

2001-2002 Budget

■ **Pieta Laut** *Executive Director*



The big news for this month has been the Commonwealth Budget. As always, it is not a “greenfields” start to a new financial year, rather the budget

retains a number of on-going programs, drops some off and generally passes money from one program to another as is seen to be expedient.

This year has proved to follow the same general pattern, and not to the advantage of public health. Although you won't see these figures in the newspapers or the portfolio budget handouts, we were told in the budget lock up that population health had contributed 26% of the funding for the new initiatives and had received in return only 14% of the new initiatives funding. That's a net loss of 12% of the funding of new initiatives. A considerable amount any way that you look at it.

Within the budget there are a number of measures in which we can take some heart:

- **Better Outcomes for Mental Health** builds on the National Depression and National Primary Mental Health Care Initiatives and is specifically funded to help the primary health care sector to provide better access to mental health services through a range of providers, with an emphasis on best practice approaches for early intervention, prevention and management of mental illness;
- **Building on the Regional Health Strategy** provides funding for additional practice nurses, rural nursing scholarships and improvements in after hours services, and the restructuring of rural and urban fringe aged care and an extension of the Community Visitors Scheme;
- **Better Health for Aboriginal and Torres Strait Islander People** is aimed at improving the health care system for Aboriginal and Torres Strait Islander communities via investment in the Primary Health Care Access Program, building on a platform to be developed from the findings of the National Evaluation of the Aboriginal and Torres Strait Islander Coordinated Care Trials, providing funding for the purchase of conjugate pneumococcal vaccine for children at risk of contracting the disease, and providing arrangements around FBT for most not-for-profit Aboriginal and Torres Strait Islander organisations;
- **More Help for People with Alcohol and Drug Problems** initiative is the previously announced funding to establish an Alcohol Education and Rehabilitation Foundation as a charitable trust which will support evidence based treatment for alcohol and other legal substance abuse, promote community education and provide funding grants to organisations with appropriate community linkages to deliver these services on behalf of the Foundation; and,
- **Safer Health Care** which contains support for the work of the Australian Council for Safety and Quality in Health Care, and provide funding to maintain continuity and confidence in Australia's blood supply amongst other things.

There are a number of measures hidden within the “Medicare – Even Stronger Now” package that should also provide better population outcomes. These deal with better GP management of asthma, increased funding of GP's for cervical cancer screening and support for GP's to manage patients with diabetes.

The other area of particular note is the measure called “Access to Quality Medicine”. This measure saw the

■ continued page 2

in this issue

2001-2002 Budget	1
Elected Office Bearers	2
Presidents report	3
Branch News - WA	4
SIG News -	
Political Economy of Health SIG	5
New Members	6
What's On	8

■ continued from page 1

funding of an additional \$21.4 million over four years to build on the National Prescribing Service, to extend its coverage to all Divisions of General Practice and for more systematic work with specialists and hospital doctors. All of this is to contribute towards savings of \$14.6 million annually in PBS expenditure. The package also included a measure for educating consumers about the misuse of medicines, and the continuation and expansion of the National Medicines Disposal Program. And last but not least the package includes a measure to clarify and improve the wording of the

current PBS instructions for prescribing cholesterol-lowering medicines, which will provide a savings of \$103.9million over four years.

Overall, there are a number of measures that should improve the health of the Australian population. However, the seeking of savings continues to put population health measures at a disadvantage against what are perceived to be 'the sharp end' programs. We will need to monitor carefully the long term wins and losses in budgetary measures in order to ensure that population health retains proportional funding and is not eroded by being the continual source of savings.

