GPSpeak

Journal of Northern Rivers General Practice Network

Budget hits stormy weather

FEDERAL BUDGET 2014

June - July 2014

GPSpeak
Journal of the Northern Rivers General Practice Network

Published by:
Northern Rivers General Practice Network
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Editorial: Budget blowback creates storm of disapproval

The Federal Budget of May 2014, the first of the Abbott government, outlined a new vision for Australia's future. It was a marked departure from previous Budgets under both Labor and Liberal governments. The Liberal Party 2013 election campaign highlighted both the economic and political failures of the minority Gillard/Rudd predecessors. Under Tony Abbott the Liberal Party ran a very disciplined campaign. Oppositions don't win elections, governments lose them. Everyone knew what a Liberal government would do. It would stop the boats, end the waste, scrap the carbon tax and there would be no new taxes.

As with previous changes of government, the firstsix months were spent looking at possible ways for implementing the new Coalition policies. A number of audits and reviews were undertaken but very few of these were made public. When the option for reintroducing a $6.00 GP service co-payment was raised in late 2013, it seemed unlikely that it would ever be implemented.

Such a scheme had been tried previously under the Hawke Labor government but abandoned within a few months. The money saved was insufficient for the political pain it caused. So it was with some surprise that we were presented on Budget night with a $7.00 co-payment ... plus a couple of wrinkles.

The Medicare rebate was cut by only $5.00 but GPs could charge a $7.00 co-payment, allowing the government to claim GPs would pocket a half billion dollar windfall profit. The transaction costs of dealing with the co-payment and the reduced

number of services expected by the change did not figure in the Minister's back of the envelope calculations. They would have, however, been studied extensively in the Department of Health's models.

The clever part of the scheme locks bulk billing GPs into the new co-payments. Under the old arrangements GPs were offered a $6.00-$9.00 incentive payment for bulk billing children under 16 years and those on concession cards. This incentive continues but only if the GP charges exactly the $7.00 co-payment. For largely bulk billing practices the decreased Medicare rebate and the loss of the bulk billing incentive will amount to a 25 per cent loss of income. Practice costs are about 50 per cent of income so this will mean a 50 per cent loss of income for the GP practice owner. This is untenable.

The co-payment scheme is designed to send patients and GPs a price signal about the cost of GP consultations, radiology and pathology investigations. **The proposal as espoused by the Minister for Health** is laudable in principle but flawed in practice. Many patients on the North Coast are not bulk billed and the pain they will feel is the $5.00 smaller rebate from consultations.

It will be the poorer members of society, particularly those with chronic disease, who will feel the brunt of the new changes. It is expected that they will attend less often for investigations, monitoring and treatment. The costs over time of badly managed diabetes and heart disease are likely to be significantly higher than the short term savings.

The Minister has also foreshadowed allowing the private health sector into the primary care insurance market. While replacing the Medicare monopoly with a market of private insurers sounds like it should be economically more efficient, experience from the USA would suggest otherwise.

Medicare has been very effective at controlling and reducing

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Budget storm (cont from P 3)

GPs' incomes over the last thirty years. Abandoning monopoly control appears to be more motivated by ideology than economics.

Nearly all of this has been discussed in the press and social media over recent weeks. PM Abbott has said that there may be room to tweak the system but once again any government plans are shrouded in secrecy. Exemptions for Aboriginal Medical Services and chronic disease management have been mooted but would be administratively difficult to manage.

The Government's view is at odds with the advice from professional Australian health economists. **John Deeble**, **Stephen Duckett**, **James Gillespie**, **Anne-Marie Boxhall** and **Jeff Richardson** have all highlighted the difficulties and inequities of the co-payment system.

In the health arena the Government seems to be taking advice from a number of private think tanks, the independence of which has been questioned. Terry Barnes of the Australian Centre for Health Research (ACRH) was the first to reintroduce the concept of co-payments. The ACRH receives funding from health funds and private hospitals.

Similarly, support for the former government's progress in **food labeling, alcohol** and **tobacco** control is gradually being eroded by industry supported bodies arguing for a less restrictive trading environment. This is promoted under the moniker **End the Nanny State**. While this concept is appealing, "No running with scissors" remains good advice.

It is still too early to determine if the government will remain impervious to the objections of the profession, the economists and the general public. The birth of the first "Medicare" was brought about through a double dissolution. One wonders if its demise might require the same.

OAM for Mullumbimby's musical GP

GPSpeak congratulates Dr Michael Pelmore for being awarded with an Order of Australia in the Queen's Birthday Honours List. Dr Pelmore was awarded the OAM Medal in the General Division of the Awards for service to medicine and the community of Mullumbimby.

Dr Pelmore has given exceptional service to his community in Mullumbimby for nearly four decades, both as a General Practitioner and as a Visiting Medical Officer for Byron Bay and Mullumbimby Hospitals.

He is originally from England, and health care ran in his family: his father was a doctor, and his mother and twin sister were nurses. Dr Pelmore visited Australia in 1974 and after driving up to the Northern Rivers, decided to stay.

Michael Pelmore playing a Charango (South American 10 string lute)

In his long and distinguished service to the public health system he has worked in the fields of General and Emergency Medicine, and Obstetrics, being available on-call and after hours to the immense benefit of patients.

Dr Pelmore also has considerable talents in the musical field, having produced two Dolphin Award-wining CDs to promote children's health and performing at local primary and pre-schools, and variety nights held to raise funds for local Hospitals. He has also undertaken the role of MC at many hospital events.

Dr Pelmore is held in high professional esteem by his peers and regarded affectionately by the wider community, a great many of whom have entrusted him with their health care over the years.

Medicare Locals bite the Budget dust

It took just **a 16-page report** and a stroke of the Federal Treasurer's pen to end the life of the 61 Medicare Locals that were established in 2011-2012 to improve the coordination and integration of primary health care in Australian communities.

At the time it was said they would "make it easier for patients to navigate their local health care system". How well this worked might be judged from the finding that the 'Medicare Local' name was so confusing that many people still came to ML offices seeking Medicare refunds.

In his report to the Minister for Health, Professor John Horvath AO noted, "I observed signs on the doors of Medicare Locals advising they were not a claims office."

Government should "reinforce general practice as the cornerstone of integrated primary health care, to ensure patient care is optimal" – Review of Medicare Locals

Unlike the proposed $7.00 GP co-payment, the decision on the Medicare Locals was one of the better-kept secrets in Budget 2014, although this may not be saying much. However, it came as little surprise, and no great disappointment to many observers, even if some of the MLs were considered good performers, with the NSW North Coast's local entity believed to be one of them.

The Medicare Local scheme, which will no longer be funded after June 2015, was a centrepiece of the former Labor government's health reform agenda. Now it is to be unpicked: the name ("confusing and without contextual meaning") will be scrapped, and its national umbrella body, the Australian Medicare Local Alliance, will be abolished ("it appears to have struggled to understand its role and fulfil its mandate").

The AMLA chair Dr Arn Sprogis described the government's decision as "shocking", asserting that it will affect frontline health services and the health and wellbeing of Australians around the country. He said replacing Medicare Locals with Primary Health was 'reinventing the wheel' and a waste of taxpayers' money.

NCML CEO Vahid Saberi

Conversely, the NSW North Coast Medicare Local (NCML) welcomed the release of Professor Horvath's report, with CEO Vahid Saberi saying it "validated the work being done by the Board and staff across the NSW North Coast." Mr Saberi added that over the past two years NCML staff had been "buoyed by the community's receptivity and recognition of the work they are doing to connect health services, fill existing gaps and ensure everyone in the community has access to quality health care when and where they need it." Because "most people who use hospital services also see a GP, specialists and other allied health services, we have created partnerships and put systems in place to make the patient journey through the health system easier to navigate," Mr Saberi said.

Importantly, GPs will be returned to a central role in the regional healthcare process as key advisers to new 'patient centred' Primary Health Organisations (the name is a recommendation only).

"It is essential GPs have a significant presence within the corporate structures of PHOs," Prof Horvath said. "Broader and deeper GP involvement can be achieved through establishing local Clinical Councils. I see these Councils as influencing intersector collaboration, developing and monitoring integrated care pathways, and identifying solutions for service gaps. GPs need to buy-in to PHOs and see benefits from their involvement."

Further addressing GP involvement, he added, "General practice is critical for a high performing, cost effective, primary health care system to orientate health care away from expensive hospital services. It is paramount that relationships with gen-

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MLs Reviewed (cont from P 5)

eral practice are rebuilt and GPs are appropriately engaged. There needs to be GP buy-in at both the governance and operational levels and for them to be able to see benefit of their involvement."

He felt the PHOs should be "boundary aligned" with existing Local Hospital Networks (known as Local Health Districts, LHDs, in NSW), a goal that may be a challenge to achieve, as he advocated fewer planning entities, not more. Yet most MLs, and certainly the NSW North Coast's, span a footprint larger than a single LHD. In our case, the ML covers Northern NSW and Mid North Coast LHDs.

Other recommendations included that,

- Government should review the current Medicare Locals' after hours programme to determine how it can be effectively administered. The government should also consider how PHOs, once they are fully established, would be best able to administer a range of additional Commonwealth funded programmes.
- PHOs should only provide services where there is demonstrable market failure, significant economies of scale or absence of services.
- PHO performance indicators should reflect outcomes that are aligned with national priorities and contribute to a broader primary health care data strategy.

"PHOs will build on the strengths of Medicare Locals, but by avoiding unnecessary corporate bureaucracy and duplication a greater proportion of funding should be targeted to frontline services," Prof Horvath said. "General practice will have a key role in PHOs and, through Clinical Councils, a greater say in the governance and strategic direction of their local primary health care systems and development of integrated care pathways.

"Similarly, local communities, through Community Advisory Committees, will have greater engagement to shape health services."

He ended on an upb\ eat note: "The future for primary health care is bright."

Read the Medicare Local analysis **"Looking over the horizon"** by the North Coast NSW Medicare Local's Chief Executive Officer Vahid Saberi.

RACGP head warns of co-payment risks

In the apparently unlikely event of being ratified by the Senate and brought into being, the Federal government's proposed $7.00 co-payment fee for GP visits may be more of a boon to Australia's corporate medicine industry than patients.

This warning was sounded by the President of the Royal Australian College of General Practice, Liz Marles (The Australian Financial Review, 13/6/14) who said the co-payment could encourage older, solo practitioners to opt for retirement rather than dealing with the administrative changes that the new legislation would foster.

Referencing areas such as western and south-western Sydney, Ms Marles said, "Given 41 per cent of GPs in urban areas are over 55 anyway, these guys are probably more like 60-pus… I think if you squeeze them… or require them to go through a lot of change in order for them to be able to continue to provide a service, then they'll just choose retirement."

She added, "I think it will probably lead to increased corporate medicine in those areas," suggesting that groups such as Primary Health Care and Sonic Healthcare may look to buy out the practices of disgruntled or financially struggling doctors.


Dr Liz Marles

The concerns come amidst speculation about the government's desire to see private health insurance funds become more involved in the primary care setting.

Health Minister Peter Dutton is understood to be keen on the concept, although he declined to comment when approached by media recently.

The new AMA President, Dr Brian Owler, has said that practitioners who opted to waive the co-payment for patients facing hardship could incur financial pressures. He said such a gesture would be likely to cost GPs $11.00 per consultation through the $5.00 cut to their Medicare fee and the loss of the bulk-billing incentive.

