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# Trading in health

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If you are busy devising and evaluating health promotion, tracking the SARS crisis, or investigating how Australians have become so overweight, you probably don't have time to pay attention to trends in international trade. The complexity of trade agreements and the technical legal mechanisms through which they are formulated and implemented make them pretty obscure to most people in public health. So why should public health academics and professionals be interested in international trade? The answer is: because it could have significant impacts on population health.

Members of PHAA will know that the contemporary trade regime arises from the conviction that freer trade yields significant benefits. Consequently, the main aim of trade treaties is to remove obstacles to the free exchange of goods and services. Tariffs, subsidies, quotas, intellectual property legislation, government regulations and standards can all be deemed to be such obstacles, so nations that sign relevant agreements are obliged to reduce or eliminate them. For example, the General Agreement on Trade in Services (GATS) commits the 145 nations in the World Trade Organization (WTO), including Australia, to the "progressive liberalisation" of markets in such spheres as education, telecommunications, energy, finance and insurance, health care, water supply and sanitation.

But does trade affect health? Several years ago, the WTO ruled that a European ban on the import of beef containing growth hormones violated the General Agreement on Tariffs and Trade (GATT), and sanctions were imposed. Similarly, Canada was penalised for trying to prohibit imports of a fuel additive that is a suspected neurotoxin. The GATT has been around for a long time, but the advent of the WTO in 1995 extended the reach of international trade law to the point where it impacts on domestic policy, regulation and legislation, and the GATS extends that trend further

Recent agreements … commit members not just to liberalizing trade in goods but also to making specific policy choices on services, investment and intellectual property. These choices can affect human development through their effects on employment, education, public health, movements of capital and labour and ownership of and access to technology.(1)

Government programs, subsidies, standards and regulations are presently vital to the protection of population health and the delivery of essential medical goods and services. Yet free trade agreements could put any of these on the bargaining table, and an agreement that leads to their erosion could have a deleterious impact on health and well-being. People in the economically weak developing world have been the most vulnerable to these effects through such processes as the collapse of commodity prices, the globalisation of tobacco markets, privatisation (and increased costs) of health care and water supplies and exorbitant pharmaceutical costs maintained by intellectual property agreements.

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# *Fertility Rates Continue to Fall*

The first national report on the reproductive health of men and women in Australia , recently released by the Australian Institute of Health and Welfare, shows that birth rates are lower than they ever have been and national fertility rates are continuing to fall. The replacement level fertility rate is 2.06, but the rate is now 1.75, down from 2.9 in the 1970s.

The continuing decrease is associated with delayed child-bearing, and increase in the number of women remaining childless and a decline in the number of women who have three or more children. The Report estimates that about one in four women in Australia will not bear children.

The findings show that Australia's reproductive health compares well with other countries in terms of maternal mortality, the proportion of low birth weight babies, teenage fertility rates, access to family planning and the incidence of reproductive tract diseases and cancers.

Data indicate that one in every 20 men in Australia experience infertility; that knowledge of HIV prevention practices is high and that the incidence and death rates for cervical cancer have fallen over the last 10 years, partly thanks to national screening programs. Unfortunately the rates for ovarian cancer have remained constant.

The report provides comprehensive information on 44 indicators covering fertility, subfertility, family planning, pregnancy, childbirth, sexually transmissible infections and cancers of the reproductive tract. It is thus an important reference and information source for all Australians with an interest in reproductive health.

Reproductive Health Indicators Australia 2002
Cat. No. PER-20, Available from Info Access (toll free tel:132 447) for $30.00

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

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## *Trading in Health*- *continued from page 1*

However, rich countries like Australia are not immune. We too could have our public health infrastructure undermined by international trade. Recent publicity about the proposed bilateral trade agreement with the United States put Australians on notice that the pharmaceutical lobby has the Pharmaceutical Benefits Scheme (PBS) in its sights. At the end of the first round of talks, the US negotiator claimed he was no longer 'coming after' the PBS, but still wanted it to be more open and 'transparent.' The internationally admired PBS relies on the Commonwealth's capacity to negotiate favourable prices on behalf of the Australian population, and on the imposition of cost effectiveness criteria in decisions before listing new drugs. In the USA, prescriptions cost about 250% more than in Australia (2). As a consequence, many older Americans forgo needed medications(3). Surely any weakening of the PBS is too high a price to pay for the promise of better access for our agricultural exports.

Medicare and publicly funded health services (such as public hospitals and community health centres) could also be vulnerable. Although the GATT contains a clause allowing governments to retain arrangements to protect public health, cases decided by the WTO disputes resolution procedures are far from clear, consistent or reassuring on this point (www.speakeasy.org/~peterc/wtow/wto-case.htm), and the GATS contains no such wording. These ambiguities could leave Australia open to complaints from nations who regard public funding as 'unfair subsidies', and want to remove barriers which impede access to the Australian market in health insurance and health care. Many Australians are already concerned about privatisation of hospitals and the subsidy of private health insurance from the public purse. If Australia does not shield Medicare and publicly funded health services from the GATS, we could be in for much more extensive privatisation.

The trend toward privatisation could also extend to the supply of water. Living in a fire and drought prone continent, Australians are keenly aware of the health risks of unsafe or inadequate water supplies. Yet thousands of Americans have been cut off from municipal water services as part of aggressive debt collection campaigns, and large multinational corporations willing to impose such penalties may want to move into the Australian market. Equitable access and affordable prices could be thrown out as barriers to free trade, as if water were an economic commodity like any other, rather than an essential public good.

Controls on the marketing and distribution of alcohol and tobacco products are now taken for granted as aspects of Australian public health policy, but the GATS could provide the basis for overturning these domestic regulations.

*WTO agreements make it possible for the measures introduced through one international agency (WHO), to be undermined by those of another (the WTO), either through direct challenge or by the chilling effects of threats of trade action.(4)*

Free trade may be a useful, albeit limited, means to specific ends. When it is treated as an end in itself, we could find our public health institutions and infrastructure up for sale.

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# Your Board Members

*Over the last 2 intouch's the PHAA have beening putting in bios of your board members. In this issue are the Branch President's representative Ilse O'Ferrall and the Special Interest Group Convenor's representative Doug Welch.*

## Ilse O'Ferrall , WA President

Before joining the health promotion industry I was involved in recording and analysing Aboriginal languages, having studied linguistics at the Australian National University. I taught field work methods at James Cook University where I also pursued a career in university administration. I had previously worked in administration in the Faculty of Medicine, Sydney University before I moved to Yirrkala in Arnhem Land for two years.

I have been in health promotion since 1985, when I began working in alcohol and drug education programs. In 1992 I was appointed Senior Policy Officer for Women's Health in the Health Department of Western Australia. From 1995 to 2001 I was Deputy Director of the Eastern Perth Public and Community Health Unit.

With the restructure of metropolitan health services, I am now Manager of School, Youth and Adult programs in the newly formed East Metropolitan Population Health Unit. This Unit is an amalgamation of community and allied health staff from three health services and the public health unit.

I have an Adjunct Senior Lecturer appointment in the School of Public Health, Curtin University and a Visiting Fellowship to Murdoch University's Division of Social Sciences, Humanities and Education.

## Douglas Welch, Political Economy of Health SIG

Doug is currently the Executive Officer of the Redcliffe Bribie Caboolture Division of General Practice. His earlier experience included health promotion and training positions in Queensland Health and a spell as a private sector manager in the exciting and challenging world of high fashion.

His association with Divisions of General Practice goes back to their establishment in 1993. Doug is interested in seeing Divisions use their resources to advance the health of the population by better links between general practice and the other players in primary health care.

Doug's response to questions about the major issues that will confront general practice over the next five years is: "General practice will be required to provide government with increasing data from general practices, particularly in relation to outcomes. I believe the Divisions are in an ideal position to provide much of that data. Divisions are strong, voluntary organizations based on recognition of the need to make primary care better integrated and more accountable. Historically, accountability has been associated with some form of compulsion. We see the best defence against unwelcome government coercion is to strengthen the organization which meets the needs of both government and local practitioners.

With a vision of an enhancing the role of GPs in population health, Divisions have the potential to achieve significant benefits for practitioners and patients."

### Email List Service & Webpage

**Dear PHAA Members**

**Recently we have undergone changes to our email list server, and as a result we have had bounce backs of over 300 email addresses. Could those of you who have not been receiving emails from the PHAA secretariat please email Jeremy at membership@phaa.net.au with your current email address.**

**Also, some of you may have noticed that we have our new website up and running. Please be patient as there are still pages to be uploaded, and this is a work in progress.**

# *Public Goods, Economics and Obesity*

*Colin D Butler, National Centre for Epidemiology and Population Health, Australian National University*

Public and private goods: symbiosis and cycles
Many recent economic debates reflect tensions relating to the ownership, distribution, protection and quality of private and public goods. While private goods are readily understood, at least in societies characterised by laws that value and enforce individual property rights, the idea of public goods is less well appreciated. In Australia, this lack of awareness partly relates to the generally high standard and availability of many public goods here. Many public goods are freely provided by nature, (McMichael et al in press), while others are the result of traditional social practices. A third class, of more recent origin, is the result of centuries of struggle and effort. All three classes can be taken for granted.

A classic example of a public good is the light from a lighthouse, which, once shining, cannot be metered, purchased or easily hidden. Such a beam does not discriminate: it aids merchant vessels as well as smugglers' boats. Others include an educated public, safety while walking and a legal system. Many public goods require substantial investment and necessitate current and private sacrifice for future public gain. Others depend upon, and are maintained by, ancient customs and social rules, many of which are deeply embedded in culture. Examples include respect for the elderly, tenderness to children, courtesy to strangers and hospitality to travelers.

