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Climate change

It's a health emergency, p3

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In this issue

Climate change is a health emergency

The AMA has formally recognised climate change as a health emergency and has called on the Federal Government to take specific and urgent steps to address it.

Those steps include transitioning away from fossil fuels, adopting mitigation targets within a carbon budget, developing a national strategy for heath and climate change, and establishing a unit to reduce carbon emissions in the healthcare sector.

The AMA Federal Council passed a climate change motion at its last meeting and has now joined other health organisations around the world in recognising the potential health crisis.

The American Medical Association, the American College of Physicians, the British Medical Association, the World Health Organisation, and Doctors for the Environment Australia have all recognised climate change as a health emergency.

The AMA Federal Council declared that climate change is real and will have the earliest and most severe health consequences on vulnerable populations around the world, including in Australia and the Pacific region.

The Federal Council Motion reads:

> *The Federal Council recognises climate change as a health emergency, with clear scientific evidence indicating severe impacts for our patients and communities now and into the future. The AMA commits to working with government agencies and other organisations to prioritise actions in line with the AMA's 2015 Position Statement on Climate Change and Human Health.*

The American Medical Association and the American College of Physicians recognised climate change as a health emergency in June this year, with the British Medical Association declaring a climate emergency in July.

The WHO recognised climate change as the "grestest threat to global health in the 21st century" in 2015.

The AMA has associated health threats with climate change since 2004, but now formally declares it a health emergency.

AMA President Dr Tony Bartone said the evidence is in on climate change and it is irrefutable.

"The AMA accepts the scientific evidence on climate change and its impact on human health and human wellbeing," Dr Bartone said.

"The scientific reality is that climate change affects health and wellbeing by increasing the situations in which infectious diseases can be transmitted, and through more extreme weather events, particularly heatwaves.

"Climate change will cause higher mortality and morbidity from heat stress. Climate change will cause injury and mortality from increasingly severe weather events.

"Climate change will cause increases in the transmission of vector-borne diseases. Climate change will cause food insecurity resulting from declines in agricultural outputs. Climate change will cause a higher incidence of mental ill-health.

"These effects are already being observed internationally and in Australia. There is no doubt that climate change is a health emergency.

"The AMA is proud to join the international and local chorus of voices urging action to address climate change on health grounds."

The AMA is calling on the Australian Government to:

- Adopt mitigation targets within an Australian carbon budget.
- Promote the health benefits of addressing climate change.
- Develop a National Strategy for Health and Climate Change.
- Promote an active transition from fossil fuels to renewable energy.
- Establish a National Sustainable Development Unit to reduce carbon emissions in the healthcare sector.

In April this year, a group of Australian health and medical associations, including Doctors for the Environment, the Climate and Health Alliance, the Royal Australian College of Physicians, and the Australian Medical Students' Association wrote an open letter to all political parties emphasising the "significant and profound impacts climate change has on the health of people and our health system".

The AMA *Position Statement on Climate Change and Human Health* is at https://ama.com.au/position-statement/ama-position-statement-climate-change-and-human-health-2004-revised-2015

JOHN FLANNERY AND CHRIS JOHNSON

Pharma chameleon

BY AMA PRESIDENT DR TONY BARTONE

"The pharmacy sector is significantly over-regulated. Only pharmacists can own pharmacies. There is no legitimate reason for this. It is anti-competitive and results in patients and the community paying the price."

We are in the middle of a well and truly long overdue public debate about scope of practice issues between GPs and pharmacists. The AMA and the Pharmacy Guild of Australia are the key protagonists.

This debate comes months away from the finalisation of the 7th Community Pharmacy Agreement (CPA), which involves billions of dollars for the pharmacy sector over the five years of the CPA.

The Guild is lobbying for pharmacists to take over more GP roles, while confronting their own battles from competitive forces within their own profession. The AMA is following the evidence and is lobbying against these moves. Meanwhile, the AMA and others are pushing the Government to change pharmacy ownership and location rules.

The pharmacy sector is significantly over-regulated. Only pharmacists can own pharmacies. There is no sensible reason for this. It is anti-competitive and results in patients and the community paying the price. But pharmacists can own medical practices, and some do. And now the Guild wants pharmacists to be doctors – but without the countless years of training and the experience in holistic medicine and patient care.

Our evidence of outcomes speaks for itself. The Guild's overtures are putting at risk those long achieved outcomes, measures which see Australia lead the world ahead of places like the UK and Canada, the very places that are used as crucibles of evidence to justify the ill-conceived attempts to offer the Australian public an inferior solution under the Guild's false promise of access and convenience.

Enough! The issues we are discussing here relate to more than just numbers or measures. It's about the outcomes to patients. My patients. Your patients. The very patients we have continued

to look after and provide the very best of care for.

The AMA is promoting a model of pharmacists working in general practice. This model offers convenience and safety for patients, and is backed by the Pharmaceutical Society of Australia (PSA), which represents individual working pharmacists, not the pharmacy owners.

Throughout this debate, the Guild, like a chameleon, changes colours according to who they are engaging with – governments, doctors, the media, and the public. But they try not to show their true colours. We will always seek to dispel the propaganda and provide the facts and the evidence about quality primary health care.

The facts and the evidence are clear – GPs are experts in quality primary health care. Their leadership of a multi-disciplinary care team of allied health practitioners in a patient-centred approach is evidence-based and results in the best outcomes for patients. This is what patients want. It is what our health system needs.

It is all about everyone working within their true scope of practice, and their training and their background in terms of that scope of practice.

Pharmacists and GPs work well together at the local community level to the benefit of patients. The key to that productive partnership is sticking to the roles for which they have trained.

If we look at the average GP, they have been trained for at least 10 years on current rates of training schedules, and that could even be longer with post-graduate and other additional work, which could be up to 14 to 15 years. How can The Guild claim that five years of pharmacy training is sufficient training to justify clinical prescribing as being within their scope?

And that clinical training, that clinical background, that direct patient contact in real life and death settings – founded on proper history taking, examination, diagnosis and formulating a management plan, as well as the grounding in all the health sciences that underpin their training – brings great benefit to patients and the health system. It is quality care and advice for all stages of life.

GPs provide continuity of holistic care. Nobody else can do that.

It is astounding that we still have to explain this reality to politicians, bureaucrats, and the media. But we do it. We must do it. We will do it. For the sake of our patients.

The growing tensions around scope of practice have called for strong action from the AMA. That is why we have formed the General Practice Pharmacy Working Group.

This Group will drive policy, strategy, and advocacy on pharmacy and dispensing, and provide the Government with strategic AMA general practice input to the 7th CPA.

It will work on developing new blueprints for dispensing, including doctor ownership of pharmacies, which would allow doctors and/or pharmacists to dispense from general practice.

The two priority issues are the pharmacy ownership rules and the pharmacy location rules.

The AMA has long called for the Commonwealth pharmacy regulations to be amended to enable pharmacies and medical practices to be co-located.

We support high-quality primary health care services that are convenient to patients, enhance patient access, and improve collaboration between health care professionals.

Co-location of medical and pharmacy services would clearly facilitate this.

Incorporating pharmacy services into general practice, including under the ownership of a medical practitioner, would improve patient care by allowing GPs to lead a team of co-located health professionals in providing multidisciplinary health care to patients at the local community level.

Many general practices already provide co-located services with pathology collection centres, and in-house psychologists, physiotherapists, dieticians, and podiatrists.

Adding pharmacy to the mix would have benefits for patients, pharmacists, and GPs.

This is world's best practice. It's available to our hospital-based in-patients right now. Why should community patients miss out on this opportunity?

The scope of practice debate has more chapters to come. So does the pharmacy ownership debate. And the whole CPA.

Improved standards of dispensing versus 'professional services'

BY AMA VICE PRESIDENT DR CHRIS ZAPPALA

The Community Pharmacy Agreement is currently being re-negotiated between the Guild and the Commonwealth Government. This perhaps explains the re-invigorated effort from the Pharmacy Guild to expand pharmacists' scope of practice beyond their trained experience into the realm of the general practitioner who has significantly greater training in the correct disciplines and skills to safely and competently diagnose and treat patients. The alternate reasoning here is no more than a beguiling substitution of convenience (and profit generation) for quality and safety.

Some may regard this view as protectionist and old-fashioned, but the statement remains unassailably true and sensible. The measure of the success of an intervention cannot primarily be if the patient found it an agreeable and convivial experience. It clearly needs to be safe, evidence-based, quality care with meaningful outcomes and provided by the most appropriately trained individual.

Retail pharmacy owners i.e. the Guild (who need to be differentiated from the more numerous pharmacists working collaboratively in hospitals, general practice and elsewhere) want two main things:

1. To dispense/prescribe more of anything they can possibly get their hands on.
2. To offer medical advice as a 'professional service' to patients as a substitute for general practitioners (or anyone else really) with MBS funding to do so.

I suspect the sole reason retail pharmacy owners desire this is to increase foot traffic in their pharmacies so more supplements, foot massagers, perfume and over the counter drugs can be sold. In discussion with non-Guild pharmacists, a significant number realise offering medical advice is out of scope and fraught. It is observed that the profit made from dispensing PBS medications is comparatively small compared to the complementary medicine items (all of which are largely non-evidence based). In addition, the Commonwealth Government's pharmacy ownership and geography rules create a small, protected group of pharmacists owning businesses at least partially insulated from true market forces. How cosy!

Let us look at the two main desires of the pharmacy owners/ Guild.

Dispensing whatever possible (which means they also shift more stock and have opportunity to up-sell).

The Guild's own policy regarding safe and effective use of medication states the following:

"The separation of prescribing and dispensing of medicines provides a safety mechanism as it ensures independent review of a prescription occurs prior to the commencement of treatment." Case closed. Pharmacists are conflicted (prescription for profit) and should never prescribe in accordance with the Guild's own policies. It is a safety issue as the Guild points out – so let's accept the only training appropriate to safely prescribe is a medical degree. Anyone can apply to do medicine – unlike pharmacy ownership! If the Guild is happy that prescribing and dispensing can occur simultaneously, then the ultimate convenience is if the general practice dispenses so patients only have one stop for all of their healthcare needs. Perhaps we can do away with retail shopfront pharmacy entirely?

As I've mentioned before, usurpers often abandon activities truly in scope that they have been appropriately trained for as they make a blatant grab for extended scope. For example, from the Guild's own policy document again, the following: "Counselling is an essential element of the dispensing process, ensuring patients or their carers have sufficient information to enable an understanding of their medicines and the intended therapeutic effect, and to minimise the risk of adverse effects." I know when I go to the pharmacy this never/rarely happens and the account of my patients supports this perception. The next professional service funded in the Community Pharmacy Agreement should perhaps be an examination of the number of times this in-scope counselling occurs and if it occurs, if it is evidence-based/helpful and not just designed to up-sell medicines with no evidence base.

I was recently asked to comment on a *PharmacoEconomics* article examining the cost savings associated with down regulation of the oral contraceptive pill so pharmacists could doll it out willy-nilly. The study was supported by Consumer Healthcare Products (CHP) Australia who represent the non-prescription medicines market. Interesting.....

The handsome figure of savings reported in this study was however almost entirely due to a projected reduction in the live birth rate (in the fine print) not due to repeats being given by pharmacists, with a concession made that STI rates would increase. No mention of the lost opportunity in preventative/ holistic care conducted by GPs, fragmentation and lack of any

Vice President's message ... continued

sense that re-appraisal of script appropriateness should occur periodically. This is not 'better self-managed care' as desired by CHP, but perhaps it is better profits?

If anyone had bothered to read the *PharmacoEconomics* issue in question, they would have also seen two other studies showing very nicely that women do not value the convenience of having a pill re-dispensed to them above a more fulsome discussion and understanding of risks/side effects and the duration of coverage (e.g. Implanon vs daily OCP) and that the cheapest contraceptive method (by far) was the longer-acting versions such as Mirena or Implanon. So, if cost is the governing variable, then down regulating the OCP to allow pharmacists dispensing is indubitably not the best option.

We need patients/consumers and Government to understand that the seductive allure of convenience or affordability is sometimes a deceptive veneer only and should never be allowed to eclipse quality, evidence and plain common sense.

Medical advice provided to patients in place of appropriately trained doctors.

A free discussion with a non-doctor to do a doctor's job is never appropriate and would not be borne in other industries/professions so should not be accepted in health care. If you cannot examine patients, do not understand pathology or read the medical literature to stay up to date with current thinking, you cannot treat patients. Pharmacists embedded within a general practice team, however, provide an invaluable resource and this very positive and integrated team-based collaborative approach is where the Government should direct funding. This model has a strong evidence base (e.g. Ankie CM et al *ScienceDirect* 2018).

