RANZCO Pre-Budget Submission 2019-2020

Content

Introduction

The Royal Australian and New Zealand's College of Ophthalmologists (RANZCO)'s mission is to drive improvements in eye health care in Australia, New Zealand and the Asia Pacific Region through continuing exceptional training, education, research and advocacy. Underpinning all the College's work is a commitment to best patient outcomes, providing contemporary education, training and continuing professional development, evidence-based decision making, collaboration and collegiality. RANZCO also seeks to educate the general public in all matters relating to vision and the health of the human eye and advocates for accessible ophthalmology cost effective services for patients.

RANZCO welcomes the opportunity to provide comment through the pre-budget consultation process.

The Australian health system

Public hospitals:

RANZCO believes that maintaining a healthy, robust public hospital sector is imperative for the wellbeing of all Australians.

According to the Australian Prudential Regulatory Authority (APRA), almost half of all Australians (45.9%) did not have any level of private health coverage in September 2018.[1] Given this, the public hospital system must maintain appropriate level of coverage.

RANZCO is concerned about the ongoing high median waiting times for elective surgery and in particular the inequity in accessibility for indigenous Australians when compared to the non-indigenous Australian population. For cataract surgery, a sight-saving surgery and the most common 'elective surgery' in Australia, the national median waiting time for surgery is currently 85 days[2] (AIHW 2018). However, Aboriginal and Torres Strait Islander Australians have a median waiting time of 130 days.

Prolonged waiting times for vision-saving surgeries also have a number of downstream affects particularly affecting the elderly, including a significant increase in the rate of injuries and death from falls while waiting for surgery,[3] increased reliance on carers, and less functional independence.

AIHW data further shows that regional hospital (in both RA2 and RA3 – inner and outer regional) have waiting times up to double the national average. Regional areas are sometimes underserved in the private sector as well, it is therefore imperative that public hospitals are appropriately funded to offer a high standard of care, in a timely manner.

RANZCO is aware of particular issues with hospitals in NSW, where median cataract surgery waiting times in a number of hospitals nears a full year: Manning Hospital (346 days), Lismore Hospital (340 days), and the smaller Hawkesbury Hospital (339 days).[4] Reports from South Australia Health show an ongoing issue with the State's elective surgery waiting times as well.[5]

Medicare Benefits Schedule (MBS):

RANZCO supports a comprehensive and contemporary MBS schedule, to continue ensuring that all Australians can access the highest quality of medical care.

For this, it is important to ensure that clinical practice in Australia keeps up with the cutting edge of contemporary medical science and discovery. RANZCO supports strengthening the existing regulatory mechanism of the Medical Services Advisory Committee (MSAC), with view of allowing a timely introduction of innovative medical services to the MBS Schedule, while maintaining the rigor of the review process. Where possible and appropriate, collaboration with overseas regulators for adopting equivalency processes should be explored.

RANZCO supports completing the lifting of the freeze on indexation for the entire MBS schedule as soon as possible, given the erosion of rebate value when compared to the rising costs for service providers.

Private Health Insurance

RANZCO supports upcoming changes to ensure higher transparency in private health insurance (PHI) products, with the planned introduction of standardised tiers.

However, RANZCO has expressed its concern in a number of submissions made to the Department of Health in this process arguing for an improved standard in the categorisation of cataract and eye health (as expressed in correspondences from RANZCO dated 4 May 2018, 20 July 2018, 8 August 2018). Based on the proposed model, the most common sight-saving operation will be limited from all but the highest tier of private health insurance ("gold").

RANZCO's view is that access to PHI tiers should not only be affordable but provide basic frequently accessed items such as pregnancy, cataracts surgery and the heart and vascular system to all policy holders rather than the "top" tiers of PHI only. RANZCO is deeply concerned with the exclusion of Cataract from all but the highest tier of health insurance coverage, as well as with the exclusion of all other eye and eye-related conditions from the basic coverage category. Cataract is a vision-saving operation. In most cases, a patient's vision can be restored overnight. Moreover, vision is a key determinant for a person's ability to maintain functional and economical independence. A loss of vision has far-reaching impact on the individual, their family, and the community.[6] [7]

Given the prevalence of cataract, especially in the older population, and given the cost-effectiveness of cataract surgery to restore vision, cataract surgery should be covered by all levels of private health insurance. Restricting coverage to only the highest (gold) tier can have far-reaching negative impact on individuals, their family and community, and ultimately, on the health and welfare system, given the potential loss of ability to work and loss of economic independence associated with loss of vision.

