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When FTA spells BSE: Trading away our food safety

By Hilary Bambrick

Australia is fortunate to be one of few countries to remain free of BSE, the degenerative brain disease in cattle that causes the deadly variant CJD in people. But the Free Trade Agreement recently signed with the United States may change this. Despite Australian Government assurances to the contrary, free trade agreements weaken Australia's capacity to use quarantine to protect the safety of our food supply.

Throughout the recent trade negotiations, Minister Mark Vaile frequently said that Australian quarantine was not 'on the negotiating table'. Maybe not, but Australia made several concessions to our quarantine system sought by the US.

In addition, our food standards are under constant fire from the World Trade Organization (WTO). In theory, WTO member countries can set their own health standards on imported foods. However, disputes between trading partners are being settled increasingly in favour of the lowest common denominator. Minimum international standards are fast becoming the maximum that any country can impose on imported food. Food standards are driven downwards in the interest of increasing trade rather than protecting human health.

Under the WTO rules, countries cannot invoke quarantine to exclude an import unless they can prove a specific risk exists. Concerns over *potential* risks are insufficient, and banning potentially dangerous imports is not considered scientifically justifiable. But scientific knowledge is incomplete and uncertain, making precautionary action the only way to protect public health. Science is always a work in progress, never a finished masterpiece. Decisions on public health should not wait for the bodies to pile up. When British cattle were fed the remains of sick sheep, BSE and its human health dangers were unknown. Nevertheless, in 1966 Australia banned the importation from Britain of any stock feed that contained animal parts, which later had the effect of protecting Australia from BSE.

However, when Australia tries to adopt similar precautionary measures today, its actions are condemned by trading partners as restrictive trade practice. Australia's 'choice' is either to accept potentially dangerous imports or face retaliatory action by trading

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partners. Several countries still feed sheep to cattle, proving that a practice that is internationally accepted can still be dangerous.

Despite everything we now know about the specific risks, testing cattle for BSE remains inadequate. Until last December, when their first case of BSE was confirmed, the US tested only 0.01 percent of all cattle slaughtered, and most of these were obviously sick. Now the US is increasing sampling ten-fold, to one percent.

The first US case may not be an isolated incident – two thirds of the cattle imported from Canada with the infected cow could not be traced. Furthermore, Canada says the cow was infected via stockfeed from the US. The cow that tested positive had not appeared to be ill and was tested because of an unrelated injury, after it had been declared fit for human consumption. Yet calls from Japan for the US to test all its cattle intended for human consumption have been branded by the US meat industry as ‘unscientific’.

The infective protein that causes BSE is extremely hardy, and is resilient to high temperatures and ordinary cleaning methods. Even hospital sterilisation is insufficient to destroy it. BSE’s resilience raises questions about the safety of ‘sterilised’ pet food, manufactured from slaughterhouse leftovers – materials that are particularly high risk. A few years ago Australia banned the importation of pet food from all countries except Canada, the US and New Zealand. Neither the US nor Canada can continue to claim BSE-free status, but Australia still accepts pet food from them.

Transmission of the disease via pet foods may be unlikely, but it is conceivable. Cats in the UK have been infected with BSE. Half of Australia’s households have at least one cat or dog, and most of these are fed manufactured pet food. Even if Fluffy or Rex don’t live long enough to develop the disease, millions of Australians have been handling their pets’ food, perhaps even using the same cutlery, or been lovingly licked by a tongue that just finished dinner. Under the US Free Trade Agreement, direct pressure to accept US imports is increased. Should Australia be compelled to accept beef products from a BSE-affected country that only samples 1 in 100 of their slaughtered cattle? Australia’s cautious approach to quarantine should be recognised as best practice and minimum safety standards must not be treated as a ceiling. The BSE disaster provides an opportunity to learn from mistakes, but practices in the global marketplace still favour small short-term economic gains over major human health considerations.

Dr Hilary Bambrick is the Vincent Fairfax Family Foundation Postdoctoral Fellow with the National Centre for Epidemiology and Population Health, ANU. She has recently written a report entitled ‘Trading in Food Safety’, published by The Australia Institute.

First printed in The Australia Institute, Dec 2003 No 41

Australia’s Mothers and Babies 2002

This is the twelfth report in the annual series prepared by the Australian Institute of Health and Welfare’s National Perinatal Statistics Unit (NPSU), providing national information on the pregnancy and childbirth of mothers and their babies. Two special features are included in this year’s report: a chapter on homebirths and birth centre births, and a chapter on births from assisted reproductive technology (ART). The report also provides data on the number of mothers with a history of previous caesarean section and their current method of birth, and the type of anaesthetic administered for operative deliveries.

Catalogue No. PER-29, Available (mid Jan 2005) from CanPrint (ph: 1300 889 873); \$30.00

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Is Depo-Provera Safe?

By Mary Osborn

Where is the equity in the use of contraception?

The irony about information currently available in Australia on depot medroxyprogesterone acetate (Depo-Provera) is that despite current warnings and past scaremongery by so called "Feminists" it is now official, Depo-Provera is unsafe. However, as outlined in this article most available information as at December 2004 illustrates that leading agencies continue to promote Depo-Provera as safe?

In November 2004 Pfizer Inc. issued a press statement warning women who used Depo-Provera contraceptive injection that they might lose significant bone mineral density. Furthermore Pfizer stated that "Bone loss is greater with increasing duration of use and may not be completely reversible."¹ The warning came as a result of findings from a controlled clinical study of nearly 400 young women aged 12 to 18 enrolled in a study in 1997 who were taking the drug to restore lost bone mineral density. The risk for those women of developing osteoporosis and consequently the risk of bone fractures is very real.

In Australia the Depo-Provera contraceptive injection has been on the market for at least 20 years. Depo Provera is made by the pharmaceutical company Upjohn and is widely available in more than 80 countries in the world and has been used by 30 million women. The World Health Organization estimates that about four million women are currently using Depo Provera.

Who are the users of Depo-Provera?

In 2003 in Australia 85.3 per cent of men and 89.5 per cent of women reported to be in a regular heterosexual relationship.² In 1995 47 per cent³ of women aged between 18 and 49 years reported current use of a method of contraception and this increased to 58% in 2001.⁴ Other studies report use of a method of contraception from 47 per cent- 77 per cent.^{5 6 7 8} The reported use of Depo Provera varies, in 1995 0.3 per cent⁹ of women replied that they had had a contraceptive injection and in 2001 the use had increased to 2 per cent.¹⁰

How has Depo-Provera been reported in scientific journals in Australia?

In 1983¹¹ it was suggested that there was evidence that Depo-Provera was being given to disadvantaged women in Australia. The author raised concerns about the testing of the drug and called for long term monitoring in Australia once its use became more widespread.

In 1987¹² a profile from a study of women using Depo-Provera suggested that the women were of average intelligence, well informed, had tried other methods of contraception, had a high number of unplanned pregnancies and chose to use Depo-Provera as other methods of contraception were unsuitable.

