Submission for Senate Inquiry: Supply of chemotherapy drugs such as Docetaxel

ICON Integrated Clinical Oncology Network

HOCA

QHO GROUP

Tennyson Infusion Centre

Dr Brett Robinson, CEO

March 20, 2013

Introduction

Integrated Clinical Oncology Network Pty Ltd (ICON) is pleased to have the opportunity to make this submission regarding the safe and sustainable provision of chemotherapy in the private cancer care sector.

ICON is Australia's largest provider of private cancer care, managing around one in five of all patient separations in Australia and around two in five within the private sector[1]. In Queensland, where we currently operate most of our day hospitals, we treat one in every two private cancer care patients, while in South Australia we treat around one in every three cancer patients.

Put simply, our mission is to provide exceptional, personalised care to cancer patients and their families.

We currently manage more than 73,000 patient separations (visits) each year under three brands – Haematology & Oncology Clinics of Australia (HOCA), Queensland Haematology & Oncology Group (QHOG), and Tennyson Infusion Centre (Adelaide) – with the support of more than 70 visiting medical officers (VMOs). In addition to supporting the VMOs who refer to our day hospitals and other smaller private hospitals in regional Queensland, ICON directly employs more than 330 staff, including 24 pharmacists.

Our HOCA operating brand has been leading the way in cancer care for 25 years and became the foundation for the ICON Cancer Care group care, a privately owned company established in February 2012 *(see Appendix 1 – ICON Board).*

Table 1 provides a snapshot of our day hospital operations and chair capacity, including a day hospital in Townsville, north Queensland, currently under development to help meet the growing demands of that region.

Table 1 – ICON Facilities

ICON Facility	Chairs
HOCA Wesley	29
HOCA Chermside	25
HOCA Gold Coast	28
HOCA Mater	27
HOCA Townsville (online late 2013)	15
Tennyson Infusion Centre (Adelaide)	27

[1] HOCA day hospitals and the Tennyson Infusion Centre combined manage more than 75,000 patient separations per year, against 335,353 in Australia (public and private) and 196,876 (private), *Australian Hospital Statistics 2009-10*

ICON aims to maintain an integrated operating model where doctors, treatment, pharmacy and research are offered under one roof, creating greater efficiencies for patients and those who treat them.

It should be noted ICON is a member of the Professionals for Safe Cancer Treatment (PSCT) group and has been involved in discussions with the Department of Health and Ageing (DoHA) around the unsustainable nature of the current funding arrangements for the provision of chemotherapy. Within these discussions, ICON has shared commercial data with DoHA in the interest of transparency and to help DoHA representatives gain a better understanding of the severe implications of the chemotherapy funding shortfall, which our organisation has been carrying since the price for Docetaxel fell by more than 76 per cent on December 1, 2012.

ICON's submission will focus on three key areas:

- the commercial inadequacy of the current funding arrangement
- the vital role of Oncology Pharmacists in the safe provision of chemotherapy
- the importance of maintaining a viable private cancer care sector in Australia.

ICON thanks the Senate Committee for its consideration of the following information and confirms the willingness of our Chairman, Mr Stuart Giles, and our CEO, Dr Brett Robinson, to appear before the Senate Inquiry hearing to elaborate on any matters which may be of interest to the Senate Committee.

Section 1. Commercial inadequacy of the current funding arrangement

Traditionally, remuneration to pharmacists for the provision of chemotherapy has been dependent on the ebbs and flows of the drug patent cycle. A very small number of high-margin molecules have subsidised the delivery of most chemotherapy drugs. Since 2008, the pharmacy and cancer care sectors have been lobbying the Federal Government to remove this ever-moving, unsustainable funding model and replace it with a set fee that recognises all of the essential activities a pharmacist plays in the safe delivery of chemotherapy.

On December 1 last year, the price on Docetaxel (commonly used to treat breast, lung and prostate cancer) dropped by 76.2 per cent as a result of the Accelerated and Expanded Price Disclosure program under the PBS. This was the last of the available high-margin molecules to experience an initial price cut. As a result of this cut, and the cumulative impact of earlier price cuts to other molecules – such as Oxaliplatin, reduced by 72 per cent on August 1 of the same year – the provision of chemotherapy since 1 December has been under-funded by around $100 per infusion.