There is emerging, compelling evidence that OTC re-supply of Ventolin is leading to a dangerous under-treatment of mild asthmatics not on appropriate preventor therapy which could be prescribed by the GP if they saw them. Not only are exacerbations and symptoms greater (Reddel H *BMJ* 2017), but under-utilisation of inhaled corticosteroid is associated with an increased risk of death (Suissa S, *NEJM* 2000). When I've asked groups of pharmacists how on earth they are going to remain current with diagnostic and treatment guidelines to safely treat asthmatics – a group they think they can manage – I get frostily told this is entirely in scope for them and if any patients are more severe they can be identified and referred on to the GP (where they should have been in the first place). This is precisely the problem – treating asthma is clearly NOT in the scope of practice for a pharmacist with a dispensing degree, and any attempted assessment regarding disease severity in this context is fraught and leads patients into further harm. How could anyone safely treat an asthmatic without listening to their chest? Insurers/litigators might be interested to get the data on patients repeatedly dispensed with salbutamol inhalers from their pharmacy without seeing a GP, who then succumbed to their disease?

The Queensland University of Technology recently published in *JAMA* (July 17, 2019) a study using standardised patients requesting emergency hormonal contraception and medication for conjunctivitis. They found that 31.3 per cent of pharmacies involved some form of overtreatment or overselling of medication. In 'advising' the standardised patients who had unprotected sex >72h prior (when the morning after pill is not indicated), appropriate management occurred in 16 per cent of cases only, whereas 80 per cent of patients were still provided with drug despite this being contrary to guidelines. Conjunctivitis treatment was no better with confusion of allergy versus infection.

This report coincides with over-treatment similarly noticed in a *Journal of Paediatrics and Child Health* study examining pharmacist treatment of infant gastroenteritis which was reported recently in the popular media. Between getting it wrong and over-selling complementary therapies to patients the prospects appear grim for genuine, safe advice to be given. In a blinding glimpse of the obvious, the Australian Commission for Safety and Quality in Healthcare noted that prescribing for a urinary tract infection "requires the expertise of a medical practitioner" due to overarching requirements for antibiotic stewardship and understanding competing medical issues and when NOT to treat. The fact pharmacists think they can prescribe safely for UTIs demonstrates the poor knowledge and expertise underlying their expectations.

If convenience and cost is paramount, let patients get two or three months' worth of drug at one time – a suggestion the AMA, PBAC and others have thought worthy of serious consideration. Let's promote online options for patients (e.g. UberPharmacy) or dispensing in GP practices! If patients and the Government want convenience, there are many ways to achieve this that streamlines and shortens the medication supply chain from wholesaler to patients and saves patients from having to trudge to their pharmacy every month for medications, all without compromising the quality of community care that remains the sole purview of the general practitioner and his/her integrated team.

AMA won't dispense with push to change pharmacy rules

The AMA will continue to lobby the Government for changes to pharmacy ownership and location rules, saying allowing chemists to dispense in general practice would be a good outcome for patients.

Health Minister Greg Hunt has so far not warmed to the idea. He is negotiating a new Community Pharmacy Agreement that he says will be finalised in December and kick in from mid-2020.

"We have a very, very clear set of rules regarding pharmacy ownership which follows in fact the recent reviews and we, through a bipartisan approach, reaffirmed those rules in the Parliament in the course of the last two years," Mr Hunt told reporters.

"So we've only just re-legislated in this space and there are no plans to change that."

The AMA says having GP-owned dispensing pharmacists inside GP clinics is world's best practice.

"It's also about improving health outcomes," said AMA President Dr Tony Bartone.

"And that's what the evidence has shown right around the world, when all members of a healthcare team work in collaboration together with the patient, with their file, with their records, with their history all together in the one location."

Dr Bartone said the AMA would press on with its advocacy for change in this area.

There are currently strict laws controlling who can own a pharmacy and where new pharmacies can be located.

AMA Vice President Dr Chris Zappala said it was regrettable that the Government does not yet appear willing to consider change.

"I think they got it wrong. Anyone can own a doctor's practice; anyone can own any business really in this country. I mean, why pharmacists should be so protected that a pharmacy is only owned by an elite small group of pharmacists is beyond understanding, to be perfectly honest," Dr Zappala told the ABC.

"And it seems to be that there's a bit of protectionism going on, and I'm not quite sure how the community is served by having that to be the case. And I do not think, when you speak to pharmacists in general, I do not think that all pharmacists are in favour of that sort of exclusivity that exists in that way.

"So, if we believe in free market forces and convenience and all the rest of it, then that means that if there are alternative models of dispensing and pharmacy that are actually good for the community and good for patients, then we should look at them. And if the current rules of restrictive ownership block that sort of innovation and evolution, then they are a problem."

The AMA has formed a new General Practice Pharmacy Working Group to drive policy, strategy, and advocacy on pharmacy and dispensing, and to provide the Government with strategic AMA general practice input to the Seventh Community Pharmacy Agreement.

The Working Group was created following an urgency motion passed at the last meeting of the AMA Federal Council.

The new Working Group will consult with the AMA Council of General Practice to develop an advocacy blueprint on new dispensing models.

Currently, some pharmacists are working as non-dispensing pharmacists in general practice. Known as GP pharmacists, they cannot dispense.

CHRIS JOHNSON

ACCC taking Medibank to court

The Australian Competition and Consumer Commission has initiated legal action against Medibank, accusing the private health insurer of misleading customers who needed certain types of surgery.

> "Some members were forced to delay surgery due to high out-of-pocket costs for these procedures and to seek alternative remedies to manage pain."

The consumer watchdog says Medibank falsely told hundreds of customers that they were not covered for spinal, hip, pelvic and knee surgeries – causing many to upgrade their cover or delay surgery.

Through its subsidiary AHM, Medibank is alleged to have wrongly told some of its 'lite' and 'boost' policy holders that they were not eligible for cover for reconstruction procedures and joint investigations.

The deception is alleged to have taken place over more than five years, from February 2013 to July 2018.

"We will allege that Medibank incorrectly rejected claims or eligibility enquiries from over 800 members for benefits that they were entitled to and were paying for," ACCC Chair Rod Sims said in a statement.

The ACCC estimates that about 60 members of the health fund needlessly upgraded their policies.

"In some cases, it is alleged that members who upgraded their policies were also required to serve a further waiting period to access these procedures," Mr Sims said.

"Some members were forced to delay surgery due to high out-of-pocket costs for these procedures and to seek alternative remedies to manage pain."

Medibank self-reported to the regulator, following numerous complaints. The ACCC is seeking severe penalties in the Federal Court of Australia, as well as orders to compensate affected customers.

Medibank has apologised to its customers and has blamed the issue on an "internal process failure" involving incorrect coding procedures.

CHRIS JOHNSON

Private health insurance tops money concerns again

Private health insurance continues to top the list of Australians' money concerns, according to the latest CHOICE Consumer Pulse survey.

The consumer advocacy group has found that for the third survey in a row, private health insurance dominates financial worries in households around the nation.

For the past four years, the survey has been conducted and published quarterly. This current survey is for the June quarter of this year.

Eighty-two per cent of the survey's respondents rated private health cover as their biggest money worry. Fuel cost was the next highest, with 80 per cent saying it was their biggest worry. And 79 per cent said the cost of electricity was the main worry.

Interestingly, while the money concerns around private health cover remains high, confusion over various policy options has fallen from 62 per cent to 53 per cent.

The survey results come as the latest Australian Prudential Regulation Authority (APRA) statistics reveal that more than 28,500 people dropped their hospital cover in the three months to June.

The survey also shows that, while still high at 42 per cent, the proportion of Australians worried about debt is at its lowest since the surveys began.

However, one in four households still struggle financially, with 44 per cent of respondents concerned that they or their partner could lose their job.

CHRIS JOHNSON

Upcoming changes to opioid prescriptions

The Therapeutic Goods Administration has announced upcoming changes to reduce harm in relation to prescription opioids.

In a statement, it says pharmaceutical opioids are now responsible for far more deaths and poisoning hospitalisations in Australia than illegal opioids such as heroin.

"Every day in Australia, nearly 150 hospitalisations and 14 emergency department admissions involve opioid harm, and three people die from drug-induced deaths involving opioid use," the statement says.

"These figures are too high, and the Australian Government has asked us (TGA) to play a role in tackling the problem. To help reduce the harm, the TGA conducted a public consultation on prescription opioids in 2018."

Several reviews and activities arose from the consultation. As a result:

- Smaller pack sizes will be available for immediate-release prescription opioid products.
- Sponsors will be required to include boxed warnings and class statements in the Product Information (PI) documents for all prescription opioids in relation to their potential for harmful and hazardous use.
- The TGA will work with sponsors to ensure that safety information, including the relevant warnings, is prominently displayed in the Consumer Medicines Information.
- The indications in the PI documents for prescription opioids will reinforce that opioids should only be used when other analgesics have proven not to be effective.
- Fentanyl is one of the strongest opioids available in Australia. In recognition of the increased potential for harmful and hazardous use, the indication for fentanyl patches will be updated to state they should only be prescribed to treat pain in patients with cancer, patients in palliative care and those with exceptional circumstances.

The changes will be phased in from January 2020. All the changes and the full TGA statement can be found at: https://www.tga.gov.au/alert/prescription-opioids

Dementia Action Week asks us to think about it

Dementia Action Week 2019 runs between September 16 and 22, with a theme of *Dementia doesn't discriminate. Do you?*

Dementia Australia is calling on all Australians to change how they respond and behave around people living with dementia.

The theme aims to start a conversation with all Australians to consider how discrimination impacts people living with dementia, their families and carers.

Dementia Australia CEO Maree McCabe said dementia doesn't discriminate in terms of who is impacted, but people can choose not to be discriminatory in the way they interact with individuals who are living with this chronic condition.

"A person living with dementia might be ignored or dismissed in conversations," Ms McCabe said.

"Sometimes people without realising will talk directly to the carer as if the person living with dementia is not even there.

"Assumptions might be made about a person's capacity to contribute to conversations, decision-making, whether they can still drive, cook or even continue to work. Friends and family might stop calling or inviting a person living with dementia to social occasions – not out of deliberate neglect but possibly out of not knowing how to include them.

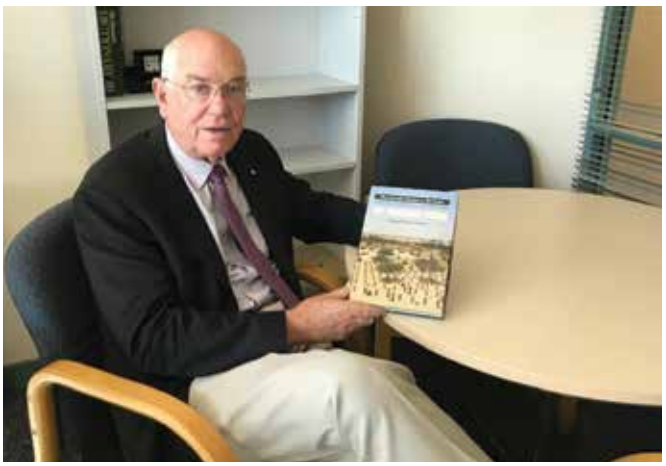
"Our focus during Dementia Action Week will deepen the enquiry into discrimination and dementia."

The national body is calling on the community to complete a short survey to help to create an informed, national picture to better understand how discrimination for people living with dementia occurs, within what contexts, and what it would take to shift that behaviour.

The survey can be found at: https://reflectionsresearch.au1.qualtrics.com/jfe/form/SV_aavTLlmC

Doctor, soldier, writer, historian

BY CHRIS JOHNSON



For Dr Robert Likeman OAM CSM, there is no such thing as a lazy retirement.

In fact, one might get the impression that this highly educated over-achiever simply has no idea what the word lazy means.

A retired Army medic, Dr Likeman has reached the heights of his profession – both in the military and in medicine.

And now, he is writing books about Australian doctors who served in WWI and WWII. *The Australian Doctors at War Series* is proving to be a valuable record, adding greatly to the nation's collective knowledge.

"The people who went to Gallipoli were the people who held their hands up first, and that applied to the doctors just as much as it did to the other people. In other words, the brightest and best," Dr Likeman says.

"And I think the fascinating thing about Gallipoli from a medical point of view is that the doctors who were at Gallipoli – there were only about 270 of them – they were the ones who built Australian medicine over the next 40 years.

"You get the same thing in World War Two for the people who volunteered first and went to North Africa."

Robert Kenneth Likeman, born in England in 1942, studied the Classics and Oriental Languages at Oxford University, before switching to Medicine and Surgery. He enlisted in the Territorial Army in the UK and served in the Middle East.

"I had always wanted to be in the Army. My grandfather was a professional soldier, my father was in the Army during the war," he says.

"In one of those light bulb moments, I came to the conclusion that it was actually a lot more sensible to take bullets out of people rather than put them in. That sounds awfully facetious, but it was very much like that, and I finished my degree and subsequently went to medical school.

