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The debate over GM foods continues



Peter Sainsbury, President, PHAA

In March I received an email from a senior academic in the botanical sciences at an Australian university (let's call her/him Dr Flower) regarding the publication by the British Medical Association (BMA) of a report from its Board of Science and Education about genetically modified (GM) foods: *Second Interim Statement, March 2004* [available at www.bma.org.uk/GMFoods].

Dr Flower was aware of the PHAA's policy on GM foods and pointed out that the BMA's report noted that 'there is no robust evidence to prove that GM foods are unsafe', and that 'the potential for GM foods to cause harmful health effects is very small and many of the concerns expressed apply with equal vigour to conventionally derived foods'. Dr Flower urged the PHAA to reconsider the available evidence and revise our policy to reflect the informed opinion of scientific experts.

My responses to Dr Flower follows:

10 March 2004

Dear Dr Flower

Many thanks for bringing this to my attention. I haven't read it yet but will. Whether the PHAA will change its policy will, however, depend on whether we are convinced that GM foods are safe from a public/population health perspective, rather than any assertions along the lines of 'there is no robust evidence to prove that GM foods are unsafe'; the lack of proof of harm does not demonstrate safety, in our view, particularly when we are dealing with entirely new processes, eg artificial manipulation of an organism's genetic code, with few if any adequate public health monitoring systems. That said by way of explanation of our current position, we are of course delighted to review new evidence; that is exactly what we are arguing for.

Best wishes

Peter Sainsbury

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The debate over GM foods continue - continued from previous page

29 March 2004

Dear Dr Flower

I've now had the opportunity to read the BMA's March 2004 *Second Interim Statement* that you brought to my attention.

With all due respect, I do feel that your email to me quoted very selectively from the BMA's statement. For instance, as these direct quotations show, the statement also says:

- Many unanswered questions remain, particularly with regard to the potential long-term impact of GM foods on human health and on the environment
- The few robust studies that have looked for health effects have been short-term and specific
- There is a lack of evidence-based research with regard to medium and long-term effects on health and the environment
- It is crucial that the public's concerns are taken into account
- Safety concerns cannot, as yet, be dismissed completely on the basis of the information currently available
- It remains possible that any new food products could elicit new allergies
- GM foods could conceivably have different effects on those of poor nutritional status and/or those belonging to 'vulnerable groups'
- Research is needed to assess whether transfer of DNA from GM foods is more likely to occur as it contains additional material used to assist insertion of the GM DNA in the first place
- Major concerns still surround the use of herbicides with GM crops and their effect on the environment
- There is still a need for long-term case-by-case research into the effects of GM crops on the environment and biological diversity
- The potential to create 'super-weeds' also gives rise to concern
- Recent research has supported the contention that hybrids between GM crops and their non-GM equivalents are 'almost inevitable'
- More research is required on how best to carry out experiments, risk assessments and surveillance studies with respect to GM crops and foods
- Acquisition of baseline data on the composition, purchase and consumption of food will be imperative for nutritional and health surveillance
- Labelling of GM-containing foods should be continued in order to facilitate further health research and allow the public to choose whether they consume GM food or not
- Robust population health surveillance in relation to consumption of all foods, including GM foods, is essential
- Any new technology such as genetic modification must be examined for possible benefits and risks to human health and the environment

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The debate over GM foods continue - continued from previous page

- The evidence for real benefit is not yet sufficiently persuasive to grow GM crops at the expense of conventionally derived alternatives that can be grown at least as effectively
- There should be an end to assumptions that GM crops are necessary to feed the starving given the complex food distribution, social and economic factors that lie behind such hunger
- The BMA ... does not feel that the argument has yet been made to allow widespread commercial planting of GM crops in this country (i.e. United Kingdom)
- We endorse the call for further research and surveillance to provide convincing evidence of safety and benefits.

While noting that the BMA is an industrial and professional organisation for medical practitioners in the United Kingdom, and that the members of the Board of Science and Education that prepared the statement acknowledge that 'we are not experts in agricultural techniques and crop science, but we are concerned with all issues of public health', I believe that the BMA's statement broadly supports the PHAA's position on GM foods.

Yours sincerely,

Peter Sainsbury

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PHAA ADVOCACY – March/April

Pieta Laut, PHAA Executive Director

Free Trade Agreement

A proposed policy on globalization has been submitted to and accepted by the World Federation of Public Health Associations (WFPHA). The policy will be supported by Stephanie Short and Buddhi Lokuge at the WFPHA meeting in Brighton. They will report back on outcomes next month. A copy of the proposed policy can be found under SIGs - International Health - on the PHAA website. Buddhi has been a powerhouse in the development of this policy.

Refugees

The major focus of the PHAA's work on refugees continues through the participation of the International Health SIG in the ARC Linkage Grant *An examination of refugee women at risk in Australia's refugee policy*. Dr Anna Whelan is our contact for this.

