Australian General Practice Network

Lifescripts Newsletter

• Number 11 • **March 2007**

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Update from AGPN's Lifescripts Coordinator

I am happy to advise everyone that there have been some very exciting developments in the world of Lifescripts over that past two months.

The Department of Health and Ageing is currently calling for Expressions of Interest (EOIs) from Divisions of General Practice to participate in the Lifescripts Demonstration Divisions project.

Successful Divisions will be funded to implement strategies with selected practices which assist them to incorporate Lifescripts and related lifestyle risk factor management into their activities. Demonstration Divisions will be required to collate, disseminate and share learnings/experiences through participation in an ongoing national review of project activities.

Please see the 'Focus on' section of the newsletter for more detailed information on the Demonstration Divisions project and the EOI process.

Further to this exciting development, a number of other activities have been continuing in this time. Each SBO is in the process of disseminating the Information Gathering Tool to Divisions in their state/territory. The purpose of this tool is to capture a clear picture of the Lifescripts activity that is being undertaken at the Division level, and also to determine effective and successful dissemination and utilisation strategies. I look forward to again receiving feedback from the large number of Divisions so as a true national picture can be developed.

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The successful bid for the adaptation of Lifescripts for Indigenous people has been announced. The Mt Isa Centre for Rural and Remote Health at James Cook University will be working to adapt the following elements of the Lifescripts Resource Kit:

- Lifestyle Prescriptions: prescriptions to assist health professionals to provide tailored lifestyle advice to patients (5 kinds – smoking, nutrition, alcohol, physical activity and weight management). Two new versions of each lifestyle prescription (10 new prescriptions in total) will be developed:
    - One version will be appropriate for use with Indigenous patients with low level English literacy skills and will include culturally relevant visual prompts and images and minimal words.
    - One version will be appropriate for use with Indigenous patients with good English literacy skills and will include culturally relevant messages, wording and images.
- 5As Guideline Cards**:** cards which outline the 5As (ask, assess, advise, assist, arrange) approach and provide health professionals with clear steps to assist patients change lifestyle-related behaviour (5 kinds – smoking, nutrition, alcohol, physical activity and weight management).

AGPN would like to congratulate John Cook University on their successful bid, and looks forward to the availability of these resources.

Currently, the Population Health Information Development Unit is updating population health profiles for each Division of General Practice catchment area. These profiles have been designed to provide a description of the population of each Division of General Practice, and aspects of their health. Its purpose is to provide information to support a population health approach, which aims to improve the health of the entire population and to reduce health inequalities among population groups.

Each Division of General Practice received an initial population health profile at the 2005 ADGP National Forum. An updated profile will be made available to all Divisions in late March, early April 2007. This updated profile will include new data on the number of people in the population between the ages of 45 and 49 years. This data combined with Medicare data on Item 717 – 45 year health check claiming within each Division catchment (available on the Medicare Australia web site), will allow Divisions to determine the percentage of the eligible population within their catchment that have received a '45 year health check'. I do hope Divisions find this additional data useful in supporting their local population health activity.

Please see below for further information on the 'Demonstration Divisions' project.

Happy reading!
Aimee Black
Lifescripts Coordinator, AGPN.

Focus on: Lifescripts Demonstration Divisions

From the 1st of July 2007, a new phase of Lifescripts implementation will begin. The pervious funding model (via AGPN and SBOs) will cease, and between 8 and 12 'Demonstration Division' sites will be funded. These Divisions will work intensively with practices, and the (division and practice) strategies used to support lifestyle risk factor management activity will be reviewed.

Rationale

Since June 2005, the Department of Health and Ageing has supported the roll out of the Lifescripts resources to general practice by funding the AGPN-SBO network to assist interested Divisions integrate Lifescripts into existing Divisional program activity. This funding model provided for initial education and training for Division staff, ongoing networking, and the development of tools to assist the integration of Lifescripts into core division business.

However, under this model it has been difficult to determine the level of Lifescripts resource utilisation and further supports required to increase uptake at the practice level. The Department has indicated that determining these through review of practice and division activity will be undertaken to inform future roll out of the Australian Better Health Initiative (ABHI).

