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Care can't wait

Put care back into aged care, p3

INSIDE

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In this issue

Cover pic: Dr Bartone and ANMF Federal Secretary Annie Butler.

Photo by Odette Visser.

Put care back into aged care

Dr Bartone and ANMF Federal Secretary Annie Butler

Elderly Australians and their families cannot wait another year for the Government to fix aged care.

Declaring aged care to be in crisis, the AMA has called on the Government to act urgently to address it and not wait until the Royal Commission into the sector runs its course.

Jointly with the Australian Nursing and Midwifery Federation (ANMF), the AMA has urged the Government to immediately guarantee quality and safety in aged care, appropriately fund and staff residential aged care facilities (RACFs), and increase funding for home care packages.

AMA President Dr Tony Bartone said Australians should not have to wait for the findings of the Royal Commission before the Government starts investing properly in aged care.

"We can't wait for that Commission to hand down its findings while older Australians are suffering and being denied access to quality of life – even in the community through the necessary aged care packages," Dr Bartone said.

The Royal Commission into Aged Care Quality and Safety delivers its final recommendations to the Government in November 2020. It has already identified serious and dangerous shortcomings in the system, and more concerns will surface before the Commission reports.

The AMA and the ANMF fully support the work of the Royal Commission, but older Australians in aged care, and their families and loved ones, cannot wait another year for Government action to fix the problems.

Dr Bartone said care can't wait.

"We have to put care back into aged care," he said.

"Older Australians deserve to have the same opportunity to have the best quality of life as everyone else, and the same access to high quality medical and nursing care they have enjoyed throughout their long and productive lives.

"Standards of care for our elderly should not be compromised through restriction of resources or the budget bottom line. The Government cannot stand by and watch aged care providers continue to provide poor quality care because they are deemed 'too big to fail'.

"Ignoring the health and care needs of older Australians will lead to an increase in avoidable hospitalisations and excessive costs to the health system. The aged care system urgently needs a safe and quality skills mix of medical, nursing, and care staff. The increased presence of doctors as part of the care team is vital. The Government must act now."

ANMF Federal Secretary Annie Butler said older Australians deserve affordable, high-quality aged care services, with timely access to a range of appropriate health professionals, and in residential facilities, with care delivered by the right numbers of professionally trained nurses and care staff.

"They do not deserve the pain and suffering too many are currently experiencing, nor do they deserve to continue to be ignored by their country's Government, which is meant to ensure their safety," Ms Butler said.

Put care back into aged care ...continued from p3

"We can't wait for the Morrison Government to act on recommendations of the Royal Commission to stop the suffering of our elderly; we simply cannot allow the Government to continue to sit idly on the sidelines and watch the extent of this suffering unfold.

"There is no need to wait, the Government can start taking action now. We need more nurses and more doctors in aged care. Legislated minimum staff ratios in nursing homes are needed urgently.

"Registered nurses must be available 24 hours a day, and there must be enough well-trained care workers to support the delivery of quality care. General practitioners must be supported to attend nursing homes to ensure quality medical care for elderly Australians."

The AMA and the ANMF said the Government could immediately provide:

- mandatory minimum staff-to-resident ratios, including ensuring sufficient skilled nurses in RACFs;
- increased GP aged care Medicare rebates for patients to facilitate enhanced medical practitioner care of aged care residents; and
- expanded home care investment to allow more older people stay longer in their own homes and relieve pressure on residential aged care services.

Dr Bartone said older Australians have the right to live in dignity and have safe and appropriate aged care services provided to them.

JOHN FLANNERY AND CHRIS JOHNSON

The AMA submission to the Royal Commission into Aged Care Safety and Quality is available at https://ama.com.au/submission/ama-submission-royal-commission-aged-care-quality-and-safety

Reforms proposed by the AMA and the ANMF

General funding increase

An increase in funding for aged care and increased transparency in the use of funding. Insufficient funding is the reason behind qualified staff shortages. A lack of registered nurses means that medication mistakes are made. Insufficient funding is why the food is terrible. Insufficient funding is why facilities aren't purpose-built.

Staff-to-resident ratios

Minimum mandatory staff-to-resident ratios, which reflect the level of care need of older people, should be introduced in RACFs. Registered nurses should be available on-site, 24 hours a day in RACFs to ensure older peoples' medical needs are adequately met, including the appropriate administration of medicines. That way unnecessary hospitalisations, unnecessary transfers and extended hospital stays would be avoided.

GP Medicare rebates

Increase the number of GPs working in aged care. The number of GPs willing to work in the aged care space has been reducing due to low Medicare rebates and the declining proportion of registered nurses in aged care. Medicare rebates need to increase in excess of 50 per cent to begin to adequately compensate for the additional time and complexity involved in comparison to a GP attendance in their own consulting rooms.

Home care packages

Government needs to increase the funding for home care packages, most importantly for Level 4 packages. Many older people prefer to age in their own homes or community. For this reason, ensuring access to primary, home and community care should be a priority.

As of June 2019, there were 119,524 older people waiting for their assessed home care package. The Royal Commission reported that 16,000 people died waiting for a home care package. Waiting times are more than 12 months. A greater availability of home care packages will defer and prevent the need for more complex care in RACFs and hospitals.

A rocky road ahead for the health system

Moving from the MBS review to implementation and insurer fee setting – what could possibly go wrong?

As members would know, the AMA supported the concept of the Medicare Benefits Schedule (MBS) Review, provided it was clinician-led, because we believe in a system that reflects contemporary best practice.

Of course, like the rest of the profession, we wanted a contemporary system that provides for the innovations and improvements that have been made in medicine, and the opportunities that technological advancements can offer.

As we have repeatedly stated, any review must be one that is based on robust research and a strong evidence base. It also needs to be one that provides adequate patient rebates, so that we don't end up with a two-tier system – those who can afford treatment and those who can't.

The MBS Review – A recap

Back in 2015, the medical profession made a commitment to work with the MBS Review and the many Clinical Committees and Working Groups working under the Review Taskforce.

The medical professionals on the Clinical Committees and Working Groups provided considerable time, and expertise, to the promised task of modernising the MBS.

Throughout the Review, the AMA called for a review process that is transparent throughout its full lifespan. This included consultation and feedback on proposed implementation plans, consideration of the overall impacts on health funding, and an understanding of viable service delivery.

The AMA also called for the inclusion of clinicians who have the right experience – those who work with, and use, the MBS daily in private practice. The AMA continued to remind the Government that the MBS was an insurance scheme, not a mechanism to control the clinical judgement and the decision making of highly educated practitioners.

We called for the Review not to be a savings exercise, and for the establishment of a 'reinvestment fund' to ensure that every cent taken out of the MBS Review is reinvested in new and improved items. You can read about this in our budget submission and Federal Election campaign document.

An MBS Review Forum organised by the AMA

Keeping an Eye on the Review

The AMA has also played a critical role in bringing together the profession to respond to the MBS Review. We held a meeting of all the Colleges, Associations, and Societies to discuss the MBS Review, including bringing Professor Bruce Robinson to present to us in Canberra.

We have published regular updates in *Australian Medicine*, and AMA communication channels, as well as a dedicated website, https://ama.com.au/mbs-reviews where you will find every one of the AMA's responses to the dozens of clinical committees.

Most recently, you will recall the President wrote to all Colleges, Associations, and Societies, and many members, calling for responses to the Specialist and Consultant Physician report.

This was in addition to a survey of our members on their views of the proposed changes.

A rocky road ahead for the health system ...continued from p5

Despite this extensive advocacy on behalf of, and with, the profession, there is no doubt that some of the decisions taken by the Government will be unpopular and appear to be designed with a focus of savings or compliance in mind. In discussing these publicly, either as an organisation or as individuals, it is important to understand ultimately, despite the efforts of the many clinicians on the many committees, the final decision on each change rests with the Government.

Better Communication

The MBS Review Taskforce recently sent a newsletter updating the profession about its activities. The September 2019 newsletter was the first since June 2017 – over a two-year gap. It's one of the 'asks' that the AMA has been calling for, for quite some time – more regular communications making transparent the work of the Taskforce.

Separate to that, the AMA has called for better fact sheets and education on the forthcoming MBS changes – pleasingly, the Department has now involved NPS MedicineWise to assist with this work. These materials are being refined, line by line, with feedback from the AMA.

There will now be a clearer explanation of what items are being deleted, what are being amended and what are new, and we hope soon an explanation of how the new fees relate to the old structure. They should also start to include examples of claiming, a quick reference guide, and far-easier-to-navigate formats and designs.

Implementation issues on the horizon

As with all important policy development, implementation is critical.

While actively participating in the MBS Review, the AMA has been lobbying the Minister and the Department about implementation concerns. We have repeatedly argued there needs to be adequate lead time for consultation with private health insurers, the relevant profession/s, peak bodies, and various compensation schemes.

This advocacy was rooted in real world experience. The AMA, as members know, has its own Fees List. When, last November, it came time to adapt to the new spinal MBS items (stemming from the Review) three things became apparent – firstly, that the changes were complex; secondly, practitioners, hospitals, and the insurance industry didn't have the information they needed to implement the fee and descriptor changes; and third, there was simply not enough time to adapt to them.

As a result, no insurer was ready at 1 November with their rebates. Practices and patients could not access rebates. Informed financial consent could not be carried out. The AMA, for its part, couldn't release its Fees List.

Equally troubling, it was not immediately apparent, based on the information released by the Department, how the old items and their fees relate to the new items and their schedule fees.

It is clear in talking to those involved with the MBS Review that there was deep, considered thought on how the old items should be streamlined and combined into new items. There was a clear methodology for how fees should be transitioned from old items (including taking into account the multiple services rule) to the new item structure. But none of this was publicly available to those who generate or set benefit schedules for the private health system, nor to the AMA.

As a result, it is unsurprising that none of this was reflected in some insurers' rebates. Unsurprisingly with this confusion, cuts were made to some private health insurance rebates under the new structure, even where there was not a corresponding MBS cut.

It meant the careful deliberations of the MBS Review were not being realised, due to the difference in insurer fee setting responses. The MBS Review determined that some procedures are worth less, while others more. But this wasn't reflected in the real-world outcomes via insurer schedules.

The AMA Response

Since late 2018, the AMA has undertaken a sustained behind the scenes advocacy campaign.

The AMA wrote to, and met with, the Minister and his office on many occasions, as well as the Secretary of Health and the Department's Senior Executive Service. We called for the MBS and the PHI areas of the Department to come together to hold a forum for insurers, and for the Chair of the relevant Clinical Committee to spend the day going through the MBS changes. This was necessary so that insurers, practitioners, and hospitals could glean the information they need to translate the changes to their systems.

The most recent forum, held in September 2019, was the first time that such information has been conveyed by the Department as part of a new implementation and communication strategy.

While it was still too late to ensure we avoid all difficulties with the 1 November changes on the horizon, it is a step in the right direction.

A rocky road ahead for the health system ...continued from p6

Our advocacy will continue to call for this communication approach to be improved, before any more items are released. Without it, we risk confusion, inconsistent responses across the industry, increases and greater variation in out-of-pocket costs for our patients, and the carefully thought out design of the MBS Review being undermined.