In addition a letter was sent to Minister Amanda Vanstone seeking an explanation of her deportation of an asylum seeker to Iran after she had announced that she would not be deporting Iranian asylum seekers. We are awaiting a reply.

International Health



A. The International Health SIG has continued to provide support for the YAKKUM Bali project which supports poor young people and children who have a permanent disability and who are not receiving help from any other organization. \$4,700 has been raised so far. PHAA would like to thank the donor who provided \$1,000 for the project this month.

Tax deductible donations can be made to PHERT – Bali. Receipts will be issued for all donations. Please donate to this, PHAA's only project in a foreign country. We need \$5,000 to get the project underway.

More information on the project can be found under SIGs - International Health - on the PHAA website.

Pharmaceuticals

A letter was sent to the Global AIDS Coordinator, Ambassador Randal Tobias, seeking the retention and further strengthening of internationally affordable pharmaceuticals in trade agreements and treaties, especially generic HIV/AIDS medicines. This letter is on the PHAA website under Advocacy.

Dioxins

Pieta Laut is the PHAA representative, with observer status, on the National Dioxins Stakeholders Group. She is currently preparing comments on a number of papers.



Prisons Health

Letters have been written to all State and Territory Ministers for Health seeking their commitment to the Resolutions from the 2003 Incarceration Conference. These focused on the disproportionate representation of Aboriginal and Torres Strait Islanders in Australia's prisons and the need for goals to be "healthy settings" within the context of the Ottawa Charter. The letters are on the PHAA website under Advocacy. Some replies have already come in. These will be collated as part of the next steps in our advocacy.

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PHAA ADVOCACY – March/April - continued from previous page

Initial feed back from those who attended the Incarceration Conference suggests that there are sufficient interested people to set up a Prisons Health SIG. If anyone would like to prepare a submission for the Board to do so, please contact plaut@phaa.net.au



Immunisation

Letters were sent to all State and Territory Health Ministers and the Federal Health Minister in early February and we are awaiting replies. The letter refers to the conference registrations from the 2000 PHAA Immunisation Conference “A Boost for Immunisation.” Copies of the letters are on the PHAA website under Advocacy and replies will be posted there as they become available. The next phase of advocacy on immunization issues will be developed over the coming month.

Domestic Violence

A letter has been sent to the Prime Minister about the halt called to the domestic violence campaign which was refused permission to proceed by the Ministerial Committee on Government Communications (MCGC). PHAA is seeking his assurances that the campaign will occur and asking when this might happen. The letter is on the PHAA website. No reply has been received to date.

Neonatal Hearing Screening

Letters were sent to all Australian Health Ministers seeking a coordinated neonatal hearing screening program. We are awaiting replies and will discuss these with the Child Health SIG when they are received.

Oral Health

Letters have been sent to AHMAC and the Commonwealth Minister for Health advocating better oral health services. An additional letter has been sent the Australian Vice Chancellors, regarding workforce issues and the Department of Education Science and Technology. The letters can be found on the PHAA website under SIGs - Oral Health.

Disability Discrimination Amendment Bill

A media release on the proposed amendments to the Disability Discrimination Act has been sent out. It seeks to apprise the general public of the potential dangers in the proposed amendments. The document is on the PHAA website under Advocacy - Media Releases.

Genetically Modified Food Policy

Doctors for Environment Australia have requested and received permission to use our GM Food Policy as the basis for a policy vote by their members. We hope to hear of its adoption in the near future.

Healthcare Reform Alliance

Dr Jim Hyde attended the Healthcare Reform Alliance meeting wearing both his RACGP and PHAA hats.

Tobacco

A submission was provided to the Department of Health and Ageing on the draft national tobacco strategy. A copy of the can be found on the PHAA website under Advocacy - Submissions.

Obesity

Input was provided to the Insight Forum on Obesity that will screen on 27 April. We are all looking forward to seeing how much of that input has been taken up.

Items of Interest

The Comparability of Dependency Information Across Three Aged and Community Care Programs

This report is the outcome of a project undertaken by the Australian Institute of Health and Welfare (AIHW) for the Australian Government Department of Health and Ageing on the consistency and comparability of dependency information across three aged and community care programs: Home and Community Care (HACC), Aged Care Assessment Program (ACAT) and Community Aged Care Packages (CACP).

Available from Internet Only; *Free*

<http://www.aihw.gov.au/publications/index.cfm?type=new>

National Community Services Data Dictionary Version 3

The National Community Services Data Dictionary, Version 3, contains definitions and data domains that are endorsed as national standards for use by those collecting community services data in Australia. Version 3 introduces metadata items that are common with the National Health Data Dictionary (NHDD) and updates metadata items: some following endorsement by the World Health Assembly of the International Classification of Functioning, Disability and Health (ICF); and some to more closely relate to standards used for population and household surveys by the Australian Bureau of Statistics. Use of the Dictionary will help ensure that community services data in Australia are uniform and of high quality. The format for metadata items is based on international standards.

