Copayments and the evidence-base paradox

To the Editor: The recent perspective by Keane on the effects of copayments on low-income populations[1] overlooked the results of the 1968 decision in the Canadian province of Saskatchewan to impose a fee of $1.50 (all amounts are in Canadian dollars) for office visits and $2.00 for home, emergency department or hospital outpatient visits.

At the time the fees were introduced, the definition of low income was $1550 for single-person families to $4800 for families of five or more. The result of the fee was a statistically significant 14% decrease in the use of general practitioner services and a non-statistically significant decrease of 5% in specialist services by the poor.[2] The health outcomes effect of this decrease in the use of services was not examined.

The Saskatchewan natural experiment should serve as a reminder that even small amounts of money can affect the volume of services that the poor receive.

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In reply: I thank Lexchin for citing the Saskatchewan natural experiment, but we do need to exercise caution when extrapolating the findings of this study to the current copayment debate.

The Saskatchewan copayments were higher ($10 to $13 in today's money[1]), and broader (covering general practice, emergency department and outpatient visits). The study population was "essentially agrarian",[2] life

expectancy was less than 70 years for men,[3] and information-sharing technology was completely different from what we have today. The study analysed the effect of a copayment only on the poorest of families,[2] defined as having incomes (in 2014 dollars[1]) of up to $11 500 for individuals and $32 000 for a family of five. People on such incomes might be holders of concession cards today in Australia, and would be exempt from the proposed copayment.

Furthermore, "It is, of course, not possible to infer whether the reduction in these services represents a decline in 'abuse' through overservicing or overutilization, or an increase in 'unmet needs'."[2] This is a recurring theme in the copayment debate, but could not be determined in the Saskatchewan analysis.[2]

We also have to recognise there is an opportunity cost to any health care expenditure. Using Canada as an example, there has been a doubling in the time Canadians wait to receive specialist treatment since 1993.[4] This represents reduced access to health care. Therefore it can't be assumed that a reduction in use of general practitioner services, even among the poor, is necessarily a bad outcome if it contributes to a more effective allocation of health resources. We just don't know.

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> "The result of the fee was a statistically significant 14% decrease in the use of general practitioner services and a non-statistically significant decrease of 5% in specialist services by the poor"
>
> Lexchin

> "we suggest that formal assessment of capacity provides reliable evidence"
>
> Bastian et al

Competing interests: I am a non-office-bearing member of both the Australian Medical Association and the Australian Liberal Party.

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Consent, capacity and the right to say no

To the Editor: Snow and Fleming identify an important and often ignored problem.[1] Without commenting on their specific case, we would point out that assessing a patient's medical decision-making capacity is part of every medical encounter,[2] usually as an informal process and often without deliberative thought.

There are many pitfalls in the process, in Australia as elsewhere.[3,4] Formal capacity assessment is not always required and not always triggered when needed. Competence is a legal construct varying across jurisdictions, but most capacity assessments by medical practitioners are not challenged and therefore not subjected to judicial review.[5,6] The statement that all the doctors involved in the case described by Snow and Fleming agreed that the patient had capacity should be treated with caution — doctors may disagree about capacity but often keep their opinions to themselves. In difficult cases, it would be preferable to discuss the patient's capacity with the other members of the treating team. We do not

believe that the legal advice to the hospital that a neuropsychology report trumps a medical opinion is correct. Rather, we suggest that formal assessment of capacity provides reliable evidence[7] and should be considered within an interdisciplinary discussion to optimise patient outcomes.

Snow and Fleming's article has prompted a review of the use and utility of neuropsychology reports within our hospital.

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Let children cry

To the Editor: We believe that Jureidini[1] challenges one of the fundamental ethical principles of medicine; namely, a doctor's duty to relieve suffering whenever possible. While we willingly accept this principle when dealing with physical pain, why should it be called into question when dealing with mental suffering? For young people and families directly affected by suicidal behaviour, social isolation, exclusion from education and employment, and worsening mental and physical health, a staged approach to intervention is entirely appropriate.[2]

We now have extensive evidence from epidemiological and clinical studies that mental disorders affect more than 50% of young people during their transition to adulthood.[3,4] When clinically significant, these disorders result directly in premature death, widespread disability, failure to reach potential, and huge economic costs.[2]

In Australia, *headspace* services[2] and other online psychological and social support options (eg, http://www.eheadspace.org.au; http://www.youthbeyondblue.com; http://au.reachout.com) ensure that distressed young people can access measured and appropriately targeted clinical assessment and psychosocial care. *headspace* services prioritise strengths-based approaches for young people and provide psychological and behavioural interventions that focus on building coping skills, resilience and a healthy lifestyle. Indeed, the majority of *headspace* clients receive these interventions rather than psychotropic medication.[5] Newly available data highlight the functional gains associated with these approaches.[6,7]

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Competing interests: Patrick McGorry is a director of the board of *headspace*. Debra Rickwood is the Chief Scientific Advisor, Evidence and Knowledge Transfer, *headspace*. Ian Hickie played a part in the design and implementation of *headspace* and was a member of its board until 2012.