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Australian Food and Nutrition Monitoring Unit Project

Further details about the project can
be obtained from the website at:
[http://www.acithn.uq.edu.au/
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Presidents report

▣ Peter Sainsbury *National President*



The promotion of public health (the health of the public, that is, not the interests of public health workers) is, of course, the prime aim of our

Association. In a system that is so heavily dominated by illness care and where 'health' is such a hot political potato however, it is not surprising that most of the media's health interest goes to hospital beds, emergency department waiting times, neonatal intensive care units, access to GPs, etc. I'm discovering as President, though, that not infrequently the PHAA is contacted by a member of the media for comment on a health-related issue. Occasionally the issue has little significance for us as an organisation and we decline to comment – an industrial dispute involving one of the health professions in one of the states is a recent example. More frequently, however, the contact provides us with an opportunity to promote public health – a 'free shot', so to speak, as our opinion is being sought rather than us having to generate some interest in an issue.

Sometimes the issue is one on which we already have a policy, for instance health insurance, and it is relatively easy for us to identify an appropriate spokesperson and what we wish to say. Sometimes, although we do not have a policy directly related to it, the issue is so closely related to one of our policies that it is not difficult to identify the public health aspects that we should highlight. The recent controversies regarding the Pharmaceutical Benefits Schedule (PBS) and the Pharmaceutical Benefits Advisory Committee (PBAC) are recent examples here. Occasionally, however, the issue is one about which we have no relevant policy. A couple of weeks ago I was contacted by the ABC to comment on a report concerning the ownership of and access to medical

records. The AMA had criticised the report, so the reporter said, because it had recommended greater access to records by patients and the ABC wanted to include a different perspective in their coverage. *'What is the Public Health Association's view on this?'*, the reporter asked. My secretary had already ascertained this much before asking me if I'd like to take the call so I was able to have a quick look through our policy book before speaking to the reporter. On confirming that we do not have a policy that is in any way relevant I was initially tempted to tell the reporter that I didn't really think I wanted to comment on behalf of the PHAA. But after a moment's reflection I realised that although we do not have a definite policy on medical records it would not be difficult to apply some basic public health principles that inform many of our policies: openness, access, consumer participation, for instance. As a result, I was able to make some comments in support of the overall direction proposed in the report which I'm fairly confident would have the support of the vast majority of our members because they were promoting public health.

At other times it is important for the PHAA to act in concert with other organisations to promote public health. A month or so ago the Federal Minister and the AMA issued press releases calling for greater control, even banning in the Minister's case, of boxing. This followed yet more serious injuries and deaths as a result of boxing. Again the PHAA does not have a directly relevant policy, although we do have policies relating to reducing injuries and deaths due to accidents and violence. It seemed, however, that this was an issue on which we could legitimately make a stance and following a rapid exchange of emails among the National Executive, Branch Presidents and SIG convenors we issued a press statement supporting the Minister and the AMA and calling for greater safety measures in the ring. I,

personally, would like to see the PHAA support a total ban on boxing but that is a more controversial matter and one on which it is appropriate for the whole membership to have a say through the policy making process.

Promoting public health is not an easy task and we must grab every appropriate opportunity. The forthcoming federal election will provide us with a great chance to bring the matters that move us most in to the political limelight. Many thanks to all those members who voted on the issues for inclusion in our election agenda. The agenda is now being finalised and we will then produce information sheets for wide distribution to politicians and the media on each of the ten selected issues. We will be seeking interviews with the leading health figures in each of the major parties. We are also keen to involve members as much as possible in 'selling' our agenda to their local candidates, and to build alliances with like-minded organisations.

To help us develop our advocacy skills, Terry Slevin, our Vice President (Development), has been developing a program of 'advocacy workshops'. It is intended to run one workshop in each of the larger states over the coming months. Terry has managed to persuade some very high profile people to participate in the workshops, so look out for them in a cinema, sorry meeting place, near you.

Finally, I encourage you to become involved in the Association's policy setting process. We have developed a very careful, comprehensive system for developing and endorsing policies to ensure that the views we promote reflect the opinions of the majority of members, and we have a Vice President (Policy), Helen Keleher, and a Policy Action Committee. We are, however, reliant on members letting us know what they feel strongly about and what could be done to solve public health problems, and doing some of the backroom work preparing our policy statements.