AIHW Cat No. HWI-65; Available from [CanPrint](#) (ph: 1300 889 873); \$35.00

Rural, Regional and Remote Health: A Guide to Remoteness Classifications

The development over the last decade of geographical classifications for Australia that describe areas in terms of relative remoteness has provided an opportunity to compare a wide range of health and welfare indicators across Australia's major cities, regional and remote areas. This publication reviews the methodology behind the three

major classifications that describe areas in this way - the RRMA (Rural, Remote and Metropolitan Areas) classification, the ARIA (Accessibility/Remoteness Index of Australia) classification and the ASGC (Australian Standard Geographical Classification) Remoteness Areas classification. This publication also summarises each classification's strengths and weaknesses and describes how the classifications are applied to administrative and survey data.

AIHW Cat No. PHE-53; Available from [CanPrint](#) (ph: 1300 889 873); \$20.00

AIATSIS Health Seminar Series 2003

"Indigenous health service delivery at the community level" presented by Julie Tongs and Craig Dukes in the AIATSIS Health Seminar Series on 11 August 2003 is now available as a downloadable PDF by following the link on the web page: http://www.aiatsis.gov.au/rsrch/smnrs/smnrs_healthandsociety.htm

Books Available from World Health Organization

Food and Health in Europe: A new basis for action
WHO Regional Publications, European Series No 96
Cost US\$90.00 Order No. 1310096
email: bookorders@who.int

Making Choices in Health: WHO Guide to Cost Effectiveness Analysis
World Health Organization, Geneva
Cost US\$27.00 Order No. 1150542
Email: publications@who.int

The World Health Report 2003: Shaping the Future
World Health Organization
Cost US\$13.50 Order No. 1242003
Email: bookorders@who.int

Climate Change and Human Health: Risks and Responses
World Health Organization
Cost US\$18.00 Order No. 1150551
Email: publications@who.int

Breast Thermography

Joan Bartlett, Executive Officer, The Cancer Council ACT

The Cancer Council ACT (TCCA) is very concerned about the promotion of breast thermography as a screening tool for breast cancer. Like BreastScreen ACT, BreastScreen Australia and the Australian and New Zealand College of Radiologists, TCCA does not recommend the use of thermography for the early detection of breast cancer.

Thermography, or infra-red digital imaging as it is also known, uses infra-red imaging to produce 'heat pictures' of the breast. The rationale is that the skin overlying breast cancer tumours will be 1-2 degrees warmer than that of surrounding areas. Different colours are assigned to different temperature ranges to produce a temperature contour image.

There are two common approaches to breast thermography: contact thermography and tele-thermography.

- Contact breast thermography involves placing a heat sensitive plastic film on the skin of the breast. The plastic film changes colour depending on the infra-red energies being emitted by the breast. The resultant image is photographed to produce a permanent image.
- Tele-thermography uses an electronic infra-red detector developed from modern night vision technology. The image recorded from the infra-red detector is a computer based digital image. Different colours are assigned to different temperature ranges to produce a temperature contour image. Tele-thermography is the approach that is currently being promoted in Australia. It is referred to as digital infra-red thermal imaging (DITI).

Breast thermography has been around for about 35 years and in its early days looked promising as a method of breast cancer detection. However, a report from the Breast Cancer Detection Demonstrated Project, edited by Behrs in 1979, found that when used for population screening for breast cancer, breast thermography had an unacceptably high false negative rate: that is, test results showed negative when in fact breast tumours were present. The same report revealed that thermography had only detected 42% of the breast cancers found by mammography.

The Cancer Council ACT is concerned that women may be attracted to breast thermography as an alternative to mammography as there is no compression of the breast and no use of radiation. Sometimes there are claims that thermography is able to provide earlier warning of possible breast disease than methods. There is no current scientific evidence to support this claim in relation to breast cancer, and in fact the evidence suggests the opposite.

Breast tumours can be, and have been, found using thermography. However, studies have shown that a tumour has to be large (several centimetres in diameter) before it can be detected by thermography (Homer 1985). This may lead to women with a negative thermography result being falsely reassured that they do not have breast cancer, which in turn may lead to unnecessary delays in the diagnosis of breast cancer.

On the other hand, although a screening mammogram will not detect all breast cancers, it has the ability to identify breast cancer when the cancer is much smaller and most amenable to treatment and care, and therefore the capacity to reduce the number of deaths from the disease.

There have been new developments in breast thermography since 1979. However, there is no scientific evidence that demonstrates an improvement in its sensitivity and specificity for breast cancer detection, and further investigation and trials into the efficiency and efficacy of this new technology are needed. Until then, The Cancer Council ACT does not recommend the use of thermography in the detection of breast cancer.

