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## Mifepristone (RU-486) and limits to abortion

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**TO THE EDITOR:** As politicians prepare to debate the *Therapeutic Goods Amendment (Repeal of Ministerial responsibility for approval of RU486) Bill 2005*,<sup>1</sup> one question is central: why should mifepristone require special approval from the Minister of Health and Ageing, when all other drugs are simply assessed by the Therapeutic Goods Administration (TGA)? The answer is that abortifacients such as mifepristone are unique in that they are the only drugs designed to end a human life, and therefore their use demands a unique level of ethical assessment and accountability, beyond the scope of the TGA.

The TGA has the vital but limited role "to ensure the quality, safety and efficacy of medicines". These criteria are adequate for assessing most medications, but inadequate for a drug designed to extinguish life.

The TGA in its approval process does not consider ethical criteria.<sup>2</sup> However, without broader ethical considerations, such as what medical conditions might justify the use of mifepristone, or the moral status of the life to be extinguished, no meaningful assessment of an abortifacient can be made.

Abortion "on demand" (ie, without medical justification) is readily available in Australia, even where, as Judge Fred McGuire stated in a Queensland case: "There is no legal justification for abortion on demand".<sup>3</sup> Evidence for the predominantly non-medical justification for abortion was documented in a 1995 survey of women seeking termination of pregnancy in New South Wales.<sup>4</sup> The most frequently listed contributing factor, given by 60% of the 2249 respondents, was "financial concerns". Younger women were more likely to cite youth, career, single parenthood and changes to lifestyle, while women aged over 30 were more likely to cite completed family and problems in their relationship with their partner.

Because abortion law is under state jurisdiction, the federal government has no stated position on abortion "on demand". Now that it is being asked to authorise a drug for abortion, the government has the

opportunity and responsibility to defend basic standards of law and ethics by limiting mifepristone use to medically essential terminations of pregnancy, excluding abortion for non-medical reasons.

The government should establish, in consultation with medical authorities, valid medical indications for mifepristone, including certain cancers, hormonal diseases, and medically essential termination of pregnancy, and approve the drug for those uses. The criteria could be specified using the existing authority prescription mechanism. This would exclude abortions for which there is no medical indication; for this category, the compelling task for government and the profession is to address the underlying social stresses for which abortion is seen as a solution, reconstructing social supports for women distressed by unplanned pregnancy.

Certainly, setting ethical parameters for the use of mifepristone will not affect the availability "on demand" of surgical abortion, which operates without effective ethical or legal restraint. Yet, even largely symbolic acts can be important. If it is right ethically and medically to set limits on the use of abortifacients such as mifepristone, these limits should be set.

The medical profession should use the debate on mifepristone to reaffirm ethical limits on abortion, upholding our duty of care to both mother and unborn baby. Disappointingly, in the debate so far, leaders of organised medicine have limited discussion of mifepristone to sterile technical matters of safety and efficacy, as if ethical concerns have no bearing on public policy or medical practice.<sup>5</sup>

Much expert advice would be needed concerning authentic medical grounds for the use of mifepristone, and even then the authority prescription system could still be abused. But at least the attempt will have been made to establish valid medical indications for this gravest of medical acts, and the profession will be seen to distance itself from abortion "on demand".

1 Australian Government Attorney-General's Department. Commonwealth of Australia Law. Therapeutic Goods Amendment (Repeal of Ministerial responsibility for approval of RU486) Bill 2005. Available at: <http://www.comlaw.gov.au/ComLaw/Legislation/Bills1.nsf/0/1EBC6A783DF06F5ECA2570D20016C30D?OpenDocument> (accessed Jan 2006).

2 Commonwealth of Australia. Senate Community Affairs Legislation Committee. Inquiry into Therapeutic Goods Amendment (Repeal of Ministerial responsibility for RU486) Bill 2005. Proof Committee Hansard, 15 December 2005. Available at: <http://www.aph.gov.au/hansard/senate/commtee/S8992.pdf> (accessed Jan 2006).

3 McGuire DCJ. *R v. Bayliss & Cullen* (1986) 9 QLR 8 at 45.

4 Adelson PL, Frommer MS, Weisberg E. A survey of women seeking termination of pregnancy in New South Wales. *Med J Aust* 1995; 163: 419-422.