However, even long established public goods can be taken for granted and therefore vulnerable to erosion or abolition. For example, the public good of universal franchise is eroding as voting participation declines in countries where it is optional. Other long-fought for public goods that are now threatened, partly because of complacency, are social security systems and the five day week (Szreter 1997).

The recognition that the promotion of private goods can enhance some public goods is arguably the greatest contribution of the early classical economists, particularly Bernard Mandeville, John Locke and Adam Smith. For example, Smith pointed out that the insecurity of private property in Turkey was a major impediment to the development of that country's economy, thus reducing total production and consumption (Smith 1776). More recently, this principle has been understood and embraced by the Chinese government. But carried too far, an emphasis on the acquisition of private goods can harm public goods, including public health and even national security. For example, it was recognized that nutrition needed improvement in 19th century Britain when it was realised that the average height of naval recruits was declining.

Even the most enthusiastic supporters of free markets lobby to retain state supported policing, legal and military structures. In so doing they implicitly recognise that a total conversion to private goods will never be possible. Smith, always mindful of the ability of monopolies to undermine public goods, never advocated total free marketism (Schlefer 1998). Indeed the inequality and corruption associated with unrestrained free marketism will probably increase resentment, crime and loss of social cohesion, necessitating imaginative ways to protect ever more vulnerable private goods. Such dark scenarios of corruption and chaos may seem fantastic, but advocates of private goods have often been able to lobby successfully for economic deregulation, claiming that the total gain exceeds the cost. Sometimes they may be right, but at other times, the case for re-regulation should carry more weight.

The preference for more or fewer private and public goods is often cyclic, with a coalition of social, media and political forces tending to drive one view or another (Butler in press). In post World War II Britain for example, the drive to promote the public goods of health care and social security systems was overwhelming. Yet only three decades later, another generation was keen to embrace Thatcherism, with its promises of Utopia emerging from a tunnel of deregulation.

**Public goods and obesity**

More recently, in English speaking economies in particular, those who argue for the public good of widespread fitness, desirable body mass index and routine exercise have encountered many social and technological obstacles. These have included accelerating mechanization, abundant and cheap calorie-dense food and the fascination and sophistication of many passive forms of entertainment.

Several macro-economic factors, consistent with the wider move towards private goods evident since the demise of Keynsianism (Butler et al 2001), have also influenced the emergence of obesity.

One is the aggressive promotion of carbonated drinks and calorie-dense foods to children (Bellisle & Rolland-Cachera 2001; Anon. 2002). This advertising is condoned by a society that values the promotion of the private good of consumption over the public good of nutrition. Yet free speech is also an

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important public good. As well, the health and nutrition community, already comparatively weak and resource-constrained, has been further weakened by the alleged co-option, or at least confusion, of some of its spokespeople (Nestle 2003).

A second factor, also related to the relative decline of public goods, is the comparatively weak position of public transport in most cities in both the industrial and developing world. A tension exists between the desire to promote the public goods of clean air, greenhouse gas emission reductions, rapid, safe and uncongested public transport and the desire to promote the private goods of a car, tollways and so on. A “tragedy of the commons” problem (Hardin 1968) also operates: light traffic on a wide road permits rapid transit, but such roads rarely remain so for long, as each additional individual seeks to utilize the openness that remains. Governments and affluent lobbyists promoting private goods then favour the use of scarce transport funds to expand the road network, thus limiting investment in public transport and bike paths. As well, threshold effects, high capital costs and diseconomies of scale hinder the development of mass transport systems, especially where none already exists.

A third large-scale factor is a more risk-averse public. This partly arises from the relative paucity of the public good of health care for the severely injured and a consequent rise in compensation payouts as courts and juries have tended to err on the side of generosity. Other pressures related to the rise of private goods have caused insurance premiums borne by local governments and other bodies that provide and foster recreation to rise as the number and risk of their facilities have declined. There is even speculation that fewer facilities and changes in parental behaviour are reducing the gross motor skills of young people, driving ever more negative spirals of reduced exercise and weight gain with the attendant risk of poorer self-esteem and therefore greater risk of unhealthy eating patterns.

**Conclusion:**

Beyond a certain threshold of conformity, it makes little sense for an individual to try to swim against the tide. Someone living in a ghetto may believe passionately in the development of a fairer society, yet feel forced to send her children to school in a wealthier neighbourhood. Similarly, in an environment of ever-declining public health services, a person who believes in a publicly provided health care system takes a great risk if he ignores private insurance.

Nevertheless, there is growing evidence that the current cycle that has privileged private goods over public goods in recent decades will soon change course. This is evident not only in increased academic concern, (Kawachi et al 1999), but, even more importantly, by deepening public concern about growing inequality (Krugman 2002).

One can speculate that the peaks and troughs of these cycles follow an upward trajectory, so that civilisation does slowly advance. The struggle to reduce obesity is part of this effort to restore public goods. Whether the current forces that drive obesity can be overcome remains uncertain, but at least there is hope.

Acknowledgement: My thanks to Dr Jane Dixon for discussions that stimulated this paper.

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# The crisis in health(care)

*Peter Sainsbury, President, Public Health Association of Australia*

For years I have repeated endlessly: There is no Australian health care crisis. Australia enjoys very good health by international standards. Australia has a very good health system. Australians like Medicare. Medicare has some problems and they need fixing. But ... THERE IS NO CRISIS!

Recently though, I have thought again. There is a crisis looming. But it isn't dollars or waiting lists or nurses or emergency departments or hospital beds or GPs – or any other recurrent headline-grabber. It isn't even medical indemnity, although I concede that, unlike the others, this is a new problem. And it isn't the continuing appalling state of Indigenous health (how can that be 'a crisis' ... it's been bad for decades and is improving slowly) or the growing epidemic of obesity – or any of the other health, rather than healthcare, problems that beset Australians.

No, the real crisis is the totally inadequate attention being given to the development of long-term goals and coordinated strategies for Australia's health system. The division of power between the Commonwealth and State governments has created problems since Federation, and not only in health care. But it seems that we are moving into a new phase where cooperation, willing or unwilling, between the jurisdictions is being replaced with health ministers preferring to blame each other publicly for the symptoms of poor planning and coordination ("he can't run his state's hospitals efficiently"; "she won't improve bulk-billing rates") rather than work together to create a sustainable system. The result is an increasingly dysfunctional health system that will eventually fail to deliver good health and good health care for all Australians.

So why is this so and how might we proceed? Having nine jurisdictions with different parties in power and different electoral cycles is a major impediment to good planning and coordinated service delivery. This will not change, however, so we must continue to live with it.

The split responsibilities, grounded in the Constitution, are another hurdle. Simply, almost all public sector health funding originates from the Commonwealth Government, which also directly pays GPs and out-of-hospital specialists and funds the Pharmaceutical Benefits Scheme (which doesn't include drugs provided in hospital); states and territories provide the hospital, community-based and public health services.

Even though it would involve major upheavals, it has long been mooted that we must move to a simpler health care system. The Commonwealth controls the money, so maybe they should be responsible for all the services …

Despite its rhetoric, the current Commonwealth Government is deliberately dismantling Medicare piece by piece. It is misrepresenting the aims and principles of Medicare. It is shamelessly wasting over two billion dollars a year on the totally ineffective private health insurance rebate. It is redefining bulk-billing to destroy its purpose. It is entering into trade agreements with the USA and other countries (through GATS) that seriously threaten the integrity, efficiency and excellent cost control record of Australia's health care system. Why a government would want to destroy a highly productive, cost effective, well-liked and internationally admired system and create a more fragmented system which will be more costly for individuals and for Australia, is totally beyond me. Anyone who cares about health, equity, universality and service availability on the basis of need rather than ability to pay, must oppose this underhand deconstruction of Australia's health care system.

Forces whose primary interest is neither improved health nor improved health care are driving many of the current developments in Australia's health care system. Reduced direct taxation, international trade agreements, doctors' incomes' corporate profits, cost-shifting, political point scoring, and professional rivalries, are but a few of the factors at work. This is compounded by an all too frequent focus in parliaments, policy and the press on inputs ('we're spending more on health than the previous government'; 'we need more hospital beds') and outputs (number of bed days per year, length of waiting lists, etc) rather than service quality, value for money and health outcomes.

Health departments across Australia have plans for every conceivable service, population group, illness and risk factor. We also have the Australian Health Care Agreements between the Commonwealth and State/Territory Governments. But these are like railway carriages with no engine and no track. We need a national plan, agreed by all jurisdictions, that clearly specifies the overall goals of the health system, its underlying values and the broad strategies to achieve it.

As President of the Public Health Association of Australia, I must point out that such a plan should include more emphasis on and more funding for health promotion. This would provide an approach that is evidence based and cost effective - a wise investment. Moreover, the national plan must be developed in consultation with informed consumers who know what they need and what they are prepared to pay and service providers who know what's practical now and what will be practical soon.

Such a plan will not be developed overnight, and it will involve many compromises. But the real crisis is looming, and those who should be taking it seriously are ignoring it. The alternative - continuing to undermine a good , if imperfect, system, will have disastrous consequences for all Australians.

***This article was first published in Hospital&healthcare***

# Farm Safety – how do we build capacity?

*Beth Fuller*
*Convenor, Injury Prevention Special Interest Group*

Susan Pettifer's article describes a "gradual erosion of the concept of health promotion". I share her concerns, and wonder if we are seeing erosion across a number of public health areas?

