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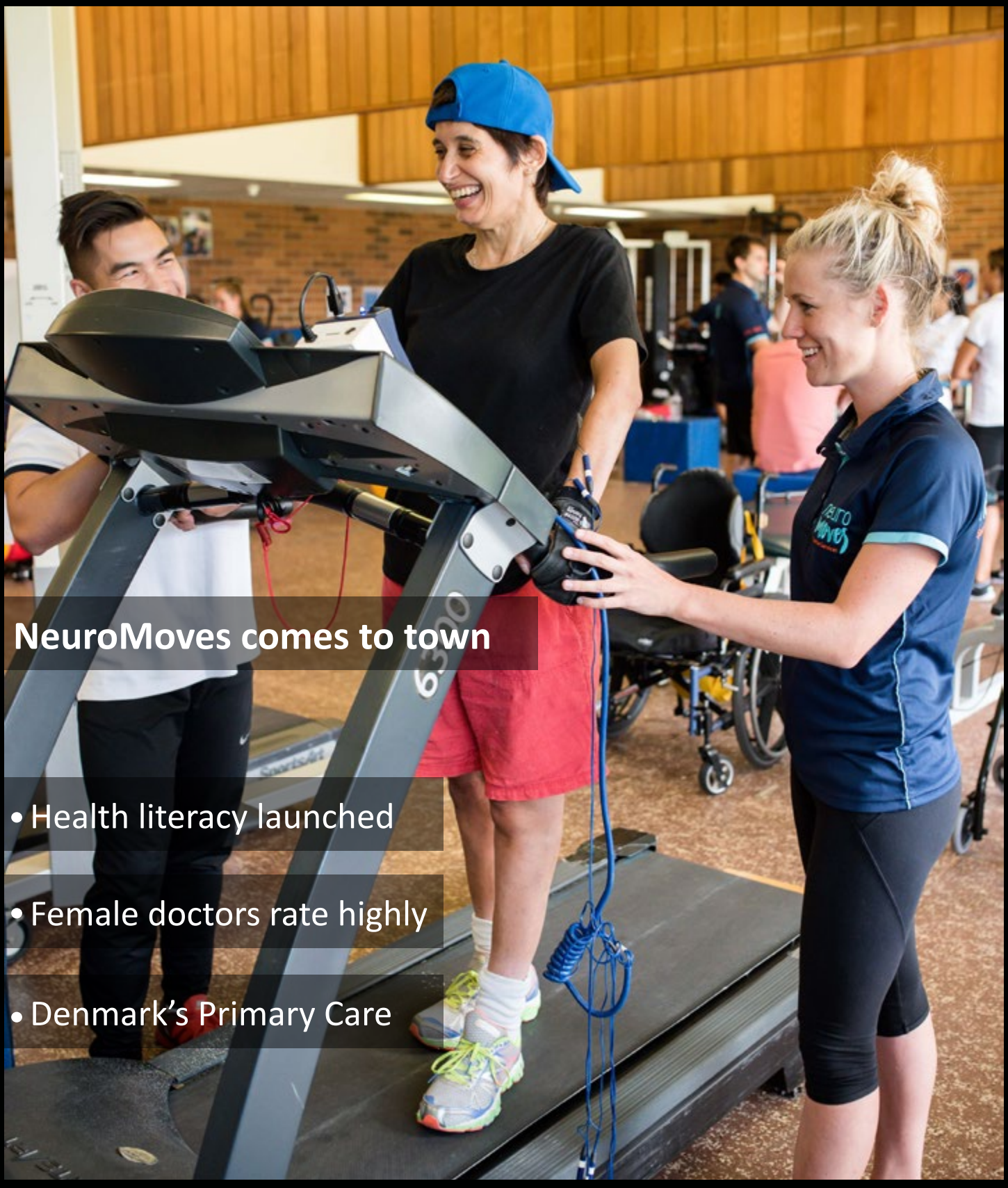

NeuroMoves comes to town

- Health literacy launched
- Female doctors rate highly
- Denmark's Primary Care

GPSpeak

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General Practice Australia 2017 - Don't worry. Be happy.

Editorial

by Dr David Guest

"Why can't a woman be more like a man?", sang Rex Harrison in My Fair Lady, Lerner and Loewe's 1964 musical adaption of George Bernard Shaw's, Pygmalion.

It would seem poor advice for medical practitioners, however. In this issue of GPSpeak, Dr Jane Barker reports on the significance of the recent JAMA article showing patients of female physicians in American hospitals had a lower mortality rate and were less likely to be readmitted within the month. This finding adds to previous knowledge of differences between female and male medical practitioners.

Female GPs spend longer with their patients and squeeze more into their consultations (1). They are more like to provide counselling and address the social aspects that affect their patient's health. They have longer consultations and refer patients more often while prescribing less medication. They earn 6 per cent less per hour, work fewer hours per week and do more non-billable hours than males.

So what do GPs think about their consultations? Australia's fee for service approach for primary care delivery financially rewards shorter consultations. Previous studies had shown that general practitioners are usually happy with their response to the patient's presenting problems and their management.

However in 2000, GPs were not satisfied with 20 per cent of consultations in the areas of preventative care, lifestyle advice, psychosocial assessment and care co-ordination. The Enhanced Primary Care scheme from 1999 and subsequent Chronic Disease Management program that replaced it in 2005 have gone some way to address these deficits.

Well-respected surgeon and public health researcher, Atul Gawande (3), has recently written in praise of general practice. Clinical Editor, Dr Andrew Binns, recommends Gawande's "Heroism of Incremental Care" (page 7) and reflects on the importance of teaching these values to the next generation of GPs.

Interviewed by Australian Doctor (17 February, 2017) NRGPN Board member, Dr Chris Mitchell has also emphasised the value of having a regular GP. It is the trust relationship, which can take months to years to develop, that underpins the success of the primary care model, he notes. There is also value for the system when the patient has a regular GP. A recent British study (4) showed that older, sicker patients who saw the same GP regularly were 12 per cent less likely to be admitted to hospital that those who did not.

British GPs are struggling, however. Growing patient lists and fewer resources are making it increasingly difficult for patients to see their usual GP. Professor Helen Stokes-Lampard, Chair of the Royal College of GPs, believes the problem is made worse by "super surgeries" of multiple doctors, which are increasingly relied on by patients (5).

Denmark is one country that is said to get general practice right. On page 13 we give an overview of how the Danes have managed practice size, funding and patient access to enhance the GPs role as the coordinating gatekeeper. It seems to be working. Patient satisfaction with the Danish system is over 90 per cent.

All is not doom and gloom in Australia. The Commonwealth Fund's 2015 survey of primary care physicians (6) found Australian GPs were mostly satisfied with their work and income, although they felt somewhat hard done by in relation to their specialist colleagues. Dissatisfaction with one's work correlated strongly with finding the job very or extremely stressful. Pleasingly, Australian GPs ranked near the bottom on these two parameters.

This issue also briefly reports on the improving preoperative management of iron deficient patients in our area (page 15). A normal ferritin but with an elevated CRP still raises the possibility of iron deficiency in patients with renal and inflammatory diseases. In surgical conditions iron replacement can be started by GPs once it is recognised, since early treatment does not interfere with subsequent investigation.

Dr Jackie Andrews (page 30) also gives a few tips on how to optimise patients to get the most from the scarce resources of our Community Paediatric Services.

Commissioning is a new topic for Australian medical practitioners to consider. History may give us some guidance on the principles to be followed (page 16).

Despite the structural impediments to efficient health care in Australia, GPs and their patients are doing pretty well. Having a little more time with your patients and a little more money might improve the well being of both parties.

We can improve by being more in tune with our patients' needs and views. Our female colleagues will show us the way. For, as Charlotte Payne-Townshend, is said to have replied to her husband, George Bernard Shaw, when asked:-

"Isn't it true, dear, that men are smarter than women?"

"Yes dear. That's why I married you and you me."

1. Women GPs earn less, more cost-effective, AMA 4 July 2016
2. Measures of health and health care delivery in general practice in Australia, Australian Institute of Health and Welfare and University of Sydney, 2000
3. Heroism of Incremental Care, New Yorker, January 23, 2017
4. Association between continuity of care in general practice and hospital admissions for ambulatory care sensitive conditions: cross sectional study of routinely collected, person level data, BMJ 2017;356:j84
5. Seeing the same family doctor cuts the risk of being rushed to hospital, The Telegraph, Herny Bodkin, 11 February, 2017
6. 2015 International Survey of Primary Care Doctors

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NeuroMoves exercise program is a regional first

by Robin Osborne

The first exercise program for people with spinal cord injury and similar disabilities to be established in an Australian regional centre starting up on Southern Cross University's Lismore campus from 20 February 2017.

The NeuroMoves program delivered by Spinal Cord Injuries Australia will be based at SCU's Health Clinic, which has a range of clinical linkages with local health care providers, including GPs and the chronic care programs operated by Northern NSW Local Health District.

NeuroMoves will occupy one of the Clinic's large rehabilitation gyms, fitted out with specialised exercise equipment provided by SCIA. A full-time exercise physiologist is being recruited, and students in SCU's exercise physiology program will do practicum work with the many clients expected to attend.

Health Clinic manager Marlene Assim told GP Speak she was "absolutely amazed" to see how many potential clients and carers had turned up to an information session held in Lismore last November.

SCIA organisers said the aim was to explain how the variety of exercise programs could be tailored to the needs, goals and budgets of participants.

"SCIA now offers a suite of exercise services for people with a neurological condition or other physical disability across Australia in an accessible facility, at a range of price levels," says SCIA's chief executive Peter Perry.

"We currently see adults and children with either a spinal cord injury, acquired brain injury, stroke, multiple sclerosis, motor neurone disease or cerebral palsy and in the future we will welcome other neurological conditions."

Marlene Assim revealed that the university is not charging SCIA for the space because it regards the program as a much-needed community service. It is also a valuable resource for providing 'real world' training for undergraduates, she added.

"There's no other service like this between Newcastle and Brisbane," Ms Assim said, "and we're tremendously excited to have the ideal space to be hosting it. NeuroMoves is a well-established program in major centres [five capital cities] and we have no doubt that there is a significant need in the Northern Rivers."

Southern Cross University Health Clinic manager Marlene Assim with new equipment for the NeuroMoves program

She added, "The program has real benefits for clients with these kinds of disabilities, and the combination of professional staff, the latest equipment and a keen student cohort will deliver great outcomes.

"There will be a high ratio of staff to clients, and consultations are likely to be lengthy. At present, people wanting to access such a service would have to travel long distances, or more likely, forego such support altogether."

While clients will pay SCIA session fees for the service - many will be using NDIS packages after the scheme starts locally from 1 July - the funding to establish the program has come from the Newcastle Permanent Charitable Foundation and a NSW Government body known as the icare foundation, established last year to prevent injury and improve the wellbeing of people injured at work or on the road.

The foundation will invest $100 million over five years, focusing on new research, family support programs, and better partnerships with businesses and community organisations.

"Without the right care, recovery can be a long, dark road for the seriously injured, their families and the whole community," said NSW Finance Minister (now Treasurer) Dominic Perrottet.

SCIA's Peter Perry said his organisation's partnership with the icare foundation would bring potentially life-changing programs to areas they have not been available, including Lismore.

"Our NeuroMoves program has a proven track record, and now more people with spinal cord injuries will be able to experience the benefits it can deliver," he said.

"Our aim is to decrease the barriers that arise for people with a disability to access quality exercise services – from the most basic of exercise to the highly specialised and intensive options. Our gym and fitness program is also accessible to people with amputation or other physical deficit."

SCIA has an Australia-wide staff of around 40, including physiotherapists, exercise physiologists and therapy assistants, and hosts over 23,000 hours of student clinical placements per year.

***For further information on NeuroMoves contact SCIA on info@scia.org.au or 1800 819 775.**

Spinal cord researcher is Australian of the Year

Acknowledged for giving hope to thousands of Australians with spinal cord injuries, Professor Alan Mackay-Sim has been chosen as Australian of the Year 2017.

A world authority on the human sense of smell and the biology of nasal cells, Prof Mackay-Sim led the world's first clinical trial using these cells in spinal cord injury.

As the director of the National Centre for Adult Stem Cell Research for a decade, his research has championed the use of the stem cells to understand the biological bases of brain disorders and diseases such schizophrenia, Parkinson's disease, and Hereditary Spastic Paraplegia.