In 1994¹³ Depo Provera was labeled as a much maligned drug and a drug that merited a legitimate place among the contraceptive choices available for Australian women. The authors called for accurate, unbiased information about the extensive worldwide experience to be made available to all Australian medical practitioners.

More recently it has been reported that there is good quality evidence for the non contraceptive health benefits of depot medroxyprogesterone acetate.¹⁴ In 2003 it was suggested that depot medroxyprogesterone acetate could assist in the long-term maintenance of bone mineral density.¹⁵ The Pfizer study contradicts this advice and there is a need for clarity for women who are using Depo-Provera and for doctors who may be considering prescribing it based on this 2003 advice.

The Royal Australian and New Zealand College of Obstetrics and Gynaecology in November 2003 stated that "It is now recognised that depot MPA is an effective and safe contraceptive for those women who are attracted by its particular advantages and who understand and accept its possible disadvantages which should, of course, be
continued on next page

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discussed with the patient.¹⁶ FPA Health presents information in a fact sheet, part of which are outlines the possible side effects of Depo-Provera.¹⁷ There is no warning for those women who may be on Depo-Provera that they may be at risk of reduced bone density.

AusAID has a policy of restricting types of contraceptives able to be funded within the development assistance program.¹⁸ Depo-Provera as a three monthly injectable is available for their overseas programs. There appears to have been no consideration of the Pfizer study.

Why in 2005 is there no safe effective and economic contraceptive available for women?

There is information on the number of women who are sexually active and who use contraception. As far back as 1991 Dr Weisberg was concerned that contraceptive choices were being reduced rather than being expanded. Reasons given for this reduction were dependent on commercial considerations and affected by liability issues. These factors have in turn affected costs and availability. The image of Depo-Provera has been diminished by feminist groups at least in part because of perceived issues of safety, lack of long term clinical studies and equity.¹⁹

Finally, in Australia we do not know who the users of Depo-Provera are? No studies use variables to indicate equity in contraceptive use. The use of social economic status and contraceptive use would give service providers and policy makers an indication of Depo-Provera distribution. An international study of family planning programs found that what women most want from family planning programs is explicit information about contraceptive method side effects.²⁰

Is this another case of Vioxx and Celebrex, where the long term use of an approved and marketed drug has safety concerns? All these cases call into question the adequacy of our drug evaluation and approval mechanisms that were designed in an era of short term curative pharmaceutical use, and not in an era of long term prevention.

(Footnotes)

¹ Pharmacia & Upjohn, N.V./S.A. Puurs, Belgium Division of Pfizer Inc, NY, NY 10017 LAB-0149-4.0 November 2004

² Rissel CE, Richters J, Grulich AE, de Visser RO, Smith AM. Sex in Australia: selected characteristics of regular sexual relationships. *Aust N Z J Public Health*. 2003; 27(2):124-30.

³ Australian Bureau of Statistics. National Health Survey. 1995 Australia

⁴ Australian Bureau of Statistics. 4364.0 National Health Survey - Summary of Results. 2001 Australia

⁵ Kovacs GT, Dunn K, Selwood TS. Gynaecological and sexuality profile of new patients attending a family planning clinic. *Aust N Z J Obstet Gynaecol*. 1986 Aug; 26(3):235-8.

⁶ Bryson L, Strazzari S, Brown W. Shaping the life course: women, control and contraception. *Family Matters* 1999; 53: 31-38.

⁷ Richters J, Grulich AE, de Visser RO, Smith AM, Rissel CE. Sex in Australia: contraceptive practices among a representative sample of women. *Aust N Z J Public Health*. 2003; 27(2):210-6.

⁸ Hollingworth S, Russell A, Dobson A. Contraceptive behaviour of young women in Australia – Women's Health Australia project. 2001 School of Population Health, University of Queensland, Brisbane

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¹¹ Bacon W. Testing times for women in body lab. *Lamp*. 1983 May; 40(3):38-40.

¹² Jarman H, Kovacs GT, Westcott M. *Aust N Z J Obstet Gynaecol*. 1990 Feb; 30(1):74-6. Depo Provera: a profile of current users. Family Planning Association of Victoria.

¹³ Fraser IS, Dennerstein GJ. Depo-Provera use in an Australian metropolitan practice. *Med J Aust*. 1994 May 2; 160(9):553-6.

¹⁴ Hickey M, Fraser IS. The contraceptive use of depot medroxyprogesterone acetate. In: Peterson CM, editor. *Clinical use of progestins and androgens*. *Clin Obstet Gynecol* 1995; 38: 849-858.

¹⁵ Fraser IS, T Kovacs G. The efficacy of non-contraceptive uses for hormonal contraceptives *MJA* 2003; 178: 621-623

¹⁶ www.ranzcog.edu.au/publications/statements/C-gyn4.pdf

¹⁷ www.fpahealth.org.au/sex-matters/factsheets/44.html - 18k - 20 Dec 2004

¹⁸ Research Report. Australia's Contribution to Family Planning, Reproductive Health and Population Programs in the Pacific Islands and Papua New Guinea Prepared by Myra White Australian National Internships Program 15th May, 2000 For Mr Colin Hollis MP

¹⁹ Weisberg E. Contraceptive choices—turning back the clock. *Adv Contracept*. 1991; 7(2-3):115-27.

²⁰ Family Planning International. What People Want From Services. *Network*: Summer 1998; 18: 4

High flyers tackle emerging diseases and biosecurity

The 2004 High Flyers Think Tank was held on 19 October in Brisbane's Custom House. Entitled *Emerging diseases – Ready and waiting?*, the Think Tank targeted Australia's preparedness to deal with the increasing threat of new diseases in today's world of increased global trade, tourism and bioterrorism. It was hosted by the Academy as part of its 50th anniversary celebrations and brought together fifty of Australia's brightest young minds — early- to mid-career researchers from a broad range of science, technology, communication and social science disciplines. Think Tank participants discussed current trends and brainstormed novel applications of their research to improve



Dr Jim Peacock with some Queensland high flyers at the 2004 Think Tank.

biosecurity preparedness, surveillance, diagnostic procedures and enhanced ability to control and eradicate exotic diseases affecting humans, animals, plants and aquatic organisms. Given that Australia is a land girt by sea, it is particularly important to recognize that diseases are not restricted to the territorial realm. For example, on two occasions in the late 1990s, mass fish kills across the southern coastline caused by a herpes virus severely affected in-shore fishing and aquaculture industries across three Australian seaboard states.

Academy President Dr Jim Peacock facilitated the Think Tank. Dr Peacock is a member of Biosecurity Australia's Eminent Scientists Group, a group formed earlier this year to strengthen the import risk analyses process. Dr Peacock said, 'In addition to increased threats in the tropics from insect-borne human diseases, government agencies like the Queensland Department of Primary Industries and Fisheries have had to deal with the recent citrus canker outbreak, the giant African snail incursion, fire ants and the constant threat of foot and mouth disease'.