Farm safety is one such area, where the constantly changing public health environment has impacted on the opportunity to achieve effectiveness in the long-term through consistent action.

Farm safety involves more than exposure to chemical sprays, child drowning or tractor rollovers. Farm safety, or farm-related injury prevention initiatives, are broad. While the main priority is reducing the burden of farm-related injuries, the farm safety umbrella provides an effective method of reaching a number of Australians who are at high risk of health, safety and social problems on a range of issues.

Farming is among the most dangerous of occupations. For the period 1990-1993, the age standardised death rated for male farmers aged 15-65 years was 39% greater than the age standardised death rate for the working male population.[1] Each year, non-intentional injuries on farms result in around150 deaths, including about 30 child deaths, approximately 6500 admissions to hospital and some 6000 workers compensation claims.[1 2] Estimates of current injury related costs range between 0.5 and 1.29 billion dollars per annum.[1]

The Farmsafe movement in Australia is relatively recent. Born of concern at the high levels of farm-related mortality and morbidity data, the first Farmsafe conference was held in 1988. One outcome was the establishment of Farmsafe groups, modelled on a community development approach, and targeted at reducing the injury burden from farm-related injuries.

Starting with an initial 2 groups in 1988, there are now over 50 groups across 4 states and Australian initiatives in farm safety have gained international regard. While community-based in approach, the health sector frequently operates as the lead agency.

The challenges and threats that beset farm safety are related to general capacity, and a capacity building approach provides a contextual framework for the discussion of these major challenges. [3]

| Key component | Challenges and Threats |
|---|---|
| Organisational Development | • Increased issues on the public health agenda<br>• Time available to "achieve change" may be inappropriate/unrealistic given the nature of the issue and the size of the problem<br>• Fewer opportunities to apply strategic approaches as organisations assume a more task-oriented approach<br>• Few resources available to develop, implement and monitor policies |
| Workforce Development | • Few projects or resources come with a training budget<br>• Economic stress mean most farmers and farm families placed training at a lower priority<br>• Few organisations to retain professionals with skills specific to the target population and specific issues<br>• Farmers operate in isolation, in a largely unregulated workplace |
| Partnerships | • Competing priorities challenge most collaborative approaches<br>• Where organisations don't recognise or acknowledge their interest, long-term action is unlikely |
| Leadership | • Leadership is often compromised by short term activity, without the vision which values safety on farms as a vehicle for delivering a range of information and resources to an otherwise hard to reach audience |

To be effective, farm safety, like other areas of injury prevention, must focus on these components of capacity building and be supported to do so. It then has a framework to guide planning, effective intervention and evaluation.

Rigorous approaches used in farm safety include:

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*Farm Safety - how do we build capacity?* *- continued from page 8*

- problem-oriented injury control models, drawn from analytical and epidemiological approaches that describe each injury problem, prioritise the issues, determine their aetiology and identify interventions;

- models drawn from health promotion/ population health, where attention is directed to social determinants of health and a settings approach, and from risk management, where strategies are developed after identifying the hazard, assessing the risk and following risk control principles; and,

- the organisational framework developed by Farmsafe Australia, that provides an outline of the purpose, goals and key strategies.

A review of farm-related mortality and morbidity data shows clear gains: policies have been implemented to address a number of key issues; training and awareness campaigns have targeted injury hazards in a range of settings and collaborative approaches have provided a strong framework for action at local and broader levels.

However, the constant state of flux of the public health system is a cause for concern. Health promotion and injury prevention initiatives aimed to reduce farm injury require a long-term commitment. Access to farmers and farm workers is often be restricted by the very nature of their occupation, and jeopardized by economic factors which can prevent their purchasing new safety equipment or attending training. The challenge for those working in this area is to balance these agendas: sustaining long term programs, while working in an environment where short term changes compromise community-based action.

Attempts to incorporate farm safety within organisational performance agreements have had limited success. Yet without organisational commitment, strategic approaches are compromised. Should we shift from the public health framework to one more aligned to community development, and work with organisations more comfortable with and capable of long term action? Should we find farm safety a new home?

The challenges outlined here compromise effective injury prevention in general. While solutions may not be clear cut, the continual erosion of the capacity for effective farm safety action should be of concern to all public health practitioners, researchers and policymakers.

While the current call is that "*Farm safety should be everyone's business"* it would be more reassuring if it was someone's business!


1. Fragar L and Franklin R (2000) - The health and safety of Australia's farming community. Moree, Australian Centre for Agricultural Health and Safety & Rural Industries Research & Development Corporation

2. Farmsafe Australia (2001) - Child safety on farms: a framework for a national strategy in Australia. Moree, Farmsafe Australia

3. NSW Health (2001) - A framework for building capacity to Improve health. Sydney, NSW Health.



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# *Virtual Water*

G. Venkataramani,

Virtual water - the amount of water needed to create goods - is a new concept that is gaining momentum among the water-scarce countries as they determine their agricultural and industrial production strategies. It was widely discussed at the third World Water Forum which was held in Kyoto in March.

"When you consume one kilogram of grain, you are also consuming 1,000 litres of water needed to grow that grain; when you consume a kilogram of beef you are consuming 13,000 litres of water needed to produce that amount of meat, and this is the hidden or virtual water," explained Daniel Zimmer, Director of the World Water Council, in his presentation on Virtual Water Trade and Geopolitics. "It is this unconscious behaviour that causes humans to consume so much water."

About 70 per cent of all water used by humans goes into food production. There is a huge contrast in water use between continents. In Asia, people consume an average of 1,400 litres of 'virtual water' a day, while in Europe and North America, people consume about 4000 litres a day.

"The magnitude of this variation demonstrates that diet is very important for water consumption," said Dr. Zimmer. "If the entire world consumed as much virtual water as do people in North America, the world would need 75 per cent more water than it currently uses for food production." There will probably never be a practical way to trade large enough volumes of water in the way other products are traded, simply because its weight and volume make this prohibitively expensive. However, the country that opts to be a net importer of virtual water, as opposed to real water, can relieve pressure on its own water resources.

Among the biggest net exporter countries of virtual water are the U.S., Canada, Thailand, Argentina, India, Vietnam, France and Brazil. Some of the largest net importing countries are Sri Lanka, Japan, the Netherlands, South Korea, China, Spain, Egypt, Germany and Italy. "Unconsciously, through food imports, many water- scarce countries have already eased tensions over their water problems, so that virtual water imports are already playing a role," said William J. Cosgrove, vice-president of the World Water Council. "Now, virtual water trade is becoming more of a conscious decision."

The meeting considered the difference between food security and food sovereignty. Many countries could resort to virtual water trade in order to achieve a sufficient food supply for their people, but governments may not want to become dependent on global trade, or simply cannot afford to do so. "This is crucial for countries like India and China," Dr. Zimmer said. "They feel that because they have such large populations, the world market would not be able to supply their food demands in any crisis and so, as much as possible, they want to take care of their own food needs."

"We advocate making the concept of virtual water more and more conscious. The governments should start thinking in a different way; at the regional level, we should begin to think how they could share the benefits of water, instead of sharing the water," Dr. Cosgrove said.

Source: The Hindu, March 19, 2003
http://www.thehindu.com/2003/03/19/stories/2003031903891200.htm

## HOW YOU CAN HELP ACHIEVE A VISION

The PHAA relies on membership subscriptions, sponsorship and occasional donations to assure its future. The Board needs your support to enable it to maintain and extend its research and education services.

In 1991, the Public Health Association Education and Research Trust (PHAERT) was put in place. All donations to the trust are tax deductible.

There are a number of ways that you can help further its aims. For example,

- you could give a donation to the trust now;
- after you have made provision for your family and friends in your will, you could consider making a bequest - a specific cash amount or a gift of articles of property, shares etc, to the Trust; or,
- you could volunteer time to help the Trustees find sponsorship for projects financed under the Trust.

Whatever you donate or bequest to the Trust will help the Association to progress the development of evidence based public health education and research.

Please call Pieta Laut on (02) 6285 2373 if you would like any further information about our donation and bequest program.

# The HILDA Survey

*Mark Wooden, HILDA Survey Project Director, Melbourne Institute of Applied Economic and Social Research, University of Melbourne*

In 2001 the collection of data for the first wave of The Household, Income and Labour Dynamics in Australia (or HILDA) Survey commenced. For a number of reasons, this survey represents a significant new direction in data collection in Australia.

First of all, it is a panel, or longitudinal, survey, meaning that sample members are re-interviewed each year. This methodology enables researchers to track the changing circumstances of individuals and so identify factors that influence outcomes more easily. Secondly, all members of the household are included in the sample and, if aged 15 years or over, are interviewed. Whenever possible, those interviews are conducted in person. Thirdly, unlike other longitudinal designs, as household composition changes, so does the sample. Thus new children born to, or adopted by, sample members automatically become sample members. More importantly, when households split and new households are formed, the sample is also extended to include any other persons who are members of these new households. The sample for the HILDA Survey should thus reflect changes in the composition of households within the wider population.

Data from the HILDA Survey are being made available to researchers (subject to signing an agreement with the Commonwealth), with unit record data from Wave 1 now available on CD-Rom for $75.

The primary objective of the HILDA Survey is to support research, both within government and within the wider research community, on three major topics areas – income dynamics, labour market dynamics and family dynamics. However, its coverage is extremely broad – indeed it is marketed to respondents as a survey about life in Australia. For example, it includes a range of questions on health issues. All respondents are asked to complete the SF-36, an internationally recognized tool for measuring general health and well-being, every year, The HILDA Survey thus offers researchers the potential to examine relationships between health outcomes, and changes in those outcomes over time, and a very wide range of socio-economic indicators.

