



AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

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- Surgical mesh problems cost millions in ACC claims
- The Myth of research and development costs of new drugs
- Overcharging women for cervical smears

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THE SOLUTION TO CHILD ABUSE IS A DATABASE

A significant proportion of the submissions on *The Green Paper for Vulnerable Children* emphasised the need to address poverty, unemployment, and low levels of educational achievement as part of dealing with the issues surrounding child health, neglect and abuse. Despite this, both the Summary of Submissions and *The White Paper for Vulnerable Children* downplayed the role that poverty and health inequalities play in the lives of New Zealand's disadvantaged and vulnerable children.

Paula Bennett's *White Paper* was released at the beginning of October and was judged by many of those who produced submissions on *The Green Paper* to be a disappointment because it lacked vision and was a patch up approach that targeted a small group of the nation's children, those deemed to be most at risk after their families' characteristics have been put through a new "predictive risk model." The children found to be most at risk will then be put on a new database.

Viki

So rather than doing something about what one commentator referred to as the urgent need for "a much more fundamental realignment of resources and effort," (1) New Zealand is going to get "Viki" – a national Vulnerable Kids Information System. This new database of 20,000 – 30,000 "vulnerable" children will be established following the extraction and combining of information on children from existing databases. By late 2014 various professionals will be able to view the information on the

'at risk' children on the new database as well as enter information about them.

As government databases appear to be accessible to anyone who knows how to work a computer this presumably means that we will all be able to view the information on *Viki* and add our own two cents worth.

Just how the Social Development Minister went from the recommendation that teachers, social workers, doctors, the police and other professionals should be able to freely share information about the children they are working with, to the solution of setting up a brand new database is extremely puzzling, especially when experience both here and overseas shows that databases cost many more millions than the quote the government gets to develop them, and that they present privacy time-bombs just waiting for someone to set them off.

The chosen few children who will be placed on *Viki* will get there by two pathways. One is via the predictive risk model that purportedly has the ability to predict the children most likely to be maltreated based on their families' past history. The other way of getting onto the database is through reports of suspected abuse or neglect made to a new Child Protect call centre.

The predictive risk model

The predictive risk model has not been tried anywhere in the world, so neither the experts working in the area of child abuse nor the general public are able to look to other countries for evidence that this will work. There is however, evidence on other countries' experience with child databases.

Britain created a national database of all children in 2004 and disbanded it six years later because of questions about the accuracy of the data and serious concerns about security. This is referred to in *The White Paper*.

Of course New Zealand has its own experiences with problems with the inaccurate data found on databases – the National Immunisation Register (NIR), the National Health Index (NHI) system, and the National Cervical Screening Programme (NCSP) Register to name just a few – as well as with data security problems. So we don't need a crystal ball to tell us that we can expect more database scandals to appear in the media in the not-too-distant future.

Universal programmes

What was also emphasised in many submissions on *The Green Paper*, was the amount of good evidence on what actually does work. Universal programmes have been shown to be far more successful in correcting the problems caused by inequalities in health and income. In contrast programmes that attempt to target the most disadvantaged simply don't work. Thousands of those who need assistance miss out and there is a stigma attached for those on the receiving end of narrowly targeted programmes.

In the UK an independent review was commissioned to find the most effective evidence-based strategies to reduce health inequalities. Chaired by Sir Michael Marmot, the review's report "*Fair Society, Healthy Lives*" revealed that while it is tempting to focus limited resources on those most in need, such an approach only tackles a small part of the problem. "Actions must be universal, but with a

scale and intensity that is proportionate to the level of disadvantage," the report states. The report refers to this as proportionate universalism. (2)

The best start in life

Disadvantage starts before birth and accumulates throughout life. As the Marmot Review noted, this means that "action to reduce health inequalities in children must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken." Giving every child the best start in life was the Marmot Review's highest priority recommendation. (2)

If Paula Bennett and the government are really serious about reducing inequalities and ensuring every child thrives, belongs and achieves, they need to abandon their misguided attempts at targeting. Such short-sighted measures won't work. "Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society." (2)

References

1. Simon Cunliffe. *Sunday Star Times*. 14 October 2012.
2. The Marmot Review "*Fair Society, Healthy Lives*." Strategic Review of Health Inequalities in England post-2010.

PROBLEMS WITH SURGICAL MESH COST MILLIONS

The October 2011 issue of the AWHC newsletter featured an article on the use of the gynaecological mesh and the serious complications that many women have experienced as a consequence of having had this medical device implanted. After placing the article on the AWHC's website (1), the Council has been contacted by several women with horrific stories of what the mesh has done to them. Over the past month a number of articles have also appeared in the *NZ Herald* with further examples of the devastating problems caused by mesh implants in both men and women. (2) (3) (4)

The AWHC's October 2011 article about this medical device outlined how the mesh was able to be marketed and used without having to undergo clinical trials either in the USA or in New Zealand. It also stated that "New Zealand has Medsafe to ensure that the New Zealand public is protected from unsafe medicines and medical devices."