Therapeutic goods

Similar to the MBS, it is important that therapeutic goods are assessed in a timely manner by both the Therapeutic Goods Administration (TGA) and the Pharmaceutical Benefits Scheme (PBS), to ensure that Australian health practice is able to keep up to date with cutting edge medical research, innovation, and discovery. For this, RANZCO supports the move by TGA to adopt equivalency processes with overseas (EU) regulators. Further consideration should be given to strengthen the regulatory agencies to allow for a timely yet robust evaluation system.

Proposed changes to Therapeutic Goods Administration (TGA) scope of the medical device regulatory framework in Australia is a sensible step forward to set transparent criteria. The criteria should capture the rigour of existing FDA and EMA drug and device approval processes which assess applications against robust clinical trial evidence and manufacturing

standards. This process is crucial in establishing best patient outcomes and safety as a result of health professionals working within their scope of practice in accordance with specific definitions of medical devices. The continued advancements in Artificial Intelligence (AI) and the development of diagnostic medical devices is set to shape society and affect the nature and scope of the workforce. It is imperative to ensure Australia is developing in accordance with countries excelling in the development of artificial technologies.[8]

Access to intravitreal injections of anti-VEGF agents is a key issue in the therapeutics area. Intravitreal injections are used for the management of diabetic eye diseases, as well as macular degeneration, the leading cause of blindness in Australia, as well as other eye conditions including retinal vascular diseases.

Most intravitreal injection therapies require an ongoing schedule of regular injections, often in six to eight-week intervals. This poses a significant challenge of ensuring appropriate ongoing access to intravitreal injections and associated follow-up appointments. Logistics (transport) is a key part of this challenge and the system costs, given the need to ensure a 'cold chain' due to the temperature sensitivity of the substance). This change in practice patterns requires a dynamic health systems response.

Workforce

RANZCO recognises the need to increase medical service availability for Australians who live in regional and remote areas. Current data[2] suggests that waiting times for elective surgery in regional public hospitals are over double that of urban public hospitals.

RANZCO welcomes the recent regional medical workforce summit meeting, organised by Minister of Regional Services, The Hon Senator Bridget McKenzie. RANZCO has also recently met with the Rural Health Commissioner to discuss the rural generalist pathway, as well as planned RANZCO training activities in regional and remote areas. RANZCO is currently establishing a training network based in regional areas, to increase local specialist workforce.

RANZCO supports the increased drive to improve local specialist medical workforce, and to reduce the reliance of regional and remote areas on Fly In, Fly Out (FIFO) style services, where possible.

This however requires an appropriate level of funding commitment to ensure that the available facilities, equipment, and ancillary support required is available. A review of existing training funding modalities needs to be conducted with a view of ensuring greater flexibility, such as funding the trainee rather than a particular training site and providing incentives to encourage doctors to consider locating themselves in regional areas (RA2-RA5). Further, where possible and appropriate, increased funding for the development of and greater resourcing of regional centres should be considered to support training hubs for trainees.

A recent study amongst Australian and New Zealand Ophthalmologists highlights significant discrepancies between male and females in terms of work-life balance and experiences of discrimination, bullying and sexual harassment. Female ophthalmologists experienced more

frequent discrimination in the work-place and greater obstacles to career advancement whilst reporting working fewer hours, mainly in the private sector, in order to meet their increased share of family commitments. Research highlights women in ophthalmic research and clinical careers are still lost from the pipeline; receiving less grant funding and promotions. In order to increase female participation at all levels, there is a need to better understand this clinical and academic pipeline and the losses that occur.

Research and innovation

As mentioned, RANZCO believes that the task of ensuring timely introduction of innovations into clinical practice is critical in ensuring patients have access to the most contemporary, best available treatment. This is a significant regulatory challenge given the rapid pace of innovation in some areas.

Artificial Intelligence (AI) is one particular area which is likely to have significant impact on clinical practice in the near future. In the medical field, AI often refers to the research and production of a device that replicates intelligent behaviour with minimal human input.[9] This enhances the ability to perform a task as the AI devices analyses its environment and generates a perception based on this to optimise success.