It is for this reason have asked for a formal agreement between the AMA and the Department, outlining the information and timing we need to successfully implement wholescale MBS changes.

For our members, this additional information and time is critical in carrying out Informed Financial Consent, as per our guide.

Interestingly, it is one of the occasions where we have the support from the Private Health Insurers, and State and Territory workers compensation providers who are in the same predicament as the profession.

At the time of writing, the Government has not responded in agreeing to the new process. We are hopeful a response will be provided soon.

AMA Fees List Changes

While the AMA has been relentless in our pursuit of the right information at the right time to ensure that the AMA Fees List is ready at the same time as the new MBS item takes effect, we continue to be reliant upon the timelines set by the Department of Health.

We will work to have the AMA Fees List ready as soon as is possible after the MBS items take effect – but it is unlikely it will all be loaded by 1 November 2019. There is a significant volume of changed MBS items expected in anaesthesia, gastroenterology, diagnostic imaging, a new suite of eating disorder items for GPs, specialists and allied health providers, GP telehealth, and several other minor changes.

To better prepare the AMA for the tight timelines, and the considerable volume and expected complexity of the changes, the AMA has undertaken an extensive review of our AMA Fees List processes.

Over many meetings and with Federal Council approval, we have put in place a new Fees List Committee to provide governance of a rigorous, but streamlined, approval process and a new methodology for adaptation of the AMA Fees List.

The AMA has a deep knowledge of the Department's ongoing and increasingly comprehensive compliance activities targeted at those who may utilise MBS items outside of an item's descriptor, notes, or intent. The last thing we want is practitioners to breach MBS compliance rules by relying on an AMA item descriptor that differs from an MBS item one.

Because of this, the AMA Fees List, in an attempt to better inform members of these limitations within the MBS, will more closely align item descriptors, along with warning notes where we have identified restrictions in the corresponding MBS items with which we may disagree.

The AMA List will also try as far as possible to reflect the changes in the MBS item structure and fee relativities – while still setting a fair and independent fee suggestion via a robust methodology.

We are very aware that members find great value in the AMA Fees List providing a guide on what a fair fee to charge is for any particular MBS item – failure to adapt the AMA Fees List to a new MBS structure will make life harder for our members, something we wish to avoid.

At the same time, we will continue to ensure that the AMA Fees List represents a fair fee, without leading to excessive fee suggestions, noting the current prolonged media debate about medical fees.

Some MBS changes may not be reflected in the AMA list, and will be clearly marked, to indicate that the AMA does not support the change, and there may be some AMA items retained where there is now no corresponding MBS item.

Our move to an online platform two years ago means that we are now prepared to adapt the AMA Fees List as MBS Review changes roll out – the previous process of printing a physical book once a year would have rendered adapting to the constantly changing MBS a near impossibility.

Finally, in considering any changes to the AMA Fees List we will continue to engage with the relevant Society or Association before our Fees List Committee considers any change.

A rocky road ahead for the health system

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For the 1 November changes, we have been working closely with representatives from the Australian Society of Anaesthetists (ASA) and the Gastroenterological Society of Australia (GESA) to ensure that we have the anaesthetic and colonoscopy changes ready as close to 1 November as is possible.

Other speciality groups will be consulted on the other expected 1 November changes, including eating disorders, diagnostic imaging, sleep study, further spinal changes, ENT, reconstructive, urology, and cystic fibrosis.

However, these changes will not be able to be reflected in the AMA List in November and will follow anaesthesia and colonoscopy as closely as possible before the end of the year. Of course, our annual fee indexation will occur, ready for 1 November.

There is no doubt the next few years will be interesting ones as we seek to bed down this significant change.

LUKE TOY
AMA DIRECTOR MEDICAL PRACTICE

Indigenous conference talks innovation

Dr Bartone (seated centre) watches Dr Jessica King deliver the Welcome to Country at the AIDA Conference in Darwin. Also seated (L-R) are Professor Shannon Springer, Dr Olga Havnen, Marion Scrymgour, AIDA President Dr Kris Rallah-Baker, and conference MC Jeff McMullen.

Disruptive Innovations in Health Care was the theme of this year's Australian Indigenous Doctors' Association (AIDA) Conference, held in Darwin on October 3.

AMA President Dr Tony Bartone was a keynote speaker and talked about the importance of harnessing such innovation.

"As a General Practitioner who has been practising medicine for over 30 years, I well and truly understand that innovative health care is needed to achieve improved outcomes for patients," Dr Bartone said.

"Indeed, innovation will be crucial as we deal with a health system that is so under strain.

"This is especially true for Indigenous health, given the much higher burden of disease and mortality rates among Aboriginal and Torres Strait Islander people, and the need for care to be delivered in a manner that is culturally safe.

"We all know that Indigenous health statistics paint a bleak picture. And we all know that Aboriginal and Torres Strait Islander people have poorer health than other Australians.

"Medical science is constantly evolving and we have, only in recent times, recognised the innovations and practices of Indigenous people here and overseas...

"Sadly, investments in Indigenous health are often inadequate, and they are implemented without proper engagement with, and direction by, Aboriginal and Torres Strait Islander people.

"We all know that this approach does not work. However, I know that there are many innovative health services that are delivering high quality health care for their communities, driven by local leadership.

"There are models of health care that are delivering proved health outcomes for Aboriginal and Torres Strait Islander people, and these should be supported in terms of funding and workforce."

CHRIS JOHNSON

Dr Bartone's full address can be found at: https://ama.com.au/media/harnessing-innovation-health-care

Codeine overdoses plummet since rescheduling

Codeine overdoses in Australia have more than halved since the Government banned over-the-counter sales of the painkiller early last year.

The rescheduling of codeine to prescription-only from February 2018 was fiercely resisted by the pharmacy sector, but firmly supported by the AMA as a wise and much-needed move.

The AMA's advocacy on the issue has proved right and the Government has been vindicated for its strong decision.

The first peer-reviewed study into the effect of the rescheduling has revealed that the monthly rate of codeine overdose has more than halved since patients have been required to get a doctor's prescription for the drug.

University of NSW analysis of NSW Poisons Information Centre data shows the sale of codeine painkillers has halved in the 18-months since the rescheduling, and so too has the number of overdoses.

The monthly rate of codeine overdose calls related to low-strength codeine has more than halved since the law changed.

The AMA has welcomed the news, saying the move to reschedule codeine was the right decision for the health of Australians.

Chair of the AMA Council of General Practice, Dr Richard Kidd, said it was a "huge relief" to see the fall in codeine overdoses.

"We had had years of coroners all along the eastern border of Australia, and the western, expressing grave concerns about the numbers of people who were dying from overdoses of codeine-containing compounds, and that these were, at that time, available over the counter," Dr Kidd told ABC News.

"And so, the coroners raised the alarm. Groups like the AMA, ScriptWise, NPS, TGA, worked together to try and come up with a solution, which was up-scheduling anything that contains codeine."

Dr Kidd said the addiction rate was nearing that recorded in the United States, and something had to be done about it.

"We're very, very close to the US in a per capita sense, and much higher than just about anywhere else in the world," he said.

"And the problem with the codeine-containing compounds is that it was an insidious kind of entry into addiction without people even knowing it was happening. They were buying it over the counter and they didn't realise that the codeine was giving them a bit of a hit.

"And they were thinking that they were getting headaches or other pains and the codeine-containing compounds were helping, not knowing that as the codeine withdraws, it actually gives you a headache and can give you other pain.

"They were taking more and more of it and then getting poisoned by, quite often, the other thing that was in it, whether it was paracetamol or an anti-inflammatory. So, people were destroying their livers, their kidneys, their stomachs.

"It's a great relief to see that there's been a dramatic reduction in the number of overdose calls being made to the New South Wales Poisons Information Centre.

"They reported over a 79 per cent reduction in the calls about overdoses with weaker codeine-containing compounds and half for the slightly stronger ones. So, it's a big change. And a lot of people have not had preventable deaths or preventable terrible injuries to their organs.

"As a GP who tries to provide quality care, I'd argue that it's not too expensive to go to a GP. Access in Australia is very good. I think less than six per cent of Australians have reported not going to a GP because of cost. And in a lot of places, they have got the options of bulk-billing doctors if they want to do that."

CHRIS JOHNSON

Health spending figures show non-PBS medications driving out-of-pockets

Non-PBS medications are driving patient out-of-pocket health costs, with a new report showing Australians spent $30.6 billion on out-of-pocket health-related expenses in 2017-18.

The Australian Institute of Health and Welfare (AIHW) report *Health expenditure in Australia 2017-18*, showed that individuals spent $9.4 billion on medications that were not subsidised through the PBS; with $6 billion on dental services; and $4 billion on referred and unreferred medical services.

AMA President Dr Tony Bartone said it was clear that the greatest contributor to patient out-of-pocket costs continues to be non-PBS medications, which includes vitamins and minerals and complementary therapies that are purchased over the counter at pharmacies.

"Medical costs make up only 13.1 per cent of out-of-pocket expenditure for individuals," Dr Bartone said.

"The AIHW report shows clearly that there is little change overall in national health spending.

"Medical services are not the highest or even second highest area of expenditure for an individual.

"The greatest contributor to patient out-of-pocket costs is over the counter medications, vitamins, and health-related products, many of which have no proven efficacy."

Dr Bartone said one of the most telling statistics in the AIHW report is that total spending per person was $27 less per person than in the previous year.

"This is in spite of the ageing of the population, an increased complexity of the caseload, and the advent of new and more expensive interventions," he said.

"We need to increase health funding enough to keep up with an increasing and ageing population with more complex health needs.

"Maintaining funding at the same level will only see the situation get worse for our overstretched hospitals and patients waiting for their care."

The AIHW report shows almost $7,500 per person was spent on health goods and services in Australia during 2017-18, totaling more than $185 billion nationally.

Total health spending increased by $2.2 billion in 2017-18 to $185.4 billion in constant prices.

"This was a 1.2 per cent increase on 2016-17 against a backdrop of 3.9 per cent average annual growth over the decade," said the AIHW's Dr Adrian Webster. "The lower growth rate in 2017-18 was partly due to the previous year having included one-off capital expenditure on projects such as the new Royal Adelaide Hospital. It was also a result of a previous spike in Australian Government spending on new drugs to treat hepatitis C.

"Governments funded two-thirds ($126.7 billion) of total health spending in 2017-18, with the Australian Government contributing $77.1 billion — $1.8 billion more than the previous year."

State and Territory governments spent $49.5 billion — $1.3 billion less than the previous year.

"Health expenditure by governments represented 24.4 per cent of tax revenue, a decline from 2016-17 where 26 per cent of tax revenue was spent on health," Dr Webster said.

"The decline in health expenditure as a proportion of tax revenue was primarily due to relatively rapid revenue growth when compared with previous years."

In 2017-18, personal out-of-pocket health costs amounted to an average of $1,578 per person. There was little change in the proportion of individual net worth spent on health over the decade.

Contributions to health spending by private health insurers rose by $400 million to $16.6 billion in 2017-18.

