A life - and an election - that was

As Australia’s pre-eminent public health advocacy body, we threw a lot of ourselves into the federal election campaign, responding to announcements as they were made and generating media and an election scorecard to advocate on PHAA's immediate policy priorities.

Despite a strong expectation of a Labor win at the May poll, more cautious pundits (including PHAA!) also correctly predicted that the results would be unpredictable, with a “lumpy” picture across Australia as seats ended up changing hands in both directions.

When Shorten’s mentor, charismatic former prime minister Bob Hawke (pictured), passed away two days prior to the election both sides of politics curiously embraced Hawke as visionary (anything but a small target) and, further, both leaders pitched themselves as characters with a lot in common with the reforming ex-union boss.

The electorate seemed to mourn Mr Hawke's passing because he embodied authenticity, compassion and a global outlook. PHAA celebrated him on Twitter as a complex man who fought racism, championed national parks and Medicare.

Labor, of course, lost the May 18 poll and Mr Shorten stepped down as Opposition leader, brow-beaten.

We rebooted with our Public Health Prevention Conference held in Melbourne in June. Ahead of it, we reminded Health Minister Greg Hunt that he had acknowledged that health prevention had not been a major focus of his time in the role and that he had vowed in April to change that should he regain government.

To his credit, Mr Hunt used our Public Health Prevention Conference to announce plans for a National Preventive Health Strategy. We anticipate being part of a roundtable to advance it. All the while, we will present good and bold ideas for improving public health.
Climate health still in need of a federal map

After a bruising federal election, public health advocates championing an urgent response to the climate emergency are having to regroup.

PHAA member and Executive Director of the Climate and Health Alliance (CAHA), Fiona Armstrong, asks, ‘Where to from here for policy and advocacy on climate and health?’

As someone who very rarely gets ill, it was telling that I woke with a vicious flu the day after the May 18 federal election. A month later, it’s still hanging around, rather like the sense of unease that accompanied the surprising result.

Engaging in a period of reflection and review has been somewhat therapeutic, appreciating many others also anticipated a different outcome and share my lament.

It’s not all hopeless. There have been some gains made in the form of key Independents elected to the federal parliament on a strong climate action agenda and while I would have preferred a different overall result, climate change was prominent in public debates that preceded the only poll that really matters.

Having said that, the Coalition’s re-election is a serious setback for national action on climate change and health in Australia, especially given the alternative government (the ALP) had agreed (along with The Greens) to implement a comprehensive, national strategy on climate change and health.

So where to from here?

Fortunately for all of us, some of the states and territories are beginning to wake up to the climate-health emergency and there is an increasing appetite to develop policy frameworks to respond. Victoria might reasonably be expected to lead in this space, given their Climate Change Act (2017), the sectoral obligations this will imply, and its explicit recognition of “climate change as one of the biggest threats to the future of the State”.

Work is ongoing in Victoria to develop a climate adaptation plan for the health sector in the state, and the Victorian Department of Health and Human Services (DHHS) has released and is implementing an environmental sustainability strategy for the health sector, part of which involves DHHS joining the Green and Healthy Hospitals (GGHH) network that CAHA coordinates.

However, Queensland was first out of the blocks on climate-health policy, in a position inconsistent with its approval of the Adani mine. Last year, the Labor government of Annastacia Palaszczuk developed the first state-wide climate change and health strategy (Disclaimer: CAHA was commissioned, along with NCCARF, to develop the Human Health and Wellbeing Climate Adaptation Plan for Queensland by the Queensland Department of Science and Environment). Further work is underway to develop a climate risk assessment tool for health services for the state.

Western Australia is also showing signs of long term and strong leadership, with its Sustainable Health Review, also developed in 2018, which asserts: “the WA health system must also prepare itself to manage the health effects of climate change” and “the WA health system must work in alignment with... targets already agreed internationally and nationally to address climate change”.

