



Secondhand Smoke in Cafés, Pubs and Cars

Julia Stafford, WA Tobacco Document Searching Program, Curtin University of Technology.

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In 2009, the WA Parliament will consider amendments to the Tobacco Products Control Act 2006. The proposed amendments would ensure:

- Smoke-free *al fresco* eating and drinking areas;
- Smoke-free cars carrying children;
- Smoke-free areas around children's playgrounds and on patrolled public beaches; and
- Removal of retail displays of tobacco products.

As part of an advocacy campaign to support the amendments, staff from the WA Tobacco Document Searching Program (WATDSP) teamed with the Australian Council on Smoking and Health (ACOSH) to test the air quality in *al fresco* areas of Perth cafes and pubs to find out how much secondhand smoke patrons and employees are being exposed to. An air monitor (TSI SidePak AM510) fit inconspicuously into the tester's handbag during visits to 28 cafes and pubs located in eight local government areas in and around Perth.



(left) Julia Stafford (Curtin University of Technology) and (right) Tina Moukhaiber (Australian Council on Smoking and Health) at a café in Subiaco, WA.

It was found that the average level of airborne particles given off by just one smoker would be enough to put particularly sensitive people at risk of respiratory effects according to the United States Environmental Protection Agency (US EPA) Air Quality Index. When just two or more people were smoking in the *al fresco* area, the average level of airborne particles was at a level the US EPA warns is a health risk to children, seniors and anyone with heart or lung disease.

ACOSH also tested the amount of secondhand smoke a child would be exposed to when driving with a smoker. The following levels were reached after only two cigarettes – and many children will be exposed to much higher levels. With all the car windows closed, after just one minute of smoking, the airborne particle level was already five times the level the US EPA considers to be hazardous. After just 14 minutes, the airborne particle level reached 70 times the hazardous level. Airborne

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Secondhand Smoke in Cafés, Pubs and Cars

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particle levels as high as this are cause for caution to everyone, but particularly children, older adults and those with heart and lung disease.

Airborne particle levels were still disturbingly high with the driver's window completely open and the car in motion. When the driver was smoking, the airborne particle level reached over twice the hazardous level and afterwards remained in the very unhealthy range.

Even modest levels of smoking in *al fresco* areas and cars were shown to expose patrons and passengers, and especially children, to unacceptable health risks. The results were sent to all WA Members of Parliament and received coverage in The West Australian newspaper, regional newspapers, and local and interstate radio. The study also featured in a Stateline WA television report about the Tobacco Products Control Amendment Bill 2008.



TSI SidePak AM510 air monitor.

A report of the research findings and resulting media are available on the WATDSP website at <http://healthsciences.curtin.edu.au/watdsp/> and the ACOSH website at <http://www.acosh.org/>
References available upon request from j.stafford@curtin.edu.au



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Research study provides evidence for dental therapists' role expansion

*Prof Hanny Calache, Director Clinical Leadership,
Education and Research at Dental Health Services Victoria*

Workforce shortages in the medical sector are well known. Oral health workforce shortages are similarly acute. The oral health workforce includes dentists, dental assistants, dental hygienists, dental therapists, lab technicians and pathologists. It is predicted that by next year there will be 1,500 fewer oral health providers than needed to service the Australian population, with the greatest shortages in rural areas.

One of the ways to address workforce shortages is to reassess how the current workforce operates. In 2004, the National Advisory Council for Oral Health (NACOH) identified the potential to use oral health practitioners other than dentists to meet clinical demand.

In Victoria, dental therapists have been restricted to providing restorative treatments (dental fillings) to patients under 26 years of age. This restriction limits the number and age-group of patients and the variety of work that can be provided by dental therapists.

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Research study provides evidence for dental therapists' role expansion

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In 2007, The Royal Dental Hospital of Melbourne studied the capacity of dental therapists to provide restorative treatment to adults older than 26 years on the prescription of a dentist.

The study's objectives were to:

- report on the success rate of restorations placed by dental therapists;
- assess patient satisfaction with the services provided by dental therapists; and
- assess dental therapists' satisfaction with the provision of restorations to adult patients older than 26 years.