Prof Mackay-Sim's pioneering work has led to collaborations with teams of health professionals who are translating his research into clinical practice.

GENIUS 3D™ MAMMOGRAPHY

Research shows a significant improvement in early detection rates and a reduction in the number of women who are unnecessarily recalled for further testing.

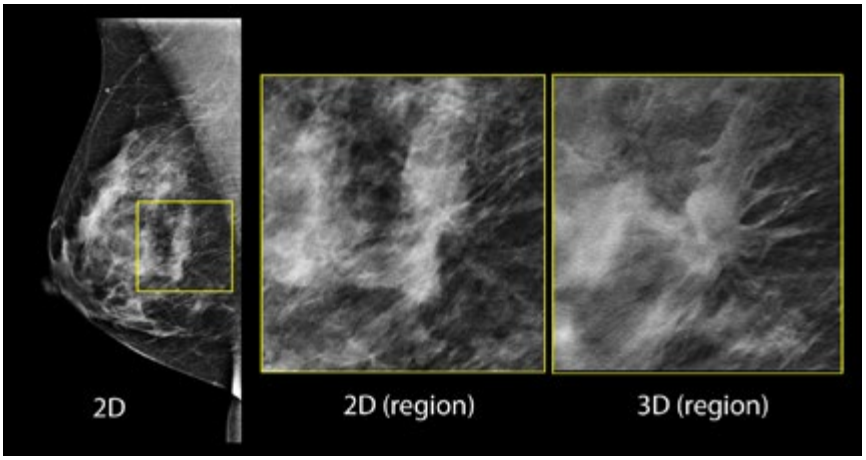
North Coast Radiology Group has been offering Genius™ 3D MAMMOGRAPHY™ exams to women living in the Northern Rivers Region since Sept 2016. This newer technology produces a three-dimensional view of breast tissue and has been shown in clinical studies to be significantly superior to traditional 2D mammograms.

3D Mammography with Tomosynthesis enables Radiologists to identify and characterise individual breast structures without the confusion of overlapping tissue, which can result in false positive findings with traditional 2D mammography. This means more women will be spared the anxiety of being called back for further testing with a 3D MAMMOGRAPHY exam.

Donna Riley, Modality Leader for X-ray, BD and Mammography and Radiation Safety Officer says: "The new Genius 3D Mammography system only takes a few seconds longer than a standard 2D Mammogram and the compression used is the same as for a 2D Mammogram. This ensures that we receive a more accurate and detailed examination with no increase to patient discomfort."

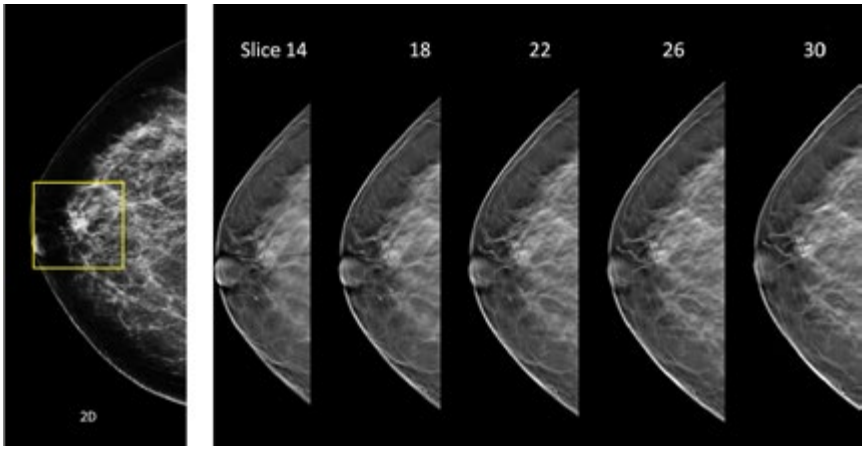
Dr Warren Lun, Women's Imaging Specialist Radiologist at North Coast Radiology says "We expect that digital mammography and tomosynthesis will allow earlier detection of smaller cancers, with less frequent misleading findings from overlying normal breast tissue. This should benefit all patients but will be especially valuable for women having diagnostic mammography such as those with a strong family history, patients with breast changes or symptoms, as well as younger women with dense breast tissue."

For women having a Genius 3D MAMMOGRAPHY™ exam, the experience is very similar to a traditional mammogram. During a 3D MAMMOGRAPHY™ exam, the X-ray arm sweeps in a slight arc over the breast, taking a series of images at various angles in just seconds. The technology then produces a series of very thin layers or 'slices', typically around 1mm thick, allowing Radiologists to view a 3D reconstruction of the breast.



Requesting 3D mammogram

To ensure your patients benefit from this superior examination please include in request forms, in addition to 'Mammogram' requests, either '2D and 3D views' or 'Tomosynthesis'. The 3D component of the examination will be performed if specifically requested, thus also ensuring maximum Medicare benefits for patients.



The importance of incremental care in general practice

by Dr Andrew Binns

GP1 registrars are beginning their first term in general practice training. While some will have had experience in the GP setting during their student years, a greater number will have been engaged predominantly in hospital training and had relatively little exposure to the GP environment.

Feedback indicates that transitioning from RMO placement in the supportive hospital environment, characterized by ample resources such as medical specialist skills and technology, to the primary care setting can be daunting. The registrars need to be more self-reliant on clinical skills and on developing an ability to understand a patient's psychosocial background, family history and lifestyle practices.

Consider the difference between working in an emergency department and a general practice. In ED the requirement, often under significant time pressure, is to work out a diagnosis and treatment plan and decide whether to admit or not. In general practice a more incremental style is needed. This entails participating in a continuum involving a number of visits that may be required to diagnose and develop a management plan.

As a GP supervisor I question my own ability to impart knowledge to a training registrar or medical student. Their skills in accessing information and research from the best medical institutions in the world are likely to be superior to mine in these times of self-directed learning.

So what can I teach them? I believe it's probably more about the art of medical practice rather than the science. How can one approach a clinical case when there are complex biopsychosocial factors to consider? Perhaps experience and wisdom does count for something here.

GP registrar Dr Noah Verderio with Dr Andrew Binns

I have seen a registrar change from being disillusioned with general practice in those early placement days to eagerly embracing the incremental approach to medical care within a couple of months.

"This incremental approach is likely to be less expensive because of more judicious ordering of tests …"

Often people recover from an illness or injury with the passage of time alone and if they don't then more clues to the diagnosis will emerge and treatment can be planned, including referrals if needed.

As regards health costs this incremental approach is likely to be less expensive because of more judicious ordering of tests rather than the 'shot gun' approach of testing everything in the first instance.

Incremental care involves a long-term approach and is particularly needed for the growing prevalence of chronic disease. The challenge for GP1 trainees is to shift focus from 'rescue medicine' to lifelong incremental care.

A recent article by well-respected surgeon, public health researcher and New Yorker staff writer Atul Gawande is recommended. "The Heroism of Incremental Care" would be of interest not just for newcomers to GP training but to all doctors and the team of health professionals they work with.

It would also be helpful if health administrators and politicians could take heed of the importance and relevance of incremental medicine as they look at health costs and the allocation of funding to primary care services.

The current freezing of Medicare rebates is having an impact on GP practices and if continued will lead to less GP services provided for the neediest in our community. This will have consequences for hospital costs when patients with progressing chronic diseases cannot be appropriately managed. Presenting to an emergency department for episodic care is less efficient clinically and is a much greater impost on the national health budget than incremental, and more personalised, care provided by a general practitioner.

So whilst episodic care has a crucial role to play for an acute severe illness, complex chronic disease presentations are best managed with a slower, one-step-at-a-time approach.

Dr Andrew Binns Clinical Editor of GP Speak

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What women are bringing to Medicine

by Dr Jane Barker

In late 2016 a landmark paper published in The Journal of the American Medical Association featured a study of around 1.6 million urgent medical admissions of older people, for a variety of different diagnoses. The authors found that when the caring physician was a woman, the mortality rate was lower and fewer discharged patients were readmitted in the following month.

While the differences may not appear large, if extrapolated the findings suggested that 32,000 fewer patients would die annually if male physicians could achieve the same outcomes as female physicians.

Half a century after I entered medical school there is now gender equality in medical admissions, but still inequality with women on average earning less than men and being under-represented in certain specialties, particularly surgery. Thankfully our area is leading the change with seven women surgeons - three general surgeons, one urologist and three ophthalmologists. Great role models for any women students wanting to pursue a career in surgery.

I would like to look at the qualities women bring into medicine that may be contributing to this outcome difference, which is not only in morbidity and well-being in the community, as we see from studies in general practice, but to mortality in the acute hospital setting.

The JAMA paper suggests that female physicians are at least as competent and capable as their male counterparts, but what do they bring that makes this differential?

This particular paper does not explore the reasons for these disparities. However, previous studies have shown that women are more likely to practice good communication, take more time over their consultations, follow guidelines and provide psychosocial counselling.

Love and compassion have always been difficult to quantify and take little place in the world of evidence-based medicine, despite a sense by most in the caring professions that they are of vital importance.

The particular qualities that women bring into medicine are by no means gender specific. Many men in medicine are deeply caring, good communicators and thorough in their approaches, while some women, of course, are not. Is it possible that some of these qualities have not been as valued by the profession and certainly not by management that gives precedence to technical skills, controlling waiting lists and time limited medicine?

Does this attitude still serve us in 2017? This way of practicing medicine is destructive for us as physicians and is not healing for our patients.

Moves towards patient centered care and the Medical Home can only be effective if we are able to take more time over consultations, are skilled communicators, take a broad holistic view of health and take into account the psychosocial determinants of health, as well as following guidelines and pathways.

Dr Andrew Binns' article on incremental care aptly describes the nature of general practice, allowing as it does for consultations over time to take us from uncertainty to certainty, and to truly build an understanding of the particular patient's needs through developing a trusting relationship.

Dr Jane Barker

I feel that for a long time the women in Medicine have been unable to bring the qualities they really value into medical practice because they have needed to be able to prove their worth in a male dominated profession.

Now this can change. I feel we could all, men and women, change the face of Medicine if we made those qualities foundational not only to our work with patients but to our relationships with one another.

Surely, as this paper suggests, if our hospitals and clinics were more supportive to both clinicians and patients then the outcomes could be greatly enhanced and as physicians we could feel we are practicing the kind of medicine we originally, and have long since, dreamed of practicing.

Dr Jane Barker is Academic Lead - General Practice, University Centre for Rural Health North Coast

GPs and AMA urge new Minister to lift Medicare freeze

The new federal Health Minister Greg Hunt has been left in no doubt about Australia's doctors' views on the need to lift the government's freeze on Medicare rebates.

While welcomed to the job by the Royal Australian College of General Practitioners and the AMA, Mr Hunt, who replaced Sussan Ley, heard the heads of both bodies say the freeze, which limits the amount reimbursed to GPs from the government at $37 per consultation, should be ended.

RACGP president Bastian Seidel described the appointment of a new minister as "a timely opportunity for the government to regroup and bolster its focus on general practice."

Dr Seidel continued, "The provision of essential medical care for Australians has reached a crossroads and the nation's general practice profession is at breaking point... Here is a fresh opportunity for the Federal Government to demonstrate once and for all it is committed to equity in health care and a general practice system accessible to all Australians."

He said "the first and most effective move Minister Hunt should make is to heed the RACGP's call to lift the Medicare freeze."

According to Fairfax Media (19 Jan) Mr Hunt spoke within ten minutes of the prime Minister's announcement of his appointment with AMA head Michael Gannon who spoke of GPs feeling "undervalued" and later said he believed Mr Hunt was receptive to ending the rebate freeze.

The aged-care portfolio, also held previously by Ms Ley, was allocated to WA MP Ken Wyatt, who has extensive experience in Aboriginal health administration in his home state and in NSW. He will have responsibility for aged care as well as Indigenous Health, making him the first Indigenous person to hold a federal ministry.

The importance of primary health care is also receiving high-level attention in the USA, not only because of Donald Trump's views on 'Obama-care' but through a major article in The New Yorker this week by noted surgeon/author Atul Gawande. Dr Gawande writes of his changed view of primary care's key role in the medical mix - I finally had to submit. Primary care, it seemed, does a lot of good for people—maybe even more good, in the long run, than I will as a surgeon...

General practice may not be as "sexy" as thoracic surgery but Gawande acknowledges the therapeutic effect of a strong patient / GP relationship will often catch the disease process early and obviate the need for heroic interventions.

