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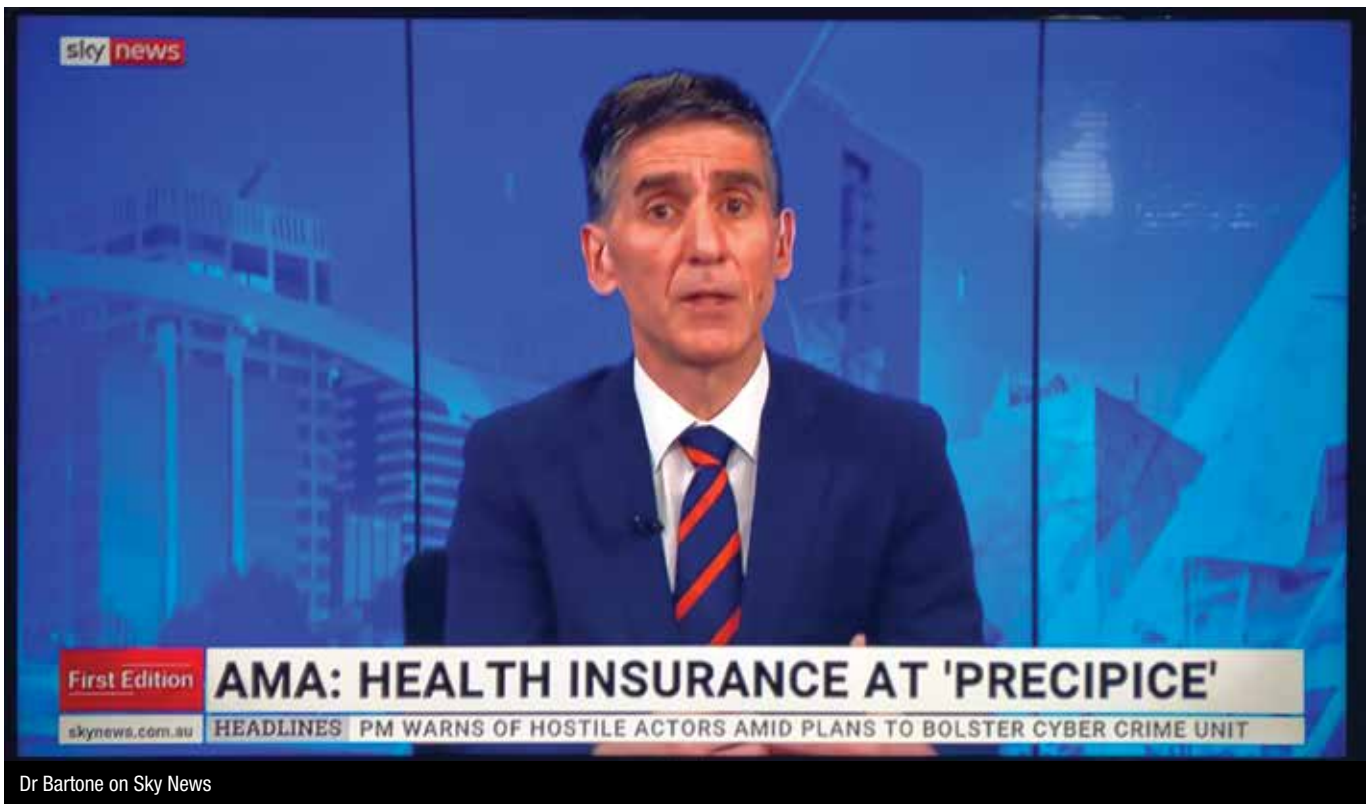
In this issue

Private Health Insurance needs urgent attention



Dr Bartone on Sky News

Private health insurance must be made more attractive for more Australians if it is to survive.

The AMA has released its latest report card into private health insurance (PHI) and has warned that urgent action is needed to fix the troubled sector.

In launching the *AMA Private Health Insurance Report Card 2019*, AMA President Dr Tony Bartone said PHI in Australia is on the precipice.

He called on all stakeholders to work together to improve the system and make it more palatable for consumers, especially for young Australians.

"We've got many years now where we've had consumers making a decision to drop their cover because of lack of affordability, increasing premiums, decreasing coverage, decreasing product utility, and of course that's just putting further pressure on the premiums which leads to that vicious cycle," Dr Bartone told Sky News.

"And we need to remember that the private health system underpins access and equity in the public system. So, the more and more Australians drop out of private health, the more the pressure's on public health and the more the burden and that delay in accessing treatment will be. So, it's a perfect storm, we might say."

The Report Card provides patients and consumers with clear, simple information about how health insurance really works, in the hope that better information instills more confidence in the private health insurance system.

It explains what insurance may cover, what the Medicare Benefits Schedule (MBS) covers, and what an out-of-pocket fee may be under different scenarios.

It also highlights the frustrating fact that what insurers pay varies significantly from State to State – this variation can even occur within the same insurance fund.

To help consumers better understand what they are buying, the Report Card sets out the percentage of hospital charges covered by State and insurer, and the percentage of services with no gap, State by State.

Private Health Insurance needs urgent attention

...continued from p3

It shows that some insurers perform well overall, and some only perform well for certain conditions.

Health insurance policies are unnecessarily complicated and opaque. Each insurer sets the rebate amount that they are willing to pay. If the insurer's rebate is low, the out-of-pocket cost to their customer will be high. And these out-of-pockets can vary by thousands of dollars.

The Report Card reveals that the same doctor performing the same procedure can be paid significantly different rates by each fund. This is often the untold story behind patient out-of-pocket costs, despite there being high levels of no gap and known gap billing statistics.

"With more than 60 per cent of elective surgery in Australia occurring in the private sector, the prospect of greater stress and demand being placed on the already overstretched public hospital system is looming large unless the drift away from private health insurance is stopped," Dr Bartone said.

"Australians need and demand private health policies that are affordable, transparent, good value, and appropriate for their individual or family circumstances, or they will walk away from private health insurance altogether.

"The private health insurers must work closely with the Government to ensure that the hard-won reforms of 2018 deliver on the promise of better cover, more transparency, and greater value – or more and more people will drop their cover or not sign up at all.

"An increasing number of younger and healthy Australians are opting out of private health insurance.

"This is leaving a higher proportion of older patients who are increasingly more likely to be suffering from illness or chronic disease and, as a result, they are more expensive to insure, further driving up premiums. This trend is not sustainable.

"We are still seeing increases in premiums averaging three to five per cent a year, when wages growth is firmly stuck at around two per cent.

"Sooner or later, the number of people with private health insurance will fall further – and dramatically."

A proposed Government website to allow people to search specialists' fees is meaningless, Dr Bartone said, as it will do nothing to fully inform patients about their likely out-of-pocket costs unless it also lists what patients can expect back from Medicare and their private health insurance fund.

In an interview with the ABC, Dr Bartone said the last four years had seen a continuing decline in market penetration, with customers deciding not to renew their private health insurance.

"That fall in penetration means that more and more people are opting out. More of the older population are remaining in or joining. That's putting an increase on the funds to pay out and that means that premiums go up, and we have that vicious cycle of increasing premiums, decreasing product value, and more consumers then making the decision to opt out," he said.

"The private health system underpins our world-class public health system and that – the affordability, the access and the equity in our public health system – depends on a vibrant and robust private health system."

The AMA welcomed the introduction of the Gold, Silver, Bronze, and Basic categories for policies and the standard clinical definitions applied under each category.

But the Government review and the new insurance policy structure did not address the key issues of affordability and value for money.

In a statement to the ABC's AM program, a spokesman for Federal Health Minister Greg Hunt said the Government was delivering the most significant reforms to private health insurance in over a decade, which will make it simpler to understand and more affordable.

The Opposition has called for an inquiry into the PHI sector.

JOHN FLANNERY AND CHRIS JOHNSON

The *AMA Private Health Insurance Report Card 2019* is available at: https://ama.com.au/article/ama-private-health-insurance-report-card-2019

Shocking aged care neglect detailed in Royal Commission report

The aged care system fails to meet the needs of elderly and vulnerable Australians and in too many instances it neglects them.

The Royal Commission into Aged Care Quality and Safety has delivered its Interim Report to Parliament, finding what it describes as a 'shocking tale of neglect'.

According to the report, the system does not deliver uniformly safe and quality care, and it is unkind and uncaring towards older people.

The Interim Report is even titled *Neglect* and calls for a fundamental overhaul of the design, objectives, regulation and funding of aged care in Australia.

"The neglect that we have found in this Royal Commission, to date, is far from the best that can be done. Rather, it is a sad and shocking system that diminishes Australia as a nation," said Commissioners Richard Tracey and Lynelle Briggs.

In their report, they describe the many problems older people and their families have in trying to get access to aged care services, service shortfalls, the dispiriting nature of residential care, serious substandard care and unsafe practice, an underpaid, undervalued and insufficiently trained workforce, and isolation of young people with disabilities.

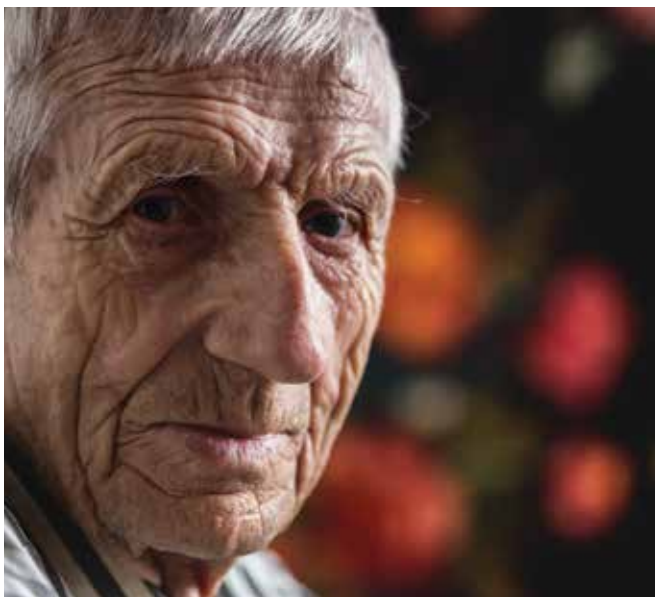
The Interim Report sets out the extent of the failure of Australia's aged care services and what the Royal Commission has learned to date.

Three areas where immediate action can be taken have been identified. They are:

- to provide more Home Care Packages to reduce the waiting list for higher level care at home;
- to respond to the significant over-reliance on chemical restraint in aged care, including through the seventh Community Pharmacy Agreement; and
- to stop the flow of younger people with a disability going into aged care, and speed up the process of getting out those young people who are already in aged care.

Over three volumes, the Interim Report explains that the aged care system needs fundamental reform and redesign.

The systemic problems identified include that the sector is designed around transactions, not relationships or care; that it



minimises the voices of people receiving care and their loved ones; is hard to navigate and does not provide information people need to make informed choices about their care; relies on a regulatory model that does not provide transparency or an incentive to improve; and has a workforce that is under pressure and under-appreciated and that lacks key skills.

The Royal Commission's Interim Report can be found on the Royal Commission's website https://agedcare.royalcommission.gov.au/Pages/default.aspx, where the volumes can be read, downloaded, or ordered in hard copy.

The document covers much of the work of the Royal Commission through to September 2019. But most of the work on quality and safety considerations will be in the Final Report, which will be handed to the Governor-General in November 2020.

Federal, State and Territory Health Ministers discussed the Interim Report at their COAG Health Council in Perth and emerged having focused only on medication.

Federal Health Minister Greg Hunt said there was agreement from the Ministers to recognise "quality use of medicine and medicine safety" as a national health priority.

Mr Hunt has commissioned a "national baseline report".

CHRIS JOHNSON

Damning report shows why care can't wait

The Royal Commission into Aged Care Quality and Safety's interim report has confirmed everybody's worst fears about the poor care, neglect, and abuse that has been occurring unchecked in Australia's aged care system for years.

AMA President Dr Tony Bartone said the Royal Commission's report is a call for action – urgent action.

"Care can't wait. We have to put the care back into aged care," Dr Bartone said.

"The Royal Commission has exposed numerous examples of neglect, abuse, mismanagement, under-resourcing, and under-funding in aged care.

"It has also given us insights into the failures of successive Governments to fix the system.

"The background papers and reports produced by the Royal Commission have highlighted how Australia compares poorly internationally in terms of staffing in aged care, and it makes for troubling reading.

