening or alternative course of action based on guidelines.

About the colorectal cancer trends study

- ‘Trends in colon and rectal cancer incidence in Australia from 1982 to 2014: Analysis of data on over 375,000 cases’ is a

study by led by Cancer Council NSW researchers published in *Cancer Epidemiology, Biomarkers & Prevention*.

- In Australia, colorectal cancer (CRC), also referred to as bowel cancer, estimated to be the third most commonly diagnosed cancer overall in 2018, with estimated all-age incidence rates of 67.3 per 100,000 in males and 49.4 per 100,000 in females. Incidence of CRC in people under 50 years of age is rising in a number of high-income countries according to the latest evidence.
- The study assessed colon and rectal cancer incidence trends in people aged 20+ in Australia from 1982 to 2014. There were 375,008 CRC cases diagnosed, including 248,162 colon and 126,846 rectal cancer cases. Approximately 7 per cent (17,859 cases) and 9 per cent (11,457 cases) of colon and rectal cancer cases, respectively, were in people under 50 years of age. The annual percentage change (APC) was quantified in rates by age group using Joinpoint regression.
- At-risk levels of these behaviours have reportedly increased at the same time as the observed increases in CRC in those under 50 years of age, and these phenomena could be linked.
- Bowel cancer screening can lead to reduced bowel cancer incidence, as well as mortality, through the early detection of both precancerous conditions and cancer. The Australian National Bowel Cancer Screening Program (NBCSP) is currently at an advanced stage of a phased implementation process. As of 2019, all those aged 50-74 will be invited to participate biennially in screening, with 2015-16 biennial participation rates approximately 40 per cent.

About the NBCSP age extension study

- ‘Benefits, harms and cost-effectiveness of potential age-extensions to the National Bowel Cancer Screening Program in Australia’ is a study by led by Cancer Council NSW researchers published in *Cancer Epidemiology, Biomarkers & Prevention*.
- The study was performed to underpin the 2017 review of Clinical Practice Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer, which recommends that the age range for organised population bowel screening should continue to be 50–74 years.
- Before this study, there was no systematic evaluation of the trade-off of benefits to harms of screening at different ages in Australia.





Research

- The aim of the current study was to evaluate the incremental health benefits, harms, costs and resource utilisation of extending the age of screening to people in their forties, and to people in their late seventies and early eighties, and to compare this with the current program involving screening in those aged 50 to 74 years.
- Extending screening to people outside of the current range would be associated with a large increase in number of colonoscopies required (3-36 per cent increase if screening start age was lowered, and 9-53 per cent increase if the screening cessation age was increased).
- Only the current program and screening at 45 to 74 years were found to be cost-effective under all screening adherence assumptions, but starting screening at 45 years would increase colonoscopy demand by 3-14 per cent and be associated with 55-170 additional colonoscopies per additional death prevented over the lifetime of a cohort compared to the current program.

E-cigs liquids can kill children

Risks to children from the accidental ingestion of e-cigarette liquids containing nicotine “should not be underestimated”, according to the authors of research published by the *Medical Journal of Australia*.

One millilitre of a highly concentrated nicotine solution such as those contained in e-cigarette refill bottles can be lethal if ingested by a child, wrote the authors, led by Carol Wylie, manager of the Queensland Poisons Information Centre in Brisbane.

“Imported products may not conform to Australian standards, including having child-resistant closures and appropriate labelling, and refill bottles containing highly concentrated nicotine solutions ... can be purchased online,” the research states.

The authors undertook a retrospective analysis of calls to Australian Poisons Information Centres (PICs) during 2009–2016.

“The numbers of calls about e-cigarette exposures increased considerably across the study period, although the overall PIC call volume was stable at about 164,000 cases per year,” they wrote.



“Of 202 sequential e-cigarette-related cases, 38 per cent were from relatives of children worried about their exposure to the liquid component of an e-cigarette after children were found with uncapped vials, sucking the mouthpiece, drinking from separated liquid containers, inhaling the liquid, eating the cartridge, or having splashed liquid in their eyes.

“Adults and adolescents were the subjects of calls in 126 cases (62 per cent), including calls about the potential side effects of routine use or accidental ingestion, or about skin or eye splash exposures. Twelve calls followed deliberate administration for self-harm, ten by oral ingestion and two by injection.”

Although most patients had mild symptoms – mainly gastrointestinal disturbances and, in some cases, sedation – the authors warned that children were particularly vulnerable.

