#Prevention2018 - a spotlight on preventive health

The PHAA will soon host its inaugural Public Health Prevention Conference in Sydney on 2-4 May, a major public health conference that is the first of its kind in Australia focusing solely on the leading public health issue of preventive health.

Prevention has come to dominate contemporary public health discussions as the evidence of its effectiveness continues to stream in from research all over the globe. From nutrition, alcohol, and tobacco policy to urban planning and mental health, it is clear to public health experts across multiple fields that past treatment-oriented approaches to health policy have failed us, and preventive health is now essential to curb the spiralling rates of obesity, addiction, and non-communicable disease.

In recognition of this spiralling, the theme of Prevention 2018 is ‘We can do more and we must’. As is the case with the other pressing health issue of our time, climate change and planetary health, we can no longer afford to ignore the effects of preventable disease.

For the first time in a long time, our younger generations are facing the prospect of shorter lifespans than their parents. The health system is buckling under the weight of preventable diseases as treatment becomes necessary for huge segments of the population. Those who are on the margins of society are most likely to miss out on healthcare services, and are more likely to suffer from the non-communicable diseases which would cause them to seek treatment.

More positively, it appears that many of our policymakers are starting to recognise that we need to embark on a new era in health where the goal is not the successful treatment of illness, but rather stopping it from occurring at all where possible. This approach is clearly of greatest benefit, both to the individual and to government.

Changing our health policies to reflect this new era is not an overnight process, as public health advocates are acutely aware. Instead, it takes considerable time and often occurs in a series of steps rather than through sweeping changes. The current political environments of western countries which are geared more toward protecting unhealthy industries than the public’s health continues to be a major hurdle, but one which is not insurmountable. We have seen early successes with tobacco control and we could see more success through similar control measures for unhealthy foods and alcohol. If we can also implement more harm-reduction strategies for drug use, engage in better urban planning, and tackle mental health from an early age, we will be well and truly ahead of the game.

We look forward to discussing these issues and more at the Public Health Prevention Conference 2018. We can only hope that in future we will be able to look back saying, ‘we knew we could do more, and so we did’.

Michael Moore AM, CEO of the PHAA. Michael will be opening #Prevention2018.
Prevention has been the Cinderella for too long. The ugly sisters of apathy and commercial interests continue to ensure that public health gets minimal resources and maximum opposition to evidence-based action that could bring enormous benefits in terms not only of preventing disease and prolonging life, but also addressing the health and other gaps that exist between disadvantaged populations and the rest of our privileged and affluent community.

We know so much about the measures that work, from good and well enforced legislation to strong public education and a wide range of supports in the community. There is no shortage of expert reports, evidence and recommendations from health authorities as to the action that is needed.

Despite all the obstacles, people at all levels in the PHAA and public health have played crucial roles in ensuring that we have strong prevention programs. As a result, Australia is rightly seen as a world leader across many areas of public health. But the frustrations remain. The public health scandals remain, from the massive and preventable toll of death and disease arising from tobacco, alcohol and junk food to the life expectancy gaps experienced by Aboriginal communities and people with mental health problems that shame us all – and so many more.

Advocating for public health action is not easy. Even apart from lack of resources, there are all too few who are willing to play active roles; many who should know better stay silent – or even resist effective prevention; and there is fierce opposition from commercial interests and their allies.

So public health has done well – but, in the words of the conference theme, we can do better and we must. Apathy and commercial opposition are not new – they have throughout been the key obstacles to evidence-based prevention. There are roles for all in public health to contribute, from the researchers who provide the evidence to health and related professionals to the principled decision-makers who can make decisions in the long-term interests of the community. And there is inspiration to be found in the history of public health leaders, practitioners and organisations who persisted, challenged the naysayers, pressed for action, exposed the opposition, and ensured that we are, as we should remain, one of the longest-lived populations in the world.

The Prevention Conference 2018 provides an important opportunity to consider the challenges, identify the action that is still needed – and ensure that we work together for the benefit of the entire community.

Professor Daube will be a keynote speaker at #Prevention2018.