"At the time when I was finishing, I met an old school friend who had been in Adelaide doing a PhD. He was a soil chemist and he said 'you gotta go to Australia Robert. Australia's the place.' So I went to Australia House with ten quid in my pocket. I'd hoped to come by boat, but they had stopped by then. I came in March 1972 and I flew."

He joined the Army Reserve in Australia.

Newly migrated, it wasn't long before he was living in Papua New Guinea as the Government Chief Medical Officer, before becoming the Medical Superintendent at Te Kuiti Hospital in New Zealand.

Back in Australia, Dr Likeman, whose specialisation was in gynaecology and obstetrics, became the Acting Director of Gynaecology at the Royal Brisbane Hospital and Deputy Medical Superintendent, Royal Women's Hospital Brisbane.

But it was in 1986 when his career took a big leap. A new women's hospital was opened in Townsville and he became the Medical Superintendent. He was there for ten years. He had also transferred to the Royal Australian Army Medical Corps and by 1992 was promoted to Lieutenant Colonel.

"We pioneered laparoscopic hysterectomy in Townsville," he says.

Then one day he "got a call" after the hospital had been closed, asking if he would you like to transfer to the Regular Army?

"I said 'I live in Townsville and have a lovely house on the beach, why would I want to join the Army?' And they said, 'well it just so happens that the job we want you to do is in Townsville'.

"So I was the Senior Medical Officer of Third Brigade for eight years and I went overseas twice with them."

In 2001, he was awarded the Conspicuous Service Medal. In 2005, he was appointed Medical Officer to Prime Minister John Howard.

"Then in 2011, I got another one of those phone calls – would you like to come to Canberra?" he says.

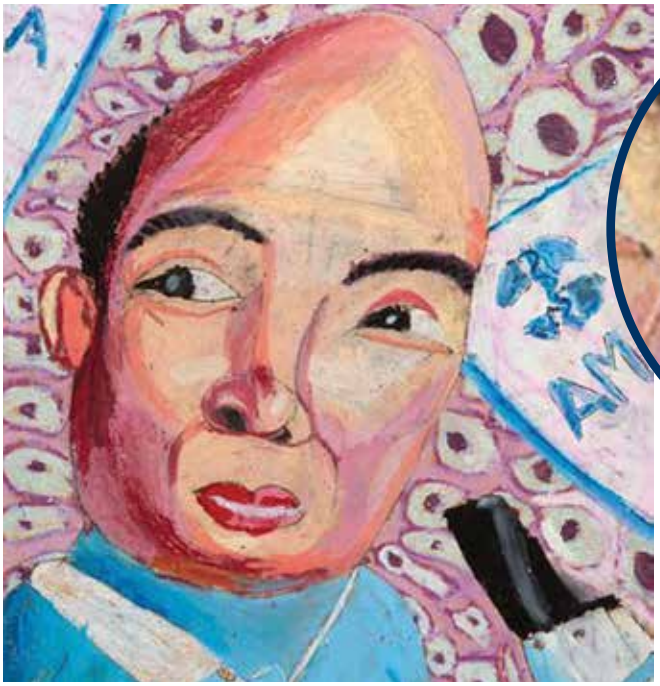
Promoted to Colonel, Dr Likeman was appointed Director of Army Health. He was awarded the Order of Australia Medal in the Australia Day Honours 2019.

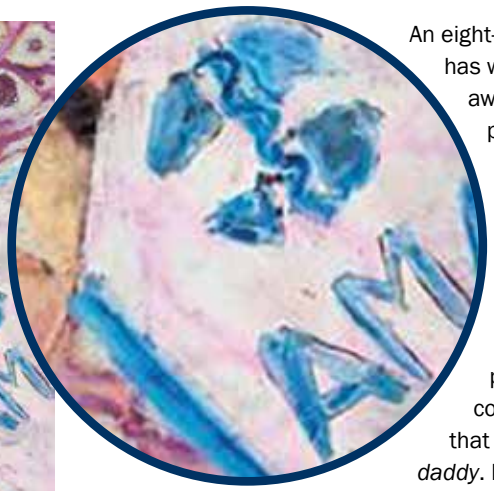
Now, 'quietly' retired on the Gold Coast, he continues his writing ventures – dedicated to Australia's wartime doctors. It is an ongoing task, with more volumes underway.

"Somebody has got to write the history of this ... and you know where the buck stops," he says.

"And each one unfolds into the next one."

AMA features in award-winning art





An eight-year-old Sydney boy has won a Young Archie award for painting a portrait of his doctor father, complete with AMA logo.

Mathew Chen won the award in the 5 to 8 year-old category of the prestigious youth art competition for his work that he titled *My super daddy*. Matthew describes his father Dr Xin-Min Chen as a "great medical scientist and a wonderful father".

Dr Xin-Min Chen is an Associate Professor at the Sydney Medical School at the University of Sydney. His research focuses on the links between diabetes and chronic kidney disease.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

WITH CHRIS JOHNSON

Government allocates funding for new research projects

The Federal Government will invest more than $440 million for a total of 298 new world-leading health and medical research projects. The projects will receive funding from the National Health and Medical Research Council (NHMRC).

Each State and Territory will benefit, including:

- $1.3 million to the University of Adelaide for a targeted vaccination program trial for children and young adults in the Northern Territory and South Australia. Titled Gono B Gone, the program trial will evaluate the effectiveness of the 4CMenB vaccine against gonorrhoea and meningococcal disease. The findings of the trial will inform the policy considerations for vaccination program in Australia and globally;
- $120 million in research funding for 78 grants in New South Wales to support research into improving medication safety in hospitals. This includes $2.5 million to Macquarie University to research the use of information technology to advance medication safety by reducing medication errors in hospitals;
- $203 million in research funding for 132 grants in Victoria to support research into new treatments and trials for lung cancer. This includes $2.6 million for The University of Melbourne for clinical trials and laboratory based translational research, to deliver precision medicine and improve outcomes for patients with lung cancer;
- $59 million in research funding for 46 grants in Queensland to support research into genomics. This includes $1.5 million for The University of Queensland to understand the relationship between DNA and changes in health and well-being;
- $25 million in research funding for 17 grants in Western Australia to support research into mental health. This includes $236,437 for The University of Western Australia to design a suite of tools, resources and guidelines to support principals, school counsellors and teachers to respond to their students' social and emotional well-being and mental health needs;
- $19 million in research funding for 16 grants in South Australia to support research into maternal and child health. This includes $2 million to The University of Adelaide to transform antenatal care by delivering early pregnancy screening tools to identify the factors that lead to life-threatening complications in pregnancy;
- $4 million in research funding for four grants in Tasmania to support research into cardiovascular disease. This includes $1 million for the University of Tasmania to measure cardiovascular disease risk and to improve awareness, understanding, diagnosis and treatment of heart conditions;
- $5 million in research funding for five grants in the Australian Capital Territory to support research into suicide prevention. This includes $1.2 million to The Australian National University of research into the drivers for suicidal behaviour, and the use of positive social connections and timely help-seeking to reduce the rates of suicide in young people; and
- $6 million in research funding for three Indigenous health grants in the Northern Territory. This includes $2.5 million for an NHMRC Centre of Research Excellence at The Menzies School of Health Research to prevent and manage bronchiectasis.

The complete list of projects can be found at www.nhmrc.gov.au and Health Minister Greg Hunt said the funding included the first grants delivered through the Investigator Grant Scheme, part of NHMRC's new grant program.

"These grants provide five-year funding certainty for high performing health and medical researchers from across all career stages, as well as support for their research groups," the Minister said.

"This first round of Investigator Grants was highly competitive and the quality of applicants was extraordinary, resulting in an outstanding inaugural cohort of 246 Leadership and Emerging Leadership Fellows.

"This vital investment across the broader health spectrum will continue the proud Australian tradition of discovery and translation into better health for all."

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

New action plan commissioned for blood cancers

A national taskforce has been established and a national action plan commissioned to improve diagnosis, treatment and the understanding of blood cancers.

The Federal Government will provide $150,000 to the Leukaemia Foundation to support the development of the National Action Plan.

The Blood Cancer Taskforce will be co-chaired by Bill Petch, CEO, Leukaemia Foundation and Professor John Seymour AM, Director of Cancer Medicine and Haematology at the Peter MacCallum Cancer Centre.

The Taskforce will work with leading clinicians, Cancer Australia, researchers, industry and patient groups in the blood cancer community to recommend actions across the cancer control continuum that will reduce mortality from, and improve outcomes for people with blood cancer.

"In 2019, more than 12,000 Australians will be diagnosed with leukaemia, lymphoma and myeloma," Health Minister Greg Hunt said.

"Survivors can face lifelong side effects so we must find ways to ease the burden on adults, children, their families and the wider community.

"This action plan will concentrate our collective efforts to drive better health outcomes and improve survival for all Australians diagnosed with blood cancer.

It will develop a comprehensive blueprint for action and provide its advice and recommendations to the Government."

The Taskforce's work will include:

- providing advice to the Government on the state of blood cancer in Australia, including variations in health service delivery and survival outcomes in urban and regional areas;
- reviewing domestic and international evidence and experience, including a stocktake of current practice, programs and initiatives, with a focus on Aboriginal and Torres Strait Islander people and people from culturally and linguistically diverse backgrounds; and

ensuring the action plan reflects the outcomes of a comprehensive consultation process and identifies best practice, evidence-based recommendations that can

be implemented across the sector by governments and non-government organisations.

Two new drugs listed

Two new medicines have been listed through the Pharmaceutical Benefits Scheme (PBS), at an investment of more than $40 million, to help Australians with opiate addiction and those suffering breathlessness throughout their final stages of life.

Under the PBS, new treatments for opiate dependency and chronic breathlessness will now be available to patients in need. They were listed from September 1 and are:

- **Buvidal® (Buprenorphine)** to help treat patients living with opiate dependency. Buvidal provides a more flexible option for people to manage their addiction replacing daily treatment at a pharmacy or dosing point with weekly or monthly injection, removing cost burden for daily dispensing, reducing travel requirements, especially in regional Australia.
- **Kaponal® (Morphine)** will be extended on the PBS to include a new indication on the Palliative Care Schedule. Kapanol® helps with the relief of distressing chronic breathlessness in the palliative care of patients with severe chronic obstructive pulmonary disease (COPD), cardiac failure, malignancy or other causes.

"Every medicine was recommended to be added to the PBS by the independent expert Pharmaceutical Benefits Advisory Committee (PBAC)," Health Minister Greg Hunt said.

"By law, the Morrison Government cannot list a new medicine without a positive recommendation from the PBAC. Unlike Labor, we are subsidising all medicines recommended by the independent medical experts."

But Shadow Health Minister Chris Bowen said the Government was slow to list the new medicines, because both medications were recommended by PBAC in March this year.

"That means that Minister Hunt has taken six months to deliver assistance to the 50,000 patients treated for opioid dependence daily, and 20,000 people per year who struggle breathing in palliative care," Mr Bowen said.

Time to move forward

BY DR RICHARD KIDD, CHAIR, AMA COUNCIL OF GENERAL PRACTICE

General practice as a career can offer great diversity. As GPs, we deal with patients across all walks and stages of life. We deal with all manner of issues across the spectrums of physical and mental health. There is also great diversity in how we work. Some of us own the practice we work in, either solely or in partnership, some of us are independent contractors, others are employees. While the diversity our career provides is a strength, it can also serve to fragment us on occasion. Recent calls to delay the introduction of the Practice Incentive Program (PIP) Quality Improvement Incentive (QII) a recent example.

> "The AMA nevertheless endeavours to consider the great breadth of perspectives and embark on a course of action that will best serve the general practice profession and our patients."

As a long-time member of the AMA and as Chair of the Council of General Practice, balancing the diverse views of the profession is often a challenge. The AMA nevertheless endeavours to consider the great breadth of perspectives and embark on a course of action that will best serve the general practice profession and our patients.

For the better part of the last decade, the AMA has been working towards seeing GPs better supported and rewarded for providing quality care in a rapidly changing environment. Furthermore, the AMA wants to see the central role of general practice in the provision of cost-effective, holistic and comprehensive care for its patients recognised and appropriately funded.

For most of that time, the AMA has been working with other key organisations and the Department of Health through the PIP Advisory Group (PIPAG) to bring the QII to fruition. This work focussed on developing and implementing an incentive that would better support more general practices and equip them with information to direct and drive their quality improvement activities; an incentive that would support continuous quality improvement in both the delivery of best practice care and patient outcomes.

Central to any quality improvement activity is the collection of data. Data that provides information about where things are at, and how they are improving. In developing the QII, it was important for the AMA that all PIP eligible practices could undertake their own quality improvement journey, while demonstrating collectively the value of general practice within the health system. Regardless of where practices sat on the quality improvement continuum, the AMA wanted all PIP eligible practices to be supported in establishing their own base line data against which they would assess their progress.

Also important was ensuring the privacy of patient, practitioner and practice, and minimising any unintended consequences, particularly those that work against the quality of patient care. Such as those seen with the introduction of the Quality Outcomes Framework in the UK, where the focus is more about the measure than the patient. Due consideration was given to the appropriateness of measures, what data would inform those measures and the framework that would govern the collection and use of the data.