He said that wonder drugs such as antibiotics are increasingly coming under pressure from the development of drug-resistant strains of pathogens, while emerging diseases of humans originating from animals (zoonotic diseases) are also on the rise. 'Last year the world threat from deadly SARS (severe acute respiratory syndrome) had authorities struggling to contain the spread of the disease, an outbreak that also had a major impact on the global economy, especially tourism. 'With the avian influenza virus again

causing deaths in South-East Asia, the time is right for a multidisciplinary approach to biosecurity by pooling the skills and enthusiasm of fresh young talented minds.' The Think Tank allowed the younger professionals to hear from some of the nation's eminent experts, such as Professor Mark von Itzstein, Executive Director and Federation Fellow, Institute for Glycomics, Griffith University; Professor Aileen Plant, Head, Centre for International Health, Curtin University, and Deputy CEO CRC for Biosecurity; Dr Martyn Jeggo, Director, Australian Animal Health Laboratory; Dr Graeme Garner, veterinary scientist, Department of Agriculture, Fisheries and Forestry; Dr John Manners, Deputy CEO, CRC for Tropical Plant Protection; and Dr Brian Jones, Principal Fish Pathologist, Department of Fisheries, WA. In 2005, the annual High Flyers Think Tank, *Sustainable infrastructure in tropical Australia*, will be held in Darwin. The proceedings from the Think Tank, including workshop discussions and a final report are available on the Academy's website at www.science.org.au/proceedings/emergingdiseases.

Reprinted from the Australian Academy of Science Newsletter
August-November #60

Desert knowledge identifies plants with market potential

Indigenous people from desert communities are being encouraged to use their traditional knowledge of native plants for use as food, medicine and other products for their long-term livelihood.

The University of South Australia is a key researcher in the South Australian study of the national Plants for People Project, which involves working with Indigenous communities to help them establish and manage business enterprises to commercialise native plant products and develop community members' skills in areas such as plant identification, cataloguing, classifying, propagating and growing native species.

The project is one of the areas being studied by the Desert Knowledge Cooperative Research Centre, led by the CSIRO in Alice Springs. UniSA and Curtin University are core partners in the Plants for People Project, along with Tjutjunaku Worka Tjuta Inc (TWT) and the Tapatjatjaka Community Government Council.

Associate Professor Brian Cheers, Director of UniSA's Centre for Rural and Regional Development at Whyalla campus, is the team leader for the South Australian site, with other study sites in Western Australia and Northern Territory. Aboriginal people in the Ceduna Region have accepted the invitation to be South Australian partners through a steering committee established through TWT at Ceduna and many of them will be community researchers in the project.

Selected arid-land plant species from all sites with market potential are being collected and analysed in laboratories in UniSA, Curtin University, Charles Sturt University and the University of Western Australia to determine their nutritional and medicinal properties.

“Our study will focus initially on nutritional, rather than medicinal, properties of the plants. We are working with the communities involved to enable them to document traditional knowledge of the cultural uses of local plants so that they can use the information on the nutritional and medicinal properties of plant species to develop a range of initiatives for their use, including community health. Each community retains full ownership of their knowledge and will decide which knowledge they make available for the project,” Professor Cheers said.

“We are committed to communities producing culturally and environmentally appropriate business development plans, and conducting relevant skills training programs with the aim of establishing at least one plant-based business enterprise in the Ceduna region. This project will enhance cross-cultural understanding and increase recognition of Aboriginal traditional knowledge, while ensuring that Indigenous communities own and gain the benefits of this knowledge.”

Activities within the program could include field studies on plant distribution and ecology, establishing local herbariums containing specimens of selected plants, developing appropriate technologies for cultivating plants, laboratory evaluation for food and medicinal value, ecological restoration, and applying the knowledge and new technologies in health and training programs and business enterprises. One possible project being considered is establishing a 'native plant trail' in the region surrounding Ceduna.

Professor Brian Cheers is supported by UniSA team members Dr Susan Semple (pharmacy), Ian Gentle and Colin Weetra (Spencer Gulf Rural Health School), Joan Gibbs (natural and built environment), Dr Mary Oliver (nursing and rural health), and Martin O'Leary (Plant Biodiversity Centre/State Herbarium, Department of Environment and Heritage).

The national Plants for People Project has been awarded CRC funding of \$448,130, with more than \$1.5 million in-kind support from partner organisations.

Reprinted from Pharmacy Review December 2004

Annual Public Health Conferences: US vs Australia

By Liz Hanna. Victoria. Environmental Health SIG Convenor



APHA (American Public Health Association) 132nd Annual Meeting and Exposition – “Public Health and the Environment”.

Attending the Annual Conference of the APHA is an interesting exercise, and highly recommended, almost for the mental gymnastics required to fathom the sheer size of the event, and as an exercise in comparisons with the PHAA approach to public health and conferences, if not for the vast array of sessions.

True to form, the U.S. do things in a BIG way! Held November 6-10 in Washington DC., it was their 132nd meeting (difficult to contemplate such an organisational history), and it attracted 14,500 delegates. This is massive, and equates to about 30 times the size of PHAA conferences, which is interesting as their population (“estimates” given no true census exists) is a mere 14 times larger than Australia’s. Few cities, even in the states, can accommodate such numbers, and offer sufficient conference venues for break out sessions within reasonable proximity, or attempt to hold opening and closing sessions.

The draw card for me of course was the environmental health theme, which ran over 52 sessions, with Erin Brokovich as the keynote speaker at the opening address. The quality of papers was, as could be expected, quite variable, some brilliant, most good, and one or two were feeble. But the joy was attending papers describing programs and approaches not yet in practice here, such as GIS (Geographic Information Systems) in action in the field, and the Health Tracking System. There is enough to satisfy all interest groups. However, the word ‘bi-polar’ comes to mind when contemplating public health in the U.S. In some quarters the U.S. health system appears so advanced and up-beat, whilst in others lurks a darkness. Some of the more ‘prehistoric’ policies are the focus of APHA action, but, and maybe this was due to the general post election gloom, I spied little fervour to suggest a strong movement for imminent change.

With a program booklet resembling a medium sized telephone book, the enormity of this conference effectively resolves any futile ambitions to attempt to attend all sessions that strike your fancy. So I saw fewer furrowed brows on people frenetically trying to dash between sessions. The ambience was more relaxed, almost calm, which is seemingly counterintuitive. However it was scheduled but a week after the presidential election, which cast a uniform sense of doom and gloom about the halls. Sessions planning to discuss the “Post election future of “ (insert your subject), rather than being upbeat, as anticipated, were very sad gatherings. It cheered them little to hear (from an Australian in the audience) that much of the world was similarly depressed.