5 Australian Medical Association. AMA supports use of RU486 for termination of pregnancy. Media release, 7 Nov 2005. Available at: <http://www.ama.com.au/web.nsf/doc/WEEN-6HW5DZ> (accessed Jan 2006). □

## "GP Psych Opinion": evaluation of a psychiatric consultation service

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**TO THE EDITOR:** In their letter on "GP Psych Opinion", Wong and Tiller highlighted the poor uptake by general practitioners of a psychiatric consultation service based in a private psychiatric hospital in Melbourne.<sup>1</sup> They compared the results of their service to the similar poor uptake by GPs of the public hospital-based psychiatric consultation service in Brisbane.<sup>2</sup>

One explanation for this disappointing result may be that most psychiatric illness is chronic, and continuity of care and advice from a consistently available psychiatric colleague is of great importance to GPs — over and above having the patient assessed. This does not seem to have been a strong characteristic of the Melbourne service, given that the assessing psychiatrist was a psychiatric trainee registrar, who is usually either rotating between clinical placements as part of training, or waiting to move on to a more senior position.

GPs' referral practices to specialists are based on a multitude of influences, of which availability is only one. Personal contact, quality of service and continuity of assistance are highly relevant. Perhaps if the Melbourne and Brisbane consultation services can push on and attend to these issues, then utilisation by GPs will increase over time — as this is what happens in more conventional private practice referrals.

1 Wong GK, Tiller WG. "GP Psych Opinion": evaluation of a psychiatric consultation service [letter]. *Med J Aust* 2005; 183: 494.

2 Simpson AE, Emmerson WB, Frost ADJ, Powell JL. "GP Psych Opinion": evaluation of a psychiatric consultation service. *Med J Aust* 2005; 183: 87-90. □

## Clinicians prescribing exercise: is air pollution a hazard?

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**TO THE EDITOR:** There should be no contradiction in recommending that people enjoy recreational exercise when air pollution is low but nonetheless walk/cycle for transport.<sup>1</sup> I cycle home after 5 pm, when pollution increases to health-hazardous levels (Box), but it is astounding to see people out jogging in such unhealthy air.

Cycling for transport is undoubtedly better than driving. Despite dangers from pollution and busy roads, commuter-cyclists have 40% lower mortality than drivers.<sup>2</sup> Nonetheless, cycling in diesel fumes at concentrations typically present on busy roads causes significant damage to blood vessels,<sup>3</sup> and should be avoided if there is a choice.

This concept is no harder to understand than the concept that moderate intake of mono- and polyunsaturated fats is beneficial but excessive saturated fat intake is bad. Regrettably, this distinction was once considered so complicated that people were told simply to reduce all fat consumption.

Until people understand the hazards of air pollution, controls will remain inadequate. In Sydney, Melbourne, Brisbane and Perth, air pollution causes an estimated 1611 premature deaths every year, with more than 3000 estimated for Australia as a whole. The most serious health problems relate to fine particles (PM<sub>2.5</sub>), emitted predominantly by

diesel-powered vehicles and woodheaters.<sup>4</sup> Winter measurements in Liverpool, Sydney, follow a similar temporal distribution to those in Armidale, in regional New South Wales (Box), suggesting that both regional and metropolitan residents should jog at lunchtime in winter, rather than after work.

A recent review estimated that health costs of PM<sub>2.5</sub> emissions in urban Australia range from \$100 to \$300 per kilogram of particles. A typical woodheater (emitting 20 kg of these particles every winter) therefore generates \$2000–\$6000 in health costs — considerably more than switching to non-polluting heating.<sup>4</sup> Older (pre-1990) diesel cars and utilities emit about 0.75 g PM<sub>2.5</sub> particles per kilometre (13.8 kg per 20 000 km), generating estimated annual health costs of \$1380–\$4140. This exceeds the cost of converting to liquid petroleum gas or retrofitting a particle trap/oxidation catalyst.

When PM<sub>2.5</sub> pollution was reduced in Dublin by banning non-smokeless coal in 1990, there were 2154 fewer deaths in the first 6 years of the ban than the previous 6 years (15.5% fewer respiratory and 10.3% fewer cardiovascular deaths/year).<sup>1</sup>

Euro II emission limits for new diesel-powered vehicles became mandatory in 1996/97 in Europe (and in 2002/03 in Australia). Simple, cost-effective measures for reducing the major sources of urban PM<sub>2.5</sub> pollution — including converting or retrofitting diesel-powered vehicles that exceed Euro II limits, phasing out woodheaters and strongly discouraging stubble-burning in areas where it increases smoke

pollution in rural towns<sup>1</sup> — would significantly reduce pollution-related illness. It would also allow cyclists, pedestrians and joggers to exercise whenever desired, with fewer worries about air quality.