Excelling at being #JustAGP (as those who congregate on Twitter will attest) is the most important factor in improving the health of the nation. Unfortunately, so far this argument has not moved Treasury.

Northern NSW birthrate continues to drop

The birth rate in the Northern NSW Local Health District has continued its downward slide of the past five years, with 2557 babies born in 2015, a reduction of 2.7 per cent since 2011, three times the statewide average.

The state at large recorded 0.9 per cent fewer births than in 2011. The statistics were revealed in the NSW Mothers and Babies 2015 report.

They also show the region having the state's second highest percentage of young mothers (after the Far West), with 12-19 year olds accounting for more than one-in-twenty deliveries.

The eighteenth annual snapshot of birthing practices and outcomes in NSW shows that the percentage of teenaged mothers in NSW fell from 3.2 per cent in 2011 to 2.5 per cent in 2015, less than half the Northern NSW figure.

In our region, 92.5 per cent of births were in hospitals, with 44.6 per cent of those in a birth centre. The area had the state's highest number of planned home births (1.4 per cent), and the state's equal-highest number of babies born before arrival at hospital (1.3 per cent, the same as in Southern NSW).

Mothers of Aboriginal and Torres Strait Islander descent accounted for 9.4 per cent of births, the state's fourth highest total.

Elective caesareans accounted for 12.9 per cent of births, and emergency caesareans, 11.1 per cent.

"Among privately insured mothers the rate of normal vaginal birth fell from 44.9% in 2011 to 43.6% in 2015 and the caesarean section rate increased from 40.4% to 43.0%," the report noted.

"Among publicly insured mothers the rate of normal vaginal birth fell from 63.3% to 62.3% and the caesarean section rate rose from 26.5% to 27.3%."

The proportion of mothers in Northern NSW who reporting any smoking during pregnancy was 11.1 per cent, the statewide average in 2011, which has now dropped to 8.9 per cent.

The perinatal mortality rate in Northern NSW 2015 was 8.1 per 1,000 births, compared to the state average of 8.2 per cent, with the average for Aboriginal or Torres Strait Islander babies standing at 9.6 per cent.

Doctor's daughter begins local placement

She's already a qualified pharmacist and now Northern Rivers-born Sophie Wagner is studying to become a doctor as well.

Sophie, whose mother Fiona is a well-known GP working at St Vincent's in Lismore, grew up in Woodburn and completed high school at Summerland Christian College and later Trinity Catholic College. Her father Stephen is a local mechanical engineer and farms sugar cane and cattle.

She finished a four-year pharmacy degree at The University of Queensland before undertaking her full registration at Dubbo Base Hospital where she got a close-up look at the medical world. Later, she worked in a local pharmacy in Sydney. Now Sophie is in her third year of medicine at The University of Sydney, a milestone marked by supervised practicum placements in clinical settings that include hospitals and primary care.

Opting to spend the 40-week period in a rural/regional area, Sophie has joined 16 other USyd medical students whose local placements in teaching hospitals, GP practices and community and Indigenous health services are being coordinated by The University Centre for Rural Health.

The UCRH has campuses adjacent to the hospitals in Lismore, Grafton and Murwillumbah, and close working relationships with the Northern NSW Local Health District and the North Coast Primary Health Network.

During their year-long residency students engage in a range of placements that introduce them to specialised areas of medicine they may choose to follow in the future. These include surgery, emergency medicine, obstetrics, chronic disease management, general practice and Indigenous health.

Doctor-to-be Sophie Wagner told GP Speak she is delighted to return to the Northern Rivers after working in big city hospitals, and thinks she will come back here to work some time after graduation, but in which medical field is too early to tell.

"Perhaps as a rural GP, or as a rural specialist," she added, "but there's still a long way to go."

Sophie Wagner (centre, orange top) with fellow medicine students at the Indigenous orientation program organised by the University Centre for Rural Health. Here, they are learning to make fish traps with Bundjalung woman Monica Kapeen.

Before setting foot in any health facilities the USyd student group embarked on a two-day cultural immersion program in Evans Head focusing on Aboriginal culture and health.

"The aim is to give a better understanding of how to build relationships when working clinically with Aboriginal people, and give the students an opportunity to talk with Aboriginal people about their real life experiences," coordinator Emma Walke said.

"The two days included a yarning circle, and some tasks and challenges, such as making fishing nets and canoeing. Going bush may take them out of their comfort zone, but the experiences will be priceless, and a great benefit to their careers."

UCRH director Professor Bailie added, "The cultural immersion program for medical students addresses the importance of ensuring that new generations of doctors have a sound understanding of Aboriginal culture and history.

"This will enable them to understand the underlying determinants of health and enhancing their ability to relate appropriately to Aboriginal and Torres Strait Islander patients and colleagues."

In a secondary-educational first for the North Coast, the UCRH has announced a program aimed at encouraging Indigenous students from Year 8 upwards to consider a career in medicine, allied health and nursing.

Prof Bailie said the initiative is a key part of UCRH's commitment to improving the health of Aboriginal and Torres Strait Islander people in this region and Australia-wide. Baribunmani Wanyi Ngay - Bundjalung for "I dreamed about you" - will begin in three local high schools in the first school term of this year. It is being coordinated by Emma Walke and Darlene Rotumah, and draws on experiences from a health academy program at Broken Hill, with local adaptation.

"We want to be able to show Goori students the gamut of careers that are available in health and inspire their confidence to know they can do it," Ms Walke said.

Prof Bailie said the program is another of UCRH's student-focused initiatives aimed at increasing the numbers of Aboriginal and Torres Strait Islander people in the health workforce.

"Encouraging and supporting school-aged children to take up health careers is a vital step in the systematic, multi-pronged and long-term approach to improving health among Aboriginal and Torres Strait Islander people," he said.

UCRH is also hosting The University of Sydney's Graduate of Indigenous Health

cont on p12

UCRH student placements

Cont from P11

Promotion, a year-long course starting in early February.

"We plan for a cohort of 15 local people to attend the course, which gives opportunities for employment but also brings more of our mob into the learning environment of the UCRH Lismore campus," Emma Walke said.

UCRH is liaising with local health service providers to arrange placements for those students who may not already be engaged in health careers. Prof Baillie said UCRH's commitment to these programs is aimed at addressing the wide gap in health status, access and quality of care between Aboriginal and Torres Strait Islander people.

"These are vital initiatives in developing the health workforce in Australia generally. Aboriginal and Torres Strait Islander people make up a relatively high proportion of the population in rural areas, including here in the Northern Rivers, so these initiatives are of even greater importance in our context", he added.

Understanding family relationships was a key part of the UCRH's cultural immersion program for University of Sydney medical students beginning a 40-week placement on the NSW North Coast. Pictured: Darlene Rotumah (l) and Emma Walke whose extended family is shown.

"I congratulate Emma Walke and her small team in taking the lead on these initiatives, and thank members of the Aboriginal community, local and other organisations who have contributed to this important work."

UNIVERSITY CENTRE FOR RURAL HEALTH NORTH COAST
education research workforce

Denmark leads in Primary Care

by Dr David Guest

Primary Care systems vary widely in economically advanced societies around the globe. The Danish system is often touted as Primary Care done right. So what are the key features of the Danish general practice?

Overview

Like most western European countries Denmark has a national health service that covers the entire population and is free for all to attend. Most specialists are hospital based employees but general practitioners operate as small businesses, usually in one or two man practices. Every two years they negotiate a contract with the local health service for the Primary Care management of their patients. The contract states that they are responsible for the care of at least 1600 people but once this number is reached they may close their books to new patients. The contract provides more than 95% of a GP's income.

Patients can choose any registered GP as their local doctor, if her books are open, and can optionally register on that GP's "list". This is not a requirement but it is financially advantageous to do so and 98% of the population nominates a GP for their routine care. Patients can change GPs but only once every three months.

Apart from ophthalmology and ENT, patients need a GP referral to see a specialist. Patients can see a private specialist who does not have hospital privileges but there is no government subsidy for these visits. Private hospitals similarly receive no government funding and account for only 3% of services nationally. There may be copayments for medication and dental services and copayments make up 17% of all medical costs.

The five Danish regional governments are responsible for the provision and funding of both the primary and secondary care in their jurisdictions. Contracts with the GP practices specify the fee schedule and accessibility, such as consultation within 5 days, as well as the list size. Practices typically have one or two full time equivalent employees fulfilling reception and practice nursing duties. Surgeries are open from 8 am to 4 pm four days per week with the first hour devoted to telephone consultations. One day per week the surgery will stay open later to 6 or 7 pm.

After hours is shared amongst local practitioners often working from a specific after hours service usually colocated with, but separate from, a hospital's emergency department. In addition to manning the after hours facility, practitioners will field local telephone calls and provide a limited roving service for home visits. Patients may attend Accident and Emergency services at any time but are increasingly encouraged to be processed through the after hours service first.

All practices are fully computerised with the ability to send prescriptions to local pharmacies and referral letters to the hospital. They also support email consultations. The average number of consultations per patient is 7 per year but this figures includes surgery, after hours and phone contacts.

GPs do 5 years of specialty training one year after medical graduation. There is no requirement for recertification. The quality assurance program is organised by the Danish College of General Practitioners. Practice data from a centralised database is used to give feedback on clinical guideline adherence. Practices also receive feedback through patient surveys that allows them to compare their results with their peers. Practices have support from their local quality improvement organisation which includes part time GPs providing practice support.

GP remuneration is made up of one third capitation and two thirds fee for service. There is debate about the mix but areas that are deemed high priority are paid on a fee for service basis since this is associated with higher productivity. GP remuneration is set higher than senior hospital consultants.

It is difficult to recruit practitioners to rural areas since many of the practices are solo with the GP at retirement age. There is therefore an increasing trend for health services to use an employee model to fulfill these positions.

Discussion

The Danish Primary Care system has matured over the last 100 years and differs in many significant aspects from Australia's.

The gatekeeper function in Denmark is more extensive. Both systems require GP referral to the secondary care system but the smaller size of the one or two doctor practices, coupled with the high proportion of patient enrollments on GP lists gives Danish GPs a stronger role in managing a patient's care.

Patient satisfaction with health care system is high with over 90% rating the Danish system as good or very good. The gatekeeper system supports the medical home concept of delivering services at the lowest effective level of care. This has kept health care costs in Denmark to just under 10% of GDP.

The computerised Primary Care system with central reporting allows the health commissioners to closely scrutinise GP activity and to give feedback about both patient satisfaction and clinical performance. This degree of scrutiny would be strongly resisted by Australian general practitioners but the high remuneration for Danish GPs may make this aspect of the system more palatable.

Vesting responsibility for both the delivery and financing of primary and secondary health care at the regional government level has allowed the Danes to avoid the gaming and cost shifting of care delivery typical of the Australian system. The focus on organisational structures and appropriate communication technology has made them one of the most efficient health care systems in the world.

Compared to Denmark there are almost twice as many Australian GPs per head of population. This coupled with the lack of income security makes the Danish model an unlikely prospect in Australia for years to come.

"In Denmark, our focus on putting the patient first – combined with constant efforts to improve efficiency and quality – has resulted in a wide array of innovative healthcare solutions.
I sincerely believe Danish technologies, products and expertise can have a positive impact on global health."

Her Royal Highness Crown Princess Mary is patron for HealthCare Denmark

Image above courtesy of VisitCopenhagen CC by SA

Prostate cancer study finds radiation therapy comparable to surgery

10-Year Outcomes after Monitoring, Surgery, or Radiotherapy for Localized Prostate Cancer

ADVERTORIAL

A major study for prostate cancer, the ProtecT trial, investigated the differing options for treatment and associated outcomes over the course of ten years. This study showed that men with early prostate cancer have equivalent 10-year cancer free survival results if they have radiation therapy or surgery. The study also found that radiation therapy caused less urinary incontinence and sexual problems. Despite this, less than half of Australian men with prostate cancer will see a Radiation Oncologist.

As this study concluded in 2009, it is possible with the current advances in radiation therapy and surgery could offer even better results and less side effects than reported. What also became evident was that outcomes for early prostate cancer were excellent across all modalities and that active surveillance is still a good option for some patients.

"This new study adds to the mounting evidence that there are several equally effective invasive and non-invasive treatment options for prostate cancer. Men must be given the control to consider what they prefer based on accurate and non-biased information (including costs) in order to make informed decisions," said A/Prof Turner.

