LETTERS

The first 100 days: an open letter to the new Minister for Health and Ageing

David N Durrheim, Mark Wenitong, Clare Huppatz and George Rubin

To the Editor: Russell and colleagues recently wrote an open letter to the new Minister for Health.[1] In response, we call for the Minister to champion the cause of Indigenous health.

Dear Minister,

Russell et al raise a number of pressing issues directly relevant to the health portfolio.[1] However, of all the challenges that face you, perhaps the greatest is reversing the neglect and extreme health disadvantage experienced by Australia's Indigenous people.[2] Although the task is daunting, and detractors may argue that there are no evidence-based solutions, 150 years of collective experience from across the globe provides compelling support for *real* investment in the spheres of water, sanitation, housing, education, employment and primary health care to reverse health disadvantage. Tragically, while these basic necessities are taken for granted by most Australians, they remain a dream for many Aboriginal and Torres Strait Islander peoples.

The greatest public health gains during the previous two centuries resulted from ensuring that communities had sustained access to clean water, adequate sanitation and appropriate housing.[3] It is astonishing that these basic rights should remain on the unresolved agenda of a highly developed country. To our shame, these basic direct health determinants are not yet guaranteed for Aboriginal and Torres Strait Islander Australians.[4]

Relative poverty, absolute poverty and social exclusion all have a major impact on health.[5] In Australia, relative poverty denies many Indigenous communities access to housing, education, transport and other societal benefits. It would be naïve to argue that this inequitable distribution of Australian resources has not been a major determinant of the poorer health of Indigenous Australians.[6] The recent Auditor-General's report on whole-of-government Indigenous service delivery arrangements clearly indicates that current approaches are inadequate and fall short on service delivery.[7]

There is therefore a critical need for decisive direct investment in basic infrastructure and its maintenance in Indigenous communities, along with comprehensive primary health care. This must extend to equipping and developing individuals and communities through a major investment in education and creation of employment opportunities that engages the community and is developed in true and equal partnership with respected Indigenous leaders and communities

You may argue that many of these health determinants fall beyond your direct sphere of accountability. You may choose to point to the small-scale success stories, particularly in Indigenous primary health care. However, as Minister for Health and Ageing, you will continually be confronted by the direct evidence of the deleterious results of these health determinants on the life expectancy and health of Indigenous Australians.[8]

The time is ripe for a bold national leader to champion this cause in the corridors of power. We encourage you to become that advocate among your Cabinet colleagues. The challenge is yours. Will you have the courage and moral fortitude to make your mark on Australian history?

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Will Australian rural clinical schools be an effective workforce strategy? Early indications of their positive effect on intern choice and rural career interest

Denese E Playford, Harriet Denz-Penhey, Lesley Skinner and J Campbell Murdoch

To the Editor: The academic success of the rural clinical schools (RCS) program is clear: community-based clinical placements in rural Australia are able to produce graduates that are academically indistinguishable from tertiary hospital-trained peers.[1,2]

The effect of the RCS program on the workforce is yet to be established. Eley and Baker recently identified early career choices by Queensland RCS graduates.[3] Western Australian RCS students spend an entire academic year in the country. Here, we provide the first data on the return of WA RCS graduates to rural internship positions relative to the intern year cohort as a whole.

Based on two cohorts entering postgraduate year 1 (PGY1) positions in 2004 and 2005, 14 of 28 WA RCS graduates have requested and completed the one rural rotation that is permitted during their intern year. Given the limited rural rotations available in WA, some sought rural experience as far afield as Queensland and New South Wales.

The substantive uptake of rural experience by RCS interns is in contrast to the intern cohort as a whole (Box).

In 2004 and 2005, the three WA tertiary allocation centres placed 135 and 131 interns, respectively. As WA has no whole-year rural internships, a subset of the urban allocation included a 3-month rural rotation.

