in touch
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Heroin in the sunburnt country: droughts and flooding rains.

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"No thinking person," according to Dr Sandy Gordon, Visiting Fellow at the Australian Defence Force Academy (Sydney Morning Herald, 23 January 2002), " would claim that Australia's heroin drought has been wholly achieved by police activity". That may be, but both before and after the recent Federal election several senior members of the Commonwealth government (including the Prime Minister) and some senior police came remarkably close to Dr Gordon's definition of a non-thinking person.

There are conflicting explanations for the heroin scarcity which developed in Australia in late 2000. Almost certainly, multiple factors were responsible. Some attribute this largely to diminished supply due to a decline in opium production following a three-year drought in the Golden Triangle, the major source of heroin arriving in Australia. Others argue that improvements in domestic law enforcement were the principal factor. A more sophisticated understanding why the scarcity in heroin developed, how long it will last, and the benefits and costs of this scarcity, is needed to inform the future direction of drug policy in Australia.

Many independent experts do not support claims that the heroin scarcity resulted from improved effectiveness of domestic law enforcement. The Australian Federal Police Commissioner, Mick Keelty, has said that the heroin drought "is more the result of a business strategy". Asian crime syndicates, he noted, had "made a marketing decision to deal mainly in methamphetamine tablets instead of heroin".

Our low dollar and increasing demand for heroin in regions neighbouring the Golden Triangle (China and the central Asian republics of the former Soviet Union) may be additional factors depressing supply to Australia.

The National Crime Authority Commentary 2001 noted: "In the year 1999/2000, Australian law enforcement agencies seized a total of approximately 5.3 tonnes of illicit drugs in Australia. Of the 5.3 tonnes, approximately 734 kilograms was heroin. The NCA estimates that this represents just 12 per cent of heroin being consumed"."

Has effectiveness of domestic law enforcement doubled suddenly to 24 per cent, or trebled to 36 per cent? Supporters of the proposition that improved effectiveness of domestic law enforcement was responsible for the scarcity have not produced any heroin seizure data to support their claims. Moreover, there has been no scarcity of amphetamine, which is

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also imported by heroin traffickers. However, the fact that no other country has so far reported such a severe heroin drought suggests that improved domestic law may have contributed to the heroin scarcity.

On previous occasions when heroin production has declined temporarily, poor weather in growing regions has often ended up as the accepted explanation. Yet many will agree with Royal Commissioner Justice James Wood that “it is fanciful to think that drug addicts can be prevented from obtaining and using prohibited drugs”.

Whether we like it or not, the odds are stacked against attempts to substantially reduce drug supplies from entering our 27,000-kilometre coastline. Only one in 200 of the eight million passengers arriving by air each year and four in a thousand of the almost two million containers arriving by sea each year are searched. The price of a kilogram of heroin increases 300-fold in its journey from country of origin to country of destination. If heroin cannot be kept out of maximum-security prisons, how is it possible to keep illicit drugs out of our streets and parks?

After several decades of unsuccessful attempts to reduce drug supplies, the scarcity of heroin in Australia from late 2000 did not turn out to be the promised solution. Drug overdose deaths in Australia increased 110-fold between 1964 and 1998 so the reduction of drug overdose deaths in Australia by one-half to two-thirds in 2001 has been very welcome. However, more intensive application of law enforcement often leads to more dangerous drugs driving out less dangerous drugs. The heroin drought has also had its downsides and risks. Amphetamine injecting has increased in Australia and cocaine injecting is increasing in parts of Sydney. Rising use of these stimulant drugs has been linked to growing violence.

In Vancouver, Canada, HIV spread rapidly among the city’s injecting drug users a few years ago after a sudden switch from heroin injecting to cocaine injecting. HIV then began to spread to the general population. Let us hope that the heroin scarcity in Australia does not leave us with this terrible legacy. It is far more difficult to control HIV among cocaine injectors than among heroin injectors. Some inject cocaine up to 20 times a day, compared to a maximum of five to six times a day for a particularly entrenched heroin injector. They are at risk of paranoid or aggressive behaviour for several hours a day. Nor is there are pharmacological treatment for cocaine users comparable with methadone for heroin users.

A market correction is likely sooner or later, connecting new supplies to more than a billion dollars a year of unmet demand. There have already been reports that the Northern Alliance in Afghanistan has been busy in recent months planting opium poppies in parts of the country they control.

In the first months of 2002, there have been some indications in parts of the country that the heroin market may even be starting to return to the *status quo ante* with increasing numbers of ambulance calls to drug overdoses, more presentations of fatal and non-fatal overdoses to hospital Emergency Departments, and increasing reports from drug users of easier availability and rising purity of street heroin. If the reduction in heroin availability was caused by more effective domestic law enforcement, then surely any future increase in heroin availability must logically be attributed to decreased effectiveness of law enforcement? Ultimately the truth will emerge when official heroin seizure data for this period becomes available.

The heroin drought is a further warning that illicit drugs should be treated predominantly as a health and social issue. Like drug users themselves, the community should abandon the notion of a quick fix.

Just, Vibrant and Sustainable Communities: A Framework for Progressing and Measuring Community Wellbeing

The Local Government and Community Services Association of Australia has recently released this publication which encourages Australians to reflect on community wellbeing values, celebrate difference and diversity and promote quality of life for all people. It is written as a pocket guide and provides a ready reference for councils and their communities. The importance of sense of place to individual and community wellbing is well articulated and the essential building blocks of community wellbeing - democratic governance, active citizenship, social justice and social capital - are discussed in some detail. The publication challenges councils to take a leadership role in a new approach to community development by applying community indicators to help measure progress.

For further information contact Director, Social Development, Moreland City Council on (03) 9240 2373 email jmerkus@moreland.vic.gov.au.