Branch news: NEWS FROM THE WEST

■ Ilse O'Ferrall *WA Branch President*



I took over the presidency of the WA Branch at the beginning of the year with Terry Slevin's move to the national executive committee. Other

members of the WA committee are: Sandra Thompson (Vice-President), Philip Davies (Secretary), Kieran McCaul (Treasurer), Chris Costa, Jane Freemantle, Carolien Giele, Peter Howat, Jill Rowbottom and Terry Slevin.

The year started with the WA Branch contributing to the development of a document *Investing in Public Health* which was the subject of a previous article in *In Touch* by Terry Slevin. This document was prepared in the lead up to the State election, when the Labor Party (unexpectedly) gained government. A number of the recommendations in the booklet became Labor Party policy, which we now look forward to seeing implemented. A major change is their undertaking to change the public health care system. The Branch put in a submission to this process.

For the last few years the WA executive committee has discussed the merits of employing an executive officer to assist the committee in its tasks. Previously we encouraged students to join the committee. This ad hoc arrangement worked well for a while, however, with the turnover of students, it was felt that a more robust solution was required.

Members of the committee are extremely busy people with little time to organise the minutiae of committee business, but with a huge commitment to the furtherance of the objects of the Association.

Debate about the paid position centred on how the tasks of the officer would overlap or make redundant the tasks of the elected officers and whether there would be sufficient funds/work for the person, etc. There was a feeling that with the appointment of an executive officer, there would be less commitment from the members. Having decided finally that it was worth trialing the position for twelve months, the committee put its mind to the task of developing a detailed job description and advertising the position through our professional networks.

The job description covers such things as maintaining and updating the membership database and e-mail lists, general administrative office duties, such as filing (with quite a backlog), taking minutes at executive committee meetings, drafting submissions, assisting the executive committee with promotion of the Association, assisting in the organisation of professional development seminars and assisting with production and distribution of the Branch newsletter.

At the beginning of the year we advertised the position and were fortunate to recruit Michelle Tang for a one year trial period. Michelle is paid from Branch funds and employed through the National Secretariat.

To date Michelle has provided the services mentioned above as well as drafting the quarterly report to head office, sending out regular e-mails to members about seminars, vacant positions and edited the Branch newsletter.

It is really too early to be able to properly assess the costs or benefits of having such a position, but from a personal point of view, I can say that she has been valuable in providing excellent organisational skills which have lightened the administrative load. It is difficult to assess whether there is more or less commitment from members. We still need to re-define the role of the honorary secretary, for example. However I would guess that with some of the administrative burden being taken care of, there will be opportunity for the committee to provide further services to our members.

Advocacy and professional development have continued to be important priorities for the Branch executive. The Association is represented on a number of significant policy-making committees and continues to provide submissions to various reviews, such as the Health Administrative Review and the forthcoming Drug Summit. We have invited the new Minister for Health to come to speak to our members about the recent administrative review and what it means for public health in this State. This will be co-hosted with the Australian Health Promotion Association on 21 June 2001.

IMMUNISATION

The Commonwealth has recently published two booklets on immunisation: Keep it Cool: the Vaccine Cold Chain - Guidelines for Immunisation providers on maintaining the Cold Chain, and National Guidelines for Immunisation Education for Registered Nurses and Midwives – A Guide for Course Assessors, Educators and Training Organisations. Both publications are available from the Immunise Australia website at <http://immunise.health.gov.au> or by contacting Shannon Clarkson on (02) 6289 9334.

National Health and Medical Research Council invite applications for Primary Health Care Postgraduate Research Scholarships and General Practice Fellowships. Further information about these training awards is available at: <http://www.health.gov.au/nhmrc>

Special Interest Group news.

WHY ARE EUROPEANS ON TOP?

■ Ben Bartlett *Political Economy of Health*

Whilst some New Age philosophers might question the values system that assumes that Europeans are on top, measures such as life expectancy, education levels and economic prosperity certainly suggest that in these areas, at least, if not spiritually, Europeans have been the winners, with Third World populations and Indigenous populations struggling at the margins for a share of the action.