It appears that Medsafe has been less than successful in protecting the public when it comes to surgical meshes – as well as hip implants and other medical devices. According to the articles in the *Herald* there have been 600 ACC claims involving meshes since 2008. Only 389 have been accepted, with ACC paying out \$3.1 million in treatment and compensation to people with post-surgical complications. (2) (3)

These complications include erosion through the vaginal epithelium, infections, severe pain, urinary problems,

recurrence and/or incontinence, bowel, bladder and blood vessel perforation during insertion, and the requirement for additional surgical procedures. The US Food and Drug Administration (FDA) revealed that women have died from complications after mesh surgery for prolapsed pelvic organs. In her presentation in Auckland in 2011 Professor Julie Quinlivan described the horrendous and permanent disfigurement involved in many of the attempts to remove the gynaecological mesh.

The FDA began issuing safety warnings regarding the use of the mesh in late 2008. In the US there are now thousands of lawsuits underway. In New Zealand there have been complaints to the Health and Disability Commissioner although it is not known if any have been successful. One woman told the *Herald* that her complaint had been dismissed. (2)

Despite the increasing controversy and groundswell of complaints, the mesh is still being implanted in hundreds of New Zealanders. Women report not being warned about possible complications and risks, and there is absolutely no information on the Medsafe website about the mesh.

But one brave woman has established her own website –

<http://meshdownunder.co.nz/#>

References

1. [www.womenshealthcouncil.org.nz/Fatures/Womens+Health+Issues.html](http://www.womenshealthcouncil.org.nz/Features/Womens+Health+Issues.html)
2. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10837440
3. http://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=10838873
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THE MYTH OF RESEARCH & DEVELOPMENT COSTS

Numerous books, a growing torrent of papers in medical journals as well as occasional media reports have all attempted to alert governments, health departments and the general public to the growing health crisis caused by the way in which the pharmaceutical industry operates.

In August and September 2012 the *British Medical Journal* (BMJ) featured two articles that revealed how drug companies put profits before the development of new drugs, choosing instead to tinker with existing drugs and produce minor variations that offer few advantages but result in a steady stream of profits. In the process they have also produced an epidemic of serious adverse reactions that have added to national healthcare costs. (1) (2)

In a paper entitled “Pharmaceutical research and development: what do we get for all that money?” published on 7 August 2012, Professors Donald Light and Joel Lexchin reveal how the drug companies exaggerate research and development costs in order to lobby for more protection from free market competition. An independent analysis found that only 1.3% of revenues are devoted to discovering new molecules compared with an estimated 25% spent on promoting their drugs, giving a ratio of basic research to marketing of 1:19.

While the pharmaceutical industry continues to churn out numerous articles claiming that the costs of research and development are unsustainable for the small number of new drugs that are approved, figures

show that the reported costs rose by \$34.2 billion between 1995 and 2010, but revenues increased six times faster – by \$200.4 billion. The authors of the paper reveal how the hidden business model for pharmaceutical research, sales and profits depends on turning out scores of minor variations on existing drugs, some of which become market blockbusters.

Canada’s experience

An analysis of Canada’s pharmaceutical expenditure found that 80% of the increase in its drug budget is spent on new, patented medicines that did not offer substantial improvements on less expensive alternatives available before 1990. (3) The major contributors to the increase in costs are the newer hypertension, gastrointestinal, and cholesterol drugs, including atorvastatin, the fifth statin on the Canadian market.

Along with this, independent reviews have concluded that about 85-90% of all new drugs over the past 50 years have provided few benefits and considerable harms. One study found that 29% of the new biological drugs approved by the European Medicines Agency (EMA) received safety warnings within the first 10 years on the market, and therapeutically similar drugs by definition have no advantages to offset their unknown risk of increased harm. (4)

Another paper by Corinna Sorenson and colleagues appeared in the *BMJ* in September 2012. “Evidence of comparative efficacy should have a formal role in European drug approvals” argued that drug manufacturers should have to show how their new drugs compare to existing medicines before the EMA approves them. (2)

The lack of early comparative efficacy evidence can result in the widespread use of potentially less efficacious and unsafe drugs. An example of this is the diabetes drug rosiglitazone. The relative effectiveness of rosiglitazone as compared to the existing drug treatment for diabetes emerged only after years of widespread use, with rosiglitazone being shown to increase the risk of heart attacks and cardiovascular death. (2)

By requiring the drug companies to prove that their new drug offers a therapeutic advantage over older, less costly medicines before they are approved, the authors claim that clinicians, patients and other healthcare decision-makers will be able to determine whether a new drug is superior, equivalent, or inferior to the existing alternatives.