"Tragically, it has told us that in a single year an estimated 16,000 people died waiting for a home care package.

"The wording of the interim report comes as no surprise to AMA members who work in aged care and witness the aged care crisis daily.

"A lack of funding, low support from providers, and little action by Government has led to the current crisis."

Dr Bartone said the AMA welcomes the call for immediate action to reduce the waiting times for home care packages."

Dr Bartone said the AMA had been calling for this for some time, and that funding is needed to clear the backlog of almost 120,000 people waiting for a home care package at their approved level.

"It is unacceptable that people have to wait for over 12 months for a Level 4 home care package," he said.

A call for the reduction of over-reliance on chemical restraints is welcomed by the AMA.

"Our longstanding position is that restrictive practices should always be considered a last resort – where and when any potential risk or harm caused by the restraint itself is less than the risk of the patient not being restrained," Dr Bartone said.

"The decision on the use of restraints should always be made on a case-by-case basis.

"However, there must be a balance between the need to ensure the older person's safety, and the safety of those around them, including other residents and their families and friends, while respecting their right to dignity and self-determination, including acknowledging previously expressed or known values or wishes.

"But clearly, as part of reducing the inappropriate use of chemical restraints in aged care, there must be sufficient numbers of staff and an appropriate mix of skilled staff available at all times.

"Registered nurses must be available on site 24/7 to ensure appropriate care, including the safe administration of medicines, is provided for elderly and frail patients.

"Staff must be trained to better care for residents living with dementia. Currently, that training is inadequate.

"There is plenty of evidence that improved dementia management and behavioral training for nursing and personal care staff will lead to reduced prescription of antipsychotic medications.

"Staff also need training to understand the ethical, medical, and legal issues and responsibilities when using restraints. The AMA has called for a mandatory minimum qualification for personal care attendants."

Dr Bartone said a safe and quality skills mix of medical, nursing, and care staff, and minimum staff-to-resident ratios must be priorities.

"It is totally unacceptable that in 21st century Australia more than half of all aged care residents live in facilities that have unacceptable staffing levels," he said.

"We have a sad and unacceptable situation where more than 80 per cent of staff say they don't have time to provide social and emotional support to the residents."

The AMA also welcomes the call to stop the flow of younger people entering aged care. Aged care facilities are not appropriate places for younger people.

Doctors who visit aged care facilities and witness the environment experienced by young people consider it demeaning and humiliating.

"The Government must urgently explore other options and provide alternatives for younger people with disabilities who are currently residing in residential aged care facilities," Dr Bartone said.

"The Royal Commission has done an excellent job bringing to light the national shame of what is happening in aged care. We applaud the work of the Commission – but we cannot wait another year or more to start to fix things.

"The Government must act now – immediately. It cannot hide. No ifs, no buts, no more excuses. Our parents, our grandparents, our friends and loved ones deserve better. Care can't wait."

JOHN FLANNERY

Productivity Commission calls for mental health overhaul

The rate of mental health presentations at hospital emergency departments has risen by 70 per cent over the past 15 years; mental health and suicide costs Australia $180 billion a year; and mental health services are failing to meet community expectations.

These are some of the findings in the Productivity Commission's draft report into mental health.

A generational shift is needed, it states.

"In any year, approximately one in five Australians experiences mental ill-health. While most people manage their health themselves, many who do seek treatment are not receiving the level of care necessary," Productivity Commissioner Stephen King says in the report.

"As a result, too many people suffer additional preventable physical and mental distress, relationship breakdown, stigma, and loss of life satisfaction and opportunities.

"The treatment of mental illness has been tacked on to a health system that has been largely designed around the characteristics of physical illness."

The report states that the cost to the Australian economy of mental ill-health and suicide is, conservatively, up to $51 billion a year, with an additional $130 billion cost associated with diminished health and reduced life expectancy for those living with mental illness.

That totals up to about $180 billion a year – or $500 million a day – as the true cost to the economy.

AMA President Dr Tony Bartone said the figure did not surprise him.

"We've been saying for many, many years now that the cost of mental illness has been vastly underestimated," Dr Bartone told Sky News.

"You've got to add in all the factors, not just actually the cost of providing the care, but the lost productivity to GDP in terms of time off through illness, out of the workplace, and the contributing impact on the family and on the community.

"We need to ensure that we've got a proper mental health architecture in our system to deal with that complexity, that burden of illness, because otherwise we're just not doing the right things by our patients, by community, and by the Australians as a whole."

In its recommendations, the Productivity Commission calls for sweeping reforms, but notes that some of the changes have already been flagged and rejected. Some recommendations will need to be implemented in stages.

"Substantial reform of Australia's mental health system is needed and there is no quick fix," the report states.

Among the long list of recommendations is one that schools should employ mental health and wellbeing counsellors for children.

Other recommendations include promoting best-practice in initial assessment and referral stages of treatment; linking headspace centre funding to targets around care and following the stepped care model; amending MBS regulations for referrals so patients can use alternatives; encouraging more group psychological therapy; expanding online treatment options; better planning in regional areas for dedicated mental health services and hospital beds; and improving alternatives to EDs such as clinician-led after hours services and mobile crisis services.

CHRIS JOHNSON

The full report can be found at: https://www.pc.gov.au/inquiries/current/mental-health/draft/mental-health-draft-overview.pdf

Draft report confirms pressing need for major mental health reforms

AMA President Dr Tony Bartone said the Productivity Commission Draft Report into Mental Health is a welcome catalyst for much-needed political, sectoral, and community debate and discussion to urgently reshape our mental health system to better meet growing and more complex demand.

"The Commission's draft report highlights the extent of mental illness in Australia and the extent of the reforms needed to build a better mental health system," Dr Bartone said.

"We note it is a draft report and further detail is required to ensure that any solutions are appropriately and clearly resourced, and there is no additional paperwork or burdensome bureaucratic processes to overcome to access appropriate care for our patients.

"The AMA will also be seeking assurances there are no plans or recommendations to move away from current private sector models, especially specialist psychiatric care.

"We must ensure that appropriate non-GP specialist referrals are not a casualty of any reform.

"The draft report puts the cost to the Australian economy of mental ill-health and suicide at around $43 to $51 billion per year, and that is a conservative estimate.

"In addition, the Productivity Commission says that approximately $130 billion in associated costs are expended."

The draft report notes:

- In any year, approximately one in five Australians will experience some form of mental ill-health.
- Many Australians are able to manage their mental health needs but for those who need mental health treatment, they are not always able to receive the type of care they need.
- The failures in the system to help those in need means too many people are experiencing 'preventable physical and mental distress, relationship breakdown, stigma, and loss of life satisfaction and opportunities'.
- The PC draft reiterates that mental illness is a young person's condition, with 75 per cent of those who develop mental illness experiencing mental illness before the age of 25 years.

Dr Bartone said the draft report seeks to recommend to governments and policymakers where investments are needed.

"We must build a mental health system based on accountability and evaluation of programs so we know who is responsible for mental health care and how resources and funding are allocated," Dr Bartone said.

"The Productivity Commission says there is a lack of awareness about what constitutes mental illness and what types of services and supports are available.

"We welcome the call for *'clear gateways into mental health care'* and more effective ways to find out about services and supports to help individuals and their families and friends navigate the range of mental health services available.

"One of the key findings is the need for better coordination between psychosocial supports, housing services, the justice system, workplaces, and social security.

"The AMA welcomes the necessary public consultation process and the opportunity for general practitioners, public and private psychiatrists, other mental health professionals and workers, and most importantly, people with mental illness and their families to respond to this draft report," Dr Bartone said.

JOHN FLANNERY

Silver costing more than gold

Some health insurers are ripping off their customers by charging more for silver policies than other companies charge for gold ones.

New market research from consumer advocacy group Choice has revealed that Australians buying some silver and silver plus health insurance policies are paying comparatively too much.

In the cases of some silver plus polices, customers stand to lose hundreds of dollars every year – some paying as much as $1,700 more for policies with less cover.

Choice is describing them as plus policy scams, and has called on the Federal Government to hold a public inquiry into the private health insurance industry.

The introduction of the new Basic, Bronze, Silver and Gold system in April this year has opened the way for manipulation, Choice says.

Choice's Dean Price said the industry lobbied to increase complexity and confusion in the health insurance market and is now taking advantage of this confusion to trick Australians into paying more than they need to.

"We've found over 215 silver and silver plus policies that cost more than gold policies from competitors," he said.

"That means you pay these insurers more for less coverage. That's less money in your pocket and more surprises when the worst happens and you end up in hospital."

Silver plus policies allow customers to tailor health insurance to give the level of cover provided by a silver policy, plus cover for one or more procedures usually only covered by gold insurance.

Silver and silver plus policies provide less cover than gold policies, so would naturally be expected to cost less. But Choice found silver plus policies that cost up to $800 more per year than the cheapest gold policy in Queensland, South Australia and Western Australia, up to $700 more in the ACT and New South Wales, up to $900 more in Victoria and Tasmania, and up to $1,700 more in the Northern Territory.

"Health Minister Greg Hunt tried to make health insurance clearer, but the health insurance lobby succeeded in making it complicated. Choice's investigation shows how the health insurance industry is profiting from the confusion they created," Mr Price said.

"People already find health insurance high cost and low value. This investigation uncovers more reasons why people don't trust the companies offering these expensive policies. The death spiral this industry is facing is self-imposed and they can't be trusted to fix it themselves."

The worst offender nationally is Frank (GMHBA) Health Insurance, with the most expensive silver plus policy (their 'Top Hospital' cover) in every State and Territory.

All the major health insurers such as Medibank, Bupa, HCF, HBF and NIB also feature prominently in Choice's analysis of scam silver plus policies.

"The Federal Government should take this opportunity to show that it won't give in to these powerful lobby groups," Mr Price said.

"The Government should call a public inquiry into the health insurance industry. They need to listen to the people affected by the industry's bad decisions so that we can deliver fair health care and fix the problems together."

Shadow Health Minister Chris Bowen said Mr Hunt was not prepared to take action.

He said the Choice research was yet another crisis call regarding private health insurance.

"Labor agrees with Choice. The only way to address the private health insurance crisis is with a root and branch review of the system," Mr Bowen said.

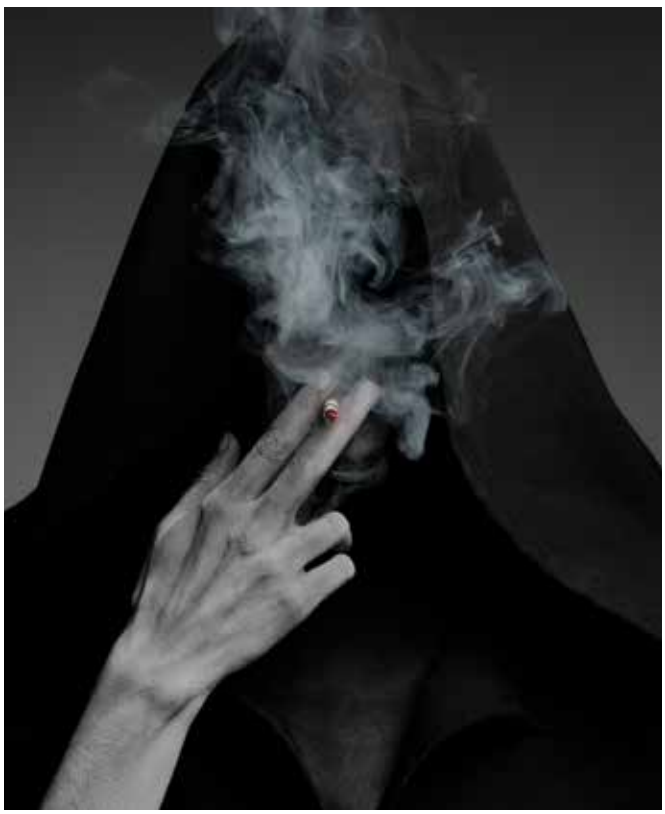
"It is time the Government listened."

The full list of high-cost plus policies is available at: https://infogram.com/1pegmym6p11vwxim7jlp660m50blmxjq9l1?live

The analysis is based on single policies with a $750 excess without the rebate. Families and couples pay about double. The majority of policies analysed were silver plus policies, and a smaller number of silver policies. They all cost more than at least one gold policy in the same State.

