Letters

Should the legal age for buying alcohol be raised to 21 years?

To the Editor: Toumbourou and colleagues argue that the Australian legal age for buying alcohol should be increased.[1] However, they overstate their case by only citing research that supports their position, giving an impression of scientific consensus on several key issues when there is strong contrary evidence.

They consider the effects of legal access to alcohol on traffic safety. But they neglect to mention the only recent Australian evidence on this topic, which found that legal access did not increase the risk of serious motor vehicle accidents in New South Wales.[2] They also cite research suggesting that lowering the buying age from 20 to 18 years in New Zealand impaired traffic safety, based on an increase in accidents involving alcohol among 18–19-year-olds relative to 20–24-year-olds after the policy change.[3] However, a follow-up study found that the crash rate for 18–19-year-olds was rising relative to the older comparison group before the policy change was enacted, and that there was no evidence that the policy change affected traffic safety.[4]

They also dismiss the possibility that alcohol and illicit drugs may be substitutes for each other, ignoring recent contrary evidence.[5,6]

More broadly, their argument for increasing the legal age for buying alcohol is predicated on the idea that any policy change that promotes health should be undertaken, without any consideration of how the magnitude of such health benefits compares to the costs of implementing such a policy.

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1 Toumbourou JW, Kypri K, Jones SC, Hickie IB. Should the legal age for buying alcohol be raised to 21 years? *Med J Aust* 2014; 200: 568-570.
2 Lindo JM, Siminski P, Yerokhin O. Breaking the link between legal access to alcohol and motor vehicle accidents: evidence from New South Wales. NBER Working Paper No. 19857. Cambridge, Mass: National Bureau of Economic Research, 2014. http://www.nber.org/papers/w19857 (accessed Aug 2014).
3 Kypri K, Voas RB, Langley JD, et al. Minimum purchasing age for alcohol and traffic crash injuries among 15- to 19-year-olds in New Zealand. *Am J Public Health* 2006; 96: 126-131.
4 Boes S, Stillman S. Does changing the legal drinking age influence youth behaviour? IZA Discussion Paper No. 7522. Bonn: Institute for the Study of Labor (IZA), 2013. http://www.iza.org/en/webcontent/publications/papers/viewAbstract?dp_id=7522 (accessed Aug 2014).
5 Deza M. The effects of alcohol on the consumption of hard drugs: regression discontinuity evidence from the National Longitudinal Study Of Youth, 1997. *Health Econ* 2014; Jan 24 [Epub ahead of print].
6 Crost B, Guerrero S. The effect of alcohol availability on marijuana use: evidence from the minimum legal drinking age. *J Health Econ* 2012; 31: 112-121. ❑

In reply: We disagree with the points raised by Lindo and Siminski. All systematic reviews show harm associated with lowering the purchasing age and reduction in harm from increasing it. We stand by our decision to emphasise findings published in peer-reviewed journals. They cite their non-peer-reviewed New South Wales study to claim that reaching the legal age of 18 years for purchasing alcohol did not increase serious motor vehicle accident risk. However, their comparison to novice drivers aged 17 years is flawed, as inexperienced drivers in their first year are at their highest lifetime risk of vehicle accidents. To support their criticisms of New Zealand research, they cite one non-peer-reviewed report. Our conclusions are based on two independent peer-reviewed studies, supported by additional studies,[1] including recent evidence of long-term negative effects of the New Zealand law change[2] not confined to traffic injury.[3]

They claim that we ignore illicit drug substitution studies showing that up to 2% of adolescents in the United States use cannabis and then change to alcohol at 21 years of age, when they can legally purchase it. However, these effects are inconsistent across models,[4] and some studies report no effect.[5] In contrast, the epidemiological trend and cross-national comparative findings that we cite demonstrate that the US age-21 laws have been associated with robust reductions in all forms of substance use, with 69% of US adolescents being abstinent.[6]

> “recent Australian evidence . . . found that legal access did not increase the risk of serious motor vehicle accidents”
>
> Lindo et al

> “US age-21 laws have been associated with robust reductions in all forms of substance use”
>
> Toumbourou et al