This is the question that Jared Diamond asks and attempts to answer in his book *Guns, Germs and Steel*, appropriately subtitled *A Short History of Everybody for the Last 13,000 Years*. In his Deakin lecture² in Melbourne in May, Diamond applies his insights to Australia. In this lecture Diamond suggests that a common perspective (often unspoken) represents the prevalent view of Aboriginal Australia:

Native Australians arrived here about 65,000 years ago, yet as of the year 1788 they were still hunter-gatherers; they still had no agriculture, no metal tools, no writing, no politically centralised government, anywhere in Australia. In 1788, Europeans arrived, and within a short time, they created a modern society with agriculture, metal tools, writing and a politically centralised government whose centenary we are celebrating today.

Apparently, this is a perfectly controlled experiment: same place, different people; the sole difference is between the two different peoples, and so the different outcomes of the two runs of the experiment must be because of biological differences between the two peoples.

He goes on to point to the fatal flaw in this thinking. The colonists from Europe brought their technologies and domestic plants and animals with them. They did not arrive naked to create the technologies and agricultural practices from what was available in the Australian environment.

Diamond presents a compelling case against the common perception that it is something about the people that led to the current situation where Europeans are dominant. Instead he documents with a great deal of scientific evidence the geographic factors that have led to this difference. He puts it this way in the Deakin Lecture:

The answer is that the rise of agriculture was fundamental to the development of human societies around the world since the end of the last Ice Age, because it was agriculture that permitted the development of high human population densities, sedentary living in villages, and accumulation of storable food surpluses that could be used to feed professional craft specialists, metal workers, scribes, bureaucrats, kings and generals, who could

devote all their time to those professions and who didn't have to spend any time hunting or gathering or growing their own food. So agriculture was prerequisite to the development of complex technologies, metallurgy, writing, politically centralised government and standing armies. No hunter-gatherer society ever developed any of those things...

Why, then, didn't some local hunter-gatherers develop farming and gain those advantages at many different places all around the world, including in Australia? It's because very few wild plant and animal species can be usefully domesticated, and those few species are concentrated in only a few areas of the world, especially the Fertile Crescent of Western Eurasia and China. So people of those few areas got a big head start on agriculture and a big advantage over other peoples.

Australia, as the smallest and least productive continent, has the fewest wild plant and animal species, and it has by far the lowest number of domesticable plant and animal species.

Is Diamond correct in his assertion that many European Australians see the disadvantage of Aboriginal people compared to Europeans as a consequence of some biological difference? Lisa Rasmussen has conducted a study on Aboriginal health education of medical students³. The following table is presented below:

Percentage of students mentioning particular causes of poor Aboriginal health during an Aboriginal health survey

Cause of Ill-health mentioned by Students	1 st Year	2 nd Year	3 rd Year
Historical legacies	9%	20%	31%
Culturally inappropriate health care	7%	16%	25%
Self-determination/ land rights	1.4%	1.6%	16%
Genetics	3%	5%	12.5%

■ continued page 6

■ continued from page 5

Those of us working in Aboriginal health would take some satisfaction from the changes in the first three categories, albeit still low percentages. The changes would seem to indicate some positive impact of the education programs delivered. However the last category, genetics, is cause for concern and reflection. Genetics is a key biological factor associated with individuals and particular population groups, and the percentage of medical students seeing genetics as a significant factor in poor Aboriginal health has increased.

This seems to be evidence that the view that biological factors explain poor Aboriginal health status is widely held. The prevalence of this view may help explain the failure to implement the 1989 National Aboriginal Health Strategy or the recommendations of the Royal Commission into Aboriginal Deaths in Custody. It may also help explain the paternalism⁴ common in many Aboriginal health programs and the failure of many programs to be

sustainable after a key non-Aboriginal player moves on.

There is much anecdotal evidence to suggest Diamond is correct in his assessment. His analysis provides us with a more rational explanation of the current state of affairs that may help counter the deeply held common (if unspoken) view that Aboriginal disadvantage is because there is something inferior about them compared with the more successful Europeans.