Ahead of the release of the report, the WA Health Minister, Roger Cook, convened a Climate Change and Sustainable Health Forum to “discuss the next steps and recommend action for climate change and health policy in Western Australia”. A Health and Climate Change Community of Practice has been established, and Minister Cook has since announced an inquiry into the impact of climate change on health in WA, the findings of which will form “the basis of a new, co-ordinated health and climate change framework for WA”.

Tasmania has commenced a process to “identify additional policies and programs to respond to the potential health impacts of climate change” in that state, after the importance of “framing climate change through a health lens in the Tasmanian context” was identified. A Climate and Health Roundtable in Tasmania in April 2019 drew heavily on the work led by the health sector through the Climate and Health Alliance, with discussions at the Roundtable centred around the themes of the seven Areas of Policy Action identified in the Framework for the National Strategy on Climate, Health and Wellbeing for Australia.

The ACT is unquestionably a leader on climate change among the states and territories with its strong emissions reduction targets and rapid transition to renewable energy, however there is more to do to develop an explicit focus on health in their climate change response. CAHA has been meeting with the ACT Minister for Climate Change and Minister for Health and we hope to support their efforts in this direction.
While NSW has a Climate Change Policy Framework, a framework specifically addressing the health effects of climate change in the state, is yet to be developed. A recent paper by PHAA members, Lucie Rychetnik, Peter Sainsbury and Greg Stewart highlights the vulnerability of NSW Local Health Districts to climate change, but reveals there is currently no “government-endorsed health sector vulnerability assessment process or adaptation advice for the LHDs”.

And it remains the case that the Australian Federal government is yet to respond to health risks of climate change. Indeed, in his most recent correspondence with CAHA, Minister Hunt referred to the “potential impact of climate change on health”, suggesting an alarming lack of awareness of the decades of scientific evidence (much of it funded by the Australian government) documenting the very real and sometimes catastrophic health consequences of climate change. Given the Director of the World Health Organization refers to climate change as a health emergency, Minister Hunt appears to be out of step with the world’s leading authorities on this issue.

So CAHA will continue our work with the states and territories to help guide climate change and health policy, and in so doing, help to steward a nationally consistent approach. We will also continue to work with willing and informed members of the federal parliament.

I urge PHAA members to stay informed on this topic, and visit www.caha.org.au for more information and resources – or sign up to our campaign www.ourclimate-ourhealth.org.au to support advocacy for action on climate change – to protect and promote health for all.
Friends, for three wonderful days, we have learned, discussed and experienced a richness about prevention, from speakers across sectors, that has been exciting and impressive. Allow me to revisit what has stuck with me:

On Day One, speaking to the theme of Systems Thinking, Lucie Rychetnik from The Australian Prevention Partnership Centre said that while we struggle with silos of prevention, we are very good at creating them! We do know a lot about what works but it is not being implemented because of political reluctance, powerful opposition and public inertia. I was heartened today when Mark Chenery from Common Cause Australia, in his paper, told us that those who oppose public health initiatives are only about 16% of the population. Lucie also reminded us about The Lancet Commission report on using triple-duty actions to address multiple public health issues, which is the future for public health initiatives.

Corinne Graffunder, the Director of the US Office on Smoking and Health stressed the three essential Ps for Prevention - “Principle, Power and People” - and argued that comprehensive progress requires all of them to be addresses. She reminded us to ask two questions - what health impact do we want in 5 years, and what things matter the most - and to support our answers with defensible criteria. Champions for the Public’s Health are, she said, as important as partnerships. But it’s not just champions from non-traditional sectors we need – we need to work harder on getting buy-in from the people we want to see have better health outcomes. As we heard from Mark Chenery, sometimes our well-meaning slogans are having the opposite effect as he deftly illustrated how the slogan about healthy choices being the easy choice is missing the mark with our population.

Corinne emphasised the importance of public health professionals understanding what new skills are needed for systems thinking in prevention, including about how to draw on the power we need to curate the changes we want to see. Curation she said, is about more than translation. Curation = finding, grouping, organising and sharing the best and most relevant content to help break down the silos in prevention globally.