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1 Huckle T, Pledger M, Casswell S. Trends in alcohol-related harms and offences in a liberalized alcohol environment. *Addiction* 2006; 101: 232-240.
2 Huckle T, Parker K. Long-term impact on alcohol-involved crashes of lowering the minimum purchase age in New Zealand. *Am J Public Health* 2014; 104: 1087-1091.
3 Kypri K, Davie G, McElduff P, et al. Effects of lowering the minimum alcohol purchasing age on weekend assaults resulting in hospitalization in New Zealand. *Am J Public Health* 2014; 104: 1396-1401.
4 Yörük BK, Yörük CE. The impact of minimum legal drinking age laws on alcohol consumption, smoking, and marijuana use revisited. *J Health Econ* 2013; 32: 477-479.
5 Crost B, Rees DI. The minimum legal drinking age and marijuana use: new estimates from the NLSY97. *J Health Econ* 2013; 32: 474-476.
6 Toumbourou JW, Hemphill SA, McMorris BJ, et al. Alcohol use and related-harms in school students in the USA and Australia. *Health Promot Int* 2009; 24: 373-382. ❑

Anomalous warning labels on alcoholic energy drink cans

To the Editor: Despite longstanding calls for mandatory evidence-based warning labels on alcoholic beverages or at point of sale,[1] they remain elusive and are actively resisted by industry groups.[2]

There is widespread ignorance of the current *Australian guidelines to reduce health risks from drinking alcohol*[3] as well as the recommended daily limits for consuming highly caffeinated energy drinks. In high enough quantities, caffeine is toxic; consequently, some advisory labelling is already mandated for these controversial "soft" drinks.[4] These labels are often difficult to find, and if the caffeine is from guarana only, a statement that the drink contains caffeine is the only warning required. This has resulted in anomalous and confusing labelling on cans of the even more contentious alcoholic energy drinks[5] — such that consumers could be forgiven for thinking the alcohol component is not as potentially injurious to their health as the caffeine.

Based on caffeine content, labelling on cans that also contain between 1.3 and 1.9 standard drinks of alcohol advises a limit of two cans per day, which equates to a daily intake of between 2.6 and 3.8 standard drinks of alcohol. This exceeds the limit recommended in the Australian guidelines — two standard drinks per day — for reducing the risk of long-term damage to the body from alcohol.[3] The advice on brands at the higher end of this range barely complies with the recommended limit of four standard drinks per day for preventing acute harm.

With such confusing advice, the general public cannot be expected to understand or follow recommended limits for either alcohol or caffeine consumption. Packaging should display unambiguous and prominent warnings, including whichever is the lower of the two daily use limits calculated according to guidelines on alcohol and caffeine intake. A second maximum might be given for usage in a single session. Public health messaging needs to be clear and consistent, and an overhaul of both alcohol and caffeine advisory labelling is long overdue.

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1 Public Health Association of Australia Alcohol Special Interest Group. Public Health Association of Australia policy-at-a-glance – alcohol policy. PHAA, 2013. http://www.phaa.net.au/documents/130919 PHAA Alcohol Policy.pdf (accessed Sep 2014).
2 Australian Hotels Association. Australian hotels: contributing to economic growth and national prosperity. A pre-election policy platform by the Australian Hotels Association (AHA) and Tourism Accommodation Australia (TAA). AHA and TAA, 2013. http://aha.org.au/wp-content/uploads/2013/07/AHA-National-Policy-Platform-2013.pdf (accessed Sep 2014).
3 National Health and Medical Research Council. Australian guidelines to reduce health risks from drinking alcohol. Canberra: NHMRC, 2009. http://www.nhmrc.gov.au/_files_nhmrc/publications/attachments/ds10-alcohol.pdf (accessed Oct 2014).
4 Food Regulation Standing Committee Caffeine Working Group. Food regulation policy options paper: the regulation of caffeine in foods. Canberra: FRSC, 2013. http://www.health.gov.au/internet/main/publishing.nsf/Content/foodsecretariat-consult-previous (accessed Sep 2014).
5 Trapp GS, Allen KL, O'Sullivan T, et al. Energy drink consumption among young Australian adults: associations with alcohol and illicit drug use. *Drug Alcohol Depend* 2014; 134: 30-37. ❑

Leaving judgement at the door

To the Editor: Swannell's article offers a refreshing reminder of the conflicted and contested scope of sexual health medicine.[1] Recent public sector changes are forcing sexual health services to revert to the "disease" paradigm that dominated for most of the 20th century. Moves towards a more holistic vision of sexual health with a focus on wellbeing, as promoted by the World Association for Sexual

> "evidence-based warning labels . . . remain elusive and are actively resisted by industry groups"
>
> Cowie et al

Health,[2] are now being pursued only in the private and non-government organisation sectors.