¹ Diamond, Jared *Guns, Germs and Steel: A Short History of Everybody for the Last 13,000 Years*. Vintage, London, 1998.

² Diamond, Jared *Australia's Past and Australia's Future* Deakin Lecture, Melbourne Town Hall 14th May 2001.

³ Rasmussen, L *Towards Reconciliation in Aboriginal Health: Initiatives for Teaching Medical Students about Aboriginal Issues* VicHealth Koori Health Research & Community Development Unit, University of Melbourne, 2001.

⁴ Paternalism may be defined as *Good Intentions + Ignorance*.

At last it's here!

The much anticipated chronic disease website is now live. The website includes information on two Commonwealth Health programs: - Sharing Health Care Initiative (1999-2000 Budget): and Rural Chronic Disease Initiative (2000-2001 Budget). This site also includes some useful links to other relevant sites. You can access the site at:

<http://www.chronicdisease.health.gov.au>

FREE Publication

The publication, *Socioeconomic determinants of health: towards a national research program and a policy and intervention agenda*, is available free of charge, from the Commonwealth Department of Health and Aged Care. This report: reviews Australian research and research capacity in the area of socioeconomic status and health; reviews policies and interventions to reduce socioeconomic inequalities in health; & makes preliminary recommendations on the development of a national health inequalities research program and a policy and intervention agenda.

For copies telephone: 1800 020 103 or email: phd.publications@health.gov.au

New Members

New South Wales

Wesley John Noffs

Victoria

Sally Fawkes

Karen Peters

Queensland

Kylie Johnson,

Darren Hauser

Tasmania

Michael Wilson

South Australia

Anna Ziersch

Northern Territory

Mary-Anne Measey

Harkness Fellowships in Health Care Policy

The Commonwealth Fund of New York is pleased to announce the Harkness Fellowships in Health Care Policy, and to invite applicants for the 2002-2003 fellowship cycle. If you have a interest in policy issues and are just starting out in your career please see The Commonwealth Fund's Webpage: www.cmwf.org

Logistic Regression and Survival Analysis in Epidemiologic Research

16 - 20 July 2001, Hobart

This intensive course provides theoretical and practical training for epidemiologists and professionals of related disciplines in statistical modelling, with a particular focus on logistic regression and survival analysis. It is suitable for those with some previous training and experience in epidemiology and/or biostatistics.

Topics include the logistic regression and Cox proportional hazards models that have become standard methods for regression analysis in the health sciences, as well as descriptive methods for survival data.

Course presenters are Professor Stanley Lemeshow (Ohio State University) and Professor David Hosmer Jr (University of Massachusetts). Both are Faculty members of the highly regarded New England Summer School Program.

For registration details please contact Wendy Spencer.

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Are you thinking of a career in Public Health?**Do you have students who are thinking of a career in Public Health?**

NHMRC funding (“Training Awards”) for Public Health is available - 2 or 4 years’ support at PhD or post-doc level. Applications are invited in all aspects of public health - epidemiology, biostatistics, social and behavioural aspects of health, health economics, health services research or other relevant area.

Awards are held in Australia except the Sidney Sax Fellowship for post-doc training which is held overseas.

Eligibility ¹	Name of Training Award	Yearly Funding Support	Years available
Graduates			
Graduate in area relevant to public health	Public Health Scholarship or Indigenous Health Scholarship Nursing and Allied Health	\$18,842 ² \$23,857 ²	Maximum 3 years
Medical or dental graduate	same	\$27,255 ²	Maximum 3 years
PhD³			
PhD relevant to public health – no more than 2 years from date that thesis was passed	Public Health (Australian) Fellowships	RO1 to RO3 level Current salary range from: \$40444 - \$43414	4 years’ support; years 1 & 2 must be with an institution & research group other than that of the PhD
PhD medical or dental graduate	same	same	same
PhD relevant to public health	Sidney Sax Fellowship		2 years overseas, 2 years in Australia

1. Eligibility: Australian citizen or permanent resident.

2. Non-taxable

3. Applicants should have no more than 2 years post-doctoral experience from the date that the doctoral thesis was passed

What do you or your student need to know to apply?