There are also separate questions about the presence of long-term health conditions and disabilities and the extent to which they affect ability to work and satisfaction with health and other aspects of life, and a range of health risk factors, such as smoking, alcohol consumption, physical exercise and time stress.

The Survey is funded by the Commonwealth, largely under the auspices of the Department of Family and Community Services, and managed by a group based at the Melbourne Institute of Applied Economic and Social Research at the University of Melbourne. Data collection is contracted out to ACNielsen, a private market research company.

The first wave involved a responding sample of 13,969 adults from 7,682 households drawn from almost all regions of Australia. This was essentially complete by the end of 2001.The overall response of 66 per cent was lower than hoped, but nevertheless compares favourably with most other voluntary surveys, especially given the onerous nature of participation: interviewers spent around 90 minutes in the average household. Comparing the sample with Australian Bureau of Statistics data indicates that it bears a close resemblance to the wider population, with arguably the only serious weakness being an under-representation of persons living in Sydney.

The second wave commenced in August 2002 and was completed in March 2003, with an expected individual sample size of around 13,000. A unit-record file containing linked data from both Waves 1 and 2 is expected to be ready for public release by the end of 2003. Meanwhile, the third wave of interviewing will commence in August 2003.

At the time of writing, a decision about funding for a further four waves is expected to be announced as part of the Commonwealth Budget in May.

Anyone who wants to know more about this survey, including how to obtain the data and or copies of the survey instruments, should consult the HILDA Survey website at: http://www.melbourneinstitute.com/hilda/

# Food and Nutrition Special Interest Group Workplan

*Mark Lawrence, Convenor, FANSIG*

With 118 members from all States and Territories and several overseas countries, the FANSIG is the third largest of PHAA's SIGs and reflects the broad range of people involved with food and nutrition issues across the public health community. A particular strength of the FANSIG is its potential to provide national leadership and build capacity in public health nutrition and to use its independence from government to advocate in the interests of public health nutrition.

In early 2003 the FANSIG was reconvened with a new executive comprising Bronwyn Ashton, Roger Hughes, Mark Lawrence (Convenor), Malcolm Riley, Christina Stubbs and Megan Wingrave. A proposed workplan has been developed to guide work on the following three priority roles.

1. Policy development
A core activity of PHAA is policy development. All PHAA policies are reviewed on a rolling three year basis so that up to date policies are in place for advocacy and reference by the Association and other organizations. The FANSIG is responsible for policy statements on a number of issues including:

- Food and health
- Prevention and management of overweight and obesity in Australia. A position statement on Promoting healthy weight was prepared recently.
- Food safety management
- Improving Aboriginal & Torres Strait Islander People's access to the food they need for health
- Tax reform, food access and health
- Health claims on food, and
- Genetically modified foods.

FANSIG also contributes to the development of other polices including including:

- Alcohol
- Breastfeeding
- Peri-conceptional folate
- Public health strategies for the problem of osteoporosis in Australia, and
- Television food advertising during children's viewing times.

2. Professional development for the public health nutrition workforce
FANSIG aims to develop public health competencies and skills among the Australian public health nutrition workforce and to plan coordinated and strategic responses to public health nutrition issues.

As a service to its members, and as a strategy to increase its capacity to respond to public health nutrition challenges, FANSIG will identify strategic opportunities and approaches to develop the competencies of members. It will explore opportunities including:

- Adding on Competency and Professional Development (CPD) workshops to conferences and meetings like the PHAA conference in Brisbane later this year. These will emphasize presenting, evaluating and debating skills.

- Planning the 2005 public health nutrition conference. This will follow on from the Eat Well conferences held in Adelaide in 1999 and Melbourne in 2001.

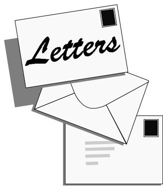
- Inviting FANSIG members to submit abstracts on interventions or evaluations on a particular theme for distribution to members as a mechanism for disseminating practice innovations and learning. This would disseminate important information among FANSIG members at a relatively low cost.

- Soliciting collaboration between university-based members to collaborate in running fee for service CPD sessions in various locations.

The emphasis will be on topical, flexible and accessible CPD opportunities. Data from the FANSIG auspiced Australian Public Health Nutrition Workforce Project will be used to help identify CPD needs.

3. Advocacy
FANSIG is distinguished from other professional groups associated with nutrition in Australia by its ability to provide leadership and independent advocacy that combines nutrition expertise with an understanding of the broader aspects of public health. In recent times There is increasing concern about the lack of a broad public health perspective in comment by some groups on public health nutrition issues.

The advocacy role involves both proactive and responsive activities and will include modest strategic media involvement. It will incorporate both soliciting media attention on public health nutrition stories and providing an informed response to relevant issues in a coordinated and timely fashion. It is anticipated that a small number of FANSIG members with common interests will work together to implement this role which will be coordinated by a member of the executive.




# Letter to the Editor

**Population Pressures**

Dear Editor

From The Sydney Morning Herald of April 1 2003: Mr Ruddock has announced that the number of migrants entering Australia under the family reunion program will rise next year to its highest level since the Howard Government came to power. The intake of migrants in the non-humanitarian categories will remain at 110,000. In addition, there will be 12,000 places under humanitarian categories, of which 4000 will be reserved for refugees. However, the NSW Premier, Bob Carr, called for the non-humanitarian program to be cut to 80,000 people, in the interests of the long-term sustainability of Australia and in easing the population pressures on Sydney. About 40 per cent of all migrants settle in Sydney, accounting for about three-quarters of the city's 1000-a-week population increase.

Yes, we must discourage those 750 extra people per week. Sydney already has terrible traffic congestion, due to the increasing number of people, cars and new freeway construction. We have residents of suburbs up in arms as they see their living environment being destroyed by developers whose aims are to subdivide, pull down beautiful houses, destroy gardens, put up either several storey chicken coops or massive homes that take up all their ground area, sell, make their money, and go and live elsewhere. Local Councils which object are overridden by the Minister. Our children are getting obese because they can no longer play in the street; there's no space outside on the property to play; there's no rough ground to explore and they don't have the freedom to roam about that my children did. We are urged to catch public transport, yet the trains are packed and the buses flash by full to the doors. The new freeways bring traffic in ever faster so that car clog all the feeder roads and everyone has to leave home earlier every day in order to get to work, and leave work later. Why would anyone want to live here?

Mr Ruddock said the program for the 2003-2004 financial year included several measures aimed at encouraging migrants to settle in non-metropolitan areas, including incentives for applicants to study in regional universities and TAFE colleges. The number of skilled migrants will rise from 63,300 to 68,300. "Our research shows the benefits of our highly skilled and targeted migration program," Mr Ruddock said. The program includes incentives for applicants who have work skills in occupations that are deemed to be in "national demand"; occupations range from computing, nursing and other medical professions to chefs, refrigeration mechanics and hairdressers.

Why do we need migrants to go to universities and TAFE colleges in non-metropolitan areas? Aren't they already full with our own students? Pretty soon we'll need qualifications to collect garbage or to drive a bus. Chefs and hairdressers in national demand? Is this because we now insist that everyone should go to university and there's no-one left to do the work that requires manual dexterity? Nurses, who now have University degrees, don't want to lower themselves to empty bedpans and clean up patients, yet that is what the job is about and what they do not find out until too late.
I would be interested to hear how other readers see this situation.

Concerned Sydneysider.
(Name and address supplied)

**Ethical Debates in Public Health**

Copies of Ethical Debates in Public Health : Series One, (Editors, Helen Keleher and Gavin Mooney) are still available at for an incredibly cheap tax deductable donantion of $12 a copy to the Public Health Education and Research Trust. Copies can be obtained by sending your donation and request to the Publications Officer, Public Health Association, PO Box319 Curtin, 2605.
These papers represent the first part of a series of debating papers on ethical issues in Australian public health. They were written because the editors and the authors are keen to stimulate debate about what we see as core public health issues. In the spirit of debate, readers should feel free to respond with comments to authors an/or editors and to use the papers to stimulate debate, in forms such as seminars and teaching.

# Working Together. Communities, Professionals, Services. Fifth WONCA world conference on rural health.

*Jeff Fuller*
*Director of Public Health, South Australian Centre for Rural and Remote Health, Whyalla, SA.*

This was the theme of the fifth Wonca world conference on rural health that was attended by 900 delegates from over 40 countries in Melbourne from the 30th April-3rd May 2002. Wonca is the world confederation of family doctors and is essentially a peak global organisation for what we in Australia know as GPs. I was encouraged that such an organisation would articulate an understanding of multidisciplinary teamwork where leadership was best held by whoever was the primary care manager (rather than only be the GP). The conference also articulated the need for recruitment and retention incentives for all health professional. Working together with communities and with Indigenous health services was also covered although not to the same extent as with the multidisciplinary team in general. If the 60 papers on recruitment and retention from a total of 194 papers and symposia presentations is an indicator, then recruitment and retention is the big ticket item, at least amongst rural health practitioners. This supports my own experience that staffing is the limiting factor in doing more in rural health services, rather than the financial resources for programs.