CHRIS JOHNSON

Fewer smokers but tobacco still kills one in eight



Tobacco contributes to one in eight Australian deaths a year and remains the highest risk factor in premature deaths.

A new report from the Australian Institute of Health and Welfare (AIHW) shows that in 2015, about 21,000 people died from tobacco-related illness – which is more than one in eight.

It also reveals that almost three quarters of the health disease brought on by tobacco proved fatal.

The report, *Burden of Tobacco use in Australia,* used burden of disease analysis to study the impact of smoking on the population in terms of premature death (the fatal burden) and years lived in ill health (the non-fatal burden).

While Australia has made significant progress in reducing smoking rates, tobacco is responsible for more than nine per cent of the total burden of diseases across the nation.

The daily smoking rate in Australia has almost halved since the early 1990s. Updated records show that in 2016, a total of 12 per cent of Australians smoked daily. That rate is one of the lowest rates among Organisation for Economic Co-operation and Development (OECD) countries.

The report shows that after accounting for population increase and ageing, the rate of disease burden due to tobacco use fell between 2003 and 2015 by 24 per cent. This pattern is predicted to continue.

But tobacco use remains the leading risk factor for ill health and premature death in Australia and was responsible for 9.3 per cent of the total burden of disease in Australia in 2015.

"Almost three-quarters of the burden due to smoking was fatal. Forty-three per cent of the tobacco-related disease burden was due to cancer and most of this was from lung cancer," AIHW spokesman Richard Juckes said.

"Chronic obstructive pulmonary disease accounted for 30 per cent of the burden, coronary heart disease 10 per cent and stroke 3.1 per cent."

Burden of disease from tobacco use was highest in the Northern Territory and in more remote parts of Australia. People living in the lowest socioeconomic areas experienced rates of tobacco burden 2.6 times those of people living in the highest socioeconomic areas.

Together, tobacco, alcohol and illicit drug use contributed to 18 per cent of deaths in Australia in 2015, equivalent to about 28,500 fatalities.

"While the burden associated with current smoking fell, the burden linked to past smoking rose by 15 per cent," Mr Juckes said.

"This is probably because some of the diseases associated with smoking – such as lung cancer and chronic obstructive pulmonary disease – can take many years to develop."

CHRIS JOHNSON

The full report can be found at: https://www.aihw.gov.au/reports/burden-of-disease/burden-of-tobacco-use-in-australia/contents/table-of-contents

Vaccinations seeing preventable diseases fall

Sickness caused by vaccine preventable diseases fell by 31 per cent from 2005 to 2015 due to national immunisation programs, according to a new report by the Australian Institute of Health and Welfare (AIHW).

The burden of vaccine preventable diseases in Australia measures the combined impact of living with an illness or injury (non-fatal burden) or dying prematurely (fatal burden), focusing on the 17 diseases with vaccines in the National Immunisation Program (NIP) schedule in 2018.

The most notable decrease in burden was among infants, young children and young adults aged 15 to 24, whereas rates of burden among people aged 65 and over increased. The latter was mainly driven by increases in influenza and shingles.

The impact of vaccines can clearly be seen as new vaccines are introduced. In the decade to 2015, large declines were seen in the burden of disease for rotavirus (85 per cent – added to the NIP schedule in 2007), chickenpox (75 per cent – added in 2005), human papillomavirus (67 per cent – added in 2007 for females and in 2013 for males) and meningococcal disease (58 per cent – added in 2003). The number of cases of these diseases decreased considerably over the period.

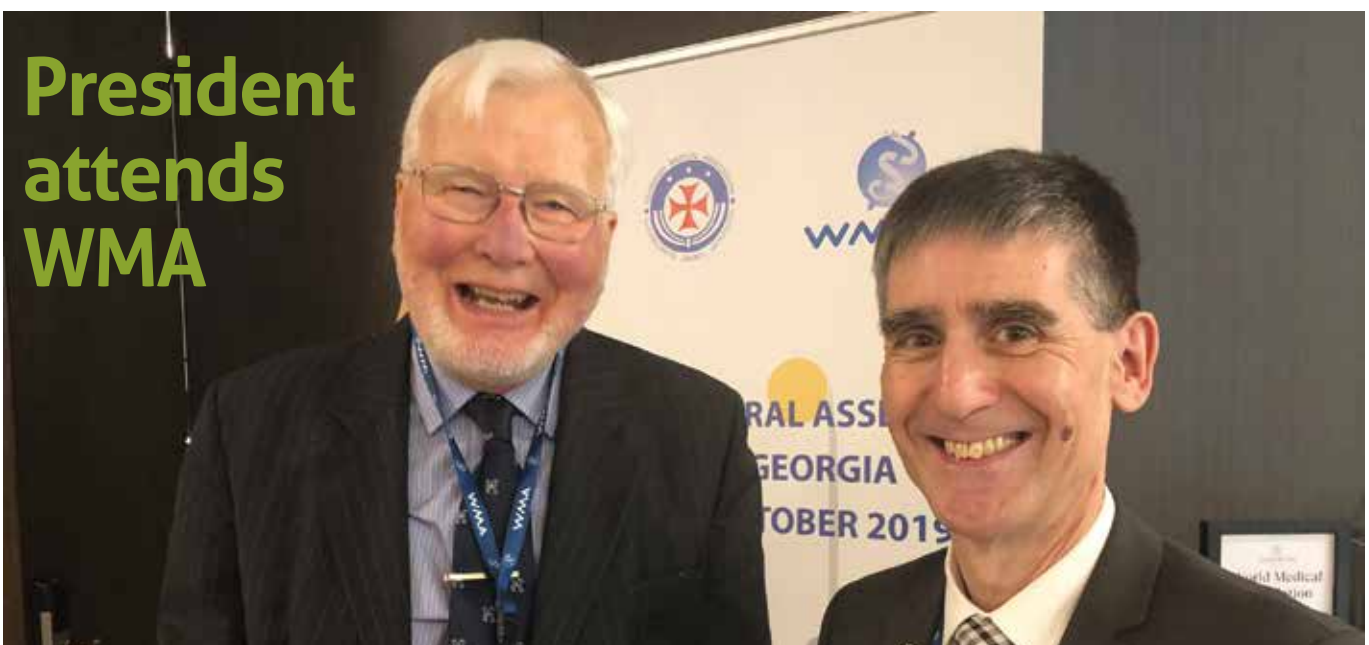
The impact of long-term widespread vaccination in Australia is also apparent, with the burden due to diseases such as diphtheria, tetanus, rubella and haemophilus influenzae type b (Hib) remaining at very low levels.

Differences in burden over time are affected by cyclic epidemics of diseases such as influenza and whooping cough, as well as changes in testing, surveillance and reporting practices.

The rate of burden due to influenza in 2015 was more than four times that in 2005, while burden rates for whooping cough and shingles in 2015 were 73 per cent and 44 per cent greater, respectively, than in 2005.

The rate of burden among Indigenous Australians in 2015 was four times the rate for non-Indigenous Australians. However, the rate of disease burden among Indigenous Australians decreased by 41 per cent between 2005 and 2015, and the gap in burden between Indigenous and non-Indigenous Australians narrowed.

CHRIS JOHNSON



AMA President Dr Tony Bartone recently attended the World Medical Association General Assembly in Tbilisi, Georgia. He is pictured here with Professor Robert Twycross from Oxford University. Reports from the WMA forum can be found in the World pages of *Australian Medicine*.

More medical groups join the AMA on informed financial consent

The Royal Australasian College of Surgeons (RACS) and the Urological Society of Australia and New Zealand (USANZ) have partnered with the AMA and 13 other leading medical organisations to provide patients with more information about medical fees for their procedures.

RACS and USANZ have signed up to the *Informed Financial Consent: A Collaboration Between Doctors and Patients* guide, which was launched by Health Minister Greg Hunt and the AMA in July.

The guide empowers patients with important information to help them understand medical costs and gives them confidence to discuss and question fees with their doctors.

AMA President Dr Tony Bartone said the addition of RACS and USANZ as partners to promote the guide to their members and patients sends a very strong signal that the whole medical profession is committed to greater transparency on medical fees and the cost of quality medical care and treatment.

"The Informed Financial Consent (IFC) guide is a major step in building health financial literacy for patients," Dr Bartone said.

"It provides people with clear, easy-to-understand information to help them navigate the health system.

"It will significantly help patients in their conversations with doctors and practice managers about fees for their medical procedures.

"The whole IFC process will provide information that will give patients and their families greater comfort and security as they go into surgery or treatment.

"Treatment should not be delayed or disrupted by any uncertainty or misinformation about the costs ahead. Informed financial consent allows patients to focus on the preparation for their procedure and make the best possible recovery."

RACS President Dr Tony Sparnon said RACS has been active in this area and is supportive of other key healthcare stakeholders to do the same.

"The responsibility for fee transparency is a shared one between patients, medical practitioners, and private health insurers alike. Initiatives such as this will help improve the communication between patient and doctor regarding costs and fees relating to a procedure," Dr Sparnon said.

USANZ President Dr Stephen Mark said USANZ supports transparency of medical costs and we believe no person should undergo financial distress to receive medical care.

"This guide provides patients a clearer picture by giving information to find out not just the surgeon's fee but also the health fund rebate," Dr Mark said.

The Informed Financial Consent (IFC) guide includes:

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

The AMA acknowledges the partnership, co-badging, and cooperation in the development and production of this guide from:

- Royal Australasian College of Surgeons (RACS);
- Urological Society of Australia and New Zealand (USANZ);
- Royal Australasian College of Physicians (RACP);
- Royal Australian College of General Practitioners (RACGP);
- Council of Procedural Specialists (COPS);
- Medical Surgical Assistants Society of Australia (MSA);
- Australian Society of Plastic Surgeons (ASPS);
- The Thoracic Society of Australia and New Zealand (TSANZ);
- General Surgeons Australia (GSA);
- Australian and New Zealand Society of Cardiac and Thoracic Surgeons (ANZSCTS);
- Australian Doctors Federation (ADF);
- National Association of Specialist Obstetricians and Gynaecologists (NASOG);
- National Association of Practising Psychiatrists (NAPP);
- Australian Society of Orthopaedic Surgeons (ASOS); and
- Australasian Sleep Association (ASA).

The AMA and these groups will promote and disseminate the guide through their memberships.

It will be available from doctors, medical practices, the AMA website, and the websites of other medical organisations.

MARIA HAWTHORNE

***Informed Financial Consent: A Collaboration Between Doctors and Patients* is available at https://ama.com.au/submission/informed-financial-consent-%E2%80%93-collaboration-between-doctors-and-patients**

Applications open for 2020 AMA Indigenous Medical Scholarship

Dr Bartone presents Ms Kastellorizios with her award.

Applications are now open for the 2020 AMA Indigenous Medical Scholarship, a program that that has supported Aboriginal and Torres Strait Islander students to study medicine since 1994.

The successful applicant will receive $10,000 each year for the duration of their course.

Previous recipients have gone on to become prominent leaders in health and medicine, including Associate Professor Kelvin Kong, Australia's first Aboriginal surgeon.

"Latest records show that there are fewer than 500 Indigenous doctors in the medical workforce, which is about 0.4 per cent of the workforce," AMA President Dr Tony Bartone said.

"To reach population parity of 3 per cent, the number should be closer to 3,500. As at July 2019, it is estimated that 310 Aboriginal and Torres Strait Islander medical students were enrolled in universities across Australia.

"We know that Indigenous people have a greater chance of improved health outcomes when they are treated by Indigenous doctors and health professionals. "They are more likely to make and keep appointments when they are confident that they will be treated by someone who understands their culture, their language, and their unique circumstances.

"Closing the disgraceful gap in life expectancy and health outcomes between Indigenous and non-Indigenous Australians requires real action from all levels of Government, the private and corporate sectors, and all segments of our community.

"This Scholarship is a tangible step towards addressing the shortage of Indigenous doctors."

The 2019 recipient, Ms Nikki Kastellorizios, a second-year medical student in the Flinders University NT Medical Program in Darwin, said that winning the scholarship had changed her life.

"I have three boys, aged five, four, and two. This will help me balance my time, and the money of course will make a big difference," Ms Kastellorizios said.

"Time is something very precious to every medical student, and it is also very precious to every parent."

Applications close on January 31, 2020. Applicants must be currently enrolled at an Australian medical school, have successfully completed their first year of medicine, and be of Aboriginal and/or Torres Strait Islander background.