With the integration of physical AI into society, advancements to robotics thus far includes presenting thousands of images of what would indicate an eye disease such as diabetic retinopathy (DR) or glaucoma.[10] The images show a scale of severity of none, mild, moderate, severe or proliferative in relation to the International Clinical Diabetic Retinopathy scale,[11] allowing for the robot to identify when a patient displays symptoms of an eye condition or disease and when referral to an ophthalmologist is essential. The results are phenomenal for AI devices which exhibit approximately 97 percent sensitivity.[12]

AI in the medical profession thus has the potential to reduce financial burden on businesses and the government which has been a concept of apprehension for the Australian Government thus far.[13] Funding from the Australian government for the 2018-2019 budget was minimal where only $0.1 million was allocated for AI to be delivered by Standards Australia.[14] Other countries, including the United States and China are far more advance in incorporating AI into the workforce.[10]

Whilst AI is in its very early stages of changing medicine, with the subtle integrations into society, along with the benefits, funding is crucial to ensure Australia integrates AI into society given the potential to reduce costs considerably. Technology will continue to progress in the future and we should not restrict or refrain from engaging in this.[12]

Population-specific considerations

Ageing population

Eye health represent a unique area in health care, as relatively small investments can produce immediate positive outcomes for patients. Most vision loss remains preventable: a cataract surgery, for example, can restore vision in most cases with a simple lens replacement procedure, whereas other intervention for chronic conditions such as diabetes can prevent associated eye conditions from developing if diagnosed and treated properly. Moreover, as explained prior, vision is a key determinant for a person's ability to maintain functional and economic independence. A loss of vision has far-reaching impact on the individual, their family, and the community. This makes eye health an area of particular high return for public investment, when considering the wider impact of vision loss.

It is projected that the number of Australians aged 40 or over with vision loss will rise to almost 801,000 by 2020, and those who are blind will rise to over 100,000.[7] In addition, the number of older Australians with their sight affected by presbyopia is estimated at 1.3 million (by self-report). This rise reflects an ageing population and assumes a policy-neutral environment.

Age-related macular degeneration (AMD) is the leading cause of blindness in Australia. In AMD, the macula goes through changes, related to ageing, which impacts the detailed central vision. The two most common forms of AMD are 'wet' and 'dry' AMD, with 'wet' AMD normally characterised by a faster onset and requires more urgent action to halt its progress.

The issue of AMD presents a significant task for the health sector. Over the past decade, AMD treatment was revolutionised using intravitreal injections of anti-VEGF agents. The success rate of anti-VEGF therapy is very high. In wet AMD for example, characterised by its quick development, intravitreal injections successfully halt its progress in up to 90% of cases.

RANZCO developed a number of relevant models of care and patient pathways, to improve consistency and efficiency in treatment. However, ensuring appropriate access to AMD treatment remains a significant challenge to the health system, which requires significant national strategy and resources. Further details about the challenges presented by ensuring appropriate levels of access to intravitreal injection therapy is detailed under the 'Therapeutics' section of this submission.

Another leading cause for vision loss and blindness among older Australians is glaucoma. Glaucoma is a group of diseases, often causing optic neuropathy and visual fields loss. Glaucoma is associated with increase in intra-ocular pressure and requires ongoing treatment. Glaucoma too experienced a large leap in clinical practice due to research and innovation over the past few years, with the introduction of Minimally-Invasive Glaucoma Surgery devices (MIGS). MIGS are inserted surgically and can be done together with common lens extraction procedures (such as cataract surgery) to intervene early in the disease with minimum discomfort for patients (unlike other glaucoma procedures) and help reduce intraocular pressure by increasing the flow of aqueous humour (the liquid inside the

eye). However, in some cases MIGS are indicated to be installed in urgency, as a stand-alone procedure, to halt rapid deterioration in some patients. Given the unique and growing clinical role of MIGS devices and the changes they are bringing to glaucoma treatment and management, the challenge on the Australian health system to allow patients access. RANZCO is pleased with the progress made in this space over the past year, with the establishment of a permanent MBS item for MIGS insertion during cataract surgery, however RANZCO is concerned by the lack of a current MBS item for standalone MIGS insertions, which are less common but more urgent when they are indicated.