“The potential risks ... should not be underestimated; we are aware that an infant recently died in Australia after ingesting a concentrated nicotine solution. Almost all exposures of children to nicotine-containing e-cigarette liquid require their hospitalisation for monitoring possible toxic effects.”

The authors wrote that nicotine-containing products should be stored where children could not access them.

“We would welcome any move to improve the safety of electronic cigarettes, including changes to their labelling, storage, and packaging,” they said.



Research

Creative study into panic attacks



Researchers from UNSW Science's School of Psychology and St Vincent's Hospital are leading a world-first study to learn more about a novel therapeutic approach for people who suffer from panic attacks. They are conducting research that seeks to treat people with panic disorder and agoraphobia – the fear of places and situations that might lead to panic attacks – with just one week of therapy.

In the study, the researchers are delivering an adapted version of cognitive behavioural therapy (CBT), an approach already known to be effective for some people with anxiety and depression. Both the concept of delivering CBT online and in intensive format has already been shown to work – but never in combination.

“We know that CBT can be delivered in intensive format over a short amount of time in-person. A few recent studies have already shown that it's an effective delivery format in panic, OCD and PTSD and specific phobias, like spiders,” said Eileen Stech, a trainee psychologist from UNSW Psychology, who leads the study.

“And a number of research teams have developed online self-help programs that people can work through – these can overcome some of the barriers to access, like cost, and people can do it at night if that's more convenient to them than having to see a therapist during regular office hours.”

The team is now testing whether the two formats can be combined.

“We're testing whether we can take that exciting intensive model and deliver it online, so we can reach people in rural and remote areas, as well as people who are too impaired to travel to therapy. No one has tested this ever before,” Ms Stech said.

The researchers are working with people with panic disorder, that is people experiencing frequent panic attacks or worrying a lot about having panic attacks, as well as avoiding situations and places in their life because of fear of panic.

“Frequency of attacks can be a marker of severity, but not always – some people might just have one really awful panic attack and then be so afraid of future attacks that they really dramatically alter their lifestyle really quickly,” said UNSW psychologist Dr Jill Newby.

“It's a vicious cycle, where they may have more panic attacks because of that.”

People who are eligible for the study after the initial screening process need to commit three to four hours a day on therapy activities for seven days. During that time, participants complete online, comic-style lessons that follow a person's journey of overcoming panic disorder through CBT. The study uses an adaption of the team's existing six-lesson panic program, focusing on the key strategies.

The online comic lessons that follow each participant's experience are accompanied by lesson summaries, which have more detail on how to implement the activities and worksheets so they can apply it to their own lives.

They then spend the rest of the time each day putting the activities into practice. A key component of the therapy is exposure – to the trigger of panic, which can be certain body sensations, places or situations. Over time, people with panic disorder become very sensitive to small changes in their body sensations, fearing they signal danger, such as a heart attack or stroke.

“Participants are guided through specific exercises that help them re-evaluate those fears and develop more realistic thoughts,” Ms Stech said.

“They are guided through a framework that allows them to re-enter feared situations in a gradual and controlled manner, always taking things step by step. Although facing your fears takes courage, many patients report it is a very empowering process.”

Participants can also access support from clinicians via email



Research

and phone throughout that week to help them complete the exercises.

The team then follows participants up with questionnaires one week and two months after the treatment week.

“We use a number of standardised self-report measures that have been widely used in many past clinical trials to measure symptom change. We’ll be looking at change from beforehand to after, but also in comparison to another study where the online panic program is run over two months. That’ll show us whether patients of both studies are getting similar outcomes,” Ms Stech said.

People who struggle with panic disorder, are over the age of 18, live in Australia, have regular access to the internet and are interested in taking part in the one-week panic program can learn more at: <https://virtualclinic.org.au/trials/panic-oneweek> - the team’s Virtual Clinic website.

Disadvantaged trust doctors to help them quit smoking

Latest research reveals that many disadvantaged people who want to quit smoking believe it is their doctors who can help them the most with the goal.

Some of Australia’s most disadvantaged groups, including homeless people, people living with a mental illness and people who are dependent on drugs or alcohol could be receiving greater support to quit smoking, according to a study released by the Public Health Association of Australia (PHAA).

New research in the *Australian and New Zealand Journal of Public Health* shows that disadvantaged people are often interested in quitting smoking, but sometimes lack the necessary emotional and practical support to do so.

A study of affected populations found that individual smokers perceived their doctors to be the best source of support for quitting.

Curtin University’s Professor Simone Pettigrew, a co-author of the study confirmed the findings, said smoking rates were significantly higher among these groups.