Further information, including the application form, is at: <https://ama.com.au/indigenous-medical-scholarship-2020>

The AMA Indigenous Medical Scholarship was established in 1994 with a contribution from the Commonwealth Government. The AMA is seeking further donations and sponsorships from individuals and corporations to continue this important contribution to Indigenous health.

Anyone interested in making a contribution can visit: <https://indigenousscholarship.ama.com.au/donate>
For enquiries, contact indigenousscholarship@ama.com.au or (02) 6270 5400.

Having the means and the heart to help others

One very generous and community minded philanthropist who has, among other things, sponsored the AMA Indigenous Medical Scholarship, agreed to tell *Australian Medicine* some of her story. She asked to be referred to by her first name only.

Philanthropy is a noble thing. Giving back to the community through significant financial donations for the welfare of others is something to be greatly admired. Not everyone who has the means will think of others and the greater good in such a generous way. For those who do, the plethora of worthy causes can make it difficult to know where to focus the goodwill and kindness.

Ann from Melbourne has found a focus that she believes is more than simply a worthy cause – it is a national necessity. Her aim is for sustainable change, not band aid solutions.

Ann has been generously and very thoughtfully directing her philanthropic efforts towards Indigenous health and Indigenous education. This has been nowhere more emphasised than with her sponsorship of the AMA Indigenous Medical Scholarship, which aims for the betterment of both the education and the health of Indigenous Australians.

The 2019 scholarship, presented to Darwin student Nikki Kastellorizios, was awarded through Ann's sub-fund of the Australian Communities Foundation.

Not only has Ann funded one year of Nikki's degree with $10,000, but plans to continue to support her through each year left of her studies.

"I recently met her on a trip I did to the Northern Territory. We met over breakfast and she told me a bit more about herself," Ann said.

"She told me how she is using the money, some of which will be used for childcare, some for medical apps and how this has taken some pressure off her while she is studying. I believe her to be a very worthy recipient of the scholarship; she certainly has her priorities right and is a level-headed person. I was pleased to see how the scholarship money had already had an impact for good on her life and her studies and how she wants to give back to her community as an Indigenous doctor."

Something of major concern to Ann is the prevalence of trachoma in Australia; that Australia should be the only developed country in the world still to have this preventable infectious eye disease which can lead to blindness is a national disgrace. Support has been given and it is ongoing to Professor Hugh Taylor AC who heads the Indigenous Health Unit at the University of Melbourne and good progress is being made towards reducing the incidence of trachoma among the Indigenous population.

About five years ago, Ann was involved in the establishment of the Melbourne Indigenous Transition School. The students, 11 girls and 11 boys, mainly from the Northern Territory but also from around Bairnsdale in Victoria, come to MITS for one year. These students are studying to bring them up to year 7 level. After this one year, they move into partner schools, mainly private, in Melbourne, although a few decide to continue their education closer to home.

She is also funding a scholarship for an Indigenous girl at University College, University of Melbourne, which began in 2015. So far, these students have been pursuing an Arts Degree, studying Indigenous subjects, but it is likely that her scholar for 2020 will be heading towards medicine.

She is currently negotiating with Orygen, the National Centre of Excellence in Youth Mental Health headed by Professor Patrick McGorry AO, for three Indigenous students to study for their PhDs in mental health, with an Indigenous supervisor, and this is likely to begin in January 2020.

Having the means and the heart to help others

...continued from p14

"I grew up in Melbourne and had no siblings. I went to school and university here," Ann said. Then I had a 40-year career as a librarian, mainly at La Trobe University. In retirement, I did some volunteer work, with Vision Australia and I selected gardens for what was then Australia's Open Garden Scheme. I also did a couple of subjects in the philanthropy course at Swinburne University.

"From there I set up a sub-fund with the Australian Communities Foundation, about 12 or 13 years ago. For the past six years I have had my own Foundation, which has funded some of the above."

She recently refocused her philanthropy from a few other areas to concentrate for the most part on supporting Indigenous Australians. This resolve was strengthened by a recent visit to Darwin and Alice Springs in the Northern Territory and Broome and Derby in Western Australia, seeing firsthand the great need in the Indigenous communities there.

Her work in that area has also been motivated by seeing inspiring Indigenous leaders and speakers encouraging emerging generations.

"I do believe there is great need within the Indigenous population in Australia," Ann said.

"It is important to me that we get on with it."

Asked why she has devoted so much of herself to philanthropy, Ann's answer is direct.

"It came from being conscious of having the wherewithal and the many needs for support and social change in the community" she said.

"It's very simple."

CHRIS JOHNSON

She made the world a better place

Dr Barbara Ann Bauert

AMA members, the broader medical profession, the Northern Territory community, her family, friends and family, her patients, and everybody touched by her kindness and generosity were saddened by the recent death of Dr Barbara Ann Bauert.

Dr Bauert was a former Vice President and multiple office holder of AMA NT. She also served on the AMA Federal Council and attended numerous AMA National Conferences representing Salaried Doctors.

Dr Bauert had a rich and rewarding life and made a huge contribution to medicine and the broader community, in the Territory and nationally. She made the world a better place.

Her life is encapsulated in the following eulogy, which was delivered at Barbara's October funeral in Darwin by Dr Ann-Maree Berrill, a close friend and colleague dating back to their medical school days.

I first met Barb in 1973, the second year of the six-year University of Queensland Bachelor of Medicine, Bachelor of Surgery Degree. She had been enrolled in a Bachelor of Science Degree, which she was completing part-time whilst working at the Queensland Museum, and her outstanding results from her Science studies allowed her direct entry into second year Med.

Barb excelled in all her studies and from an early stage showed a particular interest in Social and Preventative Medicine.

Following graduation in 1977, Barb was one of 5 class members who accepted Resident Medical Officer positions in Darwin. She arrived in Darwin on 27 December 1977 and began work at the Darwin Hospital in Smith Street the next day.

Barbara rotated through all clinical areas, before developing a real interest in Obstetrics and Gynaecology.

In 1980, Barb was the first Obstetric Registrar to work in Royal Darwin Hospital.

For the following three years, Barb worked as a Registrar in Anaesthetics in New Plymouth in New Zealand and then at the Mater Hospital in Brisbane.

Barb then returned to the NT and accepted a position as Senior Registrar in Obstetrics and Gynaecology.

In 1984, Barb was awarded the Diploma in Obstetrics from the Royal Australian and New Zealand College of Obstetrics and Gynaecology.

She made the world a better place ...continued from p16

Barb became one of the first doctors to use Ultrasonography to assess the gestation of Aboriginal women. Her work was instrumental in improving the outcome for women and their babies, particularly those from remote communities.

Her passion for Public Health continued and she was awarded a Fellowship in the Australian Faculty of Public Health Medicine of the Royal Australasian College of Physicians.

Her dedication to training of Public Health Physicians continued throughout her career and as recently as the week before her death she was actively advocating for improved resources in this area.

Barb was appointed the Director of Medical Education at the Royal Darwin Hospital in the year 2000 and continued in this role for the next 18 years.

During this time, she continued her Public Health advocacy through her involvement with the Australian Medical Association.

Barb's commitment, particularly to Aboriginal health, has been recognised nationwide.

In 2008, Barbara was admitted to the Roll of Fellows of the Australian Medical Association. Her citation reads: "Dr Barbara Bauert has been actively involved with the AMA both locally and at a national level. During that period, she has taken on leadership roles including several terms as the Territory's Vice President and Secretary, as well as representation on national committees. Dr Bauert's work has benefitted a large number of doctors, most particularly those working in rural and remote areas across the Northern Territory. She was instrumental in establishing effective Aboriginal Interpreter Services in the Northern Territory Hospitals."

In 2011, Barbara was the winner of the AMA Women in Medicine Award for her passion and dedication to improving the quality of services for doctors and patients in the Northern Territory. The Women in Medicine Award is made to an individual who has made an outstanding contribution to the medical profession. Her citation reads:

"Dr Barbara Bauert has advocated for doctors and their patients in remote areas of the Northern Territory for several decades. She is a respected member of her local community, representing them in discussions with the Northern Territory Government to increase recruitment and retention of doctors in remote areas. Nationally, her input into the debate on improving outcomes for Indigenous Australians and closing the life expectancy gap has been highly regarded. Dr Bauert was instrumental in establishing effective Indigenous Interpreter Services in Northern Territory Hospitals. Because of her persistence, passion, and dedication, more than 80,000 Northern Territory Indigenous Australians from over 65 different language groups now have access to improved communication services with their health care providers. Many Australians have enjoyed the benefits of Dr Bauert's rich source of knowledge and continuing advocacy for better health services."

Over recent years, Barb had devoted most of her energy and dedication to mentoring and supporting Junior doctors and medical students in the Northern Territory Medical Program.

In conclusion, I shall quote Professor John Wakerman, Professor of Remote and Rural Health Services Research. He says: "I was greatly saddened by the news of Barb's death. I am very grateful to have had the opportunity to work with Barb for several years in the NT Medical Program. I very much appreciated her sage advice, based on a deep understanding of local issues. I also appreciated her no-nonsense approach. It was a privilege to work with someone with such huge reserves of compassion and kindness, from which so many of the students benefitted in the early, sometimes difficult years of the NTMP. Many people in our sector owe her a huge debt of gratitude."

Vale Barb, you were a remarkable Doctor

Health experts right in calling for stronger air pollution standards

BY ASSOCIATE PROFESSOR VICKI KOTSIRILOS AM

Leading health groups across Australia have united to call for stronger national air pollution standards to limit dangerous pollutants that include nitrogen dioxide (NO2), sulfur dioxide (SO2) and ozone (O3), to save lives and reduce illness.

The health groups involved in the joint position statement include Doctors for the Environment Australia (DEA), the Royal Australasian College of Physicians, the Lung Foundation of Australia, the Thoracic Society of Australia and New Zealand, the Lung Health Research Centre and the Climate and Health Alliance.

The call comes in response to the long-awaited revision of Australia's ambient air quality standards, known as National Environment Protection Measures (NEPM), which will be finalised by the end of 2019.

Australian medical practitioners are concerned with the negative impacts of air pollution on human health. Air pollution in Australia is attributed to more than 3,000 premature and preventable deaths per year, as well as poor lung and cognitive development in children, asthma, heart disease, lung disease and cancer, especially when living in close proximity to a major source of pollution.

Many people who live, work or attend schools near major roadways are exposed to higher levels of pollutants, not only SO2, NO2 and O3, but also other air pollutants such as particulate matters PM2.5 and PM10, carbon monoxide, diesel particulates and volatile organic compounds. When combined, all these pollutants impact human health and potentially affect every organ in the body. In line with international studies, Australian research demonstrates there is no safe level of air pollutants; even well below the threshold standards.

Australia's air quality standards that were set in 1998 do not meet international best practice and lag behind developed countries such as the US and those in the EU. The purpose of the NEPM is to minimise the risk of adverse health impacts from exposure to air pollutants and needs to be based on up-to-date research.

Health experts right in calling for stronger air pollution ...continued from p18

Coal-fired power stations and motor vehicles are the main sources of sulfur and nitrogen dioxide respectively in Australia. Diesel powered vehicles emit higher amounts of nitrogen dioxide compared to petrol vehicles.

There are a number of EPA monitors to measure ambient levels of these pollutants in major cities in Australia, but hot spots, such as along or near major roads and industry are often excluded from monitoring. Roadside exposure can be many times higher than urban background, especially for NO2. In urban areas, vehicle emissions contribute up to 80 per cent of nitrogen dioxide emissions.

Over the last 10 years, the prevalence of asthma increased in the Australian population from 9.9 per cent in 2007-08 to 11.2 per cent in 2017-18. Australia's current annual NO2 standard is set at the upper limit of 30 ppb. Recent research by the Australian Child Health and Air Pollution Study (ACHAPS) of children (7-11 years) across 12 Australian cities found small increases in NO2 exposure are significantly associated with increased risk of asthma and reduced lung function, with mean NO2 at exposure of 8.8 ppb.

Asthma is multifactorial, but recommendations to reduce the new annual standard of NO2 to 9 ppb in line with the science will have substantial benefits for children's health and help reduce asthma prevalence. A recent study in California found lowering NO2 levels by improving vehicle emissions can significantly reduce the incidence of asthma in children.

However, the levels proposed by the NEPC for NO2, SO2 and O3 do not go far enough to protect the health of the community.