Professor Mike Daube AO, Professor of Health Policy, Curtin University, Perth
Immunisation is not just for the young

Professor Raina MacIntyre, Head, Biosecurity Program, Kirby Institute, University of New South Wales & Director, NHMRC Centre for Research Excellence in Epidemic Response.

Australia and many other countries are facing an ageing population. Adults comprise over 80% of the population, with 15% being over 65 years. Many vaccine preventable diseases have a peak of incidence at the extremes of age, with the elderly being susceptible to more serious disease due immunosenescence, a predictable, age-dependent decline in immune function. This also makes vaccines less immunogenic in older people, who are then doubly disadvantaged by being at increased risk of infection, and less protected by vaccines. Research shows that health providers have less confidence in vaccines for the elderly compared to children, and are more likely to miss opportunities for vaccination. Yet the public health benefit of vaccines is a function of both efficacy and burden of disease. A vaccine that offers 50% or even less protection against a disease with high prevalence will have substantial public health impact at a population level. Many accepted public health interventions such as statins for preventing heart disease, have efficacy of less than 30%, but are accepted globally as worthy interventions because of the large burden of disease which they prevent. Further, even if a vaccine does not prevent infection, it can prevent hospitalisation or death. Vaccines in adults need to be viewed through this lens, rather than being compared to childhood vaccines.

We still see vulnerable older people who have not been vaccinated – especially those in aged care facilities, those over 80 years old, and those with dementia. We still hear people saying “pneumonia is the old man’s friend” (but I have never heard anyone saying the same of a heart attack). Ageism and value judgements in health care must be addressed, as must the ethics of withholding vaccination from frail elderly people. Infectious diseases are transmissible to others, and cause individual suffering. No eligible person for whom vaccines are recommended should be denied it.

Whilst the number of vaccines for adults has not risen as rapidly as those for infants and children, there are more diseases that can now be prevented for adults – influenza, pneumococcal disease and shingles are all on the National Immunisation Program. A newer shingles vaccine has shattered the myth that older people cannot respond as well to vaccines by showing very high immunogenicity. Novel influenza vaccines using high dose antigen and adjuvants respectively have also shown an improvement of about 25% in immune response in the elderly compared to standard influenza vaccines. This is great news - what we need more research to improve immune responses to vaccines in the elderly. There is room for so much more, against a landscape of an ageing population whose health care needs are a major contributor to acute care. We have had other gains in recent years, including a whole of life immunisation register, which will make keeping track of adult vaccination easier. Immunisation is low hanging fruit and can prevent serious infections. The 16th PHAA Immunisation Conference has the theme of “Immunisation for all: gains, gaps and goals” and will address key issues across the lifespan, including in adults and the elderly. It is a welcome reminder that immunisation is a whole-of-life concern.

Professor MacIntyre will be a keynote speaker at the PHAA National Immunisation Conference 2018.

Raina MacIntyre (MBBS Hons 1, M App Epid, PhD, FRACP, FAFPHM) is Head, School of Public Health and Community Medicine, UNSW and Professor of Infectious Diseases Epidemiology. She runs a highly strategic research program spanning epidemiology, vaccinology, mathematical modelling, PPE and clinical trials in infectious diseases. Her work falls under 4 areas: Personal protective equipment, Vaccinology, Biosecurity and Epidemic response to emerging infectious diseases. Her research is underpinned by extensive field epidemic investigation experience. She is a graduate of the only Australian Field Epidemiology Training program and has extensive experience in shoe-leather epidemiology of investigating infectious diseases outbreaks including influenza, meningococcal disease, clostridium perfringens, hepatitis A, legionella, mycoplasma, pertussis and gastroenteritis to name a few. Her in-depth understanding of the science of outbreak investigation draws from her practical field experience, combined with her formal training in medicine, public health and epidemiology (with both a Masters and PhD in Epidemiology). She has dual medical specialisations in both internal medicine and public health. Her passion for field epidemiology led her to co-found the ARM network for Australian outbreak response, Australia’s first emergency response network for epidemics, which has already deployed members to many international outbreaks. She leads a NHMRC CRE in Integrated Systems for Epidemic Response. She has over 280 per reviewed publications in medical journals, has regularly won competitive grants and sits on national and international expert committees in infectious diseases. She has received many awards including the Sir Henry Wellcome Medal and Prize from the Association of Military Surgeons of the US, The Frank Fenner Award for Research in Infectious Diseases, and the PHAA National Immunisation Award.
The 16th National Immunisation Conference is now less than 2 months away, to be held at the Adelaide Convention Centre from 5th-7th June 2018. It will be my second occasion attending this conference, and the first time that I am able to share some findings from my PhD research-in-progress with a large audience.

