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Newborn Hearing Screening – Progress Report: Child Health SIG

Peter Baghurst, Child Health SIG

Between one and two children in every thousand are born with a permanent hearing impairment (PHI). In Australia this means between 225 and 450 children are born with PHI every year. In the early 1990s, new technologies made it possible to detect PHI at a very early age and now children born with this condition can be identified within days or even hours of birth – a vast improvement on the average age at detection using the old methods of ‘distraction’ testing, or simply waiting for families or teachers to request an investigation into developmental problems.

When I last reported on this topic in In Touch, the Universal Neonatal Hearing Screening Working Party (SA), the PHAA Child Health SIG and the Women’s and Children’s Hospital in Adelaide were about to co-host a one day National Forum to discuss the implementation of universal hearing screening in newborn children throughout Australia. The main purpose of the meeting was to allow audiologists, ear, nose and throat specialists, educationalists, paediatricians, epidemiologists and consumer advocates to come together and discuss a coordinated approach to the introduction of these technologies across Australia.

Adelaide Forum 2001

More than 110 people attended the event which was held in Adelaide in March 2001. A consensus statement (which used the PHAA policy as a starting point) was developed and a National Committee, consisting of two members from each state, a representative from Australian Hearing and a consumer advocate was set up. The Committee meets regularly by teleconference with Victorian paediatrician Dr Melissa Wake in the Chair.

As is so often the case on health issues, state sovereignty is proving to be a major obstacle to progress. The federal government regards screening activities as a state responsibility, so instead of having to approach just one government and convince it of the value of implementing, or at least trialling, newborn hearing screening, the National Committee has to convince eight jurisdictions. It is hardly surprising that different state and territory governments are at different stages of acceptance of the notion of newborn hearing screening, so advocates have had to begin whenever their particular government decides to support them and with different levels of resources. The result is that we have a number of independent screening programs or trials springing up around the nation, each with variable resources, each in varying stages of implementation and each having to develop its own infrastructure.

What can a national committee do in this situation?

There are still many things that can be done to minimise the inefficiencies inherent in a system that delivers health care through both federal and state governments. First of all, a national committee provides a vehicle for sharing the knowledge and experience of the most advanced programs with the newest. For example, the literature suggested that only half of all children born with PHI exhibited recognised risk factors such as a family history of deafness or prematurity/very low birthweight). In WA, which has now screened upward of 20,000 babies, the proportion of babies with PHI and known risk factors has been much higher. This has raised the question of whether newborn hearing screening should be targeted or universal. Targeted screening has been rejected in the US, the UK and a number of European countries, usually on the basis that the time it takes to establish the risk factors would be better spent just performing the test!

Secondly, there is the question of monitoring the progress of the

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Community Health Special Interest Group



Helen Keleher
PHAA Vice President (Policy)

This is a call for expressions of interest from PHAA members to join a new Community Health Special Interest Group (SIG) that will be proposed at the next PHAA AGM. This SIG has been discussed already by PHAA Council which is now only awaiting the required documentation in order to give final approval for its formation.

The final application must include:

- a proposed name for the group (should this be just Community Health SIG or Community and Primary Health Care SIG? or Primary Health Care SIG?);
- proposed aims and objectives;

- the names of five PHAA members who agree to join an interim committee; and,
- the names of 15 other PHAA members willing to join this SIG.

I am happy to put the proposal together and to be the interim SIG Convenor after my retirement as PHAA Vice-President in September.

Please forward expressions of interest (ie. a statement of willingness to be on the interim committee and/or to join this SIG) to me at hkeleher@deakin.edu.au or facsimile 03 9244 6017. Comments and suggestions regarding the name and aims and objectives for the proposed SIG would also be very welcome.

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various trials and programs around the country. For this to be practicable, a common minimum dataset should be collected. A data sub-committee has been formed to try and standardise this.

Finally, while the possibility of the Federal government supporting newborn hearing screening may seem rather remote at this time, we should not abandon the bigger dream of a more coordinated national approach. If childhood immunisation data can be stored and administered at a national level, why can't this be done for other aspects of child health? How much extra infrastructure would it take to collect multiple health outcomes?

But perhaps the biggest threat to the introduction of universal newborn screening comes from challenges to the evidence on which it is based.

The US Preventive Services Task Force (USPSTF) recently published a review claiming that:

the evidence is insufficient to recommend for or against routine screening of newborns for hearing loss during the postpartum hospitalization.

A closer look at this apparent bombshell revealed that in fact their findings were in two parts:

1. There is good evidence that newborn hearing screening leads to earlier identification and treatment of infants with hearing loss.
2. Evidence to determine whether earlier treatment resulting from screening leads to clinically important improvement in speech and language skills at age 3 years and beyond is inconclusive.

Thus the contentiousness of the final USPSTF recommendation is based solely on the second statement which refers to the level of evidence that early detection of permanent hearing loss results in better long-term speech and language skills.

It is true that the results of the studies which are most frequently quoted^{1,2} in support of an effect of early detection on long-term speech and language skills could be interpreted differently. They are not randomised controlled trials. However, there is a welter of information from the discipline of linguistics which supports, albeit circumstantially, the concept that late detection of permanent hearing loss will severely hinder child development.

For those who hold that only a randomised controlled trial can provide adequate evidence, the weight of this observational evidence is not sufficient – but for many health professionals it is. Here, for example, are comments from a professional who holds that the observational evidence is strong enough to preclude the need for further investigation. They refer to an application I made for funding to study the language skills of hearing impaired children registered with Australia Hearing and to relate those skills to the age at which their impairment was detected and managed:

I cannot rate this proposal highly in terms of its urgency or necessity. The applicants base their claim for the

need for the project on the grounds that very little evidence is available to support the notion that early detection of hearing loss and access to appropriate intervention facilitates the development of children with hearing loss. I cannot accept such a proposal. It has been widely accepted for over sixty years that the earlier hearing loss is detected and intervention obtained, the better will be the hearing impaired child's development in language, social behaviour, and identity etc. Data is available to support such a proposition, beginning with the Ewings and Whetnall and Fry in England in the forties/fifties, Pollock and the Central Institute for the Deaf group in St Louis and others in the sixties/seventies and the recent work of (inter alia) Yoshinaga-Itano.

It is hardly surprising, with a reviewer who rates the strength of the existing observational evidence so highly, that this grant application was not successful!

Could we undertake a randomised controlled trial?

A randomised controlled trial would require screening in a random selection of hospitals or in randomly chosen newborns within postnatal wards of all hospitals. The language skills of children with permanent hearing loss detected by neonatal screening could then be compared with the language skills of children with PHI detected at later ages. The political and ethical difficulties associated with such a trial, while not insurmountable, would be considerable!

Yoshinaga-Itano et al compared language skills in children group according to the age at which their permanent hearing loss was detected. They reported an improvement of 1 standard deviation in Language Quotient among the children whose impairment was detected and managed before 6 months of age. A randomised controlled trial designed to detect an effect as high as 1 standard deviation with a power of 90%, would require 15 children with PHI in each of two equally sized groups (a group screened neonatally and an unscreened group). If the frequency of permanent hearing loss in Australia is assumed to be 1 – 2 per thousand, this would require a study population of around 20,000 newborns and take many years to complete. And even supposing that by, say, 8 years of age, those children with PHI detected late had caught up with those children whose impairment was detected early, are we to attach no importance at all to the enormous resources required for that catch up, and for the interim effects of undetected impairment on those children's quality of life?

References

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President's Column



Peter Sainsbury, PHAA President

I can't help being somewhat amused by the irony of private doctors threatening to stop work and/or move into the public sector unless the Federal government provides big bucks and guarantees their professional indemnity.