Ensuring this new incentive was appropriately funded and did not replace other valuable incentives such as the GP Aged Care Access Initiative, the Procedural GP payment and the Indigenous Health Incentive was a high priority for the AMA. For the AMA, it was important the incentive supported general practices rather than the commercial interests of some third party.

For those who think a quality improvement incentive has been a long time coming, you are correct, it has. A lot of discussion, concern raising and addressing, and work has gone on to get the incentive to the starting blocks. While some transitional issues are still being worked through, the overall response of general practice to the incentive is reassuring and it is time to move forward with no more delays. At last advice, more than 4,000 general practices, that is two-thirds of PIP eligible practices, are now registered for the QI Incentive.

Confronting the problem of suicide

BY **PROFESSOR STEPHEN LEEDER, EMERITUS PROFESSOR,** PUBLIC HEALTH, UNIVERSITY OF SYDNEY

World Suicide Prevention Day – Tuesday September 10th – has provided an opportunity for reflection on this sad phenomenon.

A million people suicide each year, with rates varying by country. The World Health Organisation and other agencies estimate that about 3,000 Australians suicide each year. In the WHO's ranking, we come 51st of 183 (starting with the worst) countries. Worldwide, men account for three in four suicides, but women make more attempts.

> "This is not a simple problem, as is borne out by the complex web of services constructed to assist those considering suicide to identify alternative pathways to relief of their stress."

The figures are often speculative: deaths from suicide may be coded to heart disease or other more socially acceptable causes. For example, where suicide is illegal, such as in Malaysia, Syria, Lebanon, the Bahamas, Kenya and Papua New Guinea, reported rates might be low. Deaths are not certified in many countries.

Although we might expect suicide to follow lines of economic advantage, the figures are mixed. Wealth is no insulator.

Historically and socially, several factors have been important determinants. An example cited in Wikipedia is of a Japanese Samurai who intentionally ends life (*Seppuku*) to preserve honour. "Indian, Japanese, and other widows sometimes participate in an end of life ritual after the death of a husband, although Westernised populations have abandoned this practice. Some perceive self-immolation as an altruistic or worthy suicide." Recall suicide bombers and the *Kamikaze* pilots.

These variations are important when wondering how in our society we might mitigate or prevent suicide. This is not a simple problem, as is borne out by the complex web of services constructed to assist those considering suicide to identify alternative pathways to relief of their stress. It is not as though nothing has been done in recent years, especially for young people. We should remember this reality when considering new preventive strategies.

As with all psychiatric disorders, diagnosis and prognostication depend heavily on clinical information. This makes the identification of, and assistance to, people who might be on the brink of suicide very difficult.

If you go into a coronary care ward and measure everyone's cholesterol, the mean will be as it is in the general community. So, it is not of much use, except when extremely high, for predicting potential cardiac events. Precision medicine might one day provide a better approach, but, for the moment, predicting which individual will have a heart attack (or take their life) is imprecise. While a strong link exists between depression and suicide, not every person who suicides is depressed, nor does every depressed person contemplate suicide.

In recent decades, service development for mental illness has moved forward with clear plans and stronger investment. Indisputably, much remains to be done; there are still big holes in the fabric of care.

And indeed, much more could be done. The multifaceted work of the Suicide Prevention Hub in Australia https://suicidepreventionhub.org.au/programs through several evidence-based programs that develop skills in recognition and support are to be welcomed. Work by Ernest Hunter, a public health researcher, Jo Robinson and Anton Clifford provide analyses of what research has revealed about suicide prevention in Australia, including among Indigenous communities, many of whose younger members experience the ennui of future uselessness in mainstream Australian society. Christine Morgan, the chief executive of the National Mental Health Commission, has been appointed to the new role of National Suicide Prevention Adviser, reporting directly to the Prime Minister.

We should, while remaining cognisant of the complexity and multiple factors contributing to suicide, strongly support these efforts. Much remains to be learned and applied.

Lifeline Australia – 13 11 14

A rural workforce for today and tomorrow

BY DR SANDRA HIROWATARI, CHAIR, AMA COUNCIL OF RURAL DOCTORS

Traffic rules are a bit odd when I am the only doctor in town. I drive to a stop sign, stop and wait. And wait and wait. The vehicle with right of way has recognised the doctor's car and is insisting I go first. I have learned to hustle on forward.

My experience is not unique. Towns across Australia are screaming out for a doctor (sometimes singing and dancing). Once they find a doctor, the community lets you know you are welcome in simple ways – like allowing you to skip to the front of the line in a grocery store.

After years with minimal policy direction and workforce planning, there have finally been positive developments, in particular the National Rural Generalist Pathway and the National Medical Workforce Strategy.

While both of these initiatives have great potential if they are properly funded and Governments work together to enact the recommended strategies, they do not solve the immediate issues being faced by rural communities. In fact, many of our proposals for fixing rural health are long-term reforms. We won't see the results of these initiatives for many years. Many rural towns are without a doctor today.

So, what do we do? We rural docs keep providing services, trying hard to not jump the queue, and hoping that someone else will come to take our place when it is time for us to move on.

The simple answer is that rural health services need more support through immediate investment.

The *2019 AMA Rural Health Issues Survey* found that the issues have not changed since the previous survey in 2016. Funding and resources to support improved staffing levels and modern facilities and equipment at rural hospitals are still the top priorities. This can and should be done now.

The AMA recently updated the *Easy Entry Gracious Exit Position Statement*. The Position Statement outlines a model that works as the title states: it makes it easy for a doctor to begin practising in a town without requiring them to become small business owners and managers. The 'walk-in walk-out' model is not always popular, but if it gets a doctor into town then the result is positive.

Don't get me wrong – this is a stop-gap, not a solution. In an ideal system, this model would not be required.

One of the main revisions in the updated Position Statement is the need for more support for towns adopting this model from State/Territory and Federal Governments. It should not be the requirement of rural ratepayers to prop up a medical practice that is a result of policy failure at the highest levels.

We have seen this mentality with the More Doctors for Rural Australia Program (MDRAP). The MDRAP was introduced originally as a program to help Australia's nearly 6,000 non-vocationally registered doctors working in general practice to join a pathway to fellowship while working in rural areas. Doctors on the program will be able to bill Medicare at 80 per cent of A1 rebates, and then 100 per cent once they join a formal pathway. The AMA raised concerns in October last year that this would place a significant burden on supervising practices as many participants would require intense supervision with limited earning potential. Again, rural doctors were expected to bear the costs.

After months of lobbying the Department of Health, we have now been told that a grant of up to $30,000 will be made available for supervisors of MDRAP participants. This should be closer to $50,000 to provide adequate support for training and supervision. Still, this funding comes with an acknowledgement of what the program is asking of rural general practice.

Rural health ... continued

All rural health based programs must begin by considering this: what are we asking of rural doctors and rural communities? Is it more than is asked of urban doctors and communities? If the answer is yes (and it almost always is), then there must be more funding and support accompanying it.

At the same time, we need to keep working on those long-term plans.

We want more accredited training posts and we want certainty of funding for these posts – there must be continuity.

We need to encourage all medical students with interest in rural medicine to pursue it, and we need to provide clear pathways for all graduates.

We need innovative funding and support. There needs to be jobs for partners, there needs to be access to many of the sanity stabilisers we are used to in the cities, like gyms and high-speed internet, and there needs to be support for us to travel for our CPD when we need to. I shouldn't have to take unpaid leave to complete my rural hospital credentialing.

We don't want to hear governments say "we funded this training scheme, so we can't provide incentives for rural practices today". That is akin to saying "just hold out for a few more years", or "you can't retire for another five years". We want to see an acknowledgement of the fact that this problem won't be solved overnight, so while we work out the solution, here are some resources to assist you.

Finally, we want you – the doctors reading this in the cities – to know that we keep trying to recruit you because we know you will love it like we do. The work is more interesting and varied, the patients and communities invite you in, try to find you a partner or a pet and make you feel welcome. You can see the difference you make. We just need a bit more support.

Risky Business

BY DR JOHN ZORBAS, IMMEDIATE PAST CHAIR, AMA COUNCIL OF DOCTORS IN TRAINING

I bought a motorcycle in March. I know; the obvious choice for a guy who works in ED and ICU. Nothing huge mind you. Just a simple 250cc Honda that goes where I need it to go.

I had no idea at the time that I had just purchased an instant dichotomy generator. See, my bike generally elicits one of two responses. Either you think that motorbikes are the greatest thing since sliced bread, or you are convinced I'm going to die in a fiery blaze of pain and suffering. Now for a population where roughly 4 in every 100 passenger vehicles is missing two wheels, I was amazed at just how many people had strong opinions on my impending death, invitation-less as they may have been.

This is not an esoteric topic. We've got the data to prove to you whether I have increased my risk of death or not, and yet the feedback was anything but definitive. And in forecasting my death, I found a number of factors missing in their decision-making process. Was I wearing a helmet? Was I wearing protective clothing? Did I ride at night? Did I ride drunk? Where did I ride and under what road conditions? Did I carry passengers? Am I male or female? How old am I?

These are easily more important variables, but the jury had made its choice without this data. Motorcycles equals death, or joy. Risk was definitely not in the eye of the beholder, but everyone else. This process became a daily reminder, and my thoughts moved to risk in health care. It's not a new topic, not by a long shot. But our risk management systems are as broken as the opinions on my motorcycle. I want you to picture where you work. Conjure up your practice or hospital, and mentally advance through your day. How many practices or situations can you imagine that you would consider a risk to patient safety? There are more than you'd care to admit, but we have no tools with which to address them in a meaningful manner.

And it's not your fault. You see, you're either suffering from risk normalisation or risk fatigue. If you've ever submitted a risk management report and watched it fall into a large vortex with no meaningful follow-up or outcome, you're risk fatigued. If you notice the risk, but everyone around you is saying "this is fine" as the house burns down, you're suffering from risk normalisation. I'd argue that every doctor in Australia falls into one of these two categories, with the exception of interns and the mad. And I need you to get mad. I need you to get mad, because nothing is going to change until you do. You're the person who sees the patient. You're the one with that intimate contact and understanding. You're the patient's strongest advocate, save for the patient themselves.

So you can't afford not to be mad. And besides, aren't you sick of it? I don't believe that any of you are shocked by the media this month surrounding 24-hour ED wait times in one of Australia's newest hospitals. But you don't have to look too far to find tales of woe in your own neighbourhood. And patient safety doesn't rely on the single primary treating doctor. It relies on everyone with any degree of contact with the patient as they make their way through the opaque waters of our healthcare system.

Are you the ortho reg passing through the over-census ED who can't make the wheels turn in theatre bookings for your open reduction? Guess what. Your problem too. Are you the RMO covering a private ward somewhere, who is continually stuck working late because of the lack of clinical escalation systems? Your problem too. Are you the clinical executive member who hasn't invested in a clinical redesign unit/program/manager? Most definitely your problem.

Risk should not be viewed as only negative. Change is constant and change carries risk. Without risk, we'd be stuck in the medical Middle Ages. However, we're no longer managing risk in a prospective way that can correct hazards. We're managing it in a reactive way that only cleans up after the disaster. It's for this reason that I believe that anyone who blames poor hospital performance on winter, an entirely predictable change in the weather that has occurred on an annual basis below the Tropic of Capricorn since time immemorial, should instantly be fired on the spot. Risk is present every day. And every day, corporate directors are deciding on the risk appetite for the management of their company.

So if it's good enough for Bunnings to help keep my house in order at the right price point, why the hell isn't it good enough for my patients when it comes to their literal life and death? Risk management in Australian hospitals is broken, and it needs to be rebuilt. We can't claim to be acting in the best interests of our patients until we start to demand more from those who manage risk in our hospitals and practices. Risk appetites need to be set by executives with appropriate clinical information. Risk management systems need to be timely, relevant and most importantly need to be closed loop. And whistleblowers need to be empowered to speak against those places of work with a toxic risk culture.

Otherwise, who will put me back together when I finally come off of my motorcycle?

Making waves: a medical student's voice in the wide world of global health

BY JESSICA YANG, PRESIDENT, AUSTRALIAN MEDICAL STUDENTS' ASSOCIATION

> "Perhaps I will never find myself practising outside of Sydney, or even outside of a clinic's particular radius as I move into my career – how can I possibly care for people that I may never interact with?"

AMSA's 15th annual Global Health Conference saw 750 medical students from around Australia converge in Sydney early last month. Delegates called UNSW's recently refurbished Roundhouse their academic get-away from Friday to Sunday, with a taste of Sydney's vibrant nightlife as their social program, and a festival on Monday to round out their conference. This year's GHC had a specific vision: to make waves.