ICON derives its income from three revenue streams: pharmacy, the management of doctors' practices and day hospital treatment. Overall, the organisation operates on a modest, yet commercially sustainable, profit margin that allows us to strike a sustainable balance between managing costs and delivering high-quality cancer care to private patients.

In the four months of operation from December 1, 2012 to February 28, 2013, ICON pharmacy revenue, after costs, has been eroded by 73 per cent as a direct result of the price drop on Docetaxel and the absence of an alternate funding arrangement. Financial forecasts indicate the profitability for our Pharmacy Services moving forward will be reduced by an average of more than 90 per cent per month, resulting in a negative earnings (EBITDA) to Sales contribution of -1.4 per cent, reflecting costs in excess of revenue. The historical contribution of this service was a modest 7 to 8 per cent EBITDA to Sales prior to the most recent funding changes, and a return to these levels is essential for ongoing sustainability of safe cancer care delivery. The continued worsening financial performance reflects the next price drop for another off-patent chemotherapy drug, Paclitaxel, due on April 1.

A reduction of pharmacy profitability of this magnitude in the medium to long term would challenge the threshold of commercial viability, raising serious concerns around the sustainability of our service. The serious implications for cancer patients should ICON and other private cancer care providers reduce services or cease operations are explored in *Section 3.*

ICON has been able to sustain the significant revenue loss in recent months only through its economy of scale and diversity of revenue streams, safety nets that may not be available to other, smaller regional providers of cancer care or stand-alone community pharmacies (this issue is also further explored in *Section 3).* However, if the organisation had to continue in the medium to long term to carry significant losses on our pharmacy services, we would have to consider our ability to continue to provide the cancer care services we currently offer. There would be no option to consider closing our pharmacy service and outsourcing the provision of chemotherapy because an outsourced provider would not only face the same remuneration challenges, but have a higher return expectation on their efforts as a sole income activity.

We equally have no option to recoup the loss via a charge of around $100 per infusion to patients as this would be in breach of our PBS Approval obligation and outside of our existing health fund contracts, which prevent us (and other private health providers) from charging patients directly. We would need to enter significant renegotiations with our health fund partners to amend payment via this funding mechanism. Initial signals from these stakeholders are that there is no appetite to consider such renegotiations, given the current cost management tensions for health funds.

ICON has also considered carefully whether or not to inform patients we are currently subsidising the cost of their chemotherapy and has, so far, in the hope of reaching an outcome with the Commonwealth, agreed not to add to patient angst at an already difficult time. However, the organisation – like many providers facing this funding challenge – is reconsidering how it may sensitively educate cancer patients on the current situation.

Section 2. Vital role of oncology pharmacists in the safe delivery of chemotherapy

The current funding arrangement does not provide for the clinical role of pharmacists in the delivery of chemotherapy, nor does it adequately support the critical, highly specialised training required for the safe and sustainable provision of chemotherapy.

The role of pharmacy in the provision of chemotherapy spans far more than the reconstitution and dispensing of these complex, highly toxic, life-saving treatments. A clinical oncology pharmacist (OP) is very accessible to patients and constantly interacts with them and the consulting physician to ensure safe, accurate and appropriate delivery of chemotherapy.

An OP works closely with clinicians (including medical oncologists, haematologists and nurses) to ensure patients are well informed about and prepared for treatment, and to identify any risks that may arise from a prescribed treatment.

Critical clinical functions of pharmacists in the provision of chemotherapy within ICON (in addition to reconstitution and dispensing) include:

2.1 Patient engagement and education

Pharmacists attend the pre-admission clinic to inform new patients about the role of the pharmacist during their treatment and gain an understanding of any existing conditions and medications.

Prior to treatment, pharmacists instruct and counsel new patients in regards to their intravenous chemotherapy and/or oral chemotherapy, including advice on preventing or managing side effects. The OP also regularly engages with existing patients to discuss their medication management and any side effects, and provide advice on management strategies, escalating issues to the treating physician if required.

Pharmacists also continually monitor for interactions with other medications and for drug-disease interactions, such as a medication prescribed to manage the common chemotherapy side effect of nausea interacting adversely with a patient's Parkinson's disease.