Seven dental therapists were selected for the project and were educated to provide direct restorative treatment to eligible patients aged 26 years and older, under the guidance of a supporting dentist. The Dental Practice Board of Victoria provided provisional endorsement for the therapists to undertake this work.

Over a six week period, 115 patients were treated by the dental therapists, placing 356 restorations with the support of a dentist. The patients' age ranged from 26–82 years, with 82% of patients being older than 40 years.

Patients were very satisfied with the services provided by the dental therapists. The dental therapists considered the experience of treating adults older than 26 years rewarding, and the supporting dentists considered the standard of treatment provided by the therapists to meet or exceed that expected of a newly graduated dentist. Clinical results indicated that 94.6% of the restorations placed by dental therapists were successful at the six month review.

The results of this study provided the evidence to support the removal of the age limitation on dental therapy practice in Victoria. This change was implemented by the Dental Practice Board of Victoria in January 2009, allowing Victorian dental therapists to provide care to adults older than 26 years provided they undertake an approved educational program. Dental Health Services Victoria is developing a modular educational program to facilitate the therapists' expanded scope of practice.

Broadening the dental therapists' scope of practice in this way will help to address the ongoing demand for routine restorative care. Incorporating dental therapists into oral health teams will enable dentists to spend more time on providing complex treatment to those patients who are most in need.

This study demonstrates that expanding the capabilities and duties of existing personnel can help to address oral health workforce shortages. This is particularly important for the public sector and rural areas where workforce shortages are most acute.

Dental Health Services Victoria is the State's leading public oral health agency, promoting oral health, purchasing services and providing care to Victorians.

Work and Older People Focus Group Research Project

Dr Lynne Parkinson, Ms Julie Brookes, Dr Margaret Harris, Mr Ivan Skaines, Ms Robynne Quiggin, Ms Meredith Tavener, Ms Taylor Dong, Professor Julie Byles.

The Work and Older People Focus Group Research Project was undertaken for the NSW Department of Ageing, Disability and Home Care on behalf of the NSW Ministerial Advisory Committee on Ageing (MACA). The Focus Group Project, based on previous work by MACA, explored what older people thought about various models of work such as paid work, self employment, volunteering, caring and so on and looked at issues that helped or held back older people from taking part in, and moving between, the different models.

Eight focus groups with diverse older people from around NSW including different cultural groups and those with different levels of disadvantage were held from August to November 2007. Given the distances and deadlines, people were generally asked if they would like to take part by Community Group leaders from local organisations during a planned meeting time. The focus groups themselves were also generally run with people from existing community groups and organisations during planned meeting times.

The types of transitions (that is, the movements between models of work) which people made were different among different groups. Some groups, such as the younger, working people in unskilled, semi-skilled and trades jobs, and those in the more socioeconomically advantaged groups, had made transitions between all the different models: full-time, part-time and casual paid work, small business, study, caring, volunteering and home duties.

The older unskilled, semi-skilled and trades group and one of the CALD (Culturally and Linguistically Diverse) groups had mostly moved from school to paid work then to non paid work. This CALD group also took up caring and grand parenting roles after stopping paid work. Another CALD group had made transitions to paid work in which they were not skilled, and into volunteering and caring roles, when coming into Australia.

The theme of influences on choices and opportunities was one of the most constant across the groups. There was a strong contrast between the more socioeconomically advantaged groups' perception that they had the power to choose their ways of working, when and if they liked, and the less advantaged groups' control of choice by financial and job availability and other external circumstances. Discrimination was also an issue for one of the CALD groups.

There were a few different types of disadvantage and hardship across different groups related to job, education, culture and racism, general health and mental health, location, finances and family. Mostly, these were problems for those less socioeconomically advantaged. The main problems caused by disadvantage were people not feeling they had real choices or work opportunities, and feeling they had less control over work changes and current work, a lack of knowledge and skills to find the right information, and lack of financial security.

The suggestions for changes that might help address these issues which came out of focus groups included actions around information, training and policy. Each of these will be dealt with in turn.



