# Temporary protection visas and child refugees

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**TO THE EDITOR:** Since 1999, most asylum seekers in Australia who have been detained and subsequently found to be genuine refugees have been issued temporary protection visas (TPVs). Missing from much of the debate about management of asylum seekers has been the impact of the provisions of TPVs on children. A comparison of the entitlements of refugees on permanent and temporary protection visas is given in Box 1.

To estimate the proportion of TPVs issued to children under 18 years of age, we analysed data provided by the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA). The denominator population was drawn from data on numbers of temporary and permanent protection visas issued between June 1999 and June 2002.[1,2] Numerator data were drawn from information provided by DIMIA on request.[3] As shown in Box 2, we found that between October 1999 and June 2002, 23% of all TPVs were issued to children under the age of 18. Some of these children are now over 18 years of age. However, as children born to TPV holders in Australia are also given TPV status, more children will be recruited into this visa category.

Australia is a signatory to the UN Convention on the Rights of the Child, which enshrines key rights for children, such as the right to health and safety.[4] However, we believe that several of these basic rights are undermined by the lack of provisions afforded to TPV holders: they are prohibited from sponsoring family members, and they have limited access to settlement services for refugees (Box 1). Withholding of family reunion provisions increases the risks for children, as it makes it more likely that parents will take their children with them when they undertake hazardous travel to seek asylum. This is in contrast to the traditional model of families sending an index person, who then sponsors other family members.

The lack of a comprehensive settlement package for TPV holders, and the temporary and indeterminate nature of the visas, is likely to compound the psychological distress experienced by both adult and child refugees. Children who have experienced ongoing adversity are vulnerable to developing psychological disorders.[5] The children of TPV holders must also live in families

**Addendum 13/07/04**
While a recent federal government initiative will allow current Temporary Protection Visa holders to apply for permanent Australian residency, we urge ongoing review of refugee visas.

**1 Comparison of entitlements of refugees on permanent and temporary protection visas**

| Services funded by the Australian Government | Refugees with permanent visas | Refugees with temporary protection visas |
|---|---|---|
| **Settlement services** | | |
| Translating and interpreting service | Eligible | Not eligible |
| Accommodation support | Eligible | Not eligible |
| Assistance from Migrant Resource Centre | Eligible | Not eligible |
| Early health and intervention service | Eligible | Eligible |
| Torture and trauma counselling | Eligible | Eligible |
| English language tuition | Free tuition for adults and children | Adults not eligible. Children eligible from July 2002 |
| Family reunion | May apply to sponsor family members | Not eligible |
| Employment | Access to all assistance programs | Not eligible except for most basic services |
| Income support | Eligible for full range of social security benefits | Restricted entitlements |
| Medicare | Eligible | Eligible |
| **Education** | | |
| Primary and secondary education | Eligible | Eligible |
| Tertiary education | Eligible for HECS | Must pay upfront fees |
| Travel | Right of return if holder travels overseas | No right of return if holder leaves country |

HECS = Higher Education Contribution Scheme.

**2 Proportion of temporary protection visa (TPV) holders who were children when visa was granted (1999–2002)**

| Years* | No. of TPVs granted | No. (%) < 18 years when TPV granted |
|---|---|---|
| 1999–2000 | 871 | 108 (12.4%) |
| 2000–01 | 4456 | 907 (20.3%) |
| 2001–02 | 3196 | 952 (29.8%) |
| **Total** | **8523** | **1967 (23.1%)** |

* Financial years.

**Correspondents**

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where the parents bear an ongoing burden of fear and destabilisation.

The effects of TPVs are borne by large numbers of children. There is a need for concerted advocacy by health professionals to ensure that the health consequences of TPVs for children are recognised and addressed.


1 Department of Immigration and Multicultural and Indigenous Affairs. Fact Sheet 60. Australia's Refugee and Humanitarian Program. Available at: www.immi.gov.au/facts/60refugee.htm (accessed Mar 2004).

2 Minister of Immigration. Border protection. Available at: www.minister.immig.gov.au/borders/detention/fs_64_tpv.htm (accessed Mar 2004).

3 Manning S. Surviving, not thriving. Refugee children granted temporary protection visas. Canberra: ANU Internship Program, May 2003.

4 United Nations General Assembly Official Records (UNGAOR). The United Nations Convention on the Rights of the Child, Resolution 25, 44th Session. New York: United Nations, 1989.