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

Professor Don Nutbeam, now Head of the UK Dept of Public Health, talked about the efforts in the UK since the 1998 Acheson report to tackle inequalities in health. He made the point that rural health status was not overall worse than urban health status, but that as it was poverty (or more precisely relative poverty) that was more clearly linked to healthy inequity and hence rural health programs needed to be targeted to the rural poor and isolated, rather than be applied as generalised programs as if rural communities are undifferentiated. The compounding problem for the rural poor and isolated is the more difficult access to services that are faced by their urban counterparts.

Dr MK Rajakumar, the past president of Wonca, articulated the global perspective on rural health, where in the developing world, rural communities are make up around three quarters of national populations and are significantly poorer that the urban populations. This is very different to the developed world, such as Australia where it is the urban communities that are the majority. Hence, global rural health is very much an issue of poverty and he challenged conference delegates to think beyond only their patients in their waiting rooms and he proposed a global coalition initially of doctors, nurses, teachers and technologists to work on improving the health of all rural peoples. Dr Bruce Chater, an Australian GP, medical superintendent and convenor of the WHO-Wonca Co-Sponsored Consultation for the Health of all Rural People described the recent international consultation in Taralgon (Victoria) that is developing an action plan for rural health. Once again I was impressed that a medical organisation would articulate three measures of success through this action plan, one of which was about processes and structures that followed community development framework.

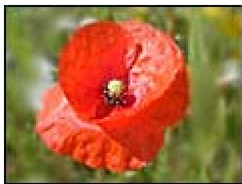
As is often the case with conferences, there was insufficient time in most sessions for a good debate about issues between speakers and delegates, however an interesting formatting arrangement was to divide us all into five 'villages' at the close of each day where we were able to have small group discussions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

The conference had 3 outcomes, that were:

- an update of the Wonca policy on rural practice;
- the drafting of a policy on women family physicians in rural practice (particularly important in developing countries were health poverty and health inequities are often experienced significantly by women and girls); and,
- a manifesto on the ethical problems of international recruitment of health professionals by developed countries from developing countries.

There was of course a lot more. The ABC also screened the virtual conference through the web and some of the conference highlights will remain on its website at abc.net.au/rural. The sixth Wonca conference on rural health will be held in Santiago, Spain in September 2003. The Wonca website is www.wonca.org.

# The Paradox of the Poppy Seed



*Arthur Hanks, Canadian*
*just-food.com correspondent*

**An interesting food with a controversial pedigree is the subject of a thriving international trade, despite its ambiguous status.** You've probably eaten this little seed. It's a popular confectionery ingredient, commonly found in baking and bread products from many cultures. It is in itself innocuous and seemingly unremarkable.

But you are not allowed to grow it and you could face life imprisonment in some countries if you do so. Despite this prohibition, its flowers are seen in gardens across Canada, viable seeds are legally sold over the counter in gardening supply shops, and they are also found in grocery spice racks and bulk bins.This is the poppy seed.

**In bagels… and heroin**
The paradox of poppy is a good example of how nature mocks mankind's sense of order. This flower blurs the border of food and drug policy. Poppy seed may be the tiny sprinkles you find on your toasted morning bagel or the source of oil that helps make the novel lemony salad dressing you just discovered. But the same genus, Papaveraceae, is also the source of pharmaceutical-grade opium and derivatives such as heroin, morphine and codeine. How can this be?

While there are an estimated 200 species of poppy, with different levels of alkaloids present, the most commonly grown is Papaver somniferum which produces both opiates and seed at different points in its life cycle. The pods are the source for opiates: immature seed heads are lanced to allow an latex containing opiate to flow from the flower pod. The latex hardens and is carefully scraped out. However, as the flower matures, the poppy loses its ability to produce the latex. It's just a pretty flower with a nice-tasting seed.

**Commercial production outlawed in many countries**
Because of the fear of illicit use, many countries have outlawed commercial poppy production. The United States outlawed the poppy in 1942. However, the related species of California poppy (which also contains alkaloids) was not outlawed and is in fact today that state's official flower. Similar legal prohibitions apply in Canada and many other countries.

However, over 100 other countries have continued to grow poppies for one reason or another. Turkey is the largest international trader of seed; in 2001, the UN Food and Agriculture Organisation (FAO) estimated that country exported 25,000 million tonnes at a value of close to US$20m. The Netherlands is home to the top-rated 'blue' seed. Hungarian 'blue seed' is also commonly used in Europe. Tasmania is also a place of special interest, as the island state plants an exceptional 8,000 hectares annually for the pharmaceutical industry under a controlled licence system. Seed is a by-product of this industry and large amounts are exported.

**For the gourmets and the health-conscious alike**
Poppy seed's gastronomical appeal comes from its nutty taste and the crunchy texture that it gives to food. The little blue, grey or white seeds also add visual appeal. The seed's oil is used in Europe and in North America as a gourmet item.

Different cultures have enjoyed eating poppy seed as a specialty food, mostly in baked goods, for years. Russians boast of the poppy seed roulette (a spiral bread) and sooshka cookies with poppy seed. Austrians eat Hackbraten and Germans Spätzle with poppy seed, while Silesians created Mohntorte (poppy cake). Indians enjoy the seed in naan bread, and Columbians in their buenelos. Poppy seed is also often mixed with sesame seed to make halva.

Poppy seeds are not just used bakery items. In India, poppy seed (usually 'Persian whites') is also used as a thickener for curries. In Austria poppy seed is found in Viennese noodles au gratin. In Turkey, poppy oil cake and meal are often used as goat feed, and the milk is often used to make yoghurt. Poppy seed is also used as bird seed known as maw seed, according to some sources after the Old English word for mouth. Poppy seed is very nutritious. The small seeds have a very high oil content of about 45-50%. As with other seeds, they are good sources of protein, fibre and fats. In the case of poppy seed, these include the nutraceutically valued linoleic (60%) and oleic (30%) acids. The seeds have less than 10% saturated fats. Poppy seed is also a mid-range source of calcium. In fact, as well as being " heart smart", poppy seed is a very useful food for vegetarians and vegans.

Yet to date there seems there has been little dedicated scientific research into this aspect of poppy seed, although there is also some quiet controversy about it because of the drug issue.

As it come from the mature plant, poppy seed cannot be considered a drug. But, as with hemp seed, there has been concern that poppy seed consumption might confound standard urinalysis testing. According to a 1999 New York Times story, a New York Police Department directive

*continued on page 16*

# *Websites of Interest*

## To learn more about SARS:

**Commonwealth government**
http://www.health.gov.au/sars.htm
This site has a series of Frequently Asked Questions.

**McGill University Health Sciences Library:**
http://www.health.library.mcgill.ca/resources/sars.htm

**Severe Acute Respiratory Syndrome**
http://www.nlm.nih.gov.medlineplus/
severeacuterespiratorysyndrome.htm

**Communicable Disease Network Australia**
http://www.health.gov.au/pubhlth/cdi/cdna/press/index.htm

**US Centers for Disease Control & Prevention**
http://www.cdc.gov/ncidod/sars

**World Health Organisation**
http://www.who.int/csr/don/2003_03_16/en/ Vicki, can you check this address, please. Looks odd.

**UK Public Health Laboratory Service**
http://www.phls.co.uk/topics_az/SARS/menu.htm

## Up to date and On-line

Many journals and other sources of information are now also available by email on-line sites. Here a few which may be of interest.

Australian Broadcasting Commission's ***Health Updates*** include a weekly alert about recent ABC health coverage. Go to the subscriber based website: http//abc.net.au/health/
subscribe.htm

For health economics, go to: http://
www.healtheconomics.com.au

***Quality :International Journal for Quality in Health Care***, the official journal of ISQua. Go to http://www.isqua.org.au/
isquaPages/Journal.html

***Health & Technology*** is a weekly email that looks at the top e-health and technology news predominantly out of the US, but also includes some Australian oriented information. Go to: http://www.healthleaders.com.news.newsletters.php.

Telemedicine continues to be an emerging influence on health care access and financing and crosses into issues involving rural Australians, service providers and those at the interpretative end. A good way of keeping up-to-date.

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*The Paradox of the Poppy Seed* - *continued from page 15*

implicitly prohibited poppy seed bagels because of the presence of trace opiates.

"Why should someone lose their job over eating a poppy seed bagel or two?" asked concerned police. To date, it is unclear how this issue has been handled by the various testing authorities.

**Ambiguous legal standing**
Poppy seed's status in neighbouring Canada is also enigmatic. Despite the long history of poppy seed and hemp seed as food, the production and distribution of plants such as the opium poppy and cannabis are controlled by United Nations conventions on narcotic drug. However, in the case of poppy seed, there is no real restriction on use or possession. Nor is there a requirement that seed sold in stores be sterilized. A crackdown on backyard gardeners is not anticipated, and so if you go, say, to the backwoods of British Columbia or do some searching on the Internet, you may find evidence of larger-scale "illicit" production.

We know Canadians like poppy seed, as the country imports between 1 million to about 1.5 million kilograms (kg) a year, with a value of roughly C$1 (US$0.65) a kg. Australia, specifically Tasmania, is the major Canadian supplier, but Turkey and the Netherlands are also prominent. Poland, Iran, Romania, Russia, the Czech Republic, Slovakia and Argentina are also noteworthy exporters.

With some marketing, and the creation of distribution channels, growing poppy seed could be a good business opportunity. The large US market for poppy seed would welcome a North American source and the increasing appreciation of ethnic foods could make this concept a winner.

However, Health Canada did not return phone calls for this story and so I could not comment on licensing or changes in regulations that would give a clear legal right to grow this crop. Perhaps they are waiting for a good business plan. Or perhaps the paradox of the poppy confounds them as well?