2.2 Provision of medication

For each new order, the specific protocol and dosing are confirmed against the patient's disease. The initial order and all subsequent orders are then screened for correct dosing against the patient's body surface area and pathology results (bloods, liver and renal function) and checked and confirmed. The order is then physically checked against the chemotherapy and any ancillary medication (pre-medications, supportive care and take-home medications) prescribed for the patient. Only after all of these critical steps, is the chemotherapy provided for administration.

It is also worth noting that cancer is more common among older Australians, with 73.5 per cent of new cases diagnosed in men aged 60 and over, and more than 63 per cent in women aged 60 years and over, according to the AIHW. This prevalence among older Australians adds to the complexity of care as other conditions common to seniors are treated in conjunction with cancer. This complexity of care will continue to call on the critical clinical role of OPs.

2.3 Special access programs

In Australia, a number of patients are fortunate enough to be granted special access to new treatments prior to PBS listing in Australia, either on compassionate grounds or through co-payments with pharmaceutical companies. This early access to drugs that are coming off trial contributes to Australia's reputation as a world leader in cancer acre.

OPs play a critical role in facilitating special access programs. Due to their broad pharmaceutical knowledge and continual education, they are at the coalface of trial activity and able to identify potential new treatments, often making recommendations for a treating physician to consider. This symbiotic relationship between OP and physician in determining the best possible treatment is highly valued within ICON and the broader cancer care sector within Australia, and one that would be greatly diminished if pharmacy services were curbed in the face of inadequate funding.

2.4 Examples of the day-to-day clinical role of oncology pharmacists

In the short period of time we have collated information to support this submission, ICON has observed the following simple case studies that highlight the vital clinical role of pharmacy in the safe delivery of chemotherapy for cancer patients each and every day:

Case 1

A patient produced a highly abnormal amount of saliva (one cup) during a consultation with her medical oncologist due to side effects of a disease-drug interaction. The doctor consulted on site with the pharmacist, who recommended a successful treatment to reduce the discomfort and distress for the patient.

Case 2

A patient was concerned about the removal of a drug from his treatment after he

experienced significant side effects in his hands. The pharmacist took the time to explain the new treatment options that had been proposed by the consulting physician to provide peace of mind to the patient about the new treatment options.

Case 3

The oncology pharmacist counselled a newly diagnosed cancer patient in consultation with the treating physician. The pharmacist identified a number of interactions between the proposed treatment and the patient's existing medications, allowing the doctor to identify a more appropriate course of treatment.

Without an additional $100 in funding to support the provision of chemotherapy, pharmacy services are currently operating at a loss. It is inevitable, the key clinical services outlined above will soon cease because there is simply no longer a commercial capacity to provide them. Unfortunately, due to the need for so much pharmacist-related activity in the handling of this highly toxic medicine and its administration directly into a patient's body, there are very few service reductions we could contemplate before deciding on safety grounds not to offer treatment at all.

Section 3. Importance of maintaining a viable private cancer care sector in Australia

As highlighted in *Section 1*, ICON's scale has helped mitigate some of the impacts of the current funding shortfall for a short period. We will not, however, be immune over the longer term, and it is critical the Senate Committee understands the implications for cancer care in Australia if ICON and other similar private cancer care services are forced to reduce services or cease operations.