Key recommendations in the joint position statement by Australia's health groups include:

- Adopting world's best NO2 standard of 9 ppb in line with current research.
- Adopting the World Health Organisation's one-day SO2 standard of 8 ppb. Australia's current one-day SO2 standard of 80 ppb is 10 times higher than the recommended WHO standard.
- Making air quality monitoring data publicly available through a coordinated national website, allowing access to real-time and historical data will help enforce State and Territory standards of the air pollutants.
- Vehicle emission control and electricity generation are areas of technological change where low or zero pollution options are rapidly entering the market. Strong pollution reduction policies based on good standards will assist Australia in reaching the best outcome during this period of change.
- Exposure to vehicle pollution is reduced by better vehicle emission standards, situating schools and childcare centres away from busy major roads, improving public transport, reducing the use of diesel fuel and by encouraging a shift to tighter Euro 6 vehicle emission standards, or electric or hybrid vehicles to reduce air pollution.
- Coal-fired power station pollution can be reduced by post-combustion treatment of flue gases, however, wind and solar-based electricity avoids air pollution completely.
- A network of NEPM air monitors should be expanded near hotspots such as major roads to closely monitor air pollutants and better enforce air quality standards to meet tighter guidelines.

So what can you do to help Australia meet these recommendations and reduce the health burden from air pollution? Write to your State and Federal Ministers of Environment calling on these recommendations. See the Doctors for the Environment Australia website for more details.

ASSOCIATE PROFESSOR VICKI KOTSIRILOS AM
MBBS, FACNEM, FASLM,
AWARDED HON. FELLOW RACGP
DEA MEMBER

The full regulatory impact statement can be found at:

https://www.epa.vic.gov.au/your-environment/air/review-of-national-ambient-air-quality-standards

Full joint statement of health experts:

https://www.dea.org.au/wp-content/uploads/2019/08/NOXSO203_Expert-Position-Statement_FINAL2.pdf

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

WITH CHRIS JOHNSON

Government's Indigenous health report shows some goals on track

The annual report card on the implementation plan for the *National Aboriginal and Torres Strait Islander Health Plan 2013 to 2023*, shows 12 of the 20 goals named are on track to be achieved within four years.

Eight goals are behind predicted figures or are currently unmeasurable.

But the Government says there is good progress being made in Indigenous Health.

The immunisation target for five-year-old children has been exceeded, with 97 per cent of Indigenous five-year-olds fully immunised, compared to 95 per cent of other children.

All three goals in the maternal health and parenting domain, plus the target for immunisation of two-year-olds, are on track to be achieved by 2023, while all goals related to smoking are expected to be accomplished by the Plan's completion.

Health Minister Greg Hunt has thanked the members of the Implementation Plan Advisory Group, the National Health Leadership Forum and other Aboriginal and Torres Strait Islander leaders, communities and stakeholders, for their involvement in the development of the Report Card.

"The IHRF is the first national research program led by Indigenous people at all levels, and conducted with close engagement with Indigenous communities," Mr Hunt said.

"We have set other clear goals to end avoidable Indigenous blindness by 2025, end avoidable Indigenous deafness, and eliminate rheumatic heart disease over the course of this decade.

"These are top priorities within the Morrison Government's new $160 million, 10-year Indigenous Health Research Fund (IHRF), funded through the Medical Research Future Fund."

Minister for Indigenous Australians, Ken Wyatt, welcomed the announcement, saying the progress was a result of strong collaboration between the Government and Australia's Indigenous community.

"Our focus is on practical outcomes and empowering local communities to have their say when it comes to the decision-making of Government," Mr Wyatt said.

"That's why we're working with Indigenous communities and governments throughout Australia to improve health outcomes and help close the gap through co-design."

Expansion of telehealth Medicare rebates

The Federal Government is investing $45.5 million in GP telehealth consultations to give more Australians in remote parts of the country better access to a doctor.

The funding spreads over three years from November 2019, with the aim of encouraging patients to maintain a strong relationship with their existing GP.

GPs will be able to conduct regular telehealth consultations with their patients in remote areas, with rebates available through the Medicare Benefits Schedule.

This expansion of Medicare rebates for telehealth is for patients in areas classified as Modified Monash Model 6 and 7, which encompasses remote parts of Western Australia, the Northern Territory, Queensland, New South Wales, Victoria, South Australia and Tasmania.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

Regional Services Minister Mark Coulton said the Government was determined to ensure Australians who live in remote areas are able to access world-class health services.

"These changes will be implemented through 12 new telehealth specific items being included on the MBS," Mr Coulton said.

"Expanding the range of services means that patients will get more access to health care."

To be eligible for subsidised telehealth consultations, patients are required to:

- Live in a Modified Monash Model 6 or 7 location;
- Have an existing clinical relationship with the GP providing the telehealth consultation (defined as three face-to-face consultations in the past 12 months); and
- Be at least 15 kilometres by road from the GP.

"A range of existing MBS telehealth arrangements are already in place, including extra telehealth support for people in drought-affected areas," Mr Coulton said.

"Medicare also supports specialists, consultation physicians and psychiatrists to conduct telehealth consultations with eligible patients in non-metropolitan areas.

"Another telehealth program enables psychologists, GPs, social workers and occupational therapists to provide mental health consultations under the Better Access initiative."

Mobile Medicare x-ray services begin

Changes to Medicare will now allow aged care residents to have x-rays without having to go to hospital.

From November 2019, a Medicare rebate will be available as a call-out fee for the provision of mobile skeletal x-ray services conducted at a residential aged care facility (RACF).

"These services include x-rays of the shoulder, pelvis, ribs and sternum; chest x-rays for suspected pneumonia or heart failure; and abdominal x-rays for acute abdomen or bowel obstruction," Health Minister Greg Hunt said.

Mobile Medicare x-ray services were recommended by the independent expert Medical Services Advisory Committee (MSAC).

Aged Care Minister Richard Colbeck said residents within a residential aged care facility who would otherwise need to be transferred to a hospital through an emergency department will get more timely diagnosis and treatment.

"This will significantly improve access to medical treatment for older Australians, and save on expensive costs, often including an ambulance, that come with transferring a resident from an aged care facility to a hospital," Senator Colbeck said.

The AMA lodged a submission to MSAC supporting this new item. The submission's main points to support this were:

- Transfers to hospital for imaging services are expensive, can be confusing/stressful for the patient and can increase risk of infection.

Health on the Hill

POLITICAL NEWS FROM THE NATION'S CAPITAL

- Many RACFs rely on family members/staff taking the resident to the imaging service. This can take up a lot of time.

The AMA argued that the item fee had to be financially viable for providers as many RACF services are bulk-billed.

Breast cancer MRI also added to Medicare

In another previously flagged change to rebates, Women with or suspected of having breast cancer can claim Medicare benefits for magnetic resonance imaging (MRI) scans.

Starting November 2019, Medicare rebates will be available for MRI scans for:

- Diagnosis of breast cancer in patients where other imaging was inconclusive and a biopsy has not been possible; and
- Pre-surgical planning for patients diagnosed with invasive breast cancer, where there is discrepancy between clinical assessment and conventional imaging assessment.

The new items for breast MRI should significantly reduce the out-of-pocket costs faced by breast cancer patients. The Government will provide $32.6 million for Medicare benefits for the services.

Senate reveals true number of new PBS listings

Senate estimates has revealed that only 227 new medicines have been listed on the Pharmaceutical Benefits Scheme since the Coalition came to office in 2013, despite Health Minister Greg Hunt claiming 2,200 listings have been made.

Under questioning from Labor, Health Department officials confirmed that 1,354 listings were at no cost to the Government and of them, 316 were just price changes to existing subsidised medicines. Only 227 could be properly claimed as new medicines being listed, the Department confirmed. A new listing is when patients can get subsidised access to a medicine they previously were not able to.

Another 80 medicines recommend by the Pharmaceutical Benefits Advisory Committee remain unlisted.

Shadow Health Minister Chris Bowen subsequently said the Health Minister was patting himself on the back for PBS listings, but the actual figure of true new listings was 10 per cent of what the Government is claiming.

"All they've got is spin about medicines in the Pharmaceutical Benefits Scheme," Mr Bowen said.

"Well if Greg Hunt wants to claim credit for listings, he'll also be held to account for non listings."

Funding continues for youth cancer

Youth cancer services have received a boost with an extra $22 million over four years from federal funding committed to CanTeen.

The Federal Government marked the 25th National Bandanna Day to announce the investment and said about 6,300 young people living with cancer are expected to benefit from CanTeen's Youth Cancer Services (YCS) program due to the continued investment.

In the four years to 2014, 4,843 new cases of cancer were diagnosed in young Australians aged 15 to 24, an average of more than two people per day.

Health Minster Greg Hunt said no young person deserves to go through cancer, and so the Government is proud to continue its support for the YCS program.

"The program is tailored to meet young people's unique health, social and emotional needs," Mr Hunt said.

"It helps young people with cancer access clinical trials and link to appropriate community based support services following their treatment."

The YCS program provides access to expert multidisciplinary teams which work together to plan and provide the best treatment, management and social and emotional support for a young person with cancer wherever they are.

There are five statewide YCS hubs based in major hospitals in Sydney, Melbourne, Brisbane, Perth and Adelaide, which work with a network of more than 25 hospitals and health services across Australia.

Research

WITH CHRIS JOHNSON

Fast food, slow testosterone

New research shows that fast food meals consumed by obese or overweight men have an immediate negative impact on testicular performance and testosterone production.

It is already known that obesity is associated with impaired testicular function, potentially resulting in androgen deficiency and sub-fertility.

But the latest research from Flinders University and UniSA has found that a high fat intake from fast food meals has a decisive negative effect on a man's serum testosterone levels.

An investigation into the impact of dietary fat on testicular endocrine function showed some alarming results. Researchers found the ingestion of a high-fat fast food mixed meal, which is a common practice for obese men, produced a 25 per cent fall in serum testosterone within an hour of eating, with levels remaining suppressed below fasting baseline for up to four hours.

While many facts are involved in the underlying cause of obesity-related male hypogonadism, this study suggests that the passage of fat through the intestinal tract elicits a response that indirectly elicits a post-prandial fall in testosterone.

The study only investigated the impact on overweight and obese men.

"The observed falls in serum testosterone (25 per cent decline from baseline, 2–3 nmol in absolute terms) are likely to be clinically significant for the obese or older man with low baseline levels of testosterone," Professor Kelton Tremellen from Flinders University said.

"These men are likely to be placed into a continuous hypogonadal state during waking hours if they frequently consume meals and snacks high in fat. This will clearly have an adverse impact on both their mental and physical wellbeing, plus possibly their fertility potential.

"Our results suggest that these men should minimise their fat intake and avoid inter-meal snacking in order to optimise testicular function."

Professor Tremellen undertook the research with UniSA's Dr Karma Pearce

Their paper – *Mechanistic insights into the aetiology of post-prandial decline in testosterone in reproductive-aged men* – by Kelton Tremellen, Amy Hill and Karma Pearce, has been published in *Andrologia* journal

Research

Unintended pregnancies study exposes high rate of ill-informed

Two-thirds of sexually active women who wished to delay or limit childbearing, stopped using contraception for fear of side effects, health concerns, and underestimation of the likelihood of conception.

This led to one in four pregnancies being unintended, a new study conducted in 36 countries has found. The research was conducted by the World Health Organisation.

While unintended pregnancies do not necessarily equate to pregnancies that are unwanted, they may lead to a wide range of health risks for the mother and child, such as malnutrition, illness, abuse and neglect, and even death, WHO stated.

Unintended pregnancies can further lead to cycles of high fertility, as well as lower educational and employment potential, and poverty – challenges which can span generations.

The WHO study found 4,794 women who had an unintended pregnancy after they stopped using contraception. A total of 56 per cent of the women who became pregnant were not using a contraceptive method in the five years prior to conceiving. And 9.9 per cent of women with an unintended pregnancy indicated that the last method that they had used was a traditional method (e.g. withdrawal or calendar-based method); 31.2 per cent used a short-acting modern method (e.g. pills and condoms); and 2.6 per cent used long-acting reversible methods of contraception (e.g. intrauterine device (IUD) and implants).

The study's findings highlight the need for services that:

- take a shared decision-making approach to selecting and using effective methods of contraception that most fit the needs and preferences of clients;
- identify early when women and girls are having concerns about the method they are using; and
- enable women and girls to change modern methods while remaining protected through effective counselling and respect of their rights and dignity.

