in touch
newsletter of the Public Health Association of Australia Inc.

Vol 17 No 7 October 2000

Australia, NGOs and the UN: What Next?

The democratic life of Australia has been inclusive of non-government organisations (NGOs). NGOs are an important avenue for citizenship and have long been seen as a mechanism for strengthening civil society, domestically and globally. In the health and community sectors, NGOs serve members and the wider community by promoting awareness of upcoming important issues, bringing together expertise on particular issues, distilling information through a variety of fora, development of advocacy tools and providing a moral consciousness. In the health sector, NGOs have strengthened the capacity of governments to find solutions to problems of equity and provided the expertise to help governments manage potentially disastrous health issues. NGOs are an important channel for social capital in a democratic and pluralist society.

Governments use NGOs as policy sounding boards, seek their policy input and are alert to their policy analysis. They are used by governments as transmitters of policy information to and from the wider community and may even be seen as useful service providers. In this way, NGOs are a source of public opinion as well as expertise, given that people's voluntary joining of an NGO is because they feel sufficiently passionate about something to commit the necessary funds and time that belonging requires. NGOs therefore, comprise people with common and shared interests and frequently, very high levels of expertise and experience.

Governments have provided direct grant subsidies to some NGOs in return for their policy inputs and outputs, but many NGOs have found it necessary to have other sources of funding perhaps greater than the proportion provided by government. In return for subsidies, NGOs enter in agreements with relevant government departments that set out conditions for receiving the grant. Some NGOs prefer not to be beholden to government preferring to maintain their independence from government and so as not to compromise the quality of their work. For most though, subsidy is the difference between survival and demise. Most NGOs don't get corporate sponsorship because they do not have the capacity to sell on products so they find a medium between receiving the subsidy, providing policy advice and disseminating policy analysis.

However, by the year 2000, NGOs in Australia are becoming increasingly marginalised. The Howard government has progressively defunded large numbers of NGOs, usually after criticism of policy by that NGO. There are clear messages that this action is being taken with dissenting NGOs, their defunding intended to push them over a financial edge perhaps towards their end. Without subsidy or the capacity for sponsorship, they become further and further disenfranchised. The problem is significant because it is a kind of repression.

Are the downgrading of government's relationships with NGOs and deliberate efforts to subordinate their role, leverages for reform? Where will the government seek its policy advice in the future? We are reliably told that government now has lists of preferred consultants to provide this advice. This raises questions about the independent nature of that advice as well as just how democratic is the preferred consultant's system. Reform then will be undemocratically acquired and very selective. This is a

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slippery slope for government, one that is linked to its position on the United Nations.
The Howard Government's August 29th statement on "Improving the effectiveness of United Nations committees" seeks to subordinate the role of NGOs, this time in the international arena and in relation to the human rights treaty committee system. The Government wishes "to ensure adequate recognition of the primary role of democratically elected governments and the subordinate role of non government organizations." This and other strategies are to be levers for reform of the treaty committee system. Will Australia advocate subordination of the role of NGOs in other UN bodies that it is seeking to reform, such as the World Health Organization (WHO)? Australia has been a strong and effective advocate of reform of the WHO. Together with the US and Britain, this country was instrumental in seeing a new director-general of WHO installed in 1998.

The constitution of the WHO recognizes that WHO may make suitable arrangements for consultation and cooperation with nongovernmental international organizations. Many such organizations are in special relations with WHO and arrangements are made for them to address the World Health Assembly and the Regional Committees. Why shouldn't the Government turn its attention to WHO, and apply the same policies of downgrading its relationship and subordinating the role of NGOs as leverage for reform? What would be the impact if it did?

WHO's disease control programs have historically been dependent on universality of participation in WHO by its member states (about 190), and close cooperation with NGOs. The World Bank in its 1993 report, in respect of the successful eradication of smallpox which cost $US300 m over the 12 year life of the program (compared with a cost of smallpox vaccination, quarantine and treatment in 1968 of $US300 million in one year alone) said that "Few investments of any kind generate human and financial benefits on that scale". Polio eradication is close to being achieved. The mass vaccination efforts using immunisation days in countries such as China and India have been regarded as the largest mobilizations for peaceful reasons ever. NGOs have contributed major resources to the eradication effort. The Framework Convention on Tobacco Control is the next epidemic in WHO's sights to reduce the growing toll of tobacco deaths which will reach 10 million a year by 2020. Will the Howard Government downgrade its contribution to the Framework Convention in order to achieve WHO reform?

What about WHO's normative function in respect of such things as the biological standards of vaccines? How would a downgrading of the Howard Government's participation affect such matters? What about WHO's role in technical cooperation and its ability to convene the world's experts to deal with local issues, such as the H5N1 Hong Kong chicken 'flu or New Zealand's meningococcal meningitis epidemic? Would the Howard Government want to reduce Australia's role in contributing to such efforts, and reduce Australia's opportunities to be beneficiaries if the need should arise?