- 1 Rissel CE. Clinicians prescribing exercise: is air pollution a hazard [letter; with other letters by du Plessis and Sharman] *Med J Aust* 2005; 183: 334-336.
- 2 Andersen LB, Schnohr P, Schroll M, Hein HO. All-cause mortality associated with physical activity during leisure time, work, sports, and cycling to work. *Arch Intern Med* 2000; 160: 1621-1628.
- 3 Templeton S-K. Urban cyclists raise their risk of heart disease. *The Sunday Times* [London] 2005; 21 Aug. Available at: <http://www.timesonline.co.uk/article/0,,2087-1743309,00.html> (accessed Oct 2005).
- 4 Robinson DL. Air pollution in Australia: review of costs, sources and potential solutions. *Health Promot J Aust* 2005; 16: 213-220.
- 5 Clancy L, Goodman P, Sinclair H, Dockery DW. Effect of air-pollution control on death rates in Dublin, Ireland: an intervention study. *Lancet* 2002; 360: 1210-1214. □

## The price of health care for Medicare-ineligible asylum seekers in the community

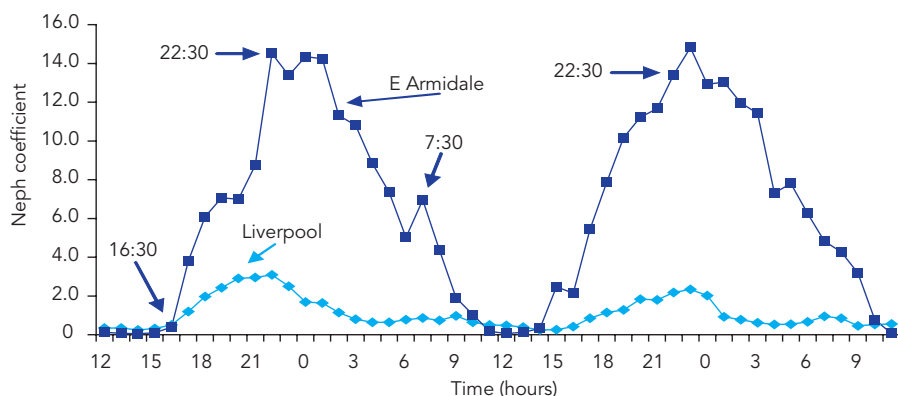
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**TO THE EDITOR:** Not all asylum seekers in Australia are confined to detention centres. Those who arrive with a valid visa live in the community. If they apply for refugee status within 45 days of arrival, they are entitled to work and to Medicare while their refugee claims are processed;<sup>1</sup> if they apply too late, they are denied these benefits. In New South Wales in 2003 about 1500 men, women and children were in this situation, which may last from 3 months to 3 years. Asylum seekers who appeal a refusal of their application, or are released from mandatory detention with an application outstanding, are in the same situation.<sup>2</sup> Some are eligible for the federally funded Red Cross Asylum Seeker Assistance Scheme, but, for most, access to health care is jeopardised because they are unable to pay full fees for medical services.<sup>3,4</sup>

We asked health professionals working with asylum seekers about the costs of asylum seekers' difficulties in accessing health care. Their responses, with illustrative quotes, are divided into "tangible costs" and "intangible costs" (Box).

Liverpool (Sydney) and East Armidale — hourly smoke pollution, 10–11 June 1997



Hourly concentrations of fine particle pollution (PM<sub>2.5</sub> measured by nephelometer scattering coefficient) in Armidale (regional NSW) and Liverpool (Sydney) on the first occasion (11 June 1997) that Sydney residents were asked to reduce pollution by not using woodheaters. (Data sources: Sydney, NSW EPA; East Armidale, Armidale Air Quality Group, with assistance from CSIRO Department of Atmospheric Resources.)