Modern methods of contraception have a vital role in preventing unintended pregnancies, WHO states. Studies show that 85 per cent of women who stopped using contraception became pregnant during the first year. Among women who experienced an unintended pregnancy leading to an abortion, half had discontinued their contraceptive methods due to issues related to use of the method such as health concerns, side effects or inconvenience of use.

Many such issues could be addressed through effective family planning counselling and support.

"High quality family planning offers a range of potential benefits that encompass not only improved maternal and child health, but also social and economic development, education, and women's empowerment," Dr Mari Nagai, former Medical Officer for Reproductive and Maternal Health at WHO's Western Pacific Regional Office, and an author of the report, said.

Unintended pregnancies remain an important public health issue. Globally, 74 million women living in low and middle-income countries have unintended pregnancies annually. This leads to 25 million unsafe abortions and 47,000 maternal deaths every year.

A related WHO study, recently published in the Philippines, found that only three per cent of women wanting to delay or limit childbearing received contraceptive counselling during their last visit for any reason to a health facility. Screening all women for family planning concerns could help prevent the large numbers of unintended pregnancies and unsafe abortions occurring in

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many countries in Asia. In the Philippines alone, it is estimated that there are almost two million unintended pregnancies each year and more than 600,000 unsafe abortions.

Without adequate counselling, improved quality of service, expansion of effective and acceptable contraceptive choices, and respect for the rights of all women and girls, the cycle will continue. Equity is also an important concern. The recent Philippines study showed that women with the least education who did not want to be pregnant were one-third as likely to use modern contraceptives as the most educated.

"Access to high-quality, affordable sexual and reproductive health services and information, including a full range of contraceptive methods, can play a vital role in building a healthier future for women and girls, as well as contributing to attainment of the Sustainable Development Goals," Dr Ian Askew, Director of the Department of Reproductive Health and Research at WHO, said.

Overcoming legal, policy, social, cultural and structural barriers will enable more people to benefit from effective contraceptive services, the report states.

Testing cost-effectiveness of Lynch syndrome and CRC risk

Lynch syndrome, a mutation of four genes involved in DNA repair, is associated with increased risk of developing a range of cancers, particularly colorectal cancer (CRC).

In the most comprehensive analysis for Australia to date, published online by the *Medical Journal of Australia*, an international team of researchers led by Professor Karen Canfell from the Cancer Council NSW, evaluated the health impact and cost-effectiveness of systematic testing of people with incident CRC for Lynch syndrome, with the aim of providing evidence that could inform a national Lynch syndrome testing policy.

"Our specific aims were to determine the most cost-effective Lynch syndrome testing strategy for people with incident CRC; and to estimate the health and economic impacts of limiting testing to specific CRC diagnosis age ranges and of different colonoscopic surveillance intervals for confirmed Lynch syndrome carriers," Professor Canfell and colleagues wrote.

The researchers modelled the cost of testing all patients diagnosed with CRC during 2017, with detailed modelling of outcomes for patients identified as Lynch syndrome carriers (probands) and their at-risk relatives throughout their lifetimes (censored at 100 years).

In Stage One, they examined eight testing strategies -- no testing (strategy 1); universal mismatch repair deficiency (dMMR) tumour testing (immunohistochemistry or microsatellite instability testing) with or without somatic *BRAF* V600E or *MLH1* promoter methylation testing, followed by germline gene panel testing for confirmation of Lynch syndrome (strategies 2–7); and universal germline gene panel testing (strategy 8).

In Stage Two, they investigated the impact of key parameters in an exploratory analysis of both the most cost-effective strategy in Stage One and the universal germline gene panel testing strategy.

In Stage Three, they investigated the effects of key parameters on the cost-effectiveness of the most cost-effective testing strategy identified in Stage One and the universal gene panel testing strategy.

In Stage One, the most cost-effective strategy was immunohistochemistry and reflex *BRAF* V600E testing followed by gene panel testing to confirm Lynch syndrome (strategy 3).

"It would require an additional 30,995 colonoscopies over the lifetimes of 2,420 Lynch syndrome carriers and would avert 189 CRC deaths (164 extra colonoscopies to avert one CRC death)," the researchers said.

The discounted costs for immunohistochemistry with *BRAF* V600E testing are $10 645 per Lynch syndrome proband identified and $7,044 including both proband and identified Lynch syndrome-positive relatives.

In Stage Two, the most cost-effective strategy was MMR immunohistochemistry and reflex *BRAF* V600E testing, with two-yearly colonoscopic surveillance of confirmed Lynch syndrome carriers.

"An additional 4778–15 860 colonoscopies would be required over the lifetimes of 2420 LS carriers, and 46–181 CRC deaths would be averted (88–103 extra colonoscopies per averted CRC death)," they wrote.

In the Stage Three, the parameter with the greatest influence

Research

on cost-effectiveness was the assumed impact of colonoscopic surveillance on CRC incidence; that is, colonoscopic surveillance down-stages diagnosed cancers but does not reduce the incidence.

"We found that all universal dMMR tumour testing strategies for people with incident CRC, without age limit and with annual colonoscopic surveillance of confirmed Lynch syndrome carriers, were similarly cost-effective (compared with no testing) at an indicative willingness-to-pay threshold of $30,000–$50,000/life years saved; the most cost-effective strategy was immunohistochemistry with reflex *BRAF* V600E testing," Professor Canfell and colleagues wrote.

"Universal dMMR tumour testing strategies could reduce the number of CRC deaths by 184–189 while increasing the number of colonoscopies by 30,597–31,084 over the lifetimes of 1,000 people with CRC and Lynch syndrome and 1,420 relatives confirmed to be Lynch syndrome carriers (164–166 additional colonoscopies per death averted).

"Universal gene panel testing is not yet cost-effective, but should be re-evaluated should its costs drop, as is expected," the researchers concluded.

Vitamin D best naturally

Research from Deakin University says most Australians do not need vitamin D added to food, because a couple of minutes in the sun each day is enough to keep vitamin D levels normal.

Vitamin D supplements can also lead to overdose.

Emeritus Professor Caryl Nowson, from Deakin's Institute for Physical Activity and Nutrition, said that in late spring and summer it is important to wear sunscreen during the day, but that it's just as vital to get enough vitamin D from its natural source – ultraviolet rays from the sun.

"For many people, the fix for not getting enough sunshine is a vitamin D supplement. While supplements have a place, it's for the minority of the population," Professor Nowson said.

"Supplements are only useful for those where the risk of vitamin D deficiency is high and low vitamin D status has been

identified with a blood test. It is preferable for the body to make natural vitamin D because, unlike with supplements, there is no possibility of an overdose.

"However, this is not possible for everyone. Frail elderly people or those who are in hospital or rehabilitation are at genuine risk of not getting enough ultraviolet rays from the sun. Also, people with naturally very dark skin, nightshift workers with limited sun exposure and breastfed babies of vitamin D deficient mothers are at the greatest risk of deficiency."

Research

Professor Nowson said those in the high-risk group taking supplements must ensure they stick to the prescribed daily amount.

"Vitamin D supplements are available in supermarkets and over the counter at chemists. There appears to be a view among the general population that vitamin D tablets are safe and you can't have too much, as the body will expel what it uses, but that's misguided," she said.

"Overdoses are caused by megadoses of supplements, not diet or sun exposure, and are toxic."

How much time the average person – free of deficiency – needs to spend in the sun to naturally make the hormone, depends on skin colour and their distance from the equator. People with darker skin need longer exposure to UV light to produce vitamin D.

"These requirements change with the seasons. In summer most people make enough vitamin D because UV levels are high and we spend more time outdoors. During these months, Victorians (for example) need just a few minutes of sun exposure mid-morning or mid-afternoon to get enough vitamin D," Professor Nowson said.

Longer stints of sunshine after a long winter and cold start to spring won't expedite vitamin D production and storage.

"People make the mistake of thinking they can spend more time in the sun to bring vitamin D levels back up quickly, but that's not the case," Professor Nowson said.

"The minute your skin starts to go a little pink, or red, your body stops making vitamin D. It's the body's natural way of preventing a vitamin D overdose. Vitamin D needs to be produced by the body, from sunshine, daily. It is a nutrient that is needed for health, particularly to maintain strong bones and teeth by helping the body to absorb calcium."

Too many Australians not getting CVD assessments

Fewer than one in five Australians aged 45 and over are having their cardiovascular disease risk assessed in line with guidelines, new research reveals.

The Heart Foundation is pushing for more eligible Australians to see their doctor for a Heart Health Check, as the new primary care data shows only about 17 per cent of adults 45 and over without CVD have had all the necessary CVD risk factors recorded as frequently as recommended.

Heart Foundation Risk Reduction Manager, Natalie Raffoul, said the results, drawn from an analysis of national Australian general practice MedicineInsight data, highlight the need to place a greater emphasis on absolute CVD risk assessment and the primary prevention of CVD.

"We looked at how often CVD risk factors are being assessed in more than 350,000 Australian patients aged 45 and over without heart disease and found too many are missing out on the vital checks needed for comprehensive CVD risk calculation," Ms Raffoul said.

"Assessing CVD risk in the primary prevention setting requires up-to-date blood pressure and cholesterol levels, yet close to half (46 per cent) of Australians 45 and over did not have a cholesterol recorded in the last five years, and a third didn't have a blood pressure recorded in the last two years."

According to the data, about 20 per cent of people 45 and over had their diabetes status checked through ordering of HbA1c tests in the last two years, but close to 80 per cent had their smoking status recorded.

"It's concerning to see that overall, fewer than one in five adults within this at-risk group had all four of the necessary risk factors recorded to enable absolute CVD risk calculation – blood pressure, cholesterol, diabetes and smoking status," Ms Raffoul said.

"Heart disease is Australia's leading single cause of death, so if you are 45 and over, or 30 and over if you are Aboriginal or Torres Strait Islander, the best chance of reducing your risk starts with seeing your GP for a Heart Health Check.

"The Medicare-funded Heart Health Check provides GPs and practice nurses with an opportunity to regularly assess and manage CVD risk factors within this population.

"Absolute CVD risk assessment is the most effective, evidence-based approach to guide decision making around initiating medicines and ensures that high-risk patients are getting the right support they need to lower their risk of CVD."

Research

More breast cancers detected with 3D mammography

A pilot trial of 3D mammography – tomosynthesis – has shown that breast cancer detection, recall for assessment, and screen reading time were each higher than for standard mammography.

But it is too soon to tell if more detection leads to better health outcomes for women, according to the authors of research published in the *Medical Journal of Australia*.

Researchers led by Professor Nehmat Houssami, Professor of Public Health at the University of Sydney, compared tomosynthesis (with synthesised 2D-images) and standard mammography screening of women attending Maroondah BreastScreen, a BreastScreen Victoria service in the eastern suburbs of Melbourne.

The participants were women at least 40 years of age who presented for routine breast screening between August 18, 2017 and November 8, 2018.

During the trial, 5,018 tomosynthesis and 5,166 standard mammography screens were undertaken in 10,146 women; 508 women (5.0 per cent of screens) opted not to undergo tomosynthesis screening. With tomosynthesis, 49 cancers (40 invasive, nine in situ) were detected; with standard mammography, 34 cancers (30 invasive, four in situ) were detected.

The estimated difference was 3.2 more detections per 1,000 screens with tomosynthesis; the difference was greater for repeat screens and for women aged 60 years or more. The recall rate was greater for tomosynthesis (4.2 per cent) than standard mammography (3.0 per cent). The median screen reading time for tomosynthesis was 67 seconds; for standard mammography, 16 seconds.

"We found that tomosynthesis screening was feasible to implement at BreastScreen Maroondah, with a low opt-out rate, and could increase the breast cancer detection rate," Professor Houssami and colleagues wrote.

"However, it also had disadvantages, such as longer screen reading times, that need to be considered when making decisions about larger trials of tomosynthesis screening or screening policy.

"More frequent cancer detection by tomosynthesis screening than in standard 2D mammography could indicate that it is more sensitive than standard mammography, but if it reflects increased detection of indolent malignancy it may not be associated with improved health outcomes.

"The increased radiation exposure associated with tomosynthesis ... also needs careful consideration before adopting it for routine screening.