Co-morbidities

Diabetes is fast becoming one of the biggest contributors to the burden of disease in Australia. In particular, diabetic eye disease is increasingly becoming a major contributor to vision loss. Diabetic patients need to be regularly screened for the development of diabetic eye disease, as early intervention is crucial to halt progression. RANZCO supports a number of existing initiatives, including the KeepSight initiative, to ensure the best rates of screening. Furthermore, RANZCO developed detailed referral pathway for diabetic retinopathy, and works closely with other organisations in the eye health sector to improve screening and treatment compliance.

Diabetic eye diseases also present the challenge of co-morbidities, increasing across the population and across different health conditions. It is estimated that about 23% of Australians are affected by two or more chronic conditions.[15] Vision-impacting conditions, when presented with co-morbidities, present a particular challenge given the reduction of independence often associated with low vision and increased reliance on formal and informal carers, as well as the need to access different services and doctors for treatments.

The challenge of managing co-morbidities is monumental to the Australian health system, and RANZCO supports innovation in public health approaches to reduce the burden of disease caused by co-morbidities, and where possible, manage treatment in a way that is more cost-effective for patients by increasing accessibility to multiple services.

Gender differences in the burden of disease

Women are affected by blindness and visual impairment at a greater rate than men.[16] Inequality in eye health outcomes is a global issue, with women estimated 1.3 times more likely to suffer from vision loss than men.[17] Addressing gender inequalities in eye health requires planning in consideration of the wider social determinants of health.

In Australia, cataract is more common in women than men (4.4% vs 3.5%) and in women aged 80 and above the incidence has increased - from 13.4% in 2010-11 to 18.5 per cent in 2016-17.[18]

Women often still carry a greater role in child rearing and thus bear a greater proportion of the burden of caring for children with paediatric eye disease. It is also important, in alignment with broader public health priorities, to have effective childhood screening and

early intervention programs to minimise the impact of ocular trauma and eye disorders on the developing visual system.

Aboriginal and Torres Strait Islander Eye Health

As the primary ophthalmology body in Australia, RANZCO has a strong commitment to closing the gap in vision. [19] RANZCO maintains a dedicated Aboriginal and Torres Strait Islander Eye Health Committee, which brings together ophthalmologists from across Australia who have particular experience in service provision for Aboriginal and Torres Strait Islander communities, including via innovative service delivery models. The Committee informs the RANZCO Board, Council, and Executive about emerging and ongoing Indigenous eye health matters, advises on appropriate projects, policies, and advocacy work, as well as advise on relevant educational matters.

RANZCO supports focusing on the following areas as part of improving eye health outcomes for Aboriginal and Torres Strait Islander people:

- Focus planning on population needs analysis: Funding models for service delivery should ultimately reflect population needs, and the changing population trajectories should be reflected in funding arrangements (with built-in regular reviews) to 'future-proof' funding models and ensure ongoing appropriate coverage.
- From the perspective of eye health service availability, RANZCO supports ensuring that outreach service delivery programs are updated annually to ensure population-based needs are fully met. This is reflected in the Roadmap for Closing the Gap for Vision, an initiative which RANZCO is a formal member of.[19]
- Programs should also be flexible enough to allow adjustments to specific local contexts, and to ensure following all relevant local cultural protocols.
- Urban areas as priority: While many of the existing programs focus on rural/ regional areas, urban areas should be considered given the high Aboriginal and Torres Strait Islander population and existing access issues. A focus on dedicated metro/ inner regional eye health networks can provide good outcomes, via coordination with Aboriginal Medical Services, public hospitals, MOICDP support, and other available programs.
- Public hospital availability: Given the increased reliance on public services in non-urban areas, as well as people of lower income, ensuring appropriate public hospital ophthalmology service hours is an important step towards closing the gap. The current proportion of available ophthalmology clinical hours between public and private is about 1 to 3. The limited availability of public hospital ophthalmology posts impacts Indigenous patients disproportionally. An equitable access to publicly funded specialist services, utilising a combination of public hospital availability and appropriately funded, long-term outreach programs, should therefore be considered a key target for closing the gap.
- RANZCO recognises that, at present, a number of different programs are working to achieve equity in Indigenous eye health. The Roadmap for Closing the Gap for Vision, for example, identified systemic gaps in the health sector and tries to maximise the efficiency of public spend on health interventions. Projects like Closing the Gap for

Vision should be properly supported, and evidence-based recommendations need to guide policy planning in this area.