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Breast Thermography - continued from previous page

References

Australian and New Zealand College of Radiologists - Policy on the use of thermography to detect breast cancer

Beahrs OH et al (1979) - Report of the working group to review the National Cancer Institute and American Cancer Society Breast Cancer Detection Demonstration Projects. Journal of the National Cancer Institute 62 pp639-698

Breastscreen Australia - Program Statement on the use of thermography to detect breast cancer

Homer MJ (1985) - Breast imaging: pitfalls, controversies and some practical thoughts Radiological Clinics of North America 23 pp 459-471

If you would like more information call the Cancer Helpline on 13 11 20.

First printed in *The Council Chronicle*, March 2004

Injury Prevention SIG Report

By Natasha Howard

In September 2003, I had the opportunity to travel to Brisbane to attend the PHAA conference as the holder of a Travelling Scholarship supported by the Injury Prevention SIG. As a recent graduate of The University Adelaide, this was a fantastic opportunity to network with Public Health professionals listening to some great speakers and their current research projects. Being my first trip to Brisbane it was a great chance to be a tourist amongst the local sights, I especially enjoyed the Southbank region - there was definitely a healthy lifestyle approach in mind when designing this precinct of Brisbane!

The conference title was an excellent opportunity for many issues related to injury prevention to be presented and discussed during the conference. Injury prevention is an essential discipline to be researched and explored in public health. During the 3-day conference, there were two proffered paper sessions related to Injury Prevention as well as a plenary session on Injury and Indigenous health. The links with Indigenous health reiterated that one of the major public health issues in Indigenous communities is injury prevention. The differentials in Indigenous health and injury were areas including violence, poisoning, dog bites and injuries from broken glass. The potentials of Injury Prevention within the PHAA were confirmed with the development of new policies that were presented at the AGM including: the Violence Prevention Policy, Preventing Head Injuries Policy and the Firearms Injuries Policy. These new policies show the commitment of the PHAA and Injury Prevention SIG in undertaking advocacy for public health policy in the area of injury prevention.

The plenary sessions during the conference were excellent in linking with current issues in injury prevention. The Disease Reservoir Hypothesis: Effects of Changes in Diagnostic Thresholds was presented by international guest speaker Professor Robert Kaplan exploring the changes in the definitions such as hypertension and overweight. The impact that these changes have on health care costs must not distract from investing in worthy health care programs. The changes in definitions increase the number of disease cases and therefore have an impact on the cost of screening, treatment and pharmaceuticals. There is a need to be cost effective in those that are being treated compared with other health care resources where the money could be invested. There are many areas within injury that prevention programs could be cost effective, for example falls prevention, child safety and suicide prevention.

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Professor Ross Homel from the School of Criminology and Criminal Justice at Griffith University fascinatingly linked the discipline of social policy and approaches in crime prevention to public health. Homel's presentation explored the notion that to bring about public health change it is not about changing individuals but is about changing societal groups. A small change in a population can mean a big impact on the tail, that is rather than a focus on high risk offenders in the case of crime prevention. With reference to injury prevention, this establishes how there is a need to change societal groups into changing their behaviour or promoting a healthy message instead of targeting small populations at the tail. Examples include the wearing of bike helmets, seatbelts and lowering of speed limits. It has been found that these approaches target a whole community and overall have a greater impact in injury prevention.

An insight into programs being run in the New Zealand Maori population were seen during the presentation by Associate Professor Philippa Howden-Chapman. Linkages could be made with Aboriginal Health especially with the many issues that are associated with indigenous injury prevention. In working with indigenous communities, there is a need to adapt a holistic approach gaining an acceptance of indigenous people and building partnerships with the people – this challenges the traditional injury prevention approach.

As well as the injury prevention sessions, there was an opportunity to attend other proffered paper sessions including health promotion, research methodology and communicable disease control. Since attending the conference, I have a better understanding of the role the PHAA and the importance of such an organisation for the exchange of ideas, knowledge and information. I look forward to working more with the PHAA and meeting with other members in the future. It is with hope that the Injury Prevention SIG provides more scholarships for graduates in coming years, as do other SIG's of the PHAA.

The Burgeoning Costs of Seniors' Falls

New statistics released by the WA Department of Health reveal the projected costs of accidental falls in West Australians aged 65 and over will more than double in less than 20 years.

It forecasts falls will cost the WA health system \$174 million by the year 2021, which translates into an additional 220 bed acute care facility required to accommodate the demographic changes in the population.

The Department of Health Injury Prevention Branch in collaboration with the University of Western Australia Injury Research Centre conducted research into the health system costs of falls which is published in a report *Injury in Western* released in November 2003. The study shows the pressure of falls on emergency departments and hospital admissions and highlights the current and future impact of accidental falls by seniors on health system resources.

In the year 2001/2002 falls cost the health system \$83 million - or approximately 1.5% of current health expenditure. Falls make up for the second most expensive category for hospital admission.