"The imaging data and information infrastructure (including image display and archiving) is another important aspect; careful planning enabled modifications that supported implementation of tomosynthesis in this pilot trial, but substantial changes would be needed to facilitate its use in a high volume population screening program, and would be subject to a thorough health economics evaluation.

"Our trial provides findings that could be further examined in larger, multi-service comparisons of tomosynthesis with standard mammography for breast screening, including longer term endpoints (such as interval cancer rates) that were beyond the scope of our pilot study.

"The balance between the incremental benefit and harms of this new technology must be carefully assessed to ensure that BreastScreen provides the most effective form of screening to Australian women."

World News

WITH CHRIS JOHNSON

World Medical Association urges doctor action on climate change

The World Medical Association has urged doctors around the world to lobby their respective governments to deliver carbon neutrality by 2030.

Acknowledging that climate change has the potential for life-threatening impacts on health, the WMA has urged physicians to raise their voices in a bid to limit those impacts.

At its 70th General Assembly in Tbilisi, Georgia, the WMA passed a climate emergency resolution insisting that doctors have an important role to play in advocating for the health of people across the globe.

The resolution declared: "The WMA and its constituent members and the international health community must acknowledge the environmental footprint of the global healthcare sector, and act to reduce waste and prevent pollution to ensure healthcare sustainability."

Delegates overwhelmingly voted for the resolution.

WMA President Dr Miguel Jorge said physicians have a responsibility to demand greater action on climate change.

The recent United Nations summit on climate action, he said, demonstrated the growing recognition that climate change action must be accelerated.

"We are now calling on physicians around the world to mobilise for accelerated action. We, the WMA, are in a unique position as the voice of doctors to ensure that the health effects from climate change are not neglected," Dr Jorge said.

"We have a duty as physicians to warn the world that climate change will lead to thousands of extra deaths from malnutrition, malaria, diarrhoea and heat stroke."

The resolution adopted by the WMA General Assembly states:

Health professionals have an important role in advocating to protect the health of citizens around the world, and therefore have a responsibility to demand greater action on climate change.

The UN summit on climate action that took place in September 2019 further demonstrated the growing recognition that climate change action must be accelerated, with many countries making commitments to achieving net zero emissions by 2050 and others committing to boost national action plans by 2020.

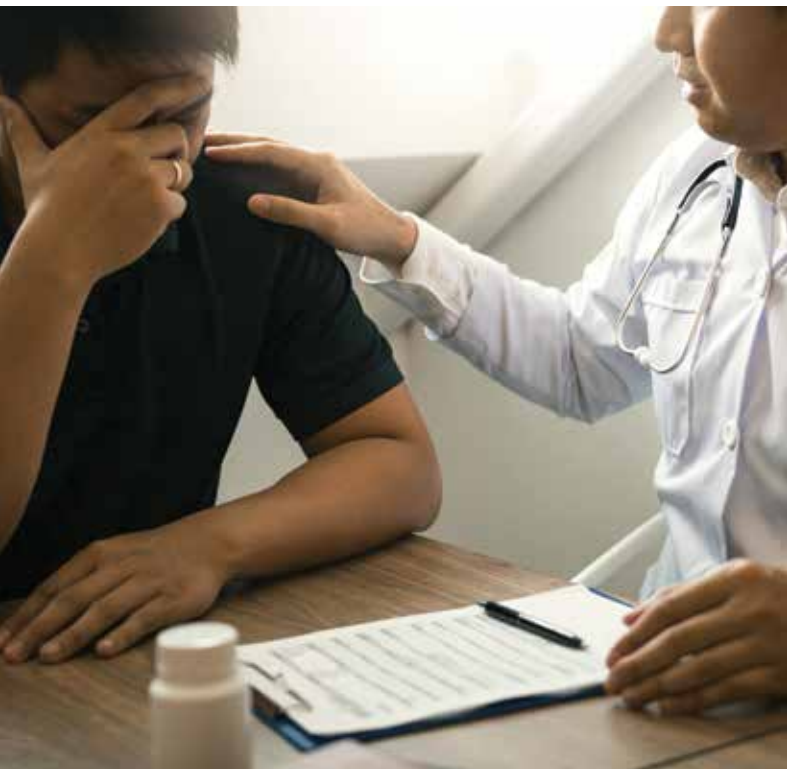
There is emerging consensus within the medical profession globally that action on climate change must be accelerated.

The WMA and its constituent members and the international health community:

- *declare a climate emergency and call the international health community to join their mobilisation;*
- *commit to advocate to protect the health of citizens across the globe in relation to climate change;*
- *urge national government to rapidly work to deliver carbon neutrality by 2030, so as to minimise the life-threatening impacts of climate change on health;*
- *must acknowledge the environmental footprint of the global healthcare sector, and act to reduce waste and prevent pollution to ensure healthcare sustainability.*

World News

New WMA President urges empathy



Doctors must not forget the emotional needs of their patients and should never lose sight of the fact that the reason they first wanted to be physicians was to help people.

That was the message from World Medical Association President Dr Miguel Jorge in his inaugural speech to the Association's General Assembly, which gathered at Tbilisi, Georgia in late October.

The new WMA President said medical students and physicians are becoming so exposed to the science of medicine that they are forgetting the emotional needs of their patients.

He said most students entering medical school did so because they said they wanted to help people who were suffering. But studies showed that when they left medical school, they were usually less sensitive to the patient's needs than when they started.

"What happened in between? One possible reason is that students, during their medical education, are more and more exposed to the biological nature of illnesses than to the social environment surrounding their patients and the development of diseases," Dr Jorge said.

"They also are not adequately taught to take into consideration the emotional aspects of those they are assisting."

Dr Jorge is also the Director of the Brazilian Medical Association and Associate Professor of Psychiatry at the Federal University of São Paulo. He reminded delegates at the General Assembly that a good physician needs to be able to put him or herself in the place of their patients, trying to feel as they feel, in order to better understand their needs.

"In medical care, it is as essential to have empathy as it is to be able to examine the patient from the outside," he said.

"We all hear that medicine is both science and art but, in the last few decades, the practice of medicine is more and more reflecting an emphasis just on its scientific nature.

"A competent physician is not a good mechanic of the human body, but someone who equally combines technical excellency with being close to their patients, respecting their dignity, and showing them empathy and compassion."

Physicians had to learn how to use the new tools provided by the progress of medical science and developments such as social media to improve the physician-patient relationship and not allow themselves to move away from communicating with their patients, he said.

Physicians working under difficult circumstances often cannot do what they consider to be the best for their patients due to the scarcity of resources. But Dr Jorge emphasised that they can accomplish at least partially their mission if they give a little more time and show empathy and attention to their patients.

World News

Physician-assisted suicide remains opposed by world doctors

The World Medical Association has reaffirmed its long-standing policy of opposition to euthanasia and physician-assisted suicide.

After an intensive process of consultation with physicians and non-physicians around the world, the WMA at its annual Assembly in Tbilisi, Georgia, adopted a revised Declaration on Euthanasia and Physician-Assisted Suicide.

This Declaration states: "The WMA reiterates its strong commitment to the principles of medical ethics and that utmost respect has to be maintained for human life. Therefore, the WMA is firmly opposed to euthanasia and physician-assisted suicide."

The revised Declaration defines euthanasia as: "a physician deliberately administering a lethal substance or carrying out an intervention to cause the death of a patient with decision-making capacity at the patient's own voluntary request."

It adds: "No physician should be forced to participate in euthanasia or assisted suicide, nor should any physician be obliged to make referral decisions to this end."

The Declaration also says: "Separately, the physician who respects the basic right of the patient to decline medical treatment does not act unethically in forgoing or withholding unwanted care, even if respecting such a wish results in the death of the patient."

It says that physician-assisted suicide: "refers to cases in which, at the voluntary request of a patient with decision-making capacity, a physician deliberately enables a patient to end his or her own life by prescribing or providing medical substances with the intent to bring about death."

WMA Chair Dr Frank Ulrich Montgomery said: "Having held consultative conferences involving every continent in the world, we believe that this revised wording is in accord with the views of most physicians worldwide."

Asbestos link to popular powder sparks US recall

Popular brand Johnson & Johnson's Baby Powder has been removed from major US retailers due to possible asbestos contamination.

The company voluntarily recalled about 33,000 22-ounce bottles of baby powder across America only, following trace amounts of asbestos samples being found in a bottle bought online.

The contamination was found by US health regulators. A month earlier, however, the US Food and Drug Administration found no asbestos in the J&J talcum powder.

Johnson & Johnson is already facing thousands of lawsuits over health and consumer concerns connected to a range of its products

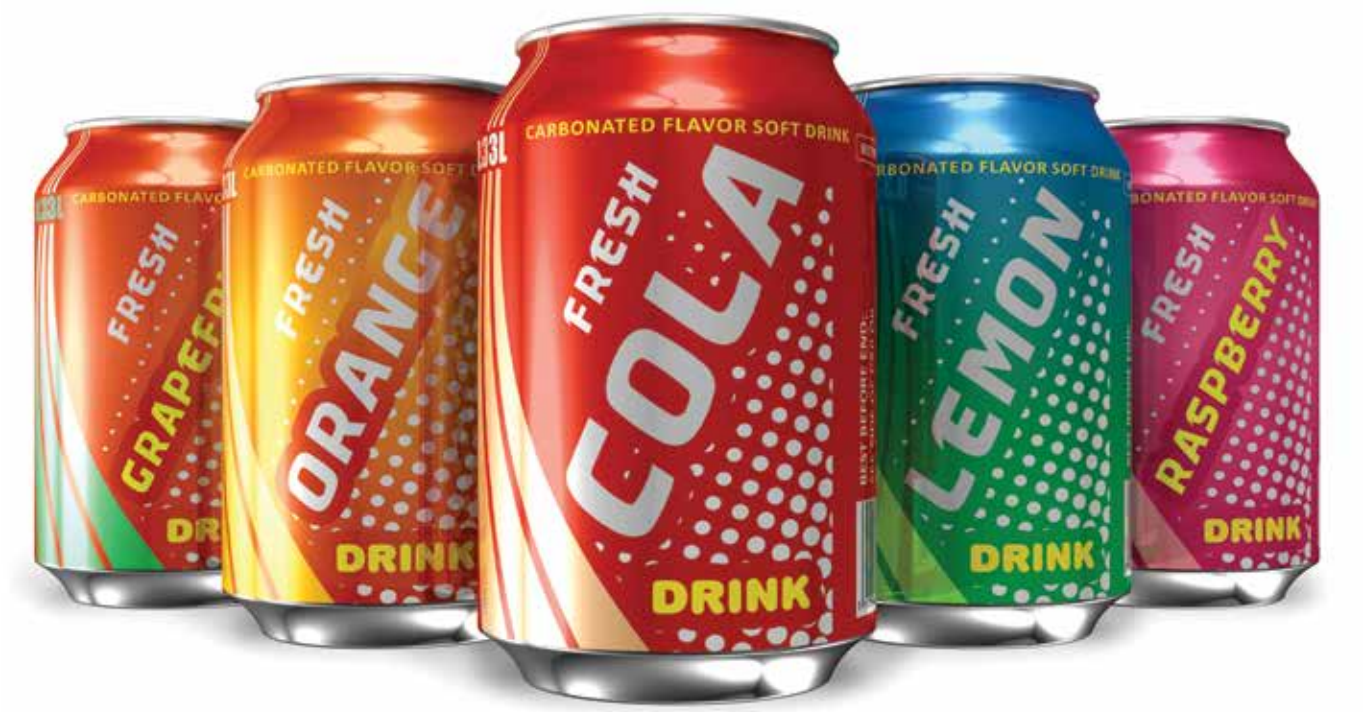
This recall is the first time, however, that the hugely recognisable and widely used Baby Powder has been recalled for possible asbestos contamination.

A Johnson & Johnson spokesman said the removal by retailers was temporary and a cautionary move.

Asbestos is a carcinogen linked to mesothelioma.

World News

All Governments should introduce sugar taxes, WMA



Support for a sugar tax in the interests of health has come from the World Medical Association.

In a new policy statement, the WMA has called on all national governments to reduce the affordability of added sugar and sugar-sweetened beverages through a tax on sugar. The tax revenue collected should then be used for health promotion programs aimed at reducing obesity and non-communicable diseases.

The WMA wants to see a reduction in sugar consumption, compulsory labelling of sugar products by food manufacturers and strict regulation of advertising targeted at children.