The Government needs to decide, both domestically and globally, whether reform is a means to an end or an end in itself. If the former, then strengthening civil society and improving health are the overriding considerations that should be enhanced and not derailed by any reform strategy. We have argued that NGOs play a number of critical roles in contributing to the development of complex solutions to complex problems to improve the wellbeing of people. Sadly, the Government is behaving as if reform is an end in itself and the objectives that relate to the wellbeing of people in Australia and globally can be swept aside to allow the reform agenda to proceed unfettered by consideration of social goals.

Dr Helen Keleher
Associate Professor Gillian Durham

Environmental & Child Health SIG Workshop

Environmental Health and Child Health SIG Workshop on *Children and Environmental Health* is to be held on Sunday 26 November at 10:00am - 2:00pm at the National Convention Centre Canberra, in conjunction with the PHAA Annual Conference.

Speakers and the Agenda:
10:00am - 10.30am
Morning tea

10.30 am - 12:00 pm Speakers
Dr Irene Kreis - Senior Lecturer, Environmental Health, University of Wollongong will speak on *Children and Environmental Health Hazards.*
Dr Jim Fitzgerald, Acting Manager, Hazardous substances and Principle Toxicologist, Environmental Health Branch, Dept of Human Services, SA will speak on *A summary of WHO Workshop* held in Manila on Environmental Threats to the Health of Children.
Dr Kevin Buckett, Director, Environmental Health Section, Health and Aged Care, Population Health Division, Commonwealth of Australia will speak on *Children and the Environmental Health Strategy.*

12:00pm - 1:00pm
Discussion - Towards a PHAA Policy on Children on Environmental Health.

1:00pm - 2:00pm - Lunch

Inaugural Meeting of International Society for Equity in Health
June 29 in Havana, Cuba

In her introductory address to the inaugural meeting of the International Society for Equity in Health, Prof Barbara Starfield suggested that while the phenomenon of health inequalities was well documented, there remain important questions to be explored. These include:

- How much health can be improved by targetting resources at particular populations?
- Why some health outcomes reflect the gradient and others do not?
- What are the pathways for different groups, eg gender, ethnicity, etc.?
- What are the contributions of health services, when not all health services are the same?
- How to define useful research questions for action?
- What are useful and appropriate measures?
- What can be achieved by going beyond individual, isolated research projects?

Prof Sudhir Anand then posed further questions in his keynote:

- Are some aspects of health inequalities more important than others?
- Is health inequality more important than other inequalities?

Having had these challenges raised, over 300 people from around the world engaged in debates, heard research and action projects from each other, and endorsed the founding of the International Society for Equity in Health.

From the research end, some of the highlights included Jack Geiger's review of 650 articles about racial discrimination in accounting for ethnic disparities in health; Amy Schultz's overview of the work of the Urban Health Research Centre in Detroit on context-specific, multi-level interventions that address multiple and interrelated health risks; Philippa Howden-Chapman and Ilmo Kesikimaki's comparative study of economic recession and impact on health (including government's attempts to soften the blow); the disastrous consequences on health access for the poor in China and Vietnam as result of economic reforms being applied in the health system.

Some of the policy suggestions raised during the meeting included: using international public health regulatory framework to mandate rights to basic services and to information; benchmarking for fairness as an approach to improve performance; developing priority-setting criteria and measurement using such dimensions of inequality as "unnecessary", "avoidable", and "unjust"; better social marketing for public health through better understanding of public perceptions of equity.

Further keynote vignettes came from a number of prominent researchers who were unable to attend. Michael Marmot suggested that the research question is not which are the most important determinants of health and how these could be distributed in an equitable fashion, but how to enhance people's freedom to benefit from material and social resources and how such benefit may improve health. John Lynch remains unconvinced, theoretically and empirically, about the potential for social cohesion or other aspects of psychosocial functioning to reduce health inequalities, and he argues for a more material approach that recognises the political-economic processes that generate inequality and influence availability of health-enhancing resources at the individual and community levels. George Kaplan's agenda included: use what we know, attend to gradients but help the neediest, avoid a policy of "compound disinterest" by investing in children, build communities, reduce and mitigate the ravages of income inequality, and prevent lost opportunities (to demonstrate the health impact of social and economic policies).

The Australian contingent had a noticeable presence, if not the most sizeable on a per capita basis, with delegates identified from such fields as general practice, Aboriginal health, and public health. The Australasian meetings (by the pool side, with *guajitos* in hand) included delegates from several Southeast Asian countries as well. Jane Dixon was elected to be on the Executive Committee, along with representatives from New Zealand and Malaysia. The next meeting is expected to be held in 2 years.

Yes, the music was great.