"The decade has seen an overall increase in spending by private health insurance providers per person covered. In 2017-18, private health insurers spent an average of $1,470 per person covered, compared with $1,043 in 2007-08," Dr Webster said.

The total number of people holding private health insurance decreased by almost two million over the decade.

Shadow Health Minister Chris Bowen said the report confirmed that the Government "just isn't getting it" when it comes to health care.

"Australians have never paid more for health care out of their own pocket while the Coalition Government's health spending growth is going backwards," Mr Bowen said.

"According to (the report's) numbers, Australians spend over $30 billion a year on out of pocket health costs," Mr Bowen said.

"This is while Government spending growth on health is at decade lows and health expenditure has reduced as a percentage of revenue."

CHRIS JOHNSON

Vaping warnings justified and timely

The AMA has thrown its support behind a joint governments statement urging caution in the use of e-cigarettes.

Australia's Federal, State and Territory governments have responded firmly to emerging international evidence of a possible link between the use of e-cigarettes and lung disease.

In a joint statement, Australia's Chief Medical Officer and all the State and Territory Chief Health Officers have urged a precautionary approach to the marketing and use of e-cigarettes and recommended that e-cigarette users with unexplained respiratory symptoms seek medical advice.

The statement comes as deaths related to vaping are being recorded in the United States of America.

The AMA strongly supports the response from the Australian governments.

AMA President Dr Tony Bartone said the warnings are timely, with reports of a seventh death in the United States linked to vaping-related lung disease.

"The AMA has advocated for a precautionary approach to e-cigarettes for some time," Dr Bartone said.

"Along with other prominent health groups, including the Thoracic Society of Australia, the AMA was a signatory to the 2018 Cancer Australia Statement that highlighted concerns about e-cigarettes.

"We have also raised concerns about the promotion of e-cigarettes as smoking cessation aids. The National Health and Medical Research Council (NHMRC) believes there is insufficient evidence that e-cigarettes have a role as cessation aids.

"Under the direction of the Minister for Health, Greg Hunt, the National Centre for Epidemiology and Public Health is currently conducting an Australian review of the evidence around e-cigarettes.

"There is evidence that e-cigarettes normalise smoking, particularly among young people.

"International experience shows that e-cigarettes are popular among young people, increasing the risk of nicotine addiction and subsequent tobacco smoking.

"Preventing exposure to smoking among young people is a key pillar of tobacco control efforts. Young people need to be educated and assisted to resist the clever advertising and marketing for e-cigarettes – it is just a smokescreen.

"We must continue to be a world leader in combating smoking

and being vigilant about products and promotions, including e-cigarettes, that may tempt people to continue or take up the killer habit.

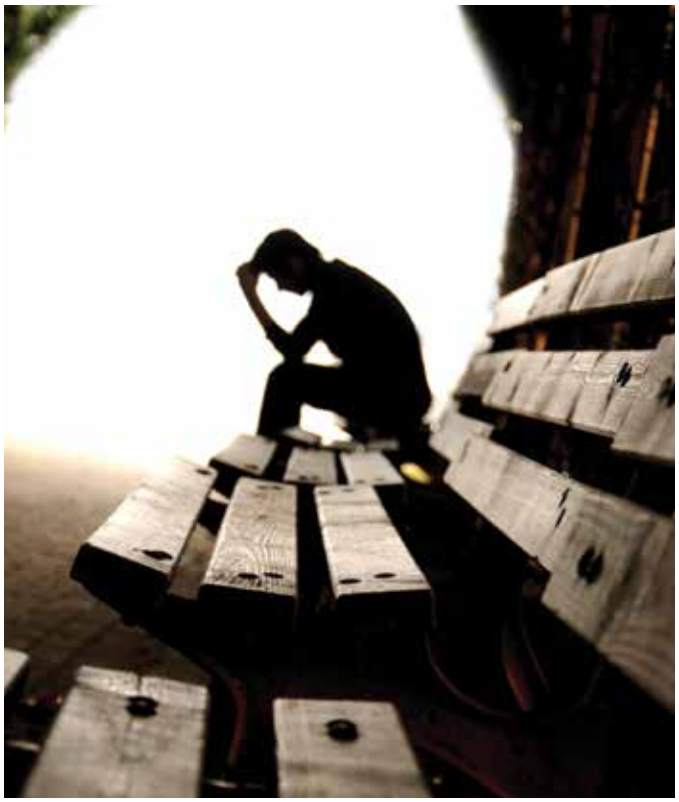
"The current experience of vaping-related deaths in in the United States reinforces the importance of a precautionary approach where there is a potential for doing harm," Dr Bartone said.

The Statement from the Chief Medical Officer and the State and Territory Chief Health Officers is available at: https://canceraustralia.gov.au/sites/default/files/statement_on_e-cigarettes_in_australia.pdf

The AMA Position Statement on Tobacco and E-Cigarettes is available at: https://ama.com.au/position-statement/tobacco-smoking-and-e-cigarettes-2015

The AMA submission to the Senate Community Affairs Legislation Committee Inquiry into the Vaporised Nicotine Products Bill 2017 is available at: https://ama.com.au/submission/ama-submission-senate-community-affairs-legislation-committee-inquiry-vaporised-nicotine

Mental health report calls for combined effort



A whole-of-government approach to mental health and suicide prevention needs to be implemented to ensure factors that impact people's lives contribute to their wellbeing.

These factors include employment, education, housing and social justice, as well as the delivery of mental health care.

The National Mental Health Commission has released its National Report 2019 on Australia's mental health and suicide prevention system, and it includes recommendations to improve outcomes.

It states that the current focus on mental health and suicide prevention marks a significant turning point in Australia's history, and is building increased awareness of the impacts of mental health from a social and economic perspective as well as from a health perspective.

The Commission's Advisory Board Chair Lucy Brogden said there was currently unprecedented investment and interest in making substantial improvements to the mental health system.

"Current national reforms are key, but complex, interrelated and broad in scope, and will take time before their implementation leads to tangible change for consumers and carers," Mrs Brogden said.

"The National Report indicates while there are significant reforms underway at national, State and local levels, it's crucial that we maintain momentum and implement these recommendations to ensure sustained change for consumers and carers."

Commission CEO Christine Morgan said the National Report findings align with what Australians are sharing as part of the Connections Project, which has provided opportunities for the Commission to hear directly from consumers, carers and families, as well as service providers, about their experience of the current mental health system.

"What's clear is we must remain focused on long-term health objectives. Implementation of these targeted recommendations will support this focus," Ms Morgan said.

The NMHC identifies four key issues in the *National Report 2019*:

- Key reforms – such as the National Disability Insurance Scheme (NDIS), the Fifth National Mental Health and Suicide Prevention Plan (Fifth Plan), the work of Primary Health Networks (PHNs) in mental health, and activities in suicide prevention – are significant and are a positive step in improving the mental health system. While full implementation of these reforms will take time, the focus needs to be on ensuring their implementation leads to sustained change for consumers and carers.
- There is a recognised need for a whole-of-government approach to mental health and suicide prevention and this needs to be implemented.
- Investment in early intervention and prevention services is key to preventing mental health problems later in life and is cost-effective.
- To plan for service delivery and facilitate ongoing improvement in outcomes for consumers and carers, there is a need for more

The Report makes a list of 30 recommendations aimed at bolstering the mental health system; addressing population data gaps; meeting the needs of consumers and carers; addressing social determinants; supporting PHNs; addressing NDIS access issues; and co-designing suicide prevention strategies across relevant portfolios.

The NMHC recommendations require collaboration across the sector. As part of its ongoing monitoring and reporting role, it will work with stakeholders to identify how progress of the recommendations can be measured.

The full Report can be found at:

https://www.mentalhealthcommission.gov.au/media/270709/National_Report_2019.pdf

Much to learn about restless leg syndrome

Restless Leg Syndrome Awareness Day (September 23) had a theme of "education", with Sleep Disorders Australia hoping to build greater awareness with medical practitioners and the general public.

Restless Leg Syndrome (RLS) is a neurological disorder characterised by an irresistible urge to move legs and other parts of the body. The urge is often accompanied by unpleasant sensations such as tingling or crawling feelings inside the legs

Symptoms most often occur in the evening and can severely disrupt sleep and reduce quality of life.

RLS Awareness Day has been staged in other parts of the world for some years, but this is only the second time it is being held in Australia. Sleep Disorders Australia (SDA) says there remains much to do in this country in building greater understanding of the disorder.

"There is so little known or understood about RLS and that needs to change," SDA said in a statement to mark the awareness day.

"This is an opportunity to raise awareness and educate the medical community and the general public of not just what RLS is, but also how it affects people who suffer from it."

SDA, founded in 1996, is a not-for-profit patient organisation for sleep disorders.

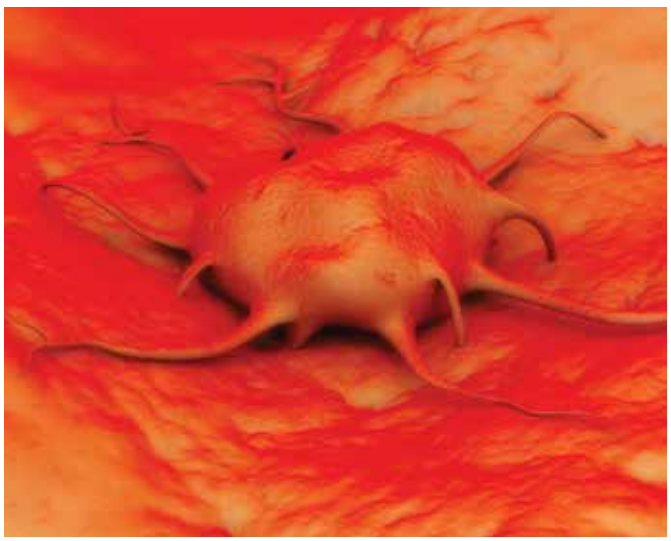
Clarifying statement

In a profile article that appeared in the September 16, 2019 edition of *Australian Medicine* about Dr Robert Likeman OAM CSM (*Doctor, soldier, writer, historian*), it states: In 2005, he was appointed Medical Officer to Prime Minister John Howard.

This was an official assignment to accompany Mr Howard to Papua New Guinea for the 36th Pacific Islands Forum. It was not a permanent role for Dr Likeman.

As is widely known, Dr Graeme Killer AO was the official Medical Officer to five Prime Ministers, which included Mr Howard's full term. Dr Killer also travelled at times as the Governor-General's physician. It was during such an occasion that Dr Likeman – who was based in Townsville, was a senior Defence medic, and had experience in PNG – was appointed to stand in for Dr Killer with the PM for the duration of the Forum and the flights to and from PNG.

Big savings in cancer drugs



Medicines to treat lung cancer, lymphoblastic and acute leukaemia, and nausea associated with chemotherapy are now available to patients on the Pharmaceutical Benefits Scheme (PBS) for $40.30 per script, or $6.50 with a concession card.

A further $390 million in mandated price reductions across 175 medicine brands will also flow through to patients.

In announcing the new PBS listings, Prime Minister Scott Morrison said the cheaper medicine would benefit more than 500,000 patients, and in some cases save more than $100,000 per patient.