Over the days, students were challenged to think of issues that might not be seen in their PBL cases. From speakers like Mark Isaacs, author and advocate for asylum seekers, and Anita Vandyke, who lives a zero-waste life, or a closing panel on how we can do more for intersex patients in our healthcare. GHC is one of the most unique events in a medical student's calendar, with a very specific call-to-action that is often missing from other conferences: to think globally and act locally.

As medical professionals, it is often easy to dismiss global health issues, and even some public health issues, as outside of our scope. Perhaps I will never find myself practising outside of Sydney, or even outside of a clinic's particular radius as I move into my career – how can I possibly care for people that I may never interact with?

While any one individual might never be able to reach every person across the globe, it is true that we have a particular duty that comes along with our individual voices. Medical students borrow a generous amount of legitimacy from doctors (thank you!) and as 'baby doctors', we have an obligation to utilise our position and whatever influence we can muster to address the concerns of the under-represented or neglected in our global community.

As a salient example, medical students came together to take part in the #MyIDMyIdentity campaign, coordinated at the event by AMSA Queer, our National Project which advocates on the health of LGBTIQ+ individuals and medical students. The campaign pushed for the Victorian bill to allow transgender and gender-diverse people to change their recorded sex on their birth certificates without needing gender affirmation surgery. On the night of August 27, the bill was passed and Victoria joined Tasmania, Northern Territory, South Australia and the ACT in making this change.

In a country as diverse as Australia, the reality is that issues that may seem 'global' are making it to our front step and are affecting the health of our future patients. Global health is not only a far-off disaster medicine placement. We are already interacting with global health in our local community in many forms: changing health outcomes from climate change; patients from a refugee or asylum seeker background; queer and questioning individuals who are coming to their GP for advice. To 'think globally and act locally' is preparing medical students to best care for these patients as we encounter them now, and further into our careers.

Congratulations to Ceren Guler and her amazing team for their tireless work bringing AMSA's GHC to life.

Helping patients understand fees and charges is key to avoiding bill shock

BY ASSOCIATE PROFESSOR JULIAN RAIT OAM, CHAIR, AMA COUNCIL FOR PRIVATE SPECIALIST PRACTICE

On August 21, 2019, Australia's largest health insurer Medibank Private announced that it's full-year net profit rose three per cent to $458 million. Medibank also added a net of 15,000 new customers over the year, despite the downward trend of private health insurance (PHI) membership.

However, in every newspaper now, you can't help but hear about the plight of PHI, the increasing cost of health care and the impact of out-of-pocket medical expenses. Doctors are being blamed for rising insurance premiums and for the falling numbers of people taking out insurance. Consequently, the Commonwealth Health Minister has responded by launching a national strategy to tackle excessive out-of-pocket costs charged by medical specialists by developing a website, a website designed to inform patients and help combat 'bill shock'.

While the AMA does not support egregious billing, known out-of-pocket medical costs are not the major cause of discontent with health insurance – premium pricing (mainly driven by for-profit insurers), and a lack of coverage with unexpected gaps are the real problems. The AMA continues to advocate for consumers having access to an affordable, value-based product, while recognising changes to the current policy settings will need to be made. But the AMA has also been working to help medical practitioners reduce bill shock and increase health financial literacy of patients more directly.

For many patients and for some doctors, talking about charges and bills can be an uncomfortable conversation. But as medical practitioners we understand that patients have the right to be fully informed about all their medical costs before they make their decisions.

That surprise – that bill shock – is a difficult challenge. So, the AMA has been working to create a better Informed Financial Consent (IFC) guide that aims at empowering patients, increasing their knowledge and transparency about the options they have in choosing a doctor, specialist, or pathway for their treatment, and helping them to make sure there are no financial surprises.

This new IFC guide provides people with clear, easy-to-understand information to help them navigate the health system. It helps patients in their conversations with doctors and practice managers about fees for their medical procedures. It's why we have called this guide a collaboration – we are working with patients to try and end the uncertainty where possible. The guide also provides patients with suggested questions – the right questions that they need to be asking to get the information they need.

It is up to the medical profession to take the lead in the health debate hence the unprecedented support the AMA received for this valuable resource. This the guide has been developed with, and is co-badged by, more than a dozen leading medical Colleges, Associations, and Societies. Finally, the guide was endorsed and launched by the Health Minister at Parliament House, Canberra.

The IFC guide includes:

- an Informed Financial Consent Form for doctors and patients to use together;
- information on fees and medical gaps; and
- questions for patients to ask their doctors about costs.

The guide is also accompanied by an updated webpage (https://ama.com.au/article/ama-informed-financial-consent) that includes a range of material you can use in your practice or provide to your patients. This includes:

- AMA Informed Financial Consent Form Template;
- "let's talk about fees…" brochures, pads and posters;
- What is a medical gap?;
- Gaps Poster;
- Questions to ask your doctor about costs before you go to hospital;
- AMA Position Statement on Informed Financial Consent 2015; and
- AMA Position Statement on Setting Medical Fees and Billing Practices 2017.

But this guide is only as good as we as practitioners make it. The next step is ours – we need to provide patients with the weblink, help them to use it, assist them in working out their health finance journey, as we do with their health care.

The final page of the guide is a form that the practitioner or patient can print out and use in their appointments. This form will assist in establishing a clear estimate of the out-of-pocket fees which may arise across a whole episode of care. This form is how we can help our patients achieve more transparency over the costs they face, reducing their bill shock and helping them maintain their trust in the health system.

Are doctors to blame for the fragility of PHI?

BY DR OMAR KHORSHID, CHAIR, HEALTH FINANCING AND ECONOMICS COMMITTEE

The economics of private health insurance (PHI) is usually a pretty dry subject, but it is a topic that should engage us all irrespective of whether we work in the public hospital sector, private practice, or primary health care.

The media hype about PHI membership is true. The latest Australian Prudential Regulation Authority (APRA) data indeed confirms people are dropping out of PHI at a very high rate – nearly 30,000 (28,000) in the last quarter alone, leaving just 44.2 per cent of the population insured for hospital treatment. The lowest level of PHI hospital insurance in 12 years. What is more alarming, is who drops their PHI. If it is the elderly, PHI will falter in the delivery of reducing pressure on the public hospital system.

Yet, a fact so far missed in the media to date, is that older cohorts are not leaving PHI – they are taking it up in increasing numbers. This means two things – those dropping out of PHI are mostly the young and the remaining pool of PHI members is ageing quickly. These membership trends ramp up the pressure on PHI premium increases and trigger even more young people to leave.

Although the prevailing narrative is to blame doctor fees for undermining the 'value proposition' of PHI, especially in the eyes of younger Australians, a quick reflection suggests blaming doctors is a beat up and a diversion. Especially since young people in general are statistically least likely to require hospital treatment and PHI, and therefore be exposed to an out of pocket cost.

Instead, young people are likely to be dropping PHI for a host of other economic reasons. For instance, the labour market has been deregulated for well over a decade and early career workers have weak wage bargaining power, broader wages growth is flat, the fragmented employment of the gig economy continues to rise as an important employment sector, and under-employment within the labour market prevails. Add to this, the fact that young people leave university with large debts, the rental housing market remains high in most cities and the affordability of buying a house remains out of reach for many young people. More likely than not, young people are leaving PHI because they are genuinely squeezed by cost of living pressures. This is not something doctors can fix.

Conveniently ignored in this debate is why doctor gap fees emerge. It is not because specialists are avaricious. Instead, it is because government and health insurers have failed to fully index the MBS rebates and the rebate levels paid by insurers. Until around the year 2000, many clinicians could maintain a viable business model without charging significant Gaps. Gap fees were relatively modest[1]. It could be argued that this link was broken in the mid-1990s when the Government decided to switch the MBS indexation formula to match the Wages Cost Index. It was a cost saving to government, but the decision shifted the indexation cost onto clinicians and patients and we (patients and clinicians) have continued to bear this cost and reputational damage ever since.

It is timely to consider who loses if PHI does fall over. The financial health of PHI is not just a concern for private practice specialists who rely on privately insured patients to provide sustainable, high quality services. All clinicians will be negatively affected if PHI were to fail. A health sector totally reliant on an already over- capacity public hospital system will simply mean longer and longer wait times for hospital treatment. As noted in the *2019 AMA Public Hospital Report Card*, there is already emerging evidence of public hospital bed block in emergency departments which delays patient transition to in-patient ward beds and puts patients at greater risk of complications. The Commonwealth Government also caps public hospital growth funding at 6.5 per cent per annum, limiting the extent to which public hospital wait lists can be reduced.

It is hard to imagine how public hospitals, that struggling to manage existing demand under this funding formula, would accommodate the additional patients if PHI shut down and private patient treatment in private hospitals was not an alternative. This scenario should be of concern to all clinicians – including those in the primary healthcare sector who already struggle to get their patients admitted to public hospitals in a timely manner.

The sustainability of PHI is not an academic discussion or an issue for private practice specialists. It is worthy of the serious attention of all who work in the healthcare sector and dedicate themselves to treating patients and improving the health of Australians.

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1 Australian Government Department of Health, Quarterly Medicare Statistics accessed 27 August 2019

A new way forward to closing the gap

BY **AMA PRESIDENT DR TONY BARTONE, CHAIR OF AMA INDIGENOUS TASKFORCE**

> "With Aboriginal and Torres Strait Islander people experiencing more disadvantage than other Australians across a wide range of areas, these priority reforms are key to making the new Closing the Gap agreement a success."

In an *Australian Medicine* column earlier this year, I mentioned the AMA's support for the Council of Australian Governments (COAG) decision to establish a formal partnership with a Coalition of Peak Aboriginal and Torres Strait Islander organisations to refresh the Closing the Gap strategy. As part of this agreement, a Joint Council on Closing the Gap, comprising of equal representation from Government and the Coalition of Peaks, was formed to guide the Closing the Gap refresh and monitor its implementation over the next decade.

The AMA is pleased to see that at its most recent meeting in August this year, the Joint Council agreed to work towards a new National Agreement on Closing the Gap to ensure better health, education and employment opportunities for Aboriginal and Torres Strait Islander people. It is also pleasing to see that three priority reform areas have been identified to underpin joint efforts. These are:

- Developing and strengthening structures to ensure the full involvement of Aboriginal and Torres Strait Islander peoples in shared decision making at the national, State and local or regional level and embedding their ownership, responsibility and expertise to close the gap;
- Building the formal Aboriginal and Torres Strait Islander community-controlled services sector to deliver closing the gap services and programs in agreed priority areas; and
- Ensuring all mainstream Government agencies and institutions undertake systemic and structural transformation to contribute to Closing the Gap.

With Aboriginal and Torres Strait Islander people experiencing more disadvantage than other Australians across a wide range of areas, these priority reforms are key to making the new Closing the Gap agreement a success. Aboriginal and Torres Strait Islander people know what works best in their own communities and have long been calling for governments to heed their advice when it comes to developing new policies and programs.

When COAG established the Closing the Gap strategy in 2007 to end the health and social disparities between Indigenous people and their non-Indigenous peers, it was ground-breaking – it was the first time that governments undertook a concerted effort to improve the health and wellbeing of Aboriginal and Torres Strait Islander people. Despite this, Aboriginal and Torres Strait Islander people themselves were not part of the decision-making process.

What followed over the next decade, was successive governments producing reports that showed consistent failures to achieve their own Closing the Gap targets, with the most recent report showing that only two of the seven Closing the Gap targets are on track to being met. The unacceptable progress against the Closing the Gap targets is reflective of the need to better incorporate the knowledge of Aboriginal and Torres Strait Islander people into policies and programs and include them in the negotiating process. This has long been called for.

WhilE this new formal partnership with COAG, is a positive step forward, we still have a long way to go until Aboriginal and Torres Strait islander people can enjoy the same level of health and wellbeing as their non-Indigenous counterparts. Governments must ensure that this partnership is more than just symbolism – they must acknowledge the solutions that Aboriginal and Torres Strait Islander people have, and will, put forward and incorporate it accordingly into the refreshed Closing the Gap agenda.

The AMA is hopeful that this unique partnership between Aboriginal and Torres Strait Islander people and governments will provide a pathway for governments to achieve tangible improvements in life expectancy and other key health indicators for Indigenous Australians.

Research

WITH CHRIS JOHNSON

Adolescent concussion links to depression

Young people who play sport are exposed to a range of neurological, emotional and developmental benefits but are also at risk of injuries that can threaten these, according to researchers at the University of the Sunshine Coast.

The overlap in the parts of the brain undergoing most development in an adolescent, and the areas most effected by concussion, mean the management of concussion in young Australians requires special consideration, research published in the *Medical Journal of Australia* suggests.

Post-doctoral research fellow in suicide prevention at the university's Sunshine Coast Mind and Neuroscience – Thompson Institute, Dr Amanda Clacy, led the study.

"Adolescents with a history of concussion have been found to be up to 3.3 times more likely to experience depression in their lifetime than their uninjured counterparts," Dr Clacy said.