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The Burgeoning Costs of Seniors' Falls- continued from previous page

Composition of Health System Costs by Type of Cost, 2001/02

Item	Cost	
	\$000	%
Inpatient hospital treatment	43 400	52.1
High-level residential care	7 900	9.4
Hospital outpatient services	7 000	8.4
Emergency department presentations	5 000	6.0
Allied health consultations	4 300	5.2
Ambulance transport	4 000	4.8
Specialist consultations	3 200	3.9
Domiciliary care services	2 800	3.4
GP consultations	2 100	2.5
Community nursing	1 900	2.3
Other	1 200	1.5
Pharmaceuticals	400	0.5
Total	83 200	100.0

Seniors falls prevention is a state health priority and collaborative falls prevention programs can play an important role in reducing the incidence and severity of fall-related injuries.

The Injury Prevention Branch of the Department of Health coordinates the development and implementation of the Stay On Your Feet WA (SOYFWA) Program. This is a community based falls prevention program for seniors aged 65 years and over which has the potential to reduce the number of older adults with falls related injury presenting to emergency departments and subsequent hospital admissions.

The SOYFWA falls prevention program costs \$330,000, which equates to \$2.20 per head of people aged 65 years and over. As a public health program, SOYFWA primarily increases the focus of the health and other systems on the importance of preventing falls related injury among older people. Specifically this includes education and raising awareness of self-management strategies in older people, developing an informed and responsive workforce, improving links between health professionals, older adults and other sectors and generating local falls prevention initiatives in regional and local areas.



Stay On Your Feet WA Volunteers - Kalgoorlie

Supermarket sweep hits small farmers in developing countries

Fragile Future



By Aaron Priel

Multinational supermarket chains are revolutionizing food retailing in developing countries, but while consumers are flocking to the new stores, a new survey from the International Food Policy Research Institute (IFPRI), indicates farmers are having a hard time getting into the supply chain.

Supermarkets are expanding and putting the squeeze on small farmers across the developing world, from Accra to Rio de Janeiro to Ho Chi Minh City. The survey shows that supermarkets “are opening with breathtaking speed in country after country,” particularly in Latin America.

The market share of supermarkets in food retailing is surging, according to Tom Reardon, Professor of International Development and Agribusiness/Food Industry at Michigan State University. “This retail revolution poses serious risks for the developing country farmers who have traditionally supplied the local street markets,” he noted. David Hughes, Professor of Agribusiness and Food Marketing at the Centre for Food Chain Research at Imperial College in London, qualifies this: “The growth of supermarkets is good news for big farmers and efficient, well-organized farmers. For others it can be troublesome.”

In the early 1990s, developing countries around the world liberalized their economies, opening them up to a wide range of foreign investments. Large supermarket chains from Europe and the US, seeing the rising incomes and urbanizing populations in developing countries, rushed into these markets. Latin America has seen the fastest growth of supermarkets, since this is where incomes and cities are growing most quickly.

The IFPRI survey notes that supermarkets in Latin America achieved a rate of diffusion in one decade that took five decades in the US. “In Brazil, supermarkets’ shares of food sales went from 30% in 1990 to 75% in 2000. Market share for supermarkets in Guatemala rose from 30% to 35% between 1999 and 2001.”

Public Health Association of Australia Inc



*9th National Immunisation/1st PHAA Asia Pacific Vaccine
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*Immunisation at the crossroads
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Terror, Community Autonomy and Public Health

Gavin Mooney, Social and Public Health Economics Research Group, Curtin University

How should the public health community respond to current global and national threats of terror and to governments' reactions to these? September 11, Bali, the Iraq war, weapons of mass destruction (WMDs), the lack of WMDs, lies about WMDs, the war on terror, the tightening of security: are these matters outside the scope of public health? Surely not, yet to date there has been relatively little formal response from the Australian public health community on these issues.

Notions of social capital and social determinants of health appear a good place to start. These have become almost commonplace in the public health lexicon. Yet the public health community has been slow to grasp the full implications of the perspectives that these phenomena allow. This is especially true when it comes to community autonomy whereby members of a community are able to combine, in some appropriate and acceptable mix, the freedoms to do with, as Berlin expressed it, the freedoms not to be done to.¹

Such autonomy can apply in a village, in a club, a professional body, a country or even in the world community. It is supported by the Hegelian concept of freedom where social institutions play a pivotal role. Community autonomy assumes both a coalition of the willing to act but, just as importantly, a coalition of the unwilling to be acted upon.

We have of late heard much of freedom and liberation, US style. Such freedom, such democracy, is good for the US and so good for everyone else. Those who seek to question this are dubbed not simply questioning or doubtful, but defiant, as the French discovered in the UN before the Iraq war. It is a one-sided freedom to do. Freedom not to be done to is ignored. Yet any concept of community autonomy must bring these two freedoms together in some sort of equilibrium.

This will not happen on the world stage until it is recognized that such equilibrium is both required and desirable. How to reach that equilibrium in the current context of the United States hegemony must be debated openly and the conclusions of that debate developed into a strategy for a better world. Truth was not the only early victim of the Iraq war: community autonomy was also seriously wounded in Australia and across the globe.