3.1 Role of private cancer care in Australia

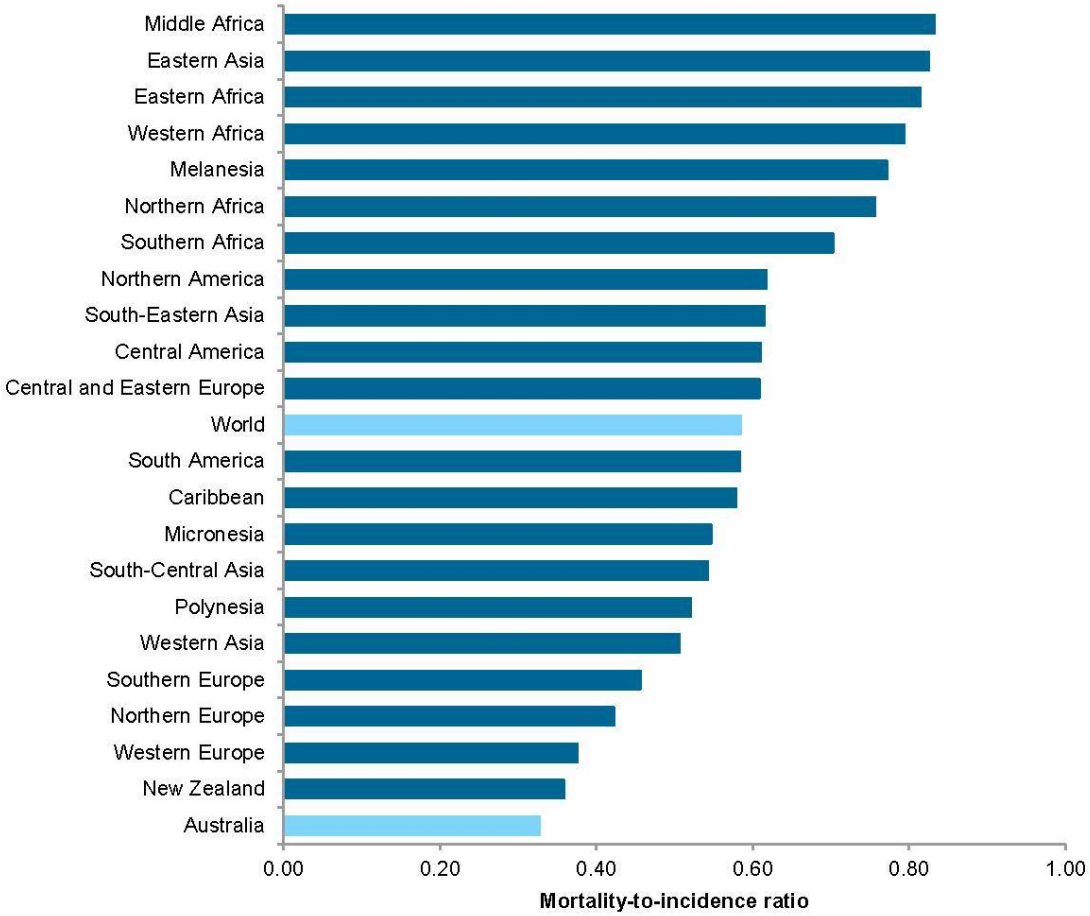
The Australian Institute of Health and Welfare (AIHW) estimates more than 124,900 Australians will be diagnosed with cancer in 2013. By 2020, 149,990 new cases are expected to be diagnosed, an increase of 20 per cent on today.

Around 60 per cent of cancer patients in Australia are treated privately, significantly alleviating the burden on the public sector. In Queensland, ICON (through its HOCA operations) treats around 50 per cent of the state's private cancer patients, managing nearly 60,000 separations per year. Two of our sites, HOCA Wesley and HOCA Mater, operate at capacity with around 100 patient visits a day.

Should ICON be forced through financial burden to limit the types of cancers it treats or remove services altogether, the burden on the already-stretched public sector in south-east Queensland in particular would be significant.

Decision-makers also need to consider how a diminished private cancer care sector would affect Australia's ability to deliver world-class care, considering the significant portion of patients who are treated privately.

Australia has one of the highest five-year cancer survival rates in the world, as demonstrated on the graph below[2].



Notes

1. The ratios are based on incidence and mortality data for 2008.
2. The mortality-to-incidence ratio equals the age-standardised mortality rate divided by the age-standardised incidence rate.
3. Cancers coded in ICD-10 as C00–C97 with the exception of code C44 that indicates non-melanoma skin cancer.
4. Data for this figure are in online Table D4.5.

Source: Ferlay et al. 2010.

Whilst improved survival rates are the ultimate aim for cancer treatment, more Australians are living longer with the disease[3], extending treatment requirements and costs, a scenario that will require a sustainable private cancer care sector if Australians are to continue to benefit from world-class treatment and care.

[2] Based on GLOBOCAN Data, 2008, *Cancer in Australia: An overview 2012,* P59, AIHW
[3] The Global Burden of Disease Study 2010

As highlighted in *Section 2*, consideration must also be given to the fact cancer is more common among older Australians, with 73.5 per cent of new cases diagnosed in men aged 60 and over, and more than 63 per cent in women aged 60 years and over, according to the AIHW. This prevalence among older Australians adds to the complexity of care as other conditions common to seniors are treated in conjunction with cancer. If Australia's health system is to continue to meet the demands of our ageing population, a viable public cancer care sector is critical.