In Swannell's article, the dimensions of the broader approach (beyond sexually transmitted infections [STIs]) were given only token lip service — a brief mention of "sexual assault, contraception, sexual dysfunction, reproductive health and gender identity issues". Most of the article reverted to a narrow biomedical emphasis on STIs and their management, and neglected the management of other crucial sexual health issues. This is disappointing, and a lost opportunity to advocate for a better response from the medical sector.

While the medical profession is central to STI service delivery, the broader realm of sexual health services requires a multisectoral response that involves sex therapists, counsellors, nurses and educators. Groups such as the Society of Australian Sexologists are working towards a more comprehensive approach through the professionalisation of sex therapists and others, with strict accreditation requirements. Sadly, it appears that a more comprehensive vision in the public sector is decreasingly likely, despite its importance in promoting sexual health.

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1 Swannell C. Leaving judgement at the door. *Med J Aust* 2014; 201 (4): C1-C2.

2 World Association for Sexual Health. Sexual health for the millennium. A declaration and technical document. Minneapolis: WAS, 2008. ❑

The health impacts of the 2018 Gold Coast Commonwealth Games: proactive planning is required, but who will do this?

To the Editor: The recent Commonwealth Games in Glasgow are a timely reminder of the 2018 Games planned for the City of Gold Coast. In 2013, the Queensland Government, in collaboration with Gold Coast City Council, produced a legacy plan to identify actions to be taken across government and to invite community input and engagement with the Games, including creating a health legacy.[1] However, in the document supporting this plan, only two explicit health actions stand out: an accessible and inclusive active living and healthy eating program, and a local health and knowledge precinct to help generate economic development.[2]

> "the broader realm of sexual health services requires a multisectoral response"
>
> Neilsen et al

In early 2013, separate to legacy planning, the Gold Coast City Council also commissioned a social and health impact assessment (IA). The IA, which is not publicly available, reviewed the evidence base to reveal a more mixed picture about health concerns than is included in the legacy plan, and found:

- Mass gatherings provide ideal conditions for influenza transmission and amplification of preseasonal viruses, even in contexts of low seasonal influenza activity.[3] Cases of *Neisseria meningitides* type b and leptospirosis occurring during

Correction

Missing author initial: In "*Antibiotic prescribing practice in residential aged care facilities — health care providers' perspectives*" in the 21 July 2014 issue of the Journal (*Med J Aust* 2014; 201: 101-105), the name of one of the authors should have been published as Anton Y Peleg.

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LETTERS TO THE EDITOR

The MJA welcomes letters on new topics (no longer than 350 words) or commenting on an MJA article (no longer than 250 words). All letters should have no more than three authors. Comments about MJA articles should be submitted within 1 month of that article's publication and should be given the same title as the article. Letters should be appropriately referenced in the same style and format as other MJA articles, with no more than 5 references. All research letters are peer reviewed, and other letters may also be peer reviewed. All letters are subject to editing. Proofs will not normally be supplied unless significant changes are made.

(***See*** https://www.mja.com.au/journal/mja-instructions-authors)

sporting events have been documented, the latter associated with heavy rains.[4] Risks to mental health and from sexually transmissible infections can be mitigated by prior planning.

- With regard to exposure to environmental risks, in addition to the more obvious areas of health and safety and food hygiene, transport infrastructure and planning for Games also have major health implications.[5]
- The population health benefits of Games are at risk of being inequitable. The anticipated "festival effect" of Games, whereby the whole population increases healthy behaviour such as physical activity, has yet to be demonstrated.[6] The inevitable increased police presence heightens the risk of negative health consequences for already at-risk groups such as homeless people, injecting drug users, and sex workers.[7]

Since the IA was conducted, there have been three suspected cases of Ebola virus disease — later proven not to be Ebola — in Queensland, including the Gold Coast.