Here be Dragons

by Robin Osborne

While the roots of dragon boat racing lie in an ancient Chinese fertility rite and a 4th century BC homage to the patriot/poet Qu Yuan, its benefits for post-operative breast cancer patients were not considered until 1996.

In that year, a Canadian sports medicine specialist, Dr Don McKenzie, began to interrogate whether, as was claimed, repetitive upper-body exercise in women treated for breast cancer encouraged lymphoedema. His study began with a team formed to paddle a dragon boat. The crew gave themselves the catchy and courageous name of 'Abreast in a Boat', and their progress was monitored closely by a sports medicine physician, a physiotherapist and a nurse. When the results were in the women had turned the prevailing wisdom on its head: no new cases of lymphoedema had occurred and none of the existing cases had worsened. Dr. McKenzie concluded that, by following a special exercise and training program, women could avoid lymphoedema and enjoy active, full lives.

"...It is helping to change attitudes toward 'life after breast cancer'..."

The rest, as they say, is history. In a **paper published** two years later in the Canadian Medical Association Journal he said the activity - although culturally quirky in the West - would benefit breast cancer survivors by providing "strenuous upper body activity in an aesthetically pleasing and socially supportive environment."

McKenzie's paper went on, "How important is the Abreast in a Boat project? It is an approach to promoting health and raising breast cancer awareness that is driven by women with the disease.

"It reaches out to other women and offers them a message of hope and support. It is helping to change attitudes toward 'life after breast cancer', and it encourages women to lead full and active lives. It is making a difference."

Nearly two decades later, it is continuing to significantly benefit the physical and emotional well-being of breast cancer survivors, locally, nationally and internationally. Moreover, dragon boating for women and men has become one of the most appealing 'newer' sports in the world, from both the participant's and spectator's perspectives.

Yet it retains true to its roots, with every regatta honouring the historical legend by starting with an 'Awakening the Dragon' ceremony, which involves the dotting of the eyes on the dragon's head to awaken it from its slumber.

Then the action starts, with the teams of twenty paddlers, a sweep (steerer) and an on-board drummer launching into a high-voltage dash to the finish line. The sedate Henley regatta this is definitely not.

Australia was an early adopter of dragon boat racing for breast cancer survivors, its introduction due to Michelle Hanton OAM who brought it to Darwin in 1998. Presumably it was necessary to paddle fast in order to outpace the crocodiles.

Since then the uptake has been widespread, with the Northern Rivers group, Rainbow Dragons Abreast (RDA), forming ten years ago and gaining strong support from the region's breast cancer survivors, family members and a range of supporters. Support has come from many quarters, including the YWCA's Encore program, while District Lions funded one of the club's two boats.

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Rainbow Dragons (cont from P 7)

by Robin Osborne

Rainbow Region Dragon Boat Club

Veda Dorrough, a foundation member, told GPSpeak, "We've found that the way you paddle, especially the rotating action, stimulates the lymph glands. The movement of the arms is very beneficial, and all the evidence indicates that women getting fit and meeting others who have gone though similar experiences can do nothing but good."

The on-board view is echoed by the academic one: "Research has shown that, "The interview data support the emerging hypothesis that dragon boating is a vehicle for improving women's wellness and post-treatment quality of life."*

While the affiliated Rainbow Region Dragon Boat Club is more competition based, RDA members – now numbering 70, of whom 32 are survivors and supporters - train up to five times a week, including a Sunday morning workout at Lennox Head's Lake Ainsworth.

Along the NSW coastline there are six regattas a year, with survivor races featuring in two of them. Regular races are also held in Sydney's Darling Harbour, on the Gold Coast (where RDA breast cancer survivors won Gold and Silver in the 2012 Pan Pacific Masters Games) and in Brisbane, the location of Dragons Abreast Australia's head office. The Rainbow Region Regatta is held in Ballina's Shaws Bay on the last weekend of August.

The mandate of the International Breast Cancer Paddlers' Commission, based in Canada, is to "support the development of recreational dragon boat paddling as a contribution to a healthy life style for those diagnosed with breast cancer."

After Canada, Australia, with 29 groups, is the second largest member, outstripping even the USA, which will host the international breast care regatta in October. Six local RDA paddlers, Veda, Juliette, Chris, Marj, Jan and Sue, will be attending.

Go, dragon ladies!

For information about Rainbow Dragons Abreast, contact Veda Dorrough on (02) 6624 5481.

Bahia is on the nose

Although described as the "major culprit" for triggering allergic reactions in residents of the Northern Rivers - see article P - Bahia Grass (Paspalum notatum) is also regarded as a useful fodder crop for low fertility, light-textured soils, according to the NSW Department of Primary Industries.

However, they warn that it should not be grown on or near fertile soils, as it may become an invasive weed. Further, intensive grazing is essential to prevent Bahia dominating the pasture.

The grass grows vigorously in the warmer climes, such as Northern NSW Queensland, WA and the NT, where it can release its potentially allergenic pollen up to four times a year, compared with annually in the cooler south.

The grass originates in north and south America, as might be gathered from the names of two of its varieties, Pensacola and Argentine.

Bahia grass image © State of New South Wales through Department of Trade and Investment, Regional Infrastructure and Services

Budget changes to GP training a potential waste

Another Federal Budget, and another round of changes to the way Australia's health services are planned, funded and delivered to those who need them. This year, perhaps because it's the first Budget of a new government, the changes are greater than they have been for some time. Many of them, if implemented as envisaged, will have long-lasting consequences – at least until a future government comes along to place everything under the microscope yet again.

Among the many re-directions of health policy is the decision to revert from our current regionally decentralised GP training body, North Coast GP Training (NCGPT), to a centralised body run by the Department of Health.

It seems that a decision has been made that the regional governing body for GP training, General Practice Education and Training (GPET), will be closed and its governance transferred to DoH by end of 2015. During next year, the Government will run a competitive tendering process.

No doubt cost reduction and efficiency measures are in the health advisors' minds

Health Minister Peter Dutton (right) with Page MP Kevin Hogan in Lismore.

- but it is hard to imagine how a large city-based organisation can efficiently, and more importantly effectively, run a GP training program. One is inclined to fear that administration costs could rise with added bureaucracy.

NCGPT has had 11 years of experience in building up a strong working relationship with the region's 60 training practices and 150 GP supervisors. This is no easy task, not least because it involves the key 'human element' of building goodwill with support, trust and teaching skills for GP supervision.

NCGPT's numerous awards are testimony to how well the professional staff have performed.

For DoH, directed by the government, to face the expense (in time, energy and money) of undertaking a tender process seems a major distraction from the core business of coordinating all-important training for GPs. Their precious resources would be better placed recruiting new supervisors and facing the challenging task of keeping the current ones involved.

It is a huge commitment for a practice to take on a training role, whether for medical students or GP training registrars. Aside from the physical infrastructure there is a welter of administrative costs and teaching time for busy practitioners.

Nowadays, the number of GP trainees coming through the system is increasing rapidly, and new training practices are potentially struggling to keep up with the demand. There is also competition with medical student training places.

With only 10-20 per cent of vocationally registered GPs teaching or being accredited to teach, increased medical student and graduate numbers are placing growing pressure on existing teachers and practices. This is unsustainable.

In 2015 the number of GP registrar training places in the AGPT program will be increased by 300, taking the total to 1500. The funding for this has largely come about as the controversial axing of the PGPPP. This scheme allowed training RMOs to spend 3 months of their training in general practice and has resulted in many new recruits joining GP training programs.

The barriers to teaching will need to be addressed. One of these is the physical infrastructure needed for teaching. By way of incentives, the Health Minister has also announced an additional $52 million in infrastructure grants to develop the facilities that practices need to take on more trainees. This comes after the Government has been highly critical of the high cost SuperClinic infrastructure grants. The newly proposed grants are targeted pecifically at developing more GP training

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GP Training (Cont from P9)

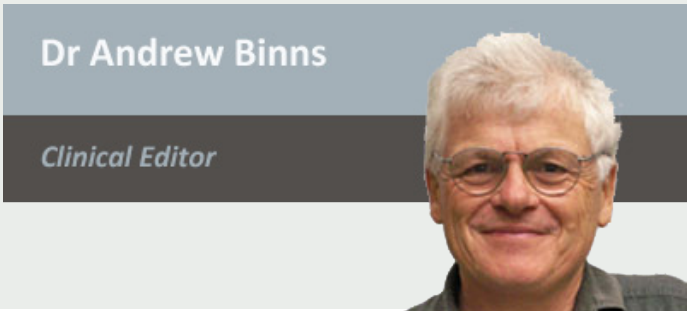
practices, one of the shortcomings of Super-Clinics that opened before Canberra placed a freeze on the program recently.

The practices that will miss out on the benefits of these grants are those that have already invested their own money in infrastructure. This mattr will need to be properly addressed in order to prevent the alienation of existing GP training practices. Perhaps a rental arrangement for consulting room space could be a way of compensating those practices that have already made a significant investment in their practice for GP teaching infrastructure.

It is heartening to see the doubling of PIP payment for teaching medical students from $100 to $200 per session. It seems no such increase is planned for registrar teaching, which remains a marginal commitment for practices.

An example is the costs of employing GP1s/GP2s after hours under the National Minimum Terms and Conditions which have become prohibitive (55 per cent of gross billings plus 9 per cent superannuation). This is causing some serious concern amongst practices that remain open and provide staffing for after hours consultations with high out of normal business hours overheads.

Meantime, before all these changes and before consultation with our GP supervisors it's business as usual for now. The NCGPT will undoubtedly get the strong support it deserves from existing GP supervisors in the tendering process. However, it seems a tedious and wasteful undertaking at a time when the organisation has managed to get real 'runs on the board' in a challenging environment.



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Commonwealth Budget comment by CE

The Commonwealth Budget was expected to be a difficult one for the NSW Health System but it turned out to be much worse than expected. Even before the 2014/15 Budget was brought down by the current Commonwealth Government, NSW Health knew that it would be losing $320 million due to the ceasing of two Commonwealth/NSW Partnership Agreements by the former Commonwealth Government.

The current Commonwealth Government has reduced the anticipated levels of Health Funding for NSW Health. It has ended the "guaranteed" growth that NSW Health would have received in 2014/15. The bonus funding that NSW Health had being relying on to assist it to undertake more Surgical procedures and to provide more timely Emergency Department treatment has also been cut from 2014/15 onwards. As well, other Partnership Agreements have also been ceased or unilaterally amended, which means that some anticipated funding for services like Health Promotion will not be received.

Each year the situation gets worse. From 1 July 2015, the Commonwealth Government will introduce co-payments for General Practitioner (GP), Pathology and Medical Imaging Services. This change will be a particular problem for NSW Hospitals. Their Medical Imaging Services and the Statewide Pathology Services rely on bulk billing of their services to raise revenue. As they will not charge the co-payment, they will lose revenue, which supports Hospital expenditure. Without this revenue, Hospitals will have to reduce their expenditure. Another difficulty for Hospitals will be Patients presenting sicker and requiring more complex and expensive treatment, because they put off going to the GP, because they could not afford the cost. This is likely to add significantly to pressures on Public Hospitals.