Lifescripts Demonstration Divisions Project

The Department is seeking to directly engage 8-12 Divisions in the implementation of locally designed practice based solutions to lifestyle change. National coordination and engagement of an external consultant to carry out project review will be undertaken by AGPN. Partnerships between Divisions and SBOs (or other relevant local partners) to undertake this project are permitted.

Participating Divisions will be selected through an Expression of Interest (EOI) process. It is anticipated that Divisions in a range of settings (e.g. rural, remote, metro and outer metro) and with varying practice settings (e.g. solo, large multidisciplinary etc) and from a number of states and territories will be selected, based on best value for money and ability to deliver on EOI selection criteria.

The review and dissemination of this work to other Divisions in the network, related health care professionals and their peak organisations will ensure the learnings, strategies and experiences of the Demonstration Divisions are utilised in future Lifescripts and lifestyle risk factor related interventions. The review of the project will identify:

- effective and sustainable strategies utilised by divisions
- effective and sustainable strategies utilised by practices.

Benefits of this approach

The Australian Better Health Initiative, announced by the Coalition of Australian Governments in February 2006, will provide a number of opportunities for the network in the area of lifestyle risk factor management.

The work of Divisions clearly aligns with ABHI priorities in areas such as chronic disease management, nursing in general practice, supporting multidisciplinary care and lifestyle risk factor management (including Lifescripts). With this in mind, the Department and AGPN see that the results from the Demonstration Divisions project will provide a clear picture of effective strategies and models (at both Division and practice level) for effective lifestyle risk factor management that could inform the ABHI roll out.

Drawbacks

The limitations of the Lifescripts Demonstration Divisions project include:

- the small number of 'Demonstration Divisions' (between 8 and 12) that will be funded
- the reduced capacity at SBO level to liaise with relevant state health and community organisations and to provide Lifescripts related support to Divisions.

Recent feedback provided by AGPN and the SBO network to the Department outlined these limitations, and recommended appropriate funding to all 3 tiers of the network for comprehensive and effective implementation.

However AGPN recognises that in light of the available funding, the Demonstrations Divisions project is the most pragmatic way forward for the future of Lifescripts and lifestyle risk factor management. We acknowledge that there are some short term limitations to this model; however national coordination for the program will help provide consistency and support to the network. Most importantly, this model will assist us to position the network for the future opportunities expected under ABHI.

Further information about the Demonstration Divisions Expression of Interest process, including the following documents to inform and support Divisions and SBOs in the preparation of their applications is available at: http://www.adgp.com.au/site/index.cfm?display=24306

1. Deaprtmental cover letter
2. Expression of Interest package
3. EOI attachments

If you require further information about the Demonstration Divisions project or Lifescripts, please do not hesitate to contact Aimee Black on 02 6228 0829 or via ablack@agpn.com.au.

Articles of interest:

Updated AHA guidelines focus on women's lifetime risk

The American Heart Association's (AHA) updated prevention guidelines for women emphasise the lifetime risk of women.

Published in a special women's health issue of Circulation, the 2007 Guidelines for Preventing Cardiovascular Disease in Women provides the most current clinical recommendations for preventing CVD in women 20 and older and are based on a systematic search of the highest quality science interpreted by experts in the fields of cardiology, epidemiology, family medicine, gynecology, internal medicine, neurology, nursing, public health, statistics and surgery.

"The updated guidelines emphasize the lifetime risk of women, not just the more short-term focus of the 2004 guidelines," said Lori Mosca, chair of the AHA expert panel that wrote the guidelines. "We took a long-term view of heart disease prevention because the lifetime risk of dying of cardiovascular disease (CVD) is nearly one in three for women. This underscores the importance of healthy lifestyles in women of all ages to reduce the long-term risk of heart and blood vessel diseases."

The guidelines include new directions for using aspirin, hormone therapy and vitamin and mineral supplements in heart disease and stroke prevention in women.

"Since the last guidelines were developed, more definitive clinical trials became available to suggest that health care providers should consider aspirin in women to prevent stroke," Mosca said. "In addition, providers should not use menopausal therapies such as hormone replacement therapy (HRT) or selective estrogen receptor modulators (SERMs) such as raloxifene or tamoxifene to prevent heart disease because they have been shown to be ineffective in protecting the heart and may increase the risk of stroke."