Genesis CancerCare Queensland offers both VMAT and IMRT external beam radiation therapy as well as Brachytherapy for prostate cancer. Developments such as SpaceOAR are also on offer to help reduce the likelihood of side effects from radiation treatment.

For more information please go to www.genesiscancercareqld.com.au

Update to Ironing Out Perioperative Challenges

Written by Beverley Hiles, RCHSG Blood and Blood Products CNC Products CNCw

Preoperative iron management has improved on the North Coast in the last 18 months. However there is still room for further improvement, particularly in major bowel surgery. The local co-ordinator of the project, ***Beverley Hiles****, reports on progress to date.*

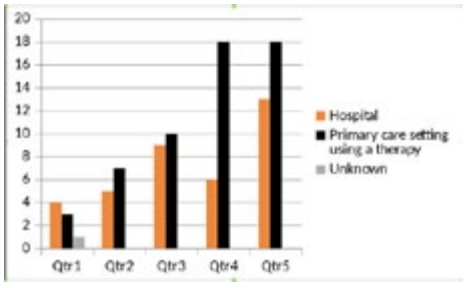
The Australian Commission on Safety and Quality in Health Care has been conducting the National Patient Blood Management Collaborative (NPBMC) since July 2015. Lismore Base Hospital and Lismore St Vincent's Private Hospital along with the North Coast Primary Health Network have been a part of this national collaborative.

The aim of the collaborative is to identify and manage preoperative anaemia and/or iron deficiency in patients scheduled for elective surgery where significant blood loss could occur, namely in gynaecological, gastrointestinal and orthopaedic surgical streams. It is a key patient blood management strategy for optimising red blood cell mass before surgery while aiming to reduce blood transfusion which may be an independent risk factor for increased morbidity and hospital length of stay.

Our focus on the North Coast was to engage GPs in optimizing a patient's blood prior to surgery as we recognized that GPs are best placed to manage iron deficiency and anaemia and would play an important role in the collaborative.

Letters are sent to GPs once the hospital has a request for admission for the selected surgical groups, requesting preoperative assessment and management of anaemia and/or iron deficiency ahead of surgery.

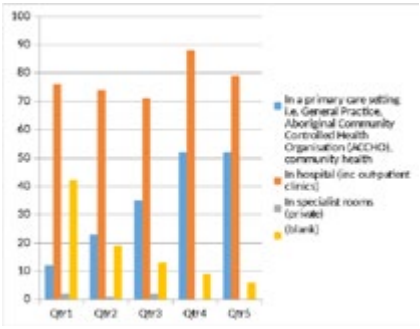
The results to date show a promising upwards trend for iron deficiency assessment and management throughout each quarter of data collection.



Graph 1: Where was iron deficiency managed

Graph 1 illustrates a steady increasing trend in iron deficiency management in the primary care setting.

Graph 2 demonstrates that although there is an increasing trend in primary care in the assessment of iron deficiency preceding surgery, 60% of iron assessment by the 5th Quarter is still performed by hospital services at the preoperative assessment clinic.



Graph 2: Iron deficiency assessment

Following an in-depth discussion between the NPBM and national teams on management of iron deficiency and anaemia, teams undertook a small audit of non-managed iron deficiency to better understand why management was not recorded and to identify potential areas for improvement.

Some management factors identified were:

- a decision not to treat borderline results
- unawareness of the impact of iron deficiency in the absence of anaemia
- or lack of acknowledgement that there may be iron deficiency if haemoglobin is within range.

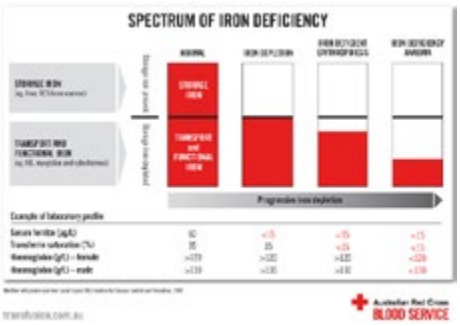
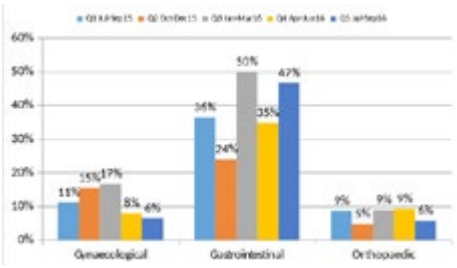


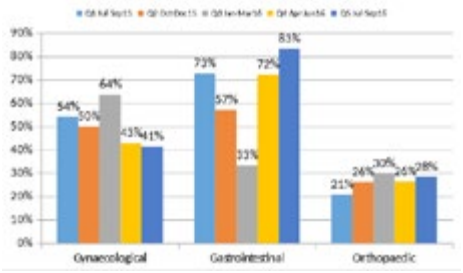
Table 1: Spectrum of Iron Deficiency

Table 1 from the Australian Red Cross Blood Service explains the spectrum of iron deficiency, highlighting that normal range haemoglobin can be maintained in iron depletion and iron deficient erythropoiesis. It is possible therefore for a patient facing major surgery where bleeding may occur, to be iron deplete with normal haemoglobin, and reliance on FBC alone may be a less favourable option in the preoperative care process. See the Spectrum of Iron Deficiency

Our local data in Graphs 3 and 4 indicates also that while anaemia may be present in each surgical cohort, iron deficiency is more prevalent and may be present without anaemia.



Graph 3: Confirmed Anaemia



Graph 4: Confirmed Iron Deficiency

Current guidelines from the National Bowel Screening Program recommend checking iron studies for iron deficiency prior to colonoscopy/cancer screening. Our local NPBMC team advocates **early iron replacement in iron deplete patients referred for gastrointestinal surveillance,** as iron management will not alter the outcome of any investigations and will optimize the patient should surgery be required.

GPs interested in further information on correcting iron deficiency are referred to the excellent, well written and easy 6 minute read. 'Correcting iron deficiency' in the Australian Prescriber, Volume 39: Number 6: December 2016. Correcting Iron Deficiency

Access secure on My Health Record

Addressing concerns about possible unauthorised access to the My Health Record system, the North Coast Primary Health Network is reassuring the public that code setting restricts access to those healthcare professionals who receive patients' consent to put their details online.

The PHN is also stressing the benefits of providers having fast digital access to information such as allergies, current conditions, medicine details and pathology and lab reports in the event of accident or medical emergency. This is particularly valuable if people are away on holidays or business and might need emergency care.

Addressing the security issue, the PHN points out that healthcare professionals can only access My Health Record if they have been given permission to do so. In addition, the system has a history capability whereby patients can monitor who has looked at their health details.

It is an offence for an unauthorised person to collect health information from an individual's My Health Record, with penalties of up to $108,000 for an individual or up to $540,000 for a body corporate, or up to two years' imprisonment.

"You can control who can see your e-health record through setting a record access code and only giving the code to those health professionals you wish to access your history," it says.

This consent extends to emergency department staff who might need to urgently access medical histories.

To protect their privacy, patients can, in consultation with doctors, control what information goes onto My Health Record, so that only those conditions, medications or past operations they wish to be displayed are made accessible. Or contact by **phone 1800 723 471**

Sins of Commission

by Dr David Guest

General practitioners are small business owners working independently and unfamiliar with the process of tendering. The awarding of contracts is a discipline that has matured over the last 230 years. History has much to teach us.

The loss of the American colonies in 1783 marked the end of transportation of British convicts to the New World. It is estimated that over 50,000 made the trans Atlantic journey in the century prior. The industrial revolution was changing British society and increasing numbers of workers were replaced by machines. The unemployed flocked to work in the cities but industrial growth was not strong enough to accommodate their number. Idle hands are the devil's workshop.

Convictions for theft and forgery rose and Britain's prisons and overflow prison hulks on the Thames were soon at capacity. Treasury needed a solution. The largely unknown land of Terra Australis would be the new destination for the detritus of British society.

Britain had over a hundred years of experience in transporting convicts around the Atlantic but the much longer passage to Australia, posed new logistical problems.

Bound for Botany Bay

The 11 ships of The First Fleet sailed on 13 May 1787 and stopped in the Canary Islands and Rio de Janiero before final provisioning in Cape Town for the long passage across the Southern Ocean. Despite the eight month journey, of the 1,487 who embarked, only 48 died on the journey; a death rate of 3 per cent.

The success of the fleet has been attributed to the careful provisioning of the ships and the attention to prisoner welfare overseen by Governor Arthur Phillip and by the successful contractor for prisoner transportation, William Richards. Richards was an evangelical Christian and reportedly was as concerned for the welfare of his charges as he was for his fee.

The cost of this epic journey and the establishment of the new colony at Port Jackson were staggering, at least for the British Treasury. The final sum came to £55,000 and equates to $75 million dollars in today's currency.

As a result, the commissioning for the second fleet was pitched at a quarter of the price of the first and awarded to the lowest bidder. Camden, Calvert and King were the largest slave trader firm in London and their priorities did not extend to convict welfare. Their three vessels of the second fleet carried 1,026 convicts, stopped only once at the Cape Town and made the journey in five months, three month's shorter than The First Fleet's.

First Fleet in Botany Bay, 21 Jan 1788

During the voyage 267 died and 486 were deathly sick on arrival at Port Jackson, of these 124 subsequently died. The death rate was a staggering 40%.

Governor Arthur Phillip wrote:-

"I will not, sir, dwell on the scene of misery which the hospitals and sick tents exhibited when these people were landed, but it would be want of duty not to say that it was occasioned by the contractors having crowded too many on board these ships, and from their being too much confined during the passage."

Contracts for The First Three Fleets

There appears to have been no formal contract for **The First Fleet** since many of the costs were too hard to estimate. Richards was paid on a cost plus small profit basis. Britain has successfully established a penal colony on the other side of the world but the price for prisoner transportation was too great.

The Second Fleet contract was therefore made much more explicit. It specified standards of accommodation and rations, and the employment of a qualified surgeon

- Lessons in Contracting from Australian Convict Transportation

with access to a stocked infirmary. Captains were required to keep journals monitoring the voyage. However, there were penalties if prisoners escaped and there were no minimal number of landfalls specified. In addition, excess food and supplies could be sold by the contractors at the end of the journey to the struggling inhabitants of the new colony. Starved and confined below decks for most of the journey the Second Fleet's prisoners' lives were a living hell.

The contract was paid in three installments:- on fitting out the the ships, after loading the prisoners and on arrival at Port Jackson. This last payment was not contingent upon the health of the prisoners or even of them still being alive.

When the news of the death rate got back to London there was a scandal. There was no official investigation, however, and a criminal prosecution failed. In fact Camden, Calvert and King went on to be awarded the contract for **The Third Fleet.** Thankfully, with previous experience behind they managed to get the mortality rate for The Third Fleet under 10%.

Transactional versus Relational Contracting

The last 40 years has seen an increase in tendering for the delivery of government services. The United Kingdom has led the way and shown that it is an effective means to contain costs. Private contracting has driven down the price of prisoner care and vocational education in Great Britain while demonstrably maintaining or even improving the quality of the service.

Commissioning is not a panacea, however. Fear and greed are the drivers of a market. Camden, Calvert and King were slave traders and indifferent to criticism they were heartless opportunists. Their reputation as a profitable company was their only criteria for success. Two consecutive contracts suggest that this approach held some sway in Treasury.

Sturgess et al (Gary Sturgess is a former NSW government bureaucrat) argue in a recent article, Commissioning Human Services: Lessons from Australian Convict Contracting, that unfettered "transactional" contracting is not appropriate for the delivery of human services.

He makes the distinction between **"transactional" and "relational" contracting.**

Prior to the American War of Independence contracts between the government and contractors were usually underpinned by a long term relationship between the two parties. The British government knew the reputation and capabilities of the contractor and awarded them repeat contracts. As a result the contractor built up skills and efficiencies in the delivery of the service allowing them over time to achieve a better service at a lower price.

After the American War of Independence there was a push to change to open or transactional contracting. By opting for the lowest bid bureaucrats could escape any suggestion of cronyism and corruption while keeping Treasury happy. Everybody understands price.

The problem with open contracting is that the contractor is not rewarded for providing a better service. There is no value in building up expertise since this entails additional costs while not increasing the likelihood of repeat contracts.

Commissioning for Human Services

The death rate on subsequent voyages to Australia trended down to under 5%. This has been largely attributed to the requirements of the Inspector of Transports, surgeon Sir Jeremiah Fitzpatrick.