The changes to Medicare Locals to rename them as Primary Health Care Organizations and to make them much bigger will not cost the Hospital System more but will be a missed opportunity. They will no longer be local and so it will be more difficult for them to engage with LHDs in particular parts of the State. Instead they will concentrate on the biggest population centres within their boundaries. This will make it much more difficult for the Primary Health Organizations to assist LHDs to change the way care is provided, through initiatives such as improving the Integration of Care between different providers, especially between Primary and Secondary Health Care Providers.

But the news gets still worse! In the "out years" of the Commonwealth Budget Forward Estimates and Projections, the current Commonwealth Government has cut $50 billion from the amount that the former Commonwealth Government intended to invest into the Australian Health System. This change is brought about by indexing the Health Budget to Consumer Price Index movements and population growth and not taking account of population ageing and technological advances, which are the other major drivers of increasing health costs.

Honing in on the allergy curse of the north

A research collaboration between one of Australia's largest diagnostic practices, Sullivan Nicolaides Pathology and The University of Queensland has identified the molecule responsible for the majority of subtropical grass pollen allergies and developed the first molecular-based test.

Head of Immunology at Sullivan Nicolaides Pathology, Dr Daman Langguth, and a team of departmental scientists, have been working with one of the world's authorities on subtropical pollen allergy, Dr Janet Davies, and her small university research unit in Brisbane.

The first molecular-based blood test developed for one of the commonest grass pollen allergies in Northern NSW

Here in Australia, grass pollen allergy accounts for about two thirds of all allergic rhinitis (AR) with Bahia grass, a type of Paspalum, the major culprit in the northern regions – Northern New South Wales, Queensland, Western Australia and the Northern Territory. AR is a particular problem in these warmer climates where grasses can release pollen up to four times a year compared with annually in the south.

They have been able to show that Bahia/ Paspalum has a unique allergy signature and that almost all related allergy is due to the single molecule, Pas n 1 and not, as in many other grasses, a range of allergens.

By purifying the molecule the team has been able to develop and trial a novel blood test (RAST or specific IgE). Over two years, they have worked with hundreds of samples from five allergy clinics across Australia and developed the technology in conjunction with a world leader in allergy diagnostic test development, Thermo Fisher Scientific. (Sweden).

Molecular-based allergy (MA) tests can deliver a far higher level of accuracy over those based on allergen extracts. The Pas n 1 test has an accuracy of above 97 per cent. It not only promises to play an important future role in allergy diagnostics and prognostics but it opens the way for more targeted immunotherapy agents to improve quality of life in the grass pollen allergic.

Dr Langguth and Dr Davies are also involved in a project looking at the relative contributions of grasses to AR in Australia, something that outside Sydney and Melbourne has had little scientific attention.

These research projects are being carried out under a partnership agreement with additional funding from an NHMRC development grant.

Sullivan Nicolaides PATHOLOGY

Two steps forward, one back?

The Aboriginal Health Strategy after 25 years

Well attended by community representatives, local clinicians and staff from health service providers, the forum focused on evaluating the gains, and disappointments, of the Aboriginal Health Strategy which has just turned 25 years old. The event was timed to be held during National Reconciliation Week.

In a well-focused discussion, facilitated by UCRH Director of Education, Dr Michael Douglas, participants shared a range of experiences and views of Aboriginal participation in health care delivery, from both the provider and patient/client perspective. What might be celebrated - antenatal and early childhood care, and the Aboriginal Community Controlled Health Organisation model were generally considered key successes - and what aspects of health service provision to Aboriginal and Torres Strait Islander people and communities should be improved?

It was noted that many significant challenges remain, including high rates of largely preventable chronic disease and hospitalisations, a continued life expectancy gap between Indigenous and non-Indigenous Australians (11.5 years for men, around 10 years for women), and in certain groups, high rates of alcohol use, although the same applies to non-Indigenous people - who on average are more likely to drink to excess than Aboriginal people. It was agreed that alcohol availability and misuse is unlikely to be countered until the power of the alcohol industry lobby can be addressed at the governmental level.

It was agreed that the state of Aboriginal health in Australia is hard to summarise simply. However, one participant drew support with the comment that, "It seems to have gone two steps forward, and one back."

Despite general agreement that funding adjustments in Federal Budget 2014 could impact negatively on the provision of various services, including healthcare, to Indigenous people, there was one remark to warm Treasurer Hockey's heart: "Our message is not want-want-want... we need to plan on not having to rely on handouts." The same speaker also expressed a sentiment relevant to the Reconciliation theme: "We [the Indigenous and non-Indigenous communities] need to walk together."

Another key focus was whether health indicators alone are a benchmark of Indigenous health and wellbeing, and can they be improved in isolation of attachment to Country, daily living environments, educational participation, employment opportunities and other factors (which are as much mainstream as Aboriginal specific)?

The linkages are undeniable, participants felt, drawing on examples from locations as diverse as Kempsey, Lismore, Sydney and Alice Springs.

Released in 1989 after extensive consultations with individuals, organisations and communities, and governments, the National Aboriginal Health Strategy was considered a landmark document. It provided agreed direction for Aboriginal and Torres Strait Islander health policy in Australia.

In the general view of forum speakers, the time has come for a comprehensive review of the strategy. It should be considered in conjunction with the various studies, plans and strategies that have been developed at federal and state level over recent years. One such development is an integrated planning process for Abrigi-

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Participants in the "How far have we come?" forum hosted by the University Centre for Rural Health North Coast (UCRH) in Lismore on Thursday 29 May included (l-r) Steve Blunden/Casino AMS, Scott Winch/University of Wollongong, Cris Carriage /University of Western Sydney and Jenny Smith/Northern NSWLHD.

Another key speaker was Dr Lilon Bandler/University of Sydney (not pictured). The Welcome to Country was delivered by Bundjalung Elder Aunty Thelma James (top, centre).

Strategic investment advice pays off

Therese Pearce

Many medical professionals look to include residential property in their investment portfolio.

Therese Pearce, Medfin Finance's Port Macquarie relationship manager, helps medical professionals manage their business and personal finances and can also help structure residential home loans to suit their unique needs.

Therese believes that while each investor requires their own individual strategy, property investment does not have to be complicated. Here, she shares her top tips for investing in property.

Choose a property tenants will find attractive

Look for property which suits the majority of tenants in your area to ensure your investment is always attractive to local renters. For example, in a region popular with young families, you may want to focus on a home with a backyard as opposed to a one bedroom apartment.

Talk to your financial advisers regularly

This is vital to ensure you have the correct structure in place for your investment and know what fees and charges you are outlaying. A good adviser will understand your financial goals and partner with you to help you meet them.

Look for growth opportunities

Properties which are close to the CBD, leisure facilities, schools, public transport and beaches are often more likely to gain value over time. However, it's really important that you understand the local conditions.

Take a long term view

Taking a long term view to your investment is critical. Selling a property incurs sales costs and taxes, so if you can afford to buy and hold on to your asset for longer, the greater potential rewards you can reap.

Create instant equity through simple renovations

Making simple but high impact renovations can be a good way to maximise the value of your investment property. A good rule of thumb is to aim to get back at least $1.00- $2.00 in value for every dollar you spend on renovations.

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Before making any financial decisions you should make sure you receive appropriate financial, legal and tax advice.

Award–winning resource helps Aboriginal patients take heart

Indigenous heart disease patients in the Northern Rivers and around Australia are the real winners of an award given to a local team that developed a pioneering self-management guide for Aboriginal and Torres Strait Islander people with a history of heart problems.

Kerry Wilcox, Cardiac Services & Chronic Disease Program Manager, Northern NSW Local Health District, Darlene Rotumah, UCRH Associate Lecturer and Coordinator e-Social & Emotional Wellbeing Project, and Lindy Swain, UCRH Pharmacist Academic with the new resource to help Aboriginal people manage their heart conditions.

Officially, the award in the 'Excellence in Consumer Information' category in the prestigious NPS National MedicineWise Awards 2014 went to Lindy Swain, UCRH Pharmacist Academic, Dr Lisa Pont, a pharmacist at The University of Sydney's Nursing Faculty, UCRH's Assoc Prof Janelle Stirling and Ms Kerry Wilcox, Cardiac Services and Chronic Disease Program Manager, Northern NSW Local Health District.

The acclaimed resource, Living every day with my heart failure, resulted from a partnership involving The University of Sydney, through the University Centre for Rural Health (UCRH) North Coast, Northern NSW Local Health District and the Heart Foundation.

The 33-page information booklet, also available as a PDF download, followed the formation of an advisory team comprising researchers, pharmacists, health promotion educators and a specialist cardiovascular nurse, plus extensive consultations with Indigenous communities.

The production has a 'This is your book' introductory section for patients to record their health details, including contact information for health worker/ nurse, doctor, clinic and pharmacist. Sections such as 'When I feel sick what should I do?', 'Shortness of breath', 'Chest pain', 'Exercise', Medicines' and more are colour-coded.

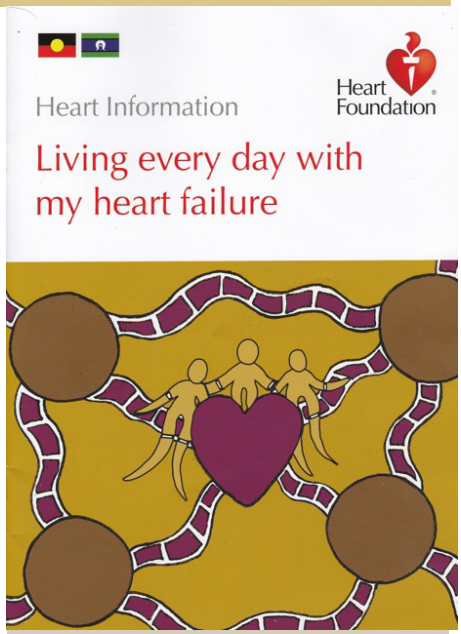
"Chronic heart failure is a major course of illness and death among Aboriginal and Torres Strait Islander communities," Lindy Swain said.

"Previously, standard health resources were not culturally or linguistically useful for many Indigenous people.

"Art and design had an important role, not only to identify the resource as belonging to the Indigenous community but also to explain key messages in a non-verbal way. All key messages are presented visually as well as in text."

The resource is intended to be equally useful to clients, families and carers, and already it has been well received, with 4,000 copies distributed. Clinicians have also welcomed it, while early feedback shows it is proving of value in non-Indigenous settings as well.

Copies of the booklet are available from the Heart Foundation, with **downloads of the pdf version.**



The painting on the front cover of 'Heart Information - Living every day with my heart failure' is by Tina Weston (Barkindji). It represents different clans/tribes all travelling on the connecting pathways to having healthy hearts and lifestyles.

Two Steps

(cont from P 13)

nal health that the Northern NSW Local Health District will be commencing shortly.

Participants welcomed the opportunity to share their views on the all-important topic of Aboriginal health care provision, with many hoping it could be followed by similar, more in-depth forums in the future.

Nine Ways To Avoid A Tax Audit

Peter Morrow (partner) **Kris Graham (partner)**

The Tax Office annually releases its compliance program to let taxpayers know which areas will be their focus for the year. To provide some perspective, they expect to data match over 640 million transactions to tax returns this year.

Below are nine common ways to ensure you are not subjected to an ATO audit:

1. Have financial performance that is in line with industry standards

As a matter of course the tax office will statistically analyse your tax return. If your statistics are inconsistent with averages for your industry, if may be an indicator of tax issues such as unreported income, transfer pricing and other issues.