3.1.1 Quality of private care

Queensland has very much led the way in private cancer care in Australia, largely on the back of the establishment of HOCA in 1988.

There has long been a perception that patients treated publicly receive better treatment and have improved outcomes. Although difficult to obtain accurate data on private vs public cancer care outcomes, studies indicate quality outcomes for those in private care. A study[4] of colon cancer patients in private and public care across four years (2009-2013) showed survivorship among those in private care to be equal to, if not better than, those treated publicly. The *Cancer in Australia* (2012) report found that for the period 2006 to 2010, five-year survival from all cancers combined was significantly higher in the highest socio-economic status areas, compared with the lowest. While not conclusive, it would be reasonable to assume there were a high number of privately covered patients in the higher socio-economic areas.

ICON, through experience, expertise and an integrated approach, provides all of the clinical benefits of a leading public cancer care provider:

- multi-disciplinary care;
- sub-specialty management;
- evidence based medicine;
- peer review/audit;
- access to latest imaging modalities – e.g., MRI, PET;
- access to clinical trials.

In addition, we, and other private cancer care providers, bring the benefit of continuity of care under one lead physician, along with ease and speed of treatment. These efficiencies are discussed briefly in *Section 3..3*

3.2 Access to care

Although ICON currently operates in major metropolitan areas, we share concerns with others in the sector around access for patients should private hospitals in regional and rural areas opt out of cancer treatment as a result of the current funding gap.

[4] TRACC Study data 2013

Traditionally, cancer care in Australia has centred around metropolitan centres with large tertiary hospitals. The high patient volumes at our HOCA Mater and HOCA Wesley sites are testament to this model. Since cancer care was declared a National Health Priority in 1996 significant investment has been made in increasing service coverage in regional centres with a view to improving outcomes for cancer patients in regional and remote areas. The current funding arrangements for chemotherapy threaten to unravel this significant investment and would appear counter-intuitive to the National Service Improvement Framework for Cancer, developed by DoHA, which recommends "development of appropriate service delivery models for people living in regional, rural and remote areas, for people managed in the public and private sectors…"

ICON, in line with the national cancer strategy and considerable government investment in public services, is planning a 15-chair facility in Townsville within an existing private hospital site to meet the demand for private cancer care in north Queensland. In addition, we manage practices for a number of doctors who travel regularly to treat patients in regional private hospitals in Toowoomba, Bundaberg, Cairns, Mackay, Rockhampton, Maryborough and northern NSW. If the pharmacy providers to those smaller, regional private hospitals pass on the costs to service, rather than absorb the $100 per infusion gap as they currently do out of goodwill, it is inevitable some hospitals will have to opt out of providing cancer care. This will see regional private cancer patients travelling further to access public or private facilities in larger centres, an outcome that is completely counter to the national plan.

A hint of this development was aired in November 2012 when St Andrew's Toowoomba Hospital, which is serviced by several HOCA doctors, warned its 25-chair unit would struggle to find the increased costs of between $800,000 and more than $1 million to keep its cancer services open.

Not only would regional patients experience significant inconvenience and angst if forced to travel long distances for treatment, but regional and metropolitan public hospitals and metropolitan private hospitals (including those operated by ICON that are already at capacity) would struggle to cope with the increased demand.

3.3 Cost of delivery

Although there is little publicly available information to accurately compare the cost of delivering chemotherapy in the private sector with the cost of delivery in the public sector, there is broad acceptance that private cancer care is more cost efficient. Recent analysis by ICON estimated our cost to deliver chemotherapy in one private day hospital setting in northern Brisbane was up to 40 per cent lower than delivery in a similar public setting. More streamlined processes, leaner administration and greater capacity to control levers to manage costs are all contributing factors in driving greater cost efficiencies, while still maintaining world-class cancer care.

Conclusion

The current funding arrangement for chemotherapy is failing to facilitate a sustainable, safe cancer care sector for Australia. It is failing to allow private cancer care providers to operate profitably and, if left unchecked, will ultimately lead to reduced services.

