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

To the Editor: Toubourou 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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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, 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

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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, they remain elusive and are actively resisted by industry groups.

There is widespread ignorance of the current Australian guidelines to reduce health risks from drinking alcohol 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. 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 potentially injurious to their health.

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. 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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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. 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 Health, need to be firmly entrenched in policy and practice.

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Health, 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.

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. 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.

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 preseasional viruses, even in contexts of low seasonal influenza activity.
- Cases of Neisseria meningitides type b and leptospirosis occurring during
sporting events have been documented, the latter associated with heavy rains. • 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. 
• 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. • 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.

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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Acknowledgements: The impact assessment was funded by the Gold Coast City Council but was undertaken independently. The views expressed are mine, and this letter is based on, but independent of, the impact assessment. Alison Ziller provided valuable feedback on early drafts.

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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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 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. 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 just 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 on an generalism — is translating to an average of 43% of our graduates choosing internships in rural settings, and 61% choosing internships outside of metropolitan areas.

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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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 sub-specialties (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 under-representation 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, 36244 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).

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.

Slape et al

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<tr>
<th>Demographic details of Indigenous and non-Indigenous survey participants in the Medical Schools Outcomes Database and Longitudinal Tracking project, 2005–2012</th>
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<td>Demographic characteristics</td>
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<td>Identify as being from a rural background</td>
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<td>First preference to pursue general practice</td>
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*P < 0.05 for comparison with non-Indigenous participants.
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No relevant disclosures.

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Competing interests: No relevant disclosures.

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Newborn bloodspot screening: setting the Australian national policy agenda

TO THE EDITOR: Maxwell and O’Leary’s article1 and Wiltshire and Cameron’s letter2 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.

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