The guidelines include a new paradigm for risk assessment based on risk factors and family history, as well as the Framingham risk score. They also include expanded recommendations on lifestyle factors such as physical activity, nutrition and smoking cessation, as well as more in-depth recommendations on drug treatments for blood pressure and cholesterol control.

Highlights of the updated guidelines include:

- Recommended lifestyle changes to help manage blood pressure include weight control, increased physical activity, alcohol moderation, sodium restriction, and an emphasis on eating fresh fruits, vegetables and low-fat dairy products.
- Besides advising women to quit smoking, the 2007 guidelines recommend counselling, nicotine replacement or other forms of smoking cessation therapy.
- Physical activity recommendations for women who need to lose weight or sustain weight loss have been added - minimum of 60--90 minutes of moderate-intensity activity (e.g., brisk walking) on most, and preferably all, days of the week.

- The guidelines now encourage all women to reduce saturated fats intake to less than 7 percent of calories if possible.
- Specific guidance on omega-3 fatty acid intake and supplementation recommends eating oily fish at least twice a week, and consider taking a capsule supplement of 850-1000 mg of EPA (eicosapentaenoic acid) and DHA (docosahexaenoic acid) in women with heart disease, two to four grams for women with high triglycerides.
- Hormone replacement therapy and selective estrogen receptor modulators (SERMs) are not recommended to prevent heart disease in women.
- Antioxidant supplements (such as vitamin E, C and beta-carotene) should not be used for primary or secondary prevention of CVD.
- Folic acid should not be used to prevent CVD - a change from the 2004 guidelines that did recommend it be considered for use in certain high-risk women.
- Routine low dose aspirin therapy may be considered in women age 65 or older regardless of CVD risk status, if benefits are likely to outweigh other risks. (Previous guidelines did not recommend aspirin in lower risk or healthy women.)
- The upper dosage of aspirin for high-risk women increases to 325 mg per day rather than 162 mg. This brings the women's guidelines up to date with other recently published guidelines.
- Consider reducing LDL cholesterol to less than 70 mg/dL in very high-risk women with heart disease (which may require a combination of cholesterol-lowering drugs).

Reference
Mosca, L. et al. 2007, 'Evidence-based guidelines for cardiovascular disease prevention in women: 2007 update' Circulation doi:10.1161/CIRCULATIONAHA.107.181546

First, don't get sick

Author: John Breusch
Publication: Australian Financial Review (25,Sat 03 Mar 2007)

The latest buzzword in health care is "prevention", not least because treating avoidable conditions costs lots of money.

It seems pretty obvious: preventing disease is preferable to treating it. Yet this simple idea has not been the driver of health policy in Australia. In fact, the reverse has been true.

But the traditional approach may be about to change and Sydney University's Australian Health Policy Institute director Stephen Leeder has a theory to explain why everyone in the health sector is suddenly talking about prevention.

"I'd have to say a lot of it is driven by the fact that our kids are fat," he says.

More than ever, the new buzz is not about what happens in hospitals but what can be done to keep people out of them.

The issue is shaping as perhaps the central plank of Labor's health policy as it heads into the federal election. Tapping into the current zeitgeist, Labor health spokeswoman Nicola Roxon claimed recently that ignoring the need to act now on preventable illness was "the health equivalent of ignoring climate change".

But it's not just the hordes of overweight children causing alarm, there's also the not so small matter of cost - $21 billion. This was the figure cited in a report released in October by Access Economics: the annual cost of 3.2 million obese Australians (in 2005).

The reason? Obesity leads to a range of diseases, such as type 2 diabetes, coronary heart disease, arthritis and various cancers. Not only do these conditions drive up health costs, they also mean work time lost.

"Hours are diverted from unpaid [work] - such as providing child care, housework, yard work, shopping and so on - and these activities must be undertaken by someone else or their value lost," Access warned. "If the condition is terminal, then the labour pool is reduced, decreasing the capacity of the economy."

As many of these conditions can be avoided, it is obvious that a prevention strategy merits attention. Keeping people out of hospital is in everyone's interest: the patients, private health funds and government beancounters.

Canberra isn't ignoring the problem. Under landmark reforms due to come into force next month, private health insurers will be able to fund chronic disease management programs that take place outside hospital walls.