However, the notion of a better world is problematical when there is no agreement on what is a good one. It always seems to be the good who divide the world into good and evil. In a world that does not stop to ask why the good might perceive others as evil, evil, as the good perceive it, flourishes.

Again and again, the UN, the institution where equilibrium of the freedoms might be established for the world community, is ignored or ridiculed. We live in a world where terrorism and the fear of terrorism are equally significant. Whether terrorism is 'stalking the planet' depends not only on the terrorists, but on the role of governments in reinforcing the perception that it is.

Terror not only results in death. It is also a primary risk factor in public health. A standard EBM approach to terror would count the dead and physically wounded, but by and large ignore the psychological damage brought about by fear. There are links between the numbers of deaths and injuries and the amount of psychological damage of terrorism. These may be purely correlative. They may also be causal: the more death and injury, the more terror. Or it may be that the more perceived terror, the less death and injury, as greater precautions are taken. But if we seek to maximise the public's health, what is the optimal mix of death and injury on the one hand and fear on the other?

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Our government's efforts, from fridge magnets to the spectre of leaky boats laden with terrorists, are meant to scare us. This may well result in reduced death and injury. But is this optimal for the public's health?

Furthermore, such an approach cannot be quarantined. Asylum seekers become potential terrorists. Advertising the need to build security breeds fear and building security breeds conservatism. Fear and conservatism foster an introspective individualism which provides no basis for furthering social capital or community autonomy.

Recall John Howard's reaction to the approaching Tampa: these *others* shall not pass. We must protect our borders, our very way of life, from people who throw their children overboard - even if they did not! Desperate actions by despairing people become blackmail, acts of defiance. Whoever is at the gate is the enemy. Such a climate of fear results in retreat and disengagement from community life and public debate. Our reservoirs for concern are finite. As we are induced to be more and more concerned for ourselves, the other – the asylum seeker, the Aborigine, the poor – gets shorter shrift. Fearful, we lack the trust and the confidence to embrace the other. Individualism and disengagement, and the policies and fear mongering which promote them, are bad for our health and undermine our social capital.

Members of the Western Australia Social Justice Network are angered and frustrated by the lies of those in power. Politicians apparently have a licence to lie—about the Iraq war, for example: why Australia went to war, why the US went to war, WMDs... The institutions of government are thereby discredited. As the freedom to lie grows, so a blind eye is turned on the freedom not to be lied to.

The meaning of language disintegrates before our ears. “There are things we know we know. We also know there are known unknowns. That is to say, we know there are some things we do not know. But there are also unknown unknowns, the ones we don't know we don't know...”

This is an extreme example certainly, but this sort of language threatens the very vehicle of communication. Management and political speak, as Don Watson has pointed out with such insight, creates treacle of the mind so that we cease to know (and perhaps cease to care) when we are being lied to. Meaning becomes devalued by the very tools designed to promote communication: words.

It is relatively easy to identify these problems. But how should we respond to them as a public health community?

Public health must come to embrace broader concerns than it does now. EBM, epidemiology and biostatistics are worthy subjects. However, they need to be put in their rightful place and to their proper use. They must not be allowed to lead, but to serve. They constitute but measuring rods. They provide little or no basis for debate or thinking though the principles of public health, nor of how to respond to terrorism or the war on terrorism. As Kawachi says, epidemiology ‘has been defined as the science of counting’.⁴ It risks *reductio ad absurdum*, not *absurdum*, but numbers. It is not necessary to go as far as Le Fanu who advocates closing most of the epidemiology departments to “extinguish this endlessly fertile source of anxiety mongering”.⁵

We need these tools, but there is a greater need to accept the challenge that a concern for the role of social capital offers. We need to extend the domain of public health to community autonomy. The public health is threatened if professional and public debate is blunted, if freedom becomes stunted. Hegel was very much opposed to what we know today as freedom in its neo-liberal form: to be free to do what we like. In his conceptualisation of freedom, he emphasised the crucial role of institutions ‘so that self-conscious individuals could become more aware of the meaning of the institutions

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in which they participated – a step towards feeling at home in these institutions⁶.

Institutions matter. It is important that we – citizens of Australia, citizens of the world – ‘feel at home’ in our institutions. It is important that we, as public health professionals, encourage participation in our institutions. Yet our major social institutions have been devalued. Respect for government continues to decline, the law is used to usurp the rights of asylum seekers and when it does attempt to speak for human rights is chastised by our government. Our health care system is diminished by a government that no longer recognises universality as one of its pillars. The language of the market place – providers, consumers, business plans – further demeans our social institutions. Every attack on our institutions is an attack on our freedom and on community autonomy.