Private cancer care providers, such as ICON, will not allow patient safety and care to be compromised. The provision of chemotherapy, a highly toxic and complex treatment, needs to be adequately funded so it can be delivered safely. It is not a case of pharmacists cutting corners here and there to make the service viable, as service providers in other sectors might consider when margins are under pressure. Such is not the nature of this life-saving treatment and the expertise required to deliver it.

We ask that serious consideration be given to the grave and wide-sweeping implications of an under-funded private cancer care sector, and that changes to the existing chemotherapy funding arrangement be made as quickly as possible to ensure all Australians can continue to access world-class cancer care.

The ICON Board

Stuart Giles B.Pharm MAIPM
ICON Board Chairman
APHS Managing Partner &
Executive Chairman

Stuart Giles is the Managing Partner and Executive Chairman of APHS, a national organisation delivering pharmacy services to hospital, oncology, aged care and community pharmacy sectors.

Stuart brings an energetic and innovative approach to developing the commercial success of APHS. It is this approach that continues to see APHS expand the boundaries of healthcare, including development of their award winning APHS Packaging medication compliance solution and Integrated Clinical Oncology Network (ICON) dedicated to delivering a best practice day oncology service across Australia.

Named a Regional Winner in 2010 Ernst & Young Entrepreneur of the Year, Stuart continues to lead APHS to success alongside his wife, business partner and co-owner of APHS, Cathie Reid.

Dr James Morton
MBBS, BSc (Med), FRACP, FRCPA
ICON Board Member
Clinical Haematologist / Oncologist

Dr Morton was born in Brisbane and received MBBS from University of Queensland in 1987 (University Gold Medal). He completed general internal medicine training in 1991, before undertaking specialist training in Clinical Haematology and Stem Cell Transplantation at the Royal Brisbane and Mater Hospitals (1992-1995). Dr Morton was the International Fellow at the prestigious Fred Hutchinson Cancer Centre, Seattle, from 1996 - 1997.

In 1998 Dr Morton returned to Australia as Staff Specialist at the Royal Brisbane and Women's Hospital, Brisbane. Dr Morton joined Haematology & Oncology Clinics of Australia in 1997 and practices at HOCA @ Mater and HOCA Chermside. Dr Morton is an accredited specialist at the Mater Private, Greenslopes and Royal Brisbane and Woman's Hospitals, as well as attending St Andrew's and St Vincent's Private Hospitals in Toowoomba. Dr Morton's particular clinical interests include Leukaemia, Lymphoma, Multiple Myeloma, Stem Cell Transplantation, and Clinical Apheresis. He has published widely in these fields.

The ICON Board (cont'd)

Dr David Grimes MBBS FRACP
ICON Board Member
Medical Oncologist

Dr David Grimes is a Medical Oncologist based at HOCA @ Wesley, as well as visiting HOCA Chermside, North West Private Hospital and Greenslopes Private Hospital for regular sessions.

Dr Grimes graduated from the University of Queensland in 1984 and became a Fellow of the Royal Australasian College of Physicians in 1992. Following successful residencies at The Princess Alexandra Hospital and registrar and senior registrar positions at The South Brisbane Haematology/Oncology Unit and The Queensland Radium Institute at Royal Brisbane Hospital, Dr Grimes completed a clinical fellowship at the Roswell Park Cancer Institute, New York, in 1993 and 1994. Here he specialised in bone marrow transplantation and medical oncology.

Dr Grimes continues to participate in clinical research and serves on several national advisory boards. He has, since its inception, been convener for The South East Queensland Oncology group.

Dr Brett Robinson MBBS, D.Phil
ICON Board Member
ICON Managing Director & CEO

Brett brings natural leadership and a strong understanding of healthcare to his position as ICON Managing Director & CEO. Brett completed a medical degree at the University of Queensland, worked as a surgical trainee and later completed a Doctorate of Philosophy in Clinical Orthopaedics at Oxford. He is registered to practice in Queensland and assists Orthopaedic colleagues once a month in advanced joint replacement surgery. He remains actively involved in clinical research and supervises a PhD student at the ANU.

Until 2010 he occupied the role of Australian CEO for Mondial Assistance, a French based global medical and travel insurance support organisation. This was preceded by executive roles in the insurance sector, including Queensland State Manager of NRMA, CGU and Swann brands for Insurance Australia Group, and three years as the General Manager of Australian Rugby Union's High Performance Unit. Here he oversaw the development of elite players, coaches and referees to maintain Australia's position of power within international rugby.