### Costs of asylum seekers' difficulties accessing health care and who bears the costs: responses of health professionals working with asylum seekers

Theme	Illustrative quote
<i>Tangible costs</i>	
Insufficient voluntary aid to address all health needs	"We have one patient ... with a urinary infection, and it was decided that ... he needed a TURP [transurethral resection of the prostate], and then they realised he didn't have any funds and they discharged him ..."
Inconsistent attitudes of hospitals	"There's quite a difference between different hospitals. For example, the X hospital at Y is very tough. ... much tougher than the hospital here, on refugees. ... They are different Area Health Services ... it may not even be the Area Health Service directors, but the hospital manager's idea that these people should pay."
More costs in the long term	"I have a lot of patients with diabetes and high blood pressure ... Now if their diabetes or their blood pressure or their cholesterol is not managed properly, then they get heart disease or strokes. So, I have a patient who has had a stroke ... high blood pressure and so on ... if he had [had] better access to health care, would he have had the stroke? ... So [now], the government has had to pay ... it doesn't make any sense really."
<i>Intangible costs</i>	
To the asylum seeker (recounted by a health professional)	"If you say to someone, I really think you need to have this test, but, if I refer you, you have to pay a lot of money, so I'm not going to refer you, how does that make you feel? It makes you feel worried and powerless."
To health professionals	"... if someone came in complaining about it [diarrhoea, losing weight], you would do a whole lot of checks, and with that particular lady ... we were able to negotiate to get a couple of tests done free, and the family and she paid a certain amount of money to get some others [done] ... if the person had Medicare, you'd take it that step further and do extra just to be 101% sure. So, there is that real ethical dilemma ..."
To the Australian society	"... if people actually knew on a face-to-face level ... what it meant to deny a newborn baby the right to health care, [or] ... turn away someone who is extremely depressed ... [Would they] actually be able to say 'No, they don't [have a right to health care]'." ◆

Some individuals and institutions sympathetic to the plight of asylum seekers give their professional time or donate money to pay for health care, but are not able to address the full range of health care needs. Obtaining access to secondary care, particularly admission to hospital, is very difficult. There is no uniform approach to charges, either between hospitals or within any one hospital on different occasions. The approach seems to depend on the decision-maker present.

Such difficulties in accessing care may lead to uncomplicated health problems developing into chronic and more serious ones. The attempt to save costs is likely to lead to higher costs in the future. The effect on asylum seekers is increased physical, psychological and social disadvantage and diminished opportunities for a healthy life.

Health professionals are faced with the dilemma of turning these people away, or aiding them without financial compensation. In either case, they cannot provide the necessary standard of care.

Although many Australians are conscious of the hardship of these people, the society as a whole seems unaware of it or of the impact that its unfairness may have on the social fabric of their communities.

If all Medicare-ineligible asylum seekers in NSW were to have the same access to health services as other Australians, we estimate that the total annual cost would be about \$3.4 million.<sup>5</sup> This is about 0.015% of the total annual recurrent health expenditure in NSW in 2000–01.<sup>6</sup> This economic cost, some if not most of which will be spent regardless, does not justify the disadvantage created by the Australian Government's immigration rules.

We suggest that state governments consider giving this small group of asylum seekers free access to public hospital services.

**Acknowledgements:** Thanks to Dr Glenn Salkeld, Associate Professor of Health Economics, School of Public Health, University of Sydney, for his help with calculating health care costs, and Dr Mitchell Smith and the nursing staff of the NSW Refugee Health Service for data collection and other information.

- Shields L, Stathis S, Mohay H, et al. The health of children in immigration detention: how does Australia compare? *Aust N Z J Public Health* 2004; 28: 513-519.
- Correa-Velez I, Gifford S, Bice S. Australian health policy on access to medical care for refugees and asylum seekers. *Aust N Z Health Policy* 2005; 2: 23. Available at: <http://www.anzhealthpolicy.com/content/2/1/23> (accessed Nov 2005).
- Sinnerbrink I, Silove D, Manicavasagar V, et al. Asylum seekers: general health status and problems with access to health care. *Med J Aust* 1996; 165: 634-637.
- Telfer B. Hostility and hospitality: a qualitative analysis of three, key perspectives on barriers to and opportunities for community based asylum seekers accessing health services in Australia, 2001-2003 [MPH treatise]. Sydney: University of New South Wales, 2003.
- Kardamanidis K. Tangible and intangible costs of the "No work – no Medicare" policy for community based asylum seekers in New South Wales, Australia [MPH thesis]. Sydney: University of Sydney, 2004.
- Australian Institute of Health and Welfare. Interactive expenditure data. Select State health expenditures, current and constant prices, 1996-97 to 2002-03. Available at: <http://www.aihw.gov.au/expenditure/datacubes/index.cfm> (accessed Dec 2005). □