"A longitudinal understanding of the neurobiological mechanisms associated with concussion recovery in adolescents is urgently needed, as the same structures in the frontal cortices and hippocampus that are known to undergo rapid development throughout adolescence are also implicated following concussion and in young people experiencing depression and suicidal behaviours."

Physical activity and team sports have been shown to significantly benefit adolescent psychological health, including improvements in depressed mood, suicidality, anxiety and stress. Physical activity in the context of team sports even affords additional protection against negative affect by facilitating social support and integration.

"Unfortunately, the benefits of participation in sport and the associated risk of injury present potentially contrasting outcomes when it comes to the risk of developing a mood disorder," wrote Dr Clacy and her colleagues.

"Given the overlap in the regions of the brain significantly associated with depression and concussion and those most sensitive during development, two main concerns are raised.

"First, whether these developmental neurophysiological changes render adolescents more susceptible to emotional disturbances following concussion; and second, what can be done to make these mechanisms more resilient to adverse and ongoing consequences of concussion."

The researchers identified three key gaps in knowledge:

- the neurophysiological mechanisms involved in sport-related concussion recovery in adolescents have not been explored longitudinally, therefore current concussion management protocols do not have a strong evidence base in terms of neural recovery or appropriateness for the developmental uniqueness of adolescents;
- the neurobiological concussion recovery profile has not been considered with regard to the onset of mood disorders such as depression and suicidality; and,
- the efficacy of physical activity and team sport interventions as both prevention and treatment tools for concussion-related and general mood disorders in adolescents has not been explored from a neurological perspective.

"An improved understanding of the neurological and developmental benefits of physical activity for the treatment of mood disorders in adolescents would offer the opportunity to concurrently promote neurological development and recovery while also mitigating many of the known risks of depression and suicidality, such as social isolation and lack of engagement," Dr Clacy said.

Health the number one reason for weight loss

Health trumps appearance when it comes to what motivates people to lose weight, according to new CSIRO research.

A survey of more than 3,000 Australians has revealed that two out of three people start a diet because of health concerns rather than wanting to look better.

Survey respondents were CSIRO Total Wellbeing Diet (TWD) online members, with half of them also reporting improvements

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in chronic health conditions such as type 2 diabetes and high cholesterol, when losing weight through a scientifically developed diet.

TWD respondents also reported using fewer prescription medicines the longer they stuck with the diet. Savings averaged about $270 per year.

CSIRO Research Scientist and report co-author Dr Gilly Hendrie described the findings as very hopeful for the millions of Australians affected by obesity and chronic health conditions.

“Almost nine out of 10 survey respondents who were largely overweight or obese reported a pre-existing health condition at the commencement of the program, while 43 per cent had been diagnosed with three or more chronic health conditions,” she said.

The most commonly reported health issues among the respondents were high cholesterol, high blood pressure, arthritis, mental illness, asthma, chronic body pain and pre-diabetes.

“Our analysis showed that after following the CSIRO Total Wellbeing Diet program, more than half of those with pre-diabetes, type 2 diabetes and high cholesterol reported an improvement in their health conditions,” Dr Hendrie said.

“Almost half with high blood pressure, sleep apnoea and mental health also reported an improvement. Obesity is a major contributor to many chronic diseases and symptoms – around four out of five people who reported conditions such as diabetes, pre-diabetes and sleep apnoea were classified as obese.”

Sea snail helping out with cancer

A purple compound the Australian sea snail produces to protect its eggs, could also help scientists in the fight against cancer.

Researchers at Monash, Flinders, and Southern Cross universities have isolated one compound in the gland secretions from the Australian white rock sea snail (*Dicathasis orbita*) that has antibacterial and anti-inflammatory qualities.

More importantly in the context of the research, the compound is also appearing to hold important anti-cancer properties.

Using the latest mass spectrometry technology, the research team has been able to pinpoint the lead active compound which, in future, could be put to good work.

“After a decade of work, we have found an active compound derived from the substance produced by the mollusc’s gland

Photo: Dr David Rudd, Monash

that could be used as a preventative in bowel cancer,” said senior lead scientist Professor Catherine Abbott from Flinders University.

“We’re very excited about these latest results and hope to attract investment from a pharma company to work on a new drug to reduce development of colorectal cancer tumours.”

Colorectal cancer is the second leading cause of the 9.6 million cancer deaths every year, with the World Health Organisation reporting 862,000 deaths in 2018.

Southern Cross University marine scientist Professor Kirsten Benkendorff said natural compounds from marine and terrestrial plants and animals are valuable sources of current and future medicines for human health.

“In this latest research we have not only shown that a specific snail compound can prevent the formation of tumours in a colon cancer model, but we were also able to use sophisticated technology to trace the metabolism of the compound inside the body,” Prof Benkendorff said.

“This is very important for drug development because it helps demonstrate the absence of potentially toxic side-effects”.

Along with tracking the active compound inside the body to confirm it reaches the colon where is has the anti-tumour effect – which is important for oral drug delivery – the snail compound comes from a class of compounds called indoles, which are commonly found in both natural plant medicines and some pharmaceuticals.

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"We were able to use the fact that snail compound contains bromine like a unique fingerprint to trace how these types of compounds are metabolised inside the body and identify some potentially toxic metabolites from the crude extracts that were not found with the pure snail compound," Prof Benkendorff said.

"This research is very important for understanding the safety of these types of natural compounds for human medicine."

The research paper *'Mapping insoluble indole metabolites in the gastrointestinal environment of a murine colorectal cancer model using desorption/ionisation on porous silicon imaging'* is published in *Scientific Reports.*

Red wine good for the gut, so long as it's not a gutful

Latest research out of King's College London says red wine could be good for the gut because it increases the number of different types of helpful bacteria that can live there.

A mere glass of red a fortnight is enough to make a difference though, so the findings are no excuse to binge drink.

The research team at Kings say the benefits are likely to come from polyphenols – compounds that white wine, beer and cider have far less of. Polyphenols are also found in many fruits and vegetables.

Polyphenols, such as resveratrol in the skin of red grapes, are micronutrients that are thought to have beneficial properties and act as a fuel for useful microbes living inside the bowel. Human guts contain trillions of bacteria and other micro-organisms and this community of 'friendly' bugs helps keep people healthy.

A growing body of research suggests small changes to microbiota can make people more susceptible to illnesses such as irritable bowel syndrome, heart disease and obesity and may even affect moods and mental health. Diets, lifestyles and some types of medication upset this finely balanced gut ecosystem.

The study, published in the journal *Gastroenterology*, looked at thousands of people living in the UK, the US and the Netherlands. The participants were all twins enrolled in health research programs and were asked about their diet and how much and what type of alcohol they typically drank.

The gut microbiota of red wine drinkers was more diverse than that of non-red wine drinkers. Gut bug diversity increased the more red wine a person consumed, although occasional drinking – one glass a week or fortnight – appeared to be sufficient. None of the participants was a heavy drinker.

The researchers stressed that heavy consumption was not recommended and would probably have a bad effect on gut bugs, as well as on a person's general health.

"This is an observational study so we cannot prove that the effect we see is caused by red wine," said researcher Dr Caroline Le Roy.

"If you must choose one alcoholic drink today, red wine is the one to pick as it seems to potentially exert a beneficial effect on you and your gut microbes, which in turn may also help weight and risk of heart disease.

"You do not need to drink every day and it is still advised to consume alcohol with moderation.

"We are starting to know more and more about gut bacteria. It is complex, and we need more research, but we know that the more diversity there is, the better it appears to be for our health."

Paracetamol poisonings on the rise

The annual number of cases of paracetamol poisoning in Australia has increased by 44.3 per cent since 2007-08, and the number of cases of toxic liver disease due to those overdoses ballooned by 108 per cent over the same period, according to research published in the *Medical Journal of Australia.*

The researchers, led by Dr Rose Cairns, Director of Research at the NSW Poisons Information Centre and the University of

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Sydney, wrote that public health measures that restrict the availability of paracetamol, such as reducing non-prescription pack sizes, are needed to stem the increasing number of paracetamol overdoses.

After analysing data on paracetamol-related exposures, hospital admissions, and deaths from the Australian Institute of Health and Welfare National Hospital Morbidity Database (NHMD; 2007–08 to 2016–17), the NSW Poisons Information Centre (NSWPIC; 2004–2017), and the National Coronial Information System (NCIS; 2007–08 to 2016–17), Cairns and colleagues found that:

- there were 95,668 admissions with paracetamol poisoning diagnoses (2007–08 to 2016–17);
- the annual number of cases increased by 44.3 per cent during the study period (3.8 per cent per year; 95 per cent CI, 3.2–4.6 per cent);
- toxic liver disease was documented for 1,816 of these patients; the annual number increased by 108 per cent during the study period (7.7 per cent per year; 95 per cent CI, 6.0–9.5 per cent);
- most paracetamol overdoses involved women (about 70 per cent);
- the NSWPIC database included 22,997 reports of intentional overdose with paracetamol (2004–2017);
- the annual number of intentional overdoses increased by 77.0 per cent during the study period (3.3 per cent per year; 95 per cent CI, 2.5–4.2 per cent);
- the median number of tablets taken increased from 15 in 2004 to 20 in 2017;
- modified release paracetamol ingestion report numbers increased 38 per cent per year between 2004 and 2017 (95 per cent CI, 30–47 per cent);
- 126 in-hospital deaths were recorded in the NHMD, and 205 deaths (in-hospital and out of hospital) in the NCIS, with no temporal trends; and
- the median age of patients in the NSWPIC database was 18 years. The median age in cases of fatal overdoses recorded in the NCIS was higher (53 years), perhaps reflecting greater suicidal intent in overdoses by older people or the presence of comorbid conditions that increase the risk of liver injury.

“Access restrictions, including reduced pack sizes, could reduce the harm caused by paracetamol overdoses in Australia, and should be considered, together with other policy changes, to curb this growing problem,” Dr Cairns and colleagues concluded.

New research centre for fertility services

UNSW Sydney and The Royal Hospital for Women have collaborated to form the first of its kind fertility and research centre in Australia.

The state-of-the-art facility, known as the Fertility & Research Centre (FRC), will offer women across NSW publicly funded, low-cost IVF treatment and on-site fertility preservation services for young people with cancer and rare genetic diseases.

The centered was opened in August by NSW Health Minister Brad Hazzard.

“This centre will provide first-class fertility preservation services, giving people with a cancer diagnosis or rare genetic conditions the chance to make their future plans for children a reality,” Mr Hazzard said.

Led by UNSW’s Professor William Ledger, the FRC will hold an assisted reproduction laboratory and procedure room where a full range of clinical services, including complete reproductive investigations and comprehensive IVF services, will be available to patients in a public hospital setting.

Professor of Obstetrics and Gynaecology at UNSW and Director of Reproductive Medicine at the Royal Hospital for Women, Professor Ledger, said the service will be linked with the Kids Cancer Centre at Sydney Children’s Hospital.

“Cancer patients diagnosed at Sydney Children’s or Prince of Wales Hospital can now speak with doctors about fertility preservation the very same day they are told they need chemotherapy,” Professor Ledger said.

The FRC will be a teaching centre at the cutting edge of fertility research bringing together top fertility experts to examine the possibilities of hormone-free IVF and new ways of slowing down the possible decline in egg quality as women age.

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Researchers at the FRC are working with UNSW's Dr Lindsay Wu to find new ways of slowing down the ageing of eggs and find ways to translate those findings into practice.

The team will also work with Professor Robert Gilchrist, a specialist in oocyte and reproductive biology from UNSW's School of Women's and Children's Health, to introduce hormone injection-free IVF treatment; and with Dr Kirsty Walters, a senior lecturer in Women's and Children's Health, on the impact of polycystic ovary syndrome on infertility.

Professor Ledger said oncofertility services will be available to patients diagnosed with cancer to preserve fertility before undergoing chemotherapy.

"Many young people will encounter cancer in their lives. Chemotherapy and radiotherapy will treat their cancer but will destroy their store of eggs. The answer is to take quick and pre-emptive action by freezing eggs and embryos," Professor Ledger said.

"We will also offer genetic screening of embryos, helping to eliminate devastating genetic disorders from future generations as well as counselling and psychological support."

Researchers will examine high powered genetic approaches, which will be used to improve pregnancy rates and pre-implantation diagnosis for couples at risk of hundreds of genetic diseases.

New approaches will be examined into preserving eggs, ovarian tissue, gametes and embryos for younger people with cancer, and reducing the risk of implantation failure and miscarriage in women in their 30s and 40s.

Technique is paramount in melanoma biopsies

Punch and shave biopsies are increasingly popular techniques for partial biopsies of melanomas, with their proportion of all biopsies rising from 9 per cent in 2005 to 20 per cent in 2015.

But researchers warn they are associated with inaccuracies in staging melanomas.

A study published in the *Medical Journal of Australia* assessed changes in the choice of skin biopsy technique for assessing invasive melanoma in Victoria, and to examine the impact of partial biopsy technique on the accuracy of tumour microstaging.