When it suits them, for instance when trying to avoid unwanted interference in their professional practice or maximizing their incomes, doctors who work in the private sector assert their status as independent business people and remind everyone who'll listen that civil conscription is unconstitutional. When private enterprise fails to provide them with the security and benefits that they want, however, private doctors have no hesitation in demanding government subsidies and all the benefits of being public servants – professional indemnity, workers' compensation, etc. In different political circumstances, the current medical indemnity crisis would be a wonderful opportunity for the Federal government to shift the financial support it provides to the private health care industry to the public system. Regrettably, this won't happen.

On the contrary, Medicare and the Pharmaceutical Benefits Scheme (PBS) continue to be steadily undermined. The services they offer are being eroded. For instance:

- the 30% rebate for private health insurance is depriving the public health care system of funds – funds the system could use to improve a whole range of community and hospital services;
- the recent Federal budget increased the price of medications on the PBS, thus making it more likely that poor Australians will go without necessary drugs because they can't afford them;
- the percentage of medical services that are bulk-billed is slowly but steadily falling, making consultations more expensive for everyone and increasing the difficulties of the disadvantaged and the sick.

Just as worrying, however, is that the principles underpinning Medicare and the PBS are being eroded. Both were designed for, and are still provided for, all Australians, not just the poor. They are there to ensure that all members of the Australian community have access to the best available health care – access that relates to need, not ability to pay. Repeatedly, however, we hear politicians, journalists and members of the private health care industry asserting that the public sector is really just a safety net for the most disadvantaged in society and that everyone else has a moral obligation to 'go private'. And as I reported in April, we have even seen an Area Health Service in NSW arguing along these lines in court.

Although it's a difficult path to tread at present, the PHAA and our partners in the National Medicare Alliance will continue to

do all we can to promote awareness of the advantages, for individuals and Australia as a whole, of a well resourced public health care system. No one would suggest that Medicare and the PBS are perfect, but they have been extremely successful in delivering high quality care at a price individuals and Australia can afford. We must do all we can to ensure that we do not return to the chaos and uncertainty of pre-Medibank days.

On a more positive note, I'm delighted to report that the 8th PHAA Immunisation Conference in Melbourne in May was a tremendous success. Over 500 registrants heard excellent presentations by international and Australian speakers. Immunisation is not a particular interest of mine, but I was greatly stimulated to learn about the many advances being made in immunisation coverage (see box) and vaccines, and I was absolutely thrilled to experience the passion felt for the issue by those present. It was especially pleasing to see that the immunisation field is attracting so many talented young public health workers. Believe it or not, such was the interest that it was only with considerable skill that Rosemary Lester was able to bring the discussions about the conference resolution to a close at 4.45pm on a Friday afternoon! Congratulations and many thanks are due to Rosemary and Margaret Burgess, the conference co-convenors, the conference organising committee, the sponsors and the PHAA secretariat.

Finally, I know members will be pleased to learn that Anna Whelan coordinated the preparation of a very professional and well-argued PHAA submission to the Human Rights and Equal Opportunity Commission's National Inquiry into Children in Immigration Detention. Recognising Australia's international obligations and the harm suffered by children in detention, the submission recommended that refugee children and their families be released from detention as a matter of urgency. Copies of the submission are available from the secretariat.

Childhood immunisation in Australia today

Copies of Immunisation Coverage: Australia 2001 (Commonwealth Department of Health and Ageing, 2002) were available at the Immunisation Conference. The 130 page report includes the following findings:

- immunisation coverage for all scheduled vaccines is now approximately 94% by 12 months of age and 90% by 24 months;
- 2-3% of children aged 12 months have parents/care-givers who disagree with, or have concerns about, immunisation;
- low Australian Childhood Immunisation Register (ACIR) coverage in inner capital city areas appears to relate more to inadequate reporting by immunisation providers than to low uptake;
- low ACIR coverage in some rural areas appears to be due to low uptake;
- linking the Maternity Immunisation Allowance and the Child Care Benefit to immunisation status appears to have had a positive effect on immunisation rates;
- children in larger, lower income families are less likely to be age-appropriately immunised; and,
- by 6 years of age, 86% of children have received the second dose of measles-mumps-rubella vaccine (95% have received at least one dose).

Decriminalising Abortion in the ACT

Hazel Moir, Women's Electoral Lobby & Options for Women.

Like all Australian jurisdictions, the ACT inherited much of its Criminal Code from the UK, and this included the criminalisation of the termination of pregnancy. While there has been no specific test, decisions in NSW are thought to apply in the ACT, and consequently the 1971 Levine decision is considered to set up the conditions under which abortion may be lawful. A stand-alone pregnancy termination service was established in the early 1990s under the auspices of Family Planning ACT. In 2000 it carried out 1527 first trimester terminations for women from the ACT and surrounding districts of NSW.

The ACT has a unicameral legislature, with just 17 elected members. Given the complexities of the Hare-Clark voting system, there is usually a minority government. Prior to the elections in October 2001, the Liberals governed with support from 2 independents – one an ex-footballer and the other an ex-policeman. The Assembly was unusual in that there were only two women members. One of the independents, Paul Osborne, introduced a bill to place restrictive conditions on access to pregnancy termination. The minority Liberal Government went along with this – though in a diluted form – in exchange for support on other matters.

The result was the Health Regulation (Maternal Health Information) Act 1998. The key features of this Act include a compulsory 72 hour “cooling off” period between counseling and termination. Women must also be offered a government approved pamphlet on options. This pamphlet included pictures of foetuses. Women's groups and medical practitioners contested the introduction of this legislation and worked hard to get the original provisions watered down.

Women's groups, particularly the Women's Electoral Lobby (WEL), have always objected to this legislation, seeing the cooling off period as insulting and the foetal pictures as a cause of unnecessary distress. In the run-up to the 2001 election, WEL started raising the issue of repeal of this legislation and removal of the abortion provisions of the Crimes Act 1900. The outcome of the election was an Assembly with 6 women, a minority labor government, and the balance of power held by two pro-choice women, Kerrie Tucker from the Greens and Ros Dundas, Democrat and WEL member.

WEL then initiated a meeting with other interested groups, notably Family Planning ACT, the Women's Centre for Health Matters and the Women's Legal Centre, to consider developing a campaign for decriminalization and repeal of the 1998 regulatory act. In part this was made feasible by the actions of long-standing pro-choice Labor MLA Wayne Berry, who introduced two private member's bills to achieve these objectives,

The outcome is not yet clear. Our initial assessment, based on information gathered during the election campaign, was that there were 5 definitely pro-choice MLAs, 5 definitely anti-choice and 7 whose opinions were less clear-cut. We need 9 MLAs to vote in favour of these two bills in order to achieve our objectives.

Our campaign, launched outside the Supreme Court on Valentines Day 2002, has operated under the slogan “Options for Women”.

We held a Rally on 9 April which was attended by about 400 people. We have lobbied the 7 MLAs whose opinions appear to be open and we have set up stalls at shopping centers, gathering more than 1500 signatures on letters to them seeking their support for the bills.

The operational and financial support of Family Planning ACT and the input of a small number of women who have been prepared to give their time have been critical. However, it is clear that the Right [of the Foetus] to Life Association have much better funding. They have run radios spots and prominent colour advertisements in the local paper and appear to have much better access to comment articles in the Canberra Times than the pro-choice groups do.

Survey data shows that community support lies with the right of individual women to decide whether and when to have children. The Options for Women coalition has found that individual members of the community have been appalled to find out that abortion is a crime. And they are less than impressed by the uncertainty and ambiguity of a Crimes Act that says “this is a crime” overlaid by a NSW case which says ‘maybe not’.