2. Pay the correct amount of superannuation for your employees

If your employees complain to the ATO that their employer has not paid them the right amount of superannuation (or not paid it on time), you are more than likely to get a review from the ATO.

3. Minimise variances between tax returns and BAS

Large variances between the information reported in a tax return compared to Business Activity Statements are likely to trigger an ATO review.

4. Lodge your tax returns on time

A good compliance history will improve the ATO's perception of your business. This includes lodging income tax returns, BAS, PAYG Summaries (Group Certificates), fringe benefits tax returns plus the on-time payment of any tax liabilities

5. Don't consistently show operating losses

Losses in 3 years out of the last five are likely to trigger indicative of problems. There may be genuine reasons, but the ATO is likely to want to investigate these.

6. Ensure all transactions are included

The ATO receive data from the Banks, Stamp Duties Office, Land Titles Office, Centrelink, Share Registries and the RTA, and matches this with your tax return. If an enquiry is triggered because of missing data, the audit will generally cover include income tax, Capital Gains Tax, GST and FBT.

7. Profitability fluctuations are a possible indicator.

The ATO will compare your tax returns year-on-year. Big fluctuations in financial position or particular line items in the tax return can trigger an inquiry from the ATO.

8. International transactions

International transactions with tax havens and related parties are a key area of focus for the ATO.

9. Avoid Publicity

Not all publicity is good publicity when it comes to tax audits!! A major transaction or dispute that is reported in the media will undoubtedly be seen by the ATO. Many business owners are selected for an ATO review after the sale of a high value asset is reported in the paper.

Should you require assistance in dealing with a tax audit or review, or would like further information about audit triggers, please contact Peter Morrow or Kris Graham at Thomas Noble & Russell on (02) 6621 8544

Kevin Hogan

MP for Page

Order in the House

As you would know the Government has made numerous changes to health in the May 2014 budget – many have been warmly welcomed, like creating the world's largest Medical Research Fund, while others have been more controversial.

What is underpinning all the changes is the government's commitment to deliver better health care for all Australians on a sustainable basis. Under the changes, the government is asking people to take more personal responsibility for their health, through modest contributions to the cost of their care.

Apart from the retention of bulk billing, we are providing a second safety net by capping the contributions at 10 (or $70) per calendar year for concessional patients and children – for whatever mix of GP visits, pathology tests and eligible diagnostic imaging services they need.

We are also lowering the thresholds and simplifying the Medicare Safety Net so more families are protected from high out-of-pocket expenses. The threshold will be cut to $400 for individual and family concession card holders, and to $1000 for non-concessional families.

One of the other changes is that the nation's 61 Medicare Locals will be replaced with a smaller number of Primary Health Networks. GPs will be at the centre of the new model that and will better match with the boundaries of local hospital networks. With well-defined roles, they will not be direct providers of service but will link up services to meet community needs to help keep people out of hospital and provide support to individual general practices. A tender process will be held later this year to select providers for the networks.

The third area where change is urgently needed is in funding for public hospitals. Let me make it clear that a lot of the commentary on this issue is dead wrong. We are not reducing funding for public hospitals. In fact, we are increasing the Commonwealth's contribution to the funding of state and territory owned and managed public hospitals by more than 9 per cent a year over the next three years and an average of about 6.5 per cent from 2017 and each year after that.

We will also continue to pay efficient growth funding until 2016-17 and then from 2017 we will provide an indexation factor which is equivalent to CPI and population growth. That is not cutting spending. It is providing a fair and reasonable margin for growth in the short term, and a strong incentive for the states to work harder on efficiency in the medium term.

There is more positive news for the health sector in the budget, such as a 300 increase in the number of Commonwealth funded GP training place to 1500 from next year, and the doubling of the Practice Incentives Programme payment to GPs.

ALDI's alcohol push for Byron Bay

Amidst mounting concern about the widespread availability and consequent misuse of alcohol in Byron Bay, the well-known supermarket chain ALDI is seeking a licence to trade beer wine and spirits from its downtown premises.

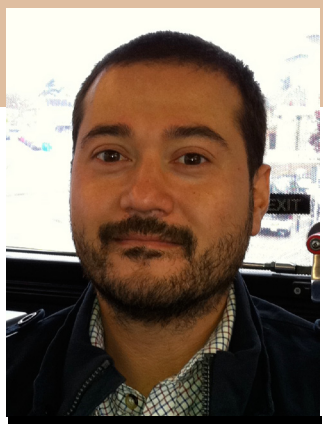
Concerns have been raised that the discount operator would be able to undercut local bottleshops, not only affecting their trade but further adding to the amount of alcohol consumed locally, especially by younger visitors.

The licence application has attracted strong opposition from Byron Shire Council, the town's Liquor Accord and the BUDDI Drug Action Team, according to the Northern Star (9 June 2014).

The paper's front-page report quoted BUDDI's Nicqui Tazdi: "If ALDI gets a licence, we're worried it will set a precedent allowing supermarkets in Byron Bay to sell alcohol."The town already has more licences than the state average, BUDDI says, and a high rate of alcohol related violence and DUI offences.

ALDI has a strong online presence where the cheapest wine currently on offer retails at $2.69 per bottle. The firm's **online liquor store** commenced trading on 1 August, 2013, a date its website describes as a 'world first'. In addition to online, many ALDI supermarkets sell alcohol, ninety of them in NSW, including Lismore – just down the road from the Woolworths-owned liquor giant Dan Murphy's - Grafton and Tweed Heads, and a greater number in Victoria.

Abdominal Aortic Aneurysms: Part 2



Dr Dom Simring

1 - Screening

There have been several large screening trials that have been published for AAA. The screening methods employed were duplex ultrasound, a cheap non-invasive, reproducible and reliable tool for diagnosing AAA. The overall messages from these trials were:

- there is a 5% prevalence of new AAA in males aged 65-74 years
- in those invited to attend screening, about 80% will attend
- of those that attend screening, the risk of an aneurysm-related death (operative death, or ruptured AAA) is reduced by 50%
- the majority of ruptured AAA's occurs in the 20% who do not attend screening
- AAA screening programs are cost-effective when gauged against other screening programs
- in communities where "background screening" is high (that is where many of the patients have had abdominal imaging performed for some other reason) there are fewer new AAA diagnosed and therefore some of the benefit is lost
- Women don't appear to benefit from screening, therefore selecting "high risk" females provides the greatest benefit especially those with a family history of AAA, smokers and those with hypertension
- Repeat screening is unnecessary unless there is a positive family history, or the initial screen is undertaken at a young age.

A special case for screening exists in those with a family history of AAA - there is a 25% prevalence of AAA in first-degree male relatives. These patients tend to be younger and more symptomatic and accordingly in this high-risk group, screening should start at 50 years of age. For standard-risk patients, 65 years is a reasonable age to commence screening.

2 - Medical management of AAA

As with all vasculopaths, medical management must encompass an approach to secondary prevention of cardiovascular events. This includes assessment and treatment of:

- hypertension
- dyslipidaemia
- smoking cessation
- diabetes

While a comprehensive review of medical management of vascular patients is beyond the scope of this topic, it is worthwhile recalling that a number of medications have been shown to reduce the number of recurrent major vascular events, including:

- antiplatelet agents
- statins
- ACE inhibitors
- Beta blockers

Specifically for AAA, a number of medications have been trialed for their potential to slow growth and reduce rupture risk. These include beta blockers, indomethacin and doxycycline. While animal studies have been

cont on page 19

Part two of two Parts about AAA:

- ***Screening***
- ***Medical Management***
- ***When to refer***
- ***Post-operative care***
- ***Surgical Management***
- ***Prognosis and Future***

Dom Simring

BA, BSc (Med), MBBS (Hons), FRACS (Vasc)

AAAs *(cont from p18)*

promising, human trials have been less encouraging and at present there are no recommended drugs for this purpose.

3 - When to Refer

The decision of when to refer is easy when the patient is symptomatic. Patients with abdominal pain, back pain or abdominal tenderness overlying a palpable aorta should be referred urgently to the local hospital for further assessment and treatment. Those with uncommon symptoms such as "blue toe syndrome" (due to distal embolisation) should also be referred to a vascular surgeon regardless of the aneurysm size.

Those whose AAA's have been identified and are asymptomatic should be referred when the aortic size is more than 35mm in maximal diameter, or the iliac arterie(s) are more than 20mm. This allows for early identification of high-risk patients, risk factor modification, maximizing medical therapies, patient education and explanation of the need for ongoing surveillance.

4 – Post-operative care

Following EVAR problems that a general practitioner may encounter include wound infections, lymph leaks or collections in the groin incisions, on-going back pain which is usually related the aortic sac thrombosis and a systemic inflammatory response known as SIRS and described in the literature as "post-implantation syndrome".

Groin complications should be referred back to the surgeon for review and may require the commencement of antibiotics and rarely surgical re-intervention.

The inflammatory response can be variable and usually lasts several days. It is noted as a raised white cell count (WCC), elevated temperature and ongoing back pain. This is usually seen whilst an inpatient and is generally self-limiting. If this continues after discharge, discussion with the surgeon should occur as sometimes it requires further blood tests including inflammatory markers and WCC. CT scans are also useful to ensure no abnormality has occurred with the graft and this can aid in reassuring patient, surgeon and general practitioner. Infection of a stent-graft is fortunately very rare. Generally, post-operative follow-up with the surgeon occurs at 6 weeks, then 3-6 months for an ultrasound and, if all is well, annually thereafter for ultrasound surveillance.

Open repair of AAA require longer stays in hospital and sometimes respite or rehabilitation. This means that the abdominal wound has healed enough not to present with many problems but collections and infections are still possible and may present late. Appetite is usually poor and this can last up to 6 months following the operation, as can alterations in bowel habit. Post-operative depression occurs quite frequently. These findings are usually self-limiting. Once again, follow-up occurs at six weeks and then perhaps a few months after. Unlike EVAR, annual ultrasound is not necessary though a CT scan at 5 yearly intervals is wise to ensure no anastomotic aneurysm.

Surgical Management of AAA

There have been two major trials that have allowed us to determine when it is safe to continue surveillance and when to operate based on aneurysm size and rate of growth. In these trials, patients with aneurysms between 40 and 55mm were randomized to "immediate open surgery" or "surveillance".

Some major points to emerge from the trials were that:

- under surveillance, less than 1% of male patients ruptured, though the rate was higher in women
- the operative mortality was 2-7% for open surgery
- in both groups, the survival was equivalent up to 5 years
- in those under surveillance, 70% eventually went onto aneurysm repair as they continued to grow.

This has led to the conclusion that while it is safe to continue to survey male patients with serial ultrasound at 3-6 monthly intervals until the aneurysm reaches a diameter of 55mm, it is reasonable to consider repair at 50mm. In females, the threshold for treatment is lower and many would consider repair at 45-50mm given the lack of clear data.

Apart from size, risk factors for rupture include :

- female sex
- hypertension
- ongoing smoking

cont on page 20

AAAs *(cont from p19)*

- chronic airways disease
- family history of AAA
- rapid expansion
- eccentric or saccular shape

Over the past decade, EVAR has become the default approach to aneurysm repair. Large multi-centre trials have established the efficacy of EVAR in preventing aneurysm rupture in the long term, and have demonstrated a significant and sustained reduction in aneurysm-related mortality when compared to open surgery due to a reduction in peri-operative mortality from 5% to 2%.