“And while they are often aware of the risk which smoking poses to their health, they are less likely to have success in quitting than other people,” Professor Pettigrew said.



“The study found that doctors were seen by disadvantaged people as the best providers for emotional and practical support in quitting smoking – particularly when there was an established relationship of trust between them and their patient.”

The study also showed that in some instances doctors and community services providers who work with disadvantaged people were less likely to recommend they quit smoking if they thought it would be too much of a burden to the individual or exacerbate their existing health issues.

Terry Slevin, Chief Executive Officer of the PHAA and a co-author of the study said there was sometimes a belief among some professionals that people who are already grappling with homelessness, addiction or poor mental health would be overwhelmed by attempting to quit smoking.

“It might also be viewed as the ‘one small pleasure’ disadvantaged people have and a lower priority to other social or health or health challenges.

“However, this not the case. The truth is that while smoking might be seen as a smaller issue that these individuals are facing, it actually feeds into their overall poor health and then continues an ongoing cycle of disadvantage, financial insecurity and lower employability.

“Cigarettes are an unnecessary financial and health burden to those Australians who are already struggling a great deal.

“Service providers need to be assured of the importance of encouraging cessation and that many disadvantaged people do want assistance to quit. It’s also important they are equipped with the appropriate tools and knowledge to fully support their patients in quitting smoking.”



Research

Routine colonoscopies after enterococcal infection

Colonoscopies for people with an enterococcal infection should become routine, according to the authors of new research published in the *Medical Journal of Australia*.

Recent international research has shown an association between *Enterococcus faecalis* bacteraemia and colorectal neoplasia (cancer). The link between *Streptococcus gallolyticus* (previously *S. bovis*) bacteraemia with infective endocarditis and colorectal neoplasia has been recognised for many years, resulting in routine colonoscopies for those patients.

E. faecalis is a gram positive bacterium which can cause urinary tract infections, endocarditis, and wound infections.

The *MJA* research, led by Professor Eugene Athan, Director of Barwon Health, set out to investigate the association of enterococcal infection with colorectal cancer in the Barwon region of southwestern Victoria, using data from 376 patients diagnosed with *E. faecalis* from 2010 to 2017.

“Of 180 patients for whom we had detailed medical records, 12 had been referred for colonoscopy solely because *E. faecalis* bacteraemia (seven cases) or infective endocarditis (five cases) had been diagnosed,” Prof Athan and colleagues wrote.

“Colonoscopy identified previously undiagnosed colorectal neoplasias in nine patients (75 per cent) ... including two instances of adenocarcinoma and nine of adenoma (two with high-grade dysplasia, five with moderate-grade dysplasia, and two with low-grade dysplasia).

“Our study is the first in Australia to identify the importance of evaluating patients with *E. faecalis* bacteraemia for underlying colorectal neoplasia.

“Routine colonoscopy should be considered for patients with either *S. gallolyticus* or *E. faecalis* bacteraemia or infective endocarditis with an unclear source of infection.”

Focus on food allergy

Awareness of a poorly understood food allergy, often misdiagnosed in infants as sepsis or gastroenteritis, has been boosted by the publication of a narrative review in the *Medical Journal of Australia*.

Food protein induced enterocolitis syndrome, or FPIES,



typically presents between one and four hours after ingestion of the trigger food, with symptoms including profuse vomiting, pallor and lethargy. Other features can include hypotension, hypothermia, diarrhoea, neutrophilia and thrombocytosis.

Co-authors of the narrative review, Dr Sam Mehr, a paediatric immunologist and allergist at Royal Melbourne Hospital, and Professor Dianne Campbell, Chair of Paediatric Allergy and Clinical Immunology at the University of Sydney, and Children’s Hospital, Westmead, wrote that in Australia the most common food triggers for FPIES were, in descending order, rice, cow’s milk, egg, oats and chicken.

“Diagnosis is often hampered by the lack of awareness of FPIES, absence of reliable biomarkers, the non-specific nature of the presenting symptoms, and the delay between allergen exposure and symptoms,” Dr Mehr and Prof Campbell wrote.

No blood test exists for FPIES, and the treatment in an acute setting is fluid replacement, with ondansetron also believed effective. Long-term management involves confirming diagnosis via a food challenge, and avoidance of identified trigger foods.

“It is likely that improved understanding of the immunological basis of FPIES will, in the future, facilitate the development of a sensitive and specific biomarker,” the authors concluded.