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Work and Older People Focus Group Research Project

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Information recommendations:

1. Simple guides with relevant contact numbers for further information should be provided through workplaces in relation to:
 - Interacting with Centrelink about work to retirement transitions;
 - Centrelink benefits;
 - Medicare and health benefits;
 - Implications of transitions for partnered workers;
 - Understanding superannuation, pensions and investments;
 - Recognising and responding to ageism;
 - Transitions and mental health;
 - Part-time paid work opportunities; and
 - General services which could help in planning for transitions.
2. These guides should be supported by a series of workplace seminars about planning transitions.
3. Directories and simple guides should be provided through local Government, local service and sports associations, health care providers and other relevant settings about:
 - Volunteering opportunities in your local area;
 - Socialising opportunities in your local area;
 - Part-time paid work opportunities in your local area;
 - Transitions and mental health;
 - Interacting with Centrelink;
 - Centrelink benefits; and
 - Medicare and health benefits.

Training recommendations:

Training should be provided through schools, TAFE colleges and workplaces on making your own decisions, taking the initiative in transitions, and planning your work life.

Policy recommendations:

New policy directions could be developed around:

- The special needs in transitions from physically demanding occupations;
- The impact of organisational restructure on older workers; and
- The impact of stopping paid work on mental health.

Reaping the Rewards - The Australasian Mortality Data Interest Group and Mortality Coding Education

Kirsten McKenzie, Sue Walker and Garry Waller

Mortality Data in Australia

Mortality data are a cornerstone of epidemiological research and health monitoring because of their extensive use for the development of public health programs and research purposes. They are important in assessing burden of disease, informing public health policy, allocating resources and setting health priorities, performing health needs assessment, targeting health promotion, assessing health service quality and outcomes, participating in clinical audits, improving case ascertainment and allowing survival analyses in specific disease registries. Mortality data are vital for policy-makers and planners for developing strategies and guidelines to promote health and wellbeing. Appropriate and relevant decisions depend crucially on the availability and use of good health information and therefore decision-makers need sound mortality data to be able to make evidence-based judgments in health.



Authors: Kirsten McKenzie, Sue Walker and Garry Waller

The reporting of mortality data in Australia follows a series of steps, each of which impacts on the accuracy and reliability of the resultant statistical data. Medical information on causes of death is reported by medical practitioners, coroners or government pathologists in a form which is based on the medical certificate of cause of death recommended by the World Health Organization (WHO). Funeral directors report demographic details of the deceased to the Registrar of Births, Deaths and Marriages (BDM) in each State/Territory. BDM Registries compile all information and submit the data to the Australian Bureau of Statistics (ABS). The ABS processes and codes the data and is responsible for reporting both demographic and medical statistical data. Mortality data is classified according to the conventions of the International Statistical Classification of Diseases and Related Health Problems (ICD), a classification system used internationally in approximately 100 WHO member countries. Using this standardised classification system allows for comparison within and between countries and over time.

The multi-stage method of mortality data collection, processing and reporting lends itself to the introduction of quality issues because of mixed responsibilities for death certification, the number of organisations and individuals involved in collection of the data, a lack of consistency between processes in each state and territory, technological limitations and the tension between balancing accuracy and timeliness. The ABS has recently implemented new reporting procedures that reflect the difficulties it has in receiving and processing all deaths data (particularly that relating to coroners' cases) in a timely manner.

About the Australasian Mortality Data Interest Group

The Australasian Mortality Data Interest Group (AMDIG) was formed in 2003 to provide a forum for the producers and users of Australian and New Zealand mortality statistics to meet and discuss issues relating to these important data. AMDIG's overall function is to facilitate information-sharing related to the collection, collation, coding, dissemination and analysis of cause of death data in Australia and New Zealand.

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Reaping the Rewards - The Australasian Mortality Data Interest Group and Mortality Coding Education

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AMDIG includes Australian representatives from the National Centre for Classification in Health (NCCH), Australian Bureau of Statistics (ABS), Registrars General of Births Deaths and Marriages, the Australian Institute of Health and Welfare (AIHW), the National Injury Surveillance Unit (NISU), National Coroners' Information System (NCIS), coroners, forensic pathologists, universities, research organisations and clinicians. New Zealand representatives are from the Ministry of Health, Coronial Services Unit in the Ministry of Justice, Injury Prevention Research Unit (IPRU), Statistics New Zealand (Stats NZ), Otago University, and mortality review committees set up under the New Zealand Public Health and Disability Act 2000.

