



PoCT – around and around we go

BY DR BRIAN MORTON

The *Medical Journal of Australia*/Wyeth Australia award was recently awarded to the team of researchers from Flinders University who examined the cost effectiveness of point-of-care testing (PoCT) for therapeutic control of chronic conditions.

The trial that they conducted between September 2005 and February 2007 is believed to be the first randomised controlled trial to investigate PoCT in general practice using non-inferiority tests. The results provide evidence that for all tests, except INR and HDL cholesterol, there was a same or better therapeutic control than with traditional pathology testing. The conclusion – PoCT can enhance good management of chronic disease.

This study was part of the Point of Care Testing in General Practice Trial.

After the eventual release of the final report of the trial, the Department of Health and Ageing set up the PoCT Review Group to provide the Department with commentary on the results published in the final report of the trial. As part of its work, the review group is looking at what scope there is to reduce the costs of the quality and safety framework without compromising quality and safety. It is also looking at which tests will offer the greatest potential clinical benefit if they are to be made available at the point of care.

The work of this group, of which the AMA is a member, is progressing, albeit slowly.

We know from the trial that PoCT was beneficial to patients in terms of medical compliance, and that there were high satisfaction levels with PoCT among GPs and patients. What is difficult to understand is why, when the Government says it is supportive of comprehensive primary health care and preventive medicine, that PoCT hasn't been introduced under a Ministerial Determination for a three-year period to determine whether the benefits offset or outweigh any additional cost to Medicare.

In support of medical practitioners and the work they do in managing their patients with chronic disease, the AMA introduced PoCT items for tests provided at the time of consultation in its 1 July 2010 update to the AMA List of Medical Services and Fees. The tests provided for cover:

- INR
- cholesterol, triglyceride, glucose or lactate
- HbA_{1c}, urine albumin or albumin creatinine ratio, and
- troponin

To help stop the Government's PoCT merry-go-round, I am keen to hear from those GPs who regularly use PoCT in their practices. Email me at generalpractice@ama.com.au and tell me your views on whether PoCT helps you provide better patient management, reduces hospitalisations, and if you believe MBS PoCT items would be a worthwhile investment for the Government in terms of preventive health and chronic disease management. ☎



REDRESSING THE DAILY GRIND OF RURAL HEALTH

BY DR DAVID RIVETT

I am writing this having just completed a busy 12-hour shift in A&E, where several perennial matters, which need redressing, have come to my attention.

First, finding beds for patients needing tertiary care remains a lottery, and is wasteful of time and energy. Today was a day where multiple serious fractures presented, and the receiving orthopaedic surgeons/surgical registrars contacted were all delighted and enthusiastic to help if their tertiary hospitals could provide a bed. Then the fun started; the end result was four out of four major fractures requiring surgery being admitted overnight to a small rural hospital on the promise that the tertiary centre's clerical admitting officers would ring back the next day if a bed was available to enable a transfer.

This fails the basic decency test, which we all apply: "Would I be happy for a loved one of mine to receive such a standard of care?"

So how does the problem get addressed? Very obviously it means more hospital beds so that there is reserve capacity in the system. The current situation of running at close to full bed occupancy must be ended, and the AMA's target for all hospitals to be run at no more than 85% occupancy embraced.

A second very ordinary problem was long delays in patients arriving at hospital after injuries due to an overstretched ambulance service. This could be addressed in several ways; more ambulance officers and vehicles, or rather more radically, either a return to a volunteer ambulance service to back up the inadequate State service, or a utilisation of taxis, in particular wheelchair-friendly maxi-cabs. Such suggestions will provoke screams from unions representing ambulance officers but I think would be accepted by most fair-minded citizens.

A third longstanding problem needing redress is the lack of accommodation provision by tertiary centres for significant family members or spouses accompanying partners/children/parents etc. Parents of children, in particular, those undergoing long city hospitalisations for surgery or chemotherapy, are distressed enough by the plight of their child. They do not need the added crippling burden of accommodation and transport costs. Neither do our Indigenous brothers and sisters who have very firm family bonds.

Provision of such accommodation should be a basic right for those who need it and need not cost a fortune. It should not be left to a Ronald McDonald House alone to try and meet the needs, even though any such charity should be warmly welcomed.

Will the reform program of the current Government address these basic issues?

Personally, I very much doubt it as the proposed changes to hospital care provision are bottom-lined as cost neutral, and the NHHRC basically ignored rural pleas for assistance in the formulation of its grand plans presented to Government. ☎