5 Friedmand RJ, Chase-Lansdale L. Chronic adversities. In: Rutter M, Taylor F, eds. Child and adolescent psychiatry. London: Blackwell, 2002: 261-276 ❑


## Gouty arthritis in Australian Aboriginals: more common than previously suspected


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**To the Editor:** A recent review suggests that acute rheumatic fever, osteoarthritis and systemic lupus erythematosus account for most rheumatic disease in Australian Aboriginals, and comments on the rarity of gout.[1] Although the increased prevalence of hyperuricaemia in Aboriginals compared with non-Aboriginals has been described,[2] clinical attacks of gout in Aboriginals have so far been extremely rare.[1,3] This is in sharp contrast to various Polynesian and other indigenous populations, including Māori in New Zealand, Filipinos in Hawaii and Alaska, Chamorros and Carolinians in the Marianas Islands, and Taiwanese aborigines. In these populations, increased prevalences of both hyperuricaemia and gout have been documented.[4,5]

In an extensive literature search, we found only one report of confirmed acute gouty arthritis in an Australian Aboriginal with normal renal function,[3] although there have been several Aboriginals in the "Top End" with crystal-confirmed gout in association with chronic renal impairment.[1]

**Aboriginals with acute gouty arthritis, Alice Springs Hospital, January 2001 – April 2004**

| Age (years) | Sex | UA level (mmol/L) | Site of joint aspiration | Possible precipitating factors | Joints involved |
|---|---|---|---|---|---|
| 46 | M | 0.37 | Right knee | Alcohol | Right knee |
| 44 | M | 0.45 | Right knee | Acute renal failure, alcohol | Right knee, left first metatarsophalangeal joint, left ankle |
| 65 | M | 0.23 | Right knee | Renal transplant, cyclosporin | Right knee, right foot |
| 64 | F | 0.50 | Right knee | Chronic renal impairment | Both ankles and first metatarsophalangeal joints, right knee |
| 61 | F | N/A | Right knee | Acute-on-chronic renal failure, alcoholism | Right knee |
| 51 | M | 0.48 | Left knee | None identified | Left knee |
| 35 | M | 0.54 | Right knee | None identified | Both ankles, right knee |

UA = uric acid. Reference range, 0.20–0.45 mmol/L. N/A = not available.

Between January 2001 and April 2004, we identified seven new cases of acute gouty arthritis in Aboriginals (Box), confirmed by joint aspiration revealing monosodium urate monohydrate crystals. Three of these patients had confirmed acute gouty arthritis without renal impairment. This series also includes the first reported cases of gouty arthritis in Aboriginal women.

Our findings suggest that the prevalence of acute gouty arthritis in Australian Aboriginals is much higher than previously reported. Discussion with physicians at Alice Springs Hospital revealed that they too have encountered gouty arthritis in Aboriginals, but whether this was confirmed by joint aspiration is not known. It appears that gout has been misdiagnosed or underreported, or both. Further epidemiological studies should be undertaken to confirm this hypothesis, and we must have a higher index of suspicion for gout when an Aboriginal patient presents with an arthropathy, as gout is a potentially disabling and yet easily treatable condition.


1 Roberts-Thomson RA, Roberts-Thomson PJ. Rheumatic disease and the Australian Aborigine. *Ann Rheum Dis* 1999; 58: 266-270.

2 Emmerson BT, Douglas W, Doherty RL, Feigl P. Serum urate concentrations in the Australian Aboriginal. *Ann Rheum Dis* 1969; 28: 150-155.

3 Chin G, Segasothy M. Gouty arthritis in Australian Aborigines. *Aust N Z J Med* 2000; 30: 639-640.

4 Prior IAM, Rose BS, Harvey HPB, Davidson F. Hyperuricaemia, gout and diabetic abnormality in Polynesian people. *Lancet* 1966; 1: 333-338.

5 Chou CT, Lai JS. The epidemiology of hyperuricaemia and gout in Taiwan Aborigines. *Br J Rheumatology* 1998; 37: 258-262. ❑


## Access block viewed as a medical model


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**To the Editor:** In physiology, the Frank–Starling curve demonstrates that cardiac muscle initially responds to an increased workload with an increased force of contraction.[1] However, after the point of maximum efficiency is reached, further workload produces a *decrease* in both the force of contraction and the ejection fraction, leading to cardiac failure.

It now appears that the same curve could describe the current situation in many Australian emergency departments.