“Some of our most unwell Australians, many battling cancer, will receive a significant boost in the fight for their health,” he said.

The new or extending PBS listings include:

- Tecentriq® and Avastin® are extended on the PBS to include first line treatment of patients with stage IV metastatic non-squamous non-small cell lung cancer. Without PBS subsidy it would cost patients more than $11,400 per script (around 16 scripts per course of treatment); or more than $189,100 per course of treatment. An average of 755 patients per year (for six years) could benefit from this listing.
- Besponsa® is extended on the PBS to include patients with relapsed or refractory Philadelphia chromosome positive (B-CELL precursor acute lymphoblastic leukaemia). Without PBS subsidy, patients would pay more than $44,500 per script (around three scripts per course of treatment); or more than $122,900 per course of treatment without subsidised access through the PBS. An average of 16 patients per year (for six years) could benefit from this listing.
- Blincyto® is extended on the PBS to include patients with relapsed or refractory Philadelphia chromosome positive (B-CELL precursor acute lymphoblastic leukaemia). Without PBS subsidy, patients would pay more than more than $74,900 per script (around two scripts per course of treatment); or more than $122,900 per course of treatment. An average of 16 patients per year (for six years) could benefit from this listing.
- Apotex® is made available through the PBS for the treatment of patients with nausea and vomiting associated with chemotherapy. Without PBS subsidy, patients would pay more than $80 per script (around 1 script per course of treatment). In 2018, 7,269 patients accessed a comparable treatment for this condition.

Fifteen common medicines – sold as 175 medicine brands – are now also cheaper for general (non-concessional) patients, and these include:

- Pregabalin: around 208,000 patients per year who have seizures or nerve pain will now pay $28.27 per script for 75 mg capsules, a saving of up to $5.11 per script.
- Ezetimibe: around 60,000 patients per year with high cholesterol levels will now pay $33.86 per script for 10 mg tablets, a saving of up to $6.44 per script.
- Ezetimibe with Simvastatin: about 245,000 patients with high cholesterol levels will now pay $37.77 per script for 10 mg tablets, a saving of up to $2.53 per script.

Every medicine was recommended to the PBS by the independent expert Pharmaceutical Benefits Advisory Committee. By law the Federal Government cannot list a new medicine without a positive recommendation from the PBAC.

More new PBS listings are detailed in *Australian Medicine’s* Health on the Hill pages.

CHRIS JOHNSON

ATO tells small employers it's time to move to STP

Small employers (those with 19 or less employees), including those in the health and medical services industries, need to now be ready for Single Touch Payroll (STP).

STP became mandatory for small employers from July 1 this year, however, the Australian Taxation Office (ATO) granted an extension until September 30 to businesses that needed more time to get ready.

Some employers and industries have unique circumstances and the ATO understands some may need more time to get ready. The ATO is working with employers to ensure they understand their options for STP, whether that is reporting now, getting a deferral, or working with their tax or BAS agent to report quarterly (if eligible).

There are also concessions available for employers that employ, family members or other 'closely held' payees, micro employers with one to four employees, those who employ intermittent or seasonal workers or employers who don't have access to a reliable internet connection.

ATO Assistant Commissioner Jason Lucchese said now is the time for small employers to be aware of their options and take the right steps to get ready.

"More than 400,000 employers are already reporting their employees' tax and superannuation information digitally through STP, but we understand all employers operate in slightly different ways and every industry has unique challenges which can affect their payroll processes," Mr Lucchese said.

"Regardless of whether you're ready to start reporting, or if you still need more time to get ready, there are options available to you.

To help small employers better understand their options, the ATO has developed a range of handy factsheets and other resources which are available on the ATO's website. There's also an interactive online quiz to help determine what their next step should be.

Jennifer Bourke, BAS Agent at D&J Bourke has worked with small employers to help them transition to STP, and says there is a solution for everyone.

"D&J Bourke services clients across metropolitan and regional

Victoria, many of which depend on our services for their bookkeeping and BAS servicing as they are small businesses sometimes employing no more than one employee," Ms Bourke said.

"We use multiple STP enabled systems on behalf of our clients and have found the upgrade and software solutions to be easy to use and have now got all our applicable clients either on to STP or have applied for a deferral to give them more time to get ready.

"The ATO is committed to working with each employer to ensure their various needs are met and the Commissioner of Taxation, Chris Jordan has reassured small employers that the ATO's approach will be flexible, reasonable and pragmatic with no penalties for mistakes, missed or late payments for the first year."

For more information about Single Touch Payroll, visit www.ato.gov.au/stp

Read the Commissioner's statement about small employer's transition to Single Touch Payroll here:

https://www.ato.gov.au/Media-centre/Articles/Transition-to-Single-Touch-Payroll-for-small-employers/

Updated guide to health privacy

The Office of the Australian Information Commissioner has updated its privacy guidelines for health practitioners.

The guide has been written to help health service providers – from doctors and hospitals, through to allied health professionals such as pharmacists, childcare centres and even gymnasiums – to understand their obligation under the *Privacy Act 1988*, and embed good privacy in their practice.

Eight key steps are outlined that should be taken to ensure health service providers are proactive in establishing, implementing and maintaining privacy processes in practices.

They are:

- Develop and implement a privacy management plan;
- Develop clear lines of accountability for privacy management;
- Create a documented record of the types of personal information you handle;
- Understand your privacy obligations and implement processes to meet those obligations;
- Hold staff training sessions on privacy obligation;
- Create a privacy policy;
- Protect the information you hold; and
- Develop a data breach response plan.

The updated guide can be found at: https://www.oaic.gov.au/privacy/guidance-and-advice/guide-to-health-privacy/

Submission for regional training networks

The AMA has called for regional training hubs to be scrapped and replaced with regional training networks to better support medical students and doctors in training to spend more time in rural and regional areas during their training.

The AMA has made a submission to the evaluation of the Rural Health Multidisciplinary Training Program, largely supporting the program but calling for some changes.

The submission calls for an increase in the intake of medical students from rural backgrounds from the current one-quarter to one-third, and the same increase in the proportion of medical students required to undertake at least one year of clinical training in a rural area.

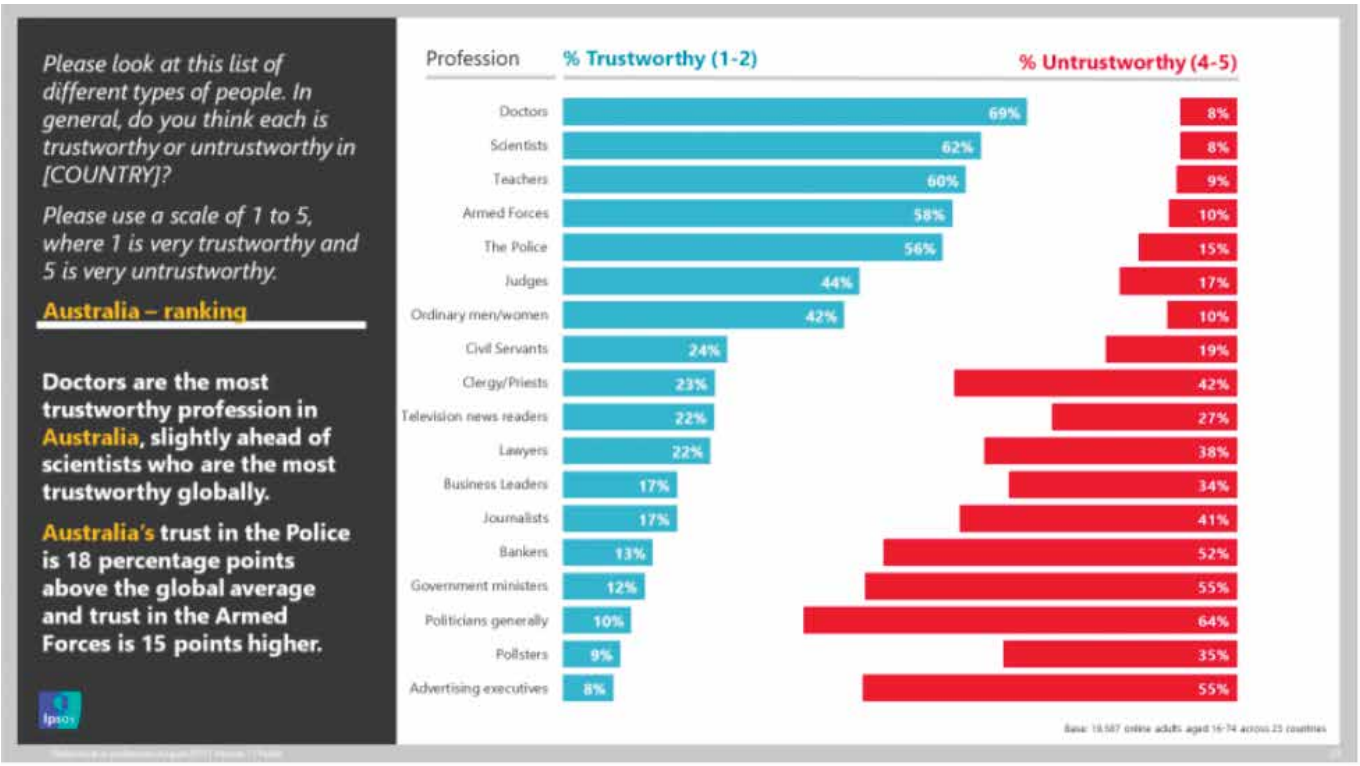
"Australia is now training more medical practitioners per head of population than most countries ... yet we are still reliant on international medical graduates to provide services in rural and regional areas," Dr Sandra Hirowatari, chair of the AMA Council of Rural Doctors, said in the submission.

"This is due to misplaced belief in the 'trickle out' strategy — the idea that market forces will direct an oversupply of doctors to rural locations, and expecting that rural exposure during medical school alone will result in more rural medical practitioners."

MARIA HAWTHORNE

The full submission can be found at: https://ama.com.au/submission/submission-evaluation-rural-health-multidisciplinary-training-program

Doctors still the most trusted profession



Doctors are the most trustworthy profession in Australia, and scientists are the most trusted globally, a new poll has found.

The latest Ipsos Global Trust in Professions survey, completed online by adults aged 16-74 in 22 countries including Australia, asked participants to rank 22 selected professions. Nurses and pharmacists were not included in the list.

In Australia, doctors topped the list with 69 per cent, followed by scientists (62 per cent), teachers (60 per cent), armed forces (58 per cent), and police (56 per cent).

Perhaps not surprisingly following the unexpected Federal Election result, pollsters are the second least trusted profession in Australia (9 per cent), just above advertising executives (8 per cent).

Globally, scientists are the most trustworthy (60 per cent), followed by doctors (56 per cent) and teachers (52 per cent).