The distribution of graduates of the RCS was different to that of graduates from other programs ($\chi^2 = 7.0693$; df = 1; $P = 0.008$). RCS students were more likely than other graduates to take a rural rotation (odds ratio, 3.1).

Furthermore, ongoing postgraduate contact with the RCS cohort has identified that 23 of 28 graduates have chosen to undertake at least some time in the country during their PGY1–3 years. There is also early indication that graduates will sign up for a rural vocational training pathway (3/28). Interestingly, only a small proportion of these graduates are from a rural background (5/28).

Our data suggest that rural practice is seen as highly desirable postgraduate clinical experience by WA RCS graduates. These results provide initial evidence that the WA RCS program will increase the rural workforce.

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Aggregate of 2004 and 2005 rural clinical school (RCS) interns versus non-RCS interns: comparison of postgraduate year 1 (PGY1) intern location choices

	RCS ($n = 28$)	Non-RCS ($n = 238$)	Total ($n = 266$)
Expected tertiary allocation centre PGY1 internships (statistically even distribution)			
Urban-only internship	20	174	194
Rural rotation during internship	8	64	72
Actual tertiary allocation centre PGY1 internships (actual distribution)			
Urban-only internship	14	180	194
Rural rotation during internship	14	58	72

Tuberculosis in children: a tertiary centre perspective

Paul D Robinson, Dianne Dalton, Terri Cripps, Nicholas J Wood, Alison M Kesson and David Isaacs

To the Editor: The growing problem of tuberculosis in resource-rich countries has been recently highlighted,[1] with immigration thought to be an important contributor. To assess a possible increase in incidence, we performed a retrospective case record review of all children who had tuberculin skin tests or who were diagnosed with tuberculosis at The Children's Hospital at Westmead for 3 years from 2004 to 2006. This period included the establishment of a refugee clinic in May 2005, which routinely tests refugees by tuberculin skin testing. We compared our findings with published data from 1982 to 1991.[2]

Latent tuberculosis infection was defined as tuberculin skin test induration of $\geqslant 10$ mm (regardless of prior BCG vaccination) and a decision by the treating physician to start isoniazid monotherapy. Proven active tuberculosis disease was defined as a child with a positive isolate of *Mycobacterium tuberculosis* from culture or positive polymerase chain reaction for tuberculosis or positive tuberculin skin test in association with a clinical picture strongly suggestive of active tuberculosis disease.

The number of tuberculin skin tests performed increased through the study period (Box 1), largely because the refugee clinic saw 90 new patients in 2005 and 150 in 2006. The proportion of children with an increased induration response increased over the study period (Box 1 and Box 2). We observed an increase in latent tuberculosis infection, both in absolute numbers and in the proportion of the total caseload. The absolute number, but not the proportion, of cases of active tuberculosis disease increased during the study period. Over the same period, hospital admissions remained static at about 26 000 per year. Extrapulmonary tuberculosis was present in 12 of 23 patients (52%) with active tuberculosis, compared with 34% in the earlier study.[2] There was no increase in tuberculosis meningitis.

The active tuberculosis cohort ethnicity was consistent with the earlier study, with 22 of 23 patients of non-European origin, and 18 born outside Australia. The predominant ethnic groups were from Africa

(eight, all born outside Australia) and the Indian subcontinent (four, two born outside Australia).

Our finding of an increase in the proportion of patients with latent tuberculosis infection but not active tuberculosis disease is largely due to increased testing of refugees. It is reassuring that we did not find active tuberculosis. The United Kingdom has reported an increased incidence of tuberculosis in African immigrants.[1,3] Australian immigration trends have shown a demographic shift, with increasing numbers of refugees from Africa.[4] Although our study is likely to suffer from referral bias, it is the largest review of paediatric tuberculosis from a tertiary centre in Australia.

Children very rarely transmit tuberculosis, but it is important to identify and treat latent tuberculosis to prevent progression to active disease.[5] We believe our results are encouraging in showing a low incidence of active tuberculosis and indicate the need to screen refugees for latent tuberculosis to direct chemoprophylaxis.