The other benefits of a minimally invasive approach include:

- smaller incisions, potentially under local anesthesia
- no ICU admission
- reduced cardiac and respiratory morbidity
- reduced blood loss
- reduced hospital stay
- faster return to function
- greater patient satisfaction

Currently, EVAR is used to treat more than 80% of AAA.

Prognosis and Future:

The prognosis following repair of the AAA is very good and patients can maintain a normal lifestyle without the concern of rupture providing regular follow-up occurs. After the usual post-operative recovery period, normal activities including driving may be undertaken without restriction.

Future advancements include further stent-graft development and refinement, fenestrations for branch vessels allowing for a higher percentage of AAA to be treated with EVAR as well as smaller delivery devices and percutaneous procedures which will result in even further reductions in operative and wound morbidity. Medications which may have impact on aneurysm enlargement and potentially stabilization are continuing to be researched, however, no clinically relevant advancement in this area has occurred yet.

Treatment of AAA has changed dramatically over the last 10 years with endovascular procedures and will continue to evolve with improved technology and complexity of anatomical lesions treated. All this means better outcomes, shorter hospital stays, faster return to function and treatment of more complicated aneurysms by endovascular techniques.

Summary: When to screen

- ***Any patient with a palpable abdominal aorta that is clinically aneurysmal***
- ***All males between 65 and 74 years, particularly Caucasians with a family history of AAA, smoking or hypertension***
- ***All females aged over 50 years with a family history of AAA***
- ***All siblings or children aged over 50 years of those with a newly diagnosed AAA***
- ***USS is the screening modality of choice – if a CTA is requested, remember to ask for an "EVAR protocol" examination, and check renal function is adequate for contrast administration***
- ***Any AAA over 35mm should be referred for specialist evaluation and surveillance***
- ***Remember to check for femoral and popliteal aneurysms in those with AAA (5% prevalence) – again, USS is the imaging modality of choice***
- ***If a screening examination is normal, repeat screening is usually not necessary for a period of at least 7 years unless the patient is high risk***

Summary: Who should be treated

- ***All those that are symptomatic, unless there is a very good reason not to treat, such as end-of-life issues or poor prospects of recovery***
- ***In those that are asymptomatic, AAA over 50mm though women may be treated at smaller sizes***
- ***-Remember that the decision to treat is based on rupture risk versus surgical risk and the advent of EVAR has significantly shifted this balance in favor or earlier intervention.***

Exercise physiology a winner for local 'blade-runner'

The distance between cute wildlife and roadkill can be short and fast, with mobile creatures such as kangaroos being just as vulnerable as plodders like echidnas.

As I discovered recently on a drive to Kakadu, roos blend well with their environment and behave, as far as humans are concerned, most unpredictably. This often leads to their death or serious injury, and although the damage to vehicles can be extensive, the occupants are seldom injured.

It is a different story for motorbike riders, as Lismore-born Jamie Maxted discovered eight years ago when he hit a roo - or vice-versa – on a rural road in Victoria. Suffering serious injuries, especially to his left leg, Jamie underwent a series of medical procedures, including what he calls "countless surgery", to save his foot, but every effort was in vain, and eventually he decided that, "If I had to lose my leg to regain my life, then so be it."

Operated on in Melbourne, he was out of hospital after four days, and within the month had a prosthetic leg fitted.

Back in the Northern Rivers, the former gymnast and martial arts student was feeling the urge to resume exercising, but for years – more than seven, to be exact - he lacked the strength and balance to even walk properly. Worse, he suffered referred back and hip pain from over-compensating on his posture.

While a prosthetic limb is a strong support, it places intense pressure on the leg, and for Jamie this meant being able to stand on his left side for only three seconds. Today, this time-span has increased tenfold, and the referred pain to other parts of the body has gone. Importantly, he is better able to handle the crutches he must use to spell his left leg because of issues such as skin irritations that affect most amputees.

More impressively to an outsider, Jamie is getting back his sporting life, including basketball, karate, and running, this with the help of the 'blade-runner' attachment – bearing the Nike logo - made famous by a certain disabled South African, now better known as 'the defendant'.

While the improvements in Jamie's physical, and as he freely admits, emotional wellbeing seem almost miraculous, the changes are no mystery to Jesse Morgan who has been working with Jamie for the past eight months.

Jesse, who runs Lismore-based Embrace Exercise Physiology, started by designing a remedial program based on Jamie's condition, limitations and identified goals, working in liaison with his client's GP and occupational therapist. Since then he has taken his client from frequent sessions involving stretching and weight bearing exercises to a monthly consultation, interspersed with daily, self-managed workouts at home.

"It is essential for Jamie - indeed any client, whatever their circumstances - to maintain the program in their own time," Jesse stresses. "His discipline, obviously learned over the years in gymnastics and karate, is really paying off."

Jamie agrees, saying that his increasing fitness and more positive attitude have given him the confidence to become involved in providing peer support to other amputees through a local support group, and to consider establishing

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beyondblue launches mental health 'fitness' program

In the area of mental health, as with any medical issue, timely intervention is seen as vitally important, and with the aim of helping local residents to address early signs of mild depression or anxiety the national organisation beyondblue has brought its NewAccess program to the North Coast.

Launched recently in Coffs Harbour by former beyondblue CEO Kate Carnell, The Movember Foundation's Australia Director Jeremy Macvean, and North Coast NSW Medicare Local CEO Vahid Saberi, the mental health 'coaching program' seeks to help more people receive appropriate support for these conditions.

NewAccess has created a mental health workforce in North Coast NSW through the recruitment of local Access Coaches, trained to create individually tailored programs for clients.

Mr Macvean said, "Much like you would enlist the support of a personal trainer to overcome a physical injury, the Access Coaches available through NewAccess work with participants to develop a tailored program that will support their return to mental fitness."

The $13.5 million program is funded with $8.15 million from The Movember Foundation and the remainder from beyondblue.

The North Coast site, which is open to anyone who lives within the North Coast NSW Medicare Local footprint, includes Port Macquarie, Coffs Harbour, Byron Bay and the Tweed. It follows the launch of NewAccess in Adelaide last month and Canberra last year.

The three sites will be independently evaluated and if the program is successful, beyondblue said it will approach the Federal Government for ongoing funding.

The program is free and can be accessed through self-referral or via traditional referral channels such as GPs.

beyondblue's Chief Executive Officer Georgie Harman said that the program was open to anyone living between Port Macquarie and the Queensland border. "Because **NewAccess is a free program and can be accessed** through self-referral or via traditional referral channels such as GPs, it makes accessing support to overcome mild depression or anxiety much easier. "We believe its practical approach will appeal to Aussie blokes and see positive results for many," said Ms Harman.

Exercise physiology benefits (cont from P 21)

a business designing individualised prosthetics, with a focus on sporting activities.

Delighted to be playing a part in Jamie's rehab, Jesse stresses that focusing on individual needs is also central to his role of helping people cope better with whatever hand life has dealt them. His clients may be young or not-so, fit or otherwise, chronic disease sufferers or those dealing with the consequences of an accident. In common, however, is the ability of body and mind to experience greater wellness through a professionally–designed and sustainable exercise program.

One is reluctant to ask how often Jesse is 'embraced' by grateful clients, but if Jamie's obvious appreciation is anything to go by, the chances are that such a response might not be uncommon.

Jesse Morgan

Embrace
Exercise Physiology.

Book Review

by Robin Osborne

So It's Cancer: now what?

Ranjana Srivastava
Penguin $29.99
(published on 23 July 2014)

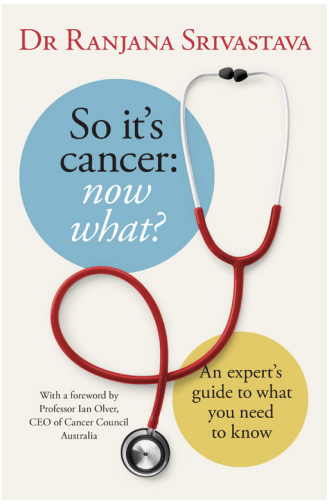
In the same way that this book's title poses a question, another might be whether patients and their supporters need another advice manual on how to cope with a cancer diagnosis and participate in the management of their condition.

In this case, the answer is a resounding yes, as the author, Melbourne-based oncologist and communicator Dr Ranjana Srivastava combines her clinical expertise and experience, and an excellent facility with words.

This work comes soon after **her interview with Phillip Adams on ABC RN's Late Night Live** in which she explained how many ED presentations could be better served through the adequate funding of out-of-hospital social services

Timely in the current health-debate climate, it confirmed Dr Srivastava as a valuable commentator on health issues, earlier contributions being two other books, also with straight-shooting titles, Tell me the Truth and Dying for a Chat, focusing on the patient-doctor nexus.This time around, the focus is squarely on cancer, a subject she is all too familiar with, as one might think, is society generally, given today's cancer rates. However, as the author recounts, "My patients often say that once they heard the word 'cancer', every other piece of information just evaporated – everything else seemed like a tide of white noise." As a result, "The initial conversation around the disclosure of cancer is important," words that aptly sum up the immense value of this book, although its scope goes well beyond digesting the initial bad news. "Unless you are medically trained it may be difficult to comprehend the pathology report or appreciate the changes on a CT scan, but the patients who navigate the journey well are those who always try to understand themselves and their motivations in life."

"They use a personal philosophy to guide them in their decision making, and in doing so, take active control of aspects of their care."



As a key part of such a control strategy I can think of no better tool than this clearly ordered, compassionately toned and easily understood work. Beginning with an overview "What is Cancer?" chapter, it ranges across the role of the oncologist, treatment modalities, exercise advice, family and sexual relationships, carer support, and, as will be inevitable in many cases, end of life issues such as 'Palliative Care' and 'Advance Care Planning'.

Most helpfully, each chapter ends with a list of key points summarising the text. For instance, following the chapter 'Will my death be painful?', Dr Srivastava advises that "pain and other troublesome symptoms are readily manageable with modern means," and that, "A peaceful death can happen at home in hospice or in hospital but it helps to articulate your wishes in an advance care directive."

The chapter "Why Natural Therapies Aren't the Answer" may have particular resonance in the Northern Rivers. It includes a tragic case history of a patient whose alternative treatment regime for bowel cancer not only failed him but cost a considerable sum that, post mortem, saddled his wife with a substantial debt.

"I should distinguish between complementary therapy such as yoga, meditation and mindfulness activities and alternative therapy consisting of unproved remedies," the author notes.

"Almost every oncologist acknowledges the importance of tending to the mind-body axis as part of comprehensive cancer treatment. It is when the treatment strays into elimination diets, super foods and vitamin megadoses that oncologists become wary."

If only for this advice the book would be well worth owning, but clearly there is much more to it, and the package, with a foreword by Cancer Council CEO Prof Ian Olver, is highly recommended to all cancer patients and their supporters.