Among the 7 “undecided” MLAs, several are fundamentally pro-choice, but worry about a totally deregulated environment. To meet these concerns, pro-choice Labor MLA Katy Gallagher introduced the Medical Practitioners (Maternal Health) Bill on 15 May. This would amend the Medical Practitioners Act to make it more explicit that an abortion can only be performed by a registered medical practitioner, and only in an approved facility. It also allows medical professionals to refuse to participate in abortions on ethical or religious grounds.

At present the date for debate on the bills to decriminalise abortion and repeal the 1998 legislation is not known. Options for Women will shortly be circulating, through unaligned pro-choice MLAs, a “kit” which takes MLAs through the history of criminalized abortion. Did you know that before 1803 it was not a crime; and that until 1869 a termination before 116 days gestation was not a sin for Catholics? The kit also goes through the human rights concerns about government interference with a woman's control of her own body, the extent of community support and other issues. We remain optimistic that we may get the numbers for decriminalisation. This would be a significant symbolic step for the women of Australia, and we would be keen to see an extension of decriminalisation across all Australian jurisdictions

Personally, I have been fascinated to learn how recently the legal and religious prohibitions on abortion were imposed. I have also become very interested in the human rights aspects on what was previously for me basically a feminist debate. The criminalisation of abortion would appear to deny women their right to the religious freedom, privacy and security of the person which are enshrined in the International Convention on Civil and Political Rights which Australia signed in 1980. The Canadian Charter of Rights and Freedoms includes these basic human rights and in 1988 the Supreme Court of Canada struck down similar inherited criminal provisions as such laws clearly interfered with a woman's autonomy over her body and were therefore a violation of the security of the person.

WONCA: *Working Together: Communities, Professionals, Services*

Jeff Fuller; Rural Health SIG

This was the theme of the fifth WONCA World Conference on Rural Health that was attended by 900 delegates from over 40 countries in Melbourne from the 30th April-3rd May 2002. WONCA is the world confederation of family doctors and is essentially a peak global organisation for what we in Australia know as GPs.

Pat Anderson, the chair of NACCHO gave the opening keynote address. She spoke about the emotional and social wellbeing of Australia's Indigenous people with particular reference to family violence. She called for an open debate about this issue and reminded us of the importance of community control as a means to reinstate a sense of purpose and hope in Indigenous communities. I found it sobering that she dedicated her presentation to Dr Puggy Hunter (previous chair of NACCHO) who recently died at the age of 50, particularly as I turned 50 the very next day and as a white Australian male I would not expect to die so young, as Aboriginal Australian men so often do.

Professor Don Nutbeam, now Head of the UK Dept of Public Health, talked about the efforts in the UK to tackle inequalities in health following the 1998 Acheson Report. He made the point that rural health status was not worse overall than urban health status, but that as poverty (or more precisely, relative poverty) is clearly linked to inequalities in health, rural health programs needed to be targeted to the rural poor. Generalised programs designed as if rural communities are undifferentiated will not be effective; for rural people who are poor and isolated, more difficult access to services compounds their socio-economic and health disadvantage.

Dr MK Rajakumar, a past president of WONCA, articulated a global perspective on rural health. In the developing world, rural communities make up about three quarters of national populations and are significantly poorer than urban populations. This is very different to the developed world, where, as in Australia, most people live in urban communities. Hence, global rural health is very much an issue of poverty and he challenged conference delegates to think beyond the patients in their waiting rooms towards a global coalition of doctors, nurses, teachers and technologists to work on improving the health of all rural peoples.

Dr Bruce Chater, an Australian GP, medical superintendent and convenor of the WHO-WONCA Co-Sponsored Consultation for the Health of all Rural People described the recent international consultation in Taralgon (Victoria) that is

developing an action plan for rural health. I was impressed that a medical organisation would include measures of success based on processes and structures that followed a community development framework.

I was encouraged that such an organisation like WONCA would articulate an understanding of multidisciplinary teamwork where leadership was best held by the primary care manager, whether or not this was the GP. The conference also articulated the need for recruitment and retention incentives for all health professionals. Working together with communities and with Indigenous health services was also covered although not to the same extent as multidisciplinary teams in general. If the 60 papers on recruitment and retention from a total of 194 papers and symposia presentations is an indicator, then recruitment and retention is the pressing priority, at least amongst rural health practitioners. This supports my own experience that staff shortages, rather than financial constraints are what is limiting rural health services.

As is often the case with conferences, there was insufficient time in most sessions for a good debate between speakers and delegates. However, each afternoon an interesting arrangement divided us all into five 'villages' where we were able to have small group discussions on the issues of the day. These discussions were then fed into the final policy session of the conference.

The conference had 3 outcomes:

- an update of the WONCA policy on rural practice.
- a policy on women doctors in rural practice (particularly important in developing countries where women and girls may experience significant socio-economic and health disadvantage); and,
- a manifesto on the ethical issues of international recruitment of health professionals from developing countries to more developed countries.

There was of course a lot more. The ABC also screened the virtual conference through the web and some of the conference highlights will remain on its website at abc.net.au/rural

The sixth WONCA conference on rural health will be held in Santiago, Spain in September 2003. The WONCA website is www.wonca.org.

ACT Branch Hosts the Chief Minister and Health Minister

Rosalie Woodruff, ACT Branch Committee

On 23 May the ACT Branch hosted a luncheon with the ACT Chief Minister and Health Minister, Jon Stanhope. Over 50 people came to hear his views and discuss public health issues. In his candid manner, Mr Stanhope touched on a wide range of issues, including drug use and access to safe using equipment, litigation, home births, professional indemnity and abortion legislation. His views, and the stated intentions of the government, are encouragingly in line with many of PHAA's national policies. The ACT Branch intends to pursue a number of key issues with the government over the coming year.

Below is an edited text of Mr Stanhope's speech.

It seems that each week there are new or more difficult public health issues that we as a society must contend with. Whether it is a question of human cloning, stem cell research, or new trends in obesity and inactivity levels, we need a system that can respond to those issues in an informed and confident manner. In the lead-up to the last election I committed my Government to conduct a Health Summit to determine the major issues and problems within our health and community care system and to propose solutions to these issues.

The proceedings of the Summit give us some strong messages and directions for the future of public health in the Territory. One of the most important of these was the message about improving health outcomes and access to services for the more vulnerable members of our community, including our Indigenous population, people with a disability and the socio-economically disadvantaged. Another theme to emerge strongly was the need to ensure equity in our health services through more enlightened drug policies and a greater emphasis on health promotion, early intervention and the prevention of illness and disease.

These themes and priorities emerging from the [Health] Summit bear a remarkable resemblance to the top ten public health issues identified by the Public Health Association of Australia. At the national level your organisation has nominated: reducing health inequalities, fair health financing, improving Indigenous health, supporting families, improving environmental health, better nutrition, effective drug policies, better health for prisoners and detainees, better reproductive health services and fair World Trade Agreements as the key public health issues facing the country. And I was pleased to see that you have also identified the Pharmaceutical Benefits Scheme, oral health and food legislation and regulation as areas of particular policy interest.

The philosophies underpinning these priorities are ones that

resonate strongly with my Government. We have a vision of a community that is inclusive of all Canberrans, is cohesive and fair and committed to protecting the vulnerable and supporting those in need. Given our shared interests and common agenda, I believe my Government and the ACT Branch of the Public Health Association can form a strategic partnership to make a real and positive impact on the lives of people in our community.

Two reports released recently have highlighted issues I believe warrant particular attention – both in the immediate term and through the Health Action Plan.

A survey of high school students in the ACT, issued earlier this month, revealed that more than half all secondary students had tried illicit drugs at least once and that 90% had drunk alcohol at least once. I was distressed to see that children as young as twelve are experimenting with illicit drugs. And I was extremely concerned to find that around 5% of students have used a needle to inject illicit drugs and that 2% have shared a needle. The survey also indicated that we cannot be complacent about our young people and their usage of licit drugs. More than half of all students have tried smoking tobacco: over 20% had smoked in the previous week. And in line with national trends, young females in the ACT are more likely to take up this deadly habit than young males.