# National Advisory Committee on Oral Health (NACOH)

*Paul F Wood, Oral Health SIG*

Oral health is integral to general health and in recent years a number of reports have highlighted growing concerns about the "silent epidemic" of oral diseases and the capacity of public and private dental services to meet the growing demand and need for care. In October 1999, the Australian Health Ministers Advisory Council (AHMAC) established a Steering Committee to report on "The burden, trends and distribution of oral health problems in Australia and the trends in clinical approaches to dealing with those problems".

The Steering Committee's report on Oral Health of Australians: National planning for oral health improvement was published in August 2001. Its major findings included:

- a highly significant burden of disease, amenable to prevention and intervention, with links with general health;
- serious access barriers for many groups in the population;
- maldistribution and fragmented services;
- need and demand will continue to outstrip supply;
- need for coordinated oral health promotion and dental care targeting those most in need; and,
- national approach needed to address workforce development, public health issues and maldistribution of resources.

In response to this report, AHMAC established the National Advisory Committee on Oral Health (NACOH) as a sub-committee of AHMAC with the following Terms of Reference:

- guiding and coordinating the development of a National Oral Health Plan; and
- monitoring the implementation and evaluation of the National Oral Health Plan.

The Committee, which is chaired by Dr Arthur van Deth, who also chaired the previous Steering Committee, first met in July 2002. It has its initial term of 2 years to prepare the National Plan. Membership includes a representative from each of the States and Territories, the Commonwealth and New Zealand. Non-jurisdictional organisations represented include the National Public Health Partnership, Australian Dental Association, Australian Dental Council, Australian Institute of Health & Welfare, Indigenous Interests, a consumer representative and two technical representatives. The Committee was recently expanded to include a representative from each of the following: Australian Dental Prosthetists Association, Australian Dental Therapists Association, Dental Hygienists Association of Australia and the Deans of Australian Dental Schools

The initial work of the Committee has focussed on the preparation of a number of discussion papers addressing major areas of concern identified by its members . These include:

| SCOPING PAPERS | THEMATIC PAPERS |
|---|---|
| Dental Workforce | Quality |
| Oral health of Older People | Access and equity |
| Oral health for A&TSI People | Effectiveness |
| Low income/Social Disadvantage | Population Health |
| | Financing oral health care |

These have provided a clearer understanding of the complex factors that must be taken into consideration in developing the National Plan. The importance of population health as the key driver for the overall direction of the National Plan has been recognised.

It is anticipated that a draft National Plan will be submitted to AHMAC in about February 2004, and be finalised by June 2004.

## PHAA
## Profit & Loss Statement

1/01/2003 through 31/03/2003

| | |
|---|---|
| **Income** | |
| Non National Income | $25,283.91 |
| National Income | $61,497.16 |
| **Total Income** | **$86,781.07** |
| **Expenses** | |
| Non National Expenses | $22,167.94 |
| National Expenses | $115,067.00 |
| **Total Expenses** | **$137,234.94** |
| **Operating Surplus** | |
| Conference Income | |
| Conference Income | $50,687.27 |
| **Total Conference Income** | **$50,687.27** |
| Conference Expense | |
| Conference Expenses | $32,850.91 |
| **Total Conference Expense** | **$32,850.91** |
| **Net Surplus/(Deficit)** | **-$32,617.51** |

# *Membership Fees*

As many members may recall from the Financial Analysis presented in the 2001-2002 Annual Report, PHAA has significant financial issues that need to be addressed. These mostly arise from the loss of the Commonwealth Government's CSSS program funding of $320,000 per annum three years ago.

The Board has discussed, and set up, a number of tactics to meet these financial concerns:

- staff in the Secretariat has been reduced from 8 full time equivalents to 4.5, and is now at an absolute minimum;
- heavy use has been made of electronic communication, reducing our paper, printing and postage bills;
- operating costs have been reduced, and further potential savings are small; and,
- sponsorship for events has been very actively pursued and wider sponsorship, including for the Journal, is now being sought.

It is also worth noting that:

- the current membership fees were set in 1997/1998 and, with the exception of adding GST, the membership fees have not been altered since then; and,
- in the six years since the current membership fees were set, the CPI has increased by 12.5%.

We are now at the point where there do not seem to be any other areas where we can reduce our costs, without damaging PHAA's capacity to advocate for better health and provide services to members. Consequently, the tactics for the coming year (2003/ 2004) have to concentrate on increasing our income.

We have approached the Commonwealth to see if it would be possible to having funding to the PHAA reinstated under the CSSS Program. The Department of Health and Ageing have declined to do so, but have pointed out that they continue to provide support for our conferences.

We have put in place, under the leadership of Leonie Short (Vice President, Development), a membership and marketing plan to increase membership, advertising and sponsorship of the PHAA and its activities. The Secretariat is now actively pursuing advertising and sponsorship, and the Board has recommended that every State and Territory Branch of PHAA strive to achieve an annual10% growth in members for the next few years. The Secretariat will have the same target for corporate memberships. Increases in the number of members is likely to provide the most sustainable increase in income for PHAA. In addition, by increasing our membership numbers we can gradually decrease the costs per member of providing membership services, for instance the Journal, intouch, the website, conferences, the email list, etc. For individual members this currently stands at approximately $350 per year.

Finally, the Board has considered the current structure and level of membership fees. The Board has agreed to retain the staged structure of the fees, believing it is necessary to support students and those starting out in public health and continue the longstanding PHAA practice of having lower income members having their membership fees subsidised by other members. It is, I believe, generally accepted by our members that our fee structure is fair and equitable, and that members get good value for money: from, for instance, the internationally recognised Journal, the up-to-date information and debate provided in intouch, the Website and our conferences. Additionally, our policies have served many members very well in their dealings with the media and politicians and are well respected by people outside the PHAA. .

However, the loss of the Commonwealth's grant and a CPI increase of 12.5% since 1997/98 has meant that we have not been able to fully meet our expenditure by stringent cost cutting in the Secretariat alone. The Goods and Services Tax has also had an effect on our income and indirect taxation payments. Consequently, to make the Association more financially self-sufficient the Board has determined that we need to raise membership fees across all categories of membership.

The new fee structure that the Board has adopted is:

Corporate membership<br>
Annual fee<br>
For profit<br>
$910<br>
Not-for-profit-government agencies<br>
$665<br>
Not-for-profit community based organization<br>
$545<br>
Individual membership<br>
Category 1 (income >$70,000pa)<br>
$470<br>
Category 2 (income $55,001-$70,000pa)<br>
$360<br>
Category 3 (income $40,001 - $55,000pa)<br>
$225<br>
Category 4 (income <$40,000)<br>
$150<br>
Associate member<br>
$100<br>
Full time Students<br>
$90<br>
SIG Membership (per SIG)<br>
$10

I realise that any increase in fees will be an unpleasant surprise for many members but I would ask you to remember (a) the valuable services provided to the Australian community and to members by the PHAA, (b) that fees have not been increased for six years, and (c) that many members will be able to claim tax relief on their membership fees. I firmly believe that the PHAA provides extremely good value for money and I hope that you will all rejoin next year and strongly encourage your non-member colleagues to join. Membership renewal notices will be sent out in the near future and membership application forms can be found in every copy of the Journal.

Best wishes,

Peter Sainsbury<br>
President

# *ACT Health Promotion Website*

ACT Health recently launched the ACT Health Promotion website, an exciting new professional resource and communication tool that will support health promotion workers in the ACT.

It is available on the internet at:
www.healthpromotion.act.gov.au

The website will benefit health promotion and related workers in the Act by
- encouraging and improving communication and coordination:
- improving access to online health promotion resources; and,
- improving access to best practice health promotion information.

Whilst it is focused on workers in the ACT, health promotion workers from other states and overseas will have access to all of the great resources the website brings together and will find the site extremely useful.

The website includes:
- introductory health promotion information and definitions;
- information about health promotion in the ACT;
- best practice health promotion information and theory;
- research resources and a directory of links;
- information about health promotion jobs and training; and,
- health promotion news and events.

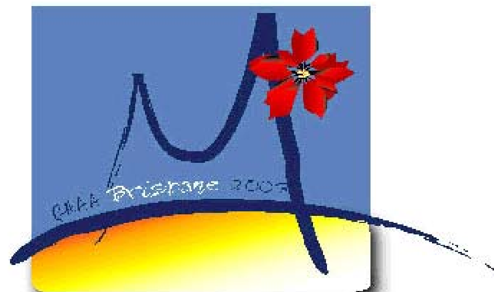
The site currently contains more than 130 pages of content and allows interactive access to over 700 records of information in its various databases.

Join the website mailing list to receive regular website updates via email. Subscribe to the mailing list via the website at:

http://www.healthpromotion.act.gov.au/utilities/feedback/mail_list.asp

For more information about the website, contact the website managers at: healthpromotion@act.gov.au

## Countdown to Brisbane Conference




This years national conference will be held from 28 September to 1 October at the Brisbane Convention and Exhibition Centre. It will be themed Essentials, Differentials and Potentials in Health

Sepeakers who have confirmed to date include:

Prof Robert Kaplan from the USA
Prof Simon Chapman
Prof Jake Najman
Prof Ian Lowe
Prof Ross Homel
Prof Robert Bush

We hope to have a provisional program in place by the next issues of intouch. In the interim, watch the PHAA website for updates and dont forget to tell your colleagues.