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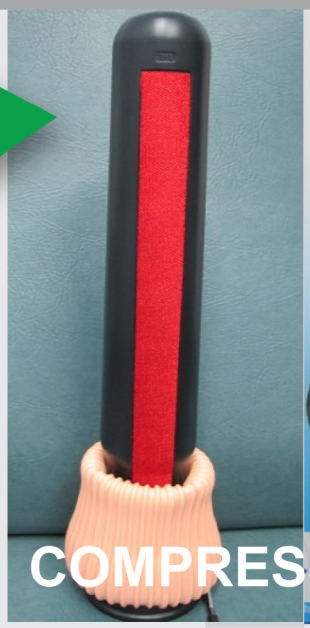

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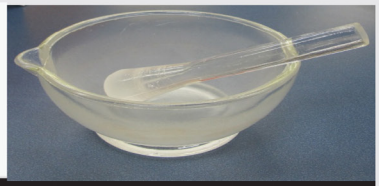

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Opinion - by Editor Robin Osborne

Ireland v. Murdoch on plain-pack cigs

In one of the most irresponsible pieces of journalism seen for some time, The Australian (no less) on 6 June 2014 reported – crowed, would be more apt - on its front page (no less) on 'evidence' showing that the former Labor government's 'nanny state' support for plain cigarette packs had failed miserably.

Citing an industry monitor called InfoView, the Australasian Association of Convenience Stores and that most reliable source, cigarette manufacturer Philip Morris, the paper reported that the 'world's toughest anti-smoking laws', introduced in late 2011, are not working.

To reinforce the point, the story was accompanied by a large photo of two attractive young women sitting in a Brisbane park during their lunchtime, happily puffing away. One was quoted as saying that plain packaging does not work because if someone is addicted to smoking they would rather spend their last money on smokes, not food.

Not a single health expert, or even an ex-smoker, was quoted, while on the page 4 spill of the story, another large photo showed a convenience store employee in front of a large rack of cigarette packs.

He supported the comments of the British American Tobacco spokesman in the preceding paragraphs who said sales had increased and quit numbers dropped.

The only people who might have defended the 'nanny state' legislation, former Labor health ministers Nicola Roxon and Tanya Plibersek, chose not to comment on the industry claims.

Why bother? You're on a hiding to nothing when you set sail against the pre-existing winds of Rupert Murdoch's national broadsheet, now celebrating its 50th year of life.

But there was more… the paper also ran an editorial, 'Suck it up nanny, plain cigarette packs have not cut smoking', in which the paper argued…wait for it… that, 'Plain packaging deprives tobacco firms of valuable assets – the intellectual property of their marketing.'

Surely it would be more logical to say smoking deprived them of even more important assets, their customers, because they die from consuming the product, not to mention costing society massive amounts of money in health care.

When friends ask why I still take The Australian, which once provided a substantial part of my income, I reply, not entirely in jest, that in the Northern Rivers one could easily become complacent about life. The Australian is guaranteed to make me angry every morning.

In this case, what especially infuriates me is that the agenda-driven coverage of the smoking issue is inaccurate, or at best (to give some credit to the little known body InfoView), misleading.

Smoking rates in Australia have been on a steady decline for decades, the reason, according to bodies such as the Cancer Council, being "sustained government [yes, Mr Murdoch, government] tobacco control strategies (e.g. high tobacco taxes, advertising bans, mass media public education campaigns and smoke-free environments legislation)."

Perhaps plain packaging is also a factor. Ireland thinks it might be, as that country – an early banner of smoking in pubs, a move that actually brought people back – is proposing legislation to remove logos, colours, graphics etc from packs, and make health warnings more prominent.

Not surprisingly, the Irish health department expects the move to be "fiercely contested in the courts by tobacco firms".

And no doubt opposed by those arms of Murdoch's News International that reach across the Irish Sea

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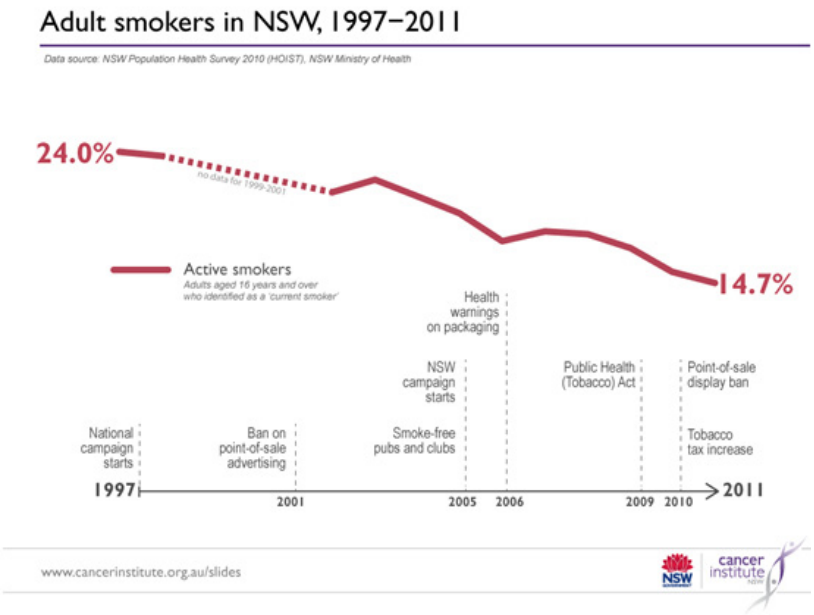
Opinion - by Editor Robin Osborne (cont from P 25)

from the UK and north America.

Similar legislation is making its way through the New Zealand parliament, guided by a government less loathed by the Murdochian stable, but surely being lined up for a full frontal assault.

Back in the real world, where the truth actually matters and reading a newspaper should not leave the aftertaste of licking an ashtray, here's what the Cancer Council has to say about Australia's gradual shift to a society where healthy quitters might be the page 1 role models - **link to Cancer Council stats.**



Postscript

Ever ready to mount an attack, or in this case, counter-attack, against Fairfax Media or, in this case, the ABC, The Australian has reacted vigorously to MediaWatch's criticism of the paper's plain cigarette packaging story of the previous week ('Plain wrong? Here are the facts: cheap smokes are on the rise since plain packaging', 18 June 2014).

Again, the topic dominated the front-page, and again the coverage featured a photo of an attractive female smoker ('Brisbane's Marianna Tigani said she was a "proud smoker"'), and comments from tobacco industry spokespeople.

While echoing its earlier claims that, despite plain packaging, smoking rates in Australia had tended to rise – an assertion contested by health sector analysts - the central focus of the follow-up was that many smokers are moving towards cheaper brands, and this was "pushing up sales and frustrating health policies."

Oddly - or not, depending on how one views its motivation - the paper did not link the rising popularity of cheap brands with the state of the economy, especially relevant as smokers tend to be in lower socio-economic brackets and thus are price sensitive shoppers. Moreover, the consumers of lower price brands are likely to be heavier smokers, around 14-17 per day, compared to 9-12 for those buying premium brands.

Instead, the paper claimed that, "Anti-smoking measures are driving a boom in cheap cigarettes."

This was explained by British American Tobacco Australia's director of corporate and regulatory affairs: "While we understand the government is trying to reduce smoking rates by raising excise, combined with plain packaging, it's actually increased the number of smokers buying cheaper legal cigarettes as well as black market tobacco."

He went on to say that people were "generally buying more cigarettes and paying less for them," which had prompted BAT to launch its $13 Rothmans packs, the cheapest on the legal market.

Well, they'd have no choice, would they?

And so it went on, spilling to a page 4 filled with stories under such headings as, 'What Media Watch package didn't tell us' [nice pun, sub-editor], 'Plain wrong? Here are the facts', 'Labor policies in the frame: it was a case of smoke and mirrors', and 'Cherry-picking stats an uncertain science'. The last, an 'Analysis' warning of a "naive reliance on ABS statistics", included the lame addendum, "This isn't a criticism of the ABS per se".

There was no doubt, however, about the coverage's criticism of anyone, whether government, media organisation or concerned individual, who might wish to curtail the community's uptake of harmful products.

In the laissez faire, free enterprise world of The Australian, it is

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Byron ED study shows high levels of 'preloading' and shot-drinking

An initial seven-week-long survey conducted recently at Byron Bay Hospital has opened a window into the drinking habits of young people in Byron Bay ¬- or at least those who seek medical attention at the Emergency Department.

At present, ED staff are not tasked to seek data on the possible links between presentations and alcohol consumption, and are generally too busy to take on a non-core activity.

However, some interesting trends were noted. For instance, 79 per cent of the presentations considered to be alcohol-associated were people between the ages of 18 and 25 years, with 75 per cent stating they lived in the Byron area.

The gender breakdown was close to balanced – 52 per cent were male, 48 per cent female.The commonest triage presentations were in category 4, with none in the critical category 1. While there seems little reason to doubt the accuracy of these figures, the number of recorded alcohol related presentations was so small ¬- only 5.7 per cent - that the finding may have little value.

As the ED in Byron is used as a GP service between 6.00pm and 9.00 am, and frequently during the day, the

number of true emergency-type presentations, including those that may be alcohol related, are proportionately fewer in this study. Further study should be undertaken when resources permit, according to local GP Graham Truswell.

Dr Truswell, Chairman of the Byron medical staff council, told GPSpeak that, "We feel this study has been worthwhile, but due to numerous issues, the true extent of alcohol related presentations does not seem to have been captured. As all staff are concerned about the amount of binge drinking and violence, the hospital plans to improve on what we have done and repeat the study when possible." That the hospital does not

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Opinion (cont from P 26)

Robin Osborne
Editor GPSpeak

all a matter of choice and personal responsibility. The fact that the number of young people buying low priced cigarettes had doubled in the past year - presuming that the BAT representative can be believed – is apparently not a matter of concern but one of market reality.

Fairfax Media broke its silence on the issue on 23 June when The Sydney Morning Herald reported, unequivocally, "Plain packaging pushes cigarette sales down". The story said Treasury had published "previously secret information that shows sales falling since the introduction of graphic health warnings and plain packaging."

It went on, cigarette sales had dropped 3.4 per cent in 2013, the period that followed the mandatory move on 1 Dec 2012.

Further, "The national accounts show a further slide of 7.6 per cent in the three months to March [2014] after the first of a number of big increases in tobacco excise announced late last year."

Unlike The Australian, **the SMH did seek another point of view**, quoting BAT as confirming that Australian smoking rates have been declining "for a very long time, but since plain packaging the rate of decline has halved. That's what we are arguing."

The Commonwealth has reported the smoking figures as **Tobacco Key Facts and Figures.**

Recent data released in Tasmania, long considered one of the nation's highest smoking (and most socio-economically challenged)

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Byron ED study (cont from P 27)

collect detailed information on alcohol is not unusual either locally, or in Australia at large. There are various reasons for this, including clinical workloads, the practice of dealing with patients' presenting issues not the causes, issues relating to patients' unwillingness to discuss their behaviours, and the absence of a culture in ED departments to collect data for research.

Anecdotal reports, however, from many hospital staff ¬ - and police - indicate the involvement of excessive alcohol in a range of trauma, including physical and sexual assaults, both in public and domestic settings, and motor vehicle accidents.

The Byron study was conducted by University of Wollongong medical student Haddijatou Hughes, whose clinical placement is coordinated by the University Centre for Rural Health, North Coast. A long-stay final year student, she has been living in the area and attending classes at Lismore Base Hospital and UCRH since mid-2013, also undertaking two days of GP placement a week at the Bangalow Medical Centre.

Dr Michael Douglas and Dr Hudson Birden provided assistance with the Byron Bay Hospital ED project.