Perhaps not surprisingly, many young people in the ACT have tried alcohol, but the survey shows a trend towards regular drinking, with around a third of all students having consumed alcohol in the previous week. However, it was the

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Primary Health Care Research Fellowships

The Victorian PHC RED partnership (Monash University & University of Melbourne) invites applications for Research Fellowships. The Fellowships will provide financial support for primary care practitioners to conduct research (0.2FTE) with a department within the partnership for up to 1 year. Applications close July 4 2002. Contact Gail Roberts on 03 93415206, or g.roberts@gpdv.com.au.

Canadian study links for-profit care with high death rates

Canadian researchers claim that hospital deaths could rise by up to 2,200 a year if private for-profit hospitals were allowed into the Canadian health-care system.

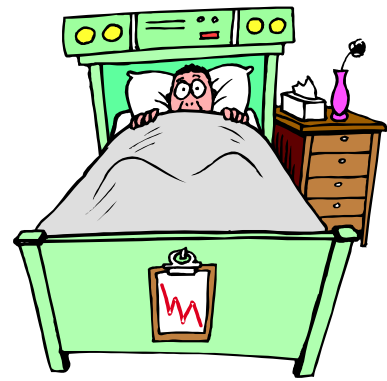
A consortium of researchers from Canada and the United States jointly analysed 15 American studies comparing death rates in for-profit hospitals to those in not-for-profit institutions. The studies, which included data on 38 million patients in 26,000 hospitals over 15 years, showed the death rate in for-profit hospitals was two per cent higher than that of not-for-profit institutions. The researchers applied that two per cent figure to the number of Canadians who die in hospital each year - currently about 108,000 - to come up with an estimate of the impact introducing for-profit hospitals would have on hospital mortality rates in Canada.

The results, published in the May edition of the Canadian Medical Association Journal, are expected to send a sobering message to those keen on inviting the private sector to play a greater role in Canada's ailing health-care system. "[Alberta Premier] Ralph Klein has indicated at the last Premier's Conference that he did not think that the public cared who delivered their care, as long as it remained government funded," said lead author Dr. Philip Devereaux. "Our research suggests that in fact the public should care."

The impact of a two per cent increase in deaths - which the authors believe is a conservative estimate - is roughly equivalent to the number of Canadians who die in motor vehicle accidents or commit suicide each year, noted Devereaux, a cardiologist at McMaster University in Hamilton. "I think that within this debate people have been hearing for so long that privatization is the answer, i.e. private for-profit, that people have started to accept it," he said at a news conference. "And that's why I think it's important to hear the results and to step back and think about that and say: 'Why would we consider switching to this?'"

While the findings will undoubtedly play a role in the ongoing debate over the future of health care in Canada, not everyone is willing to acknowledge that what has played out in the United States would play out in Canada. Dr. Wilbert Keon, a prominent Ottawa heart surgeon and a member of the Senate, agreed a two per cent higher mortality rate in for-profit hospitals would be unacceptable in the Canadian context. But Dr Keon, who recently said it was time for Canadians to embrace private health care, said that if hospitals in Canada were privatized they would have to meet strict quality standards set by a federal agency. And he insisted it is too soon to eliminate options in the search to find new ways to inject cash into the struggling health-care system. "I think this study is well done, by very good people. But I do think

we have to keep an open mind. And I think we do have to look at ways of delivering quality care at a reduced cost," Keon said.



Still, the findings convinced the Dean of Medicine at the University of Toronto, who was not involved in the study. "Does anyone still want to contract out large segments of our publicly financed health-care system to for-profit U.S. hospital chains after reading this article? I hope not!" Dr David Naylor wrote in a commentary on the article which was also published in the Canadian journal.

The team of 17 researchers, who are mainly from McMaster and the Universities of Toronto and Buffalo, NY, set out to establish if there were any health consequences of delivering hospital care in a for-profit setting. They conducted a meta-analysis, searching for all studies comparing death rates in for-profit hospitals to those in not-for-profit hospitals in the United States. Because the issue is so politically charged, they decided initially to mask the studies, blocking out the outcome so that researchers could not be tempted to include or exclude studies on the basis of their findings rather than their structure and methodology.

Fifteen studies met their criteria and were included in the meta-analysis. All but one showed higher death rates in for-profit hospitals. "The reason seemed clear," Devereaux said: "Hospitals that had to both generate profits for shareholders and pay taxes - not-for-profit hospitals didn't pay taxes - spent less money on nurses, doctors, pharmacists and other health-care professionals. To maintain profits . . . corners are cut on the delivery of health care, which is directly important to actual health outcomes."

The authors believe the results are applicable to Canada, pointing out that the US multinationals that own the for-profit hospitals in the American system were likely to be the buyers if Canadian hospitals were put on the block. The study, which cost roughly \$55,000 to conduct, was funded through an Atkinson Foundation research grant and a Hamilton Health Sciences research development grant.

Immunisation Conference – A Booster Shot



*Rosemary Lester, Immunisation Conference
Co-Convenor*

The 8th National Public Health Association of Australia Immunisation Conference was held on 16th and 17th May 2002 at the Hilton on the Park, Melbourne. This conference continued a fourteen year tradition of forums for policy development, the opportunity to catch up with the latest in this rapidly changing field and an opportunity to exchange ideas with fellow workers. Many observers commented on the spirit of enthusiasm and co-operation between conference participants. It was a time to celebrate Australia's achievements in the field: high immunisation coverage, excellent parent and provider resources and a committed and knowledgeable workforce.

We felt privileged that the conference opened with an address from Professor Sir Gustav Nossal. Professor Nossal is currently chairman of the committee overseeing the World Health Organisation's Vaccines and Biologicals Program and chairman of the Scientific Advisory Committee of the Bill and Melinda Gates Children's Vaccine Program. He gave us an update on the world situation with immunisation, the progress of polio eradication and the Global Alliance for Vaccines and Immunisation initiatives. He reminded us that although progress has been made, there is still much to be achieved.

The first overseas speaker was Dr Bruce Gellin, Executive Director of the National Network for Immunisation Information from Tennessee, USA. The NNII is a coalition of non-government professional organisations who disseminate and promote information about vaccine safety and the importance of immunisation. Dr Gellin gave a very comprehensive account of his work addressing the erosion of public confidence in immunisation and his experiences in dealing with the media in the United States on this issue. Increasing public intolerance of any level of risk from any intervention and the speed of global communications mean that unfounded theories and rumours, as well as legitimate concerns over vaccine safety, are transmitted instantly around the globe. Dr Gellin highlighted the importance of timely, factual information which enables immunisation providers to deal carefully and honestly with questions from the public. Julie Leask gave an Australian perspective on the controversy over the supposed link between the measles mumps rubella (MMR) vaccine and autism and how the reaction in Australia has differed from that in the United Kingdom. Dr Mike Gold, consultant paediatrician to the South Australian Immunisation Co-ordination Unit, gave his views on the way forward for the further enhancement of immunisation safety surveillance in Australia.

Program delivery and evaluation was the theme of the next plenary and we heard both international and local perspectives on

these themes. Associate Professor Peter McIntyre presented an overview of six years of development of the Australian Childhood Immunisation Register and the detailed studies of determinants of immunisation coverage which have been possible with this resource.

Dr Sophie Couzos presented an overview of the immunisation needs of Aboriginal and Torres Strait Islander communities, the difficulties associated with poor data and lack of indigenous identification and the need to continue to find ways to make services accessible and appropriate to these populations. The immunisation needs of refugees and recently arrived immigrants were succinctly described by Dr Sue Skull from the Royal Children's Hospital in Melbourne. Dr Heath Kelly, from the Victorian Infectious Diseases Reference Laboratory, highlighted current deficiencies in the immunisation status of health care workers which put them and their patients at risk.