Four other events were held concurrently with the opening ceremony, held at other venues about Washington, and included the Public Health Awards and Ceremony, APHA orientation programs and so on. Also scheduled on the Sunday were a series of business meetings - for SIGs (which they call Sections), caucuses, and continuing education sessions. Either logistics precluded daily plenaries, or there were ‘plenary type’ sessions held continually in all the large venues, such that the program did not differentiate these from other break out sessions. Either way, what NOT to see was the priority question as each timeslot could only be whittled away to a short list of about 4 sessions – after that choice became arbitrary.

As for the exhibition hall, doing justice required multiple visits of 2 hours each, too many book stores!! The tricky part of the layout was that to get to the hundreds of excellent posters, necessitated weaving through the maize of stalls

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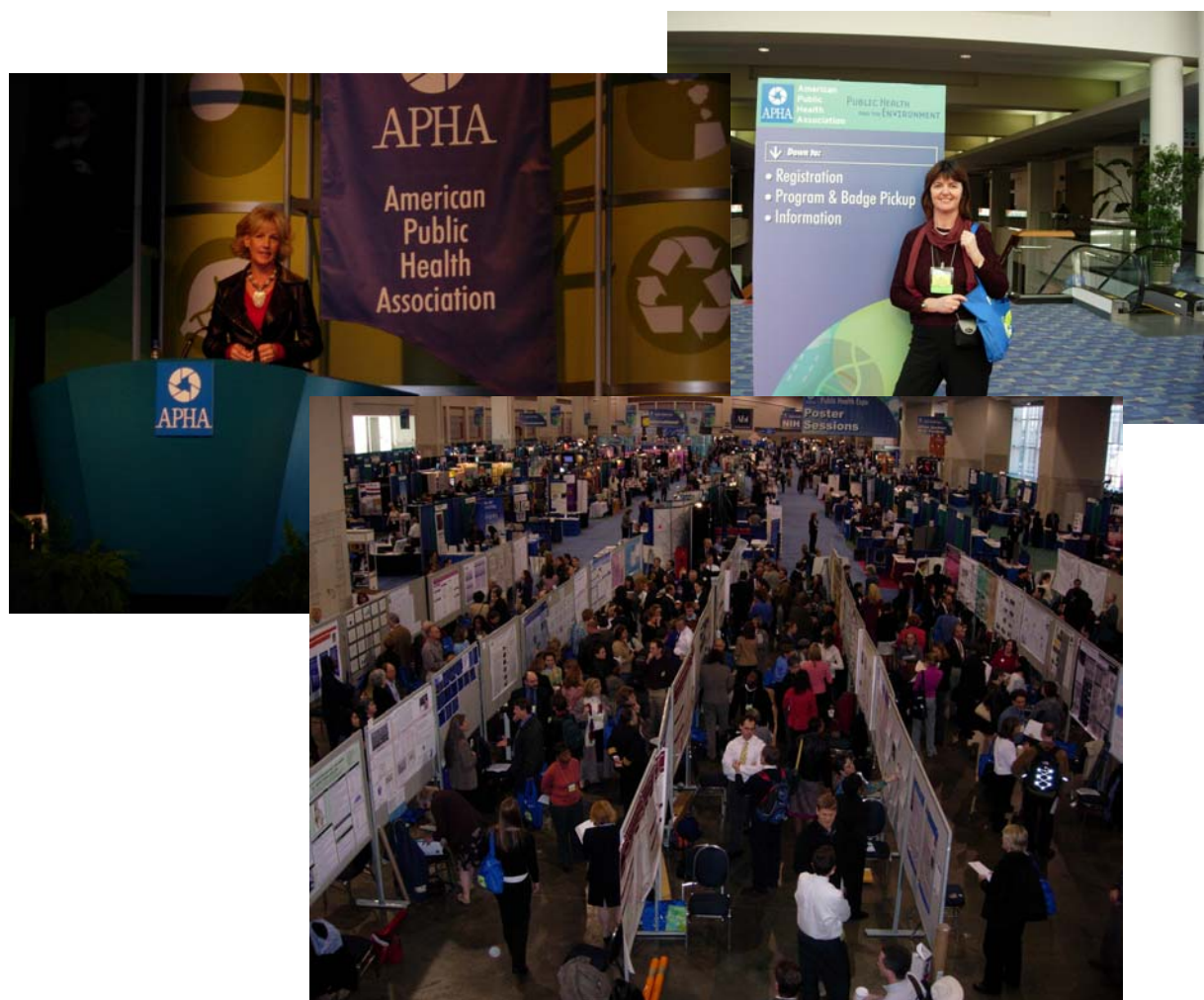
offering pens, free CDs, courses in absolutely everything, refrigerator thermometers . . . it seemed endless! A computer terminal area holding a Career Mart was also available, whereby prospective employees would log their details, likewise employers would log selection criteria. A bank of terminals for delegates to access emails (time limited) was also present, and very popular

The conference was very cheap, by comparison, due selective sponsorship. Only food and beverages supplied were found at the small sponsored Section events / book launches / meetings held in the break out rooms in the early evenings. Delegates and office bearers, in their usual friendly American fashion, were enthused to engage with Australians, and learn more about our health system, and perspectives. We all left the conference aghast at the immensity of it all, and needing to “ALT-F-DELETE”, ‘empty the recycle bin’, and then run a ‘mental defrag’. So with all this, we found it extremely difficult to duck out to the Smithsonian Institute or the National Art Gallery (both magnificent & free entry!). This year, 2005, it is in New Orleans!

Previous conference abstracts can be viewed from http://www.apha.org/meetings/future_past.htm

For those interested in travelling this year ... APHA 133rd Annual Meeting & Exposition
New Orleans, Louisiana, Ernest N. Morial Convention Center, November 5-9, 2005

Abstracts close February 7-11, 2005. <http://www.apha.org/meetings/>



Health and Well-being Seminar THE POSSIBILITIES

National Convention Centre, ACT
 9.00am–5.00pm Wednesday 15 June 2005

convened by  Canberra Inc

This Health and Well-being Seminar will be the first in a series of annual seminars convened by Lifeline Canberra, that will extend people's thinking and understanding of local and regional issues that affect us all.

Delegates will listen to international, national and local speakers with the opportunity for questions, in a forum of cutting edge potential, we believe has not been offered in Canberra before.

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HEALTH AND WELL-BEING SEMINAR SPEAKERS

Kakkib li'Dithia Warrawee'a

Kakkib li'Dithia is an internationally renowned Indigenous Australian, an Aboriginal Spiritual Philosopher, Doctor of Traditional Medicine, Keeper of the Law, Songman and Senior Elder of the Ya-idi'midung language group. He is a brilliant and erudite speaker – "an Aboriginal man of high degree".

He was the opening and closing keynote speaker along with Deepak Chopra at the Global Holistic Health Summit in Bangalore, India, in February 2003. He will be speaking to "The Possibilities" for Australia from an Indigenous and philosophical overview.