Vivian Lin

PHAA Welcomes our New Members

New South Wales
Dr Alison Rutherford
Miss Vanessa Firenze
Ms Brenda Bailey
Ms Eileen Daly
A/Prof Peter McIntyre

Queensland
Mr Terrence Moore
Ms Alison Abbott

Victoria
Ms Prue Bagley
Dr Antonio Grossi
A/Prof Frank Archer

Western Australia
Ms Annette Forbes

Tasmania
Mr Colin Butler
Ms Helen Townley

Overseas
Miss Nerissa Soh
Dr Vinod Daniel
Dr Hla Lwin
Dr Myint Zaw

FOOD AND NUTRITION SPECIAL INTEREST GROUP, PHAA WORKSHOP

TITLE: Food regulations - effective public health input to make a difference

DATE: Sunday 26 November, 2000

TIME: 2.00 – 5.00 pm

Discussions in this workshop will focus on how to improve the effectiveness of the public health input into the food regulation system. Speakers will use case studies (health claims, nutrition information panels) from the recent review of the Food Standards Code to highlight 'successes' and 'failures' of public health input into the food regulation process.

Speakers:
Introduction & Overview, Heather Yeatman, University of Wollongong
"The view from both sides", Mark Lawrence, Deakin University
"The view from the inside", Sue Jeffreson, Australia New Zealand Food Authority
Discussion: - Strategies to improve the public health input into food regulations.
- Priority public health issues re food regulations
- What do individuals need to become more effective?
- What does PHAA need to do to support its members?
- What does PHAA need to do to make a greater impact?

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WORKSHOP: Food regulations - effective public health input to make a difference

Registration Details:

Name: ....
Address: ....
....
Telephone: .... Facsimile: ....
Email: ....

Cost: SIG member $20 Non SIG member $25

Please return registration details & payment to:
PHAA Secretariat, PO Box 319, Curtin ACT 2605

Cheque payment: Please make cheques payable to Public Health Association of Australia Inc
Credit Card: Please charge my: Bankcard Mastercard Visa
For the sum of $AUD .... Expiry Date .... / ....
Card Number ....
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Labelling genetically modified foods

The ACT Government is proud of the leadership role it took when Health Ministers confirmed their stance on a comprehensive system for the labeling of genetically modified foods when they met in Wellington in late July.

The decision followed two years of vigorous debate in the public arena, in the Australian New Zealand Food Standards Council (ANZFSC) and within Cabinets in all jurisdictions. The final decision did not have the support of Western Australia, the Northern Territory or the Federal Government.

All jurisdictions involved worked hard in trying to find a compromise on the range of issues before them. Although I will attempt to deal with the issues one at a time, it is important to understand that there was often an overlapping and blurring of the issues before the Ministers.

In July 1998 ANFSC was asked to approve a labeling system based on "substantial equivalence". The argument put was that even if a tomato was genetically modified, provided it looks like a tomato and tastes like a tomato, it would not require labeling. The ACT Government argued that since all GM foods approved in Australia were substantially equivalent then a system based on this methodology was effectively a no labeling system.

The position put to the Food Council by the ACT was that since food is a fundamental determinant of health then we should provide the maximum information possible about these foods. This argument was put in the light of the position of the World Health Organisation attitude which encourages governments to allow individuals and groups control over the determinants of their health to the greatest extent possible.
The Council accepted the ACT proposal to defer any decision on substantial equivalence until Ministers could consider the issues more carefully. Issues of cost and trade barriers were also raised at the meeting.

Throughout the debate all Health Ministers expressed concerns that the costs to industry should not be prohibitive. This debate came to a head in October of 1999 when a two-week consultant's report by KPMG suggested a cost in a worst case scenario of $3 billion to industry. This result was based on the original draft Standard and quite a few false premises.

It was the $3 billion costing that brought the Prime Minister into the debate, although lobbying from industry and the US government no doubt also played a role.

The extraordinary costing was rejected by Health Ministers who agreed to delay their decision whilst a more thorough report examined the cost assumptions. KPMG again won the tender but with more time reduced the estimate to $300 million in the first year with ongoing costs in the order of $150 million.

Ministers also set up a Taskforce to provide terms of reference for the second cost consultancy and to provide options on how to redraft Standard A18, the Standard which governs labeling of genetically modified foods. This Taskforce was also charged with developing a protocol for the Standard as a guide for industry and producers.

Throughout the debate there was concern that the proposed labeling regime would create artificial barriers to protect our trade and could be subject to action by the World Trade Organisation. Under this scenario Australia and New Zealand could use the definitive-labeling regime for a market advantage particularly for the European Union.

A number of legal opinions were prepared which debated this matter and cast enough doubt in the minds of Ministers to allay such concerns.

The alternative argument was also put suggesting that labeling would restrict our trade opportunities. As it became clear that Ministers were using a system not dissimilar to the European Union, these issues became less dominant. However, even on the last day of debate the Commonwealth used WTO concerns as one of their arguments for a less stringent system of labeling.

Following the commitment of Ministers to a system of comprehensive labeling a debate emerged about the detail of small amounts of materials used in the production of food. On the one hand some argued that any food originating in any part from GM ingredients or with any GM ingredients used in the process should carry labels. The alternative, put by the Prime Minister and argued by Commonwealth up to the last day, was to exempt all highly refined food, additives and processing aids on the grounds that they were usually in the food in small amounts.