Sessions on travel medicine, and an opportunity to quiz the experts in immunisation, proved popular breakfast sessions. Two workshops – one on school based immunisation programs, and one on the MMR 18-30 age group campaign gave on-the-ground workers a chance to exchange ideas, share highlights and lowlights and formulate some positive recommendations for the policy makers and program designers.

The second day included a look into the future, with reports on progress of vaccines against Epstein Barr virus and HIV, and an overview of the risk of bioterrorism and the need for orphan vaccines to combat this threat. Dr Peter Richmond summarised issues around the policy development process for the meningococcal C conjugate vaccine - following its successful introduction in the UK. Our second overseas guest, Dr Raymond Reid, a Navajo Indian from the Johns Hopkins University Center for American Indian Health, gave his insights into clinical research in American Indian populations: the key to success lies in consideration of tribal beliefs and practices and tribal involvement. There are real lessons here for those of us dealing with our own Indigenous peoples.

A highlight of the conference was the very moving Feery Oration, "Tears often Shed", delivered by Professor Margaret Burgess, Director of the National Centre for Immunisation Research and Surveillance. Professor Burgess used Bryan Gandevis's book on the history of child health in Australia as her inspiration for this address, reminding us where we have come in vaccine preventable disease control in Australia and some of the significant milestones along the way. The occasion provided a very fitting tribute to Professor Burgess' long and very distinguished contribution to immunisation both in Australia and internationally.

The conference concluded with an agenda for action which will be used to inform governments and policy makers about a clear way forward in this exciting and very vital field of public health.

Immunisation Conference Snaps





ACT Branch Hosts the Chief Minister and Health Minister - continued from page 7

attitude towards alcohol consumption that was the most worrying aspect of this element of the survey. Half of all students think that getting drunk occasionally is no problem, more than 36 per cent believe drinking is the best way to relax, one third believe it is the best way to get to know people and 30 per cent believe drinkers are more popular.

The Chief Health Officer's report for 1998-2000 demonstrates that the ACT enjoys excellent health in comparison to most other jurisdictions. We have clean air, good quality drinking water and the highest levels of vaccination coverage in the country. But the report also highlights areas of concern. Our Indigenous population makes up a disproportionately large number of clients accessing health services, we have high rates of medium and high risk drinkers amongst certain adult age groups and mortality due to breast cancer has increased since 1995. Along with most other jurisdictions, the ACT has recorded an increase in the level of chlamydia, especially in young people. This is of particular concern, as chlamydia is often asymptomatic and, if left untreated, can cause infertility.

The recent crisis in medical indemnity has spurred all jurisdictions, including the ACT, to fast track their proposed reforms in this area. The Chief Executive of the ACT Department of Health and Community Care, Dr Penny

Gregory, has, through the Australian Health Ministers Advisory Committee, spearheaded the national effort to find long term solutions. The medical indemnity crisis is not just impacting upon our doctors. Independent midwives are amongst the most severely affected, and I have asked my Department to work with the Canberra Midwifery Program at the Canberra Hospital to develop proposals to extend the midwifery-led care in that Program to include homebirth as an option. The policy considerations involved in this exercise may, in turn, help inform the development of a potential new women's and children's health policy.

The Summit and other forums have sent strong messages about the need for greater cooperation within the health and community care sectors. What we need is a more unified way of operating – a way that shifts us from the input-output focus of the purchaser/provider model and moves toward a system that focuses on delivering services that better meet the needs of our community.

Along with other key non-government organisations and professional associations, the PHAA has a role to play in shaping the future of the health and community care system in the ACT. I thank you for the opportunity to speak to you today and I welcome each of you to participate in the dialogue we have begun to improve our health system.

8th National PHAA Immunisation Conference Sponsors

The Public Health Association of Australia wishes to thank GlaxoSmithKline, CSL Vaccines, Australian Department of Health and Ageing, State Government Victoria, Wyeth-Lederle Vaccines and Aventis for their generous conference support.

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Submission on WTO Trade Negotiations

Pieta Laut, Executive Director

The PHAA has provided the Department of Foreign Affairs and Trade a submission on the next round of World Trade Organisation negotiations. The full text of the submission is below.

The Public Health Association of Australia (PHAA) opposes the inclusion of government health care and health services in WTO GATS. Research has demonstrated that the public provision of health care ensures that services are more efficient and more equitable (Deeble 1999).

The PHAA has noted that all levels of Australian government have adopted policies that call for privatisation of government institutions, competitive tendering for services and contracting the provision of government services to private organisations. It is also aware that there are moves by the World Trade Organisation (WTO) to impose General Agreements on Trade in Services (GATS) on health and other industries. Corporations from the United States have openly admitted that the health sector is one area that they are hoping to dominate. PHAA is aware that at this stage, Australia has not agreed to include health services in its obligations under GATS. However, there will be on-going pressure for it to do so, or risk its exports in other services.

PHAA opposes the inclusion of health care and health services on several grounds: equity, efficiency, and the impact on Australia's workforce.

Equity

The inclusion of health services in GATS threatens the universal provision of health care and health services.

Governments have human rights and equity responsibilities to guarantee essential health and social services that achieve equity of access and participation for all Australians. The Government must commit to taking into account Australian cultural objectives and values relating to fair access to all essential services including health, education and housing before agreeing to further GATS commitments.

A recent five-nation survey of public attitudes toward health care reveals that the United States, the nation whose health sector is pushing for inclusion of health services in GATS, has the highest share of residents facing access problems. Americans with below-average income reported more health care access problems than their counterparts in the other four countries.. (Blendon, R.J., et al., *Inequities in Health Care: A Five-Country Survey*. Health Affairs, 2002).

Australians are very supportive of our universal health services

and believe that the public health system should be sufficiently funded to maintain its integrity and reliability so that everyone can feel secure that their care will be based on medical need not their ability to pay. Australia's expenditure on health as a percentage of GDP has been held relatively steady in the 1980s and 1990s, a comparatively favourable economic result compared to more market-driven health systems, including the USA. Australia cannot afford to sacrifice equity and at the same time experience significant growth in total health expenditure. There is a high risk of this outcome if health care is treated as another tradeable service under GATS. American families have to pay much more out of their own pockets for health care, which wipes out many of the benefits of lower taxes that the proponents argue. (Jackson, A., *Canada Beats USA - But Loses Gold to Sweden*. 2002, Canadian Council on Social Development).

To the extent that the general GATS agenda increases material inequality within nations, there is evidence that this has negative outcomes for population health. (Wilkinson, R.G., *Unhealthy Societies: The Afflictions of Inequality*. 1996, London: Routledge. 255).

Efficiency

The proportion of GDP spent on health services is much lower in nations that have higher public sector health services delivery and expenditure. The USA proportion of GDP spent on health is a drain on that nation's economy.

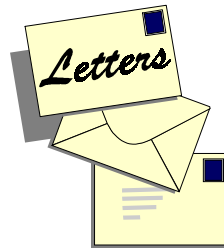
Tax-funded health insurance is much lower cost than private health insurance due to the efficiency of the tax collection and distribution systems. Commitments that the Federal Government is making under GATS, combined with increasing private sector participation in the delivery of health services, threaten the capacity of Australian governments to maintain effective control over our health system.

There is scant evidence that private provision has resulted in equal or better outcomes at a lower price in Australia. The South Australian experiment in privatisation of public hospitals is about to fail after bail-out attempts.