### Hospital in the home: what next?

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**TO THE EDITOR:** British authors Wilson and Parker in their editorial on hospital in the home<sup>1</sup> acknowledge the outdated Cochrane review of 2001<sup>2</sup> in relation to costs of hospital in the home. More recent research in New South Wales provides compelling evidence of cost saving in excess of 50% when community costs are compared with inpatient costs for certain diagnosis related groups.<sup>3,4</sup> Patient selection for these services is based on safety, functional ability, carer support, and consent. The treatment regimens are based on evidence and governed by strict quality assurance. These elements form the foundations of successful acute and post-acute care programs.

Amendments to the *National Health Act 1953* (Cwlth) in 2001 endorsed the provision of acute care in places other than hospital beds.<sup>5</sup> The Macarthur Health Service in south-western Sydney received Commonwealth acute outreach accreditation in 2004 and currently supplies at least 13% of total bed-days in the specialties of medicine, surgery and paediatrics. An added benefit is

a system that allows people to choose a private outreach service instead of a hospital bed and have expenses covered by their health fund, which pays a bed-day rate for this care in the community.

Patient quality of care, choice and satisfaction have been the drivers for hospital in the home. Demonstrated savings for ambulatory sensitive diagnoses and the opportunity for revenue from private patients should be appealing to hospital administrators in an environment of chronic bed shortages.

1 Wilson AD, Parker SG. Hospital in the home: what next? *Med J Aust* 2005; 183: 228-229.

2 Shepperd S. Hospital at home versus in-patient hospital care. *Cochrane Database Syst Rev* 2001; (3): CD000356.

3 Board N, Brennan N, Caplan GA. A randomised controlled trial of the costs of hospital as compared with hospital in the home for acute medical patients *Aust N Z J Public Health* 2000; 24: 305-311.

4 Wilson SF, Shorten B, Marks R. Costing the ambulatory episode: implications of total or partial substitution of hospital care. *Aust Health Rev* 2005; 29: 360-365.

5 *Health Amendment Act (no.1) 2001*, pursuant to section 5D of the *National Health Act 1953*. □

**Editor's note:** The Cochrane review was updated after Wilson and Parker submitted their editorial: Shepperd S, Iliffe S. Hospital

at home versus in-patient hospital care. *Cochrane Database Syst Rev* 2005; (3): CD000356. Available at: <http://www.mrw.interscience.wiley.com/cochrane/clsysrev/articles/CD000356/frame.html> (accessed Dec 2005). □

## Safety of hospital in the home

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**TO THE EDITOR:** We note with interest the studies published in the Journal by Richards et al and Ong et al.<sup>1,2</sup> The authors conclude that treating pneumonia and pulmonary emboli in an ambulatory setting is safe for selected patients. However, this represents a large change in the conditions traditionally treated on this basis, from conditions that are associated with a very low mortality (such as cellulitis) to a subgroup of patients with potentially serious infections

that are identified as being of low risk. We feel that safety is of prime importance in hospital-in-the-home programs because of limited or delayed access to acute medical care, and that both studies were underpowered to define this endpoint.

Both studies incorrectly quote previous work that suggests that the groups they have identified have mortality rates of up to 5% (for pulmonary emboli) and up to 9.2% (for mild to moderate pneumonia). Published data suggest that the mortality of mild pneumonia (with CURB-65 scores  $\leq 2$ ) is in the range 1.7%–3%,<sup>3,4</sup> and that mortality from treated sub-massive pulmonary emboli is in the range 1.0%–1.3% within the first week.<sup>5</sup> These rates, although seemingly small, are still much higher than that associated with the treatment of soft tissue infections on ambulatory care programs. Recurrent pulmonary embolus, in particular, may be sudden and unexpected. Although admission to hospital may not necessarily prevent these deaths, the additional trauma of a death at home, particularly soon after transfer to ambulatory care, may carry a higher significance in the minds of patients, their families and the public than a death in hospital.