AMDIG meets at least annually on a face-to-face basis, maintaining other regular contact through teleconferences and discussion lists. AMDIG hosts an annual education workshop for individuals interested in understanding and discussing mortality data. The annual workshops are designed to address issues of interest to researchers, public health workers, other health officials using mortality data in Australia and other countries, and those involved in the collection and processing of mortality data.

The theme for the 2009 workshop to be held in November is "Injury-Related Mortality". More information will be available at http://nis-web.fhs.usyd.edu.au/ncch_new/AMDIG.aspx over the next few months.

Interested in Mortality Data and Mortality Coding?

The International Statistical Classification of Diseases and Related Health Problems (ICD-10) is the international standard for the coding of diseases and other health issues for morbidity and mortality reporting. It is published by the World Health Organization and maintained by the WHO Family of International Classifications Network (WHO-FIC). Use of the ICD-10 for the coding of hospital discharge (morbidity) or death certificate (mortality) data, using the rules established by WHO, ensures data which is comparable between individual hospitals or between provinces or states or internationally, as well as at different points in time. The ABS uses the WHO version of the ICD-10 for the coding of Australian mortality data.

The Australian National Centre for Classification in Health (NCCH), based at the Queensland University of Technology, Brisbane, offers annual international ICD-10 training programs. The program for 2009 will be conducted over a three-week period from 22 June-10 July. This includes a preliminary week designed to train trainers who are or will be responsible for conducting coding courses in their own countries. Participants in this week will be invited to assist with the teaching in the second and third weeks of the program to practice their skills. The objectives of these latter two weeks of the program are to enable participants to:

1. understand and use basic ICD-10 coding conventions;
2. interpret and utilise WHO rules for morbidity and mortality coding;
3. accurately assign codes to reflect a main diagnosis or an underlying cause of death;
4. appreciate the concept of multiple coding for morbidity and mortality collections; and
5. appreciate inputs to quality coding and utilise strategies for improving coded data.

The 2009 program will also include visits to Brisbane hospitals, health agencies and the Australian national statistical agency, to enable participants to view the work of medical record departments and health information service units and to observe how clinical coders and statistics officers operate in an Australian environment. The third week focuses on mortality coding and would be suitable for researchers or mortality data users wanting to understand more about the creation of the coded data. Course information and registration advice are available at http://nis-web.fhs.usyd.edu.au/ncch_new/4.aspx#bris2 For further information about our training programs, please contact Sue Walker, Associate Director, NCCH on ncch.brisbane@qut.edu.au

Decreasing the Burden of Chronic Diseases through Health Promotion

Ms. Namita Bakshi, Hyderabad, India

Good health demands a "Life Course" approach to eating and physical activity that begins with pre-pregnancy, includes breast feeding, and extends to old age.

- WHO

Facts:

Chronic diseases are now the major cause of morbidity, mortality and disability worldwide.

Non-communicable conditions, including cardiovascular diseases (CVD), diabetes, obesity, cancer and respiratory diseases, now account for 59% of the 56.5 million premature deaths annually.

A relatively few risk factors – high cholesterol, high blood pressure, obesity, smoking and alcohol – cause the majority of the chronic disease burden.

Improved dietary habits, increased physical activity and tobacco control have a major impact in reducing the rates of these chronic diseases, often in a relatively short time.

The world health report by World Health Organization (2002) addressing the major risks to global health highlights the role of behavioral factors - especially unhealthy diet, physical inactivity, tobacco usage and alcohol consumption - as key risk factors for chronic diseases and non-communicable conditions. These behavioural risk factors have imposed a rapidly growing burden of mortality, morbidity and disability among the human population across both geographical regions and social classes.

Globally, non-communicable diseases account for 59% of the 56.5 million premature deaths annually. These conditions also contribute almost 45.9% of global burden of the disease world wide. As per the global health report by WHO (2002), five of the top ten selected global disease burden risk factors identified are obesity, high blood pressure, high cholesterol, alcohol and tobacco – independently and often in combination.