System preparedness for 2018 across the health system and non-health agencies is required. However, cuts to the Queensland health system in 2012 resulted in the loss of around 4000 staff (5%) and the dismantling of population health services. Given that population health is the point in the health system for proactive health-focused planning, who will do the required comprehensive planning for the Games to ensure the health of the community is fully promoted and protected?

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Competing interests: I was subcontracted to undertake the health component of the impact assessment. I am permitted to publish the findings and use them for teaching and training purposes. In the past, I have worked with Queensland Health's tropical population health services to build their capacity to undertake health impact assessments as part of intersectoral planning processes.

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1 Queensland Government Department of Tourism, Major Events, Small Business and the Commonwealth Games. Embracing our Games legacy. 2013. http://www.dtesb.qld.gov.au/__data/assets/pdf_file/0003/117606/gccg-legacy-strategy.pdf (accessed Oct 2014).
2 Queensland Government Department of Tourism, Major Events, Small Business and the Commonwealth Games. Embracing our games legacy: action plan 2014. http://www.dtesb.qld.gov.au/__data/assets/pdf_file/0020/117605/gccg-legacy-action-plan.pdf (accessed Oct 2014).
3 Blyth CC, Foo H, van Hal SJ, et al. Influenza outbreaks during World Youth Day 2008 mass gathering. *Emerg Infect Dis* 2010; 16: 809-815.
4 Brockmann S, Piechotowski I, Bock-Hensley O, et al. Outbreak of leptospirosis among triathlon participants in Germany, 2006. *BMC Infect Dis* 2010; 10: 91.
5 McCartney G, Thomas S, Thomson H, et al. The health and socioeconomic impacts of major multi-sport events: systematic review (1978-2008). *BMJ* 2010; 340: c2369.
6 Weed M, Coren E, Fiore J, et al. Developing a physical activity legacy from the London 2012 Olympic and Paralympic Games: a policy-led systematic review. *Perspect Public Health* 2012; 132: 75-80.
7 Small W, Krusi A, Wood E, et al. Street-level policing in the Downtown Eastside of Vancouver, Canada, during the 2010 winter Olympics. *Int J Drug Pol* 2012; 23: 128-133. ❑

Rural clinical school outcomes: what is success and how long do we wait for it?

To the Editor: Do we sense a touch of frustration in the letter from Adam and colleagues[1] in describing the outcomes of their rural clinical school (RCS) program? Career choices within medicine are influenced by many factors, and we agree with their comment that it is impossible to compel and unreasonable to expect all RCS graduates to enter rural practice. However, a factor that they have not taken into account is that of rural student recruitment, which has been shown by numerous studies, together with a positive rural exposure during training, to be a major factor in rural career decision making.[2-5] If, as they suggest, currently only half of RCS graduates can be expected to choose a rural career, with the present requirement for medical schools to admit 25% of their intake from a rural background, is it time for this requirement to be reviewed upward?

In our experience, it is not all doom and gloom. At the University of Wollongong, we have far exceeded our 25% rural background admission requirement. Over the past 4 years, our intake of domestic students with a rural background (Australian Standard Geographical Classification – Remoteness Areas 2–5) has averaged 67%. Although we are too young to have longer-term data, our experience of selecting students with a rural background — together with a significant rural exposure during the program with an emphasis on generalism — is translating to an average of 43% of our graduates choosing internships in rural settings, and 61% choosing internships outside of metropolitan areas.

> "cuts to the Queensland health system in 2012 resulted in . . . the dismantling of population health services"
>
> Harris

> "rural student recruitment . . . has been shown by numerous studies . . . to be a major factor in rural career decision making"
>
> Garne et al

We will be following the longer-term career choices of our graduates with interest, but feel that to date we are on track to achieve our mission of producing young doctors for regional, remote and rural Australia.