- Improving cultural competency of the workforce is a key priority. RANZCO currently examines methods of embedding cultural safety and capacity education within the RANZCO training program, however RANZCO will also support resourcing a national focus on cultural competency in medical education, to allow all health education providers to embed the highest level of cultural competency training as a core health education activity.
- RANZCO welcomes the recent announcement by Minister Ken Wyatt, funding a new, innovative cultural safety training for nurses and midwives delivering frontline care to Aboriginal and Torres Strait Islander people (Media release, 23 January). RANZCO suggests that Federal funding should be considered to support cultural safety and capacity activities for medical specialists. A national, Federal approach to cultural competency in health would ensure consistency across Australia, and across all levels of the health system.

International Development

The World Health Organisation (WHO) estimated that 90 million people in the Western Pacific Region had a visual impairment in 2010, out of which, 10 million people were blind[20]. However, eighty percent of sight loss is preventable or treatable. Cost-effective interventions are available for the major causes of avoidable blindness. The estimated impact of vision loss and blindness has been consistently linked to considerable economic burden on affected persons, as well as their families, caretakers, and society as a whole[21]. Investment in blindness prevention and eye health programs has been shown to positively contribute to poverty reduction, particularly in developing countries, and positively impact on economic development[22] [23].

RANZCO welcomes the creation of the Pacific Office and the increase in establishment of diplomatic missions in the Pacific Islands region by the Australian government.[24] A continued investment in the development and training of the medical workforce in the region will help alleviate poverty and contribute towards sound community and regional development.

However, given Australia's total aid budget is at its lowest ever level as a proportion of budget (0.23% of gross national income) [25], it is imperative for Australia to increase the aid budget and move closer towards achieving the set OECD target of budgeting aid spending at 0.7% of GNI.

A solid investment in eye health can build on past successes and implement improved systems for sustainable development of eye care in the region. Whilst alleviating poverty and contributing towards sound community and regional development, such investments will also further establish Australia as a regional and global leader in eye health development.

The best available evidence suggests that on average, aid has had a positive effect on economic development in poorer countries and brings real improvements in other important areas such as governance.

For any clarification regarding the issues raised above please contact the RANZCO Policy Team via policy@ranzco.edu .

Yours sincerely,

David Andrews
RANZCO CEO

References:

[1] Australian Prudential Regulatory Authority (APRA). (2018). Quarterly Private Health Insurance Statistics. September 2018 (released 15 November 2018). Available from: https://www.apra.gov.au/sites/default/files/private_health_insurance_quarterly_statistics_september_2018.pdf (accessed: 24 January 2019)

[2] Australian Institute of Health and Welfare (AIHW). (2018). Elective surgery waiting times 2017-18. Australian Government: Australian Institute of Health and Welfare. Available from: https://www.aihw.gov.au/getmedia/73b686ab-32e9-48b1-86f2-cd264b3cf073/aihw-hse-215.pdf.aspx?inline=true (accessed: 24 January 2019)

[3] Palagyi, Anna, Peter McCluskey, Andrew White, Kris Rogers, Lynn Meuleners, Jonathon Q. Ng, Nigel Morlet, and Lisa Keay. "While We Waited: Incidence and Predictors of Falls in Older Adults with Cataract." Investigative Ophthalmology & Visual Science 57, no. 14 (2016): 6003-10.

[4] Australian Institute of Health and Welfare (AIHW). (2018). Waiting times for elective surgery 2017-18. Australian Government: Australian Institute of Health and Welfare. Available from: https://www.myhospitals.gov.au/our-reports (accessed: 24 January 2019).

[5] Wade, The Hon. Stephen, MLC. Outpatient clinic waiting times revealed. Adelaide: Government of South Australia Media Release. 1 July 2018.

[6] Morris, Daniel, Scott G. Fraser, and Christopher Gray. "Cataract Surgery and Quality of Life Implications." Clinical Interventions in Aging 2, no. 1 (03/ 2007): 105-08.

[7] Access Economics Pty Limited. "Clear focus: the economic impact of vision loss in Australia in 2009". Melbourne: Vision 2020 Australia (2010).

[8] O'Neill, M. (2017). Explainer: What is artificial intelligence? Available from: https://www.abc.net.au/news/2017-08-07/explainer-what-is-artificial-intelligence/8771632 (accessed: 18 October 2018)

[9] Hamet, P & Tremblay, J. (2017). Artificial intelligence in medicine. Metabolism, vol. 69, pp. 36-40.