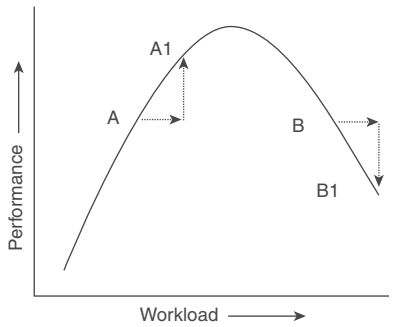
We used to operate at point A on the curve (Box). If there was a mini-disaster or a moderately large number of victims of a road accident, the department was able to increase output to cope with the situation. The "adrenalin stimulation" experienced by all members of the team meant that the department coped, and that staff were left with a sense of satisfaction.

Now our department finds itself at point B on the curve. Extra workload can result in a decrease in performance and output. The patients obviously suffer, but so do the staff. The once-challenging and enjoyable parts of the job now generate frustration and exacerbate the background dysfunction.

On a recent weekend, the emergency department experienced an influx of sick

**Access block as a medical model**

At point A, an increase in workload leads to increased performance to cope (moving to point A1). At point B, an increase in workload leads to a decrease in performance (to point B1).




elderly patients as a result of a local heatwave, with temperatures reaching 42°C. The problem was identified as a mini-disaster only in retrospect. At the time it was thought to only exemplify another bad day. This is an example of the syndrome of "learned helplessness"[2] that staff are experiencing.

Politicians and health administrators need to understand that our public hospital emergency departments are struggling with their daily workloads and are no longer equipped to deal with medium- to large-scale emergencies.

1 Ganong WF. Review of medical physiology. 21st ed. New York: Lange Medical Books/McGraw-Hill; 2003; 575-577.
2 Seligman MEP. Learned optimism. Sydney: Random House Australia, 1992; 17-30. ❑

## Coronial autopsies: a rising tide of objections

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**To the Editor:** The Royal College of Pathologists of Australasia Autopsy Working Party highlighted the decline in the numbers of hospital autopsies.[1] Forensic and hospital autopsies are a valuable safety and quality tool for improving healthcare systems. Autopsies provide an accurate cause of death and are a valuable audit tool to evaluate medical diagnostic processes and therapeutic interventions. Declines in both types of autopsies are cause for concern.

A forensic autopsy is an integral part of the coronial process. The Coroner's role is to establish the identity of the deceased, where he or she died, the cause of death and, perhaps most importantly, how the person died.[2] Without an autopsy, it can be difficult to determine the cause of death.

At the Victorian Institute of Forensic Medicine (VIFM), about 80% of all deaths that are reported to the State Coroner (in Melbourne and Geelong) undergo a full forensic autopsy. Senior next-of-kin can object to an autopsy being performed. Section 29 of the *Coroner's Act 1985* (Vic) details the objection process.[2] The decision to grant an objection is dependent on the opinion of the Coroner and his or her view on the circumstances of death.

We reviewed the number and rate of forensic autopsies performed by the VIFM between 1992 and 2002, as well as the number and rate of objections under Section 29.

The rate of forensic autopsies remained relatively stable over the decade, at 80% of deaths reported to the State Coroner. There were 94 successful Section 29 applications in 1992. This accounted for 3.25% of all deaths reported to the Coroner. Objections to autopsies have been steadily increasing since 1992. In 2002, there were 212 successful applications, accounting for 7.1% of all deaths reported to the Coroner and representing about a 4% rise over the decade.

When a coronial autopsy has been requested, but not carried out because of a Section 29 objection, substantial additional work is required. This includes medical record reviews; external forensic examinations; reviews of statements from treating doctors, independent experts and family; and inquests.

The other major ramification associated with objections to autopsies is the discrepancies between causes of death that are determined clinically and at autopsy (with 28% of presumed causes wrong in one study).[3] Without an autopsy, important pathology may remain unrecognised, and this can substantially affect the accuracy of the stated cause of death.

The inherent right of next-of-kin to object to coronial autopsies will remain. However, healthcare professionals and coroners need to be aware of the public health implications associated with objections to autopsies.

1 Royal College of Pathologists of Australasia Autopsy Working Party. The decline of the hospital autopsy: a safety and quality issue for healthcare in Australia. *Med J Aust* 2004; 180: 281-285.
2 *Coroner's Act 1985* (Vic).
3 Nashelsky MB, Lawrence CH. Accuracy of cause of death determined without forensic examination. *Am J Forensic Med Pathol* 2003; 24: 313-319. ❑

## Privacy: bad for your health?

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**To the Editor:** O'Grady and Noland, concerned about the consequences of privacy legislation,[1] draw attention to "... the findings of an Australian survey in which 61% of adults believe that even their de-identified health information should not be used for research purposes without their consent".

