



COMMONWEALTH OF AUSTRALIA

PARLIAMENTARY DEBATES



**HOUSE OF REPRESENTATIVES**

**PROOF**

**Main Committee**

**COMMITTEES**

**Health and Ageing Committee**

**Report**

**SPEECH**

**Tuesday, 24 November 2009**

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

---

## SPEECH

<p><b>Date</b> Tuesday, 24 November 2009  <b>Page</b> 85  <b>Questioner</b>  <b>Speaker</b> Rishworth, Amanda, MP</p>	<p><b>Source</b> House  <b>Proof</b> Yes  <b>Responder</b>  <b>Question No.</b></p>
---	---

---

**Ms RISHWORTH** (Kingston) (5.43 pm)—At the outset, I would like to commend the member for Swan. During the roundtable we had a number of witnesses. He was in the chair at the time and did a sterling job of keeping the meeting on track while still allowing everyone to have their say. It was a lengthy experience—I think the roundtable lasted around four to five hours—but it was critical to ensure that we got everyone’s views on a range of areas.

From the outset I would like to acknowledge that male impotence, erectile dysfunction and premature ejaculation are sensitive and inherently private issues. However, as sensitive as they may be, my experience as a psychologist before coming to this place and as part of the subcommittee that prepared the *Treating impotence: roundtable forum on impotence medications in Australia* report, informed my opinion that the secrecy and embarrassment associated with this mainstream health issue are in fact part of a wider problem that needs to be addressed.

The comments and findings of the *Treating impotence* report are connected with the issue of men’s interaction with the health system and the larger issue of men coming to terms with the health needs and vulnerabilities which are specific to them. On this note, it is encouraging to see that Australian men are in the process of facing up to these issues. This trend can be seen most visibly through the popularity of Movember. We have certainly seen a number of moes around this place—some of them are going better than others. This has increased the visibility of organisations such as beyondblue and really brought to the forefront some of the issues that men face. However, despite the important work done in raising awareness and decreasing the stigma associated with men’s health, as a society we clearly have a long way to go.

The *Treating impotence* report and the roundtable forum upon which it is based came about after several members of the Standing Committee on Health and Aging were approached by men in their electorates with complaints about the erectile dysfunction treatment they were receiving. The main grievance these men had related to the contracts they had entered into with commercial dysfunction clinics, which they allege could only be cancelled under specific conditions. Being aware of the interrelation between these grievances and the impact that commercial ED clinics are having on men’s health more generally, the committee decided to hold a public hearing in the form of a single round-table forum, gathering interested individuals and organisations to discuss issues and potential solutions.

The roundtable was held on 21 August 2009 and benefited significantly from the participation of representatives of Andrology Australia, the Freemasons Foundation Centre for Men’s Health, Impotence Australia, Medicines Australia, the Pharmaceutical Society of Australia, the Chapter of Sexual Health Medicine of the Royal Australasian College of Physicians, the Royal Australian College of General Practitioners, SHine SA, the Therapeutic Goods Administration and the Urological Society of Australia and New Zealand, as well as Patricia Weerakoon, coordinator of the graduate program in sexual health at the University of Sydney. In addition, the roundtable was enhanced by the participation of the Advanced Medical Institute, more commonly known as AMI, the largest and probably most prominent commercial provider of ED clinics in Australia. In particular I would like to thank them for their input into the committee. The committee received evidence from an additional 15 submissions and heard in-camera evidence from one patient of a commercial ED clinic.

Leaving the issues surrounding the contractual and advertising practices of commercial ED clinics to one side, the report is structured in four main themes and I would like to address each of them. First is the extent of men’s interaction with the health system. Second is the appropriateness of using telemedicine as a first option for prescribing. Third is the adequacy of regulations governing the sale of ED medications. Fourth is the interaction of commercial ED clinics with the proposed e-health records system.

As I have already indicated, the effective treatment of ED in Australia is closely linked with the interaction of Australian men with the health system. On a positive note, the committee did hear evidence that in 2003 the Men in Australia telephone survey run by Andrology Australia suggested that 90 per cent of men aged over 40

visited a GP once a year. This same survey also found that 80 per cent of men were concerned about developing ED. So the evidence does suggest that men are seeing doctors; however, they may not necessarily be talking about the common issue of ED. The committee also received evidence that, despite this increasing engagement with the health system and evidence that ED is an issue of concern, men do remain selective about what they discuss with their GP. It was suggested that reasons for this guarded attitude include both patient embarrassment as well as discomfort on the part of doctors who remained uncomfortable with discussing sexual health issues with their patients.

Whatever the exact cause, the demand for commercial ED clinics suggests that when it comes to issues of erectile dysfunction, men are not turning to their GPs as the first point of contact and as a consequence are not receiving the holistic advice and treatment that they need. Instead, they are taking advantage of the anonymous waiting rooms and telemedicine solutions offered by commercial ED clinics. In bypassing GPs these men are bypassing the gatekeepers of our health system. This bypassing of GPs is a major concern not only for individual patients but also for the health system more generally.