Ms Hughes found that around two-thirds of those presenting had been drinking most of their alcohol 'at home', which may have included rental premises, as the period spanned 'Schoolies'. The main presentation age group was 18-year-olds, some 75 per cent of whom had consumed 10 drinks or more. Approximately 20 per cent of respondents said they had consumed energy drinks, and 50per cent said they had drunk 'shots' of spirits. Although 'preloading' before going to licensed venues was around 50 per cent, most ED presentations appeared to come from those who had been drinking 'at home', rather than in licensed premises. However, those presenting on the day following an alcohol related event, or who presented appearing sober, often did not get asked about their recent drinking history.

The Last Drinks campaign, which continues to be deeply concerned about alcohol related violence and general harm, including public safety and the reputation of Byron Bay, hopes that the study can be repeated, and extended. A comparison between the town's quieter and busier periods is one aspect worth exploring, Dr Truswell said. It is also hoped that a relatively minor adjustment to the computerised triage and record system would facilitate the collection of data without creating an impost on ED clinicians.

Opinion (cont from P 27)

Robin Osborne
Editor GPSpeak

jurisdictions, has also been welcomed as good news.Director of Public Health Dr Roscoe Taylor said the Tasmanian Population Health Survey showed well under 1-in-5 Tasmanians now smoked and the trend was towards even fewer smokers in the future.

"This is a tremendous result and means many thousands of Tasmanians will live longer and more productively, and the financial burden on the health system will be dramatically less," Dr Taylor said.

The Tasmanian Population Health Survey 2013 showed the number of Tasmanian adults smoking had fallen from 19.8 per cent to 15 per cent since the last survey in 2009.

While the true percentage of current smokers "is probably a little higher than the 15 per cent shown by this latest Tasmanian survey, the survey certainly points to a very pleasing decline in smoking rates compared with four years ago."

Daily smoking rates fell from 16.1 per cent to 11.9 per cent across the same period.

Hungry for some great theatre?

Simply titled Food, the new show by dance company Force Majeure and Sydney's Belvoir, is preparing to dish up a treat for local theatregoers at Lismore City Hall on Friday/ Saturday 11 & 12 July, 7.30pm.

It runs for 90 minutes with no interval, and is billed as strong fare, recommended for ages 16+ with strong language and adult themes.

The evening will be a total experience for the eyes and taste buds, starting with a bar, live music and the Olive & Luca diner operating from 5:30pm. This latest treat in the NORPA 2014 season comes to town from sell-out seasons in Sydney, Brisbane and Melbourne. Food combines elements of drama, comedy, dance and cookery in an erotic mix of words and movement.

Playwright and co-director **Steve Rodgers** says the show draws closely on his own experiences and observations: "As the title suggests, it is a play about food and cooking. But it's also very much about sex, and how our relationship with both can define us."

Working with acclaimed choreographer **Kate Champion**, he has crafted a communion between the audience and the characters as they come together around the dining table.

Elma (**Mel King**) and Nancy (Emma Jackson) are sisters. Nancy left their remote, truck stop home many years ago; Elma stayed. Nancy chose chaos, freedom and sex; Elma stayed behind and cooked.
Now Nancy has returned and their lives are disrupted by the arrival of Hakan Leventoglu (**Fayssal Bazzi**)

'Hassan, son of Handsom', a restless Turkish traveller.

A play called Food would not be complete without the real thing. At each performance selected members of the audience will be served supper.
NB: The food in this production is vegetarian, does not contain nuts, and is composted at the end of each performance.

Bookings: **online** or 1300 066 772

Additional events :
Kate Champion Masterclass – Fri 11 July, 2-5pm $20 Experienced actors and dancers

Recipe Book Workshop – Sat 12 July, 4:30-6pm Free All welcome

Bookings essential through **NORPA** for both additional events.

Watch a video clip of Food here

St Vincent's brings up the theatre lights

St Vincent's Private Hospital in Lismore has flicked the switch to light up its new hybrid theatre, the last phase of a five-year, $8M redevelopment part-funded by the Commonwealth.

The recently appointed Chief Executive Officer of St Vincent's, Steve Brierley, said the upgrade of three existing theatres and the construction of two new theatres meant increased capacity for more complex procedures at the hospital.

The new hybrid theatre at St Vincent's was officially opened by (l-r) Board Chair Frank Hannigan, CEO Steve Brierley, Page MP Kevin Hogan and the Catholic Bishop of Lismore, The Most Reverend Geoffrey Jarrett who blessed the hospital's redeveloped theatre complex.

"By having more theatres available to specialists, patients will be able to have their surgery sooner… The extent of the upgrade doesn't just stop at space - the complexity of the equipment offered in the new theatres takes the Hospital into new areas of surgical procedures," Mr Brierley added.

One example of this technology is the angiography equipment in the hybrid theatre, which enables a full body image without moving the patient or the table. This marks the first time two world leaders in imaging and interventional surgical supply, Toshiba and Maquet, have worked collectively on a hospital project.

Coordinated by Nurse Unit Manager and project supervisor, Ms Desiree Bryant, the overall development includes two additional theatres, a new eight-bed recovery room and a new staff room, in addition to the upgrade of three existing theatres.

The redevelopment of the Short Stay Unit, the relocation and upgrade of the Endoscopy Unit and the refurbishment of the lift was also part of the funding.

The hybrid theatre that opened on 10 June 2014 will enable close collaboration between specialists such as cardiologists, cardiac surgeons, interventional radiologists and vascular surgeons.

The benefit for patients are more streamlined, coordinated care, according to Mr Brierley who stressed the importance for patients to have access to state of the art hospital care in their local area.

"Travelling outside the North Coast adds extra challenges for patients, not just financially but in terms of comfort and emotional costs.

"In our new hybrid theatre we can do more intricate and complex procedures, and with the combination of the interventional and imaging equipment, there is faster patient recovery," he said.

Representing the Australian Government, the federal MP for Page, Kevin Hogan, congratulated the St Vincent's Board and staff for the contribution they make to healthcare in the community.

"Not only will patients at St Vincent's now receive treatment much quicker than they would have in the past, but it will also take pressure off our regional hospitals like Lismore Base Hospital.

"These new state-of-the-art facilities at St Vincent's are welcome news for North Coast patients and their families, and are comparable to those found in major cities," Mr Hogan said.

Speaking of the Catholic Church's role in the provision of health care in Australia, Mr Hogan said that 12 per cent of the nation's hospital beds were in the Catholic system – a total of 9,500 beds in 66 hospitals, including St Vincent's Private Hospital in Lismore.

St Vincent's announces new leaders

The former Finance & Administration Manager at St Vincent's Private Hospital in Lismore, Steve Brierley, has been appointed Chief Executive Officer following the resignation of Tim Allsopp.

Announcing the change, Board Chairman Frank Hannigan said, "During the leadership of Mr Allsopp the Hospital underwent an expansion of building works, and we thank Mr Allsopp for his dedication and leadership at this time.

"There has been a change in the strategic direction of the Hospital as we look to new opportunities with our theatre redevelopment, expansion of our aged care services and to continue to add new facilities for our patients and specialists."

St Vincent's Private Hospital's CEO Steve Brierley and Director of Clinical Services, Kylie Rhodes.

The Board has also announced the promotion of Ms Kylie Rhodes to Director of Clinical Services, following the resignation of Mrs Margaret Neale to pursue other opportunities.

"Ms Rhodes is a great ambassador for the nurses of our Hospital, having passion and commitment to her patients and to St Vincent's. She has worked at St Vincent's for eighteen years and knows and understands the Hospital.

"Kylie is evidence of a home grown employee starting at the bottom of the pecking order, and with hard work and commitment has risen to the most senior post in nursing at our Hospital," Mr Hannigan said.

"Our management team is further strengthened with our previous CEO Mr Bob Walsh agreeing to act as a consultant and mentor to Steve and Kylie, for which the Board is very grateful.

"A strong management team is leading the Hospital into our next phase and together aim to continue to deliver outstanding Hospital and Health services to the community of the North Coast," the Chairman said.

Japanese 'sister hospital' visit possible

A delegation of clinicians from the municipal hospital in Lismore's Sister City of Yamato Takada is considering a visit to the Northern Rivers on a professional fact-finding mission, following a recent visit to Japan by Lismore Mayor Jenny Dowell. Yamato Takada is in Nara prefecture, and the Sister City link with Lismore was the first established between Japanese and Australian cities.

Lismore Mayor Jenny Dowell visits Japanese hospital

The Mayor was accompanied by Lismore City Council's General Manager, Gary Murphy, her husband, former Southern Cross University (SCU) academic Ron Dowell and Gary's wife Michelle Murphy. "The purpose of the visit was to strengthen the links of the Friendship our cities share and to extend it beyond the annual small student exchange," Cr Dowell said.

Health care provision was one area of close interest, both to the visitors and, as it turned out, to their hosts."During our visit we paid a visit to the 320-bed Yamato Takada Municipal Hospital (YTMH) and met with the Hospital Director, Dr Akio Sunakawa, Learning Institute Director, Dr Keizo Yamashita, and other senior staff. "The YTMH provides a similar range of comprehensive and specialised medicine and emergency care as our Lismore Base Hospital, treating approximately 212,000 outpatients and 94,000 inpatients, with 2,500 surgeries annually."

The Mayor said the hospital was also described as a hub for community health care, which appeared to highlight a significant gap in the Japanese system, a shortage of General Practitioners with skills in family medicine.

"Dr Yamashita put a proposal to us that their medical training department links with suitable training organisations here to provide opportunities to share issues."

"As an example, there is an increasing propensity for specialisation in medicine in Japan leading to a GP shortage. The country does not have a development system for GPs."

Cr Dowell said, "YTMH would like to explore opportunities for its medical staff to visit Lismore and this region to learn how GPs work here and how they are supported by our learning and training institutions, including our Base Hospital.

"They would also welcome visits by our medical professionals to their hospital."

Since returning home, Cr Dowell has been in contact with the region's main health care planners and providers, including the Northern Rivers Network of General Practice, to explore what clinically focused links might be possible with a Sister City that has maintained a close relationship with the Lismore area through SCU's Father Tony Glynn Centre, and the Council itself.

GPSpeak's Dr Andrew Binns has responded favourably to Cr Dowell's approach, saying that, "We do have an excellent training system for GPs here through North Coast GP training... and there is a team of trainers and GP supervisors.

"Our Australian system is aimed at providing as much primary care service in the community as possible, which will help keep the load off the hospitals, particularly the Emergency Depts. There is overall health cost savings by doing things this way.

"General Practice is now regarded as a specialty with

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Medicare Local launches online networking

A new online networking platform launched by the North Coast Medicare Local will enable health professionals to access 130 regional and craft-specific health professional networks, free of charge.Included in the networking portal are General Practice, Aged Care, Medical Specialists, Pharmacy and Allied Health. Going under the banner of **the Healthy North Coast Network, the resource can be found on the web**.

NCML Clinical Adviser Dan Ewald said the Network would greatly assist in reducing professional isolation and promoting inter-disciplinary networking.

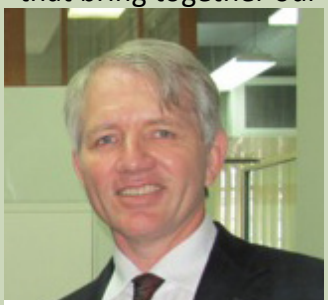
"The great thing about the Healthy North Coast Network is that health professionals can converse and collaborate on projects with colleagues without leaving their office.