Australia Day Award

Pat Mowbray
PHAA Member

On Australia Day 2002, Dr Pat Mowbray, a long time PHAA member, was made a member of the Order of Australia, General Division, for her service to community health, particularly through the Australian Healthy Cities movement in the Illawarra Region and for improvement to the environment through local community action. The Order of Australia was established in 1975 'for the purpose of according recognition to Australian citizens and other persons for achievement or for meritorious service'.

Pat was born and grew up in Dulwich Hill, Sydney and graduated from Sydney University Medical School in 1958. Following a junior residency at the Royal North Shore hospital, she married her husband Bill, a solicitor, and moved to Wollongong. After sixteen extremely busy years as Deputy Medical Superintendent of Wollongong Hospital and the birth of two children Andrew and Josephine, in 1973 she was seconded to the NSW Health Commission to plan, develop and implement community health services in the Illawarra Region. Around this time she was also very involved in the submission by Wollongong University for the establishment of an innovative medical school. Although the School eventually went to Newcastle, many of the Wollongong ideas - such as a fully integrated curriculum based on continuing theory and practice, shared learning with other disciplines and small group learning -were adopted in Newcastle.

Pat also developed a passion for community work and the importance of providing accessible health services at the real community level. She is widely acknowledged as a champion of services when they were under serious threat of major funding cuts and there are services which would not exist today in their present form if it were not for the tenacious battle Pat and others fought in the '80s. In 1984, she was appointed Director of Community Health by the newly formed Illawarra Area Health Service and in 1987 was one of the initiators of Healthy Cities Illawarra of which she became and the chairperson.

In 1992, she was appointed Director of Healthy Cities Illawarra, Aboriginal Health and General Practice Liaison, and was associated with the establishment and development of the Illawarra Division of General Practice. She resigned from the Illawarra Area Health Service in 1994 but continued her work with Healthy Cities Illawarra and fostered its view that better health is an outcome of social, environmental and economic factors and cannot proceed without real community participation. Through this involvement and her active membership of several of its taskforces, she has actively pursued her goal of creating a cleaner, greener, healthier and more caring Illawarra. She has presented papers on Healthy Cities Illawarra both nationally and internationally: she as a keynote speaker at the International Healthy Cities Conference in Tokyo in 1995 and a presenter at the Ten Year Healthy Cities Conference in Athens in 1997. In 1998, her work for the Healthy Cities Movement was recognised by a Health Impact Award by the NSW Branch of the PHAA.

In recent years, Pat has become extremely concerned about the deteriorating national and global environment and has campaigned on major environmental issues. She was one of the initiators of Futureworld, the National Centre for Appropriate Technology, which is being developed in Wollongong and which plans to open an Eco-Technology Centre in Coniston late 2002. She also represents Healthy Cities Illawarra on the Ecological Sustainable Development Committee of Wollongong City Council.

Pat was a member of the NSW Premier's Council for Women from 1996 – 2000.

Pat has earned the respect and affection of many Aboriginal people in the Illawarra through her dedicated work in Indigenous health. She has a great belief in the reconciliation process and seeks every opportunity to advance its cause. Pat is a Fellow of the University of Wollongong and a member of the Honorary Chapter of the Alumni. She continues to lecture at the University in Community and Environmental Health and Healthy Cities to local and overseas medical and other graduates.

TAS Branch News: Meningococcal Disease and Smoking

Michael Wilson, TAS Branch President

The death of five Tasmanians last year from an onslaught of meningococcal disease sent panic waves rippling through Hobart and neighboring communities. The disease is very often unstoppable and our inability to control it makes meningococcal disease particularly frightening.

In the wake of this tragedy, we thought it would be opportune to highlight research on the relationship between meningococcal disease and tobacco smoking.

About 10% of people are carriers of Meningococcus, a bacterium harbored in the back of the throat and nasal passage. Institutions world-wide have run scientific investigations looking at independent risk factors and socio-economic studies to discover high-risk categories of meningococcus carriers. A common result of studies from America, Britain and Canada indicates that smokers are ten times more likely to be carriers of the disease, and maternal smoking is associated with a fourfold increase in meningococcal risk, particularly in children under the age of 18. For instance, a study by the Centres for Disease Control and Prevention (CDC) in America concluded that maternal smoking may be a major risk factor for meningococcal disease transmission. The researchers stated that "40% of disease in children younger than 18 years of age could be attributed to maternal smoking."

The 4000 chemicals in cigarettes include some that burn cilia, the hairs on the back of the throat and in the nasal passage. This creates moist cavities which, deprived of the tiny hairs which serve as filters, provide an attractive breeding ground for the meningococcus bacteria.

The bacteria are spread from a carrier to a recipient through close personal contact. This includes mouth to mouth kissing, mouth to mouth resuscitation, sharing drinks, eating utensils and cigarettes. In some cases, the meningococcal outbreak in Tasmania was associated with nightclubbing . Everyone can picture a nightclub scene…drinks being put down, picked up by different people, non-smokers having a drunken puff of their friend's cigarette…it is an environment with high potential risk for transmission.

Once the meningococcus bacterium is transmitted, it is swift to move. Early signs include nausea, vomiting, fever, headache, stiffness of neck and joints, drowsiness, dizziness and an inability to tolerate bright lights. For many, these symptoms are common to flu, a cold or even a hangover, and therefore they are not easily distinguishable as something more serious. A more telling sign can a rash which can vary in appearance from bruising to tiny dots. Severe confusion may set in, and often the victim falls into a coma. However, by the time these symptoms appear, it may be very difficult to halt the progress of the disease.

Because of the media attention that meningococcal disease receives and the association it has with tobacco smoking, Quit Tasmania believe that it is a strong public health message which needs to be delivered to aid the anti-smoking campaign and to raise general public awareness of this relationship.