The institution of freedom of speech is undermined by polarisation: if one is opposed to some security measure, one is deemed soft on terrorists; arguing against the detention of asylum seekers is opening our borders to all and sundry. But the freedom to speak up remains crucial. We must seek to stimulate debate, to highlight the bludgeoning of social capital by government, to point to the harm done by the US government through the Iraq war. We must take a stand, not disengage. We must participate in our institutions. It is there that we can find a sense of hope, a hope that is fortunately infectious.

Freedom, Hegelian freedom, matters for public health professionals, for the public health movement and for the public’s health. The road to the equilibrium of the freedoms to do and not to be done to lies in defending our social institutions and in recognising and celebrating the importance of community autonomy. It is but a small step conceptually from social capital and the social determinants of health to community autonomy. In today’s post-September 11 world, the practical development of that community autonomy is a matter that public health professionals must embrace more fully.

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GLOBAL STRATEGY FOR INFANT AND YOUNG CHILD FEEDING

Who and UNICEF jointly developed this global strategy to focus world attention on the impact that feeding practices have on the nutritional status, growth and development, health, and thus the very survival of infants and young children.

The strategy is the result of a comprehensive two-year participatory process. It is based on the evidence of nutrition’s significance in the early months and years of life, and of the crucial role that appropriate feeding practices play in achieving optimal health outcomes. The strategy is intended as a guide for action; it identifies interventions with a proven positive impact, it emphasizes providing mothers and families the support they need to carry out their crucial roles, and it explicitly defines the obligations and responsibilities in this regard of governments, international organizations and other concerned parties.

Cost US\$9.00 Email: publications@who.int

Air Pollution Death Toll Exceeds Road Toll

Liz Hanna, Convenor, Environmental Health SIG

Australia's air pollution death toll is higher than fatalities from road accidents. "Mortality due to air pollution in Australia is higher than the road toll," according to Dr Tom Beer, Coordinator Environmental Risk Network for CSIRO's Atmospheric Research Division. "Each year on average, 2400 of the 120,000 deaths in Australia are linked to air quality and health issues – many more than the 1700 people who die on our roads. That's an average of a death every four hours. This number increases if long-term effects of air toxics on cancer are included."¹

With Australia's urbanised community becoming increasingly concerned about atmospheric health hazards, representatives from State government health and environment departments met in early March with atmospheric scientists and medical researchers to discuss how to manage the risk of dangerous and hazardous air pollutants. It is particularly important to consider this in light of the national uniform environmental measures known as National Environment Protection Measures (NEPMs)

The NEPMs were developed under the National Environment Protection Council, a statutory entity within the Environment Protection and Heritage Council. PHAA submitted a response to the Air Toxics NEPM Discussion paper during the consultation phase in 2001.

Beer presented the following Air NEPM estimates of the annual short-term health effects of the criteria pollutants, and the costs of these health effects in Australian dollars at a recent meeting of atmospheric scientists in Melbourne: ²

- CO – Loss of 1 day earning for 50,000 people at a cost of A\$6 million³
- NO₂ – 10 to 15% of the population display respiratory symptoms at a cost of A\$5 million³
- O₃ – Up to 10 deaths per year in Australia, with total mortality and morbidity at a cost of A\$810 million³
- PM10 (Particulate Matter 10) - Up to 2,400 deaths per year in Australia, with an associated health cost of A\$17.2 billion³
- SO₂ – 20% of susceptible individuals (15% of the population) display respiratory symptoms at a cost of A\$1.4 million³

The deaths attributable to short term exposure to particulate pollution increase from 2400 to somewhere between 3650 and 4185 when long term effects are also included. The air pollution related deaths identified are predominantly from fine particles. The sources of these are motor vehicles, wood smoke, bushfires and tobacco smoke. There are current federal government initiatives to reduce fine particles from motor vehicles that should lead to positive benefits. Dealing with wood smoke from home heaters is more difficult, but this problem is being addressed through initiatives such as Environment Australia's Woodheater Replacement Program in Launceston (see <http://www.dar.csiro.au/news/2003/mr02.html> for more information about this work).

In addition, hydrocarbons have long-term health effects that have been examined in Melbourne by D. Hearn.⁴ If Hearn's estimates are accepted and extrapolated to all of Australia, then there are approximately 1250 to 1785 deaths per annum as a result of hydrocarbons (excluding deaths ascribed to the particulate matter in the hydrocarbons).

"CSIRO has decades of experience in air quality research – including gas and particle measurements, computer modelling and risk assessment," says Dr Beer. "This places us in a unique position to bring together policy-relevant science within a risk framework that integrates scientific and medical concerns."¹ However the research team emphasizes that besides the obvious need for more research, risk communication is of vital importance because policy makers cannot move faster than community perceptions allow. Community awareness of the issues needs to be raised through education, the media and the provision of information through the electronic and print sources.