A former Wallaby himself, Brett's years playing rugby for Australia and leading the ACT Brumbies has given him an exceptional and unique leadership skill set.

The ICON Board (cont'd)

Andrew Reid B.Bus CA
ICON Board Member
APHS Chief Executive Officer

Andrew was recently appointed to the ICON board as a Non-Executive Director, bringing considerable finance experience to the table. As CEO of ICON's majority shareholder, APHS, he has broad experience in leading the corporate services and finance functions of a national pharmacy group.

Andrew completed his Bachelor of Business at Monash University in 1997 and undertook further studies to become a Chartered Accountant in 2000.

After a period as a senior associate with a Gippsland public practice accounting firm, Andrew relocated to Queensland to join APHS as Finance Manager in 2008.

He has strong expertise in undertaking due diligence for mergers and acquisitions, having supported the growth of APHS in its oncology and hospital pharmacy sectors and the ground-up development of APHS Packaging, a leader in medication management for aged care and retail pharmacy customers.

Mr Eric Dodd FAICD, FCA
Independent ICON Board Member

Erin Dodd brings to the ICON board a wealth of business acumen, developed through an extensive background in the finance and health sectors. He was Managing Director and CEO of leading health insurer, Bupa Australia Group, having led the significant profit growth of MBF before it merged with Bupa Australia in 2008.

Since stepping down from that role, Eric has pursued a full-time career as a Non-Executive Director. In addition to sitting on the ICON board, he is Chairman of SFG Australia, Chairman of Firstfolio Ltd, Chairman of First American Title Insurance and a Non-Executive Director of The Credit Corp Group, Clean Up Australia and Clean Up the World.

Prior to joining MBF in 2002, Eric was the Managing Director of NRMA Insurance Limited and Chief Executive Officer of NRMA Limited. In 2000, he led the demutualisation and listing of NRMA Insurance Group Limited on the ASX.

Eric has a Bachelor of Economics with statistics and accounting majors. He is a Fellow of the Australian Institute of Company Directors and a Fellow of the Institute of Chartered Accountants.

The ICON Board (cont'd)

Mr Michael Horan
Independent ICON Board Member

Mike served as the Toowoomba South Member of Parliament for 21 years, during which time he also served as Minister and shadow Minister for Health.

During his political career, Mike also served as the leader of the National Party, the leader of the Opposition, Shadow Attorney-General, and Shadow Minister of Police, Health and Primary Industries respectively.

Mike has strong board experience and is currently Chair of the Darling Downs and Hospital Health Board. He also has considerable expertise in the development and construction of small and large health facilities.

Prior to entering State Parliament, Mike was General Manager of The Royal Agricultural Society of Queensland (Toowoomba Showgrounds) and a driving force in the development of the new Toowoomba showgrounds. Mike also serves on the board of Downs Rugby Ltd and remains an active advocate for his local community.

Dr Christine Bennett
MBBS FRACP Master Paed
Professor and Dean, School of Medicine, Sydney,The University of Notre Dame Australia
Independent ICON Board Member

Christine was appointed to the role of Professor and Dean, School of Medicine, Sydney, The University of Notre Dame Australia in May 2011. Prior to this appointment, Christine was the Chief Medical Officer for Bupa Australia Group.

A specialist paediatrician, Christine has more than 25 years of health industry experience in clinical care, strategic planning and senior management. She is a Fellow of the Royal Australasian College of Physicians and has an active commitment to and involvement in medical professional issues, social policy and medical research.

In 2008, Christine was appointed as Chair of the National Health and Hospitals Reform Commission, providing advice on a blue print for the future of Australia's health system.

The ICON Board (cont'd)

Her previous executive appointments include Partner in Health and Life Sciences for KPMG Australia, CEO of Research Australia, CEO of Westmead Hospital, General Manager for the Royal Hospital for Women and Head of Planning in NSW Health. Christine is currently the Chair of:

- Research Australia
- The Sydney Children's Hospitals Network
- The Australian National Preventive Health Agency Advisory Council
- The Bupa Health Foundation Steering Committee.

She is also a Non-Executive Director of Bupa Health Dialog and sits on the board of Obesity Australia.