Home Medicines Review

The Department of Health and Aged Care (DHAC), (Enhanced Primary Care section) has released an information kit called *Domiciliary Medication Management – Home Medicines Review.* This is aimed at GPs, and the kit contains a detailed booklet about the service, a fact sheet and process chart provided as an overview, a patient information sheet and a set of referral and medication management plan forms. The idea is for patients/carers/health professionals to identify the need for an assessment and to make a request for the service to be conducted by the GP, in conjunction with the pharmacist and using the forms in this kit.

Greg Burgess at the Department who oversaw the production of the kit would be pleased to receive any comments you may have. To order and/or make comment contact Greg on 02 6289 8067 or greg.burgess@health.gov.au.

POLITICAL PARTIES, DONATIONS & TOBACCO ISSUES: Ethics & integrity - (opinion piece)

Doug McIver

Doug McIver is a member of various community groups. He is currently Vice President of Canberra Action on Smoking & Health Inc. He is also a member of the Australian Labor Party. However, this article is represents his views as an individual and is not presented on behalf of any organization.

Donations to political parties, and their possible impact on Government decisions, have again entered the consciousness of some health groups and individuals. Does a political party receive funds because the donor wishes to influence the political party in its decision making?

I have had some experience of the way the tobacco industry -functions and its relationship to political parties. So it was of interest to me to read a recent article in The Age (Feb 2, p3) which reported the Australian Labor Party (Victorian Branch) and the Liberal Party (Victorian Branch) had both received funds from Philip Morris. The Liberals also received funds from the British American Tobacco Australasia (formerly Rothmans).

The Age report also mentioned that the Liberal Party had received $45,000 from GlaxoSmithKline. This company's anti-smoking drug, Zyban, attracted $80 million in subsidies after the Federal Government agreed to list it on the Pharmaceutical Benefits Scheme. However, the article also stated: "But the company yesterday denied the donation had anything to do with the government's decision, saying the donation had been made by subsidiary company SmithKlineBeecham before the merger with Glaxo, the manufacturer of Zyban". Be as that may, the issue still raises questions, at least for interested advocates and health consumers.

Political parties send thousands of letters to companies, businesses and individuals, as well as their members and supportersseeking financial donations, especially at election times. After all, a political party is a community not-for-profit body which requires funds To survive. At the federal level, under the Commonwealth Electoral Act 1918 (Part XX), political parties are assisted financially according to a formula relating to the number of votes a party receives at an election. This augments their income which previously had depended upon membership subscriptions and donations. In the States and Territories, legislation on matters of election funding and financial disclosure varies from jurisdiction to jurisdiction.
Why do companies, small businesses and individuals make donations to political parties? It may be to support the objectives of the party. After all, political parties require funds to fulfil their mandatre to participate in Australia¹s constitutional parliamentary democracy. That¹s fine; quite altruistic and good. But is there always integrity in the process? One may consider that Phillip Morris, in providing funds to two political parties in the same financial year, or for the same election campaign, has helped both parties in their role in our constitutional democracy. But one may also wonder if there is more to this than meets the eye.

Is it possible that a donor provides funds in appreciation for work a political party has done which accords with their interests?

A political party's governing body may take many things into account when deciding from whom it will seek, and receive, donations. But there may be conflicting considerations. Let us return to the issue of the Liberals and the ALP receiving funds from tobacco industry interests.

Consider the policy parameters and priorities. In the tobacco industry, there are the primary producers, the processing and packaging industries, marketing and promotion arms, corporate sector management with direct or indirect interest in tobacco sales, trading interests, wholesalers and retailers, and so on. All sectors employ people. There is an infrastructure which creates employment and generates goods and services. Consumers have a free choice (under regulated conditions) to consume tobacco products. Capital and recurrent expenditure amounting to millions of dollars may be generated from tobacco consumption. Revenues (taxes and charges) to the public sector mount up from goods and services. Taxes out of employment, wages, and salaries go to the public sector. Therefore there are potentially conflicting agendas considering whether or not to accept donations even though they are possibly intended to sway the direction of the party's policy.

However, the central issue for health advocates rests on the clinical evidence of the impact of tobacco on the health on the community. For governments, budget outlays related to this health impacts raises important questions. Policies, programs and strategies designed to support population health

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through reduced tobacco usage are important parts of the equation for political parties. They have to balance the clinical evidence health promotion objectives, with all the other considerations in deciding whether or not to accept donations.

The production, sale and consumption of tobacco is legal, so perhaps political parties should have no concerns about the ethics of accepting funds from tobacco interests, especially in a well regulated industry. But is this sufficient to ignore other considerations? A political party may consider that the health risks of this legal product are such that, while there is no question of prohibiting its production, it must be regulated wisely and that health issues related to its sale and consumption are very important. But how will health issues be prioritized Where do the 'health objectives' of policy-making lie in the debate and decision-making on donations from the tobacco industry?

The political parties must endeavor to avoid conflicts of interest arising from accepting donations and to minimise confusing messages to the electorate. So the important questions are : Can donations compromise the party's health policy objectives? Is the integrity of the party policy paramount?

Political parties would gain great credibility with health advocates if they rejected all funding from the tobacco industry if the intent of the donation ran counter to the National Tobacco Strategy, which has agreed to by all Australian jurisdictions.

Conersely, a party or government may be seen to be compromised if it is observed that a donor company's products receive official subsidies particularly if there is some controversy about the efficacy of the products. Even if a company's product meets all the appropriate criteria, the donation can raise doubts around the issue.

In my opinion, it is incumbent on political parties to be alert to the risks of compromise when there are competing and conflicting interests. In the case of donations, it is integral to the political process to establish whether a donor's operations are in accord with party objectives and sit comfortably with the overall strategy of the party's policy platform or policy considerations.