We acknowledge that benefits for patients in ambulatory treatment programs need to be balanced against potential adverse outcomes. However, if these conditions are to be treated where access to medical attention may be delayed, it is imperative that informed consent be obtained from patients (including an awareness of the possibility of death), a mechanism be available for patients to summon urgent attention at any time, and patients and health care providers be aware that readmission to the hospital may be necessary in the event of clinical deterioration.

- 1 Richards DA, Toop LJ, Epton MJ, et al. Home management of mild to moderately severe community-acquired pneumonia: a randomised controlled trial. *Med J Aust* 2005; 183: 235-238.
- 2 Ong B, Karr M, Chan D, et al. Management of pulmonary embolism in the home. *Med J Aust* 2005; 183: 239-242.
- 3 Lim WS, van der Eerden MM, Laing R, et al. Defining community acquired pneumonia severity on presentation to hospital: an international derivation and validation study. *Thorax* 2003; 58: 377-382.
- 4 Aujesky D, Auble TE, Yealy DM, et al. Prospective comparison of three validated prediction rules for prognosis in community-acquired pneumonia. *Am J Med* 2005; 118: 384-392.
- 5 Simonneau G, Sors H, Charbonnier B, et al. A comparison of low-molecular-weight heparin with unfractionated heparin for acute pulmonary embolism. *N Engl J Med* 1997; 337: 663-669. □

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**IN REPLY:** Thank you for the opportunity to reply to the letter from Cheng et al. The mortality figures we cited are correct.<sup>1</sup> The cited article by Lim et al supports our statement that “Patients with a CURB-65 score of 0–2 have a low mortality (0.7%–9.2%)” (Table 4 shows mortality for CURB-65 score 0 is 0.7% and for score 2 is 9.2%).<sup>2</sup> The 3% figure in the abstract is a summary measure obscuring the difference across the CURB 0–2 range — important information for anyone considering community management of community-acquired pneumonia

where, we agree, safety is paramount. The rate of 1.7% cited by Cheng et al is for a *modified* CURB-65 score, which adds a further point, and thus is for the equivalent of CURB-65 scores of < 1.<sup>3</sup>

Cheng et al correctly observe our study was not powered to detect mortality differences. As explained in our discussion, mortality was not a primary outcome measure. With low mortality, large numbers are required to detect a statistically significant difference — the base rate of 3% in the validation study would require 10 602 patients in a randomised controlled trial to detect a 33% relative (1% absolute) increase in mortality. The study did provide for informed consent (including the possibility of readmission) and the ability to summon urgent attention.

Careful patient selection, routine twice-daily nurse and daily doctor visits, along with a highly trained nurse available by telephone 24 hours a day who can dispatch a doctor or nurse immediately, provides a structure that should match hospital care. Careful patient monitoring will detect failure to respond as expected.

It is important to treat in hospital those who will benefit, but not feasible to admit all with potential mortality risk (nor is there evidence of benefit). Hospitalisation also has risks. With this tool for predicting accurately who will suffer worse outcomes, it could be argued there has to be good evidence that better outcomes will result from continuing inpatient treatment of mild to moderate community-acquired pneumonia.

These wider issues are worthy of debate. There is an assumption by some professionals and consumers that hospital-sanctioned death is more acceptable, that everything possible has been done, and that community-based death implies unsatisfactory management. As a counterpoint to this, there is a clear patient preference for treatment in the home where possible. Avian influenza may, of course, drastically redefine our expectations about locus of care and of death.

- 1 Richards DA, Toop LJ, Epton MJ, et al. Home management of mild to moderately severe community-acquired pneumonia: a randomised controlled trial. *Med J Aust* 2005; 183: 235-238.
- 2 Lim WS, van der Eerden MM, Laing R, et al. Defining community acquired pneumonia severity on presentation to hospital: an international derivation and validation study. *Thorax* 2003; 58: 377-382.
- 3 Aujesky D, Auble TE, Yealy DM, et al. Prospective comparison of three validated prediction rules for prognosis in community-acquired pneumonia. *Am J Med* 2005; 118: 384-392. □

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**IN REPLY:** We acknowledge the concerns of Cheng and colleagues regarding the safety of patients with pulmonary embolism (PE) treated in an ambulatory care setting. Caution is important as this is a relatively new area of treatment in ambulatory care compared with the management of deep venous thrombosis. The main objective of our study was to describe our experience in the management of PE in ambulatory care; it was not a randomised controlled study to conclusively define safety as such.