In the UK, a recent analysis shows that the case for using a 'private finance initiative' (PFI) rests on a value for money assessment skewed in favour of private finance. Also, the higher costs of PFI are due to financing costs which would not be incurred under public financing. Many hospital PFI schemes show value for money only after risk transfer, but the large risks said to be transferred are not justified. (Pollock, A.M., J. Shaoul, and N. Vickers, *Private finance and "value for*

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Letters to the Editor



Dear Editor

It has come to my attention that applications for the fellowship programme of the 12th World Conference on Tobacco or Health are now available on-line. The conference will be held from August 3 - 8, 2003 in Helsinki, Finland.

The application deadline is September 30, 2002. To access the on-line application, go to:

<http://www.congcreator.com/wctoh-2003/> Click on "Fellowship Programme" at the top of the page.

As I understand it, priority will be given to individuals who DID NOT attend the fellowship programme preceding the 11th WCTOH (Chicago 2000.) There will also be a smaller number of scholarships available for individuals from low-income countries who will present at the conference, but not participate in the fellowship programme.

Please be in touch if you have any questions regarding the conference or fellowship programme.

With best wishes,

Allen K. Jones, Ph.D.
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Dear Editor

Physical activity promotion or injury prevention

The exchange between WJ Curnow and Beth Fuller in the last issue of *In Touch* (p8-9) is a good example of potentially conflicting public health priorities.

Curnow argues that a piece of equipment (helmet) is an impediment to a substantial proportion of people from riding bicycles (transport authorities estimated that the number of regular cyclists dropped by a third when helmet legislation was introduced) and therefore missing out on the benefits of physical activity, not to mention the collective environmental benefits of less pollution and less traffic congestion if people use bicycles as an alternative to cars.

Fuller points out that there is robust evidence that the piece of equipment has a demonstrable protective effect for that proportion of cyclists who crash.

Unfortunately there has been no examination of the overall population health benefit or loss if the gains from physical activity are weighed up against losses through injury. However, such a comparison would miss much of the social context in which cycling occurs. Cyclist crashes are generally caused by cars and road conditions, and the solution to reducing cyclists' head injuries is not necessarily to make cyclists wear helmets, but to create a cycling environment that is safe and pleasant. Making cycling a normal and common behaviour rather than one needing special protection is preferable on many counts. Indeed, the more cyclists there are,

the safer it is for them because other road users get used to encountering cyclists on the road. Livable communities where walking and cycling is encouraged are generally better for everyone!

An analogy with walking highlights the mixed message that compulsory bicycle helmets communicates. Walking is encouraged by all health departments as a great way to achieve physical activity for most people. Imagine if it were mandatory to wear special equipment like fluorescent vests to go for a walk. "But we don't need them" you say. "Ah, but pedestrians are hit by cars all the time, therefore it's safer to be more visible" say the injury protectors. And so some people are likely to be put off walking, and cars, which are central to the equation, escape without further attention.

The focus on bicycle helmets obscures the real issue for cyclists: safer conditions (through better cycleways and marked lanes) and education about and enforcement of road rules where drivers endanger cyclists. Why blame the cyclist for being an injury victim when cars and road conditions cause the problem? It is possible to create a bicycle friendly culture in other countries and is certainly desirable here.

Chris Rissel
CSAHS

Dear Editor

Bicycle Helmets Policy

I am replying to Beth Fuller's response to my suggestion that the PHAA should support a national review of the policy of compelling cyclists to wear helmets.

Ms Fuller writes about opinions on helmet wearing: the trouble is that opinions formed the policy. A 1989 poll showed 84 per cent support for it after official publicity had generated fears of death and chronic intellectual disablement from severe brain injury and suggested helmets as the remedy. But there was nothing from any competent authority to verify this.

Ms Fuller goes on to consider efficacy. In this context, efficacy must be measured in terms of the main cause of death and disablement of road users, diffuse axonal injury (DAI). DAI results from angular acceleration by a glancing blow to the head or even without any blow, as in whiplash injury.

None of the studies she cites show any understanding of this. Nor are helmets designed to reduce angular acceleration. Indeed, experimental research in Australia in 1987 showed that they may actually increase it and in 1994, the NHMRC warned that wearing a helmet can increase diffuse brain injury. These matters are explained in my article in *Accident Analysis & Prevention* (in press).

Studies have focused unduly on the existing products of the helmet industry. These evolved from helmets used in warfare and industry to protect the skull from penetration and the scalp from abrasion. The studies cited by Ms Fuller may show an association between helmet wearing and fewer head injuries of low severity and quick recovery: lacerations, simple fracture of the skull and mild concussion. As my referenced article shows, the studies that support the helmets policy do not provide evidence of efficacy against DAI. The public has been deceived.

Ms Fuller refers to a reduction in injuries to child cyclists in Victoria, but the number of children cycling declined more,

by 36 per cent. Much-needed healthful exercise was lost. That was typical Australia-wide.

In NSW, the number of child cyclists (under 16) was down by 36 per cent in the first year of compulsion and by 43 per cent in the second. As hospitalised injuries, including those to the head, declined less, the remaining cyclists were at greater risk: a 43 per cent decline from the 1310 injuries recorded in 1990/91, before the law was passed, would have resulted in 747 injuries in 1992/93, but in fact the number was 1166, showing an increase of 56 per cent.

The purpose of compulsory helmet wearing makes compliance a preventive health treatment. As such, it contravenes medical law and ethics. Cyclists do not enjoy the same rights to assess the risks and to choose whether or not to accept this treatment in the same way, say, as people might consider and decide about vaccination.

As for mandatory standards for helmets, government simply adopted the industry standard, which merely represents what can be produced and sold as a plausible safety device. The standard was revised to allow soft shells, to make compulsory helmet wearing more acceptable, but these have been shown to produce angular acceleration and disintegrate upon impact. Unlike therapeutic goods, helmets are not monitored in use and standards reviewed if adverse effects are found.

To sum up, compulsory wearing of helmets was introduced as a preventive health measure, though their efficacy against fatal and disabling brain injury was in question and medical ethics were disregarded. The standard for helmets is set by commercial values. Public health has suffered by loss of exercise and increased risk of injury.

I recommend that the PHAA should extend its monitoring of the helmets legislation to make a holistic review of its foundations and its effects on public health.

I am ready to contribute if invited.

Bill Curnow

Dear Editor

I am PhD student at the National Australian University. My thesis is on childbearing among women living with hepatitis C. I am using semi-structured interviews with women living with hepatitis C. I have so far interviewed 18 women, on their experiences living with hepatitis C and in particular, those concerning childbearing and motherhood.

Based upon my knowledge gained from these interviews I would like to raise several points:

On childbearing among women living with hepatitis C Women living with hepatitis C often experience discrimination in health care settings. In particular, this occurs in situations relating to pregnancy. Women are given very different advice from different doctors/other medical professionals, and for some this may have huge consequences. Some women have been advised to have terminations, or told that they can no longer have

children, now that they are HCV positive. Much of this appears to be influenced by the moral standing of medical professionals. There need to be clear, non-judgmental guidelines on what advice should be given to HCV positive women regarding their reproductive health.

On hepatitis C education

There is a need for greater education among health care professionals regarding hepatitis C, in order to prevent discrimination.

A widespread education campaign is required. Although the drug-injecting communities are now well served in terms of education about hepatitis C, the wider population is not. While one can argue that the wider community is not at great risk of infection with hepatitis C, there are good reasons for them to also be educated. Firstly, there is a clear lack of understanding about what

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Submission on WTO Trade Negotiations - continued from page 13

money” in NHS hospitals: a policy in search of a rationale? *BMJ*, 2002. 324(7347): p. 1205-1209).

The PHAA notes recent examples of market failure in other sectors, which have resulted in transfers of risk to the public purse and seriously doubts that privatisation arguments - about governments minimising risk by privatisation - can be taken seriously.

Workforce

The PHAA believes it is critical that in preparing for negotiations, the Department of Foreign Affairs and Trade undertake analysis of the domestic impacts of GATS agreements not just the impacts on the export sector. Four out of five workers in Australia work in the services sector, so any treaty obligations or benefits arising in this sector will have wide ranging impacts. Such analysis must be made available to the Australian public.