Hugh Mackay

Hugh is a psychologist, social researcher and author. He has written ten books, including four bestsellers in the field of social psychology and four novels. His latest book is *Right & Wrong: How to decide for yourself*.

Social commentary on "The Possibilities" for our community. Challenges and changes, implications, baby boomers and their impact on service delivery, employment, culture, and societal expectations.



Kakkib li'Dithia
Warrawee'a



Hugh Mackay



Steve Longford



Jenni Colwill



Tom Snow

Steve Longford

The Distillery Pty Ltd
Steve has a BPsych and is a qualified Intelligence and Behavioural Analyst. He is one of four forensic profilers in Australia. Steve is an expert in behavioural intelligence and its applications in a contemporary society. He will speak to "The Possibilities" that this kind of intelligence has for our community and our workplaces in the future.

Jenni Colwill

*Managing Director
Leapfrog Leadership*
Jenni has extensive experience in the public and private sector in HR Management. HR is undoubtedly going to play a more important role in our community and workplaces. She will examine some key trends in international HR management and the implications and "The Possibilities" for us in the future.

Tom Snow

*Executive Director
Canberra International
Airport*
Tom is responsible for environmental and long-term planning issues. He was the Green Star Certified Professional on Australia's first five Green Star building, at Canberra International Airport.
Tom has been working at the UN, New York and with Columbia University at Earth Institute. He has been working with the team setting long-term sustainable economic development policy for both the UN and its agencies in implementing the Millennium Development Goals. Tom will be addressing "The Possibilities" through "Building a Green Built Environment: Raising the Benchmark".

To register your interest in receiving more information about the Seminar, please complete the following and fax or mail to the Seminar Secretariat.

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*As agent for the Health and Well-being Seminar convened by Lifeline Canberra.

Victorian Branch Article: Go For Your Life

On 10th November 2004 the Victorian Premier, Steve Bracks, and Ministers for Health, Sport and Recreation, Education and Aged Care launched a whole of Victorian Government \$21.9M to a Healthy and Active Victoria strategy– ‘*Go For Your Life*’.

The aim of this multifaceted strategy is to improve the overall health and well being of all Victorians. The strategy includes an integrated, whole of government approach to providing opportunities for:

- increasing levels of physical activity;
- improving eating habits;
- getting involved with local community activities and volunteering.

To reach these objectives the Government has committed funds as follows:

- \$10 million to promote physical activity
- \$10 million to prevent obesity and diabetes; and
- A further \$1.9 million has been allocated to promote Healthy and Active living for senior Victorians.

The Victorian Department of Human Services recognises the importance of building on existing activities and underpinning the *Go For Your Life* strategy with projects targeting the community to achieve sustainable change. To reach these aims \$10 million has been committed over coming years to prevent obesity and diabetes. Some of the new initiatives include:

- *Kids – Go For Your Life*-a comprehensive, statewide public health initiative that promotes healthy eating, physical activity and healthy weight in children. This initiative will focus on children’s settings, such as primary schools, kindergartens, childcare and maternal and child health service, promoting supportive environments for healthy behaviours, and enhancing the knowledge and skills of families and supporting staff working with children’s settings to promote healthy eating and physical activity for children.
- *Community projects* - funding for additional community projects addressing underlying environmental and lifestyle issues contributing to overweight and obesity. These projects will support and work with the whole community with the aim to make healthy choices, such as healthy eating and physical activity, the easiest choices. These community projects will be similar to “Be Active Eat Well” a ground breaking project that has sparked interest all around the world and through out Australia.
- Funding for a targeted community based *Diabetes Prevention Program*. This program will apply internationally-recognised evidence that the early detection of people at high risk of developing type 2 diabetes, combined with a program to support healthy eating, physical activity and achievable weight loss, can prevent progression to diabetes in a significant proportion of people. The implementation of this diabetes prevention program in three local pilot areas will encourage close links between GPs and local health agencies. Victoria is the first State to fund extensive and systematic local programs for the prevention of diabetes. The program pilot sites will be rigorously evaluated to inform future diabetes detection and prevention efforts.

A state-wide communications campaign is currently being implemented providing greater access to information for all Victorians through a website www.goforyourlife.vic.gov.au and Call Centre 1300 739 899

The *Go For Your Life* website contains information linked to various life stages and healthy eating, increased physical activity and more active communities.

Information in languages other than English is also available on the site.

European medical associations building capacity for tobacco control

Trish Fraser, Director, Global Public Health

I recently attended the 'Capacity Building for Tobacco Control' conference in Edinburgh, Scotland (21-23 October), hosted by the British Medical Association Tobacco Control Resource Centre (TCRC) in collaboration with the European Forum of Medical Associations' Tobacco Action Group. It was immensely gratifying to be involved in such a conference organised by the medical profession for the medical profession.

As we celebrate the New Zealand government banning smoking in bars and restaurants this month, we can be proud of their achievements in building healthy public policy. Meanwhile, parts of Europe languish in the smoky dark ages. However, it is heartening to see medical associations in Europe becoming active in tobacco control and perhaps it is a model that medical associations in the southern hemisphere could well consider.

Rationale for the Conference

New European Commission policies on tobacco, the WHO European Strategy for Tobacco Control and the recent adoption and ratification of the WHO Framework Convention on Tobacco Control (FCTC) have all set the scene for effective policies for tobacco control at a national and international level. A key activity of the TCRC is to develop and build capacity for tobacco control among European medical associations. The rationale behind this event was to give health professionals' organisations some practical tools to make a real contribution to tobacco control, particularly at a national level.¹

Objectives

The main objectives of the conference were to provide delegates with information on: the nature and scale of the European tobacco epidemic; up-to-date evidence on the health impacts of smoking and passive smoking; the nature of tobacco dependence and evidence-based approaches to its treatment; international evidence on effective strategies to help smokers stop, including population based and individual approaches; case studies illustrating how smoking cessation can be promoted throughout the healthcare system; key provisions of a comprehensive national tobacco control program; WHO tobacco policies and the FCTC; strategies used by the tobacco industry in promoting tobacco use; the role of doctors and their professional associations in tobacco control; key considerations for communicating with the media; the nature of the policy-making process, strategies for influencing decision makers, and the role of education and professional development in enhancing the contribution of the medical profession.

In addition, it was expected that the delegates would identify opportunities to improve smoking cessation, encourage the implementation of the FCTC and communicate with the public, the media and policy makers.²

Program content

The first session began with a keynote presentation from Professor Sir Richard Peto on the European tobacco epidemic. This set the stage for the rest of the conference. His three main messages were: the risk for smokers is BIG, half are killed; ¼ are killed in middle age (35-69), losing many years and, most importantly, stopping smoking works.

The second session focused on tobacco and health with an overview of the health effects of smoking³ and secondhand smoke.⁴ Again there was an emphasis on quitting and also creating a world where people do not want to smoke.