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1 Adam WR, Wright JR, McColl GJ. Rural clinical school outcomes: what is success and how long do we wait for it? *Med J Aust* 2014; 200: 581.
2 Walker JH, Dewitt DE, Pallant JF, Cunningham CE. Rural origin plus a rural clinical school placement is a significant predictor of medical students' intentions to practice rurally: a multi-university study. *Rural Remote Health* 2012; 12: 1908.
3 Laven GA, Beilby JJ, Wilkinson D, McElroy HJ. Factors associated with rural practice among Australian-trained general practitioners. *Med J Aust* 2003; 179: 75-79.
4 Wilkinson D, Laven G, Pratt N, Beilby J. Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice among Australian general practitioners: national study of 2414 doctors. *Med Educ* 2003; 37: 809-814.
5 Laven G, Wilkinson D. Rural doctors and rural backgrounds: how strong is the evidence? A systematic review. *Aust J Rural Health* 2003; 11: 277-284. ❑

In reply: Garne and colleagues raise the important matter of whether the current quota of rural students in medical schools (25%) should be increased, given the

positive impact of rural background on future rural practice. We agree that this warrants serious consideration, but suggest that there should not only be an increased national quota for rural students but also consideration of the distribution of these students between different medical schools.

Medical schools are not all the same. They have differing staff expertise and facilities, and also recruit students in a number of different environments and populations. These factors facilitate student recruitment and training, and hopefully influence students' future career choices to serve in disadvantaged communities (such as underserved urban or ethnic communities), and also in underserviced subspecialties (such as dermatology and otorhinolaryngology) and other health priorities (such as public health and research leadership). Perhaps individual medical school quotas for rural students should vary depending on their staff expertise, facilities and environments.

We are not frustrated. We are proud of our achievement in training rural practitioners and congratulate the University of Wollongong on theirs.

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Aboriginal and Torres Strait Islander medical students' and doctors' career intentions

To the Editor: In the past 30 years, the Aboriginal and Torres Strait Islander medical workforce has rapidly expanded. However, proportionally, there is still underrepresentation of Indigenous people in all areas of medicine.[1] General practice has remained successful in attracting Indigenous people to undertake fellowships,[1] but there are many specialties that have yet to see an Indigenous trainee or fellow.

Indigenous medical student numbers reached population parity for the first time in 2012.[2] As these numbers increase, it is important to understand the demographics, career intentions and outcomes for this group, to achieve positive change for Indigenous health through improved support and reduced attrition of students.

The Medical Schools Outcomes Database and Longitudinal Tracking (MSOD) project collects data on Australian medical students and doctors.[3,4] All students are invited to complete short questionnaires when commencing and finishing medical school and subsequent postgraduate years. Between 2005 and 2012, 36 244 participants completed the surveys.[4]

Up to 2012, 296 Aboriginal and Torres Strait Islander students had completed the commencing medical students questionnaire (CMSQ); 45 Aboriginal and Torres Strait Islander students had completed the exit questionnaire, and 26 Aboriginal and Torres Strait Islander doctors had completed the postgraduate year 1 questionnaire. Despite attrition in response rates, which may be attributable to a prolonged time to graduation, Indigenous students and doctors tend to be older, more likely to have children and more likely to identify as being from a rural background compared with non-Indigenous participants across all surveys (Box).

> "improved strategies to encourage both Indigenous and non-Indigenous people into Indigenous health should also be further developed"
>
> Slape et al

In all questionnaires assessed so far, general practice was the highest ranked preference for Indigenous medical students (Box). Overall, of all MSOD participants in the CMSQ, only 47 (0.2%) ranked Indigenous health as a first preference. This shows that improved pathways for Indigenous people into specialty training remain important, and that improved strategies to encourage both Indigenous and non-Indigenous people into Indigenous health should also be further developed. These results and future results of the MSOD project will provide a useful evidence base to guide policy development in Australia, particularly surrounding workforce, medical education and vocational training for Aboriginal and Torres Strait Islander medical students and doctors.

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Competing interests: No relevant disclosures.