MARIA HAWTHORNE

Full results of the survey can be found at: https://campaignbrief.com/australians-have-the-least-trust-in-advertising-professionals-ipsos-study/

INFORMATION FOR MEMBERS

Communiqué

Notifications workshop with the Australian Medical Association, the Medical Board of Australia and the Australian Health Practitioner Regulation Agency held on 20 August 2019

Senior leaders from the Medical Board of Australia (MBA), the Australian Health Practitioner Regulation Agency (AHPRA) and the Australian Medical Association (AMA) met on 20 August 2019 for the fifth consecutive year to discuss the management of notifications in the National Registration and Accreditation Scheme.

The workshop focused on:

- work that has been done by AHPRA and the MBA to improve performance in dealing with notifications
- measures introduced to make the notification process less difficult for notifiers and practitioners
- work being done to develop revised guidelines and education on the new mandatory reporting laws, and
- vexatious complaints.

The MBA was represented by Dr Anne Tonkin - Chair of the MBA, Dr Debra O'Brien – Chair of the Victorian Board of the MBA and Ms Christine Gee – Chair of the Sexual Boundaries Notifications Committee and member of the Queensland Board of the MBA. AHPRA was represented by Martin Fletcher – CEO of AHPRA, Matthew Hardy – National Director, Notifications and other senior AHPRA staff.

The AMA was represented by Dr Chris Zappala - AMA Vice President, Dr Antonio Di Dio, AMA ACT President, Associate Professor Julian Rait – AMA Victorian President, Dr Malcolm Forbes – Doctor in training representative and other senior AMA staff.

Improvements in performance in dealing with notifications

It was pleasing to see that initiatives introduced by AHPRA and the MBA are yielding year on year improvements in performance. Despite an increase in the number of notifications received in 2018/19, more notifications were closed (27.3%) than received (24.1%). Compared to the end of last financial year, there are now:

- 19.3% fewer open notifications, and
- 43.1% fewer aged (>1 year) notifications.

The time frames for dealing with notifications has also reduced at all stages. In particular, the average time for:

- assessment has reduced from 65 days to 61 days
- investigation has reduced from 398 days to 362 days
- health and performance assessment has reduced from 304 days to 284 days, and

INFORMATION FOR MEMBERS

Communiqué (continued)

- the completion of all notifications has reduced from 180 days to 174 days.

A number of initiatives have contributed to the improvements in performance. These include:

- National assessment committee – The MBA has established a national committee that meets up to six times each week. Members from all states and territories are rostered to this committee and they consider all notifications soon after they arrive. Where it is evident that no regulatory action will be necessary, notifications are closed without further investigation and the first time that the medical practitioner about whom a notification has been made learns about the notification is after it has been closed.
- Medical clinical advisors – 14 part-time clinical advisors from a range of specialties have been employed by AHPRA. A medical practitioner screens every notification to identify and stratify clinical risk. The clinical advisors provide clinical context and assist other AHPRA staff to formulate recommendations to the MBA. However, they do not provide expert opinions and do not take on the regulatory role of Board members. This early clinical input has resulted in higher quality recommendations being made more quickly.

Clinical advisors also provide support during investigations, including helping prepare briefs for expert advice and in planning for performance assessments.

- Case conferencing – Originally, this initiative was directed towards dealing with complex investigations and investigations that have 'stalled'. Senior staff, including medical advisors work together to develop a strategy to progress the investigation or to recommend that it be closed. Case conferencing is being rolled out to all investigation matters.

  Establishment of the Sexual Boundaries Notifications Committee – this Committee was established following the report by Professor Ron Paterson *The independent review of the use of chaperones to protect patients in Australia*. All notifications alleging a breach of sexual boundaries are considered by this committee that meets virtually and is made up of Board members from all states and territories. Board members and the investigators who do this work are highly trained and participate in regular professional development.

  This Committee meets once or twice each week and has been dealing with increasing volumes of work. 48% more notifications about boundary issues were received in 2018/19 than in 2017/8 and 33% more investigations were completed in that period than in 2017/18. The average time to complete notifications decreased from 427 days in 2016/7 to 317 days in 2018/9 and the average age of open notifications decreased from 441 days to 336 days.

  The AMA thanked the SBNC for taking on this very difficult work.

- Work on risk assessment. AHPRA has developed a framework to assess the risk of notifications in a systematic way based on the characteristics of the notification, the practitioner, the practitioner's setting and their practice.

Measures introduced to make the notification process less difficult for notifiers and practitioners

AHPRA and the MBA actively seek feedback from notifiers and practitioners who have had a notification. As a result of this feedback, they have introduced a number of measures to support notifiers and practitioners.

Notifiers and practitioners have provided feedback to AHPRA that fairness, communication, transparency and timeliness are important to them. For notifiers, the outcome is also important and they often report disappointment as in more than 80% of cases, the MBA decides to take no further action. Many practitioners report very high levels of stress and fear that their registration will be at risk. While the evidence for this fear is unfounded in the vast majority of matters, it continues to be a big source of concern.

AHPRA and the MBA have worked on a number of initiatives to make a better (or less negative) experience for notifiers and practitioners. These include:

- Ongoing work to reduce time frames.
- Better information for practitioners – including a 'postcard' that provides succinct, factual information about notifications which is sent out with initial correspondence. See https://www.ahpra.gov.au/Notifications/Find-out-about-the-complaints-process.aspx

INFORMATION FOR MEMBERS

Communiqué (continued)

- Sharing the personal experience of other practitioners. AHPRA has produced 2 videos featuring practitioners who have had a notification. These videos are unscripted and aim to provide first-hand advice to support other practitioners with a notification. They acknowledge the intense feelings associated with a notification and encourage practitioners to seek help. The videos humanise the notifications process and demonstrate that it could happen to anyone.
- Improving correspondence by reducing the legal language and being more explicit about the reasons for decisions.
- Communicating more frequently and more meaningfully during the notification process, including by less reliance on written communication and greater use of phone conversations.

AHPRA and the MBA also expressed a wish to try to shift the narrative around notifications. With more notifications being made each year, more medical practitioners will be affected. The MBA and AHPRA are keen to partner with others to try and change the perception of notifications – how to help practitioners prepare for feedback in the form of a notification and to support them to 'keep it in perspective'.

Mandatory reporting

While Ministers have passed amendments to the laws on mandatory reporting, they have not yet started. AHPRA and the health practitioner Boards have been working on two bodies of work to prepare for the commencement of the legislation. The first is to produce amended guidelines that explain that the threshold for treating practitioners has changed in relation to impairment, intoxication and professional standards. They are being drafted in plain English and public consultation will start soon.

Work is also being done on an education campaign and this will include a number of resources including videos and case examples. AHPRA and the MBA are grateful for the support of the AMA in providing input into this work, including through focus groups with treating practitioners.

It is well recognised that medical practitioners are concerned that mandatory reporting is an impediment to seeking help for health concerns.

Ministers have decided on the amended laws and we are all keen to work with practitioners to ensure that they are not fearful of getting help, have information that is accurate and to prevent inappropriate reporting.

Vexatious notifications

While the AMA expressed concern about reports of vexatious notifications, AHPRA's evidence shows that there are few truly vexatious notifications. Many notifications that are perceived to be vexatious are actually misconceived or without substance. Nevertheless, it is recognised that a practitioner who feels a notification is vexatious (even if it does not fit the legal definition) is likely to feel higher levels of stress.

AHPRA staff have undergone education on how to identify potentially vexatious notifications. This informs the management of the notification.

AHPRA wants to better explain to practitioners the definition of 'vexatious' which is different to 'vexing' and are planning to produce a podcast.

Concluding remarks

Dealing with notifications is challenging. The AMA acknowledged the significant work done by the MBA and AHPRA to improve the notifications process. However, further improvements can continue to be made. It was acknowledged that despite significant improvements made to time frames, for those involved in a notification, investigations can still take too long. Practitioners feel high levels of stress during the notifications process and notifiers are often dissatisfied with the outcome.

AHPRA and the MBA are keen to continue to work with others, including the AMA, to try and shift perceptions about, and reactions to, notifications. With an increasing number of notifications being made, they are likely to affect more practitioners. Further work needs to be done to prepare practitioners for notifications and to help them keep it in perspective when they occur. AHPRA and the MBA are also keen to help notifiers make their complaints to the agency that can best help them. Many notifiers seek outcomes that the MBA cannot offer.

The MBA and AHPRA acknowledged the value of the feedback provided by the AMA as it helps them to continue to improve and look forward to meeting again in 2020.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

WITH CHRIS JOHNSON

Preventive health committee selected

Health Minister Greg Hunt has established an Expert Steering Committee to help progress the Government's 10-year National Preventive Health Strategy.

To be chaired by Health Department Deputy Secretary Dr Lisa Studdert, the Committee includes experts across the public health, research and health promotion fields.

The AMA will be represented on the Committee, along with two dozen other health focused organisations.

Mr Hunt said the Government's strategy aims to help Australians improve their health at all stages of life, through early intervention, better information and targeting modifiable risk factors, and the broader causes of poor health.

"At its core, the strategy will provide clear and measurable proposals to empower Australians to take a proactive approach to their health and wellbeing," the Minister said.

"The strategy is a key plank of Australia's Long Term National Health Plan and will complement a range of national strategies and frameworks."

The National Preventive Health Strategy will have a key focus on four key elements – cancer and chronic disease population screening (current and emerging opportunities); immunisation; nutrition and obesity; and public education and research.

"Furthermore, the Morrison Government has committed to reducing Australia's smoking rates below 10 per cent by 2025," Mr Hunt said.

"In the coming months, a wider consultation process with broader health experts, key stakeholders and consumers will ensure their views are heard and included in the development of the strategy."

The Opposition welcomed the announcement of the Expert Steering Committee, but has criticised the Government for not including more representative groups on the panel.

"With just under half of all Australians having a chronic condition, there has never been a more important time to get preventive health policy right," Shadow Health Minister Chris Bowen said.

Pure caffeine powder banned

The Federal Government has banned highly concentrated caffeine food products, including pure caffeine powder, for personal consumption.

The ban follows the tragic death of 21-year-old Lachlan Foote from acute caffeine toxicity.

Aged Care, Youth and Sports Minister Richard Colbeck commissioned a report into the safety of caffeine powders and high caffeine content products.

Senator Colbeck, who also has portfolio responsibility for Food Regulation, recently received the report and said the Government would accept all of its recommendations in an effort to prevent more avoidable deaths from the products.

"Lachlan Foote's death was an absolute tragedy and our Government is determined to prevent something like this occurring again," Senator Colbeck said.

"The dangers of pure caffeine powder cannot be underestimated. Pure caffeine products can contain the maximum recommended daily dose of caffeine in 1/16th of a teaspoon, with a potentially fatal dose – the equivalent of between 25 to 50 cups of coffee – in a single teaspoon."

Senator Colbeck said the average safe quantity of pure caffeine products often could not be accurately measured on standard kitchen scales.

The ban is accompanied by an education campaign to get that

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message out and to ensure that people, particularly young people, are not unwittingly harming themselves with a supplement they believe to be safe.

"Australians are also reminded to be cautious about the products they may be purchasing from overseas or online, which may not be safe," the Minister said.

In July, Senator Colbeck and Health Minister Greg Hunt wrote to Food Standards Australia New Zealand (FSANZ) requesting a review into the safety of caffeine powders and high caffeine content food products.