Melbourne-based Australian Unity is starting a program in which people who have already been to hospital for heart conditions are routinely telephoned by nutritionists who "coach" them on ways to improve their lifestyle and pay greater attention to serious risk factors.

Medibank Private plans to expand a similar scheme for diabetes sufferers which, when trialled in 2004, cut hospital admissions by 16 per cent and the fund's payouts by 8 per cent.

And in a sign of his sensitivity on the issue, federal Health Minister Tony Abbott last Monday lined up a Dorothy Dixer during parliamentary question time to boast of his government's commitment to preventing disease.

Last year, some 650,000 people with chronic illness were placed in general practitioner care plans and a further 250,000 were put on team care plans - where a GP co-ordinates other health professionals, such as nutritionists and physiotherapists.

"What this means is that the government directed nearly $200 million in Medicare funding towards preventative health and chronic disease," Abbott declared.

But is $200 million enough? In a federal health budget worth about $40 billion a year, Roxon certainly doesn't think so. "That is less than 1 per cent of the money obesity cost Australia last year," she says. "It is half a per cent of the commonwealth health budget."

Paul Gross, director of the Institute of Health Economics and Technology Assessment, describes the current level of spending on prevention as "totally inadequate".

But what would it mean in practice to reorient the health system towards prevention?

Gross, who was commissioner of national hospitals and health services under the Whitlam and Fraser governments, says the first step is for governments to nominate the diseases considered "preventable" and set targets to tackle them. It would then be a matter of encouraging GPs to

focus on prevention - including through financial incentives - and blitzing the public with awareness campaigns.

Gross says even if the government only doubled the amount it now spends on prevention, the benefits would be significant. For instance, he says, if the government were serious about tackling chlamydia it would create a Medicare item to pay GPs to advise and test women who are still at a sexually active age.

"Because that's when the disorder occurs," Gross explains.

It could extend to ailments such as hearing loss. Three in four Australians over 65 have a hearing disorder that leaves them socially impaired. Yet less than a quarter of younger people with hearing loss have any form of hearing aid.

"The consequences of that are that 1 to 2 per cent of [gross domestic product] is going out on all the conditions that are related to poor hearing, like depression, mental disorder, accidents, falls," Gross says. "The individual drops out of social networks and becomes, not moribund, but certainly socially estranged."

Leeder points out that GPs should be only the secondary line of attack. For instance, in the case of obesity, primary prevention would include education, urban planning and food policy.

The long-running campaign to cut tobacco use provides perhaps the best example, with marketing about the dangers of smoking, GPs providing advice on quitting and dispensing nicotine patches, and governments prepared to ban cigarette ads and raise taxes on tobacco. That said, cigarette smoking is relatively easy; despite tobacco companies' best efforts, the link between smoking and cancer isn't under question.

But as Leeder points out: "When you come to food, where just about all of us eat too much, it's a much trickier thing because there's no one food item that you can target, there's no one food company that's responsible for that, there's no one reason why we all get to be overweight."

And there are conditions that aren't so easy to target.

"**Mental illness** is a very big problem, but I'm not sure anybody's got the handle on how to prevent it other than through programs designed to stop young people using drugs and things like that."

As much as responsibility for prevention largely falls on the commonwealth, the issue is not immune to the federal-state bickering that persistently hinders reform of the health system.

Last month, Abbott proposed that instead of handing the states $10 billion each year to help them run public hospitals, the commonwealth might use Medicare to pay for hospital services, treatment by treatment. His aim: to give a clearer picture of what commonwealth money is actually being used for.

But Victorian Health Minister Bronwyn Pike says this misses the point. The whole idea should be to keep people out of hospitals.

So if anyone needs to be more transparent, it's the commonwealth, which runs the GP network. "Most of the preventative agenda happens at the primary care end," Pike argues.

The cost of measuring insulin levels can be justified

Allen E Gale.
Med J Aust 2007; 186 (5): 270-271.
http://www.mja.com.au/public/issues/186_05_050307/matters_arising_050307_fm-7.html

To the Editor: Samaras et al state that individuals at risk of diabetes and atherosclerotic cardiac disease can be identified simply and inexpensively by history-taking, physical examination, and very basic investigations. However, insulin resistance and beta cell failure are the hidden causes, and predate the development of overt diabetes by more than a decade. Doctors should help patients to understand that the progression of these conditions can be halted by significant changes to lifestyle. These will reduce the need for expensive medications, and in some cases even obviate their use.