The Ministerial task force had presented a compromise approach which was eventually adopted by ANFSC. Where there was any novel DNA or protein (the indicators of GM ingredients) remaining in the final food it would have to be labeled. The Ministers who supported this position were persuaded that it was more truthful to label what was actually in the final food rather than how it was derived. A 0.1% concentration for flavours was exempted.

The European Union had identified a 1% exemption for what it described as "adventitious" contamination. In adopting the same approach, although using plain English, the Council recognised that even with a carefully controlled paper trail

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Draft policy proposals are printed here for discussion and comment. Please address all comments to the policy proposers and the Policy Convenor either directly or through the PHAA Secretariat.

Draft Policy on Mandatory Sentencing

The Public Health Association of Australia notes:

1. The disastrous and ongoing consequences of colonisation on the health and well-being of the Indigenous peoples of Australia as detailed in PHAA Policy: Indigenous Health: the Continuing Consequences of Colonisation;

2. The widespread view that mandatory sentencing regimes impact disproportionately on Aboriginal and Torres Strait Islander people, especially juveniles, and their families[1];

3. Under NT laws, juvenile offenders aged 15, 16 & 17 years are given an automatic minimum 28 day sentence of detention for their third property offence irrespective of the value of the goods involved;
   both juveniles and adults in WA get mandatory minimum 12 months gaol terms for third and subsequent home burglary offences;
   Adults get a minimum of 14 days for a first property offence in NT (unless there are exceptional circumstances), 90 days for a second offence and one year for subsequent offences, and mandatory imprisonment for second and subsequent violent offences and for all sexual offences;
   Police custody rates for Aboriginal people in the Northern Territory are 12 times those of non-Aboriginal people; in Western Australia the level of over-representation is 47 times[2];
   the level of over-representation in adult prisons is 6 in the NT and 20 in WA[3];
   and the level of over-representation in juvenile corrective facilities is 2.4 in the NT and 30 in WA[4].

4. Mandatory sentencing laws directly breach the findings and recommendations of the Royal Commission into Aboriginal Deaths in Custody[5] and the Human Rights and Equal Opportunity Commission's report into the Stolen Generations[6];

5. Sentencing regimes must be individualised, taking account of the circumstances of the defendant, and be proportional to the seriousness of the offence[7];

6. The UN Committee on the Elimination of Racial Discrimination and the UN Human Rights Committee have both condemned the mandatory sentencing regimes of the NT and WA, concluding that they breach key UN human rights treaties to which Australia is a signatory, and have urged the Commonwealth Government to act to remove these the breaches of basic human rights;

7. Despite the Commonwealth Attorney-General stating his opposition to mandatory sentencing[8], the Commonwealth Government has refused to apply its external affairs powers and legislate to invalidate the mandatory sentencing regimes of the NT and WA;

8. Funding diversionary programs does not resolve the fundamental injustices of mandatory sentencing, especially the mandatory sentencing of offenders to imprisonment. Schemes to divert certain offenders from the criminal justice system or from custodial into non-custodial corrections should replace, not supplement, mandatory sentencing regimes. Action needs to be taken, however, to ensure that such diversionary schemes do not result in net-widening, especially with respect to juvenile offenders[9].

9. For many offenders, there is only limited access to diversionary programs owing to their location and the circumstances under which they may be applied while many diversionary programs are culturally inappropriate to Indigenous offenders;

10. In the spirit of self-determination and self-management, governments must accept the fact that Indigenous communities and organisations are best suited to make their own decisions about diversionary schemes to ensure that their people have equal access to those schemes[10];

The Public Health Association of Australia resolves:

11. The Executive, Branches and SIGs of the PHAA will pursue the over-riding by the Federal government, of mandatory sentencing laws in the States and Territories.

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[4] Australian Institute of Criminology: http://www.aic.gov.au/stats/juvenilecorrective.html

[5] Royal Commission into Aboriginal Deaths in Custody (1991). Royal Commission into Aboriginal Deaths in Custody: National Report. Commissioner Elliott Johnston. Canberra, AGPS, Recommendations 87 & 92.

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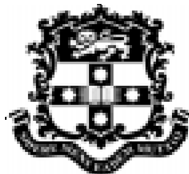

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Deadline for Applications: 30th November 2000

Draft policy proposals are printed here for discussion and comment. Please address all comments to the policy proposers and the Policy Convenor either directly or through the PHAA Secretariat.

Draft Policy on Neonatal Hearing Screening

The Public Health Association of Australia notes that:

1. Sensory-neural hearing impairment occurs in from 1.3 to 3.1 per 1000 live births.[1,2] It therefore occurs much more frequently than other congenital disorders, such as galactosaemia, phenylketonuria and hyperthyroidism (prevalence ranging from 2 to 25 per 100,000 births), for which screening is commonly performed in the newborn period.

2. Significant permanent hearing impairment, if undetected, will impede speech, language, and cognitive development,[3] and thus emotional and social well-being.