"For the first time in our region, health professionals can replace more cumbersome email lists with real time collaboration."

Dr Ewald described online collaboration as "the way of the future, especially in large geographical regions like the North Coast."

GP and NCML Chair Tony Lembke added, "The Healthy North Coast Network is a 'space' where we can easily share information and resources with our colleagues. "It breaks down professional isolation locally and across the region by allowing medical specialists to come together with other medical specialists, GPs with other GPs, allied health providers with other allied health providers."

"More importantly, it also creates 'Communities of Practice' that bring together our different crafts as one clinical community to discuss issues of importance to us all," Dr Lembke said.



Dr Tony Lembke

While Healthy North Coast Network is based around the functionality of other social networking platforms like Facebook, LinkedIn and Twitter, it provides a more private and professional space for health practitioners to work.

Health professionals can **register** for the Healthy North Coast Network with **full instructions** for the platform.To find out more about Healthy North Coast Network contact Alex Lewers, Healthy North Coast Coordinator, on (02) 6618 5419 or email alewers@ncml.org.au

Lismore's 'sister hospital' (cont from P 32)

at least three years of training before exams and qualifications, and then there is compulsory ongoing continuing education required on a long term basis to maintain vocational registration and to be registered to charge appropriate Medicare fees.

"If a Japanese delegation did come here I am sure we could compare experiences. I do know the overall standards of care and access to care are good in Japan, but it is a concern if the GP services are not well developed and they may like to see how we do things. I am sure they would be interested in talking with our hospital staff and medical specialists as well," Dr Binns said.

Lismore Mayor Jenny Dowell (right)

Keeping it local with Sullivan Nicolaides Pathology

Although Sullivan Nicolaides Pathology is one of the largest members of the Sonic Healthcare group, we are an independent, Australian owned, publicly listed company.

Sonic practices are medically managed and are thus well placed to appreciate the special needs of doctors and their patients. This means that in the Northern Rivers for over 30 years we have been employing local people made up of specialist Pathologists, Scientists, Courier, Collection and Administration Staff to serve the needs of our community. Most of our testing is performed locally at our Lismore Laboratory meaning that we can ensure a fast turn around and a personalised service to you.

We support our local Doctors and patients by providing 21 collections rooms located between Tenterfield and Ocean Shores with our main procedure room in Lismore which performs bone marrows, skin allergies, paternity testing, arterial blood gases and various other tests. Our collection staff all undergo a Certificate 3 training program with an added emphasis on customer service to ensure all patients needs are met.

Our SNP courier cars cover around 3,000 klms a day from Grafton to Brisbane to ensure specimens reach our labs in the fasting possible timeframe.

We have four pathologists residing in the area with our newest team member being Dr Andrew Bettington. Of course their expertise is underpinned by the fact that our practice is managed by doctors for doctors. Our CEO, Dr Michael Harrison, is a pathologist. All department directors are pathologists, and pathologists are represented at all levels of management.

Finally on a local level, we continue to sponsor our local Doctors with ongoing education events and training and continue to support Southern Cross university science events. As part of your local community we also support various local events including Our Kids, Westpac Rescue Helicopter, local community school awards and underprivileged families at Christmas.

By supporting us you are not only receiving the highest clinical and ethical pathology service but you are keeping our locals that have a vested interest and love of the community employed. Our pathologists and senior management staff encourage doctors to contact them for information, consultation, or advice at any time. Our local Medical Liaison Manager, Vanessa, is available to assist clinicians and their staff with the practicalities of using our services.

Health managers bring alternatives to integrated care

The support of Health Service Managers (HSMs) is vital to enabling complementary and alternative medicine (CAM) to play an appropriate role in providing Integrative Health Care (IHC) for patients/clients accessing hospital and community-based services.

IHC entails a collaborative team approach involving the providers of both conventional and complementary and alternative medicine. Its effective implementation in a range of clinical settings, including cancer care and chronic disease management, has been found to depend significantly on the support of health service managers, according to the findings of a milestone study funded by the University Centre for Rural Health, North Coast NSW.

The study was conducted in three states, has been published in a prestigious international journal*, and praised in a recent article in another**. It was led by Dr Judy Singer in collaboration with Professor Jon Adams, Director of the Australian Research Centre in Complementary and Integrative Medicine (ARCCIM), University of Technology Sydney.

The authors found the support of HSMs had been vital for improving the provision of CAM services in a range of facilities offering cancer care, chronic disease management, drug and alcohol rehabilitation, sexual assault and domestic violence services, and refugee trauma counselling.

The HSMs interviewed for the study were all women, with most having lengthy professional experience and being Social Work graduates.

Dr Judy Singer

"The importance of supportive HSMs in creating and sustaining successful integrative services at both the hospital and community-based levels cannot be underestimated," Dr Singer said. "HSMs are important stakeholders within the IHC regime, often having considerable influence in organising and directing health care policy and practice within the service they represent."

The CAM services in the surveyed facilities included naturopathy, Western and Chinese herbal medicine, acupuncture and massage. The researchers concluded that these were integrated into the care model largely because of the advocacy of well-informed and enthusiastic HSMs.

In the words of one HSM interviewed, "Complementary and alternative medicine is about giving people an opportunity to nourish their body, rather than just getting rid of the symptoms."

Another HS said, "There is no question that CAM is seen as a central part of the service that we provide to our clients . . . it has a very important contribution to the healing of the body."

The researchers noted that in Australia the inclusion of complementary and alternative medicine into public health care services is a relatively uncommon phenomenon.

In the hospital settings studied, the boundaries between CAM and Western medicine were seen as clearly defined. HSMs made clear that CAM was employed to complement the patient's medical treatment, rather than to provide an 'alternative' to their conventional care.

In the non-hospital settings, CAM was practiced alongside other disciplines, and while some clients could choose to access only CAM treatments, it was not generally considered a 'stand alone' therapy. Broadly, these services worked with clients from low socioeconomic backgrounds, often including culturally and linguistically diverse groups and Indigenous populations.

"What is striking about these services is that they enable people who would otherwise not be able to afford CAM, access to these treatments," Dr Singer said.

The Director of the

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Bali and Beyond

GPSpeak's Robin Osborne travels to eastern Indonesia in pursuit of his passion for handmade village textiles.

TRAVEL

Send GPSpeak your travel stories ...

contact us by email

In 1970, as I sometimes tell Balinese who were not born then, the popular tourist centres of Kuta beach and the hinterland town of Ubud had almost no accommodation or eating places catering to foreigners. Leave aside today's golf courses, spas and water parks.

Yet the 'Island of the Gods' was clearly so appealing that it seemed only a matter of time until a tourist onslaught came. The question was: how long? It is futile to speculate on the pivot point when Bali started to become inundated by tourists and dependent on their spending. Clearly, it lies somewhere between the seventies and last year when the number of foreign visitors (3.3M, a quarter from Australia) came inexorably closer to the total Balinese population of 4.5M (including immigrants from Indonesia's overall population of 253M, the fourth largest in the world).

On the day I boarded the flight to Bali's newly upgraded Ngurah Rai airport, Madeline Murray wrote about Bali in The Sydney Morning Herald under the ominous headline, 'Tourist tide threatens to sweep away Bali's spirit'.

GPSpeak editor Robin Osborne with a superb ikat weaving from the Indonesian island of Sumba, on sale in a gallery in Kupang, West Timor.

Murray, who studied stone sculpture in Ubud in 1983, described much of southern Bali as being 'infested with opulent hotels', while Ubud, long known as the island's cultural heart, was thronged with tourists and relentless traffic.

"There are signs everywhere of a looming cultural and environmental crisis, but the ubiquitous building sites indicate no one is paying attention," she said.

On Easter Saturday, reported 'Hector', a retired Australian journalist living and blogging in Bali, three tonnes of rubbish was collected from five kilometres of beaches at Kuta, Legian, Seminyak, and Jimbaran, with 600 residents and tourists taking part.

For me, Bali has long been a gateway to somewhere else in Indonesia, rather than a destination in itself, as welcoming as it can still be. On this occasion my destination was West Timor, 90 minutes flying time to the east, at the end of the chain of islands known as Nusa Tenggara. They begin at Lombok, on the other side of the famous 'Wallace Line' that separates it from Bali, as well as the flora and fauna it shares with Australia from the rest of Asia beyond.

Like Alfred Wallace, I was in search of specimens, but not ones that crept or leapt or flashed bright colours in the forest, but hand-loomed textiles, ideally made from local cotton and dyes produced from natural materials, not bought in the shops.

Of the many pieces I have collected over the years, perhaps the most interesting are the ikat cloths, the name taken from the Indonesian word 'to

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Seeking textiles in Indonesia (cont from P 36)

tie'. Unlike, say, batik, where designs are introduced onto a ready piece of fabric, the patterns of an ikat, often highly complex and symbolic of the local culture, are dyed into the unwoven threads prior to the start of weaving.

Where the threads are tied tight, the dye cannot enter, as with the wax on a batik. Dyed sections are then tied over to stop another colour entering. The more colours, the more tying and dyeing required, while the more complex the pattern, the greater is the challenge for the weaving women who somehow hold the intricate designs entirely in their heads. Or perhaps their souls.

Only after all the dyeing is complete, does the actual weaving begin, usually on a backstrap loom. That the whole process can take many months is impressive enough, but more astounding is the intricacy, and beauty, of the work created by people living in the simplest of circumstances.

The island of Timor, both the Indonesian West and the independent East (Timor Leste), has long been regarded as a weaving 'ground zero', but so have the adjacent islands of Savu and Rote, popular with surfers and, it seems, asylum seekers.

Then there is Flores, Indonesia's only majority Christian island, named by the Portuguese not for the flowers on the land but those under the sea, the corals; and Sumba, perhaps the best known textile island of all, its dramatic ikat blankets filled with animist motifs of villagers and the creatures they farm, eat or worship.

These extraordinary works of village art are now much copied as cheap reproductions on sale in the Bali 'art' shops, or tailored into bright clothing and furnishings. However, the real thing is still readily available, whether in the often remote villages where they originate, local markets, or in the few handicraft/antique shops that dot the main centres in Indonesia's outer islands. While prices vary as much as the quality, the most important thing is to seek assurance that the item is hand made, not from a distant factory.

After that, the details can become fascinating – in the mountains of West Timor I bought an ikat whose darkest colour came from the mud in a local pond. In Lombok, an old, intact piece, known as an osap, used for ceremonial purposes. In Kupang, West Timor's capital, I chanced on a Sumba specialist whose basement was a treasure trove of wonderful textiles, the largest, with a simple rooster motif, priced at several thousand dollars. I hope someone enjoys it as much as the more moderate pieces I was pleased to bring home.

CAM study

(cont from P 35)

University Centre for Rural Health, Professor Lesley Barclay, said, "This is a truly important study with national implications. Relatively little work has been done around the interface between the conventional and complementary health sectors, which is clearly an area that is developing momentum. "I congratulate the authors, and am delighted that UCRH was able to be involved with supporting this study."

* European Journal of Integrative Medicine 5 (2013) An exploratory study of the health service manager's role in providing effective integrative health care – Dr Judy Singer, University of Sydney, Professor Jon Adams, University of Technology Sydney,

** www.acupunctureto-day.com - 15/4/2014