He identified 8 key areas: pre-transportation medicals, layout of the quarters, sanitation, ventilation, water filtration, table of rations posted in the prison (so that prisoners knew what they were supposed to be getting), codification of surgeon's duties, certificate of performance upon arrival and review of the surgeon's journal.

Under Fitzpatrick's regime, if performance was satisfactory (prisoners made it to Port Jackson both alive and healthy) a certificate of compliance was issued that triggered the final payment.

Fitzpatrick's approach foreshadowed the recommendations of Henry Parnell, a British and Irish early 19th century politician.

Sturgess et al credit Parnell with seven principles for contracting:-

1. Set out the specifications in the "fullest and clearest manner"
2. No unnecessary expenses for the contractor
3. Set the contract price so the supplier can provide a good service and still make a profit
4. Pay in installments but reserve a small incentive payment for the completion of the work
5. Select honest and able contractors
6. Prefer contractors for continuing supply (subject to termination for non-performance)
7. Advertise widely for each contract

Alternative payment systems were trialled. Contracts that left the transport particulars largely unspecified but paid a significant portion of the contract on the basis of a successful outcome failed. They were not popular with contractors because of the multiple risks involved in achieving the end result. As a result only three voyages were financed this way.

Conclusion

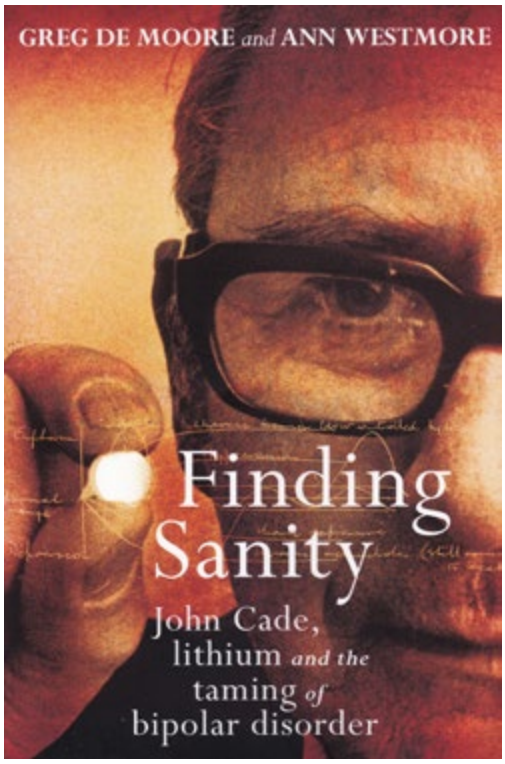
Contracting for the delivery of human services poses different problems to those for other goods and services. Investment in capability building is necessary for long term improvement. To justify this investment contractors must have a high likelihood of future successful tenders and cost alone cannot be the deciding factor.

Neither pure relational nor transactional contracting is appropriate in all circumstances and experimentation is required to determine what works in particular situations. A/B testing is the term used in business for controlled experiments on product variation. It is extensively used in online markets but is also suitable for improving human services.

Aged care, disability support, mental health care and chronic disease management can be delivered affordably and humanely in Australia. Experimentation underpinned by mutual support from both the government and the professions will help us get there.

Reviewed by Robin Osborne

***Finding Sanity** - John Cade, lithium and the taming of bipolar disorder*
Greg de Moore and Ann Westmore (Allen & Unwin)



Despite unnerving similarity to the image of Bryan Cranston for the meth-cooking series Breaking Bad, the cover photo of this outstanding book is of its subject, the Australian psychiatrist Dr John Cade, who pioneered the use of lithium for treating manic depression, now known as bipolar disorder.

It was taken in 1974 by a Melbourne news photographer, shortly before Cade departed for New York to collect the world's richest prize in psychiatry, shared with a Swedish collaborator, Morgens Schou.

"As the interview came to a close, he picked up a white lithium tablet and held it before the photographer's camera, the circular pill nipped between thumb and index finger.

"John drew back from it and momentarily looked closer at this tiny pill, squinting, to study its mysteries all the more, and as much to himself as to his interviewer, he whispered in wonderment: 'The stuff is so cheap'."

Discovering that one of the earth's original elements held value for something other than batteries or H-bombs had been a long and often rocky road for John Frederick Joseph Cade, born in 1912 in Horsham, Victoria, son of a doctor and in time the father of two others.

He was a man of great tenacity - inherited from his mother, the authors surmise -frankness and integrity, and, despite an establishment appearance, considerable eccentricity. Such characteristics held him in good stead throughout a career marked by successes and setbacks, including a harrowing stint as a POW in Changi prison.

Cade would hold a number of medical positions in what were then known as asylums for the insane, seemingly inspired by the professional orientation of his father David, a veteran of Gallipoli and France traumatised by the conflict. "As much a victim of war as the boys he saw cut down... like the refugee from war he was, David Cade took a medical post with the Lunacy Department in the small, pretty town of Beechworth in northeastern Victoria's alpine country." There, and later in Melbourne, the young family grew up, John, bright, sporty, staunchly Catholic, attending Presbyterian Scotch College, and later studying medicine at the University of Melbourne.

Written with a light touch, this wonderful biography has been superbly researched by the co-authors - Greg de Moore is Associate Professor of Psychiatry at Westmead Hospital, Dr Ann Westmore's PhD focused on psychiatry in mid-20th century Victoria.

At university Cade boxed against Edward 'Weary' Dunlop, "no slouch with the gloves himself", destined to be another prisoner of the Japanese. He also sparred with Bennie Rank, "whose nose he flattened (very apt, considering Sir Benjamin rose to be one of Australia's most prominent plastic surgeons)".

In his first year out, the doctor became a patient, hospitalised with pneumococcal pneumonia and expected to die. In recovery he met a nurse, Jean Charles, who would be by his side for the rest of his life.

In 1936, having switched from pediatrics to psychiatry, the 24-year-old was appointed medical officer in the Victorian Department of Mental Hygiene, heading off to the "gloomily impressive" Beechworth Mental Hospital, opened in 1867, with his dog Bonzo the Fourth.

The conditions were appalling and the patient mix challenging: "The deluded, the depressed, the alcoholic, the epileptic, the head-injured, the backward and the psychopathic were like a potpourri of problems, mixed together and sent 'up the hill'."

A decade earlier the German psychiatrist Emil Kraepelin had "delineated from the morass of madness a specific mental illness called 'manic-depressive insanity", but by 1937, when John and Jean wed, the causes of the illness were still mysterious.

"Of course there were pills and potions, like a mad-hatter's apothecary, which sometimes soothed, even knocked out patients for a while. But when patients woke from this drugged slumber they awoke as mad as before."

Just shy of 28, with a pregnant wife and one-year-old son, Cade went to the army recruitment centre to sign up for service.

"Any psychiatric duties were incidental to my general regimental medical responsibilities as the senior company commander in a Field Ambulance," Cade would recall later, adding wryly: "For some reason - I hope it was because of my specialist inclinations - I early attracted the nickname of the 'mad major'."

Posted to Malaya and pulled back to Singapore where in 1942 so many troops would be captured and imprisoned, Cade found himself in Changi, settling into a medical routine in the camp hospital.

Soon enough, his specialty caught up with him and he was assigned to take charge of the small psychiatric ward - earning him the affectionate moniker that would linger amongst fellow survivors to the end of his days.

He kept a record of cases, we learn, and recalled that, "I had ample time to meditate on the possible causes [of serious mental illnesses such as manic depression] and plan the sort of research programmes for when the fruitful years might return."

They returned in late 1945 when Cade

Book Review

sailed home to be reunited with Jean and the boys he had hardly known. His first stop was the repat hospital for treatment for malnourishment and bronchitis.

Although weakened, and angry that war had stolen some of his finest professional years, the 34-year-old readied himself to resume his psychiatric work in public asylums. The patients didn't frighten him, for he and his brother had mingled with them during his father's time.

A man of precise routines - grace before each meal, Mass on Sundays, exactly seven cigarettes daily, one over-full glass of sherry, two cups of tea with each meal - he was also immensely engaging with patients, many of them returned servicemen, and all asylum staff, however menial.

Amidst the rhythms of asylum life, John Cade began the research that would change the history of psychiatry and make his reputation.

It started with collecting patients' urine samples - to Jean's dismay he stored them in the kitchen fridge - and comparing their appearance to the noted condition of the patient-donors.

Working after hours in the Bundoora asylum garage he began injecting the urine into guinea pigs, gauging the effect on the test animals, most of which died and underwent autopsy.

"It sounds archaic and primitive... But somehow his upbringing, his pragmatism and his insatiable curiosity gave rise to this hands-on experimentation; it had been the shaping of a lifetime that led him here."

As it turned out, 'manic urine' is no more likely to kill a guinea pig than any other sort, so Cade powered on, experimenting with various chemicals, including uric acid to which he added the element lithium to make the former more soluble.

"And that is where lithium comes onto the scene, en passant, almost apologetically... John then injected lithium alone... That's when he drew breath, and promptly forgot everything else, except for lithium... the guinea pigs seemed restful...

"Those lovable rodents, normally a mass of vibrating muscle and fur, now with lithium in their bellies, would lie with equanimity on their backs, staring with soft eyes at John while he gently prodded them with the stub of his index finger.

"He had never seen them behave like this. They seemed alert, but they were calm... What he saw was a rodent stilled by lithium." In time he would see humans similarly calmed by lithium, the lightest and most reactive of metals.

He, and others who paid attention, would also see people die from it after receiving unsuitable doses, triggering coronial inquiries, widespread criticism of 'lithium toxicity', and a 20-year ban in the US. Only after the ban's ending could a widespread uptake of lithium enable the successful treatment of many bipolar patients.

The first step on the journey to human usage involved John Cade's testing lithium on himself.

Contrary to his documenting of the guinea pig trials, he left no records: "Perhaps this reflected the secretive nature... or awareness of his eccentricity; or of his terror of things going terribly wrong. And of course there was the fear of exposure to ridicule."

In a dramatic moment, "as the spirit of the alchemist stirred within", he mixed the powder with water, and held the elixir to his lips: "His nostrils sensed no odour... Eyes closed, he drank. At first the taste was probably a little salty, almost metallic - something to note for how a patient might react. And then, nothing. Pleasingly, nothing."

Cade would repeat the experiment, further subjecting his body to "whatever his God and the Periodic Table would deal him... The writings from the 19th century, familiar to John, suggested that lithium would seek out every organ, seeping into every cell and across the blood-brain barrier, that Great Wall of China, which separated the brain from blood. And it was the brain that was lithium's final target."

Cade believed the importance of chemistry in the mental health equation was a finger in the eye to the devout Freudians, a point he often made in lectures, much to the discomfort of some colleagues.

As the authors note, there was one last matter to resolve before Cade could try out his lithium potion on the diggers about him: he must tell his wife. Although she was alarmed, Cade was soon seeking out a patient for whom lithium "might work its spell." That man was ex-Private Bill Brand, ill before he even arrived in Britain, and never sent to the Western front. Repatriated to Melbourne in 1917, he became homeless, a declared public nuisance, and was institutionalised.

Known as a "scoundrel in the asylum", Bill had some mixed experiences with the lithium treatment that began in 1948 but when he maintained his dosage his moods showed remarkable improvement.

Within months he was allowed temporary leave: "Lithium, a salt of the earth, had found its way into the mind of a man who had lost his."

Brand would go on to have a long life, despite separating from his wife at a young age after mental illness "took him apart".

Amidst the great controversy over lithium, and running bureaucratic battles, Cade found his work supported by the Swede Schou, and valued by key Australian colleagues, including the colourful German immigrant Dr Eduard Trautner, surely a biographical subject himself.

Cade's own book, Mending the Mind - a short history of twentieth century psychiatry was published in 1979. In time he received worldwide fame and a host of awards, but none can match the letters of appreciation from the many patients whose lives he had saved.

"No patient was more important to John Cade, or perhaps more vital to the history of psychiatry, than Bill Brand, the first patient treated with lithium. ... Modern pharmacies bulge with medicines for different mental illnesses - but the first medicine ever to specifically treat a mental illness was lithium...

"Not every patient responds to it, and its dose still need close monitoring... [but] Lithium remains at its most effective for severe cases of bipolar disorder."

Rural health an early 2017 focus

The need to further expand medical services in non-urban Australia has attracted early New Year attention, with the peak body for University Departments of Rural Health seeking a national director to help build the health workforce in rural and remote Australia.