3. Current international research indicates that babies who are diagnosed before the age of six months as having a congenital sensory-neural hearing loss, and who receive appropriate and consistent early intervention, have significantly higher language levels than those children identified after the age of six months.[4,5]
   - Exposure to language in the first six months of life alters infants' phonetic perception. Consequently diagnosis of severe hearing impairment before the age of six months is critical in facilitating linguistic development.[6]
   - Of children aged 5 years with permanent hearing impairment, 90% are believed to have had the impairment in the neonatal period.[7]
   - The average age of diagnosis of hearing impairment in populations in which universal newborn hearing programs have been implemented ranges from 3 months to 6 months.[8,9]
   - The average age of diagnosis of hearing impairment in countries which screen only infants known to have pertinent risk factors is estimated at 24 months.[9]

4. Acceptable technology is now available, viz., measurement of otoacoustic emissions (OAE) and automated measurement of the auditory brainstem response (A-ABR), for the effective screening of hearing impairment in newborns during natural sleep. Such technology has been used in screening programs since 1990.[8,10]
   - Figures quoted for universal screening programs using OAE and A-ABR show very high sensitivity (proportion of infants with abnormal hearing who fail the screen) and a specificity (proportion of infants with normal hearing who pass the screen) above 90%.[8,11]
   - Currently manufactured A-ABR equipment has a reported false-positive rate as low as 2%.[12]

5. The cost for two-stage hearing screening per child ranges from $24 to $43 (depending on the technology used) and the cost of a screening program per diagnosis of significant permanent impairment ranges from $12,000 to $22,000, which includes costs of personnel and all equipment.[8,12,13] These costs compare well with the cost of the higher teacher-student ratio and greater life-long social support required for children whose hearing impairment is diagnosed late.

6. Australia already has good facilities (Australian Hearing) for the diagnosis of hearing impairment, and also for intervention and habilitation.

7. This issue satisfies the WHO preconditions[14] for the establishment of a screening program.

8. Although a randomised clinical trial to demonstrate the efficacy of neonatal hearing screening has not been conducted, The American National Institutes of Health Consensus Statement, 1993[15], the European Consensus Statement, 1998[16], the American Academy of Pediatrics, 1999[3], and the US Joint Committee on Infant Hearing[17] have all supported the introduction of screening. Neonatal hearing screening is mandatory in several states of the USA, and large scale, but not universal screening is underway in Western Australia.

The Public Health Association of Australia believes that:

1. Universal neonatal hearing screening is feasible, beneficial, and justified.

2. Principles of equity and

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efficiency demand the establishment of a program of universal neonatal hearing screening in Australia as soon as possible

3. Prompt diagnosis must be achieved for neonates suspected of being hearing impaired, and prompt interventions which are family-centred, interdisciplinary, and culturally competent must follow for those in whom the impairment is confirmed.[17]

4. To be successful a neonatal hearing screening program should endeavour to be:
   - universal, since selective screening based on high-risk criteria fails to detect at least half of all infants with congenital hearing loss,[9,12].
   - comprehensive in its approach , ie it should include training and supervision of personnel, quality assurance, the tracing of identified children, systems for reporting and monitoring outcomes, and counselling for parents.[3]

5. While existing programs in some countries have found that highest coverage is achieved by offering screening in hospital postnatal wards, with subsequent follow-up in the community,[6,16] decreasing length of stay in hospital for obstetric care, and inefficiencies of equipping small hospitals may make community-based screening programs preferable in some contexts.

6. Effective universal neonatal hearing screening will not replace the need for the vigilance and for continued surveillance to detect hearing impairment in children who do not receive neonatal screening or who develop permanent hearing loss at a later age.

The Public Health Association of Australia resolves that:

1. The Federal Government of Australia should facilitate the establishment of a national universal neonatal hearing screening in all States and Territories so that children with permanent hearing impairment can be referred to the national facility for diagnosis, habilitation and treatment (Australian Hearing) at the earliest possible age.

2. A Federal Forum should be established for developing and refining national strategies for achieving universal neonatal hearing screening in Australia.

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Draft policy proposals are printed here for discussion and comment. Please address all comments to the policy proposers and the Policy Convenor either directly or through the PHAA Secretariat.

Draft Policy on Skin Cancer Prevention

DRAFT

The Public Health Association of Australia notes that:

1. Skin cancer rates in Australia are the highest in the world and incidence rates are rising (AIHW 1998, Gies et al, 1998; Ring et al, 1989; Maclennan et al, 1992). The latest available data suggest that on an annual basis, at least 5 500 people will develop a melanoma and more than 270 000 will develop a non-melanocytic skin cancer (Staples et al. 1998, Commonwealth DHFS & AIHW 1998). This poses a major public health problem and represents high public health care costs. Recent estimates show that the direct cost to the health system is $300 million per annum making skin cancer the most expensive of all cancers to the health system. (Mathers 1998)

2. The IARC (1992) stated that there is sufficient evidence in humans for the carcinogenicity of solar radiation and that sun exposure is a well-established major risk factor for the development of melanoma.