FSANZ will now work closely with the appropriate agencies and jurisdictions in implementing the recommendations.

The Therapeutic Goods Administration has also taken steps to limit the risk of accidental overdose of caffeine, including new restrictions on the concentration of pure caffeine allowed in listed medicines.

"I acknowledge the work of Lachlan Foote's family and friends, as well as the NSW Coroner and FSANZ, and I sincerely hope that this action will prevent such tragedies occurring again," Senator Colbeck said.

The FSANZ review made five recommendations:

- That FSANZ develop and declare as urgent a proposal to amend the Australia New Zealand Food Standards Code to prohibit the retail sale of pure and highly concentrated caffeine food products.
- That FSANZ consider developing a maximum limit of caffeine in foods, based on the outcomes of the current review of Standard 2.9.4 – *Formulated Supplementary Sports Foods*.
- That a coordinated inter-agency consumer information campaign on safe caffeine consumption be developed and implemented in conjunction with the implementation of recommendation one, if adopted.
- That, prior to or in parallel with the consumer information campaign, guidance on the regulation of products containing pure or high concentrations of caffeine, and high caffeine content products, be developed by the Implementation Subcommittee for Food Regulation for, and agreed by, enforcement agencies to inform compliance action.
- That targeted research on caffeine consumption across the Australian and New Zealand population, including consumption by specific vulnerable population groups, continue to be undertaken as part of the upcoming Intergenerational Health and Mental Health Study.

The full review can be read at: http://www.foodstandards.gov.au/CaffeineReport2019

Funding to find answers

Melanoma detection in high-risk patients, the effectiveness of breast MRIs, the cost of chronic fatigue, and mobile x-rays at residential aged care facilities are the focus of the latest round of Government funded research projects.

More than $6.6 million is being injected into the four research projects seeking to answer public health questions in those fields.

The projects are funded under the Medical Research Future Fund's (MRFF) $39.8 million Targeted Health System and Community Organisation Research Initiative.

The initiative is designed to address gaps in knowledge and evidence for important health system issues. This includes the comparative effectiveness of a health service or health system practice.

"The focus areas require more targeted research and have high community need but low commercial interest," Health Minister Greg Hunt said.

This round of funding is focused on targeted research questions and topics, put forward by the National Health Technology Assessment Chairs Committee that seek to examine:

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- the effectiveness of Melanoma Surveillance Photography in high-risk individuals;
- when breast MRIs improve patient outcomes;
- the impact of Myalgic Encephalomyelitis/Chronic Fatigue Syndrome on the Australian economy; and
- whether mobile x-ray units to residents of residential aged care facilities are cost effective.

"Research findings will inform improvements in current practice and ultimately support better health outcomes for patients," Mr Hunt said.

The $20 billion MRFF aims to transform health and medical research, and innovation, to improve lives by providing sustainable and strategic funding for vital research and clinical trials.

The MRFF operates as an endowment fund and provides a sustainable source of funding for vital medical research, which beyond 2021 will disburse $650 million each year.

The four projects to be funded are:

Project	Recipient	Funding
Evaluation of clinical pathways and patient outcomes for breast MRI in preoperative assessment and staging of breast cancer. Establishing when MRI improves patient outcomes and when it does not.	University of Western Australia	$2,072,217
The effectiveness of Melanoma Surveillance Photography in high-risk individuals.	Monash University	$2,416,998
ANCHOR Project: health economics and epidemiology of myalgic encephalomyelitis/ chronic fatigue syndrome.	University of Tasmania	$155,000
Mobile X-ray services provided within residential aged care facilities.	The University of Adelaide	$1,970,000
Total		$6,614, 215

New and amended PBS listings

Patients with intestinal failure associated with Short Bowel Syndrome (SBS), and those suffering spasticity in the upper limbs, will have access to greater medicinal support, thanks to new and amended listings on the Pharmaceutical Benefits Scheme (PBS) coming into effect on October 1.

Short Bowel Syndrome is a disorder that arises from an inability to absorb food nutrients and fluid across the gastrointestinal tract, and one that is often caused by surgical removal of all or part of the small intestine.

Australians experiencing SBS will be able to purchase first time listing Revestive® (Teduglutide), a medicine that improves the absorption of nutrients and fluid from the gut.

Up to 70 patients per year will benefit from the listing, with the PBS subsidy saving patients up to $284,700 per year for treatment.

In addition, the current listing of Dysport® (clostridium Botulinum Type A Toxin – Haemagglutinin C Complex) will be extended to include patients with moderate to severe spasticity of the upper limbs, following an acute event.

Dysport® temporarily relaxes overactive or contracting muscles, and resolves stiffness in the arm and/or hand.

Health Minister Greg Hunt said up to 6,600 patients per year will benefit from that listing. Without the PBS subsidy, patients might pay more than $9,700 per course of treatment.

All of these PBS listings were recommended by the independent expert Pharmaceutical Benefits Advisory Committee.

Changes to rural places approved

Parliament has approved the *Health Insurance Amendment (Bonded Medical Programs Reform) Bill 2019*, which will completely overhaul the Bonded Medical Places (BMP) and Medical Rural Bonded Scholarship (MRBS) programs, as announced in the 2018-19 Federal Budget.

The reformed arrangements will apply to all new program participants from January 2020.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

AMA President Dr Tony Bartone said important reforms to medical bonding programs will benefit medical graduates and the rural and under-serviced communities they will serve as doctors.

Dr Bartone said the changes follow extensive lobbying by the AMA Council of Doctors in Training (AMACDT) and the AMA and will effectively standardise conditions for bonded medical graduates, moving away from the current contract-based arrangements.

"Both the MRBS and BMP schemes have failed to make meaningful progress towards addressing workforce shortages in rural areas and other underserviced communities," he said.

"This was largely due to their inflexible program design and failure to recognise that people's circumstances can change dramatically from the time they enter medical school to the period when they must complete their return of service obligations.

"The new arrangements will provide participants with greater flexibility, more certainty in relation to where they can work in the future, and will require much less red tape and compliance.

"This is good news for bonded medical graduates and for communities in desperate need of local doctors and medical services."

In working with the Government to design the new program, the AMA consulted widely with members who were participating in the BMP and MRBS schemes. The AMA is confident that the new arrangements will better support bonded medical graduates and help improve access to vital medical care in those communities where they are needed.

The AMA will continue to work with the Department of Health to finalise the implementation of these reforms.

Dr Bartone said while Australia has one of the best health systems in the world, with a highly trained and skilled workforce, not all Australians have equal access to all the benefits.

"Our rural doctors and other health professionals are highly skilled, totally dedicated to their communities, and provide high quality care to their patients – in general practices, public hospitals, and other settings," he said.

"Our hardworking rural doctors work very long and sometimes unusual hours, many are constantly on call, they provide high quality care leading multi-disciplinary health care teams, and they are committed to their patients and local communities.

"But they are working in environments and with equipment that are not keeping pace with modern and complex medicine, and the unique health and emergency demands of remote and isolated communities.

"The hospital infrastructure, the equipment, and overall resourcing are in most areas not at the levels available in the cities and larger centres.

"Rural health is at a crisis point. There is an urgent need for significant investment in rural hospitals, equipment, and medical and health workforce. Despite the difficulties and challenges, the rural health workforce continues to provide quality care."

Dr Bartone acknowledged that the Federal Government has recently acted with a National Medical Workforce Strategy and the National Rural Generalist Pathway, but so much more needs to be done.

Input sought for veteran mental health strategy

Public consultation has opened for the Veteran Mental Health and Wellbeing Strategy and National Action Plan.

The Department of Veterans' Affairs wants people to have their say on how to develop the plan.

Veterans, their families, and the broader ex-service community are being asked to help shape the strategy and action plan.

Medical professionals should encourage concerned patients to have input.

Minister for Veterans and Defence Personnel Darren Chester is encouraging those in the community to have their say and provide their ideas on how the Government can improve veterans' mental health and wellbeing.

"This Government is committed to putting veterans and their families first, and a crucial part of this is listening to their views, their experiences and considering their solutions to promote positive mental health and wellbeing outcomes," Mr Chester said.

People will be able to contribute to the topic through an online survey or by providing a written submission.

"The Prime Minister has made mental health one of his highest priorities and I am committed to driving new efforts to improve mental health for veterans and their families," Mr Chester said.

"One of the initiatives I have been working on is providing assistance dogs to veterans suffering from post-traumatic stress disorder. This is the first time the Federal Government has provided financial backing to a trial of this nature and something that I am proud to support."

The Veteran Mental Health and Wellbeing Strategy and National Action Plan was determined as a priority as part of the of the Veteran Mental Health and Wellbeing Summit the Minister convened in June this year.

To help provide informed feedback for the online survey, an environmental scan of mental health reform in Australia has been published, which highlights developments in mental health policy across Australia over the past six years.

To view the scan, complete the online survey, or provide a written submission, visit: www.dva.gov.au/nap2019

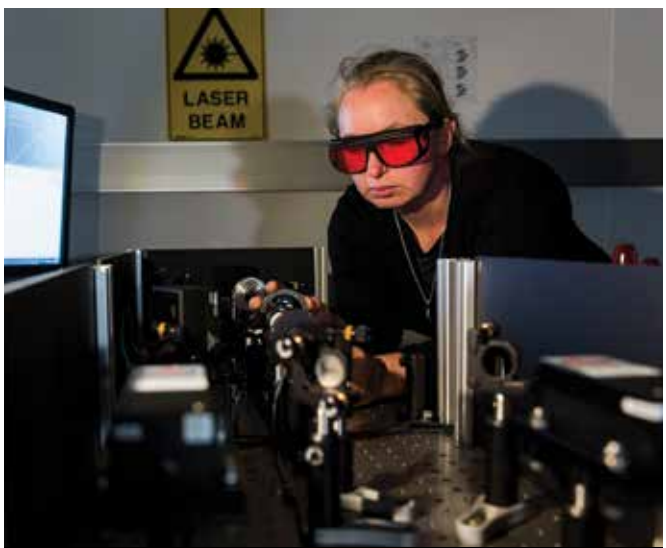
The Department's online wellbeing portal AT-Ease.dva.gov.au also provides veterans and their families with information, resources and links to services for support with mental health and wellbeing.

Open Arms – Veterans and Families Counselling, provides support for current and ex-serving Australian Defence Force personnel and their families. Free and confidential help is available 24/7. Phone 1800 011 046 (international: +61 1800 011 046 or +61 8 8241 4546) or visit www.OpenArms.gov.au

Research

WITH CHRIS JOHNSON

Incubator breakthrough has huge potential



Dr Clare Manderson

The world's first blood incubator using laser technology has been developed by scientists based at Monash University. The incubator can detect antibodies in pregnant women that can kill a foetus, and it could prevent fatal blood transfusions in critically ill patients.

Monash based researchers from Bioresource Processing Institute of Australia (BioPRIA), together with industry partner Haemokinesis, have published their findings in *Nature's Scientific Reports*, and say the development could bring pre-transfusion testing out of the pathology lab to point-of-care.

It allows for blood incubation time to be cut to just 40 seconds, compared with the industry gold standard of five minutes.