The Collaboration on Atmospheric Environment and Health is a national collaboration that is developing environmental health research methods and strategies and disseminating skills in environmental health research, risk management and policy

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Air Pollution Death Toll Exceeds Road Toll - continued from previous page

development, particularly via teaching and workforce training activities. The members of the collaboration are the National Centre for Epidemiology and Population Health, Australian National University, the School of Public Health, University of Sydney, NSW Health, CSIRO Atmospheric Research and the Bureau of Meteorology Research Centre. The Collaboration operates a list serve: **atmos_enviro_health** list.

For further information see http://nceph.anu.edu.au/Envir_Collab/index.htm or contact Dr Tom Beer, CSIRO Atmospheric Research, tel. 03 9239 4546 or email: tom.beer@csiro.au

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Advanced Level Training in Public Health Nutrition

Sam Battams

Access to public health nutrition education for post-graduate students and the broader public health workforce will be enhanced through a new national initiative funded by the Public Health Education Research Program (PHERP) Round 2 Innovations program.

The Advanced Level Training in Public Health Nutrition project and the Australian Public Health Nutrition Academic Collaboration (APHNAC) will be launched at a session on workforce development at the Dietitians Association of Australia Conference later this month.

The first meeting of the project collaborators was held in Adelaide in September 2003 (see photo below). At this meeting, governance arrangements and areas of topic development were refined. Apart from the collaborating universities, the Project Steering Group includes representation from the Commonwealth Department of Health and Ageing, the Strategic Inter-Governmental Nutrition Alliance (SIGNAL) and Indigenous health interests. The project also has links with Food Standards Australia New Zealand (FSANZ) and individual academics through a network which is likely to expand in the future.. An International Advisory Group will have input through topic development, peer review and research and information exchange.



Project collaborators met in Adelaide, September 2003

left to right: Wendy Banham, Dept of Health and Ageing, Mark Lawrence, Deakin University, Karen Cashel, University of Canberra, Sam Battams, Project Manager, Dorothy Mackerras, Menzies School of Health Research, John Coveney, Flinders University, Janine Lewis, FSANZ, Malcolm Riley, Monash University, Terry Coyne, University of Queensland, Roger Hughes, Griffith University and Karen Webb University of Sydney. Others involved included Fran Baum, Heather Yeatman and Kerin O'Dea.

The project will see the development of masters level public health nutrition topics and courses in six institutions: the Menzies School of Health Research, Flinders University of South Australia, the University of Queensland, Griffith University, the University of Sydney and the University of Canberra. The topics and courses will be available as electives in Masters of Public Health (MPH) courses and similar programs. Non-award short courses and workshops based upon these topics will also be available.

APHNAC is another outcome of this project. It will be a 'virtual faculty', a wider network of key public health nutrition academics that will contribute to the development of public health nutrition topics through advisory groups and peer review and the development and delivery of non-award short courses.

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Advanced Level Training in Public Health Nutrition

The Public Health Association's definition of public health has been adapted for the project: *Public health nutrition is the organized effort by society in the areas of food and nutrition to promote and protect the health of the population.*

The public health nutrition workforce needs to be strengthened if Australia is to address current and future diet-related population health issues, including overweight and obesity and related chronic diseases, effectively. It is recognized that better use should be made of academics in this area who are so geographically scattered that what they have been able to offer in the way of teaching and training has been limited.

The Advanced Level Training in Public Health Nutrition project will harness the skills of experts throughout Australia to provide a high quality, nationally available, coordinated and comprehensive public health nutrition curriculum. There are already a number of public health nutrition topics available through MPH degrees. This project will take advantage of individual areas of specialist skills and knowledge to increase the depth and breadth of training in this field across the country.

The consultations on which this initiative was developed indicated that the workforce is increasingly interested in flexible professional development options, so topics will be available by distance or web-based learning as well as through face-to-face short courses and workshops held in various locations.

Training is being developed under three broad key themes:

- evidence-based practice,
- advocacy and strategic leadership, and
- food sociology, behaviours and the environment.

The project will also engage in workforce development activities beyond education and training. These will include the development of public health nutrition competencies (a sub-set of existing public health competencies) and a framework for mentorship for people working in the field.

The first two topics have been developed and are undergoing peer review:

- § **Food Policy in Public Health Practice**, Flinders University (currently available, Semester 2, 2004). This topic has broad appeal and uses a critical approach to policy development and analysis in the context of national and international food policy.
- § **Applied Nutritional Epidemiology**, Menzies School of Health Research (available for enrolment in Semester 1, 2005). This topic fills a gap by applying epidemiological principles to the work of health departments in surveys, surveillance, and evidence-based policy.

Short courses and workshops based on these topics are available. **Food Policy** has been already been run as a non-award short course in Adelaide and as a workshop in Alice Springs. An advocacy group, Food Alliance for Remote Australia (FARA) emerged from the workshop. See: www.fara.bite.to

For information on other topics that are currently being developed, see: www.pherp.health.gov.au/innovations/2.htm

For more information about the project, call Sam Battams on 08 8204 6201, or sam.battams@flinders.edu.au

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