I’m really excited to share my research at this forum. With the Paediatric Active Enhanced Disease Surveillance (PAEDS) network, I am studying the facilitators and barriers of paediatric influenza vaccination of children who have had severe influenza. In 2017, we conducted in-depth interviews with parents whose children were hospitalised for influenza to understand the multi-faceted influences on parent’s knowledge and behaviours regarding influenza vaccination. We also considered the impact the disease experience had on disease perception and future influenza vaccination intentions. I will be sharing insights from these interviews in the Advocacy and Social Science session on the Wednesday afternoon of the conference.

This conference is a fantastic learning opportunity. Following the 15th National Immunisation Conference in 2016, I was able to incorporate so much of what I learnt into how I’ve conducted my research and work since, and so am looking forward to hearing about the latest national and international evidence regarding the ‘Gains, Gaps, and Goals’ of immunisation. Hearing from Professor Gagandeep Kang from the Christian Medical College in India on ‘Closing the gap: Getting vaccines to children who need them the most’ I think will be a particular highlight.

Additionally, Catherine Hughes, the director and co-founder of The Immunisation Foundation of Australia will be sharing a keynote session on ‘Effective involvement of the community in immunisation research’. Practical table top sessions run by COSSI members will be held during the workshop to facilitate problem solving and knowledge exchange amongst attendees. Topics such as ‘social media and immunisation advocacy,’ ‘how to integrate research into practice contexts’ and ‘researcher capacity building’ will be covered. You can find more information about the workshop here.

COSSI is a committee-led network that currently has over 75 members nation-wide. It aims to inform Australian immunisation policy and practice with high quality evidence from the social sciences, by supporting capacity building in research and evaluation; fostering collaborations to leverage expertise and create broader impact; and to enable more effective translation of research into practice and programs. Members are involved in research and evaluation, policy-making, and delivery of the national immunisation program through management and clinical practice. Many COSSI members are presenting their work at the National Immunisation Conference, including during the ‘Who is still missing out on getting immunised and why?’ plenary, as well as the maternal vaccination, vaccine coverage, meningococcal, advocacy and social science, vaccine safety, and the table top sessions.

Australian researchers and those working in public health policy and practice generate an incredible amount of new knowledge in relation to vaccine behaviour, coverage, efficacy and safety. Attending this conference enables us to both share our work and learn about the latest evidence. It’s also a great opportunity to catch up in person with “long distance” colleagues, meet up with fellow PhD students for informal discussions, and of course to meet new people and potential collaborators. Hope I’ll see you there!

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Do you know about My Health Record?

By the end of 2018, every Australian will get a My Health Record, unless they choose not to have one. Did you know, 1 in 5 Australians already have a My Health Record?

So what is a My Health Record?

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Real and ongoing benefits from My Health Record will be felt over time as more and more health information is added to a person’s My Health Record.

Australian Digital Health Agency CEO Tim Kelsey said the implementation of My Health Record nationally this year will deliver a system that provides universal functionality, clear and concise content and, critically, a safe and secure clinical health service for all Australians.

“My Health Record can reduce the risk of medical misadventures by providing treating clinicians with up-to-date information,” Mr Kelsey said.

“The benefits of digital health for patients are significant and compelling. Digital health can improve and help save lives.”

If you want a My Health Record, you don’t need to do anything - it will be created for you by the end of 2018. However if you don’t want one, there will be a three-month “window” this year when you can choose to opt-out.