"We want all governments to restrict the availability of sugar-sweetened beverages and products that are highly concentrated with free sugar from educational and healthcare institutions and replace them with healthier alternatives," WMA President Dr Miguel Jorge said.

"And we want all national medical Associations to advocate for healthy sustainable food with limited free sugar intake that is less than five per cent of total energy intake. That is around six teaspoons a day.

"We believe it is time for much tougher action by governments and we hope that the WMA's new policy guidelines will bring this about."

Adopted by the 70th WMA General Assembly, Tbilisi, Georgia, October 2019

PREAMBLE

1. Non-communicable diseases (NCDs) are the leading causes of death worldwide. Every year 40 million people die from NCDs. The most common causes of these diseases are poorly balanced diet and physical inactivity. A high level of free sugar consumption has been associated with NCDs because of its association with obesity and poor dietary quality.

World News

2. According to the World Health Organisation (WHO), free sugar intake that is sugar that is added to foods and beverages by the manufacturer, cook or consumer that results in excess energy intake which in turn may lead to parallel changes in body weight.

3 WHO defines free sugar as 'all sugars that are added during food manufacturing and preparation as well as sugars that are naturally present in honey, syrups, fruit juices, and fruit concentrates.'

4 Sugar has become widely available and its global consumption has grown from about 130 to 178 million tonnes over the last decade.

5. Excess free sugar intake, particularly in the form of sugar-sweetened beverages, threatens the nutrient quality of the diet by contributing to the overall energy density but without adding specific nutrients. This can lead to unhealthy weight gain and increases the risk of dental disease, obesity and NCDs. Sugar-sweetened beverages are defined as all types of beverages containing free sugars (include monosaccharides and disaccharide) including soft drinks, fruit/vegetables juices and drinks, liquid and powder concentrates, flavored water, energy and sports drinks, ready-to-drink tea, ready-to-drink coffee and flavored milk drinks.

6. WHO recommends reducing sugar intake to a level that comprises five per cent of total energy intake (that is around six teaspoons per day) and not to exceed 10 per cent of total energy intake.

7. The price elasticity of sugar-sweetened beverages according to a meta-analysis published in USA, is -1.21. This means that for each 10 per cent increase in the price of sugar-sweetened beverages, there is a -12.1 per cent decrease in consumption. Successful examples of price elasticity were seen in Mexico as the consumption of sugar-sweetened beverages decreased after imposing the sugar tax.

8. Data and experience from across the world demonstrate that a tax on sugar works best as part of a comprehensive set of interventions to address obesity and related chronic diseases. Such interventions include food advertising regulations, food labelling, educational campaigns, and subsidy on healthy foods.

Recommendations

9. The World Medical Association (WMA) and its constituent members should:

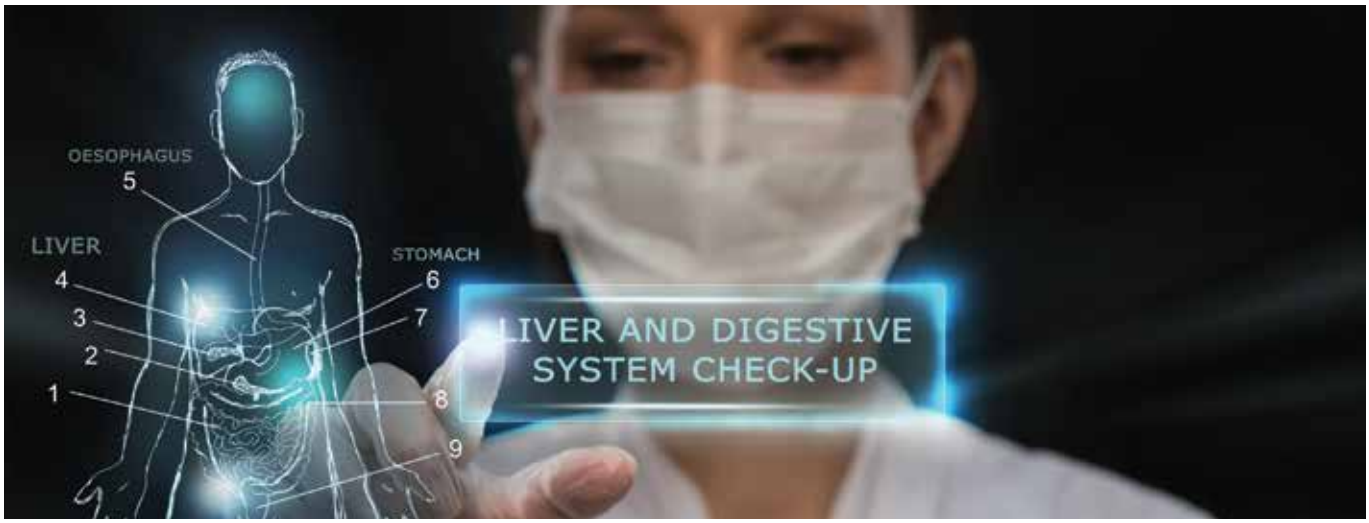
- Call upon the national governments to reduce the affordability of free sugar and sugar-sweetened beverages through sugar taxation. The tax revenue collected should be used for health promotion and public health preventive programs aimed at reducing obesity and NCDs in their countries;
- Encourage food manufacturers to clearly label sugar, if present, in their products and urge governments to mandate such labeling;
- Urge governments to strictly regulate the advertising of sugar containing food and beverages targeted especially at children;
- Urge national governments to restrict availability of sugar-sweetened beverages and products that are highly concentrated with free sugar from educational and healthcare institutions and replace with healthier alternatives.

10. Constituent members of the WMA and their physician members should work with national stakeholders to:

- Advocate for healthy sustainable food with limited free sugar intake that is less than five per cent of total energy intake;
- Encourage nutrition education and skills programs toward preparing healthy meals from foods without added sugar;
- Initiate and/or support campaigns focused on healthy diets to reduce sugars intake.
- Advocate for an inter-sectoral, multidisciplinary and comprehensive approach to reducing free sugar intake.

World News

World focus on digital health pathways



The World Health Organisation is convening global experts to help shape the its roadmap to advance the digital health ecosystem.

The WHO Digital Health Technical Advisory Group met for the first time recently to discuss topics ranging from data governance, to ethical and equitable use of digital technologies, to helping communities benefit from proven and cost-effective digital health solutions.

"All governments are facing increasing demands to provide health services to their citizens, and many digital technologies offer solutions to help meet these needs," WHO Director-General Dr Tedros Adhanom Ghebreyesus said.

"But countries require confidence in what works. The action plan agreed today focuses our efforts on helping the world benefit from digital health technologies and solutions while safeguarding the misuse of people's data and protecting their health."

The two-day meeting at WHO's headquarters in Geneva led to an agreed action plan to focus the expert group's activities and priorities over the next two years. Meeting focused on better defining WHO's role in supporting global digital transformation. Topics included:

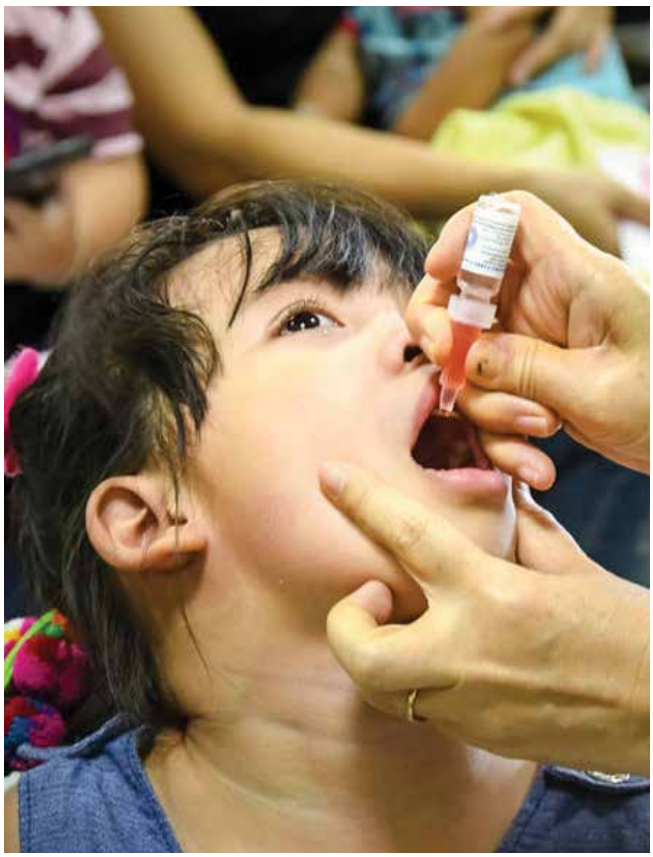
- Developing a global framework for WHO to validate, implement and scale up digital health technology and solutions.
- Recommendations for safe and ethical use of digital technologies to strengthen national health systems by improving quality and coverage of care, increasing access to health information.
- Advice on advocacy and partnership models to accelerate use of digital health capabilities in countries to achieve better health outcomes.
- Advice on emerging digital health technologies with global reach and impact, so no one is left behind.

Technical advisory group members will meet regularly over the coming year to implement their work plan in support of WHO's digital health agenda.

Representing the public, private and social sectors, the experts will provide insights, guidance, feedback, and new opportunities for WHO as it helps drive digital health transformation in countries and globally. Members come from a wide array of digital health fields, including artificial intelligence, virtual and augmented reality, biomedical innovation, robotic surgery, and wearable technologies; also represented are experts in health and wellness, ethics, governance, security, economics and law.

World News

Great news on polio eradication



An independent commission of international health experts has concluded that wild poliovirus type 3 (WPV3) has been eradicated worldwide.

Following the eradication of smallpox and wild poliovirus type 2, this news represents a historic achievement for humanity, the World Health Organisation says.

The news was announced on World Polio Day in October

There are three individual and immunologically-distinct wild poliovirus strains: wild poliovirus type 1 (WPV1), wild poliovirus type 2 (WPV2) and wild poliovirus type 3 (WPV3). Symptomatically, all three strains are identical, in that they cause irreversible paralysis or even death. But there are genetic and virologic differences which make these three strains three separate viruses that must each be eradicated individually.

WPV3 is the second strain of the poliovirus to be wiped out, following the certification of the eradication of WPV2 in 2015. The last case of WPV3 was detected in northern Nigeria in 2012. Since then, the strength and reach of the eradication program's global surveillance system has been critical to verify that this strain is truly gone. Investments in skilled workers, innovative tools and a global network of laboratories have helped determine that no WPV3 exists anywhere in the world, apart from specimens locked in secure containment.

At a celebration event at the headquarters of the World Health Organisation in Geneva, Switzerland, Professor David Salisbury, chair of the independent Global Commission for the Certification of Poliomyelitis Eradication said: "This this is a significant achievement that should reinvigorate the eradication process and provides motivation for the final step – the eradication of wild poliovirus type 1.

"This virus remains in circulation in just two countries: Afghanistan and Pakistan. We cannot stop our efforts now. We must eradicate all remaining strains of all polioviruses.

"We do have good news from Africa – no wild poliovirus type 1 has been detected anywhere on the continent since 2016 in the face of ever improving surveillance.

"Although the region is affected by circulating vaccine-derived polioviruses, which must urgently be stopped, it does appear as if the continent is free of all wild polioviruses, a tremendous achievement."

Eradicating WPV3 proves that a polio-free world is achievable. Key to success will be the ongoing commitment of the international development community. To this effect, as part of a Global Health Week in Abu Dhabi, United Arab Emirates, in November, the Reaching the Last Mile Forum will focus international attention on eradication of the world's deadliest diseases and provide an opportunity for world leaders and civil society organisations, notably Rotary International which is at the origin of this effort, to contribute to the last mile of polio eradication.

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AMA members requiring assistance can call AMA member services on **1300 133 655** or **memberservices@ama.com.au**

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doctorportal Learning: Access high quality, accredited medical education online. doctorportal Learning offers a free comprehensive CPD tracker for AMA members. www.dplearning.com.au

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

Fees & Services List: A free online resource for AMA members. The AMA list of Medical Services and Fees provides an important reference for those in medical practice to assist in determining their fees.

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Hertz: AMA members have access to discounted rates both in Australia and throughout international locations.

Hertz 24/7: NEW! Exclusive to the AMA. AMA members can take advantage of a $50 credit when renting with Hertz 24/7.

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