Unfortunately, they do not point out that the survey,[2] commissioned by the Office of the Federal Privacy Commissioner, had a 20% response rate, making it effectively useless in determining what Australian adults really think about the use of their de-identified health information.

Alarmed at the possibility that "evidence" of this quality could be used to aid decision-making that had important implications for rigorous research, I turned to Google (<www.google.com>) for assistance. A Google search using the words "61% de-identified health information roy morgan" generated 21 hits, 15 of them unique, and only five related to the subject. One of the five was the letter by O'Grady and Noland, one was the report of the survey, and three specifically cited this survey result: Privacy Victoria,[3] Privacy NSW,[4] and the Office of the Federal Privacy Commissioner[5] all used the result in formal submissions to reviews of privacy-related issues — without revealing the survey's appalling response rate.

We have privacy commissioners who are powerful advocates of the principles of respect for privacy and autonomy. Perhaps the time has come for Australia to have "public interest commissioners" who can powerfully advocate for the public interest in high-quality health research.

1 O'Grady K, Noland, F. Privacy: bad for your health? [letter]. *Med J Aust* 2004; 180: 307-308.
2 Roy Morgan Research. Privacy and community, July 2001. Report prepared by the Federal Privacy Commission. Available at: privacy.gov.au/publications/rcommunity.html (accessed Mar 2004).
3 Privacy Victoria, Office of the Victorian Privacy Commissioner. Submission to the Australian Law Reform

Commission and Australian Health Ethics Committee Joint Inquiry into Protection of Human Genetic Information. December 2002. Available at: www.privacy.vic.gov.au/dir100/priweb.nsf/download/2D286014184B00BFCA256CBF001F3D37/$FILE/Genetics_web.pdf (accessed Mar 2004).

4 Privacy NSW. Submission by Privacy NSW to the Australian Health Ministers Advisory Council National Health Privacy Working Group in relation to the Draft National Health Privacy Code. April 2003. Available at: www.lawlink.nsw.gov.au/pc.nsf/files/sub_healthcode2003.pdf/$FILE/sub_healthcode2003.pdf (accessed Mar 2004).

5 Office of the Federal Privacy Commissioner. Office of the Federal Privacy Commissioner submission to the HealthConnect Interim Research Report and the Draft Systems Architecture Report. January 2004. Available at: www.privacy.gov.au/publications/healthcsub04.pdf (accessed Mar 2004). ❑

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***In reply:*** In a world in which people are increasingly busy and mobile, increasingly concerned about invasions of privacy and increasingly approached to participate in surveys, survey response rates that could be readily achieved 25 years ago are now very much more difficult to attain. High response rates (ie, 60% and over) are still very desirable and can still be achieved. We have conducted surveys on sensitive issues, such as drug-taking, and achieved response rates that would probably satisfy even Arnolda. But this requires very intensive field activity that is not always justified by the nature of the project.

The survey in question was not a health survey. It set out to provide general background information, exploring *comparative* levels of concern about, and the *relationships* between, a very wide range of privacy issues on a scale adequate to allow relatively small groups within the population to be examined. It was not intended to yield precise and critical measurements. Measures of "concern" or "reluctance" are highly context-dependent, "soft" measures, subject to interpretation, both by the respondents and by end-users. External validity is therefore not the issue: a response rate of 80% would not have made the figures demonstrably more "accurate". Given the imprecise nature of the measures obtained, overengineering the sample relative to other components of the survey design would have been a waste of (public) money, better devoted to further research. The survey was part of a wider-ranging project and was planned in close consultation with the Office of the Privacy Commissioner in the light of their needs and priorities.

It is appropriate that this issue arose out of a debate on privacy. As privacy constraints bite harder, whether imposed by statute or codes of practice, or arising through increasing resistance from subjects, medical researchers are going to have to come to terms with problems of non-response in the same way that social-survey researchers have.