The intent of a donation is crucial. For example, interests associated with the tobacco industry might want a party to help with agricultural diversification and rural adjustment schemes to support tobacco growers who wish to grow something else. If a party's pro-active stance on tobacco cessation strategies associated with the National Tobacco Strategy was well established, sections of the industry affected by the policy and declining tobacco consumption would want to lobby the party to introduce measures to assist them adjust to changes due, in part, to government health policy. So tobacco farmers lobbying for rural adjustment schemes to diversify to other crops would, prima facie, appear to have a sound argument for political support. This support would be for social justice in a changed market environment. bodies, including the World Health Organization, and consumer groups. However, some health advocates would still have difficulty accepting this line of argument and transparent processes would be needed to reveal the intent of such a donation and the reason for its acceptance.

Donations and sponsorship for political parties raise ethical issues for all involved. Remember a recent Liberal Party Federal Conference which included sponsorship by a tobacco company? It send conflicting messages about the Federal Coalition health messages commitment to the National Tobacco Strategy and compliance with the advertising and promotion aspects of federal tobacco legislation. Sadly, the ensuing debate centred on legal issues of the product and the rights of tobacco industry interests and consumers, without appearing to consider health issues.

It is imperative that health interests, too are vigorously put to political parties. Then there may be a chance that political parties will come to a better understanding of tobacco related health risks and health costs, and so to assign more value to health promotion objectives.

Political parties must come to realise that new options are needed as proprieties change and that a new emphasiscan lead to win-win situations. In the context of a tobacco cessation culture, new strategies could be developed in primary, secondary and tertiary sections of the tobacco industry to support workforce re-skilling and diversifiication'. Party decisions on accepting donations from the industry could then be in accord with its health goals and objectives. Any party which introduced health impact statements into its paradigms would set a shining example- and come up with astonishingly positive results.

If it is happening in any of the political parties at present, well done!

COAG reforms to Food Regulatory system

Director
Food Policy, Department of Health and Ageing

Progress continues with implementing reforms to improve the efficiency of the food regulatory system, while maintaining its effectiveness in delivering safe food. Public health and safety remain primary concerns.

Reforms focus on three areas:

- *structural* – establishing a national system, incorporating key stakeholders, to achieve agreed food safety outcomes through consistent approaches;
- *legislative/regulatory* – establishing a comprehensive legislative framework for setting domestic standards based on rigorous science and assessed risk; and
- *policy* - developing a broad policy framework to guide all parts of the system.

The new model comprises:

- a **Ministerial Council**, *The Australia and New Zealand Food Regulation Ministerial Council*, charged with the development of domestic food regulation policy and policy guidelines This will be expanded beyond Health Ministers to include other Ministers with relevant portfolios including Primary Industry and Consumer Affairs;
- a **Food Regulation Standing Committee** of senior officials which will provide policy advice to Council;
- a **Development and Implementation Sub-Committee** which will develop implementation policy/policy guidelines to ensure consistent approaches to enforcement;
- a rapid-response **Technical Advisory Group** on enforcement;
- **Food Standards Australia New Zealand** – a statutory authority developing domestic food standards based on scientific/technical criteria consistent with Ministerial Council policy; and,
- enhanced stakeholder consultation.

The passing of Commonwealth legislation during 2001, together with agreement on amendments to the Treaty between Australia and New Zealand, foreshadows the full implementation of the new system in mid-2002.

The Australian Resource Centre for Hospital Innovations (ARCHI)

The Australian Resource Centre for Hospital Innovations (ARCHI) was established in 1998 as a national clearing-house for information and resources on innovative health care delivery. ARCHI is funded by the Commonwealth to make available information and resources on innovative health care delivery from hospitals to the community for both acute and chronic illness. ARCHI's information products are available through the web-site www.archi.net.au. These products include regular electronic bulletins and interactive discussion forums. Its products are about work at the coalface rather than in the research setting.

ARCHI also responds to requests for information on current health issues and models of care by conducting Tool Kit Seminars across Australia. These seminars provide practical ideas that can be used to achieve change in the health care setting (both hospital and community) as well as workable solutions that can be used to implement innovations in health services delivery and management.

If you have a project or resource you like to share, are unable to access information or just want to know more about ARCHI, contact the ARCHI National Office on 02 9382 2487, or email: NSW.Sat@archi.net.au or visit www.archi.net.au

Women's Health SIG news: Abortion Law Reform

Angela Taft
Women's Health SIG Convenor

The Women's Health SIG was delighted to support the recent successfull efforts of a Tasmanian coalition campaigning for abortion law reform. Family Planning Tasmania and Hobart Women's Health Centre coordinated the campaign, which was developed in response to the threatened closure of the only remaining abortion services in Tasmania. The threat resulted from the potential for criminal charges while abortion remains in the Criminal Code. Advocating around the SIG's policy on abortion, we sent copies of PHAA's information kits with the public health evidence on abortion and wrote letters of support to Tasmanian MPs who were allowed a conscience vote. Our press release supporting legislative change was picked up by the Hobart press, and we were grateful to Dr Alison Venn, our spokesperson in Tasmania. In the end, abortion was not removed from the code. However, the law was liberalised so that health professionals can provide this service without the threat of prosecution, and women can safely choose termination and responsible parenting without having to leave the state.

Watch this space, as in the ACT in April the Hon Wayne Berry MP is presenting a bill to decriminalise abortion. PHAA will be supporting this with a press release and other action requested by local advocates.