The report correctly notes that GPs are ideally placed to assess the totality of their patients' needs and have the ability to refer patients to specialists where necessary. An important function of a general practitioner is also to encourage their patients to adopt preventive health strategies. The concern of the committee is that men accessing commercial ED clinics may not be getting the holistic health care advice that they need. Importantly, the committee heard recent evidence which indicates that ED is an early marker for underlying conditions such as cardiovascular disease and diabetes. The danger is that in bypassing the conventional gatekeepers and treating ED in isolation and secrecy, these men might be missing out on important health advice and treatment.

The report expresses the view that a targeted public health campaign is needed to better inform men about the underlying conditions for which ED may be an early marker. In light of my earlier comments about the current momentum towards men embracing their health vulnerabilities, a successful public campaign could be very important to meet this issue. As the government has recently set up the Australian National Preventive Health Agency, this could be one issue to be looked at.

I also wanted to talk about the appropriateness of using telemedicine as a first option for prescribing. This was the second theme around which the report is structured. Telemedicine refers to the practice of using technology such as telephones and videoconferencing, reflecting the demand for patients to remain anonymous to both doctors and pharmacists. The committee heard that 50 per cent of AMI's current patient load is treated using telemedicine.

Several major concerns relating to the practice of telemedicine are raised in the report. Most obvious is the reality that many patients receiving ED treatment using telemedicine will not have a face-to-face consultation with their medical practitioner. Without such consultations it is difficult for doctors to detect and manage lifestyle factors associated with ED. Other concerns include the fact that many patients are not aware of who their doctor actually is on the other end of the telephone, and the lack of continuity of care for a patient when follow-ups are not undertaken by the original doctor. The roundtable heard evidence that when a patient decides that this treatment has not worked and decides to visit a conventional medical practice, their doctor will be unable to gain access to the patient's treatment or medical history directly by contacting the commercial ED clinics. In fact, the evidence presented, which was of great concern to me, is that if a doctor did want to find out the medication that their patient was actually being treated with they would need to write to the CEO in order to access this information. This is a concern because the ED clinics are not necessarily prescribing globally recognised first-line treatments for ED, so the GPs and some of the witnesses said it was very important for them to get that information considering that patients may not be receiving globally recognised first-line treatments.

There was also concern raised that the narrow approach taken by commercial ED clinics may not take into account mental health implications for patients. We did receive evidence that when these narrow ED clinic treatments had failed patients thought that they had been left with ED for the rest of their lives. This is a confronting and completely unnecessary state of affairs in a country with a highly advanced health system. This was also an issue of concern to the committee.

The third theme that was addressed in the report is the adequacy of regulations to govern the sale of ED medications. The Therapeutic Goods Act 1989 regulates therapeutic goods in Australia. This act makes it an offence to import, export, manufacture or supply therapeutic devices or medication unless it is included in the Australian Register of Therapeutic Goods. There remains an exception, however, whereby medical practitioners

can prescribe compounded medications for their own patients. These compounded medications are designed to be one-off products made by a pharmacy for an individual, using ingredients that may or may not have already been assessed by the Therapeutic Goods Administration. The exemption is designed to allow doctors to prescribe medication to patients where no suitable alternative exists.

The committee heard evidence that ED clinics are using this compounding exemption to prescribe a significant number of patients with individual compounded treatments. They heard evidence that the Australian Custom Pharmaceuticals has created 15 million individually compounded medications for AMI alone. This is occurring despite the fact that clinically proven and registered drugs as the globally recognised first-time treatment already exist and are readily available. In light of this frequent use of the compounding exemption under the Therapeutic Goods Act, the committee supported the recommendation of the National Coordinating Committee on Therapeutic Goods that the compounding of both high volume and high risk medications should be brought under the regulation of the Therapeutic Goods Act. This amendment would mean that individual doctors could still benefit from the exemption and prescribe individually tailored medication to their patients in the spirit of the original exemption. However, it would regulate more when this exemption is used by operators or pharmaceutical companies that do supply large amounts or medicines that are of high risk. I think this is an important amendment and it should be made.

The fourth area is the integration of commercial ED clinics with the proposed e-record system. The government has commissioned an important piece of research, done by Dr Christine Bennett, in the National Health and Hospital Reform Commission, which is considering the use of an electronic records system. This would be a patient-controlled system that would have integrated records going to their doctor, specialist, psychologist or physio. Everyone could use this patient-controlled mechanism. Noting that the records and treatment of patients who attend ED clinics are isolated from the wider healthcare system, the report encourages the government to consult with commercial ED clinics when it develops and implements the proposed e-record system. As I mentioned before, this will be important to providing the holistic health care to those men who may be suffering ED.

In conclusion, this is an issue that needs addressing. I hope that the *Treating impotence* report will start an important national conversation to break the taboo around erectile dysfunction and ultimately improve the regulation of this sector.