Professor Robert West, in the tobacco dependence session, concluded that cigarette smoking fulfils the criteria for addiction in most people.⁵ This was followed by New Zealand's Dr Hayden McRobbie who informed the audience that the best service their patients who smoke can be offered is behavioural support and medication.⁶

Dr Kerstin Schotte from WHO reported that unless current smokers quit, tobacco deaths will rise dramatically in the next 50 years.⁷ Both population and individual approaches are required to reverse this rise. National no smoking days⁸ and quitlines⁹ were highlighted as effective population strategies by Dr Sally Haw. According to Dr Haw the primary objective of health professionals should be to encourage smokers who want to quit to use the most intensive form of support available from specialist smoking cessation services.¹⁰

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European medical associations building capacity for tobacco control -continued from previous page

A major theme was the international evidence on effective strategies to help smokers stop, with particular focus on the healthcare systems. We heard that intensive interventions are more effective than brief interventions and should be used when resources permit, but every smoker should be offered at least a minimal or brief intervention.¹¹ Smoking cessation and tobacco-free health facilities are an integral part of health from primary care through to secondary care.

Evidence based public policies on tobacco covered the known effective policies: tobacco taxation, advertising bans, smokefree workplaces including hospitality venues, warning labels, cessation support and the control of smuggling. Ireland was the 'gold standard' for smokefree public places, as the first country in the world to ban smoking in bars and restaurants. New Zealand could learn from the Irish example, where enforcement has been a key to the success of the ban.

The strength of tobacco taxation as preventive medicine was highlighted¹². The delegates were particularly encouraged to advocate for hypothecation of tax revenue for health promotion. This is a strategy that perhaps is worth putting to the top of the agenda in New Zealand again.

A key session on doctors making a difference began with a presentation from Sir Richard Doll on 'Doctors and Tobacco: the first fifty years'. Sir Richard, now aged 91 years old, and Bradford Hill made the momentous discovery that smoking was a cause of lung cancer back in the early '50s. The Rt Hon Frank Dobson, MP, who was Secretary of State for Health in the late '90s was inspiring in his plea for doctors to take up the role of advocacy and to lobby politicians. His message to the doctors was that it was their responsibility to speak to the politicians as they do listen.¹³ This fits very much with the experience in New Zealand, with Doctors for a Smokefree New Zealand playing a very influential role in highlighting the health effects of exposure to secondhand smoke. Sir Alexander Macara, Chair of the UK National Heart Forum, followed with an emphasis on the importance of national medical associations taking a leading role in tobacco control. The final session of day two kicked off with practical advice for doctors on getting the message across and working with the media.¹⁴

The final presentations of the conference concentrated on educating medical professionals for tobacco control; the subject should be part of undergraduate,¹⁵ postgraduate and continuing medical education;¹⁶ medical journals are important vehicles;¹⁷ and there is a need for doctors to build coalitions with other health professionals.¹⁸

Conference outcomes

The conference highlighted the special roles and responsibilities of doctors and their professional associations in taking action on tobacco. The European medical associations have led the way with this conference, it is now up to the national medical associations and doctors to pick up 'the baton' and run with it, by taking action against tobacco in their own countries.¹⁹

(Footnotes)

¹ European medical associations. Capacity Building for Tobacco Control programme. 21-23 October 2004. Edinburgh, UK. BMA Tobacco Control Resource Centre. The rationale and objectives are almost principally directly from the conference programme.

² *ibid*

³ James Friend, Aberdeen, Scotland. The Health Effects of Smoking

⁴ Carolyn Dresler, MD, Head, Tobacco Group International Agency for Research on Cancer. Health Effects of Secondhand Smoke.

⁵ Professor Robert West, University College London. Tobacco Dependence: why do people smoke?

⁶ Dr Hayden McRobbie, St Bart's and the London Queen Mary's School of Medicine, London. Smoking cessation: helping patients stop

⁷ Dr Kerstin Schotte, MPH, Tobacco-free Europe, WHO Regional Office for Europe. WHO European Strategy for Smoking Cessation Policy.

⁸ Prof Witold Zatonski, Poland. National no smoking days. Great Polish Smoke Out.

⁹ Dr Hans Gilljam, Associate Professor, Karolinska Institutet and the Swedish Quitline, Stockholm, Sweden. EU Quitlines. Background and overview.

¹⁰ Sally Haw, NHS Health Scotland. Guidelines and tools for smoking cessation.

continued on next page

¹¹ Dr Martin Potschke-Langer, German Cancer Research Center, Heidelberg. WHO Collaborating Centre for Tobacco Control. Smoking Cessation in Primary Care.

¹² Professor Joy Townsend, London School of Hygiene and Tropical Medicine, London University. Tobacco Taxation as Preventive Medicine. Myth versus evidence.

¹³ Rt Hon Frank Dobson, MP. Doctors and policy making: an insider's view.

¹⁴ Ania Lichtarowicz, BBC World Service. Doctors working with the media.

¹⁵ Dr Anabela Serranito, European Medical Students Association. Undergraduate education.

¹⁶ Eve Kralikova, Charles University, Prague, Czech Republic. Postgraduate and continuing medical education.

¹⁷ Dr Jocalyn Clark, BMJ Assistant Editor. The role of medical journals.

¹⁸ Dr Klas Winell, Educating medical professionals for tobacco control. Building Coalitions – working with other health professionals.

¹⁹ Copies of papers of most presentations can be obtained from the author tfraser@global-public-health.com

World's Most Comprehensive Report on Diet, Physical Activity & Cancer Enters New Phase

LONDON, Nov. 16 /PRNewswire-AsiaNet/ —

WCRF International Expert Panel Meets in UK to Review, Interpret Mounting Research

A group of the world's leading scientists gathered in London today (November 16) to address a pressing and perplexing question: what does science tell us about which foods we can eat and things we can do to prevent cancer?

Chaired by Sir Michael Marmot, this latest in a series of meetings of international experts will take place over three days. During that time, the panel will review a mountain of data that has been painstakingly gathered for them by teams of scientists at prestigious research centres in the US, UK and continental Europe.

When the panel adjourns, however, its members will only have passed the midway point in a process that is expected to conclude in 2006, after they have met at least three more times.

Why will it take so long to answer the question before them? Professor Martin Wiseman, who heads the project for World Cancer Research Fund International, estimates that at least 10,000 studies relating food, nutrition and physical activity to cancer prevention have now accumulated. These studies vary in their approach, design and in the method of measurement they use and at times reach seemingly contradictory conclusions.

The panel is sorting through these thousands of studies to find where there is convincing agreement. WCRF International has developed a procedure that will take another two years, cost over 5 million pounds Sterling and involve countless advisors, seven research centres in four different countries on two continents and input from six international observer organizations, all coordinated with the 21-member panel of experts.