Trafficking in Women and Children for Prostitution and Links with Asylum Seekers

Angela Taft
Women's Health SIG Convenor

Eighty to ninety participants at a Melbourne forum supported by PHAA in late February heard about the deaths of two Vietnamese women who recently died (suicide and heroin overdose) in Villawood detention centre. The women had been trafficked into Australia for prostitution. As they had no valid immigration papers, the two were placed in Villawood to be deported back to the same poor conditions, which left them vulnerable to trafficking in the first place.

The symposium, called "Stop the Traffic", was organised by WHSIG collaborators Project Respect, funded by VicHealth and RMIT University and supported by PHAA. The day began with Detective Senior Sergeant Ivan Mckinney, Asian Squad, Victorian Police, describing the difficulties in prosecuting a Melbourne man who had trafficked 14 Thai women and held them virtual prisoners (without their travel papers) in the prosperous Melbourne suburb of Kew. The difficulties resulted from the then lack of a specific federal trafficking law. Relevant legislation now exists. However, the new law refers only to threats or actual force in the definition of trafficking and does not account for those tricked through deception or other forms of power and control.

The participants also heard about the impact of globalisation and violent conflict on the traffic in women and children. Aurora Javate-de Dios, Executive Director of the Coalition Against Trafficking in Women (Asia Pacific), Philippines, Chair, National Commission on the Role of Filipino Women and former Philippines representative to CEDAW. Aurora outlined the scale of the problem in the Asia-Pacific as well as UN initiatives including the new trafficking protocol. Professor Liz Kelly, Director of the Child and Women Abuse Studies Unit, University of North London and author of *Stopping Traffic*, commissioned by the UK government in response to trafficking, described the global problems, especially the plight of Eastern European women who were trafficked in their own countries and across Europe. The symposium organised workshops for participants to network around further action in Australia. The WHSIG will continue to be involved with this.

National Medicare Alliance

Helen Keleher
PHAA Vice-President (Policy)

This brief article is to bring members up to date on activities related to the defence of the universal elements of health care provision in Australia. The Friends of Medicare Alliance was an active group during the 2001 Federal election campaign through its members, PHAA, Doctors Reform Society, Australian Nursing Federation, Australian Council of Social Service, Australian Consumers Association, Australian Women's Health Network, Health Issues Centre. Athough it was a particularly difficult campaign in which to insert health messages, a remarkable number of media 'hits' were achieved collectively by the FoM Alliance who worked very hard to get our messages across to the media and the general public.

Within 24 hours of the election result, the Friends had agreed that the Alliance needs to stay together to develop policy and advocacy in relation to Medicare funded and other health services. We met in January via teleconference and then face-to-face in Sydney on 1 February. The meetings have been productive and positive, with a clear commitment from all members to belong to the Alliance with a sharing of costs and responsibilities. We are in the process of inviting other national NGOs to join the Alliance to strengthen our base and widen our pool of expertise. We have voted on a new name, which is the **National Medicare Alliance** and a new website will be established very soon. Friends of Medicare was a very important predecessor for the new Alliance, but members all felt that some refreshment of the name and its purposes would help to breathe new life into our activities. We are in the process of deciding our priorities and strategies but are very clear that we wish to promote social justice, fairness and equity in health.

I will keep you informed of developments and report formally to Council in April and September. Our first media release went out in relation to private health insurance premium rises but as individual organisations we will also continue our advocacy and policy development. We look forward to your support in the future.

2002 Funding available for reviews in health promotion and public health

The Cochrane Health Promotion and Public Health Field, currently coordinated from Australia, is an entity of the international Cochrane Collaboration. The role of the Field is to promote and support the production and use of Cochrane reviews of the effectiveness of health promotion and public health interventions. Australian reviewers are also supported by the Australasian Cochrane Centre.

The Field is now offering time-limited funding for the production of Cochrane reviews of the effectiveness of health promotion and public health interventions.

This year's scheme applies to applicants seeking to:

Update an existing Cochrane review
Convert an existing non-Cochrane review into a Cochrane review, ***or***
Develop a protocol for a new Cochrane review
Approximately 8 bursaries will be offered, ranging from $500 up to $5000 (Australian dollars) Applications close **25 March, 2002.**

This scheme is open to reviewers from all countries, and applicantions should emphasize the importance of the review topic to health promotion/public health practice and/or policy.

For more information, and to obtain an application form, please go to the Field's website: **www.vichealth.vic.gov.au/cochrane/news/funding.htm** Or contact the Field Administrator, Jodie Doyle by email: jdoyle@vichealth.vic.gov.au, phone +61 3 9667 1336 or fax +61 3 9667 1375

Refugees and Population Policy: a new language and ethical base is needed - (opinion piece)

Dr Anna Whelan
Convenor International Health SIG

In recent months some phrases that require some critical discussion from public health practitioners have emerged: *illegal migrants, asylum seeker, queue jumper, detention, border protection*[1]. Stereotypes have been conjured up by politicians with labels of "the kind of person Australia does not want" and "people who would throw their children overboard or sew their lips together". We have seen lies, now exposed, used cynically to maintain political power in the last election. The concept of social capital we discuss in public health circles appears irrelevant in the face of such deceit from our leaders.

Some members have asked me why I have become so vocal about mandatory detention and the deplorable treatment of refugees. With some soul searching I have to think that it must be an interplay of genes and environment! My father was a Danish teenage schoolboy in World War II who was involved in passing messages for the underground which, have recently discovered, was assisting Danish Jews to escape - with great success. My mother and her family fled from the Japanese invasion through Malaysia and into Singapore. They were refugees who had vivid stories to tell of terror, but also of amazing survival and coping mechanisms.

As a young teenage migrant in Australia in the 1970s, we had several guests that my father brought home in his capacity as a shipping agent who dealt with stowaways or crew who had "jumped ship". They were from Sri Lanka and other countries. It was an unquestioned part of growing up – our home was a refuge for them. The saddest part of this for our family was that most of them were forced to return to their countries despite the danger that might await them. We never heard from them again. Recently I have had the privilege of meeting several MPH students who are working with the NSW Refugee Health Service who have opened my eyes to the world of refugees today.