As most obese individuals have battled unsuccessfully to lose weight, and non-obese individuals may also be insulin resistant, an assessment of glucose and insulin responses in an oral glucose tolerance test should assist the physician in developing a treatment plan. Unfortunately, few clinicians take the time to explain the difficult concept of insulin resistance.

Until the recent Enhanced Primary Care program, few individuals were able to afford the advice of dietitians or an exercise physiologist. Most clinicians have given up attempts to motivate patients to exercise regularly and lose weight, and many take the easy course of prescribing medications. Although Reaven first described insulin resistance as the basic pathophysiology of type 2 diabetes in 1988, it is only since the advent of the glitazones that clinicians have embraced the concept. Furthermore, not one person with type 2 diabetes that I have encountered has heard of the term insulin resistance. An explanation of insulin resistance assumes new meaning when illustrated with a patient's own glucose and insulin responses after a glucose drink or their usual breakfast.

The medical profession is constantly under scrutiny to make effective use of the health dollar. The cost of measuring insulin levels can be justified if this leads to better clinical practice, patient compliance with lifestyle changes, and reduced prescribing.

Prescribing of metformin or other drugs and supplements should not be a first priority in controlling insulin resistance. Initial attempts should be directed at changes to diet, exercise and weight, with particular attention to loss of abdominal adiposity.

Media:

"State And Territory Health Priorities Welcomed"

Media Release, 15/02/2007 - Australian General Practice Network (AGPN)

Health reform principles decided upon at the meeting of the Council for the Australian Federation attended by all state and territory government premiers and chief ministers have been applauded by Australia's peak body representing119 divisions of general practice, the Australian General Practice Network (AGPN). The principles demonstrate the Council's recognition of the importance of a holistic approach to improve primary health care in Australia, aiming to keep people healthy and out of stretched hospital systems. AGPN Chair Dr Tony Hobbs said the principles clearly recognise the current system is unsustainable with a new approach needed that will keep people out of the hospital system. 84% of Australians visit a GP each year. Allocating more resources to primary health for further prevention and early intervention of chronic disease, Dr Hobbs said.
http://www.aushealthcare.com.au/news/news_details.asp?nid=8453

"Health check item worthwhile"

Medical observer, 16/02/2007 - Nicole Vanderkroef

THE popularity of the 45 year old health check item has prompted medical groups to call for it to be opened up to a wider range of patients. Medicare Australia figures revealed 19,198 claims worth $1.9 million were made during November and December for item 717, following its inclusion in the November MBS. The item was introduced to cover a range of tests and checks focused on the detection and prevention of chronic disease in people aged between 45 and 49. Both the AMA and RACGP said the positive uptake showed how useful the item was to GPs and called for the criteria to be broadened. NSW GP Dr Katherine Smartt said the item provided a starting point for her Potts Point practice to encourage more patients to go in for important tests, but it only rewarded doctors for the work they were already doing.
http://www.medicalobserver.com.au/displayarticle/index.asp?articleID=7425&templateID=105&sectionID=1&section

Government's message on the dangers of cannabis hit home

A new report showing that young Australians no longer considered cannabis to be a harmless drug is a testament to the impact the Howard Government's Tough on Drugs campaign is having, the Assistant Minister for Health and Ageing, Christopher Pyne, said today.
To view the full media release, click on the link below:
http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr07-cp-pyn012.htm

Major children's nutrition and activity survey starts

Thousands of children across Australia will soon be involved in a major nutrition and physical activity survey.
To view the full media release, click on the link below:
http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr07-cp-pyn013.htm

Look, see, quit: new images to shock smokers

Graphic images on cigarette packets, similar to those introduced in Australia last March, have been found in a recently-published international study to be the most effective way to get across to smokers the range and severity of the health risks they face.