“Until that time, use of standardised diagnostic criteria, improved recognition, timely fluid resuscitation, avoidance of trigger foods, and education form current best practice.”

Health insurance lacking under Trump



The number of Americans without health insurance has soared under the presidency of Donald Trump.

The percentage of uninsured adults in the US peaked in 2018 to levels not seen before President Trump came to office.

According to a national Gallup survey reported on the *Los Angeles Times*, there were unprecedented health insurance losses in the two years of the Trump administration.

At the end of 2018, 13.7 per cent of US adults were uninsured. That figure is up from 10.9 per cent at the end of 2016, when President Barack Obama was completing his second term.

“The new number represents the highest uninsured rate since the beginning of 2014, when the Affordable Care Act began providing billions of dollars in aid to help low- and middle-income Americans get covered,” the *Times* states.

“The new report also indicates that some 7 million American

adults have likely lost or dropped coverage since 2016.”

The newspaper also states that between 2013 and 2017, more than 20 million previously uninsured Americans gained coverage, fueled largely by the healthcare law popularly known as Obamacare.

“That brought the nation’s uninsured rate to the lowest levels ever recorded,” the *Times* report says.

“Since taking office, however, Trump has repeatedly attacked the healthcare law and enthusiastically backed a 2017 effort by congressional Republicans to roll it back.

“The repeal effort failed, but the administration took a series of other steps to loosen insurance rules and dial back support for insurance markets created by the 2010 law, including dramatically cutting funding for advertising and outreach efforts.”

Pork found with dangerous superbugs



Pork sold in supermarkets in Spain, Thailand and Brazil has been found to contain superbugs resistant to some antibiotics used to treat humans.

The charity World Animal Protection sent experts to test pork

sold in Australia, Brazil, Spain and Thailand, and found that in all but Australia, the meat was infected.

The widespread use of drugs in farm animals is being blame for the increase of antimicrobial resistance.

The OECD states that three-quarters of the world's antibiotics are used in factory farming, mostly on pigs.

The World Health Organisation (WHO) has warned that antibiotic resistance is a serious threat to human health. Superbugs in the food chain can cause a range of serious illnesses, including pneumonia, fever, skin and urinary tract infections, and in extreme cases could cause death.

In the UK, supermarkets are being called on to be more transparent about antibiotics in their supply chains following the test results.

Britain imports 60 per cent of its pork products, some from the countries where the meat is infected.

Lack of star power for mental health



Not even royalty can get celebrities interested in supporting mental health.

That appeared to be the insinuation made by Prince William when he told the recent Davos World Economic Forum that every celebrity he asked to support his Heads Together mental health

initiative had refused to lend a hand.

Prince William – the Duke of Cambridge – told the forum he had approached many stars but none appeared willing to be associated with mental health.

“For some reason, people are embarrassed about their emotions - British people particularly,” he said,

The Duke said he believed Britain's wartime generation helped to create some of the stigma, because people preferred not to talk about “horrendous” events. They passed a stoic attitude onto their children.

“A whole generation inherited (it). This was the way you deal with your problems. You don't talk about it,” he said.

“A new generation knows that's not normal.”

The prince created Heads Together in 2017 with the Duchess of Cambridge and Prince Harry.

He also told the forum about his own struggles with mental health.

Freight fears for insulin in Brexit debacle

Concerns grow in Britain that if a 'no-deal' Brexit becomes a reality, shipping routes will have to change for much needed medicine supplies.

The UK's largest supplier of insulin, Danish company Novo Nordisk, is stockpiling months' worth of supply in preparation for no deal, and it has chartered air freight as alternative to shipping routes to Dover and the Channel Tunnel.

Novo Nordisk's UK general manger, Pinder Sahota, told Sky News said it was crucial to establish alternatives routes to Dover so as not to interrupt the supply of insulin.

"Stockpiling is one of the solutions but it is not the only solution. The replenishment of the stock post-Brexit is the next phase, and there are certain factors beyond our control here," he said.

"The delays are unknown, which is why we have built the stocks, why we have booked air freight, and we will be looking to other ports as well in addition to Dover.

The company manufactures more than half of Britain's insulin, which is imported to about 500,000 UK patients.

The fear is that a no-deal Brexit could have the UK leave the EU without any shipping agreements in place.

Final push to eradicate polio in Afghanistan and Pakistan

The World Health Organisation has praised the governments of Afghanistan and Pakistan for their efforts in the bid to wipe out polio in their respective countries.