Demographic details of Indigenous and non-Indigenous survey participants in the Medical Schools Outcomes Database and Longitudinal Tracking project, 2005–2012

	Commencing medical students questionnaire		Exit questionnaire		Postgraduate year 1 questionnaire	
Demographic characteristics	Indigenous (n = 296)	Non-Indigenous (n = 21709)	Indigenous (n = 45)	Non-Indigenous (n = 8392)	Indigenous (n = 26)	Non-Indigenous (n = 4510)
Participant response rate	84.8%	91.0%	72.6%	83.0%	49.1%	67.0%
Women	55.1%	52.7%	48.9%	53.7%	61.5%	56.7%
Marital status (married)	9.1%*	3.6%	11.1%	10.4%	19.2%	20.2%
Have children (> 1 child)	16.8%*	2.8%	19.0%*	5.5%	15.4%*	8.7%
Mean age (years)	24*	21	28*	26	30*	27
Identify as being from a rural background	55.7%*	19.0%	48.6%*	17.9%	61.9%*	18.9%
First preference to pursue general practice	32.0%*	20.6%	25.0%*	19.4%	26.3%	26.4%

*P < 0.05 for comparison with non-Indigenous participants.

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1 Australian Institute of Health and Welfare. Aboriginal and Torres Strait Islander health labour force statistics and data quality assessment. Canberra: AIHW, 2009. (AIHW Cat. No. IHW 27.) http://www.aihw.gov.au/publication-detail/?id=6442468240 (accessed Sep 2014).
2 Medical Deans Australia and New Zealand. Indigenous health priorities. http://www.medicaldeans.org.au/projects-activities/indigenous-health/indigenous-health-priorities (accessed May 2014).
3 Medical Deans Australia and New Zealand. Medical Schools Outcomes Database. http://www.medicaldeans.org.au/msod (accessed May 2014).
4 Kaur B, Carberry A, Hogan N, et al. The medical schools outcomes database project: Australian medical student characteristics. *BMC Med Educ* 2014; 14: 180. ❑

Newborn bloodspot screening: setting the Australian national policy agenda

To the Editor: Maxwell and O'Leary's article[1] and Wiltshire and Cameron's letter[2] provide insights into the current issues facing newborn bloodspot screening (NBS) in Australia. It is clear that we have world-class NBS programs, but there is a lack of national policy guidance agreed on by governments. It has been argued that this has affected the programs' capacity to respond to the changing environment in which they operate.[1,3,4] There is a need for clear national policies to support the programs' continued success and growth, and a way to assess the benefits and harms of screening additional conditions through NBS.[5] Since the aforementioned articles were published, there has been substantial progress towards achieving these goals.

Australian governments have recently agreed to develop a national policy framework for NBS. This will include a decision-making pathway, against which congenital adrenal hyperplasia and other conditions can be assessed for inclusion in NBS. The policy framework is being developed under the auspices of the Standing Committee on Screening, through a multidisciplinary working group. The project is due for completion by early 2016, and will be informed by broad consultation, due to take place in 2015. Further information can be found at http://www.genomics.health.wa.gov.au.

The current process is a genuine opportunity for policymakers, NBS programs, clinicians, consumers and others to come together to put in place a framework that builds on the successes of NBS, safeguards the programs into the future, and enables transparent and consistent decision making.

> “Australian governments have recently agreed to develop a national policy framework for newborn bloodspot screening”
>
> White et al

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1 Maxwell SJ, O'Leary P. Newborn bloodspot screening: setting the Australian national policy agenda. *Med J Aust* 2014; 200: 142-143.
2 Wiltshire E, Cameron F. Newborn bloodspot screening: setting the Australian national policy agenda [letter]. *Med J Aust* 2014; 201: 91-94.
3 Warne GL, Armstrong KL, Faunce TA, et al. The case for newborn screening for congenital adrenal hyperplasia in Australia. *Med J Aust* 2010; 192: 107.
4 Carpenter K. Newborn screening – 50 years on. *Human Genetics Society of Australasia News* [internet] 2013; 11 May. http://www.hgsa.org.au/news/newborn-screening-50-years-on (accessed Aug 2014).
5 Australian Health Ministers' Advisory Council, Screening Subcommittee. Population based screening framework. Canberra: Commonwealth of Australia, 2008. http://www.cancerscreening.gov.au/internet/screening/publishing.nsf/Content/pop-based-screening-fwork/$File/screening-framework.pdf (accessed Sep 2014). ❑