"The aim of diagnostic skin biopsy is to accurately detect or exclude melanoma and to accurately stage the primary tumour in order to inform therapy planning," wrote the authors, led by Associate Professor Victoria Mar, Director of the Victorian Melanoma Service.

"Punch biopsies are usually intended to sample and diagnose large, clinically obvious melanomas (high false negative rates make them unsuitable for diagnosing clinically equivocal lesions), whereas the aim with many shave biopsies is to diagnose and completely remove the lesion, thereby allowing the planning of definitive therapy.

"While shave and saucerisation biopsy techniques have been promoted as more accessible and less expensive than excision, they are associated with microstaging inaccuracy.

"Shave biopsy can transect the base of invasive melanomas [which] may lead to inaccurate initial assessment of tumour depth, with negative implications for microstaging, planning of therapy, and determining the prognosis."

Prof Mar and colleagues analysed data from 400 patients randomly selected from the Victorian Cancer Registry for invasive melanoma histologically diagnosed in Victoria during 2005, 2010, and 2015, stratified by final tumour thickness: 200 patients with thin melanoma (< 1.0 mm), 100 each with intermediate (1.0–4.0 mm) and thick melanoma (> 4.0 mm).

They found that 833 excisional and 337 partial diagnostic biopsies were undertaken.

The proportion of partial biopsies increased from 20 per cent of patients in 2005 to 36 per cent in 2015; the proportion of shave biopsies increased from 9 per cent in 2005 to 20 per cent in 2015, with increasing rates among both GPs and dermatologists; 94 of 175 shave biopsies (54 per cent) transected the tumour base; wide local excision subsequently identified residual melanoma in 65 of these cases (69 per cent); 21 tumours diagnosed by shave biopsy (12 per cent) were T-upstaged.

With base-transected shave biopsies, tumour thickness was underestimated by a mean 2.36 mm for thick, 0.48 mm for intermediate, and 0.07 mm for thin melanomas.

"Excisional biopsy remains the most appropriate diagnostic biopsy technique for invasive melanoma," the authors wrote, citing clinical practice guidelines from Australia, the US and the UK.

"[We] identified a marked increase in the use of shave biopsy in Victoria between 2005 and 2015, associated with a substantial rate of tumour base transection and underestimation of tumour thickness.

"Accurately ascertaining thickness is increasingly important not only for prognosis, but also for decisions about adjuvant therapies and clinical trial opportunities. Where excisional biopsy is readily achievable, it remains the most appropriate diagnostic biopsy technique for assessing invasive melanoma."

World News

WITH CHRIS JOHNSON

Eradicating malaria needs better tools

Accelerated research and development in new tools for malaria prevention and treatment is key if the world is to eradicate malaria in the foreseeable future. According to the World Health Organisation's latest report on the topic.

Today, less than one per cent of funding for health R&D investment goes to developing tools to tackle malaria, the report states.

In its report, the WHO also flags the urgent need for progress to advance universal health coverage and improve access to services, and better surveillance to guide a more targeted malaria response.

The report, from WHO's Strategic Advisory Group on Malaria Eradication (SAGme), was published ahead of the "Rising to the Challenge of Malaria Eradication" forum held in Geneva on September 9.

"To achieve a malaria-free world we must reinvigorate the drive to find the transformative strategies and tools that can be tailored to the local situation. Business as usual is not only slowing progress, but it is sending us backwards," said Dr Marcel Tanner, Chair of the SAGme.

Eradicating malaria would both save lives and boost economies, the report states. The health benefits would be greatest among some of the world's most vulnerable populations. Children under five account for 61 per cent of all malaria deaths. More than 90 per cent of the world's 400,000 annual malaria deaths occur in sub-Saharan Africa.

The group's analyses showed that scaling up current malaria interventions would prevent an additional two billion malaria cases and four million deaths by 2030 – provided those interventions reach 90 per cent of the population in the 29 countries that account for 95 per cent of the global burden.

The cost of this scale-up is estimated to be US$ 34 billion. The economic gain would be around US$ 283 billion in total gross domestic product (GDP) – benefit to cost ratio in excess of 8:1.

In many countries, access to health services remains a major challenge. Only one in five pregnant women living in areas of moderate to high malaria transmission in Africa is able to obtain the drugs she needs to protect herself from malaria. Half the people at risk of malaria in Africa sleep under an insecticide-treated net and just three per cent are protected by indoor spraying with insecticides.

This highlights the need to advance universal health coverage and strengthen health services and delivery systems, so everyone can access malaria prevention, diagnostics and treatment, when and where they need them, without suffering financial hardship. The group noted the need to rethink approaches.

"Freeing the world of malaria would be one of the greatest achievements in public health," said Dr Tedros Adhanom Ghebreyesus, WHO Director-General.

"With new tools and approaches we can make this vision a reality."

World News

Future health threat for Mecca pilgrims

The Muslim pilgrimage to Mecca could be hampered in future years with health threats caused by the 'extreme danger' of climate change, a new study is warning.

Published in *Geophysical Review Letters*, the study found that Mecca in Saudi Arabia will experience alarmingly higher temperature summers, with heat and humidity potentially having a severe impact on the pilgrims.

Known as the Hajj, the pilgrimage involves several days of lengthy outdoor activities. While the timing of the Hajj varies, for the past two years it has been during the hottest months of summer. There will be numerous periods in the decades ahead – particularly in the middle of this century – when the Hajj will again take place at the height of summer, with those years predicted to be increasingly hotter.

"When it comes in the summer in Saudi Arabia, conditions become harsh, and a significant fraction of these activities are outdoors," study author Professor Elfatih Eltahir said.

"Because the Hajj is a very strong part of the culture in Muslim communities, it's important for Saudi Arabian officials to prepare to reduce the health risks posed by extreme heat and humidity."

Professor Eltahir is a professor of civil and environmental engineering at Massachusetts Institute of Technology (MIT) in Cambridge. He said drastic steps might need to be taken.

"This study should help in informing policy choices, including climate change mitigation policies as well as adaptation plans," Professor Eltahir said.

"In the potentially dangerous years ahead, it may be necessary to severely limit the number of participants allowed to take part in the ritual."

The study notes, however, that even with significant steps taken to limit the impacts of climate change, the health threat will still be present. The danger will be even greater though if nothing is done.

Authorities have put some things in place already in recent years, including installing water mist nozzles in various outdoor locations, and expanding gatherings areas in order to reduce overcrowding.

Hajj is a religious duty and the 1.8 million Muslims worldwide must individually make the pilgrimage to Mecca at least once in a lifetime if health and finances allow.

World News

Safe drinking water a concern for too many countries

The World Health Organisation and UN-Water have sounded the alarm for an urgent increase in investment in strong drinking-water and sanitation systems.

The call came as the international water sector met in Stockholm for its annual conference during World Water Week in the last week of August. It is triggered by a new report published by WHO on behalf of UN-Water revealing that weak government systems and a lack of human resources and funds are jeopardising the delivery of water and sanitation services in the world's poorest countries – and undermining efforts to ensure health for all.

"Too many people lack access to reliable and safe drinking-water, toilets and hand-washing facilities, putting them at risk of deadly infections and threatening progress in public health," WHO Director-General Dr Tedros Adhanom Ghebreyesus said.

"Water and sanitation systems don't just improve health and save lives, they are a critical part of building more stable, secure and prosperous societies. We call on all countries that lack essential water and sanitation infrastructure to allocate funds and human resources to build and maintain it."

The UN-Water Global Assessment and Analysis of Sanitation and Drinking-Water 2019 (known as the GLAAS report) surveyed 115 countries and territories, representing 4.5 billion people. It showed that in an overwhelming majority of countries, the implementation of water, sanitation and hygiene policies and plans is constrained by inadequate human and financial resources.

Nineteen countries and one territory reported a funding gap of more than 60 per cent between identified needs and available funding. Less than 15 per cent of countries have the financial or human resources needed to implement their plans.

"If we are to create a healthier, more equitable and stable society, then strengthening the systems to reach those currently living without safe and affordable water, sanitation and hygiene services must be a top priority," Chair of UN-Water and President of the International Fund for Agricultural Development, Gilbert F Houngbo said.

"While we need to ensure that there is sufficient funding to tackle these critical challenges, it is equally important to continue reinforcing national delivery systems."

UN-Water coordinates the efforts of United Nations entities and international organisations working on water and sanitation issues. More than 30 UN organisations carry out water and sanitation programs, reflecting the fact that water issues run through all of the UN's main focus areas.

About half of the countries surveyed have now set drinking-water targets that aim for universal coverage at levels higher than basic services by 2030, for example by addressing water quality and increasing access to water on premises. In addition, specifically targeting open defecation will have a dramatic impact on public and environmental health.

While funding gaps and weak systems are holding many countries back, the report also found that countries have begun to take positive steps towards achieving sustainable development goals on water and sanitation.

World News

Johnson & Johnson massive fine

Pharmaceutical giant Johnson & Johnson has been ordered to pay $US 572 million to the State of Oklahoma, after a judge found the company deceptively marketed opioids. The judgement even found that Johnson & Johnson bore some responsibility for Oklahoma's opioid crisis.

The case was the first opioid lawsuit to reach a verdict in the United States, where hundreds of suits are being brought across the nation.

Judge Thad Balkman found that Johnson & Johnson engaged in "false, misleading, and dangerous marketing" that caused "exponentially increasing rates of addiction and overdose death" in the State of Oklahoma.

Two other pharmaceutical companies, Purdue Pharma and Teva, were initially defendants in the same suit, but they each settled separately to avoid going to trial. Johnson & Johnson decided to fight.

After the verdict, the company stated its intention to appeal and described the case as flawed.

In statement, Johnson & Johnson announced that it and its Janssen Pharmaceutical Companies will appeal the $572 million civil judgment entered in Cleveland County District Court in the State of Oklahoma's lawsuit against opioid manufacturers.

"The Company is confident it has strong grounds to appeal this decision," Michael Ullmann, Executive Vice President, General Counsel, Johnson & Johnson said.

"The judgment disregards the Company's compliance with Federal and State laws, the unique role its medicines play in the lives of the people who need them, its responsible marketing practices...

"Janssen did not cause the opioid crisis in Oklahoma, and neither the facts nor the law support this outcome.

"We recognise the opioid crisis is a tremendously complex public health issue and we have deep sympathy for everyone affected. We are working with partners to find ways to help those in need."

First e-cig death confirmed

American health authorities have recorded the first death linked to vaping.

The Illinois Department of Public Health issued a statement saying a person who had been hospitalised with severe respiratory illness after using an e-cigarette had subsequently died.

The department also reported that more than 20 people in the State were confirmed to be suffering respiratory illness after vaping, with a dozen more cases being investigated.

the US Centers for Disease Control and Prevention said almost 200 similar possible cases have been documented across America.

Victims have coughs, shortness of breath, and fatigue in the

days and weeks after vaping, with the symptoms appearing to gradually worsen. Some people also suffer vomiting and diarrhea after vaping.

World News

Concerns for mental wellbeing of UK children

British children are not feeling happy. So says a new survey, which is sparking calls for Prime Minister Boris Johnson to place children's wellbeing at the top of his agenda.

According to the latest installment of the annual *Good Childhood* report, more than 200,000 children in the UK are not happy with their lives.

This is the lowest level in a decade, and the first time since the survey and report was launched in 2009 that overall contentment among 10 to 15 year-olds has fallen below eight on a scale of one to ten.

The contentment rate comes in at 7.89, which is down from a high of 8.21 in 2011.

Almost five per cent of those surveyed reported happiness scores below five out of 10, which points to about 219,000 children in the UK being unhappy.

This all comes at a time when British adults' wellbeing is being reported as improving.

The Children's Society, which conducted the research, described the decline in childhood happiness as a national scandal. It has called on Mr Johnson to introduce a national measurement of children's wellbeing.

"Children appear to be having declining happiness with their friends, which is concerning. And boys have seen a significant decline in how they feel about their appearance," said the charity's Richard Crellin.

"It is too soon to report a trend, but there were also big dips this year in happiness about school and schoolwork. If that continues it would suggest young people are finding school increasingly difficult."

A Government spokeswoman said: "We want young people growing up in a modern Britain to feel confident tackling the challenges life throws at them. That is why we're giving teachers the power to deal with bad behaviour and bullying in the classroom, investing billions every year in mental health support for young people, and providing quicker access to specialist treatment where needed."

But Shadow Health Secretary Jonathan Ashworth said the report should act as wake-up call.

"Our children's health should be a national priority, yet after nine years of austerity, the Government's response to the issue of child health has been piecemeal as it continues to squeeze the NHS and take money from our public health system and schools," he said.

The report is based on an annual survey of about 2,400 households and a longitudinal study involving 40,000 households.

World News

Brits are smoking less

Cancer Research UK is reporting that almost 1.5 billion fewer cigarettes have been smoked each year in England since 2011.