- the general field of public health in which the training award will be held and the future career followed
- a suitable project or proposal for the training project
- an institution and supervisor for the proposed area of study

What do you or your student need to do?

make sure the application and references are received at the Office of NHMRC **by the closing dates -**

scholarships closing date 17 August 2001

fellowships closing date 27 July 2001

- fill in an application form: aims, significance of the proposal, applicant’s background including suitability for and benefits from this training, arrange for referees’ reports
- look up the necessary information in your institution’s research office or on the NHMRC Website <http://www.health.gov.au/hfs/nhmrc/research/train/training.htm>

What's on

29 June - 3 July 2001

Short Course in Reproductive and Perinatal Epidemiology. Centre for the Study of Mothers' and Children's Health, 251 Faraday St Carlton, VIC 3053. The course covers epidemiological principles of study design and method, evidence-based practice, sociodemographic factors in reproductive and perinatal health, and the availability and use of state and national data. For more information on the course: <http://www.latrobe.edu.au/www/csmch/>

20-22 August 2001

The Australian Best Practices Drug and Alcohol Programs, ANA Hotel Gold Coast. The Conference will focus on the practical work and issues that concern drug and alcohol program providers throughout Australia. For a full list of speakers and topics please contact The Conference Secretariat, Australia-Australasia Conferencing Services. (Ph) 07 4945 7122, (Fax) 07 4945 7224. email: icsa2@bigpond.com.au

9-15 September 2001

Internet conference hosted by Nature and Society Forum Inc. Food - for Healthy People and a Healthy Planet.

www.natsoc.aust.com/~natsoc

This low cost, interactive conference aims to provide an integrated perspective on the impacts of food consumption and production on the health of both humans and the environment. For further information, email Sue Gilbert:

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Nature & Society Forum, GPO Box 11, Canberra ACT 2601, Ph (02) 6288 0760 Fax (02) 6287 4489

17 - 28 September 2001

3rd Gender and Reproductive Health Short Course for health managers, planners, and researchers. The course will be held at the University of Melbourne's Key Centre for Women's Health (WHO Collaborating Centre). Focus: Social Determinants of Health; Evidence; Gender; Reproductive Rights; and Policy. Includes participatory presentations, small group work, seminars,

individual and group presentations, development of Action Plan and field visits. Possible to take subject as credit. Phone (03) 8344 4333, fax (03) 9347 9824 or email siangt@unimelb.edu.au.

8 - 12 October 2001

Health Promotion, Planning and Evaluation Short Course at the University of Melbourne's Key Centre for Women's Health (WHO Collaborating Centre). Focus: health prevention and behaviour change, rapid needs assessment methods, planning health programs, introduction to health program evaluation, and small group exercises to reinforce learning. Possible to take subject as credit. Phone (03) 8344 4333, fax (03) 9347 9824 or email siangt@unimelb.edu.au.

26 November - 5 December 2001

2nd Tobacco Control & Gender Short Course for policy makers, planners and researchers. The course will be held at the University of Melbourne's Key Centre for Women's Health (WHO Collaborating Centre). Focus: links between tobacco use and gender, research techniques to investigate social influences on tobacco use, development of strategies for tobacco control, and linkages for advocacy policy change. Interactive presentations, small group work, and visits to local tobacco control organisations. Possible to take subject as credit. Phone (03) 8344 4333, fax (03) 9347 9824 or email: siangt@unimelb.edu.au.

2-5 December 2001

Nutrition at the Edge, Nutrition Society of Australia 25th Annual Scientific Meeting, National Convention Centre, Canberra. Contact: Ph (08) 8363 1307 Fax (08) 8363 1604 email: nsa@fconventions.com.au website: www.nsa.asn.au

12 January - 1 February 2002

5th Summer School in International Health and Development For Christian Health Professionals preparing to work in or on forlough from areas of development. Further information: INTERMED. SA, PO Box 223, Torrens Park SA 5062 email: ajr@health.on.net

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