As stated in our paper, there have been reports of the management of PE in the ambulatory care setting.<sup>1,2</sup> We now know that more than 90% of patients with sub-massive PE will have a good response to treatment. The challenge is to accurately define this group. The mortality rate we quoted of less than 5% was derived from a review article on prognosis of patients with PE.<sup>3</sup> This article quoted three studies on sub-massive PE, one of which was referenced by Cheng and colleagues in their letter.<sup>4</sup> We note also that the specific study that was referenced<sup>4</sup> included patients with cyanosis and shock; these patients would have been excluded by our selection criteria.

We do not advocate management of all patients with sub-massive PE in the ambulatory care setting. It is also important to be conservative initially in the selection of these patients. There have been various studies examining prognostic indicators for PE, which we have referenced in our paper. There is evidence now that, for patients with specific prognostic indicators, the risk of death and adverse outcomes is significant and such patients should always be admitted.

The practice of managing patients with sub-massive PE should only occur in ambulatory care units which are appropriately resourced, have strict admission criteria and well defined protocols and specialist medical input, consistent with the recommendation of the British Thoracic Society.<sup>5</sup> In the meantime, further studies are required before this becomes standard practice in ambulatory care or hospital-in-the-home units.

- 1 Wells PS, Kovacs MJ, Bormanis J, et al. Expanding eligibility for outpatient treatment of deep venous thrombosis and pulmonary embolism with low molecular weight heparin. *Arch Intern Med* 1998; 158: 1809-1812.
- 2 Kovacs MJ, Anderson D, Morrow B, et al. Outpatient treatment of pulmonary embolism with Dalteparin. *Thromb Haemost* 2000; 83: 209-211.
- 3 Douketis JD. Prognosis in pulmonary embolism. *Curr Opin Pulm Med* 2001; 7: 354-359.
- 4 Simonneau G, Sors H, Charbonnier B, et al. A comparison of low-molecular-weight heparin with unfractionated heparin for acute pulmonary embolism. *N Engl J Med* 1997; 337: 663-669.
- 5 British Thoracic Society Standards of Care Committee Pulmonary Embolism Guideline Development Group. British Thoracic Society guidelines for the management of suspected acute pulmonary embolism. *Thorax* 2003; 58: 470-483. □

## Digesting the health sandwich

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**TO THE EDITOR:** Corbett's recent proposal to create a "Ministry for the Public's Health"<sup>1</sup> has merit. However, this Ministry may not achieve its intended purpose in relation to disadvantaged people, chronic and complex health care, or the mental health problems confronting acute services in today's urban communities.

The current situation may be the result of long neglect of population health. However, a new Ministry runs the risk of becoming yet another compartment within an existing non-integrated health care system. The efficiencies of an integrated service for acute health care of older people are well known.<sup>2</sup> This integration requires a reinvestment in community care and changes in roles and relationships of health workers.

There is currently a gap between services maintained by state funding for acute care in and around hospitals, and services which are federally funded for the community sector via general practice, preventive and maintenance services. The gap created between these two workforces results in suboptimal "management" of chronic and

complex disease and mental health, and care of disadvantaged groups. The lack of a strong focus on management drives patients to rely on the acute health care system, particularly emergency departments. This situation is aggravated by the poor coordination with general practice, non-government organisations and community services. The current challenge is to develop a health environment which simultaneously addresses the present and future needs for prevention, management and response.

Another approach is to construct a health "sandwich", with a foundation layer of population health, a "filling" of illness management services, and a top layer of acute response and hospital services. A model guided by the mission of St Vincent's Hospital, and implemented in 2005, has created a partnership for emergency department, community health, aged care, rehabilitation and palliative care within an administrative division called Population Health. A Psychiatric Emergency Care Centre within the emergency department has established a shared approach to acute patient care along with the mental health services. In the future, a patient entering the emergency department for an acute response to physical, mental or combined illness should also be "consuming" a health program of management and disease prevention, which is lacking in current health service provision. This healthy sandwich may prove easier to digest than the dry biscuits of policy.

- 1 Corbett SJ. A Ministry for the Public's Health: an imperative for disease prevention in the 21st century? *Med J Aust* 2005; 183: 254-257.
- 2 Ham C, York N, Sutch S, Shaw R. Hospital bed utilisation in the NHS, Kaiser Permanente, and the US Medicare programme: analysis of routine data. *BMJ* 2003; 327: 1257. □

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