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> "For young people and families directly affected by suicidal behaviour … and worsening mental and physical health, a staged approach to intervention is entirely appropriate"
>
> McGorry et al

In reply: Doctors have a duty to relieve suffering, but with qualifications: the target is overall, not immediate, suffering; and the primary injunction is to do no harm.

McGorry and colleagues would presumably agree that interfering with healthy mourning does more harm than good, even if it lessens immediate suffering. Where we disagree is that I have faith in families' own resources to deal with a broader range of distress, while McGorry and colleagues claim there are benefits from pre-emptively attracting distressed individuals into the mental health system. Evidence needs to be provided to support the idea that medical intervention does more good than harm for less than severe

impairment. Too often, selective or exaggerated evidence is offered.[1]

While it is true that the majority of *headspace* clients at one site received interventions other than psychotropic medication,[2] nevertheless, 20% (168/858) of those who fell short of threshold diagnosis were medicated. De-identified *headspace* data should be made accessible to allow independent research groups to analyse *headspace*'s impact on disability and functioning.

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Point-of-care testing for coeliac disease antibodies — what is the evidence?

To the Editor: The recent introduction of rapid point-of-care testing (PoCT) in Australian pharmacies to screen for coeliac disease has attracted controversy[1] and provides an important opportunity to review the current literature.

PoCT provides a rapid (within 10 minutes) assessment of the presence or absence of coeliac disease-specific antibodies using a skin-prick blood sample. Based on lateral flow immunochromatography, circulating IgG and IgA antibodies to deamidated gliadin peptides, if present, bind to a membrane, which generates a coloured line of varying intensity.[2] Total IgA antibodies are also assessed to detect the 3% of patients with coeliac disease who are IgA-deficient.

Coeliac Australia's Medical Advisory Committee has developed a position statement, supported by the Royal College of Pathologists of Australasia, that reviews the evidence base for PoCT in coeliac disease and provides a detailed explanation of the technology used in currently available PoCT kits.[3]

The diagnostic accuracy of current assays to perform PoCT for coeliac antibodies is inferior to laboratory-based testing, particularly in the context of average-risk populations, where coeliac disease prevalence is relatively low.[4,5] A positive PoCT result does not confer a definitive diagnosis of coeliac disease; nor does a negative test sufficiently exclude it. Diagnosis of coeliac disease still requires demonstrating the characteristic enteropathy in a small intestinal biopsy specimen.[6]

Interpretation of PoCT results requires a suitably trained practitioner, as it is inherently subjective and greater reader experience is associated with improved accuracy. Interpretation of results where antibody binding generates a "faint positive" line is challenging.[4] Validated standards for reporting results, sound clinical governance, and protocols that establish regular control procedures will be important to ensure robust performance of PoCT.

Although it is an attractive technology, the accuracy and clinical utility of PoCT by community clinics, general practitioners and pharmacies have not been studied, and prospective data are required. Given the clinical implications of a positive or negative screen for coeliac disease and the multitude of differential diagnoses in patients presenting with a range of symptoms, professional medical review remains a crucial factor in the diagnostic work-up of coeliac disease.

> "A positive PoCT result does not confer a definitive diagnosis of coeliac disease; nor does a negative test sufficiently exclude it"
>
> Newnham et al

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Competing interests: Jason Tye-Din holds patents pertaining to the use of gluten peptides in therapeutics, diagnostics and non-toxic gluten for coeliac disease. He is a consultant to ImmusanT and a shareholder of Nexpep.

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Cytomegalovirus disease in immunocompetent adults

To the Editor: We read with interest the review by Lancini and colleagues on cytomegalovirus

(CMV) in immunocompetent patients.[1] This topic and its associations with ocular disease has garnered increased recognition in the eye care community.

Clinically, CMV can cause an anterior uveitis (iritis) or, more rarely, retinitis, in otherwise healthy patients.[2] The uveitis typically features a chronic and/or recurrent course with anterior segment inflammation, keratic precipitates, endotheliitis, iris atrophy and elevated intraocular pressure (IOP).[3] CMV retinitis is characterised by confluent or semiconfluent areas of retinal whitening with haemorrhage.[4]

As with systemic CMV disease, oral valganciclovir appears to be effective treatment for ocular disease.[3-5] CMV-associated ocular disease in immunocompetent adults is underdiagnosed due to low clinical suspicion and its capacity to mimic inflammatory eye disease associated with other *Herpesviridae* such as herpes simplex virus or varicella zoster virus.[3,5] Misdiagnosis as other *Herpesviridae* can result in antiviral treatment that is ineffective in CMV disease. Thus, CMV ocular disease should be considered as a differential diagnosis in immunocompetent patients presenting with chronic unilateral anterior uveitis or retinitis. Where suspected, an anterior and/or vitreous chamber paracentesis with viral polymerase chain reaction (PCR) analysis should be performed for definitive diagnosis.[3]

A recent case illustrates this diagnostic challenge. A 53-year-old immunocompetent and systemically well man presented with a unilateral chronic anterior uveitis and elevated IOP. Treatment with topical corticosteroid eyedrops was commenced for non-infectious uveitis. After a poor response, an anterior chamber paracentesis was performed, which tested positive for CMV (on PCR). The uveitis subsequently became quiescent with oral valganciclovir.

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> “This topic ... has garnered increased recognition in the eye care community”
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