Meanwhile the Royal Australian College of General Practice has said building workforce capacity depends on exposing Australian medical students early to rural areas, rather than continuing to rely on placing overseas trained GPs.

"I think it is far more attractive now for Australian graduates to work in rural areas," said RACGP president Bastian Seidel who is urging the federal government to remove GPs from the skilled migration occupations list.

Australian graduates are now able to meet the workforce needs of rural Australia, where overseas trained doctors are currently required to work for up to ten years, he added.

The recruitment process launched by the Australian Rural Health Network (ARHEN) is aimed at finding "a strategic thinker with strong policy and advocacy skills, an effective communicator, and [someone] experienced in government."

ARHEN was established in 2001 and is the peak body for 12 University Departments of Rural Health located in every State and the Northern Territory.

Its vision is to achieve better rural and remote health through learning, with the guiding purpose of leading and initiating the rural and remote health agenda in the areas of education and research.

In our region the University Centre for Rural Health North Coast has established a strong reputation for coordinating placements for medical, nursing and allied health students from a range of universities

UCRH Director Prof Ross Bailie

in local hospitals, GP practices and other clinical settings.

Students undertake clinical work across the Northern Rivers, with many taking up positions here after graduation.

"This work makes a vital contribution to improving health services in this region and in regional areas across Australia," said UCRH director Prof Ross Bailie, himself a former GP.

New CEO and office for Rural Docs

With new CEO Richard Colbran on board, the NSW Rural Doctors Network has opened a Newcastle office focused on becoming a hub for rural health practitioners and organisations across NSW.

The official opening was performed Federal Assistant Minister for Rural Health, Dr David Gillespie, who said the NSW RDN had been exemplary in advocating for rural health workers and rural communities for over 20 years, with many of their initiatives providing models for collaborative reform.

CEO Richard Colbran with Dr David Gillespie MP and Dr Ian Cameron at the official opening

"NSW RDN has long been a key facilitator with other organisations to fill workforce gaps, and is a real model for a cohesive approach to health services and innovation to expand rural and remote access to healthcare," Dr Gillespie said.

"Their close partnerships to coordinate solutions to GP, nursing, dental and allied health resourcing issues with Local Health Districts, Aboriginal health services, Primary Health Networks, and other relevant stakeholders means rural communities in NSW are getting better care, when and where they need it."

Dr Gillespie paid tribute to outgoing CEO Dr Ian Cameron whom he described as "a beacon for rural and remote health, and a tireless advocate for more than 20 years."

Recent successful initiatives by NSW RDN include continuing work with the Aboriginal Health and Medical Research Council, increasing the delivery of eye health services and audiometry services under the Rural Health Outreach Fund program through the Visiting Optometrists Scheme, the recruitment of almost 200 nursing and allied health professionals under the Rural Health Professionals Program, and 58 new dentists starting work across 38 different towns through the Dental Relocation and Infrastructure Scheme.

Comprehension is the missing health care ingredient

by Robin Osborne

There is a serious disconnect between the reading ability of many Australians and the complexity of the health care information they need to understand, according to the chief executive of Northern NSW Local Health District, Wayne Jones.

Consequences include up to 40 per cent of booked surgeries being postponed because written instructions such as fasting are not followed, and 20 per cent of discharged patients not understanding their medications.

On the North Coast, Mr Jones revealed, up to one-in-four patients do not comprehend what doctors and nurses tell them, adding that while the average reading age sits at around school years 6 to 8, much of the material people receive is pitched at levels 11 to 12 years.

Such figures explain surveys showing up to 60 per cent of Australians have low health literacy, a term defined as "how well people can obtain, communicate, process and understand health information and services to make appropriate health decisions."

Mr Jones was speaking at the 16 December launch in Ballina of the Northern NSW Health Literacy Project, a joint initiative with the North Coast Primary Health Network, which has appointed a project officer to help drive it.

Considerable work has already taken place, drawing on Australian as well as overseas experiences, with resources including a comprehensive website and educational kits for consumers and clinicians.

"Health literacy is a safety and quality issue," Mr Jones said, explaining that both the general community and health service providers, including GPs, would be assisted to develop a better understanding through a series of free workshops commencing early in 2017.

Initially these will be based in the top half (Northern Rivers) of the PHN's footprint.

The health literacy framework aims to focus on people with chronic conditions and complex care needs, including people with mental illness.

At the Health Literacy Project launch were (back, l-r) George Thompson, Dr Vahid Saberi, Wayne Jones, Chris Crawford, (former NNSWLHD CE), Dr Sharyn White, Jillian Adams, and (front, l-r), Melva Thompson (consumer rep), Hazel Bridgett, April Margieson (carer rep), Taya Prescott.

The advice for consumers includes the suggestion to ask three questions of their doctor at each appointment, and to write down the answers to share with family or carers.

Advice to organisations includes holding a 'Drop the Jargon Day", work shopping a case of 'communication lapse' with staff, and developing material using plain language, clear typography and icons, and audience testing with consumers.

Simplifying patient leaflets had been done very effectively in the Illawarra Shoalhaven LHD, the launch was told.

PHN chief executive Dr Vahid Saberi described the project as an important step forward for this region, saying that boosting the awareness of clinicians - "who believe they've done their job medically" - will be crucial.

"It's a paradigm change... The greatest prescription is to empower patients," he added.

"It's essential for them to be collaborators in their care, not just passive recipients. People need to have the right information in order to be agents in their care."

Dr Saberi praised the enthusiasm of former NNSWLHD head Chris Crawford, who attended the launch, for his long advocacy around the health literacy issue.

When asked by GP Speak if encouraging greater discussion around illnesses and treatments might result in longer GP consultations, Dr Saberi said the benefits of promoting better understanding, and fostering "self help", are clear.

"However, there could be a 'trade-off' and this might highlight the shortcomings in the fee-for-service payment equation."

The NNSWLHD's health promotion manager, Jillian Adams, said the outcome should be a "more efficient use of time, resulting from patients having a better understanding of their conditions."

At present, according to health literacy project officer Taya Prescott, many people have already embarked on the health literacy journey, with one-in-five 65-year olds and up seeking health information online.

No doubt the project is hoping that the advice received from Dr Actual will prove to be more valuable than that provided by Dr Google.

PREPARING YOUR SMSF
FOR END OF FINANCIAL YEAR

The end of financial year is fast approaching. Preparation for this, especially for Self-Managed Super Fund (SMSF) trustees is vitally important. This is especially the case with the upcoming rule changes to collectible, guidelines for limited recourse borrowing arrangements (LRBAs) and adviser licensing, which if mismanaged could run the risk of incurring financial penalties.

Things to consider before 30 June are:

- Consolidation of any accumulation that has built up as of 30 June 2015 with existing pensions, to ensure the maximum amount is in the pension phase
- Double-check balances to ensure members are taking the minimum pensions, especially if age changes have moved them to a new scale, such as 65, 75 or 80
- For younger trustees, consider super splitting fiscal 2015 contributions before 30 June
- In May, check how much of your contribution cap (currently $30,000 for those aged under 49 or $35,000 for those over 49) you have used and look to boost salary sacrificing before year-end
- Check the value of any in-house assets; if they have risen by 5 per cent or more, then as of 1 July 2016 you will be in breach of the limit and must then dispose of the entire investment within 12 months
- If your spouse has assessable income plus reportable fringe benefits totalling less than $13,800, consider making a spouse contribution
- Check your statements to ensure you have not paid expenses on behalf of the SMSF from personal monies which can be treated as a contribution for a tax deduction, or this may mean you have exceeded your contribution cap
- If starting a pension before budget night, ensure you have lodged your notice of intent to claim a deduction
- Consider transferring shares into the SMSF while their price is low so you can minimise capital gains tax. Look at making off-market transfers of shareholdings in blue-chip companies to your fund
- For those with a large taxable income this year who are expecting a lower income next year, consider a contribution allocation strategy to maximise deductions for the current financial year (known as a "contributions reserving" strategy).

SMSF CHANGES FOR 2017

There is a major change concerning adviser licensing requirements from 1 July. From this date advice regarding the establishment, investment strategy and closure of a fund can only be provided by an adviser with an Australian financial services license (AFSL). This excludes regular accountants, who can only provide SMSFs with administrative support, compliance and taxation advice.

In light of these changes Thomas Noble & Russell would like to make you aware of our ongoing ability to handle these matters for SMSFs through TNR Wealth Management (Authorised Representative of Magnitude Pty Ltd AFSL 221557).

Should you have questions regarding SMSFs, SMSF rule changes, wealth creation, wealth protection, cash flow management, debt management, retirement planning or any other financial planning need, please call on 02 6621 8544 or email info@tnrwealth.com.au.

**This article is to be used as a source of information and not considered as financial advice. For financial advise you should speak to one of our financial advisers and for tax advice speak to a registered tax agent, typically an accountant. *Additional Article sources of information include Australian Taxation Office, Morningstar, SuperCentral and SuperGuide*

No chickening out

***Robin Osborne** visits a heritage farm in the Byron hinterland*

It had been a long time since I'd dressed* any poultry for the table, so feeling it might be time to refresh my skills, I arrived at Dingo Farm, a beautiful property in the Byron Bay hinterland, for the morning course run by Dr Lindsay Murray, an emergency physician at Lismore Base Hospital.

In his other life, Lindsay, who grew up on a farm in the NSW Riverina, is dedicated to farming heritage animals, both poultry - chickens, ducks, geese, turkeys - and English White cattle (pictured below), prized in their country of origin as a dairy and beef breed. There are around 500 head of these handsome beasts in Australia, and he has a significant number of the best of them.

While I'd like to rekindle my connection with chickens I have serious concerns that our backyard, abutting forest, might result in their being decimated by foxes or carpet snakes, which are here in abundance.

Yet I've always loved domestic birds, both their genial company and their welcome presence on the dining table, and although killing them is hardly a pleasure, it is a necessity unless you are somehow able to outsource the task.

Lindsay Murray's heritage chickens are kept separate to ensure genetic integrity. They include Silver Grey Dorkings, the only chickens with five toes, introduced to Britain at the time of the Roman conquest, Black Copper Marron, Blue Orpington, Australorp, Barnevelders, and more.

Dr Lindsay Murray with a Silver Grey Dorking breeding rooster

"My aim is to get the older heritage breeds into the backyards of our area," Lindsay said, adding that chickens are the most marvelous domestic animals, having lived alongside humans for the past 10,000 years.

The problem for them and the benefit for us is that there's always a surplus of male birds, which requires management, in other words culling, or to be precise, killing.

Lindsay's occasional morning classes teach people how to handle excess rosters, chop their heads off (let's be honest), pluck their feathers and prepare them for cooking.

It is not a difficult process, even for the fainthearted, especially after some instruction about how to calm the birds prior to giving them the chop. Suffice to say there is no suffering, and no running around of headless chickens.

The plucking - "The feather situation," as Lindsay described it - is by far the most laborious stage. Each bird takes up to ten minutes to strip down.

At the time of slaughter, the birds are around 16 weeks of age, tender enough for roasting, or being prepared for whatever chicken recipe takes your fancy.

Lindsay is a minimal-wastage farmer, keeping the necks and other useful products for dog food, the livers for a friend who make pâté, composting the innards with camphor laurel chips in paddock heaps, and breaking down feathers for garden enrichment.

A stock pot and chicken soup fan, he lets nothing go to waste, guiding us through Chicken Anatomy 101 - the chicken gizzard is an amazing satchel of undigested food - and remarking that in an ideal world more people getting involved in preparing food from scratch would likely result in less consumption and fewer weight problems.

At morning's end, each of us work shoppers has three cleaned chickens in cool bags and all of our digits still intact. We wend our way home, better informed and skilled about how to treat one of nature's greatest contributions to the modern diet.

* "Dressed poultry" refers to the slaughtering, defeathering and eviscerating of whole birds, with the head and feet removed, i.e., a ready-to-cook whole bird.

Dementia cases and costs continue to balloon

The upward trajectory in the number of Australians with dementia will continue over the coming years, with an astounding 275 per cent increase in cases predicted by the year 2056.

Currently the national total stands at 413,106, costing the nation an estimated $14.6 billion. A rise of 33 per cent is predicted by 2025, bringing the cost to $18.7 billion, according to a research paper The Economic Cost of Dementia in Australia 2016-2056, commissioned by Alzheimer's Australia.