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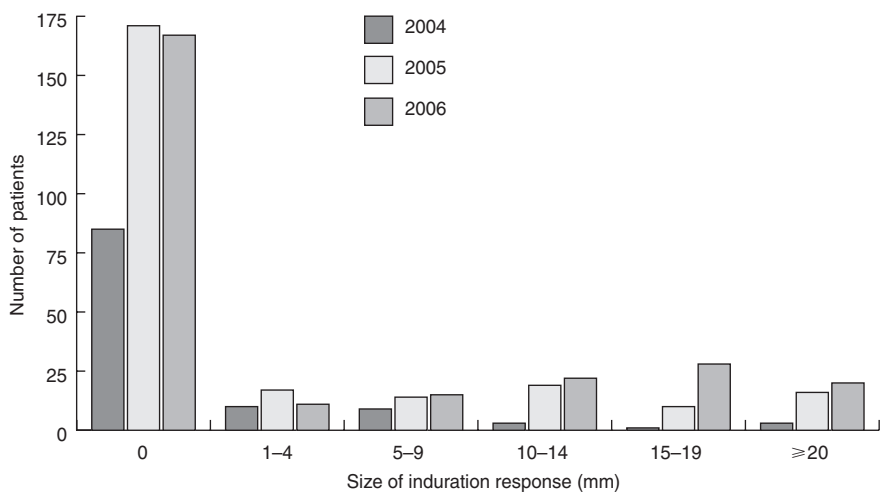
1 Comparison data on tuberculosis among children, 2004–2006

Year	Total TSTs performed	Results available	> 10 mm		> 15 mm		No. of patients commenced on isoniazid	No. with active TB disease
			No	Yes	No	Yes		
2004	116	111	104	7	108	3	5	4
2005	257	247	202	45*	221	26*	25	8
2006	278	263	193	70*	215	48*	36	11

TST = tuberculin skin test. TB = tuberculosis. * $P < 0.01$ compared with previous year. The discrepancy between the total numbers performed and the cumulative numbers in the categorisation of response is due to patients not returning to have the TST read. ◆

2 Results categorised by size of tuberculin skin test induration



It's not a tsunami — sea-levels are on the rise

Andrew W Perry

To the Editor: I write to voice my objection to the use of the term "tsunami" by many in the medical education community when describing the massive increase in medical student numbers that has begun as a result of recent government initiatives.[1-5]

Although it is true that the government has opened the floodgates, as opposed to the water restrictions they applied in the mid 1990s, I believe describing this increase using the metaphor of a tsunami is a misnomer.

I do not disagree with the potential for this phenomenon to wreak mayhem with the quality teaching and supervision of medical students and junior doctors and their access to adequate employment in both prevocational and vocational places. Nevertheless, I believe that we need to adopt a more accurate term to describe this impending event.

A term I have heard on a number of occasions is that of the "rising sea levels" of medical graduates, which (although less dramatic) I think is more accurate, because this expression indicates that the change (likely a sea change) is going to be long-lasting, if not permanent, rather than a flash flood, as signified by "tsunami".

If we are going to continue to describe this impending increase as a "tsunami", the only benefit I can see is that it may encourage us to learn lessons from the real event. As a result of the 2004 Boxing Day tsunami, a tsunami early warning system was put in place to alert citizens of an impending tsunami and give them a small window of time to prepare. A number of medical education groups, including the Australian Medical Association Council of Doctors in Training, have started sounding the alarm about the increase in medical

students. It remains to be seen whether this warning will be heeded in time. One only has to look to the fiasco in the United Kingdom this year with junior doctor allocations to see what happens when adequate preparation is not made for impending change.

Will a student who enters medicine in 2010 feel that, during their medical education voyage, they are receiving a quality education? And when they graduate, will they find a rich sea of prevocational and vocational opportunities? Or will they feel like a drop in the ocean of fellow graduates scrambling to gain a properly supervised training position?

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