The breakthrough has the potential improve the pre-transfusion testing of millions of patients undergoing blood transfusions across the world, especially those having major surgery, going into labour, or causalities of mass trauma and individual trauma.

The detection of immunoglobulin G (IgG) antibodies requires incubation at 37 °C, often for up to 15 minutes. But current incubation technology relies on slow thermal procedures, such as heating blocks and hot-water baths. This delay adds to pathology costs and turnaround time, which substantially affects a patient's chance of survival.

To address this problem, BioPRIA's blood diagnostics team developed a laser incubation model where a targeted illumination of a blood-antibody sample in a diagnostic gel card is converted into heat, via photothermal absorption.

The laser-incubator heats the 75 µL blood-antibody sample to 37 °C in under 30 seconds. Most importantly, no significant damage is detected to the cells or antibodies for laser incubations of up to 15 minutes.

The study was led by Dr Clare Manderson from BioPRIA, located within the Department of Chemical Engineering at Monash University, in conjunction with blood diagnostics manufacturer Haemokinesis.

"Laser incubation can be extremely valuable when time and accuracy is vital, especially in critical and emergency settings – like mass trauma – where pre-transfusion testing needs to be performed quickly in order to save lives," Dr Manderson said.

"We show that red blood cells act as photothermal agents under near-infrared laser incubation, triggering rapid antigen-antibody binding with no significant damage to the cells or antibodies for up to 15 minutes.

"This study demonstrates laser-incubated immunohaematological testing to be both faster and more sensitive than current best practice, with clearly positive results seen from incubations of just 40 seconds."

For the study, researchers explored the roles of incubation time and temperature of the IgG anti-D antibody and the Rh blood group system's D antigen, which indicates the positive or negative attributed to a person's ABO blood type group.

Anti-D is the most common antibody, and is present in a person's plasma. It's the biggest cause of haemolytic disease of the foetus and newborn – a blood disorder that occurs when the blood types of a mother and baby are incompatible. Accurate testing for pregnant women's antibodies is vital to save the life of the foetus.

Blood group type is based on the presence of antigens on the surface of the red blood cell membranes, consisting of proteins, glycoproteins, glycophorins, glycolipids and polysaccharide macromolecules forming roughly 346 known blood groups.

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"Giving blood transfusions to people isn't as simple as giving O-negative to anybody. The 'universal donor' of O-negative blood can seriously harm a lot of people, even kill them. The world of pre-transfusion of blood group typing is huge, and it's really important that it's done quickly and accurately to help save lives," Dr Manderson said.

"For the patient, it can mean that if there's a critical blood-loss scenario and they're in desperate need of a transfusion, they need to have their blood group typed and antibody screened as quickly as possible. We're aiming to bring that down to seconds instead of tens of minutes."

Blood transfusion is a critical treatment for a variety of haematological conditions, including cancer chemotherapy, bleeding trauma, childbirth and major surgery. Transfusion reactions are common if the recipient and donor aren't correctly matched.

More than 1.2 million blood components are transfused each year in Australia, and 21 million in the US.

While the technology isn't yet commercially available, Haemokinesis holds a patent for this innovation.

Snakebite deaths spark new look at antivenom amounts

Two recent deaths by tiger snakebites have caused some experts to question recommendations that one vial of any Australian snake antivenom is all that is ever required for treatment of an Australian snake's bite.

Associate Professors Scott Weinstein and Julian White from the Women's and Children's Hospital in Adelaide, and Mr Peter Mirtschin from Venom Science P/L, wrote in the *Medical Journal of Australia* that: "The Australian medical community should be aware that there is no consensus agreement that one vial of any Australian snake antivenom is all that is ever required for significant Australian elapid envenoming."

A 70-year-old woman who was bitten multiple times by a tiger snake, died less than 24 hours after being bitten. Two to three hours post-bite, she received two vials of tiger snake antivenom but further deteriorated and was given an additional vial six-and-a-half hours later, to no avail.

A 27-year-old man who received a prolonged bite from a large (1.5 m) tiger snake that had to be forcibly removed, received one vial of tiger snake antivenom about one hour after the bite. A vial of brown snake antivenom was provided early the next morning, but the patient died shortly thereafter.

The coroner's conclusions included reiteration of a consulted clinical toxinologist's comments that: "In treating an envenomed patient we need to successfully treat the 'outlier' case, not the 'median' case."

The coroner stated that: "In light of [the patient's] death, the current recommendation to administer one ampoule of antivenom needs refinement."

Professor Weinstein and colleagues cited the Australian Snakebite Project's 2017 study as having concluded that one vial of antivenom was sufficient to effectively treat envenoming by all taxa of Australian elapids.

"Inadequately treating patients with particularly high venom loads exposes them to unnecessary risk and decreases the likelihood of a positive outcome," they wrote.

"For example, for an envenomed patient with pre-existing medical comorbidities or older people or young children who are envenomed by a large amount of injected venom, the single

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vial recommendation may be a 'precariously narrow therapeutic strategy'.

"The severity of envenoming is also unpredictable because of the marked variability of injected venom volume and individual venom sample properties that can be influenced by geographic origin, ontogeny, as well as individual genetic factors."

There was no evidence that higher doses of antivenom were dangerous, they said.

"We do not suggest that multiple vial doses should routinely be used for all Australian snakebite patients requiring antivenom, but the patient-centred factors and biomedical reasons outlined [in our article] support our contention that recommendations for a uniform single vial treatment are inappropriate.

"Each envenomed patient should be individually assessed and provided with adequate antivenom in response to the envenoming severity and their individual clinical needs."

Study reaffirms the importance of bowel screening

New research led by the University of South Australia shows just how effective bowel cancer screening is in helping to reduce the number of bowel cancer deaths by up to 45 per cent.

Bowel (or colorectal) cancer kills almost 6,000 people in Australia each year but this number would be much higher without pre-diagnostic colonoscopies, a study has found.

Data from 12,906 bowel cancer patients indicate that faecal occult blood testing (FOBT) with a follow-up colonoscopy plays a key role in catching the disease early, before symptoms appear.

Researchers from UniSA's Cancer Epidemiology and Population Health found that having one pre-diagnostic colonoscopy was associated with a 17 per cent reduction in cancer deaths; a 27 per cent reduction with two pre-diagnostic colonoscopy procedures and 45 per cent for three or more.

Of the 12,906 records analysed, 37 per cent of the patients had pre-diagnostic colonoscopies and were more likely to live longer than those who were diagnosed after experiencing cancer symptoms.

Dr Ming Li, one of the study leaders, said that in South Australia, where the study was undertaken, those patients who had pre-diagnostic colonoscopies showed a "significant increase" in survival rates.

The risk of colorectal cancer death reduces step-wise with increasing numbers of colonoscopy examinations before symptoms appear, cutting the mortality rate from 17 per cent to 45 per cent," she said.

"Our findings show the value of the National Bowel Screening Program which is now being rolled out to everyone in Australia over the age of 50 on a two-yearly basis. It involves doing a simple, non-invasive faecal occult blood test (FOBT) which, if positive, is followed up with a colonoscopy."

Bowel cancer causes the second highest number of cancer deaths in Australia after lung cancer, but 90 per cent can be cured if detected early.

Currently, just 39 per cent of the eligible population undertake a FOBT if invited, which is predicted to prevent 92,000 cancer cases in the next 20 years. If the participation rate were to increase to 60 per cent, an additional 24,300 bowel cancer deaths would be prevented, the Cancer Council estimates.

The study has been published in *BMC Cancer.*

Successes in underaged drinking reductions

Some Australian communities have reduced underage alcohol use at twice the national rate using an innovative community engagement model, a Deakin University evaluation has found.

Deakin School of Psychology senior research fellow Dr Bosco Rowland said the results, which also included increases in wellbeing and a drop in anti-social behavior, show that problems such as substance abuse and crime can be prevented through coordinated community action.

"States such as Victoria are looking for solutions to the increasing trend for youth incarceration and death from illicit drug use, which is causing needless suffering and costing billions of dollars each year," Dr Rowland said.

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"Our findings clearly show we can reverse these problems by investing in evidence-based prevention programs that assist families, schools and communities in supporting children and young people to thrive.

"Getting serious on crime is not about building new prisons, but building communities that prevent crime from being committed in the first place."

The Communities That Care model was originally developed in the US to guide community coalitions to design and implement local action plans to improve child and adolescent health using a science-based prevention approach.

It was introduced into a select group of Australian communities in the late 1990s following studies showing Australian teens' use of alcohol and other drugs was twice the rate of their peers in the US.

"Alcohol, tobacco and other drug use are underlying causes of a wide range of health and social problems and the earlier a person starts using them, the greater their risk of harm," Dr Rowland said.

"As part of the Communities That Care Program, communities are supported to use youth surveys to identify issues that trigger community problems, such as underage alcohol sales. Communities then implement harm-reduction strategies, including the monitoring of alcohol sales at bottle shops and sports clubs, as well as parent education programs in schools."

Dr Rowland and his team have been tracking the first four municipalities to implement the Communities that Care model – Mornington Peninsula, Ballarat and Alpine shires in Victoria, and Bunbury in Western Australia – and have compared them with data from more than 100 other local government areas across the country.

The evaluation, published in the *Journal of Health Psychology*, surveyed more than 41,000 young Australians over 15 years.

"We found that crime and the use of alcohol, tobacco and illicit drugs reduced at a faster rate in municipalities where the Communities That Care planning approach was used," Dr Rowland said.

"Youth alcohol use fell 28 per cent in the intervention communities over the period studied, which was more than twice the fall in the rest of Australia. I think some of the major factors leading to this decline are less favourable parent attitudes to alcohol and drug use, and reduced availability of alcohol."

AI equals humans in some medical diagnoses

New research suggests artificial intelligence is able to interpret medical images and make diagnoses based on those images as well as human experts.

Through the use of deep learning algorithms, the potential for AI in healthcare has taken a leap forward, according to a review published in *Lancet Digital Health*.

AI advocates say the findings could help ease burdens on health systems around the globe.

But the review is based on only a small number of studies. And the experts themselves, have cautioned against suggesting that AI outperforms human capability.

Dr Xiaoxuan Liu, the lead author of the study from University Hospitals Birmingham NHS foundation trust, said the conclusion of the review had to be met with a reality check.

Research

"There are a lot of headlines about AI outperforming humans, but our message is that it can at best be equivalent," she said.

AI use in interpreting medical images, which relies on sophisticated machine learning, has shown promise in diagnosis of diseases, including cancers.

The researchers conducted the first comprehensive review of published studies on the issue and found AI to be on a par with humans in that area.

Because there is an abundance of poor quality study in the field, they focused on research papers published since 2012, which was a pivotal year for deep learning.

While the initial search offered more than 20,000 relevant studies, only 14 studies were reviewed because they were all based on human disease, reported good quality data, and tested the deep learning system with images from a separate dataset to the one used to train it. In those studies, the same images were also shown to human experts.

The researchers found that deep learning systems correctly detected a disease 87 per cent of the time and correctly gave the all-clear 93 per cent of the time, compared with 86 per cent and 91 per cent, respectively, for human experts.