I feel ashamed that I was silent about the detention centres until the Tampa issue. This shocking episode made me call talkback radio on every occasion I could, and plan a mobilisation strategy for PHAA. Whilst a moral argument for giving refuge to people fleeing persecution appears straightforward, as a public policy this issue is more complex. In some ways it can seem a marginal public health issue. How many people are affected? What makes this a public health problem and what can be done about it? Is there an effective intervention?

The number set aside for refugees and humanitarian entrants to Australia is a relatively small part of the overall immigration intake - 12,000 people per year in a intake of about 80,000. Of the 12,000 places, only 4,000 are offered for refugees who apply offshore". The ratio of refugee to host population in Australia is 1:1,130 compared to Canada at 1:572, UK at 1:681, USA at 1:588 and Germany at 1:456.
The link between immigration intake and our moral obligation to take in refugees needs to be not only separated, but also clarified.

One of the key issues to address is developing a population policy within an ethical public health framework. This was the theme of the call for a national population policy at the Population Summit in Melbourne in February 2002–a call which came from groups both for and against an increase in immigration.

In the 1990s we had a Bureau of Immigration and Population Research (previously the Bureau of Immigration Research) based in Melbourne which hosted a number of national summits. For seven years the Bureau produced research papers and stimulated public discussion on immigration, multiculturalism, settlement policy and population planning. Its funding ceased suddenly in August 1996 with the election of the Liberal National Party Coalition - an interesting beginning to an agenda that leaves debate on population, immigration and refugee policy to the polls and the media.

The Bureau produced a series of papers, which outlined the economic costs and benefits of immigration and related environmental and social concerns. Recent evidence suggests that the Australian ecosystem has limited arable land and water resources, and, based our current lifestyle and consumption patterns, could not sustain the significant population increase called for by some business interests. – However, some would argue that the complex interaction between population, technology and

consumption makes the concept of setting an optimal population level problematic. Yet while we must try to plan for the number of immigrants appropriate for sustainable growth and environmental protection, refugee intake must be responsive to global crises. Refugees are an important part of population policy and it is imperative that we accept our international obligations to take our "fair share". How do we determine what this is? As public health practitioners, these are fundamental issues for us.

What is also emerging, out of what appears to be racist hysteria against a smallish group of refugees arriving by boat, is that the costs of migration are not borne equally. Most migrants and refugees settle in Sydney and Melbourne in suburbs where unemployment rates are higher than in other urban areas, and social and economic disadvantage is tangible. Tensions can build up towards a climate of hostility towards the newer arrivals, be they refugees or migrants. It does not help to have leaders who fuel these concerns. The benefits of migration, on the other hand, accrue to the housing industry and businesses that gain larger markets.

Prevention not border protection

Prevention is a key public health principle. PHAA and other groups need to support the call to increase Australia's overseas aid budget. Refugees are different from migrants – the pull factors are less important than the push factors. Refugees have little choice over whether to leave their countries or not- they come because of war, conflict, persecution, and repression. Poverty and injustice are root causes of the global movement of people and tackling these issues must be seen as a greater priority since September 11th. The internationally agreed target for development aid is 0.7% of GNP. Australia ranks 12th out of 22 developed countries in aid spending, allocating only 0.25% of GNP to overseas aid. The Australian Council for Overseas Aid has called for an immediate increase to 0.27% and has pointed out that the so-called "Pacific Solution" is estimated to cost $400-500million - an amount which would equal Australia "fair share". But instead it is being spent on detaining refugees rather than providing better basic education, health and education, health and services education, health and in their home countries.

The detention solution is not consistent with public health values. It is a breach of human rights in its severe implementation and its explicitly deterrent purpose. The conditions in detention centres are worse than in our harshest prisons. Professor Richard Harding visited the detention centres in Curtin and Port Hedland as Inspector of Custodial Services in Western Australia, whose job it is to inspect and report on prisons. He reported that in Curtin, the huts were *grossly overcrowded; many of the toilets were broken; some of the washing machines were also broken; the so-called 'shop' was abominably stocked and rather inaccessible; the system for sending mail breached all standards of privacy and confidentiality; and above all the medical and dental facilities were inadequate*. Public health practitioners must be concerned to learn that the dentists main activity is tooth extraction and that the main health 'treatment' was advice to 'drink more water.' The imprisonment of children who have already experienced trauma can only exacerbate psychological and developmental problems in the future.

Public health as a discipline needs to come to grips with the issue of human rights and their abuse. The question of refugees is clearly a contentious one in Australian society and it requires public health practitioners to speak up with an informed voice.

The International Health SIG is keen to further the debate and support relevant action. We hope that the 2002 PHA Conference will engender discussion and guide future directions. We are also preparing a submission to the HREOC Inquiry on Children in Detention, using a broad public health approach to argue a case.

As individuals, we can all add our voice by writing letters to national and overseas newspapers and lobbying politicians, local party branches. Those who are oriented towards other strategies may find many ways to be involved through:
http://www.chilout.org
Asia Pacific International Solidarity Conference, phone 9690 1230
www.justrefugeeprograms.com.au

Evaluation of On-Road Performance of Older Drivers

A report to Austroads, Melbourne, Victoria: Monash university Accident Research Centre entitled 'Model Licence re-assessment procedure for older and disabled drivers' has been released This paper is contributing to the development of a comprehensive licence review and reassessment system for older and disabled drivers. For further information on this project contact the School of Biosciences (03) 9479 5733 or the School of Occupational Therapy (03) 9479 5733.