To view the full media release, click on the link below:
http://www.health.gov.au/internet/ministers/publishing.nsf/Content/mr-yr07-cp-pyn016.htm

"Wholegrain cereal breakfast a big boost to the heart"

There is more good reason to fill that breakfast bowl in the morning, with research showing people who eat wholegrain cereal every day are 28 per cent less likely to develop heart failure than those who skip a healthy breakfast. A study by Brigham and Women's Hospital and Harvard Medical School in Boston found even people who have wholegrain cereal less often are doing their hearts a favour, with one bowl a week reducing their risk of heart failure 14 per cent. Chief researcher Luc Djousse, who analysed data from the Physicians' Health Study of more than 10,000 American doctors, said breakfast cereals containing at least 25 per cent oat or bran were considered wholegrain for the purposes of the study. A third of the doctors surveyed said they ate this type of cereal every day.
http://www.thewest.com.au/default.aspx?MenuID=27&ContentID=22837

"Big fat tick for Maccas"

The Australian, 7/03/2007 - Peter Wilson

WHEN David Hambre and Elham Mohammed-Nur look at a Big Mac, they don't see a high-calorie hunk of fast food. Instead, in among the beef patties, special sauce and sesame seed buns, these Swedish university students see their own selfless contribution to medical science. In the name of health research, they have taken part in an unusual experiment aimed at replicating under laboratory conditions the junk-food-only diet that American filmmaker Morgan Spurlock lived on for a month to make his 2004 documentary Super Size Me. In his high-profile film, Spurlock quickly became fat, unhappy and unhealthy on his McDonald's-only diet, causing a near-crisis for the fast food chain. The wave of bad publicity generated by Spurlock's experience was one of the main factors that pushed McDonald's to adopt healthier menus across the world, with an emphasis on salads and lower-fat fare.
http://www.theaustralian.news.com.au/story/0,20867,21337014-23289,00.html

Ban junk food ads to stop childhood obesity, health expert says

An expert in population health has told a conference in Adelaide that a ban on junk food advertising on television is the most effective way to tackle childhood obesity. Government, business and community representatives have held a Healthy Weight Summit this afternoon. Professor Boyd Swinburn from Deakin University says the Government's current approach of individual responsibility is failing to stem the rise in obesity. He says a ban on advertising should be "centre stage" in a national policy. "It's one of the biggest problems that's undermining the health messages around healthy eating," he said. "From the work done in Victoria on modelling what the biggest impact of interventions might be, having a ban on junk food advertising on television turned out to be by far and away the most effective and most cost effective."
"The Federal Government has an individual responsibility, 'pull up your socks' type of approach to this, which I don't think is going to get us any more than what we've got at the moment, which is escalating obesity. "I think to really get a proper response there needs to be dollars on the table, there needs to be policies and there needs to be leadership."

Diary Dates

April 2007

Month of April: The Great Australian Bite; Diabetes Australia, www.greataustralianbite.com.au

01 – 07 April: Arthritis Awareness Week - Arthritis Australia, www.arthritisaustralia.com.au

06 April: Easter Friday

07 April: World Health Day; World Health Organisation, www.who.int

9 April: Easter Monday

14 – 22 April: National Youth Week; www.youthweek.nsw.gov.au

25 April: Anzac Day

29 April: Walk Against Want; Oxfam Australia, www.oxfam.org.au

29 April – 05 May: Heart Week; Heart Foundation, www.heartfoundation.com.au

May 2007

01 May: World Asthma Day; Asthma Foundation Australia, www.asthmaaustralia.org.au

04 May: Star Day; Starlight Children's Foundation Australia, www.starlight.org.au

04 May: Walk Safely to School Day; Pedestrian Council, www.walk.com.au

06 – 12 May: Food Allergy Awareness Week; Anaphylaxis Australia Inc, www.allergyfacts.org.au

12 May: International Nurses Day; Royal College of Nurses Australia, www.rcna.org.au

13 – 19 May: Epilepsy Awareness Week; Epilepsy Australia, www.epilepsyaustralia.org.au

14 – 20 May: National Volunteers Week; Volunteering Australia, www.volunteeringaustralia.org

24 May: Australia's Biggest Morning Tea; The Cancer Council Australia, www.biggestmorningtea.com.au

31 May: World No Tobacco Day; United Nations, www.un.org

Contact the editor:

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