For further information on My Health Record, including how to register for one now, visit https://myhealthrecord.gov.au

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16th National Immunisation Conference
Immunisation for all: Gains, gaps and goals
Tuesday 5 to Thursday 7 June 2018
Adelaide Convention Centre, Adelaide SA

#NIC2018 | www.nic2018.com
This is a complex question, which needs some unpacking. It is an open question on one level, assuming no answer. Or it suggests several different answers from different perspectives. And it carries some subsidiary questions: who is non-Indigenous? what is a relationship with Country? what is Country? whose Country?

More deeply though, why ask the question?

A couple of lines of thought converge on this topic. Human ecology looks at the human species as but one of many different species interacting with each other in the ecosystem. In this sense country might be the geographical location in which one lives. From human ecology comes the concept of biosensitivity, which is a philosophical approach advocating humans live in a respectful relationship with nature, where nature is the natural biophysical systems of the planet and other species. In this sense country extends to the planet. But in Australia, country has another cultural meaning, that of the Aboriginal and Torres Strait Islander First Nation peoples.

Aboriginal and Torres Strait Islander Peoples’ understanding of and connections with Country extend tens of thousands of years, back to the Dreamtime itself. People belonged to and cared for Country, which in turn was central to the maintenance of ecological, social, economic, psychological and spiritual balance.

Nineteenth century Europeans brought an agrarian focused concept of land (rather than country) to Australia, with a tendency to conceive of the material world primarily as a set of commodities to be exploited and used for gain. That didn’t preclude European settlers forming a relationship with the land that they farmed, or mined, or forested. But that is a different relationship, one to land, not Country.

While acknowledging other immigrant settler groups may have other views of land, this European view predominates in Australia at present. The different Indigenous and European conceptions of Country and land are a primary source of misunderstandings and conflict. Non-Indigenous appropriation of the land challenged and continues to challenge Aboriginal and Torres Strait Islander peoples’ relationships with Country.

Kerry Arabena has extended the notion of Country to include the universe and the planet. As such all humans and other species are citizens of the planet and the universe. All beings have rights and responsibilities that come from that citizen relationship. Linking to the Christian idea of stewardship, these views put responsibility to look after and respect land/Country more broadly than the Indigenous conception usually carries.

Contradicting these viewpoints, our dominant Western economic, exploitable assets viewpoint, has brought nature and society to the brink of ecological disaster. This crisis has led me and others to wonder if we could help to halt this process and return to a more biosensitive and ecologically sustainable pathway if we were to develop a different way for non-Indigenous people to regard and relate to the planet. To some extent the emerging Planetary Health movement proposes a similar response.

These intertwining themes give rise then to the original question above: should non-Indigenous people have a relationship with Country? My response is yes, we should. In which case a further set of questions emerge:

- How would we rebuild a relationship that our ancestors probably had?
- What form might non-Indigenous relationships with Country take, and how would non-Indigenous spiritual and intellectual traditions be likely to shape them?
- Who should or could authorise such relationships?
- Could Indigenous and non-Indigenous relationships with Country work together to improve ecological sustainability in Australia?
- What are the global environmental implications of Indigenous and non-Indigenous relationships with Country?

These and other questions are being asked at an event co-hosted by the PHAA Ecology and Environment SIG and the PHAA ACT Branch to be held in the evening of June 13th in Canberra. More information will be forthcoming closer to that time.
Fracking is a controversial mining process, involving pumping of large volumes of water and chemicals at high pressure into underground oil or gas deposits. This stimulate oil or gas release from surrounding rock. An inquiry into fracking in NT was promised with the election of the ALP government in August 2016, to determine whether and how fracking could be regulated to achieve acceptable levels of risk. A moratorium on fracking was lifted on 17 April while the government reviews the Inquiry’s Final Report, released 27th March 2018.

Inquiry process

The NT Fracking Inquiry’s website provides links to reports of previous Australian inquiries into fracking, including several previous NT inquiries. These reports suggest that when inquiries lead to bans on fracking (as in Victoria and SE South Australia), the issue is resolved. Inquiries that lead to recommendations that attempt to regulate fracking are followed by further inquiries. This has happened in WA, and with two previous NT Inquiries.