“Once the panel has assessed the research, we will develop a set of comprehensive, evidence-based recommendations for lowering cancer risk,” says Panel Chair Sir Michael Marmot.

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World's Most Comprehensive Report on Diet, Physical Activity & Cancer Enters New Phase - continued from previous page

Ultimately, the panel will publish a set of recommendations for lowering cancer risk aimed at governments, industry, health professionals and the public. Their report, Food, Nutrition, Physical Activity and Cancer: a Global Perspective, will be available in print and in a searchable, multimedia electronic format. The full reviews completed by each of the research centres will also be available electronically.

But even that won't end the rigorous process of analysis. Now that WCRF International has put in place a uniform and manageable process for reviewing the data, the panel says it will be easier for the organization to periodically review emerging evidence and place it in context.

The first expert report, published by WCRF/AICR in 1997, has become the essential text in the field of cancer prevention; over 30,000 copies have been distributed to policy makers, health professionals, researchers and individuals around the globe. The expert panel behind that first report examined over 4,500 separate documents to come away with 14 recommendations that continue to be cited regularly in the scientific literature.

Notes to the Editor:

About World Cancer Research Fund International

World Cancer Research Fund International (WCRF International) leads and unifies a global network of cancer charities dedicated to the prevention and control of cancer by means of healthy food and nutrition, physical activity and weight management.

The WCRF global network has a unique role of translating scientific data for global health recommendations. These health recommendations not only inform the public on cancer prevention, but they also help to set the agenda for future cancer research and national health policies.

The WCRF global network comprises WCRF International, an umbrella association and its member organisations: national charities based in different countries (in the USA - AICR; in the UK - WCRF UK; in the Netherlands - WCRF NL; in Germany - WCRF DE; and in Hong Kong - WCRF HK). The vision of the global network is to prevent cancer worldwide, through a vital partnership of education and research programs.

SOURCE: World Cancer Research Fund International

CONTACT: Nina Roman of World Cancer Research Fund International, UK
+44-0-20-7343-4207

Web site: <http://www.aicr.org>

Translations:

Chinese - Simplified (<http://asianetnews.net/Download.asp?ID=31496>)

Indonesian (<http://asianetnews.net/Download.asp?ID=31498>)

Japanese (<http://asianetnews.net/Download.asp?ID=31499>)

E-prescribing, E-entrepreneurs, E-health?

By Ken Harvey, School of Public Health, La Trobe University

The uptake of computers by Australian general practitioners (GPs) was stimulated by the Australian government in 1999. A one-off grant of around \$10,000 was offered to those practices that purchased a computer, acquired internet connectivity (an e-mail address) and promised to use computer prescribing software to write the majority of their prescriptions. This increased the numbers of GPs writing prescriptions with the aid of a computer from around 50% in 1999 to more than 90% in 2004. [1] Legible, printed prescriptions have been one of a number of positive outcomes of this initiative. However, new problems emerged.

One software vendor (Medical Director™) rapidly became the market leader because its business model relied on selling pharmaceutical advertising within the software. The end result is that prescribers using this software (and often their patients who observe the screen) are exposed to numerous pharmaceutical advertisements; not only when the doctor is prescribing but also when blood pressure is entered or patient information is looked up. Some advertisements appeared randomly, others are targeted to the clinical function. The proponents of such promotion argue that it makes physicians aware of valuable new drugs and, by subsidising the price of useful software, it has facilitated uptake.

Opponents are concerned that the advertisements selectively promote the benefits of the latest and most expensive drugs. They provide minimal information about drug side-effects, contra-indications and costs. Cost-effective generic drugs are rarely promoted and non-drug solutions usually not at all. Pharmaceutical promotion has clearly been shown to influence physician's prescribing [2] and has resulted in cost-blow outs on the PBS due to "leakage" of prescribing away from cost-effective indications approved by PBAC [3]. In addition, pharmaceutical promotion in prescribing software, occurring at the time of physician decision making, is likely to be much more influential than promotion in medical journals, gimmicks and give-ways. Clearly, the provision of objective information, such as Therapeutic Guidelines and the Australian Medicines Handbook, would provide a better way of learning about new drugs. Ironically, despite the fact that these national resources are available in electronic formats they are not incorporated in Medical Director™. Finally, software without pharmaceutical advertisements but with equivalent functionality is available at a similar price (although it is accepted that there are opportunity costs in moving from one package to another).

In 2002, the government amended regulation 19(5) of the National Health (Pharmaceutical Benefits) Regulations 1960 to stop Medical Director™ software automatically ticking a, "Brand substitution not permitted" box on every prescription. In 2005, several medical and consumer organisations have advocated further amendment of the National Health (Pharmaceutical Benefits) Regulations to prohibit prescribing software from displaying pharmaceutical advertisements. They also argue that national objective therapeutic resources should be mandatory in such software.

It would be good if the PHAA could formally support such policies. Meanwhile, individual members of the PHAA might like to participate in a relevant on-line poll being conducted by the Australian Consumers Association [4].

(Endnotes)

¹ *General Practice Computing Group, Practice Incentives Program (PIP) statistics. Available: <http://www.gpcg.org/topics/pip.html>*

² *Avorn J, Chen M, Hartley R. Scientific versus commercial sources of influence on the prescribing behaviour of physicians. Am J Med. 1982;73:4-8.*

³ *Dowden J. Coax, COX and cola. MJA 2003; 179 (8): 397-398. Available: http://www.mja.com.au/public/issues/179_08_201003/dow10457_fm-2.html*

⁴ *Australian Consumers' Association. Prescribing software poll. Available: <http://www.choice.com.au/viewArticle.aspx?id=104588&catId=100386&rid=100008&p=1>*

Bar Owners Ignite Over Italy's Smoking Ban

Bar and restaurant owners are refusing to police a smoking ban when it takes effect this week in Italy, where breaking the rules is often considered a right.

The ban - delayed for a few days so revellers could enjoy their last New Year celebrations in smoky bars - aims to end passive smoking and deter those who pursue a habit that health officials say kills 90,000 people in Italy every year. "Those who want to smoke can do it in the street or at home but not right next to people who can't stand it and who cannot tolerate being poisoned," said the author of the new law, Health Minister Girolamo Sirchia.

Mauro, an Italian smoker, begged to differ. "It's a scandal because a government which earns money on tax from cigarettes can't make laws against smoking. It's like selling cars and then not allowing you to put petrol in because it pollutes," he said. Although smokers are in the minority - 18 million out of a total population of 58 million - Italians are sceptical of a prohibition they feel smacks of puritanism.

Ireland became the first country in the world to have a smoking ban in March 2004 but US states, including Maine, Florida and California, and the cities of New York and Boston, have had similar bans since 2003. Italian law relies on bar and restaurant owners - the vast majority of whom have not built closed-off smoking rooms - to ensure their customers do not smoke, with the threat of a fine of up to ?2000 (\$A2650) if they do not.