3. Epidemiological studies agree that the susceptibility of the individual to contracting skin cancer is genetically based and is manifested by limitation of the ability to suntan, the development of multiple naevi at an early stage of life, susceptibility to sunburn and characteristics such as red hair, light-coloured eyes, fair skin and a tendency to freckle (Elwood, 1992; Kelly et al., 1994; Holly et al., 1987).

4. Research to date has been unable to quantify the amount of UVR, or the pattern of UVR exposure required to cause skin cancer. UVR exposure in the first 18 years of life has been associated with the development of skin cancer in later life (Rhodes et al., 1987; Kripke et al., 1994; Boyle et al., 1995). Children spend more time outdoors than adults (Hurwitz, 1988), and it has been estimated that more than half of lifetime exposure to sunlight occurs before the age of 18 years (UBC, 1998).

5. It has been suggested that infrequent or intermittent exposure of untanned skin to intense sunlight is hazardous (IARC, 1992). Case-control studies of adults with melanomas have indicated that an intermittent exposure, particularly to a dose of UVR that is sufficient to cause erythema (sunburn), is an important factor for developing skin cancer (MacKie, 1983; Elwood, 1988; Kok et al., 1990).

6. Researchers have reported that one or more severe sunburn episodes during youth, roughly doubles the lifetime risk of melanoma (Wernstock et al., 1980). In the past tanning has been portrayed as a preventative health strategy, for example when treating psoriasis through heliotherapy (Ness, 1999). Recent Australian surveys of adult sun protective attitudes and behaviours have identified that the desirability to tan has reduced slightly in the past decade, however, a significant proportion of people still hold a “pro-tan” attitude (Lowe et al., 1997, Lowe et al., 1999; ACCV, 1997). A research report that identified the environmental health risk perception within Australia (C’wealth of Aust, 2000) reported that sun tanning was the second highest ranked perceived risk in order of “high” and “moderate” risk.

7. A major function of ozone is the absorption of solar UVB, and this leads to a reduction of approximately 50% of solar UVB reaching the earth’s surface. The UNEP (2000) estimated that in the event of 10% decrease in stratospheric ozone, an additional 300 000 cases of non-melanocytic and 4 500 cases on melanoma could be expected worldwide on an annual basis.

8. In addition to individual actions prompted by health promotion campaigns that protect people from UVR, a comprehensive approach to skin cancer prevention requires policies to be in place to support these actions (UBC, 1998; WHO, 1996). Recreational environments would be designed to provide adequate shade and outdoor events would be scheduled

earlier or later in the day to avoid the midday sun.

9. Due to the optional nature of statutory notification, difficulties in defining cases, the expected large volume of notifications and difficulties in collecting data from General Practitioners, data on non-melanocytic skin cancers (NMSC) are not routinely collected (Queensland Health, 1998), resulting in the incidence being consistently underestimated.

The Public Health Association of Australia affirms that:

10. Reducing exposure to UVR would contribute to the reduction of the incidence of skin cancer.

11. Many risk factors are associated with the development of skin cancer and a holistic approach to prevention and early detection is required. Such approaches need to consider cultural, socioeconomic, environmental, political and legislative impacts.

12. There is a need to support high level research in skin cancer, especially in the area of alternate preventative messages and strategies (eg shade creation, new "cover-up" messages, sun safe fashions) and to effectively disseminate findings to all relevant players.

13. There is a need to create partnerships between all levels of government, non-government organisations, the community and academic institutions to ensure that a comprehensive approach to skin cancer prevention is developed and implemented.

14. There is a need to continue to develop comprehensive and cost-effective approaches to early detection of skin cancer.

15. State based registries provide essential data on the incidence and mortality of melanoma which is crucial to the planning and outcome evaluation of skin cancer control programs.

The Public Health Association of Australia recommends that:

16. All levels of government, non-government agencies, the community and academic institutions coordinate efforts to achieve a comprehensive national approach to prevent skin cancer.

17. Funding continue to be allocated as a matter of high public health priority to ensure comprehensive approaches to skin cancer prevention.

18. Partnerships be developed with private enterprise to consider strategies for the integration of sun safe designs and messages into fashion and shade industries.

19. National standard surveillance systems be established to monitor the prevalence of NMSC and adoption of sun protective behaviours and practices as a means to evaluate the outcome of skin cancer prevention and early detection programs.

20. Adequate funding be allocated to continue the research into the benefits of screening for melanoma in populations at high risk and the improvement of skills of general practitioners in the diagnosis and management of skin cancer.

DRAFT

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DRAFT

Labelling GM foods: continued from page 5

accidental contamination could occur. The example was given of a container ship of wheat carrying non-GM food picking up very small quantities of the previous load that happened to be a GM crop. A test could reveal very small amounts of GM wheat which would then be used to discredit the auditable trail, even though a process of due diligence had been followed.