Peter Anderson and John OBrien
Confernece Convenors

# PHAA Advocacy Update – April/May

PHAA's advocacy work continues to keep the national office, the Board and Branches and Special Interest Groups busy. Issues covered in the last two months include:

**War with Iraq**
While the war with Iraq has started and may, in a military sense, be over, we have continuing public health and humanitarian concerns. Amongst these are the quick restoration of basic services such as electricity, power, food distribution and health care services. We have written to the Prime Minister and the Minister for Defence seeking Australian troops to be involved in at least the initial phases of this work.

We are also currently working on a draft policy on the military use of depleted uranium.

**Refugees**
The major focus of PHAA's work on refugees is the participation of the International Health Special Interest Group in the ARC Linkage Grant, "An examinaton of Refugee Women at Risk in Australia's refugee policy". Our contact on this work is Dr Anna Whelan.

**Free Trade Agreements**
PHAA continues to be concerned about the potential impact of free trade agreements of various sorts on the Medicare and Pharmaceutical Benefits Schemes as well as the provision of other public services that affect health. Letters have been written to the Prime Minister and Minister for Foreign Affairs and Trade and are on our website along with the replies that have been received.

In addition, the PHAA provided a short submission and endorsed the NCEPH submission to the Australian Senate Inquiry into General Agreement on Trade in Services and Australia/US Free Trade Agreement. A copy of our submission and the NCEPH submission are both on the web-site.

In order to develop further awareness of the potential impact of trade agreements, a set of dot points on the most significant issues has been sent to all Branch Presidents for them to distribute to their membership. Members are being asked to write to their local members and/ or their local newspapers using these dot points for reference. Members should also feel free to draw down information from the web site.

**Medicare**
Changes to, and the undermining of Medicare remain one of our highest priority advocacy areas. In the lead up to the changes Peter Sainsbury and Angela Taft undertook a series of media interviews for newspapers, radio and in one case television. Working with the National Medicare Alliance we have sent out a joint media release on the Medicare proposals and Angela Taft prepared and released an opinion pieces for the Age and the Sydney Morning Herald on the Medicare changes under the National Medicare Alliance Banner.

In addition a set of dot points that can go to all Branch Presidents for them to encourage and undertake local actions (letters to parliamentarians and regional newspapers) have been developed and distributed.

We also took up an invitation from the Democrats to participate in a round table discuss on issues of changes to Medicare. Finally, Peter Sainsbury wrote an article for *online-opinion* on Medicare and proposed changes.

**Trafficking of Women**
A letter has been sent to Minister for Family and Community Services, the Attorney General and Minister Immigration and Indigenous Affairs on trafficking of women for sex purposes. Both the Western Australian Branch and the Women's Health Special Interest Group are working on a submission to the West Australian Government on its proposal to make 'sex slavery' illegal.

**Mental Health**
The Mental Health Special Interest Group has provided a submission on the National Mental Health Consultation Paper and had a representative at the National Mental Health Summit. A copy of the PHAA submission can be found on our web site.

**Child Obesity**
PHAA participated in the Commonwealth's Task Force on Obesity consultations and we are currently preparing a submission to the Task Force.

**Incarceration Health**
The Incarceration conference generated considerable media coverage about both prison health and asylum seekers health. The conference was a considerable success and brought forth issues that were not getting coverage in health systems.

**Research Survey**
The results of the Public Health Research Advisory Group's survey of members reactions to the NH&MRC funding processes and the balance of funding allocations has been completed and can be found on the PHAA web-site. The results will now be made available to NH&MRC.

**Aboriginal and Torres Strait Islander Nutrition**
The Aboriginal and Torres Strait Islander SIG and the Food and Nutrition SIG developed a letter to the Commonwealth Minister for Health and Ageing and all the State and Territory Ministers for Health that has called for substantial action to fulfill the commitment by the Commonwealth and State and Territory Governments in 2001 to the National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan (NATSINSAP). The letter noted that according to the current financial year's Budget Papers, no funding has been provided for the strategy in sharp contrast with other strategies.

In the letter the PHAA called for a number of urgent actions to rectify Aboriginal nutrition inequity:

1. The establishment of an implementation task force consisting of a range of people the first of which need to be Aboriginal Elders, Aboriginal community nutritionists and other Aboriginal public health professionals;
2. The adequate resourcing of this task force to put into place, within 6 months (the period May to October 2003) a range of critical high order priority initiatives outlined in the NATSINSAP; and
3. At the end of this time the initiatives to receive transparent funding allocations.

The full content of the letter is on the web-page.

# *Items of Interest*

**USA: USDA begins meat testing to prevent vCJD**

The US Department of Agriculture's Food Safety and Inspection Service (FSIS) has announced a regulatory sampling programme to ensure beef products derived from Advanced Meat Recovery (AMR) systems are accurately labelled.

AMR is a technology that removes muscle tissue from beef carcasses without breaking bones. When produced properly, products derived using AMR can be labelled as "meat".

Previously, FSIS inspectors took regulatory samples of AMR product if they believed that an establishment was not completely removing spinal cord tissue. Products labelled as "meat" found to contain spinal cord tissue are considered misbranded under FSIS policy.

The FSIS has now begun a routine regulatory sampling of beef products from AMR systems as outlined in a December directive. The new sampling programme requires inspectors to test beef product from AMR systems on a routine basis to verify that spinal cord tissue is not present. If spinal cord tissue is detected, the FSIS said action will be taken to relabel held product or recall distributed product from commerce.

Consumption by humans of beef spinal cord tissue is thought to lead to the degenerative brain disease, variant Creutzfeldt Jakob disease.

The FSIS said inspection personnel would also conduct follow-up sampling to verify that the establishment has taken appropriate corrective action. AMR production will not be allowed to resume until FSIS determines that those corrective actions have been successful.

**New Editors for the *Health Promotion Journal of Australia***

Chris Rissel, Marilyn Wise and Adrian Bauman have been selected as the new editors of the *Health Promotion Journal of Australia.* Working as an editorial team based at the Australian Centre for Health Promotion, University of Sydney, Chris is Editor-In-Chief, Marilyn is Policy Editor and Adrian is Research Editor.

The new editors would be pleased to receive high quality original manuscripts topics relevant for health promotion in Australia and the south east Asian and Pacific region. Manuscripts describing the development, implementation and evaluation of health promotion programs are encouraged.

All correspondence for the Journal should go *Health Promotion Journal of Australia,* PO Box 351, North Melbourne VIC 3051. Email hpja@substitution.com.au, or visit http://www.healthpromotion.org.au/.

A 2002 survey of 34 establishments producing beef products from AMR systems to determine the frequency that products contained central nervous system tissue, including spinal cord tissue, showed that approximately 35% of the final product samples tested positive for central nervous system (spinal cord) and central nervous system-associated tissues.
Source: just-food.com

**The five-a-day rule**

It's been a week of slapped wrists in the international food industry. In perhaps the highest profile telling-off in months, the World Health Organisation chided Anglo-Dutch consumer goods conglomerate Unilever for its implementation of the 'five-a-day' rule.

Ever since the recommendation to eat five portions of fruit and vegetables per day was introduced, it has been open to abuse. The recommendation is intended as a useful guideline for consumers seeking to eat a balanced diet and to teach their children positive nutrition. However, differing interpretations of the rule have provoked controversy on many occasions. Some products that seem not to adhere to the spirit of the five-a-day recommendation have included mention of the rule in their marketing campaigns - perhaps most famously spaghetti hoops in tomato sauce.

The latest product to antagonise those who would like to see a less liberal interpretation of the rule is Unilever's Solero Getfruit!, a combination of ice cream and fruit being trialled in Tesco stores. The product packaging claims to "help you reach five-a-day". A WHO spokesman is quoted by Marketing as saying that the move was an attempt to hijack the five-a-day concept in a way not in keeping with its spirit.

Who could argue with that? What could develop into a very useful tool for improving nutrition standards is at risk of being undermined by an overly liberal application that will leave consumers confused.
Source: JustFood.com

**Marketing Plan**

The Vice Presidents, Development and Finances, have developed a marketing plan for the PHAA. The plan sets out a number of tasks that need to be undertaken in order to help PHAA develop its membership base and develop the activities that it undertakes.

We are seeking anyone with an interest in marketing who would like to become involved in PHAA's Marketing Plan. Ideally we would like at least one person from each of the State/Territory Branches. If you are interested in helping PHAA remain a viable and interesting organisation, please contact Pieta Laut on plaut@phaa.net.au for further information.

# *Items of Interest*

### Cancer survival in Australia 1992-1997

Cancer Survival in Australia 1992-1997: geographic categories and socioeconomic status is the first national study of cancer survival variation by socioeconomic status and geographic region. It presents an analysis of five-year relative survival proportions by geographic category and socioeconomic status for persons diagnosed with cancer during the years 1992-1997. This analysis is presented by age and sex for all cancers, except non-melanocytic skin cancers, combined and for the following National Health Priority Area cancers - colorectal cancer, cancer of the lung, melanoma, cancer of the breast (females only), cancer of the cervix, cancer of the prostate and non-Hodgkin's lymphoma. The report is the third in a series on relative survival after cancer diagnosis. It is an important reference for all those interested in the health of Australians.
AIHW Cat. No. CAN-17, available from Info Access (toll free tel:132 447) for $18.00

### Disability Services Data

The Commonwealth/State Disability Agreement Minimum Data Set (CSDA MDS) has provided data on Australia's national program of disability support services since 1994. By 1999, it had become obvious that changes in the nature of service provision, information needs and technology had created a need for review and redevelopment of the collection. Australia's National Disability Services Data Collection: Redeveloping the Commonwealth-State/Territory Disability Agreement National Minimum Data Set (CSTDA NMDS) focuses on the processes undertaken to redevelop the collection and outlines how the new data will satisfy a far wider range of information needs relating to this major national program.
AIHW Cat. No. DIS-30, available from Info Access (toll free tel.132 447) for $19.00

### Occupational Violence in Australia

This annotated bibliography of prevention policies, strategies and guidance materials was compiled by Dr Claire Mayhew. The April 2003 update is now available on the website of the Australian Institute of Criminology: http://www.aic.gov.au/research/cvp/occupational/index.html

### Scholarships in Allied Health Sciences

The Sir Robert Menzies Memorial Foundation is offered scholarships to the value of $24,000 per annum free of income tax for research in the allied health sciences. They are open to people who will be working as full-time students in a research PhD program which is likely to be completed during the two year tenure of the scholarships which will begin in 2004. Further information can obtained from www.vicnet.net.au/~menzies.