A majority of chronic diseases resulting from these risk factors are preventable. The scientific evidence is strong that a change in dietary habits and physical activity arising from low cost community-based public health interventions, prevention, health promotion and other clinical interventions can immensely reduce the burden of non-communicable diseases. It is also well documented that effective prevention and health promotion interventions yields high returns that reduce the demand of scarce resources for expensive curative health services and reduces mortality,



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Decreasing the Burden of Chronic Diseases through Health Promotion

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morbidity and disability. Studies have also noted that investment in prevention and health promotion around tobacco use, alcohol, safe workplace and weight control is worthwhile. This is particularly relevant for low and middle income developing countries.



Established scientific evidence suggests there are major health benefits in:-

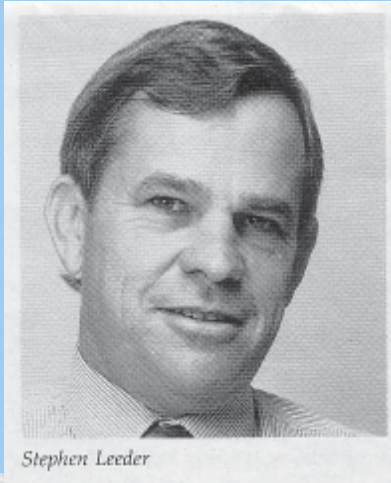
- Eating more fruit and vegetables, nuts and whole grains;
- Daily physical activity;
- Moving from saturated animal fats to unsaturated vegetable oil-based fats;
- Cutting the amount of fatty, salty and sugary foods in the diet;
- Maintaining a normal body weight (within the Body Mass Index (BMI) range of 18.5 to 24.9); and
- Stopping smoking.

Action to reduce these major non-communicable diseases should focus on preventing and controlling the risk factors in an integrated manner - intervention at all levels of society, from communities to governments, private organisations and non-governmental groups is essential since the risk factors are entrenched in the framework of the society and influenced by many areas of government policy. Cost-effective behavioural and pharmacological treatments for high blood pressure, diabetes and raised cholesterol have life-saving impact that needs to be routinely implemented. Dietary, physical activity and smoking cessation programs should be integral to both the prevention and management of chronic diseases.

In order to decrease the burden of chronic diseases the World Health Organization has begun to engage constructively in developing its 'Global Strategy' through health promotion and prevention. WHO believes that governments, health professionals, the food and advertising industries and wider civil society should all contribute to making the easy choices the healthy choices, both for diet and physical activity.

References are available and can be obtained from the author at namitabakshi78@gmail.com

NOSTALGIA

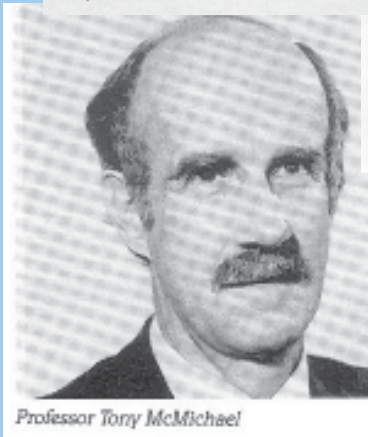


Stephen Leeder



Dr Fiona Stanley

Photog: Bill Green



Professor Tony McMichael

Recently a box filled with old PHAA branch files, included in these files were several copies of our intouch newsletter from 1987-88. Perhaps some of our long standing members will recognise these faces?

A very young Steve Leeder, Tony McMichael and Fiona Stanley

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- PHAA** - Public Health Association of Australia Inc.
- SIG** - Special Interest Group
- AIHW** - Australian Institute of Health & Welfare
- WHO** - World Health Organization
- ACT** - Australian Capital Territory
- NSW** - New South Wales
- VIC** - Victoria
- WA** - Western Australia
- TAS** - Tasmania
- SA** - South Australia
- NT** - Northern Territory
- QLD** - Queensland

Editors: Elizabeth Proude, Susan Stratigos, Jacky Hony & Pippa Burns

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