Action

The PHAA seeks the following policy directions from the Federal Government in undertaking WTO trade negotiations:

- The Australian Government must continue its commitment to Australian Government control of a universal health system that encompasses primary care, pharmaceuticals, hospitals and aged care. No Australian government should trade off our efficient and effective, universal health system in exchange for better terms for exports in other goods or services. The Government

must publicly state that the protection of our universal health care system is a non-negotiable basis for it proceeding with any further GATS agreements.

- Any commitments that have a negative impact on the efficiency, effectiveness and fairness of Medicare, universal primary health care services or the Pharmaceutical Benefits Scheme, should not be pursued.
- The Australian Government should take a lead in developing Negotiating Proposals that strengthen the principles of universal, equitable access to health services for Australians as well as people in less developed economies.
- Input into the development of Australia's negotiating proposals for any new GATS meeting should be sought from a wide range of government and non-government sectors, not just those with primary responsibility for, or interest in, supporting Australia's trading position. The Government has responsibility to all Australians to inform them fully of the effects that a particular trade liberalisation policy may have on the provision of essential services, including health, both within Australia and developing nations.

I would be happy to discuss this submission with you should you find this useful. I can be contacted on (02) 62852373 or by email on plaut@phaa.net.au.



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Selection is based on applicants professional achievement and a proposal that indicates how the proposed visit will further their professional development, contribute to fostering improved understanding between the peoples of the two countries and the potential benefits will flow to the applicant's employer and / or industry.

For further information and applications see www.fulbright.com.au (click on news), or call 02 6260 4460.
Applications close 31 August 2002.

Letter to the Editor - continued from page 15

hepatitis C is, in regards to how it is different to hepatitis A and B and how it is transmitted (it is a common misconception that the main route of transmission is via unprotected sex). In addition to greater understanding, the risks of transmission to non-IDUs will be reduced through awareness. Secondly, in order to reduce the stigma and discrimination associated with hepatitis C, there needs to be a greater understanding of what it is, and how it affects peoples lives.

On gender and hepatitis C

It should be recognised that living with hepatitis C affects women differently from men. Further research is required in this area in order to be able to develop appropriate strategies.

If I can be of any assistance in the development of a new strategy or you require further elaboration on this feedback, please contact me via email.

Kind regards, Clare Thetford, clare_thetford@yahoo.com

Dear Editor

Hepatitis C Councils and the Australian Hepatitis Council are aware of the unacceptable levels of discrimination against people with hepatitis C, particularly discrimination occurring in health care and employment settings.

Discrimination in relation to hepatitis C has been described in several recent studies and reports, including:

- National Hepatitis C Strategy, 1999/2000 - 2003/04;
- C Change, Report of the Enquiry into Hepatitis C Related Discrimination, from the NSW Anti Discrimination Board (2001);
- Australian Hepatitis C Anti-Discrimination Strategy 2001-2004; and,
- Hepatitis C: a review of Australia's Response.

Professor Sandy Gifford at Latrobe University has developed a hepatitis C research program, which includes information on hepatitis C related discrimination that can be accessed through <http://www.hbs.deakin.edu.au/healthsci/research/hepc/>.

A major activity for the Australian Hepatitis Council over the next two years will be addressing discrimination and stigmatisation experienced by people with hepatitis C. Activities such as targeted anti-discrimination education strategies in healthcare and employment sectors, removing barriers to anti-discrimination instruments and widespread community education initiatives will be conducted on behalf of our constituents.

Various social research studies addressing women's experiences of living with hepatitis C have highlighted the points raised in Clare's letter, and their findings suggest that the needs of women with hepatitis C are not being adequately addressed.

Stigma and negative experiences, both from family and friends and also health care professionals are commonly reported. The lack of understanding and fear in the general community contributes to this discrimination. Women are concerned about the ways in

which hepatitis C impacts on their health, lifestyle and their future and the Australian Hepatitis Council supports the development of further research in this area.

Please contact the Australian Hepatitis Council or your local Hepatitis C Council for further information.

Executive Officer
Australian Hepatitis Council
PO Box 357, Curtin, ACT
jack@hepatitisaustralia.com

Australian Research Centre in Sex, Health & Society

SHORT COURSE 2002 RESEARCH DESIGN IN QUALITATIVE SOCIAL INQUIRY

Dates: 2 - 6 September 2002
Venue: La Trobe University
1st floor, 215 Franklin St
Melbourne Vic 3000

This five-day short course focuses on the principles and practices of designing social and behavioural research, particularly using qualitative methodology.

Areas covered include: research question clarification, research design processes, qualitative and quantitative methodologies, research project planning and management and dissemination of research findings.

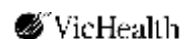
The course involves presentations by staff of the centre and workshops where participants design projects suitable for their organisational settings and needs.

Teaching will be at a graduate level, and participants are expected to have a degree in a related field or significant relevant work experience.

Registration fee \$1320.00 includes all course materials, lunch and morning and afternoon tea. Registration will be limited to 15 people. Scholarship places also offered.

FOR FURTHER INFORMATION:

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Items of Interest

Draft Business Architecture for HealthConnect

A draft Business Architecture for the HealthConnect project, (a project to look at a health information network for Australia) and a joint Commonwealth, State and Territory initiative has been developed and is available at http://www.health.gov.au/healthonline/connect/busarch_1.htm It is a large document, downloadable in four parts. It sets out the functional requirements for HealthConnect and will underpin proposed trials as well as the development of a number of building blocks to pave the way for all other major e-health initiatives in Australia.

Comments on the Business Architecture are invited: deadline 14 June 2002. A series of information sessions will be conducted in each State and Territory. Details of these will be available soon at <http://healthconnect.com.au>. The Business Architecture document can be downloaded from this site too, or hard copies are available from christopher.mount@health.gov.au (Nursing Leaders Bulletin 17 May 2002)

Protecting Participants in Research

The Federal Minister for Health and Ageing, the Hon. Senator Kay Patterson, has launched a new Human Research Ethics Handbook. Developed by the National and Medical Research Council (NHMRC), it will be a resource for the more than 200 human research ethics committees operating in hospitals, universities, government agencies and the private sector in Australia. For more information contact the NHMRC media section on 02 6289 5796.

(healthupdate, the newsletter of the Consumers' Health Forum of Australia, April 2002)

More people needing more care

An Australian Institute of Health and Welfare report, Residential Aged Care in Australia 2000-01, has found the increase in the number of nursing home residents in the "high care" category has strained aged care infrastructure and financing. The report found in June 1998, 57.8 per cent of nursing home residents were in the "high care" category, but by June 2001 the figure had risen to 63.1 per cent. Aged and Community Services Australia chief executive, Greg Mundy, said the Federal Government needed to allocate more "high care" places and fewer in the "low care" category when deciding on aged care subsidies. (The Age, 10 May 2002)

WHO Injury Surveillance Guidelines

The World Health Organisation (WHO) has recently released a set of Injury Surveillance Guidelines. The manual was

developed via broad international collaboration and has drawn on the expertise of the US Centres for Disease Control and Prevention. Its purpose is to help researchers and practitioners design, establish and maintain good injury surveillance systems and it provides advice on how to develop information systems for the systematic collection of data on injuries. While applicable to all settings, it has a particular focus on settings where resources are scarce.