How are researchers going to react when only 20% of potential subjects consent to have their information used? Will they use words like "appalling" and "effectively useless" to dismiss any studies based on such a subset? Or will they perhaps learn to use them, with due caution, for the valuable information they nevertheless contain? One does not have to look very far in the history of medicine or public health to find major advances in knowledge using less than perfect statistics. ❑



## Metformin therapy and diabetes in pregnancy

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**To the Editor:** We wish to commend the Australasian Diabetes in Pregnancy Society (ADIPS) ad hoc working party for providing an update on the safety of metformin in pregnancy.[1] However, we would like to comment on the information they provided on the safety of this drug in breastfeeding.

Metformin can be regarded as a well studied drug with respect to its distribution into human breastmilk;[2,3] most drugs are not as well served in this regard. As Simmons et al indicated,[1] the infant "dose" in breastmilk is small at less than 0.4% of the maternal dose, corrected for body weight. This is substantially lower than the arbitrary cut-off of 10% used to guide drug use during lactation and thus implies safety.[4] Further evidence for the safety of this drug in breastfeeding arises from failure to detect metformin in blood sampled from four of six infants exposed via breastmilk (limit of detection, 5–10 μg/L) and lack of adverse effects noted in nine exposed infants.[2,3]

Simmons et al stated that infant exposure to metformin could be reduced by breastfeeding immediately before maternal dose ingestion and then avoiding feeding for at least 2–3 hours after the dose. For drugs with a short elimination half-life, this recommendation — avoiding feeding at peak

drug concentrations in the milk — may reduce infant exposure. However, this is not the case for metformin.

Two studies investigating metformin in breastfeeding have shown that the metformin peak plasma concentration occurs about 2–4 hours after the dose, while milk concentrations are "flat" across the entire dosing interval. This is distinctly different from most drugs, in which the drug concentrations in milk mimic the rise and fall of plasma concentrations, consistent with passive diffusion.[2,3] The flat profile observed with metformin raises the possibility that the distribution of metformin into or out of breastmilk may involve an active process such as organic cation transporter(s), in addition to passive diffusion

Given this unusual concentration profile in breastmilk, infant exposure (albeit small) will not be reduced by the practice of avoiding breastfeeding for a few hours after maternal dose ingestion, as suggested by Simmons et al. In other words, mothers may feed their infants at any time during the dosing interval and this will not affect infant exposure to metformin.

We believe that there is sufficient evidence for metformin to be considered a safe therapeutic option in the treatment of diabetes or polycystic ovary syndrome in breastfeeding mothers, with the usual caveat of weighing up the risk–benefit ratio in each case.

1 Simmons D, Waiters BNJ, Rowan JA, McIntyre HD. Metformin therapy and diabetes in pregnancy. *Med J Aust* 2004; 180: 462-464.
2 Hale TW, Kristensen JH, Hackett LP, et al. Transfer of metformin into human milk. *Diabetologia* 2002; 45: 1509-1514.
3 Gardiner SJ, Kirkpatrick CMJ, Begg EJ, et al. Transfer of metformin into human milk. *Clin Pharmacol Ther* 2003; 73: 71-77.
4 Bennett PN, editor. Drugs and human lactation. 2nd ed. Elsevier: Amsterdam, 1996. ❑

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***In reply:*** We thank Gardiner et al for their commendation and support for our update on the safety of metformin in pregnancy.[1] We agree with their analysis regarding the timing of the use of metformin during lactation.

Nevertheless, we would like to highlight that the safety of metformin can not be assumed from the studies they quote, as these included very few subjects. Such studies, helpful as they may be, provide no imprimatur for the long-term safety for the growing infant and subsequent adult. While no babies had side effects reported during these studies, this may not be the case for other babies.

Should a woman decide against the use of insulin to control hyperglycaemia postnatally, then the risk of potential known and unanticipated side effects of metformin should be discussed while obtaining informed consent for metformin use. However, during this discussion, it would also be prudent to weigh-up metformin use against breastfeeding with continued hyperglycaemia, an activity associated with greater obesity and impaired glucose tolerance in the offspring.[2]

1 Simmons D, Waiters BNJ, Rowan JA, McIntyre HD. Metformin therapy and diabetes in pregnancy. *Med J Aust* 2004; 180: 462-464.
2 Plagemann A, Franke K, Harder T, Kohlhoff R. Long-term impact of neonatal breastfeeding on body weight and glucose tolerance in children of diabetic mothers. *Diabetes Care* 2002; 25: 16-22. ❑

## Multisite, quality-improvement collaboration to optimise cardiac care in Queensland public hospitals

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**To the Editor:** In their recent study, Scott and colleagues demonstrated benefit from a program to standardise clinical management of cardiac conditions in Queensland hospitals.[1] They found differences in the effect on "low-intensity intervention" hospitals compared with "high-intensity intervention" hospitals. The former were, by and large, district-type hospitals and the latter tertiary hospitals.