The current NT Inquiry has demonstrated commitment to consultation and community participation, interdisciplinary science and intercultural collaboration. Submissions have been accepted in every form offered: mail and email, phone, video or live presentation, in Aboriginal languages, and anonymously. All the submissions are accessible online, except if the author has actively denied this. Consultations have been held in 17 centres, including communities of as few as 300 people, both during and outside of standard business hours. The current inquiry has sent 30 community updates, and Draft Final Report is available online in English and 10 Aboriginal languages, in recognition that Aboriginal people are likely to bear disproportionate impact of fracking.

Health issues in the Inquiry Final Report

The Inquiry’s Final Report describes public health impacts of fracking: threats to water security, groundwater contamination, airborne pollutants, increased road traffic, socio-economic changes, loss of social cohesion, and threats to mental health and wellbeing. Discussion concludes that fracking may contribute to respiratory, neurological, cardiovascular and skin disease, birth defects, psychological and gastrointestinal syndromes, and cancer, but risks can be minimised by offsetting the fracking process and close monitoring of health.

Climate change

A major revision in the Final Report is the recognition of climate change as a major health risk of fracking. To minimise the risk of climate change from fracking, the Inquiry recommends that all greenhouse gas emissions associated with fracking are completely offset. This includes methane emissions both intentional and unintentional throughout the exploration, production and post-production phases, and carbon dioxide from gas combustion. To enable this to be done accurately, methane levels around the fracking site must be monitored for six months prior to any fracking, or 12 months where fracking has previously occurred.

This recommendation shows that the Fracking Inquiry has recognised the threat that climate change poses to health, and that even most known fossil fuel resources must not be exploited for humankind to avoid dangerous climate change. To fully mitigate increased greenhouse gas emissions by offsetting the entire greenhouse gas load of fracking could amount to a ban on fracking. The gas industry has responded to this recommendation by noting that there is no effective national policy on greenhouse gas mitigation, so therefore NT cannot implement such a policy. Such a nihilistic response demonstrates how challenging this recommendation would be for the gas industry.
Conclusion

The Scientific Inquiry into Hydraulic Fracturing in the Northern Territory was a major undertaking for NT as a relatively small jurisdiction, but a demonstration of the huge potential for harm or good from this industry. The Final Report contains 135 recommendations, overridden by the recommendation that there can be no partial implementation, and the entire suite of recommendations must be implemented. The costly inquiry over 15 months, including separate consultations on economic and social impacts of fracking, was a major investment by the NT government. Failure to implement its report would be a gross waste of resources.

The NT Fracking Inquiry has responded to the immense concerns about fracking as a contributor to dangerous risks, particularly climate change, and the huge concerns of people of NT and throughout Australia about these risks. The NT Government announced on 17 April that the moratorium on fracking would be lifted. However, they also committed to implementing all 135 recommendations in the scientific report. How those two announcements will work together remains to be seen. Good governance, science and democracy now require the NT government to implement solid recommendations that would make fracking uneconomic because of the cost of mitigating the risks. It is time for the NT government, businesses and communities to build alternative economies that do not have the potential for dangerous impact on human health and well-being.
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Benefits of Individual Membership

- Online access to the Australian and New Zealand Journal of Public Health, Australia’s premier public health publication, with reduced rates for author publication charges.
- The PHAA e-newsletter intouch and other electronic mailings and updates
- The right to vote and hold office in PHAA
- Opportunity to join up to 17 national Special Interest Groups (SIGs) (fees apply)
- Access to State/Territory branch events and professional development opportunities
- Reduction in fees to the PHAA annual conference and other various special interest conferences
- Access to PHAA forums and input into developing policies
- Access to emailed list of public health job vacancies
- Networking and mentoring through access to senior public health professionals at branch meetings, as well as through SIGs and at conferences and seminars
- Eligibility to apply for various scholarships and awards
- The ability to participate in, benefit from, or suggest and promote public health advocacy programs

Additional Benefits of Organisational Membership*

Up to two staff members may attend PHAA Annual Conference and special interest conferences, workshops and seminars at the reduced member registration rate

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