When the Prime Minister suggested a threshold of 1% for all foods he was effectively advocating a testing regime. The practical difficulties and expense of a testing approach were identified as not only passing an extra burden on to the States and Territories but such a system would also be notoriously unreliable. Effective testing of GM foods has not yet reached the stage where it could be used reliably.

From very early in the debate on establishing a system Ministers generally favoured establishing a paper trail which could be easily audited and was based on "due diligence". This would allow a small baker in Canberra to label according to the information gained from the flour supplier. A big supplier of flour, however, would be expected to have paper work identifying the source of the wheat.

The ACT Government sought to persuade ANZFSC that the more open and transparent the system of labeling the more the general public would see that there was nothing to hide. All GM foods used in Australia will have to go through rigorous assessment before being approved as safe for consumption. Even so, with comprehensive labeling, each Australian and New Zealander will be able to make their own decision on whether they wish to consume these products.

Michael Moore MLA
ACT Minister for Health and Community Care

Staff Profile

As you all know, the Public Health Association of Australia is a national body with it's secretariat located in Canberra. We therefore thought we could introduce you to our secretariat through a series of staff profiles.

This month *intouch* interviews Annette Mellick our conference organiser, to see how she fits into the Association.

Annette started work with the PHAA in September 1994 as finance assistant and at that time was known as Annette Markezic. In 1996 her role expanded to include conference assistant to Margarete Conroy. Upon Margarete's departure in 1998, Annette took on her new role of Conference Organiser along with her new married name, Mellick.

Now with six conferences under her belt, Annette finds each one challenging but very rewarding and still says she will quit the day before the conference but always manages to see them through successfully.

Although organising the conferences occupies much of her time, Annette still manages to utilise her book keeping and new website skills.

For enjoyment Annette enjoys tennis, running and yoga and on weekends enjoys spending time on her rural bush property near Bega. Lucky her!!!

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24th October, 6-8pm at Deakin, Toorak campus, McInerney Lecture Theatre, 336 Glenferrie Road, Malvern, Victoria **OR visit our web page** at http://www.publichealth.vic.edu.au for information and an application form.

Application forms are also available from:
Deakin University (03) 9251 7777 La Trobe University (03) 9479 5724,
Monash University (03) 9903 0563 University of Melbourne (03) 8344 8961

APPLICATIONS CLOSE NOVEMBER 20TH 2000
The MPH is in two parts:
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Environmental Influences on Health *(Monash)*
Part 2 Specialist streams include:

Deakin - Health Promotion; Public Health Nutrition; Social Determinants of Health
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The University of Melbourne - Epidemiology & Biostatistics; Health Program Evaluation & Health Economics; Women's Health
Monash University - Clinical Epidemiology; Environmental Health; Health Economics; Health Services Management; International Health; Occupational Health; Preventive Medicine; Research.

World Federation of Public Health Association Issues call to Action

The World Federation of Public Health Association meets on a triennial basis and its millennial meeting was held on Sept 2-6, 2000, in Beijing. A Leadership Forum was held on Sept 1 to draft a call for action for consideration by the congress and I was privileged to have been part of that process.

The basis for the Forum discussion was the result of questions that had been put to a number of leaders in global health. In what became known as the "3+3+3" formulation, the respondents and Forum participants commented on:

- What are the 3 major achievements since Alma Ata?
- What are the 3 missed opportunities in that time?
- What are the 3 "must-do's" for the next 20 years?

The Forum brought together some 60 people from 24 countries (covering all continents), UN agencies and such major donors as the Ford Foundation.

The major retrospective themes and key issues identified by respondents and participants in relation to the above formulation were:
(refer to table below)

There was less consensus about the future. HIV, clean water, malnutrition, healthy aging, early childhood development, mental health, violence, and tobacco control were amongst the list of health issues nominated as priorities. The wish-list for political action and resources was long. Understanding and acting on the negative sides of globalisation, inequities, poverty, and other vulnerabilities was, however, a consistent theme. Similarly, there was commonality about the need to know what we're doing with health reforms and to integrate health care and public health more closely.

The Call for Action identified the key challenges as: maintain and strengthen a focus on fairness and elimination of inequities; strengthen collaboration across all sectors and at all levels of society; and take effectie action to ensure globalisation contributes to attainment of health and solidarity. It called for sustainable health systems, leadership development, developing essential public health functions, collaboration with communities, strong and responsible governance, and harnessing the potential of information and communication technology.

Dr George Alleyne, Director of PAHO (Pan American Health Organisation), called for cultural transformation within the public health movement – to celebrate achievements rather than constantly complain; to create and support political will rather than remain factionalised and shift blame; to adopt a systems approach rather than dichotomise and be reductionist; to partner with other sectors (particularly economists) rather than be mendicant and moralistic; to focus on operationalising rather than be rhetorical.

I wonder if the public health movement in Australia were canvassed about 3+3+3, what would be our agenda?