World News

WITH CHRIS JOHNSON

Brazil burns and its hospitals overflow

Health centres in parts of Brazil have been inundated with patients seeking help for respiratory problems, as fires continue to ravage the Amazon rainforest.

Toxic smoke clouds have covered numerous cities, towns and villages in the massive South American country.

Northern states of Acre and Rondônia are particularly affected.

Rondônia's capital city Porto Velho has been reportedly hit hard, with three times the average number of children being treated for breathing difficulties there.

Locals have described the haze caused by fires, which have been running wild since August, as the worst ever because they are actually seeing what they are breathing in.

In the first three weeks of August, more than 400 children were admitted to the city's children's hospital with respiratory problems.

The Washington Post has quoted a number of parents fearing for their children's health.

"It's a crime," one mother said.

"A complete lack of respect for the population as a whole, but especially with the children."

Elderly are also suffering due to the smoke.

Across Acre, about 50,000 cases of respiratory sicknesses have been recorded.

Health experts are saying that a single day's exposure to the smoke-filled environment can have an adverse impact on health.

Asthma and bronchitis are naturally exacerbated by the smoke.

But doctors are warning that prolonged exposure to the pollution could enhance the risk of cancer.

Pulmonologist Marcos Abdo Arbex is quoted by the *Post* as saying: "You cannot put a price tag on the suffering that individuals will experience. But there is also a rise in costs for people and the government. If there is a huge increase in emergency room visits and hospitalisations, serving that population will be more costly."

Hospitals and other health centres are struggling with the sheer number of people seeking medical attention, with some desperately trying to find more staff to cope with the demand.

Authorities are even advising locals to stay indoors, keep their windows closed, and avoid exercise.

In the south of the country, Sao Paulo – Brazil's most populous city and the 12th most populous in the world – was covered in darkness in the middle of the day for a number of days.

Brazil's President Jair Bolsonaro came to office promising to open up the Amazon to development.

Deforestation is booming under his leadership and he remains at loggerheads with other world leaders over the issue.

Since his inauguration in January, more than 72,000 fires have raged across Brazil – 25,000 in the rainforest in August alone.

Even after his government temporarily banned any more deliberate burning in the Amazon, another 4,000 new fires broke out within days of the order.

The disaster is now being openly described by experts as an environmental and a health crisis.

World News

BMA joins climate action day to say it is already damaging health

The British Medical Association used the global climate day of action in September to issue a strong warning that climate change and air pollution are already damaging the health of the British public, as well as populations around the world.

The UK doctors' union added its voice to those taking part in the global climate movement, stressing it has long called on the UK Government to take urgent action by introducing legally enforced air quality standards.

The BMA also asked for the net-zero emissions target to be met by 2030 and for funding to be made available for research into the real economic and health impacts of air pollution and climate change.

One of the BMA's chief officers and GP, Dr Helena McKeown, said: "It is inspiring to see young people here in the UK and all those across the globe caring about our world, raising awareness and calling for bold action on the climate emergency we are currently facing.

"As doctors we know only too well that poor air quality leads to serious illness, even death, as it affects not just our breathing, but people with diabetes, heart disease and dementia. Extreme environmental changes and the resulting risk of disease and infections are major health concerns that will further exacerbate poverty and inequalities.

"The scale of the change needed is far greater than we can achieve as individuals; the main agent of change is the Government who has the power to act and implement the reforms needed to safeguard our health and that of future generations."

In July this year, the BMA declared climate change to be a health emergency.

The Australian Medical Association formally recognised climate change as a health emergency in September, although it has held a position on the health impacts of climate change since 2004.

Vaping ban in place to stay in India

Protests against a vaping ban in India have only resulted in the Indian government digging in and declaring there will be no lifting of new rules outlawing e-cigarettes.

India recently banned the sale and import of electronic cigarettes, saying a vaping epidemic was gripping its young people.

Protests against the new laws were staged in six cities around the nation, but media reports say only about 400 people attended in total.

Some people reported fearing being targeted by police if they protested.

Local companies have mounted legal challenges in Indian courts against the ban, and international companies Philip Morris and Juul Labs are having to rethink their business models in India.

But nothing has so far swayed the government to change its mind.

With more than 900,000 people dying each year in India due to tobacco-related illnesses, the government says it cannot let vaping lead more people to nicotine addcition.

"There is no question of a rollback," a health ministry official is reported as saying. India has 106 million adult smokers.

World News

WHO and Tanzania angry at each other over Ebola

The World Health Organisation has urged Tanzania to share information about suspected Ebola cases, suggesting the East African nation was not being completely transparent about the deadly virus.

Early in September, WHO received what it described as unofficial reports of an Ebola death in the Tanzanian capital Dar es Salaam. But the Organisation says it had received no information through official channels.

On September 14, the Tanzanian government made a statement saying there was no Ebola outbreak in the country, but added that it had investigated two recent cases of unknown illnesses – stressing that they were not cases of Ebola.

In an unusual move, WHO issued a statement calling for full transparency over the issue, and suggested there were multiple suspected cases in the country.

WHO rebuked the Tanzanian government for withholding pathology samples for independent testing.

Spokeswoman Fadela Chaib said despite repeated requests, WHO had not received any further details about the suspected Ebola death from Tanzanian authorities.

Tanzania retaliated on September 24 by summoning WHO's local representative over its assertion that the government refused to share information.

Government spokesman Hassan Abbasi said WHO's country representative Tigest Ketsela Mengestu was summoned by Deputy Foreign Affairs Minister Damas Ndumbaro.

"The representative insisted that the WHO has not declared that there is Ebola in Tanzania, nor does it have any evidence on that and pledged to cooperate with the government," Mr Abbasi said.

"During the talks, the WHO agreed to strictly follow guidelines outlined by the agency itself and ratified by the government if it wants to get any additional information from the Tanzanian government."

Ms Chaib subsequently told reporters in Geneva that WHO had not received any information after it had requested Tanzanian authorities to assess potential risks from the recent incidences.

But she said WHO had advised against any punitive actions against Tanzania.

"What we need to do is to continue communicating with them and provide them with help and expertise. We cannot sanction a country. It is not our mandate," she said.

WHO member states, of which Tanzania is one, are obligated under international health regulations to inform WHO of any suspected Ebola cases.

If Ebola has reached Tanzania, it would be a serious development in the spread of the virus. It has killed more than 2,000 people in eastern Congo since August 2018.

World News

UN boost for global health goals

Twelve multilateral agencies used the recent United Nations General Assembly gathering in New York to launch a joint plan to better support countries over the next 10 years in accelerating progress towards the health-related Sustainable Development Goals (SDGs).

It was launched and signed as part of the Assembly's High-level Meeting on Universal Health Coverage.

Developed over 18 months, *Stronger Collaboration, Better Health: Global Action Plan for Healthy Lives and Well-being for All* outlines how the health, development and humanitarian agencies will collaborate to be more efficient and provide more streamlined support to countries to deliver universal health coverage and achieve the health-related SDG targets.

The group stressed that healthy people are essential for sustainable development and for ending poverty, promoting peaceful and inclusive societies as well as protecting the environment. Over the last few decades, significant gains have been made in key areas of health, but the 2030 targets will not be met without redoubled efforts.

"The plan is called, 'Stronger Collaboration, Better Health' for a reason," said World Health Organisation Director-General Dr Tedros Adhanom Ghebreyesus.

"Although collaboration is the path, impact is the destination. The release of this plan is the beginning, not the end, of that path."

Universal health coverage is key to meeting the health-related goals and addressing health inequities. If trends continue, only up to five billion of the world's population will be covered by essential health services in 2030, as highlighted in the *Universal Health Coverage: Global Monitoring Report*, released by WHO. To leave no one behind, countries need to address health inequities. Improved collaboration and coordination can help countries tackle complex health challenges and bring innovative solutions.

Together, the 12 agencies contribute nearly one-third of all development assistance to health. Under the Global Action Plan, the agencies commit to strengthening their collaboration to:

- engage with countries better to identify priorities, plan and implement together;
- accelerate progress in countries through joint actions under seven accelerator themes, which represent common challenges for many countries and where the agencies' mandates, expertise and resources offer solutions, namely: 1) Primary health care 2) Sustainable health financing 3) Community and civil society engagement 4) Determinants of health 5) Innovative programming in fragile and vulnerable settings and for disease outbreak responses 6) Research and development, innovation and access, and 7) Data and digital health. They will also work together to advance gender equality and support the delivery of global public goods;
- align by harmonizing their operational and financial strategies and policies in support of countries to increase efficiency and reduce the burden on countries; and
- account, by reviewing progress and learning together to enhance shared accountability.

Governments are setting priorities, developing implementation plans and intensifying efforts to achieve the health-related SDG targets. Demand from countries for the Global Action Plan is growing.

One example is Nepal, whose Deputy Prime Minister Upendra Yadav said at the launch that achieving the health-related SDG goals was key for his country.

"Strengthening primary health care and enhancing data utilisation for evidence-based planning and decision-making are two accelerators that will help bring us closer to achieving the SDG goals," he said.

Through the Global Action Plan, the agencies will help countries deliver on international commitments in addition to the SDGs.

Coordinated by WHO, the *Global Action Plan for Healthy Lives and Well-being for All*, is in response to a call from Germany, Ghana and Norway, with support from the United Nations Secretary-General, Antonio Guterres, for more effective collaboration and coordination among global health organizations to achieve the health-related SDGs.

The 12 signatory agencies to the plan are WHO; Gavi, the Vaccine Alliance; Global Financing Facility for Women, Children and Adolescents; The Global Fund; UNAIDS; UNICEF; UN Development Fund; UN Population Fund; UN Women; Unitaid; World Bank Group; and World Food Program.

World News

Obesity not a choice, say UK psychologists

Psychology experts in the United Kingdom are calling for changes in the way society regards obesity, saying the condition is not a choice or due to a lack of willpower.

A recently-released British Psychological Society report also suggests the term "obese people" should not be used, but instead "people living with obesity" or "people with obesity" should be the references.

"Obesity is not simply down to an individual's lack of willpower. The people who are most likely to be an unhealthy weight are those who have a high genetic risk of developing obesity and whose lives are also shaped by work, school and social environments that promote overeating and inactivity," the report states.

"People who live in deprived areas often experience high levels of stress, including major life challenges and trauma, often their neighbourhoods offer few opportunities and incentives for physical activity and options for accessing affordable healthy food are limited.

"Psychological experiences also play a big role. Up to half of adults attending specialist obesity services have experienced childhood adversity."

The Society has called on the UK Government to approach the issue of obesity in the same way it did smoking.

It does not, however, support describing obesity as a disease, as the World Health Organisation does.

"Whilst obesity is caused by behaviour, those behaviours do not always involve 'choice' or 'personal responsibility'," the report said.

Obesity levels in England increased by 18 per cent between 2005 and 2017, with similar increases recorded in Scotland, Northern Ireland and Wales.

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MJA Journal: The Medical Journal of Australia is Australia's leading peer-reviewed general medical journal and is a FREE benefit for AMA members.

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