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PAYING FOR EXCESS

Overweight and obesity are costing Australia much more than was previously thought, say Colagiuri and colleagues, whose estimate of total direct costs in 2005 is a whopping $21 billion (*page 260*). The estimate is derived from 5-year follow-up data on participants in the Australian Diabetes, Obesity and Lifestyle study (AusDiab), and includes direct health care costs such as hospitalisations, prescriptions and ambulatory services, direct non-health care costs such as transport to hospital and support services, and government subsidies such as pensions and benefits. AusDiab used both body mass index and waist circumference to define overweight and obesity, and participants in both these categories incurred substantially higher costs than those of normal weight. The authors say their bottom-up approach of extrapolating from individual costs should provide more robust estimates than previous studies, which calculated costs by looking at obesity-related health problems and were unable to look at the effect of overweight.

DIRE DIABETES WARNING

Australian experts have joined their international colleagues in calling for nations across the globe to commit themselves to preventing diabetic kidney disease. As World Kidney Day approaches (11 March 2010), Atkins and Zimmet remind us that diabetes is now the major cause of end-stage kidney disease worldwide and that rapidly increasing rates of diabetes mean the problem is set to escalate, especially in developing countries (*page 272*). Turning this around will require a massive diabetes prevention effort, awareness of and screening for diabetic kidney disease, access to effective management, and continued resources for the development of new therapies.

ANOTHER TIME ... ANOTHER PLACE

You dig your grave with your teeth.

Proverb

COUGH & COME AGAIN

Although a very common presenting symptom in clinical practice, cough can be distressing and diagnostically confusing when it becomes chronic. The CICADA (Cough in Children and Adults: Diagnosis and Assessment) guidelines have been several years in the making by an impressive multidisciplinary group of experts. They appear in summary form, with clear recommendations for both adults and children, on *page 265*.

POACHED OR PUSHED?

The problem of less developed countries losing doctors and other health workers via migration to more developed countries has led the World Health Organization to challenge countries such as Australia to consider the global effects of their international recruitment strategies. While Australia needs to fulfil its obligations in this regard, Arnold and Lewinsohn's survey of South African doctors working in Australia (*page 288*) demonstrates that, for doctors from some developing countries, recruitment may play a relatively minor role. Of the 469 doctors contacted, 434 (93%) indicated that their desire to leave their country was a much stronger driver than Australia's attempts to attract them. Reasons for migration changed over time, with opposition to apartheid predominating before 1990, and the level of violent crime in South Africa being the main "push factor" in later years.

NATIONAL TRACHOMA SNAPSHOT

After a 30-year gap in national data collection, the 2008 National Indigenous Eye Health Survey indicates that blinding trachoma remains a problem in many remote Indigenous communities (*page 248*). Taylor and colleagues examined 1694 Indigenous children and 1189 Indigenous adults from 30 communities, finding an overall rate of follicular trachomatous inflammation of 3.8% among children (ranging from 0.6% in major cities to 7.3% in very remote areas). Half the communities in very remote areas had endemic trachoma rates (> 5%). Among adults, 15.7% had trachomatous scarring, 1.4% had trichiasis, and 0.3% had corneal opacity. Early last year, the federal government announced a $58 million funding package for Indigenous eye and ear disease, with a focus on eradicating trachoma in Australia, which is the only developed country in which the disease is still endemic.

HARMONISING ETHICS REVIEW

Late last year, Hicks and colleagues published an article road-testing the new New South Wales centralised ethics review system for multicentre trials. Although the time to ethics approval was reduced compared with the old system, the total time taken was as long as ever owing to the need for site-specific governance approval. In this issue's *Letters* (*page 292*), several other research groups add to the call for a more efficient process, with high hopes for the ongoing Harmonisation of Multi-centre Ethical Review (HoMER) initiative. For researchers in Indigenous health, centralisation of ethics review for multisite studies will not negate the need for local community approval and engagement. The National Indigenous Eye Health Survey (mentioned above and reported on *page 248* of this issue) was such a study. On *page 275*, Studdert and colleagues describe its complex ethics approval process, and put forward some ideas for future streamlining.

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