### 2002 Influenza Vaccine Survey: Summary Results

Cat. No. PHE-46, Available from the Internet only
This report was carried out as part of an evaluation of the national Influenza Vaccination Program for Older Australians. The Program is a Commonwealth Government initiative designed to help reduce the impact of influenza. The survey itself involved 8000 participants across Australia, interviewed during October 2002 - at the end of the winter flu season. People aged 40 years and over were asked whether they had been vaccinated against the flu, whether they had received the vaccine for free or had paid for it, and if they had any of the risk factors for flu infection or its complications.
http://www.aihw.gov.au/publications/index.cfm?type=new

### The Active Australia Survey

The Active Australia Survey: a guide and manual for implementation, analysis and reporting is a new publication designed to measure participation in leisure-time physical activity and to assess knowledge of current public health measures about the health benefits of physical activity. It offers a short and reliable set of questions that can be easily implemented via computer-assisted telephone interviewing (CATI) techniques or in face-to-face interviews. The manual includes an overview of the survey as well as a copy of the questions, an implementation guide with instructions for interviewers, a guide to the measures that can be derived from the survey data, information on how these measures are calculated and examples of how they are usually reported. It also provides background information on the development of the survey and an example of CATI coding.
Cat. No. CVD 22 . This is an internet only release that can be viewed on the AIHW web site:
http://www.aihw.gov.au/publications/index.cfm?type=new.

### The Child Dental Health Survey, Australia 1999: Trends across the 1990s

This new Australian Institute of Health & Welfare (AIHW) report looks at the oral health of Australia's school-age children. It includes age-specific and age-standardised measures of dental caries experience and treatment within each State and Territory and national estimates of these measures for 1999. Australian children enjoy comparatively low levels of dental caries although a minority still experience extensive decay. Trends in caries experience for the period 1990-1999 are presented. The findings show that caries experience in both the deciduous and permanent dentations has changed over time and that improvement stopped in the later half of the 1990s. Knowledge of these changes can serve as a guide for future policies to enhance the oral health of Australian children.
Cat. No. DEN-95, available from Info Access (toll free ph:132 447) for $20.00

# *Items of Interest*

## Child Protection Australia 2001-02

This new report from the Australian Institute of Health & Welfare (AIHW) provides comprehensive information on the child protection services provided by State and Territory community service departments. The report contains data for 2001-02, as well as trend data on child protection notifications, investigations and substantiations, children on care and protection orders and children in out-of-home care. Detailed information on the characteristics of children in the child protection system is presented, specifically data on their age, sex and Indigenous status. In addition, for child protection substantiations, data on the family type, the relationship of the person believed responsible and the source of notification are also included. For children on care and protection orders there are data on types of orders and living arrangements, and for children in out-of-home care there are data on types of placements and length of time in out-of-home care.

AIHW Cat. No. CWS-20. Available from Info Access (toll free ph:132 447) for $18.00

## NSW Child Health Survey

The NSW Health Department has released its survey provides the first state-wide data on the health and wellbeing of children aged 0-12. The report, which will inform health policy and planning, outlines the development of the survey, including the consultation process, the development of the survey instrument and the survey methods used. The results of the survey, including an outline of the final methods, are available on the NSW Department of Health's web-site at www.health.nsw.gov.au/public-health/phb/phb.html

## Needle and Syringe Programs

The Commonwealth Department of Health and Ageing has released a report entitled Return on Investment in Needle and Syringe Programs in Australia. The study analyses the effectiveness of needle and syringe programs in preventing transmission of HIV and hepatitis C in Australia from 1991 to the end of 2000. It then uses these findings to calculate the return on investment from needle exchange programs over this period. The report can be obtained from the Publications Production Unit of the Commonwealth Department of Health and Ageing, tel (02) 6289 1555.

## Population Health

The World Health Organisation (WHO) attempts to delineate measures of population health in a recent publication: Summary Measures of Population Health: Concepts, Ethics, Measurement and Applications. This book addressees a wide range of critical issues relating to the measurement of population health using comprehensive indices combining information on mortality and ill-health. The various uses of such summary measures of population health are described and the appropriate measurement framework and specific ethical and social value choices are discussed and debated. The contributors include leading experts in epidemiological methods, ethics, health economics, health status measurement and the valuation of health status. For further information about these three publications, contact WHO, Marketing & Dissemination, 1211 Geneva 27, Switzerland or email publications@who.int

## Veterinary Drug Residues in Food

Evaluation of Certain Veterinary Drug Residues in Food presents the conclusions of a Joint FAO/WHO Expert Committee convened to evaluate the safety of residues of certain veterinary drugs in food and to recommend maximum levels for such residues.

## Food Additives and Contaminants

Evaluation of Certain Food Additives and Contaminants presents the conclusions of a Joint FAO/WHO Expert Committee convened to evaluate the safety of various food additives and contaminants, with a view to recommending Acceptable Daily Intakes and Tolerable Intakes and to preparing specifications for the identification and purity of food additives.

## Salmonella in Eggs & Chickens

FAO and WHO undertook a risk assessment of Salmonella in eggs and broiler chickens in response to requests for expert advice on this issue from member countries and the Codex Alimentarius Commission. Risk assessments of Salmonella in eggs and broiler chickens: interpretative Summary provides current information relevant to risk assessment of Salmonella in eggs and broiler chickens although it does not include a cost-benefit analysis of potential mitigations.
For further information email nutrition@fao.org or foodsafety@who.int

# What's on

<u>22 November 2003</u>
Eleventh National Symposium on Hepatitis B and C, St Vincent's Hospital Melbourne. International Speaker is Prof Christian Brechot, plus leading speakers from across Australia. Contact: Ms Eleanor Belot, Meeting Administrator, Ph: 03 9288 3580 Fax: 03 9288 3590, Email: belote@svhm.org.au

<u>5- 24 January 2004</u>
7th **Summer School in International Health & Development** for Christian Health Professionals. Optional 4th week and 2-week OUTREACH. At Flinders Medical Centre and Tabor College, Adelaide, SA. Further enquiries: Intermed.SA, PO Box 223, Torrens Pk, SA 5062. Email: intermed@radford.id.au. Tel 618 8271 9558.

## Risk seen in common chemical

*Reprint from New York Times*

A common industrial chemical used to produce Teflon may pose health risks for young girls and women of childbearing age.

Scientists of the United States Environmental Protection Agency are concerned because the chemical, ammonium perfluorooctanoate, accumulates in human blood and demonstrates toxic properties.

Teflon is used in many common household products, including nonstick pans, irons and paint.

The agency has initiated a priority review under the Toxic Substances Control Act, which can be invoked to ban chemicals that pose significant risk of cancer, gene mutations or other defects.

Studies have shown the chemical, C-8, causes liver damage in rats.

Applied in high doses, C-8 has also been found to cause development and reproductive harm in rats.

Manufacturer DuPont contends that at lower levels the chemical had no effect. Studies of C-8 exposure in humans had not been conclusive, and the EPA report urged further study.

The chemical, which is part of a family known as perfluoro-chemicals, plays a critical role in materials widely used in the aerospace, transportation and electronics industries.

# New Members

NEW SOUTH WALES

Sally Redman
Michelle Cretikos
Lyn Gilbert

VICTORIA

Julie Bernardson
Jessica Chellappah
Alex Thompson
Emma Byran
Maria Theresa Ho
Marita Hefler

SOUTH AUSTRALIA

Marguente Tyson

NORTHERN TERRITORY

Vicki Taylor

QUEENSLAND

Angela Mallberg
Elizabeth Helen McLeay
Kelley O'Donohue
Rachel Darken
Patricia Haycock
Ian Ross Gillies

WESTERN AUSTRALIA

Cancer Foundation of WA

EDITORS: Elizabeth Proude and Susan Stratigos

# Advertising in

***1/4 page***

Members .............................. $225
Non-members ..................... $318

***1/2 page***

Members .............................. $355
Non-members ..................... $497

***Full page***

Members .............................. $638
Non-Members ..................... $878
***camera-ready copy preferred but PHAA staff can prepare your advertisement (rate of $20 p/h)***

***Conference listing (5cm column)***

up to 5 lines ........................... $35
up to 10 lines ......................... $58

****Inserts (2000 x single A4 page)***

Members .............................. $462
Non-members ..................... $578

*after booking, send to PHAA, attention:
***Vicki Thompson***
***20 Napier Close***
***Deakin ACT 2605***

Costs for larger/thicker inserts are available on request. Copy deadline is for the 23th of the month for publication on 10th of the following month. If further information is required please contact PHAA via email:

***publications@phaa.net.au***

or phone ***02 6285 2373***