A Vision for a Public Health Contribution to the Refugee Debate - (opinion piece)

Cathryn Finney Lamb
Research Officer, NSW Refugee Health Service

There is a difference between a mandate to solve a problem and the logistics of solving it.

The moral imperative to uphold principles of equity and protection for refugees provides the mandate for ongoing debate about how we do this in a sustainable way in Australia

The formal mandate is located in Australia's humanitarian obligations as a signatory of the 1951 United Nations Refugee Convention. Australia has agreed to provide protection for those outside their country of origin and unable or unwilling to return due to a well-founded fear of persecution. This protection ensures that refugees are not returned to their country of origin and that their basic human rights are met whilst they are here. Access to health care and living standards needed to maintain health are recognised as basic human rights in United Nations instruments.

Critics have labelled these humanitarian imperatives as simplistic and naive. Some may base their response on different ethical grounds. Others may believe that the complexity of finding solutions for processing refugee claims in a manner that reconciles all concerns is impossible. Apparently practical arguments can then be used to over-ride the mandate, as has occurred with children in detention.

Even within the public health field, there is a danger that the debate will become fractured. Durable solutions can only be developed when all issues of this multifaceted problem are held in dynamic tension. A clear example of this is the reconciliation of the population debate with humanitarian principles. The population debate can provide important input into policy decisions about population levels and the mechanisms for the environmental, economic and social management of sustainable population growth. However, injustice could occur if the principles for accepting refugees into Australia become the same as those underpinning our skilled migrant immigration program, or if proposed population ceiling levels were used to dismiss humanitarian principles in responding to the actual needs of refugees.

In situations where opposing interests appear incompatible, there is a risk that professional debates can become mutually exclusive and locked into in an ideological power struggle. However, sustained interaction between those holding differing positions can provide an opportunity for alternative solutions to be developed. The ethical mandate to find a solution can provide an impetus for this ongoing debate.

Since the refugee issue is multifaceted and complex, the multidisciplinary base of public health means that the field is well positioned to help develop solutions. Not only do we have access to a diversity of disciplines and skills, but we have natural networks, forums and partnerships within which these debates can occur.

Public health professionals can contribute to the discussion of population policies, public health protection, settlement services, detention centre health care and the impact of current asylum seeker policies on health. Much public debate is rhetorical and evidence is framed within particular value systems. Expert voices have a strategic role and credible scientific evidence is needed to inform the debate and the development of sound policy. Public health research is also needed to underpin effective health services for refugees.

However , we have to overcome several hurdles if the research base and infrastructure of public health is to meet these challenges effectively. Public health research informing refugee issues is limited. Most published studies are descriptive or focus on health status in clinical or screened populations. Few of them have been conducted in Australia.

Refugee health research needs to be set within an equity framework to secure necessary resources to redress gaps. Mainstream public health professionals need to take up the challenge. Perceiving refugee health as a specialised role or minority issue obscures the importance of its impact on the rest of our society and relegates it to a low priority in population-based research.

Rigorous multidisciplinary debate is needed to identify new research directions that can contribute to the resolution of competing interests. Research infrastructures may also need to accommodate new partnerships for interdisciplinary research.

The 2002 PHAA conference is a perfect place to start!

WHO Commission - Macroeconomics and Health

The Commission on Macroeconomics and Health (CMH) was established by the Director-General of World Health Organisation (WHO) in January 2000 and was chaired by Professor Jeffrey Sachs of Harvard. Its members and helpers included former ministers of finance, people from the World Bank, the International Monetary Fund, the World Trade Organisation, the United Nations Development Program, the Economic Commission on Africa and the Organisation for Economic Cooperation and Development. The Commission was financially supported by the Bill and Melinda Gates Foundation, the Rockefeller Foundation and the UN Foundation and by the governments of the UK, Luxembourg, Ireland, Norway and Sweden.

David Legge, from the School of Public Health at La Trobe University has made a broad invitation to health activists, NGOs and academics, to form a collaboration in developing a strong response to the CMH, which challenges many of its assumptions and conclusions. David describes the report as large and difficult to analyse, but says that the core of the report is that globalisation is on trial: unless there is a dramatic increase in development assistance for health care in low income countries the legitimacy and stability of the current regime of global economic governance will be seriously threatened.

David has prepared a preliminary analysis which can be found at: http://users.bigpond.net.au/sanguileggi/PrelimAnalCMHReport.html. He hopes this preliminary review will encourage people to read and think about the CMH report.

David has stated that he hopes that the perspectives that he has presented may be useful to others in the task of interpreting, analysing and critiquing the report. However, he notes that the work involved in considering thoroughly the report and that of the working groups is not trivial. The Commission had the resources of Bill Gates and the World Bank at its disposal. The networks of activists, NGOs and academics who might wish to take the opportunity to challenge the logic and legitimacy of the current regime of global governance do not have such resources. But we have our own experts and we are in touch with the current lived circumstances of different settings and different countries. Consequently, David is proposing a global collaboration around the task of analysing and responding to the CMH report.

David has said that he envisages it the material outcomes of this collaboration would be a collection of articles published in a very wide range of websites and journals. He is expecting that through this collaboration people in different parts of the world might collaborate in producing different critiques or commentaries for different purposes and different audiences.

As a starter he has produced the preliminary analysis (address mentioned above). He would like to publish this commentary but is not sure where and would greatly appreciate feedback and commentary on the current draft before he does.

David would like individuals to please read the report and his preliminary analysis and answer the following questions:

- Do you agree that the report of the CMH justifies a strong and critical response?
- Do you agree that we could organise and collaborate in a globalised analysis and response through the medium of this and related lists?
- How does a loosely knit global community of health activists undertake such a project?
- What can you and your organisation contribute to such a process?
- Are there particular aspects of the report that you would like to focus upon?