[10] Abramoff, A., Lavin, P., Birch, M., Shah, N., & Folk, J. (2018). Pivotal trial of an autonomous AI-based diagnostic system for detection of diabetic retinopathy in primary care offices. NPJ Digital Medicine 1, 39

[11] Gulshan, V., Peng., L., Coram, M., Stumpe, M., Wu, D., Narayanswamy, A., Venugopalan, S., Winder, K., Madams, T., Cuadros, J., Kim., R., Raman, R., Nelson, P. C., Mega, J. L., & Webster, D. (2016). Development and Validation of a Deep learning for Detection of Diabetic Retinopathy in Retinal Fundus Photographs. The Journal of the American Medical Association, 10(1001) E1-E9

[12] Verma, N. (2018, November 20). Diabetic Retinopathy presentation presented at the Royal Australian and New Zealand College of Ophthalmologists Annual Congress, Adelaide, Australia.

[13] Carrington, A. (2017). Artificial Intelligence and government regulation. Available from: https://www.governmentnews.com.au/artificial-intelligence-government-regulation/ (accessed: 18 October 2018)

[14] Andrews, D. (2018, November 20). Diabetic Retinopathy presentation presented at the Royal Australian and New Zealand College of Ophthalmologists Annual Congress, Adelaide, Australia.

[15] Australian Institute of Health and Welfare. (2018). Australia's Health 2018. Chapter 3.3: Chronic conditions. Available from: https://www.aihw.gov.au/getmedia/6bc8a4f7-c251-4ac4-9c05-140a473efd7b/aihw-aus-221-chapter-3-3.pdf.aspx (accessed: 21 January 2019)

[16] Australian Institute of Health and Welfare (AIHW). (2015). 1 in 2 Australians affected by eye problems—higher for Indigenous Australians. 15 December 2015. Available from: https://www.aihw.gov.au/news-media/media-releases/2015/december/1-in-2-australians-affected-by-eye-problems-higher (accessed: 21 January 2019)

[17] Vision 2020 Australia. (2018). Global gender imbalance in eye health highlighted this International Women's Day. Available from: http://www.vision2020australia.org.au/media/2018-03-08/global-gender-imbalance-in-eye-health-highlighted-this-international-womens-day (accessed: 25 January 2019)

[18] Medibank. (2018). Medibank Better Health Index. Available from: https://www.medibank.com.au/livebetter/tag/better-health-index/ (accessed: 24 January 2019)

[19] Minum Barreng – Indigenous Eye Health Unit. (2017) Roadmap to Close the Gap for Vision. Available from: https://mspgh.unimelb.edu.au/__data/assets/pdf_file/0010/1984177/roadmap_to_close_the_gap_for_vision_summary_july.pdf (accessed: 25 October 2017)

[20] World Health Organisation Regional Office of the Western Pacific (2015) Regional meeting on implementing "Towards universal eye health: a regional action plan for the Western Pacific (2014-2019). Manila: WHO.

[21] Köberlein, J., Beifus, K., Schaffert, C. and Finger, R. P. (2013) 'The economic burden of visual impairment and blindness: a systematic review', British Medical Journal (BMJ Open), 3(11).

[22] Kuper, H., Polack, S., Mathenge, W., Eusebio, C., Wadud, Z., Rashid, M. and Foster, A. (2010) 'Does Cataract Surgery Alleviate Poverty? Evidence from a Multi-Centre Intervention Study Conducted in Kenya, the Philippines and Bangladesh', PLOS ONE, 5(11), pp. e15431.

[23] Jaggernath, J., Øverland, L., Ramson, P., Kovai, V. and Chan, V. F. (2014) 'Poverty and Eye Health', Health Promotion Journal Australia, 6, pp. 1849-1860.

[24] Cornish, L. (2018). 'Australian aid's new focus: Infrastructure finance, security, sports'. 19 November 2018. Available from: https://www.devex.com/news/australian-aid-s-new-focus-infrastructure-finance-security-sports-93855 (accessed: 21 January 2019)

[25] Doherty, B., Aige Roy, E. (2018). 'In Australia's historically low aid budget, Pacific gets lion's share'. 9 May 2018. Available from: https://www.theguardian.com/australia-news/2018/may/09/in-australias-reduced-aid-budget-pacific-gets-lions-share (accessed: 21 January 2019)