The two countries are the only two where wild poliovirus cases were reported last year.

WHO Director-General Dr Tedros Adhanom Ghebreyesus recently undertook a four-day visit to Afghanistan and Pakistan and commended their governments for providing provide universal access to health services.

Dr Tedros met with heads of state and senior government officials in both countries and witnessed first-hand WHO-supported health programs.

He also visited the Emergency Operations Centre for Polio Eradication in Islamabad, Pakistan, where he commended the work of government and partners as "one team under one roof" and highlighted the critical importance of working closely with Afghanistan to prevent cross-border transmission.

"We must all give our best on this last mile to eradicate polio once and for all. My wish for 2019 is for zero polio transmission. You have WHO's full support to help reach every child and stop this virus for good," Dr Tedros said.

In Afghanistan, Dr Tedros and the Government there launched the newly developed Integrated Package of Essential Health

Services. This package includes the most cost-effective evidence-based interventions that reflect the most common causes of mortality and morbidity in the country. It keeps the focus on primary health care but also adds noncommunicable diseases and trauma care. Dr Tedros confirmed WHO's support to the Government to develop financing options to help ensure access to health services for all Afghans.

Dr Tedros also visited the Trauma Care Hospital run by the Italian NGO Emergency in Kabul, where Dr Tedros thanked humanitarian workers for their important work.

In Pakistan, Dr Tedros helped the Government launch of the first Pakistan Nursing and Midwifery Summit and the Nursing Now campaign. Pakistan faces a critical shortage of health workers including nurses and midwives. The country needs more than 720,000 nurses to achieve universal health coverage by 2030.

He also visited a basic health centre in Shah Allah Ditta where WHO signed an agreement with the Government of Pakistan to develop a model health care system for universal health coverage in Islamabad.

Dr Tedros commended the Government for its initiatives to tax tobacco and sugary drinks, as well as its plans to increase the health budget to 5 per cent of GDP by 2023 (from the current 0.9 per cent of GDP).

WMA condemns lethal force against doctors in Sudan

The World Medical Association has condemned in the strongest terms the use of violence, particularly lethal force, against protesters and physicians during recent demonstrations in Sudan.

The peaceful demonstrations have been in protest at the collapse of the public sector, with physicians denouncing the breakdown of the health system and their working conditions.

Physicians have been on strike several times about their inability to perform their duties of saving lives and providing adequate care to their patients.

WMA President Dr Leonid Eidelman, in a letter to the President of Sudan, said: “We deplore the fact that health care providers and facilities constitute the target of attacks from the security force. Rather than opening a constructive dialogue with doctors and other relevant stakeholders based on their claims, such repression violates the right to work of physicians by preventing them from practicing their profession, depriving millions of people of access to health as a result. It threatens further the health system, public services and ultimately the economy of the country.

“We are appalled to note the violent repression of these demonstrations by the Sudanese security force. Different reliable sources of information relate ‘deadly onslaught’ on protesters, with security forces opening fire on protesters. The death of a physician, a civilian and a child from gunshot wounds inflicted during protests in Khartoum earlier this month were reported.”

The WMA is urging the Sudanese authorities to take immediate charge of the security forces to ensure they stop using violence against protesters, to bring to an end attacks against medical facilities and personnel, and people seeking hospital treatment and to conduct an independent and impartial investigation into the use of violence, bringing to justice those in the security forces found to have ill-treated demonstrators or other members of the public.

Dr Eidelman called on the authorities to open a dialogue with doctors about their claims, to address the root causes of the economic crisis that has driven the people to the streets.

Measles hotspot sparks public health emergency

A measles outbreak near Portland, Oregon, USA has sparked a public health emergency in nearby Clark County, Washington.

Health officials in Clark County had declared the emergency because the number of measles infected people in the area was growing rapidly.

With more than 20 cases confirmed in just a couple of weeks to mid-January, officials said the majority of those who fell ill from the virus had not been immunised against it.

Schools, churches, shops, department stores and even a dentist clinic have all been named as places where people known to have been infected with measles had visited.

Portland International Airport and a home game of the Portland Trail Blazers basketball team were other locations where people with measles were pinpointed to have been.

Health officials said it was disturbing that there was such an outbreak of measles when there is a safe and effective vaccine for it.

Clark County data shows 7.9 per cent of school children there were exempt from vaccines required for kindergarten entry in 2017-18 – with most of those being exempted for personal or religious reasons rather than medical dispensation.

Clark County is now labelled as a hotspot for measles, with most of the cases being children under 11.

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