University College London (UCL) examined cigarette sales data as well as the monthly self-reported cigarette use from more than 135,000 people in the Smoking Toolkit Study, which was funded by Cancer Research UK.

The results have been published in *Jama Network Open*. The study found that an average of 118 million fewer cigarettes had been smoked each month between 2011 and 2018 – a drop of almost a quarter.

Dr Sarah Jackson from UCL's tobacco and alcohol research group, said: "It's brilliant that over a billion fewer cigarettes are being sold and smoked in England every year. Studies like this help to give us an accurate picture of cigarette consumption so we know where we're at and what more needs to be done."

The decline in use has been encouraged by stricter laws on tobacco marketing, and advertising aimed at encouraging people to quit smoking.

"It's great news that fewer cigarettes are being sold and smoked," Cancer Research UK's senior policy manager George Butterworth said.

"Big tobacco said that introducing stricter regulation wouldn't work and campaigned against it but this is proof that smoking trends are heading in the right direction.

"But smoking is still the biggest preventable cause of cancer and certain groups have much higher rates of smoking, such as routine and manual workers, so we can't stop here and think that job's done.

"The Government committed to making the UK smoke-free by 2030. But stop-smoking services, which give smokers the best chance of quitting, have been subject to repeated cuts in recent years."

Blood pressure meds contaminated in the US

United States health officials are trying to reassure patients there is an extremely low risk from ongoing contamination problems with widely prescribed blood pressure drugs.

Associated Press reports from Washington say that since July, pharmaceutical companies have issued more than 50 medicine recalls due to low levels of a probable cancer-causing chemical found in generic drugs that are taken by millions of Americans.

The affected medications are low-cost versions of lifesaving heart-regulating drugs, designed to allow blood to flow more easily. They are sold as single-ingredient pills and tablets, and also in combination with other drugs.

The Food and Drug Administration (FDA) is struggling to police the industry, which is increasingly relying manufacturing plants in China and India.

Last year, the FDA said that if 8,000 patients took the maximum dose of the drugs for four years, the contamination issue could cause one extra case of cancer over their lifetimes.

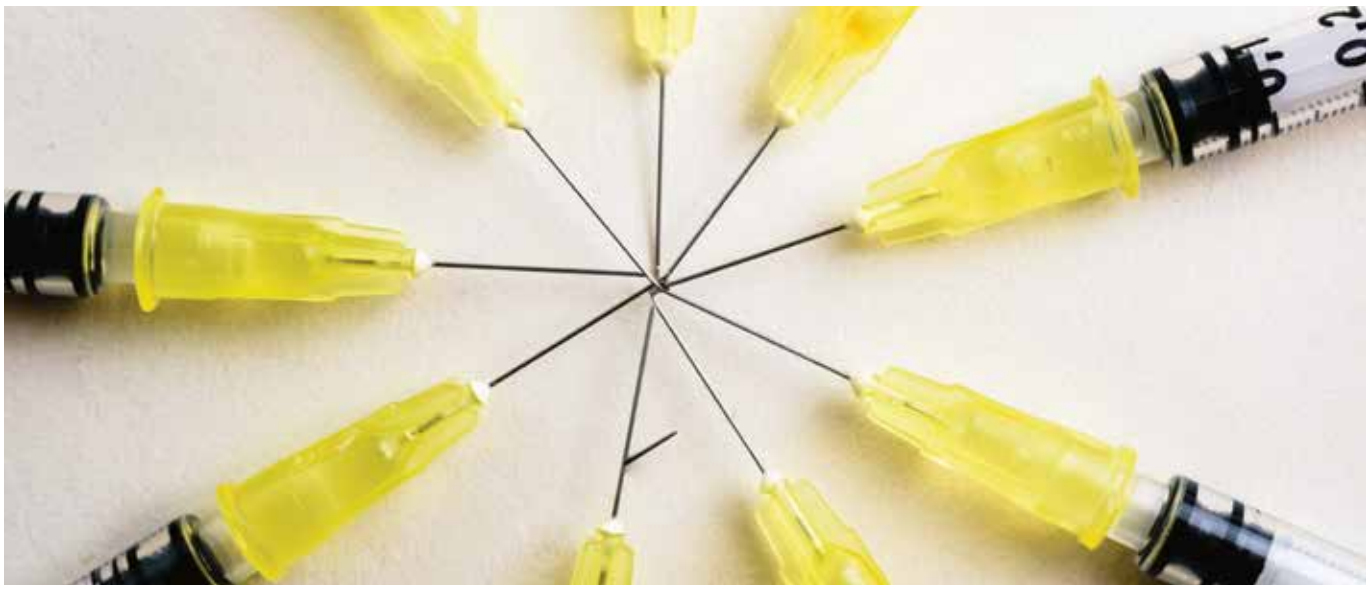
But in August this year, the FDA moved to state that the actual risk to patients from the medications was even lower than that.

The agency said patients should continue taking their medication, because the risk of untreated high blood pressure and heart failure "greatly outweighs the potential risk of exposure to trace amounts" of contaminants.

The FDA also noted that 43 blood pressure medications had not been affected by the contamination issues, and that no drug shortages have been reported due to the contamination.

World News

Pinterest leads social media in banning anti-vax propaganda



Social media company Pinterest has announced it will only show information from health organisations on its platform when people search for information about vaccines.

It is doing this, it says, to help counter misinformation being distributed by anti-vax campaigners.

Searches on Pinterest for words and terms such as "measles" and "vaccine safety" will now only bring up results from credible health organisations.

"We're taking this approach because we believe that showing vaccine misinformation alongside resources from public health experts isn't responsible," the San Francisco-based Pinterest said in a post.

Pinterest has previously tried blocking all searches for vaccines with varying results, but now it will completely block anti-vax sites. It won't even show ads or other users' posts on the issue, in order to prevent misinformation being spread that way.

The World Health Organisation has applauded the move, saying misinformation about vaccines is as contagious and dangerous as the diseases it helps to spread.

"WHO welcomes Pinterest's leadership in protecting public health by only providing evidence-based information about vaccines to its users," it said in a statement.

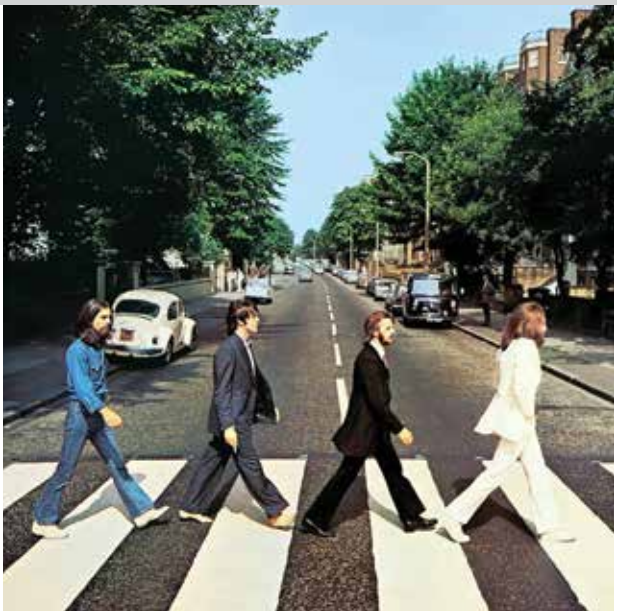
"We hope to see other social media platforms around the world following Pinterest's lead. Misinformation about vaccination has spread far and fast on social media platforms in many different countries, including during critical vaccination campaigns like those for polio in Pakistan or yellow fever in South America.

"Social media platforms are the way many people get their information and they will likely be major sources of information for the next generations of parents. We see this as a critical issue and one that needs our collective effort to protect people's health and lives.

"The truth is, vaccines work. Smallpox has been eradicated thanks to vaccines, and vaccines have brought us to the brink of eradicating polio. Rates of many other diseases including measles have been dramatically reduced thanks to the life-saving power of vaccines."

Ten things you didn't know about *Abbey Road*

BY CHRIS JOHNSON



The Beatles' *Abbey Road* was unleashed on the world 50 years ago this month. It became an instant record-breaking hit and is still regarded today as one of the greatest albums ever recorded. The recording sessions in the Abbey Road Studios, however, were fraught with artistic differences and rising tensions as the Fab Four reached the end of their journey as a band. It was the last time John Lennon, Paul McCartney, George Harrison and Ringo Starr would record together as a unit.

Making sure tensions remained at their peak, John insisted that his new wife Yoko Ono was present in the recording studio to observe the sessions. When Yoko sustained back injuries in a car crash midway through the sessions, a doctor told her she had to remain in bed to recover. So, John got a bed installed for Yoko inside the studio. But here are ten things you didn't know about the recording of *Abbey Road*. Seriously, you won't find these facts anywhere else.

1 The last song on the first side of the album *I Want You (She's So Heavy)* ends suddenly when it abruptly stops mid riff and jolts into an unexpected silence. That's because Yoko stepped out to go to the bathroom and John didn't know what to do anymore and so, looking lost and confused, he just stopped playing.

2 Yoko didn't like Ringo's drumming on the album's side two medley and so snuck into the studio late one night to record over it with her own playing. She came in through the bathroom window.

3 After Paul recorded *Oh! Darling*, Yoko told John it was way better than the sappy *Oh Yoko* he was working on at the time.

4 Yoko wanted George to change the name of his *Here Comes the Sun* to *Here Comes the Son*. She was pregnant at the time. George refused.

5 On the album cover, everyone except George is wearing a suit while walking across the road. George is wearing all denim. That's because Yoko issued the dress code invitations for the photo shoot and decided to mess with George over his refusal to change the name of *Here Comes the Sun*.

6 Paul isn't wearing any shoes on the album cover because he couldn't find them. Yoko remained poker-faced the whole time he was frantically searching for them before the photo shoot.

7 After George's *Something* was released as a single from the album, Frank Sinatra described it as the greatest love song ever written. Yoko called a press conference to say she agreed with Sinatra – and to stress that it was far superior to Paul's *Oh! Darling*.

8 Yoko used the same press conference to remind everyone that the single was actually a double-A side. She did this by signing an a cappella version of John's *Come Together*. She invited Linda McCartney to step out from the crowd and join her at the microphone for a duet. Linda wasn't there. There was no crowd.

9 Tension and arguments during the recording sessions of *Abbey Road* resulted in numerous threats from Yoko that she would quit the band.

10 Yoko told Ringo that his *Octopus's Garden* was by far the best song on the whole album.

Lifetime world maps

BY DR CLIVE FRASER

When I first graduated in 1981, the average life expectancy of a male in Australia was 71.4 years.

Unsurprisingly, for a female the average life expectancy back then was seven years better at 78.4.

In the 38 years since then, the life expectancy figures for both sexes have improved dramatically to 80.5 years for males and 84.6 years for females.

You might say that in terms of gender bias, men have been closing the gap.

Advances in cancer and cardio-vascular care in Western society probably have played the biggest part in this improvement for both sexes.

Elsewhere in developing countries better nutrition and reductions in infant mortality have steadily improved life expectancy figures there as well.

But anyone who has recently purchased a so-called smart device will not be surprised to see the life expectancy of those devices may be measured in months rather than in years.

I recently experienced this first-hand when I splashed out my cash for a portable GPS device.

I won't mention the name of the brand.

I was persuaded to buy it because it was on sale at a 30 per cent discount and came with the promise of lifetime world map updates.

So in June 2019, I splurged $244 for my SatNav device.

I must admit that I did download maps of the USA and Western Europe with no plans to go there, but I was disappointed to find that my soon-to-visit Japan still appears to be un-mapped by any Western SatNav device.

Then in July 2019, I received an unexpected email advising me that the device that I'd purchased only four weeks previously was no longer up-gradable.

The actual email said: "Your current SatNav is incompatible with ... latest map update. Consider upgrading your hardware."

How could this be, I thought, particularly as the up-graded device they suggested was the same model as the one I'd just purchased?

I'd even registered my device within 30 days of purchase to be eligible for the lifetime world maps offer

The email went on to explain what they meant by lifetime.

"Lifetime is the useful life of the device, which means the period of time that ... (the company) continues to support your device with software updates, services, content or accessories. A device will have reached the end of its life when none of these are available any more. The useful life of the smartphone app means the period of time that (the company) continues to support the app with updates."

All of this sounds suspiciously like the Apple model of programmed redundancy which keeps customers coming back for a new device year after year.

This idea of a lifetime seemed to be very different to my idea of 80.5 years.

In the Orwellian company's world, it seems that the maker of the device can decide for you when its life is over and it's time to step up to the newest model.

But I'm sure all of this was just a mistake, because I'm pleased to say that my device is still up-dating.

I have a draw full of old SatNav devices that all still work, but have fallen into the crevasse of redundancy.

Perhaps the email referred to one of them.

Safe motoring,

Doctor Clive Fraser

doctorclivefraser@hotmail.com

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