David can be contacted on 03 9479 5849 or d.legge@latrobe.edu.au

The report of the WHO Commission on Macroeconomics and Health (CMH) was released in December 2001 and is now available at: http://www3.who.int/whosis/menu.cfm?path=whosis,cmh&language=english

The PHAA has changed the format for its newsletter intouch, it now has two columns instead of three, please give us your views on what you, the reader prefers at: publications@phaa.net.au

Topics of Interest

Addition to the Infection Control Guidelines

The Department of Health and Aging recently released the draft of an additional chapter to the infcction Control Guidelines on Creutzfeldt-Jakob disease. This can be downloaded from www.health.gov.au/pubhlth/strateg/communic/review/.

Health Information Symposium

The Seventh International Symposium for Health Information Management Research (iSHIMR 2002) will be held in Sheffield, UK from 26-28 June 2002. The event is organised by the Centre for Health Information Management Research (CHIMR) at the University of Sheffield. iSHIMR2002 aims to bring together people who are carrying out, or are interested in, research in the general area of health information management and technology, and to provide a forum for the presentation and discussion of their research activities. <http://www.shef.ac.uk/is/research/chimr/shimr/index.htm>

Average Life Expectancy

The Australian Bureau of Statistics has released figures indicating that although the average Australian life expectancy has reached its highest point ever, with a 3 per cent drop in death since 1999, the life expectancy of Indigenous Australians has failed to significantly improve. Cancer was the leading cause of death in 2000, but had dropped 9.5 per cent since 1990, while heart disease fell by 39 per cent. (SMH, 12/12)

International Congress on Women's Health Issues

The 13th International Congress on Women's Health Issues will be held at Ewha Women's University in Seoul Korea from June 26 to June 29, 2002. The best-known international experts in the field of women's health will be invited as the speakers for the scientific program. Organisers are keen to ensure that this congress will improve the academic communications on issues of women's health. The call for abstracts has been made and must be received by March 31, 2002. For more information visit http://icowhi.ewha.ac.kr

Occupational Violence in Australia

The January 2002 update of *Occupational Violence in Australia: an Annotated Bibliography of Prevention Policies, Strategies and Guidance Materials*, compiled by Claire Mayhew and Jessica Marshall, has been added to the website of the Australian Institute of Criminology. It can be found at: http://www.aic.gov.au

Hepatitis C Directory

The Australian Hepatitis Council is still looking for additions to their National Hepatitis C Resource Directory. For more information contact Rhonda at the Council on 02 6232 4257 or rhonda@hepatitisaustralia.com

Management of Non-Melanoma Skin Cancer

The Australian Cancer Network (ACN) has released a draft version of *their Clinical Practice Guidelines for the Management of Non-Melanoma Skin Cancer*. The ACN is asking for feedback on the draft Guidelines which can be obtained from www.cancer.org.au/clinical_guidelines.html or in hard copy from Christine Vuletich on 02 9380 9177, email acn@cancer.org.au

"Indigenous Australians and Tobacco: a literature Review".

The Menzies School of Health Research and the Cooperative Research Centre for Aboriginal and Tropical Health have released the reportThe ISBN for this work is 1 876831 60 X

Recent Publications - Legionella Link

A number of resource documents have been released by the Legionella Risk Management Project. These include:

- A Guide to Developing Risk Management Plans for Cooling Towers;
- Managing the Risk of Legionnaires' Disease - Supplementary Notes for Hospitals;
- Recommended Legionella Detection Communication Plan;
- A Guide to Selecting a Cooling System for Acute Health and Aged Care Facilities;
- Legionella fact sheets addressing Legionella in the Environment and the Workplace;
- Code of Practice for Water Treatment Service Providers (Coolinbg Tower Systems); and,
- the Third Edition of Legionella Link.

Each of these documents is available on the Legionella Risk Management Project web-site at http://www.legionella.vic.gov.au.

Helping Older People with Dementia and Their Carers

La Trobe's Gerontic Nursing professional Unit and the Alzheimer's Association of Victoria have completed a research project for the Victorian Department of Human Services aimed at improving the care if people with dementia. For further information about this project contact the School of Nursing and Midwifery (03) 9479 5950.

Australian Medicines Handbook – New Release

The latest (3rd) edition of the Australian Medicines Handbook has just been released. To order contact Australian Medicines Handbook Pty Ltd on 08 8222 5861 or visit www.amh.net.au or email amh@amh.net.au

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What's on

12-14 September 2002
RANZCP Section Social and Cultural Psychiatry
Conference: Cairns, FNQ
12-14 September 2002
"Setting Strategic Directions in Mental Health Policy and Practice: The Challenge of Understanding and Addressng the Social Determinants
Enquiries: The Conference Organiser
PO Box 214 Brunswick East 3057
(03) 9380 1429 Fax: (03) 9380 2722
Email: conorg@ozemail.com.au

More Topics of Interest

National Nutrition Strategy: Eat Well Australia

The National Public Health Partnership (NPHP) launched a number of national nutrition strategy documents late last year. The Strategic Inter-Governmental Nutrition Alliance (SIGNAL) has driven the development of the national nutrition strategy focusing on the whole of population and on Indigenous Australians.
The strategic reviews are:

- *Eat Well Australia*: an agenda for action for public health nutrition 2000-2010
- National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010.

Both reviews have been endorsed by a number of organisations including the Heads of Aboriginal Health Units and the National Aboriginal Community Controlled Health Organisation Board. The documents can be obtained from the SIGNAL web-site www.dhs.vic.au/nphp/signal or for hardcopies call 1800 020 103 (ext 8654).

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Costs for larger/thicker inserts are available on request. Copy deadline is for the 28th of the month for publication on 15th of the following month. If further information is required please contact PHAA via email:

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