But restaurant and bar owners say they refuse to be the state's sheriffs and will not call the police if their customers light up. "Well, first of all, we aren't going to make any reports to any of the authorities. The law is a just one, but it has been introduced too quickly," Rome bar owner Paolo Rosetti said.

Mr Rosetti and others risk being caught out by undercover police who were planning crackdowns in the early hours of yesterday. One mournful restaurant owner in the Tuscan city of Grosseto held a mock funeral dinner. He distributed free cigarettes and cigars to customers and urged them to light up while eating.

<http://www.theage.com.au/news/World/Bar-owners-ignite-over-Italys-smoking-ban/2005/01/10/1105206045823.html>

- Reuters, Rome, January 11, 2004

Ethics in human research

The NHMRC is currently reviewing the National Statement on Ethical Conduct Involving Humans. The first consultation draft of the review is available at:

www.nhmrc.gov.au/issues/natstrev.htm

Submissions are due by 16 March.

As PHAA no longer has an Ethics SIG, we are looking for an individual or a group of people who have expertise or an interest in this area, and who would be willing to develop a submission.

If this is you, please contact Pieta Laut on (02) 6254 8275

Items of Interest

Counting Kids: Developing a New National Collection for Childcare and Preschool Services

A number of organisations currently collect information on children's services. All of these data collections are undertaken at different times, collect different information and use different data definitions. While there is some duplication of information across the collections, there are also notable gaps, and no single collection or combination of collections, is able to provide an accurate measure of the number and proportion of children who attend child care and/or preschool. Therefore, despite a high level of government and community interest in the provision of children's services and the number of children who use them, no one data collection currently exists which gives a comprehensive and comparable picture of children's services in Australia. This bulletin identifies the requirements needed for developing a new national collection for child care and preschool services.

Catalogue No. AUS-55, Available from CanPrint (ph: 1300 889 873); \$10.00

CSTDA NMDS Tables Prepared for the CSTDA Annual Public Report 2002-03

In July 2004 the Community and Disability Services Conference approved the release of the Commonwealth State/Territory Disability Agreement Annual Public Report 2002-03 (NDA 2004). By agreement with the National Disability Administrators, the Australian Institute of Health and Welfare prepared a set of tables to be used in Chapter 4 of that report. The present brief report contains the tables supplied for that purpose, for the use of those readers requiring the tables underpinning the text and figures in the CSTDA Annual Public Report. These tables are based on the first six months of available data from the 2002-03 Commonwealth State/Territory Disability Agreement National Minimum Data Set (CSTDA NMDS).

Catalogue No. DIS-36, Welfare Working Paper Series No. 46. *Internet Only*

First Medical Indemnity National Data Collection Report: Public Sector

Catalogue No. HSE-34, *Internet Only*

This report describes the development of and presents the first six months' data from the newly developed national collection of data on medical indemnity claims in the public sector. The medical indemnity national collection (MINC) includes both claims that have materialised (eg where legal action has commenced) and potential claims (ie matters considered likely to materialise into a claim, where a reserve has been set). The data in this report cover claims current at any time during the reporting period 1 January to 30 June 2003.

Go to: <http://www.aihw.gov.au/publications/index.cfm/title/10092>

Injury Deaths, Australia 2002

This report describes injury mortality in Australia during 2002. It includes information about the major causes of injury such as transport-related deaths, suicide and accidental falls. The data provided in relation to each cause include age and sex, State and Territory differences, trends over time, and other associated factors. The report will be relevant to anyone interested in gaining an insight into patterns of injury mortality and the burden it imposes on the Australian community.

Catalogue No. INJCAT-65, Available from CanPrint (ph: 1300 889 873); \$30.00

Items of Interest

Measuring the Impact of Asthma on Quality of Life in the Australian Population

This report provides a comprehensive review of approaches to measuring the impact of asthma on quality of life that can be used in population-based monitoring. It is concluded that no single measure can be used in all circumstances. Rather, selection from the range of alternative measures should be based on the specific monitoring task and the attributes that are most relevant to that task. This report is intended for use by policy makers, data agencies and researchers involved in measuring population health. While the main focus is on population monitoring in relation to asthma, the findings will be of interest to those whose focus is on other chronic diseases.

Catalogue No. ACM-3, Available from CanPrint (ph: 1300 889 873); \$22.00

Cancer in Australia 2001

Cancer in Australia 2001 present comprehensive national data on cancer incidence and mortality and summary data on cancer screening, the cancer workforce and cancer expenditure in Australia. The report provides 2001 data for cancers by site, age and sex, and summary data for each State and Territory. Incidence and mortality trends since the early 1980s and age patterns for selected cancers are features of this report.

Cancer in Australia 2001 is an important reference from the Cancer Series for all those interested in the health of Australians.

Catalogue No. CAN-23, Available from CanPrint (ph: 1300 889 873); \$25.00

Nursing Labour Force, Victoria, 2003 (AIHW Bulletin No. 15)

This report was commissioned and funded by the Victorian Department of Human Services (DHS) to assist with its policy strategies and planning to address issues with the State's nursing workforce shortfalls. The report focuses on changes in nurses' work patterns over time, particularly hours and areas of clinical work, and is part of a series of studies on nurse workforce issues being coordinated by the Victorian DHS.

Catalogue No. AUS-47, Available from CanPrint (ph: 1300 889 873); \$10.00

Children with Disabilities in Australia

What is known about children with disabilities in Australia, in terms of their characteristics, and the needs and circumstances of them and their families? What is known about the services, benefits and assistance provided to them? The report Children with Disabilities uses a range of information sources to explore these questions and present for the first time, an overview of this important group in Australia.

Catalogue No. DIS-38, Available from CanPrint (ph: 1300 889 873); \$22.00

Australia's Babies: Their Health and Wellbeing

The AIHW has been reporting on the health and wellbeing of Australia's children since 1998. This bulletin complements the Institute's four comprehensive national reports in this area that cover childhood health conditions and injuries, major risk factors and determinants of health, child development and wellbeing. This bulletin on the health and wellbeing of Australia's babies is the first in a series to be published as part of a key national indicators project being undertaken by AIHW. It focuses on four selected topics - birthweight, gestational age, birth defects and infant mortality - and presents data for the five-year period from 1997 to 2001.

Catalogue No. AUS-54, Available from CanPrint (ph: 1300 889 873); \$10.00

Books Available from World Health Organization

Guidelines for Conducting Community Surveys on Injuries and Violence

World Health Organization, Geneva
Cost US\$36.00 Order No. 11500594
Email: publications@who.int

World Report on Knowledge for Better Health

Strengthening Health Systems
World Health Organization, Geneva
Cost US\$27.00 Order No. 11500607
Email: bookorders@who.int

Immunization in Practice: A practical guide for health staff

World Health Organization
Cost US\$27.00 Order No. 11500593
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Cost US\$13.50 Order No. 11500605
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