The study found that about 50% more patients in the larger hospitals had assessments of left ventricular function. Three times as many patients in the larger hospitals accessed rehabilitation. Nearly three times as many patients in the smaller hospitals were readmitted with a diagnosis of acute coronary syndrome within 30 days, perhaps a surrogate for angiography rates, which were not reported differentially.

It may be that the most urgent intervention required is "high-intensity" funding of district hospitals, so that they can achieve rates of echocardiography, rehabilitation and coronary angiography approaching those of tertiary hospitals. This intervention would need no further justification than that the population served by the district hospitals has paid its share for these treatments. Let us hope that the remaining comparative outcome data are published.

1 Scott IA, Darwin IC, Harvey KH, et al. Multisite, quality-improvement collaboration to optimise cardiac care in Queensland public hospitals. *Med J Aust* 2004; 180: 392-397. ❑

Ian A Scott,* Irene C Darwin,† Kathy H Harvey,‡ Andy B Duke,§ Nicholas D Buckmaster,¶ John Atherton,** Hazel E Harden,†† Michael Ward,‡‡ for the CHI Cardiac Collaborative
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***In reply:*** We agree with Hadfield that optimising cardiac care may require extra resources targeted at increasing access of patients in regional Queensland to specific interventions, such as coronary angiography, cardiac rehabilitation and echocardiography, in addition to the quality-improvement strategies used within our collaborative. We contend that both approaches are necessary, and that the magnitude of improvement achieved by either will depend on the intensity with which they are applied. Indeed, the "high-intensity" quality-improvement hospitals in our study were defined on the basis of more funding being made available to undertake quality-improvement activities at those sites.

We concede that some of the differences in quality indicators between "high-intensity" and "low-intensity" quality-improvement hospitals may be attributable to inequities in capital expenditure on service delivery that we did not measure. However, some of the differences may have also arisen from variation in systems for identifying and referring those patients who have most to gain from receiving the care targeted by our collaborative. ❑

## The upsurge of interest in Indigenous health in the 1950s and 1960s. Barry Christophers' letters to the *MJA* editor about Indigenous health

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**To the Editor:** I write concerning the recent article about my letters to the *MJA* in the 1950s and 1960s drawing attention to Indigenous health issues.[1]

Mention is made in the article of the campaign waged by the Federal Council for the Advancement of Aborigines and Torres Strait Islanders concerning the exclusion of Queensland Aboriginal patients with tuberculosis from the generous allowance paid to other TB patients.

This campaign was successful. The Tuberculosis Act was amended so that Aboriginal people were not excluded from receiving this allowance. The Australian Medical Association supported this campaign. Without its support it would have failed.

1 Thomas DP. The upsurge of interest in Indigenous health in the 1950s and 1960s. Barry Christophers' letters to the MJA editor about Indigenous health. *Med J Aust* 2004; 180: 521-523. ❑

## Vaccines: the new Australian best-practice schedule

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**To the Editor:** The recent editorial by Burgess and McIntyre on the recommended vaccination schedules in Australia[1] points to the fiscal constraints on offering the new, costlier vaccines. Overcoming these constraints would not be insurmountable if vaccinations were to be linked with annual festivals and celebrations in the life of individuals and the community.

Birthday celebrations are important for infants and preschool children. Rather than giving conventional birthday gifts, varicella vaccine, costing $40, would be most appropriate. For those in the sixth or higher decades of life, gifts of influenza vaccine, 23-valent pneumococcal polysaccharide vaccine or the adult formulation of the diphtheria–tetanus vaccine would be memorable on Mother's Day or Father's Day and silver, golden or platinum wedding anniversaries.

Similarly, slight adjustments to the allocation of funds for celebrating festivals such as Christmas and New Year, Dewali or Eid could make costly vaccines available to all. Vaccine producers, like department stores, could gear up for a Christmas vaccine sale.

The public should be motivated to consider vaccines the most appropriate gifts. This is bound to address any poor coverage of costlier vaccines, such as varicella or the pneumococcal polysaccharide vaccine.

1 Burgess MA, McIntyre PB. Vaccines: the new Australian best-practice schedule [editorial]. *Med J Aust* 2004; 180: 494-496. ❑



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