It will also reduce the toll of morbidity and mortality in patients who currently are being used as guinea pigs in what are in essence unofficial and unacknowledged drug trials.

References

1. <http://www.bmj.com/content/345/bmj.e4348.pdf%2Bhtml>
2. <http://www.bmj.com/content/343/bmj.d4849.pdf%2Bhtml>
3. SG Morgan et al. "“Breakthrough” drugs and growth in expenditure on prescription drugs in Canada." *British Medical Journal* 2005;331:815-6.
4. TJ Giezen et al. "Safety-related regulatory actions for biologicals approved in the United States and the European Union." *Journal of American Medical Association* 2008;300:1887-96.



OVERCHARGING FOR CERVICAL SMEARS

An AWHC member recently had a cervical smear taken by her GP and found an extra charge of \$25 on the account for ThinPrep, one of two liquid based technologies now used throughout New Zealand in place of the conventional cervical (Pap) smear test. The other is known as SurePath.

Liquid based cytology (LBC) involves the smear taker taking a sample of cells from the cervix and putting them into a liquid solution that preserves the cells. It was introduced into New Zealand in 1997 and while it offered a number of advantages over the conventional smear, its use involved an extra cost to the woman.

From 1 July 2009 the Ministry of Health's National Screening Unit (NSU) began covering the extra cost of ThinPrep and SurePath as the country had now largely switched completely to the use of LBC for taking smears. This means that women should no longer be charged extra for her smear.

The AWHC has recently become aware that there are a number of GPs in Auckland who are still charging women extra for their LBC smear. It is not known if the problem is confined to Auckland as the NSU does not monitor or audit GPs to ensure that they are not double-dipping by accepting the payment from the NSU for the LBC smear as well as charging the woman an extra amount. Women should contact the NSU if their GP is charging them extra.

For further information on LBC see: http://www.nsu.govt.nz/files/NCSP/LBC_Qs_and_As_29.9.09.pdf

THE MSCC PRODUCES THREE NEW LEAFLETS

The Maternity Services Consumer Council has produced three new leaflets in its *The Facts* series.

Induction of Labour

This leaflet describes the process of inducing labour, lists the reasons for induction, describes the methods used in inducing labour including both medical and nonmedical or 'natural' methods, outlines the risks to both mother and baby of induction, and discusses the important role of oxytocin.

Birthing the Placenta

This leaflet is about what the medical model of birth refers to as the third stage of labour. It defines what is meant by the third stage of labour, describes what a physiological or natural third stage involves, outlines what an active management of the third stage consists of, lists the reasons for active management, and describes the risks that active management poses to mother and baby, especially the dangers of clamping the umbilical cord before it has stopped pulsating.

Labour and Birth in Water

This leaflet outlines the history of women's use of water during labour, lists the benefits of labouring and birthing in water, discusses the research evidence on the use of water during labour, describes the process of giving birth in water, as well as water births at home.

There is a small charge for these leaflets. An order form for these and other leaflets is on the MSCC's website: www.maternity.org.nz

AWHC GENERAL MEETING 25 October 2012

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- COGS Grant applications
- Ethics committee meeting
- Cervical Screening governance group
- Calls from women about the gynaecological mesh

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.



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The newsletter of the Auckland Women's Health Council is published monthly.

COST: \$30 waged/affiliated group
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Send your cheque to the Auckland Women's health Council, PO Box 99-614, Newmarket, Auckland 1149.

UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for November/December 2012:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)

Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 12 December 2012 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 21 November 2012.

Auckland DHB (Website address: www.adhb.govt.nz)

The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 5 December 2012 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Room, Clinical Education Centre, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)

The Counties Manukau DHB Full Board meeting will be held at 1pm on Wednesday 7 November 2012 at 19 Lambie Drive, Manukau City.

The Hospital Advisory Committee meeting will be held at 9am on Tuesday 27 November 2012 and will be followed by the Community & Public Health Advisory Committee meeting at 12.30pm at 19 Lambie Drive, Manukau City.



ETHICS COMMITTEE meetings – dates for the four new ethics committees are at: <http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes>



'IT'S A GIRL'

UN Women are hosting a White Ribbon Day Film Evening at 7pm on Sunday 25 November at the Roxy Cinema, 5 Park Road, Miramar, Wellington.

'It's a Girl' is shot on location in India and China, and tells the story of abandoned and trafficked girls, of women who suffer extreme dowry-related violence, of brave mothers fighting to save their daughters' lives, and of mothers who would kill for a son.

For further information contact Yvette Rigby at unwomennz@xtra.co.nz