Locally, the trend would see total cases in Lismore and Ballina (state electorates) more than doubling from 1717 and 1729 respectively within forty years; Tweed's rise will be even greater, up from 2238 to 4854 cases.

The paper, released in mid-February, said more than a million Australians will be experiencing dementia by 2056, creating the need for more than half a million carers in the community and a quarter of a million carers in residential aged care facilities.

Christine Vannucci (left), Project Officer, Tweed Dementia Sector Development, Alzheimer's Australia NSW spoke on brain health at the University Centre for Rural Health's Social Connections breakfast series on 16 February. Also speaking were Rosalie Kennedy, Social Work Department, Lismore Base Hospital, and Hannah Bartrim, Social Work graduate with Family Support Network Inc in Lismore

Alzheimer's Australia, which recently appointed Maree McCabe as its new National Chief Executive Officer released the study to highlight the vital need for carers, now and in the future, as well as the massive direct and indirect costs of the nation's second leading cause of death.

Dementia is also the leading cause of burden of disease in women aged 85+ years, and the second leading cause in men in that age group.

At present, around 94,672 paid carers look after people with dementia in the residential aged care setting, and a further 196,491 carers assist people with dementia in the community, the majority of the latter group being informal carers.

The costs of hospitalization (53 per cent) and care (37 per cent) are the largest components of direct dementia costs, with indirect costs including forgone income by carers ($3.2 billion) and loss of income ($2.3 billion) from people with dementia withdrawing from the workforce.

The average direct cost of dementia for a person living in the community was estimated at $45,393 in the first year, compared to $55,904 for a person with dementia living in residential aged care.

UCRH expand collaborations in 2017

The North Coast's University Centre for Rural Health is set to further expand its role in developing regional health care capacity, according to its Director, Professor Ross Bailie who said 2017 is seeing the organisation drawing further its highly regarded research team and coordinating the practical training of more university students from medical, nursing and allied health programs.

Prof Bailie said UCRH has already developed strong links with the region's key health bodies, Northern NSW Local Health District and the North Coast Primary Heath Network, and is looking to collaborate closely with other relevant groups in the coming year.

"Last year our research team was involved with a wide range of research of both local and national importance, ranging from the health impacts of hazard-reduction smoke around Sydney to the risks of improper condom usage by young people attending music festivals.

"You can't get more diverse than those examples, yet both are serious health issues that our researchers helped to identify."

The research team has been recognised with major grants and awards in focus areas such as Aboriginal health, chronic diseases, mental health, ageing, substance misuse and the role of integrated care planning in keeping people out of hospital, or shortening their inpatient stay.

Students at Cape Byron lighthouse

Prof Bailie said UCRH's work has regional significance, which includes coordinating clinical placements for health care students who work for periods up to a year in local hospitals, GP practices, Aboriginal medical services and community health.

"This taste of rural health care not only benefits them but also our region, as many are choosing to return here to work after they have fully graduated," he added.

UCRH has an 85-strong team at its campuses in Lismore, Murwillumbah and Grafton, with significant investment in developing purpose-built student accommodation in Ballina, and an increasing extension of programs in other towns in the region.

The UCRH is primarily a collaboration between The University of Sydney, Southern Cross University, the University of Wollongong and the University of Western Sydney.

Fluoridation critics claim fake research, industry conspiracy

*One of the most contentious public health issues in the Northern Rivers has become the subject of an academic research study, as **Robin Osborne reports**.*

Water fluoridation opponents participating in a Northern Rivers research study* have attributed their views to such concerns as 'fraudulent research' and the influence of industry on those bodies (NSW Health and local councils) supporting the measure to improve the population's oral health status.

Ten participants with known anti-fluoride views underwent 15-25 minute interviews with four doctors, now working as RMOs in NSW hospitals, supervised by University Centre for Rural Health staff member Dr Sabrina Pit.

At the time they were undertaking practical placements through UCRH. Realising the significance of the subject in a region where oral health was atypically poor because of the long lack of fluoridation (it has now been rolled out in most LGAs, despite legal challenges), they aimed to investigate the key issues and hopefully contribute to a better understanding in the future.

According to the report on the study, six dominant themes emerged - five of them were reasons for opposition, leading to 'suggested alternatives to water fluoridation'.

The report noted: "All participants expressed scepticism about water fluoridation. The majority discussed the evidence for the benefits... Some participants were sceptical about whether fluoride was beneficial in preventing caries. This was based on anecdotal reports and personal understanding of the water fluoridation literature.

"A predominant belief was that the evidence for fluoridation of water was outdated and not applicable in a modern context."

Several participants viewed fluoride as an industrial waste product and unsafe for consumption, and there was concern about 'fraudulent research' because of pressure by industrial powers attempting to find a cheap way to dispose of industrial waste.

"When large corporations start to twist arms of bureaucrats to pushing their own agendas onto communities to have things like this happen, then you know there's a problem ... once science is being manipulated by corporations to get what they want, through governments, that's it ..." one respondent said.

Fluoride opponents Dr Andrew Taylor, Dr John Ryan and Merilyn Haines addressing Lismore City Council at an information session in December 2013.

There was a lack of trust in the bodies responsible for making decisions about fluoridation. Many participants believed that the NSW government lacked transparent public consultation, and that the decision to fluoridate had already been made.

Regarding the health aspects of fluoridation, participants were concerned that fluoridation might exacerbate pre-existing disease symptoms.

Community health concerns were also raised, with participants speaking of 'mass medication' and calling fluoridation a 'band-aid' fix for a much wider problem. They claimed it did not target the vulnerable populations it was designed to benefit, including children and lower socio-economic groups.

The concept of a 'one size fits all' approach to medicine was considered inappropriate.

The majority cited concentration versus dose concerns, saying differing ingestion amounts between individuals could not be regulated.

"A little, tiny 5-week premature baby ... should he be having the same amount as my six-foot-five child?" one asked.

Noting that water fluoridation had been shown to be "an effective, safe and cost-effective means of preventing dental caries", the researchers concluded that "scepticism and concerns about health, ethics, economics and the environment are the major reasons for opposition... and these are inextricably linked to possible alternatives to fluoridation."

They suggested that governments might better engage with the public when designing persuasive educational campaigns by using the data and addressing the reasons for opposition.

"The concerns raised could potentially be used in future population health campaigns, research, public education, consultation and allocation of resources," they said.

NHMRC project

The Fluoride Reference Group of the National Health and Medical Research Council is currently considering input to a discussion paper 'Effects of Water Fluoridation on Dental and Other Health Outcomes'.

NHMRC Health effects of water fluoridation

The public had ample opportunity to comment on the draft, with the final Information Paper due to be issued mid-2017.

The Group was formed "to guide the evaluation of the evidence on the health effects of water fluoridation... [and] advise on how relevant these findings are for Australia, given that concerns regarding water fluoridation vary across international and geographic regions [emphasis added]."

The focus of the project includes evaluating the effects of water fluoridation (artificial or natural) for the prevention of dental caries, and the effects of water fluoridation (artificial or natural) on dental fluorosis.

*Qualitative investigation of the reasons behind opposition to water fluoridation in regional NSW, Australia - Knox et al- Public Health Research&Practice, February 2017

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Glen Innes – East Avenue Medical Centre, 39 East Avenue
Armidale – 3/121-123 Allingham Street
Tugun – Suite 2B, John Flynn Medical Centre, 42 Inland Drive

FRACS Fellow of the Royal Australasian College of Surgeons

The Fourth Industrial Revolution

by Dr David Guest

Each year the world's leaders in business, economics, politics and technology meet in the remote Swiss town of Davos in the depths of winter. They are not there for the skiing, but to contemplate what future worlds might be like.

Professor Klaus Schwab
at the World Economic Forum

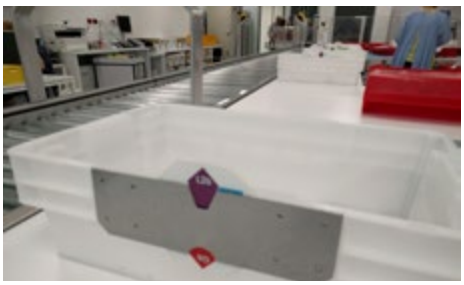
The World Economic Forum founder, Professor Klaus Schwab, believes the world is entering the Fourth Industrial Revolution where the integration of digital, physical and biological technologies has a disruptive effect on society and government which will be at least as significant as the three industrial revolutions that preceded it.

"The future is already here. It is just not very evenly distributed", wrote science fiction writer William Gibson in 1993. He is correct.

On 12 July 1956 Dr John Sullivan reported on his first test result from his new rooms in a cottage on Wickham Terrace. Eighteen months later he was joined by Dr Nicolas Nicolaides. Sixty years later Sullivan and Nicolaides Pathology is now one of the largest pathology groups in Australia.

To keep at the forefront in its field Sullivan Nicolaides Pathology (SNP) has recently moved into a multi-story purpose built laboratory in Bowen Hills, not far from Royal Brisbane and Women's Hospital and close to all major transport links.

As with general practice, pathology companies have felt the squeeze on profits in the last few years. The key to survival has been increasing efficiency through automation.



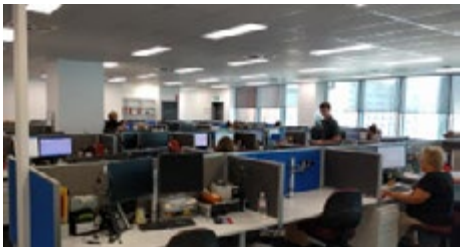
Specimens and supplies arrive in the lower bowels of the building, are sorted and then ascend on a conveyor belt system to the appropriate departments.

After initial testing is complete most specimens are kept for a week although some samples such as serology may be kept for several years. The dense packing of the specimens in the refrigeration units means that they can only be placed and retrieved by the robotics system.

Specimens may be digitally tagged long before they get to the laboratory. Some electronic health record systems will generate a digital request in addition to the paper form when ordered by the doctor. The request is sent to SNP during the same internet connection as pathology result downloads and can occur several times per hour. Electronic requests save time and eliminate errors occurring from transcribing doctor's hand writing.

Security is tight and visitors are required to "log in". Before accessing the clinical areas where pathologists and scientists are spread over three floors.

The help desk department is extensive and fields calls from doctors from Northern Territory and northern NSW in addition to all of Queensland.



Head of Histopathology and former Lismore pathologist, Dr David Papadimos, with supervising Endocrinologist, Dr Lee Price

David Papadimos, is head of the Departments of Histopathology and Cytology. His current rooms are a far cry from those that he shared with the real estate office in the Gum Tree Shopping Centre in Goonellabah 30 years ago.

Medical "wearables", telehealth and robotics may be the medical poster children of the fourth industrial revolution but the advances in diagnostics whether they be in molecular pathology and cytogenetics or the more traditional fields of biochemistry, haematology and immunology is impressive. The pace of technology change is quickening and who knows what medicine will be like in the fifth industrial revolution.

Spreading doctors through rural areas

A new $93 million national Rural Workforce Agency program announced by the Federal Government in late February is aimed at delivering better health outcomes for people living in regional, rural and remote Australia, according to the Federal Assistant Minister for Health, Dr David Gillespie.

The Minister said the Australia's Future Health Workforce Report - Doctors indicated an oversupply of 7,000 doctors in Australia by 2030, and highlighting the challenge of distributing the medical workforce to ensure all Australians have access to the services they need.

"Over the past 20 years, Australia has had some success in boosting the number of medical and health professionals in metropolitan areas and some parts of regional Australia, however our primary focus must now ensure we address the lack of doctors and allied health professionals in many other parts of regional and remote Australia," Dr Gillespie said.

"The redesigned programs will build and strengthen our health workforce and support ongoing quality improvements to ensure we connect medical and health professionals with the communities who need them.

"Access to essential primary health care, quality of access, and future planning to build a sustainable workforce will be the key tasks for the workforce agencies," he added.

"The redesigned programs will begin mid-year, following a targeted grants round."

The redesign of the program is part of a suite of reforms that include the creation of a National Rural Health Commissioner, reform of medical training and distribution, and development of the rural generalist pathway to upskill GPs in regions who require a broader range of medical services.

Dr Andrew Binns comments:

My experience in general practice over nearly 40 years is that the situation for rural and remote GP supply has gone from undersupply to oversupply in cycles and it looks like oversupply is now on the agenda for 2030 but the supply graph must be going up already.