Vivian Lin, La Trobe University

Topic Area	Achievements	Failings
Illness and well - being	Vaccine-preventable diseases; childhood mortality	Misuse of antibiotics; HIV/AIDS
Knowledge	Biomedical sciences	Lack of coherent vision for public health
Political	-	Quick fix and vertical programming; insufficient resources for prevention; Health for All abandoned
Values	Equity; community involvement; ethics	Lack of partnerships and collaboration; community manipulation (rather than participation); privatisation
Health systems	Primary health care strategies; diversity of health providers; growing importance of prevention	Poor collaboration with community, private, and other sectors; unbalanced resource allocation; unsustainable vertical programs
Reproductive Health	Reduction of fertility; link reproductive health with development	Population growth not stabilised; lack of gender dimension to health

Curtin

UNIVERSITY OF TECHNOLOGY

Health promotion studies by distance education

Australia's No.1 university of science and technology (Asiaweek 1998, 1999, 2000) invites applications for the Postgraduate Diploma in Health Promotion. The diploma can be studied internally or by distance education over a period of one to two years, or longer by arrangement.

The course consists of four core units:

- Health Promotion Planning
- Health Promotion and the Media
- Health Promotion Strategies and Methods
- Evaluation of Health Promotion

A range of optional units may be selected according to individual study needs and interests: school health promotion; physical activity and health; injury control; environmental health; workplace health promotion; public health nutrition; nutrition promotion; organisational behaviour; principles of health behaviour; health promotion professional practice. Each unit is also available on a continuing education basis for non-degree credit.

Applications are invited from health, welfare, education and other community professionals. The course is particularly appropriate for professionals working in rural and isolated regions. Applicants must have successfully completed a recognised degree course or equivalent in a relevant area of study. No on campus attendance is required, however the course is also available by internal mode.

Further information and application forms are available from the Department of Health Promotion, telephone (08) 9266 7365, facsimile (08) 9266 2958 or email enquiry@health.curtin.edu.au

32nd PHAA Annual Conference
26-29 November 2000, Canberra
Keynote Speaker: Dr Milton Lewis

Dr Lewis is a NHMRC Senior Research Fellow, Public Health and Community Medicine at the University of Sydney and his presentation is titled, *Ode to a Universal Health Care System.*

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What's On

12 - 18 November 2000
Everybody People Hepatitus C Affects Us All Awareness Week. **November 12th**, Awareness Week Launch, Treasury Gardens, from 1-3pm (look for the white marquee). **November 17th**, SecondCommunity-based hepatitus C conference. *Hepatitus C: Everyday People Conference (working for change).* Carlton Crest Hotel, 65 Queens Rd, Melbourne. Contact Loretta or Michelle at the Hepatitus C Council for registration forms and fees on 03 9639 3200.

16 November 2000
Family Planning Victoria is running three seminars in one day on Adolescent health, titled *FPV Unzipped... Sexuality, Good Health & All the Rest*, at the Dallas Brooks Centre, East Melbourne. Topics include adolescent sexuality, mental health and communication, health promotion, contraception and STI's and intellectual disability. Contact Csilla on Ph: 03 92570133, Fax: 03 92570111 or email: ckosa@fpv.org.au

Short Courses
Health and Social Impact Assessment: Techniques for Managing Change. Deakin Uni, Melbourne Campus - 2pm Wed. Nov. 22 & 4pm Sat. Nov. 25, Cost $650. School of Health Sciences, Deakin Uni. is hostinga short course in HIA & SIA for personnel working in health management & policy. The course will cover HIA as a tool for environmental health management & in the health policy context as well as impact assessment methodologies & techniques. Details contact Sharon Melder on 03 9244 6091 or email sharonm@deakin.edu.au

23 - 24 November 2000
Biostatistics Workshop: *Analysis of Longitudinal/Repeated Measures Data in Health Studies.* Greenmount Beach Resort, Coolangatta, Gold Coast. Guest speaker: Geert Molenberghs, Director of CenStat, Centre for Statistics, Limburgs Universitaire, Belgium. Further information contact: Pauline Fraley 07-3365-55377, Email:p.fraley@mailbox.uq.edu.au web site: http://ww.sph.uq.edu.au

26 -29 November 2000
32nd PHAA Annual Conference *Public Health Futures*, National Convention Centre, ACT. For further information email: conference@phaa.net.au

Various Dates
National Short Courses in Environmental Health, Adelaide. Course 1 *Risk Communication in Practice* 27-29 Nov; Course 2 *Principles of Risk Assessment & Management* 30 Nov-6 Dec; Course 3 *Risk Assessment & Management for Water* 6-8 Dec; Course 3A *Politics, ethics, economics & law in relation to Environmental Health* 6-8 Dec 2000. Further details contact nancy.cromar@flinders.edu.au or http://som.flinders.edu.au/FUSA/EnvHealth/EH_Home.html

6 - 7 April 2001
It runs in the family VI: Twins and Families in Biomedical and Behavioural Research Conference, run by the Australian Twin Registry to be held at the WEHI, Melbourne. All researchers welcome. Enquiries: m.lenaghan@unimelb.edu.au

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