Printed copies of the Injury Surveillance Guidelines can be ordered from Injuries and Violence Protection Department, Non-communicable Diseases and Mental Health Cluster, World Health Organisation, 20 Avenue Appia, 1211 Geneva 27, Switzerland, Fax 0041 22 791 4332, email pvi@who.int. A PDF version of the manual can be downloaded from www.who.int/violence_injury_prevention/surveillance.htm. (Injury Issues Monitor 24, May 2002)

New Mandatory Standards for Bunk Beds & Baby Walkers

A new mandatory safety standard, effective from 1 November 2002, has been introduced for bunk beds. It makes the provision of guard rails to the upper bunk and the elimination of head entrapments in the bunk bed structure compulsory. For further information contact John Wunsch, Manager of the Safety Policy Unit in the Consumer Affairs Division of the Treasury, tel 02 6263 3961, email recalls@recalls.gov.au.

A mandatory consumer product safety standard for baby walkers will be declared by regulation under the Trade Practices Act later this year. The new standard will require all walkers to have a braking mechanism that is designed to stop the walker if one or more wheels drops off the riding surface, such as the top of a stairway.

For a list of all current mandatory standards visit www.accc.gov.au/product_safety/fsproduct (Injury Issues Monitor 24, May 2002)

Injury Researchers' Network

Injury Prevention Research Institutions [IPRI] of Australasia, a formal network of leaders of injury prevention research institutions, has been established in recognition of the great value of a formal opportunity for regular communication between leading researchers. For further information please contact Joan Ozanne-Smith at MUARC, tel 03 9905 1810 or email joan.ozanne-smith@general.monash.edu.au. (Injury Issues Monitor 24, May 2002)

Evidence-Based Health Promotion: Child Injury Prevention

This Victorian Department of Human Services publication presents a systematic review of child injury prevention

Items of Interest

interventions as they relate to specific types of injuries (eg scalds and burns). Printed copies of this document are available, free of charge, from the Victorian Department of Human Services, email julie.hoy@dhs.vic.gov.au. (Injury Issues Monitor 24, May 2002)

Health and Safety Risks in Primary Industry

The Australian Centre for Agricultural Health and Safety has released publications which detail specific health and safety risks associated with sugar cane production, sheep and wool production and cotton production on-farm. Printed copies of the reports are available from the Australian Centre for Agricultural Health and Safety for \$25: tel 02 6752 8215 or fax 02 6752 6639. (Injury Issues Monitor 24, May 2002)

NHMRC Support Oral Health Research

Following public consultation and consideration of existing evidence, the NHMRC's Strategic Research Development Committee (SRDC) believes that improving a person's oral health could have a flow-on effect to their general health, but that further research is needed in this area.

As a result, the CEO of the NHMRC, Professor Alan Pettigrew, has announced that the NHMRC will provide over \$1.5 million to fund 18 oral health research projects across the nation. In recognition of the importance of good oral health, the HCF's Health and Medical Research Foundation has contributed \$300,000 to the pool of funding for projects in the area of clinical research into oral health. Funding for the 18 projects totals more than \$1.8 million.

During community consultation on research priorities we were surprised at how often the issue of oral health as an area of major concern was raised in discussion, Dr Sarah Robertson, Chair of the SRDC's Oral Health Research Working Committee, said.

We also noted that the National Health Survey of 1989-90 had ranked symptoms of oral disease as the sixth most frequent illness condition, and a later publication, Australia's Health 2000, stated that oral health had been found to have a link to each of the major chronic diseases. Oral health was also thought to be a marker of general health.

Funding will be provided to research projects in all States and the Northern Territory. The aim of the research is to improve the oral and general health of Australians:

- younger Australians;
- older Australians;
- Indigenous Australians;
- people in rural communities;
- people with chronic disease; and,
- those on low incomes.

The research projects include investigating the suggested link between periodontal disease, inflammation of the gums and cardiovascular disease; new methods of dental treatment; dietary strategies to prevent dental disease in asthmatic children; and water fluoridation. Details about each project can be found at www.nhmrc.gov.au.

Health Care for the Elderly

The Australian Divisions of General Practice (ADGP) Aged Care Taskforce has recently completed a report that identifies an urgent need for more dentists, nurses and allied health workers to work in aged care. The report also highlights other barriers to improving aged care services. For a copy of the report summarising responses to the ADGP Aged Care Taskforce Aged Care Questionnaire for Divisions of General Practice phone 02 6251 3380. (Source: report Age, Council on the Ageing (Australia) Parliamentary and Policy Bulletin, April 2002).

Aboriginal and Torres Strait Islander Food and Nutrition

FoodChain, the newsletter published by the Strategic Inter-Governmental Nutrition Alliance (SIGNAL) provided an extremely interesting April edition. This edition focussed on the success of food programs and projects being undertaken by Aboriginal and Torres Strait Islanders. If you have an interest in Aboriginal and Torres Strait Islander food issues, the edition is well worth reading. To obtain copies of the April edition, write to the SIGNAL Secretariat on signal@health.gov.au

Information on hepatitis

A WEB site providing information on hepatitis has been launched by the Australian Hepatitis Council.

The Site covers all types of hepatitis, but targets hepatitis C, the most commonly notified infection in Australia. This site gives information about living with the virus, testing, treatment, health maintenance and monitoring care and support. The site is at www.hepatitisaustralia.com

Ageing

<http://www.ucop.edu/cprc/publist.html#AGING> is a web-site worth visiting if you are interested in strategies for planning on ageing. The site belongs to the California Policy Research Center, and publishes a series of reports, briefs and working papers called Strategic Planning on Aging.

EnableNet

Enablenet at www.enable.net.au is a disability portal created and maintained by the Disability Information & Resource Centre (DIRC) in South Australia. It provides access points to over 2,700 websites, which are summarised

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Iodine Important for Pregnant Women

A study by the Royal North Shore Hospital in Sydney and the New South Wales Newborn Screening Programme claims that Australians have a borderline iodine deficiency because of changes in diet. The researchers measured the newborn babies' levels of thyroid stimulating hormone – an indicator of iodine deficiency. The results met World Health Organisation (WHO) criteria for a mildly iodine deficient population.

Iodine deficiency is a problem for the developing brains of foetuses and young children. According to WHO, it is the single greatest cause of mental retardation. However, the levels of deficiency recorded are not nearly high enough to cause cretinism, rather they could potentially lead to the loss of one or two IQ points.

The Australian population previously received iodine from milk, and iodine was added to salt as a public health measure. New cleaning methods for milk vats have reduced the amount of iodine in milk. In Tasmania, iodine is added to flour so residents obtain their iodine levels from bread.

Dr McElduff, whose report appeared in the Medical Journal of Australia in April, suggested that a public awareness program similar to that promoting the benefits of folate before and during pregnancy would be good for iodine.

(Source: ARHA Newsletter Vol.6 Issue 2, March-April 2002).

New Members

New South Wales

Robyn Richmond
Wyeth Australia

Victoria

Inner Eastern Melbourne Division of
General Practice
Anna Madden
Linda Bieleny
Kyi Minn
City of Boroondara
Bernadette Pockinghorne

What's on

5 – 9 July 2002

Centre for the Study of Mothers' and Childrens' Health, Carlton VIC 3053
Short Course in Reproductive and Perinatal Epidemiology.

The course will include discussion of 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. There will also be a preceding half day workshop on Epidemiology and Biostatistics on Thursday 4 July. **For more information: ring 03 8341 8500 or email: csmh@latrobe.edu.au**

29 September - 2 October 2002

34th Public Health Association of Australia Annual Conference
Mobilising Public Health, Adelaide Festival Centre. For more information please email the Conference Secretariat at: conference@phaa.net.au or phone 02 6285 2373

23 November 2002

The "Tenth National Symposium on Hepatitis B and C" will be held at St Vincent's Hospital Melbourne on Saturday, 23 November 2002. Further information may be obtained from: Eleanor Belôt, Gastroenterology Department, St Vincent's Hospital Melbourne, Phone: (03) 9288 3580
Fax: (03) 92883590, E-mail: belote@svhm.org.au

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