That should mean there will soon be GPs looking for work in our region and more remotely.

It may surprise you but in 1979 when I came to Lismore I could not find a practice to join despite knocking on many doors - so I was forced to set up in my own. I believed at the time that my qualifications and experience were suited to this region.

Because I am now registered on recruitment sites I am getting lots of requests to go to remote and even not so remote areas and even in outer urban areas.

This is no doubt destined to change as supply increases and there will always be a challenge to fairer distribution, i.e. less GPs along the coastal areas and more inland and supposedly less desirable areas.

The government has some control on this but it seems a never ending problem for them and for practices in rural, remote regions and even outer urban areas to supply an adequate workforce. The government will no doubt rely on supply and demand to solve this issue plus some carrots to massage the formula.

This latest initiative is interesting – how it will evolve and the effect it has remains to be seen but GP Speak will keep watching this unfold. One focus will be on the more inland demands for GP services, say the GP/patient ratio in Kempsey compared with Lennox Head/ Byron Bay for example.

More beds, tree names for mental health units

After a wait since the opening of the new Byron Central Hospital in mid-2016, the impressive sub-acute mental unit at BCH will open on Monday 16 January. In keeping with a re-naming of mental health facilities across the Northern NSW LHD, it will have an aboreal moniker, in its case 'Tuckeroo'.

"By mid-2017, we will see an increase of 20 additional mental health beds across the

LHD, bringing the total number to 93," Chief Executive Wayne Jones said.

Included in this number will be 'Lilli-Pilli', a new 16-bed dedicated older persons' mental health treatment space within Lismore Base Hospital.

Lilli Pilli fruit (CC attribution- John Tann)

This image was originally posted to Flickr by John Tann

The Child and Adolescent Mental Health Unit at LBH will be called "Kamala", while the Lismore Adult Mental Health Unit will be known as "Tallowwood".

The Tweed Valley Clinic is now "Kurrajong – Tweed Mental Health Unit"

.

Community mental health facilities are now known as Tweed Mental Health Services, Byron Mental Health Services, Lismore Mental Health Services and Grafton Mental Health Services.

More information about local mental health services at www.nnswlhd.health.nsw.gov.au or by phoning the 24-hour Mental Health Line on **1800 011 511.**

Poorer NSW residents live in an unhealthy state

A survey of 417 low-income residents of NSW has found that a 'quality health system' is the main issue they want the State Government to take action on, with affordable dental care to be given top budgetary priority.

Almost 50 per cent of regional respondents cited cost as the major barrier to improving their health, while dental treatment, unaffordable for 38 per cent of interviewees, was the number-one 'cannot afford' item in a list that included decent housing, medical treatment and prescribed medication.

According to the AIHW, "The affordability of oral health care has both personal and system-wide implications, with dental conditions the third highest reason for acute preventable hospital admissions in Australia."

Poor Health: The Cost of Living in NSW, the report based on the survey was released by the NSW Council of Social Service this week. NCOSS works with and for people experiencing poverty and disadvantage to see positive change in communities.

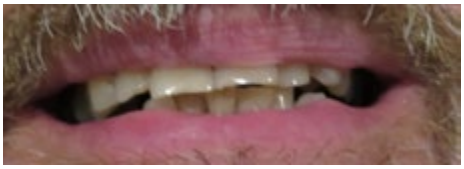
Interviewees included recipients of the Age or Disability Support Pension, a Carer Allowance, Newstart, people receiving a parenting payment, and families with dependent children.

"The high and growing cost of health is having a very real impact on people experiencing or at risk of poverty and their families across NSW," said CEO Tracy Howe.

"There is plenty of research highlighting the negative health outcomes that low-income people experience as a result of being unable to meet growing health costs. But we wanted to... [also] hear directly from people experiencing or at risk of poverty about their experiences and what would make a real difference in their lives."

Ms Howe added that people on low incomes – of whom there is a disproportionate number in regional areas, including the Northern Rivers - are less likely to eat well, more likely to be overweight or obese, and less likely to participate in physical activity.

"They are more likely to experience a



broad range of chronic health conditions, such as arthritis, kidney disease, diabetes, heart disease, stroke, poor oral health and some cancers," she said.

The report noted that Australians pay more out of their own pockets for health treatment than most other OECD countries, and the cost of health care in NSW has risen by just over twice the rate of CPI over the last ten years:

"The cost of things like GPs who don't bulk bill, allied health treatment, and over-the-counter medicines are increasingly out of reach for people on low incomes"

The impact of affordability on accessing specialists was found to be "particularly acute", with only 30 per cent of specialist appointments bulk-billed. In NSW the average patient contribution is $78. 24.

"People ... often do not know in advance how much a service will cost... this can create stress, act as a deterrent to accessing care, and risks exposure to bill shock." Some 39 per cent of respondents said they could not afford appointments or sessions with allied health professionals, while 33 per cent said they could not afford counselling or other support to address depression, anxiety or other mental health concerns.

Around one-quarter of those surveyed described imaging services and other diagnostic tests as unaffordable, with imaging especially unaffordable (53 per cent) for those with dependent children.

Nearly 1-in-ten cannot afford prescription medicines, despite the subsidies, with adults who delay filling or do not fill a medical prescription due to cost ranging up to 15 per cent.

Transport to and from medical appointments was another issue, especially for regional people, with 11.5 per cent unable to afford the cost: "In NSW, patient travel subsidies recognise this to some extent, but do not cover all modes, including hire cars and community transport. People who have no option but to use these modes of transport – usually because they have limited mobility, do not have access to a car, or live in areas with no public transport – can end up paying significantly more in order to access healthcare."

Almost half of the survey respondents could not afford private health insurance, while 14.4 per cent were unable to afford food for a balanced diet. Activities or equipment such as sport, gym membership, swimming, cycling were unaffordable for many people, a matter of concern "when we also know that less than half (45 per cent) of people in the lowest income quintile have participated in sport or physical activity within the last year, compared to 80 per cent in the most advantaged quintile."

NCOSS said that while all levels of government play a role in ensuring access to appropriate health supports, its focus is on what the NSW Government can do to minimise affordability barriers to good health and improve the health outcomes of vulnerable people.

Summarised, the recommendations are

- Increase access to timely and affordable dental care for people on low incomes.
- Invest in communication efforts to ensure all families are aware of the dental health services available for their children.
- Increase the availability and affordability of community mental health services, including through implementation of Living Well: A strategic Plan for Mental Health in NSW 2014-2024.
- Further investigate transport as a barrier to accessing health care with a view to increasing investment in health transport.
- Increase investment in onsite accommodation and carer-friendly wards in order to enable the important role that carers play in the health care of hospital patients.
- Efforts to improve people's diets, particularly current responses to the NSW Premier's commitment to reduce overweight and obesity rates in children, should take affordability barriers into account.
- Strategies aiming to increase the participation rates of under-represented groups in organised sport must recognise that cost (including the cost of transport) is an important barrier to participation and work to address this.

Streamlining Community Paediatric Care

by Dr Jackie Andrews, Community Paediatrician

Waiting times for access to community paediatric services are long. At GPSpeak's request Dr Jackie Andrews offers the following advice to improve the patient's journey as well as the efficiency of this valuable resource.

GPs are often asked to do a referral to a paediatrician for children who have difficulties with their behaviour in the home or school environments. Developmental delay is another common reason for referral. GPs will greatly assist if they can get some initial assessments organised prior to the paediatrician appointment.

Important areas are:

- Ensuring hearing and vision are screened if clinically indicated.
- Asking the school to forward a summary letter of concerns to the relevant paediatrician, as well as forwarding any other reports including school counsellor reports prior to the appointment.
- Ensuring the family brings with them any reports from Allied Health workers or others involved already with the child.
- Assessing and managing any sleep difficulties or medical issues that may be impacting on the child.
- Assessing and managing any mental health, drug and alcohol or other issues affecting the parents that may impact on the child in the home environment.

The more information that we are given by the GP the more thorough our assessment can be. If you are aware of issues within the family environment that may be impacting on the child could you please include this information in referrals.

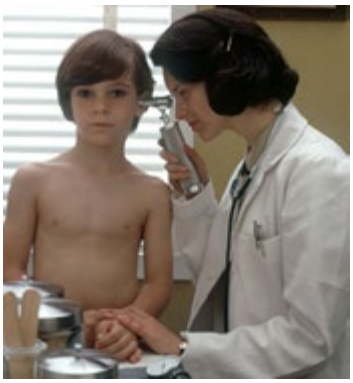
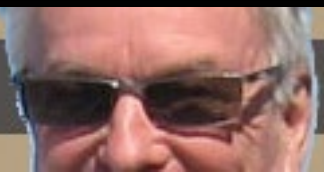


image courtesy of Wikipedia by CC BY-SA

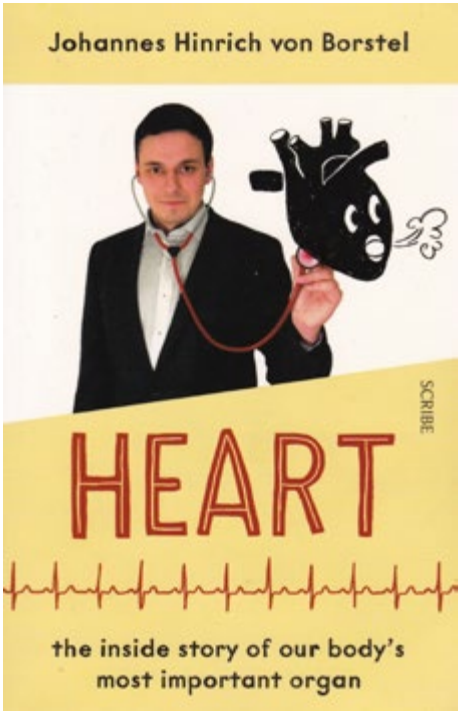
Book Review



Reviewed by Robin Osborne

Heart - the inside story of our body's most important organ

By Johannes Hinrich von Borstel
Scribe $29.99



The splendidly named author of this ambitious and generally successful work was an early-age (15 years, work experience) paramedic, now a doctor and an aspiring cardiologist, and 'one of Germany's most successful science-slammers'.

Nor surprisingly, then, the book is a blend of paramedical anecdote, cardiology theory, and folksy tips about things we can, and should, do to keep our hearts healthy. Have more sex, for example.

In a chapter titled 'Bedroom Sport for the Heart', presumably a popular slam topic, he writes about a candlelit room, empty wine glasses, discarded clothing, Marvin Gaye music... "This trail of clothes leads to a couple engaged in an intensive workout. What they're doing is not only a lot of fun, but also good for their hearts."

Unless, I suppose, they're not healthy in the first place and one or other suffers a cardiac arrest in flagrante. Come to think of it, the uber-fit Bruce Lee died from one of those whilst engaging in some extra-marital bedroom kung fu.

The broad thrust (pun intended) of the chapter is that the benefits of bonking are undeniable: "Bedroom sport provides a great way to combine physical exertion with stress-reducing effects while protecting our bodies by means of the hormones that sexual intercourse releases inside us".

However, he does add a caveat about the risks: "Vigorous sexual activity can be counterproductive to the health of those with pre-existing cardiovascular conditions... it isn't effective as a cure."

Amidst the sex and some slammish puns, JHvB has delivered a thoughtful 278-page paperback that should have as much interest to the professional as to the lay reader, assuming the latter can persist with the medical terminology.

What is the heart, how can it go wrong, and what can we do to give it - hence, us - the best chance of having a long and healthy life?

These are the key issues discussed in a stylistic mix ranging from the common sensical (eat more vegies and less fat, drink less, don't smoke, do more exercise) to the somewhat technical: "When inactive B lymphocytes encounter a foreign substance (known as antigen) as they circulate in our bloodstream, they waste no time in absorbing it pulling it apart, and presenting the resulting fragments on their surface."

At its best this is a valuable compendium of 'ticker tips', but I hope he simplifies the messages when he engages in a slam.

Compare and contrast the following -

- "With the exception of a patent ductus arteriosus, which can sometimes be closed using medication, almost all of the congenital heart defects described here require surgery to correct them."
- "Research has taught us one fundamental thing: a healthy heart requires a healthy body and a healthy mind. Only then can it function perfectly."

No doubt JHvB has a cardiological bent and should do well in his ongoing career, whatever the stage he performs on. The value of a paramedic turned specialist is all too clear.

Those general readers able to stay the course will derive much benefit from the life-enhancing advice he delivers.

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