Kate Palmer, who heads Sports Australia (which supports elite sports), talked about her work in persuading the organisation to promote physical activity because, as she said, physical activity is a life-saving activity! That’s a powerful shift given Sports Australia was previously seen as a non-traditional partner in prevention.

Patty Knippersley, leader of OurWatch, talked about the challenges of making prevention ‘stick’ and the importance of developing approaches to prevention that sit alongside the everyday work of organisations. OurWatch works in the prevention of violence against women and children is creating a broad-based movement for change that creates mutually reinforcing actions, and prevention of violence against women is becoming a shared endeavour. She talked about building processes and tools to assist organisations to understand the processes and practices of prevention as this allows us to think big, to think sustainability and creates an integrated system.

Speaking on Day Two with the theme of the Economics of Prevention, Todd Harper from Cancer Council Victoria asked, ‘Why don’t funders recognise how important prevention is?’ He reminded us that to be good value, we don’t always need economic evidence – that evidence-based knowledge is often good enough to make the case for investment.

Then Teresa Fels from Victoria’s Treasury asked, ‘If health is an elastic good, why hasn’t investment in prevention grown?’ One of her key points was that we need to examine the efficiency of the health spend on acute care and make the case about savings if governments are to be persuaded to invest earlier. Common Cause Australia’s Mark Chenery spoke on values-based messaging. He provided us with good evidence about how we often miss the mark with our use of language in health promotion. Among his key messages for effective health promotion were:

- Don’t waste time on Nanny State debates
- Don’t tap into choice and responsibility frames
- Do highlight the external barriers that people face
- Do frame health promotion as a social justice issue.

And then Toby Roderick from Customedia presented us with data about the best value in media exposures. He cautioned against public health campaigns which frequently rely on Facebook/Instagram to get messages out. While reliance on one media company is never a good thing, Facebook refuses to approve many public health campaigns, particularly graphic ones.

In addition to the plenary papers, the paper presentation sessions were also impressive – many of us who have been around the
field and the PHAA for before some of you were born, know that the future is in good hands because the work you are doing is sophisticated and important. Go back over Twitter @Prevention2019 to find more take-home messages from our inspirational speakers!

I would like to congratulate all who came to #Prevention2019 on making this such a successful event – registrations were booked out which shows that there is a thirst for how we can all do prevention more effectively. Federal Health Minister Greg Hunt has asked for bold and fearless ideas on prevention to inform the new National Preventive Health Strategy – so go forth, and be fearless because so much important work remains to be done to meet the challenges of inertia and inaction on prevention.

We share common platforms to make Australia a better place in which all people enjoy better health. We have learned so much about how we need to work from systems thinking to build new systems of influence. Finally, I am reminded of the extraordinary shift in actions to prevent violence against women over the last 5 years and Patty’s words which apply to all our prevention endeavors:

- That we need to keep telling the story about what primary prevention is
- That we need to invite a breadth of people and organisations into the prevention space
- That we need to keep developing the evidence base
- That we need to keep driving people to the issues
- That we can’t underestimate the importance of working deliberately and over time, with the people who do choose to engage – keep giving them the information and where to find the tools and resources to assist them to create change
- And then over time, we move the dial on the issues and Smash the Silos on prevention which hold us back.
Looking Back: Pioneers of Public Health - Edwin Chadwick, John Simon, William Farr and Lord Morpeth

UK Health Minister Aneurin Bevan was the post-war architect of the UK’s National Health Service. He celebrated Chadwick, Simon, Farr and Morpeth in a speech given to mark the centenary of the 1848 Public Health Act on May 7, 1948.

This is an edited version of Bevan’s speech.

In paying tribute to the Pioneers of Public Health it is not my task to stretch back to the earliest pioneers, to the forgotten Roman engineers whose pipes and paving made Londinium [a settlement established on the current site of the City of London around AD 43] a healthier city than it was to be for another 1,500 years, nor to look at the work of the reformers of the Renaissance, Sir Thomas More and Sir T. Elyot, not even to the edicts of the Lord Mayor and the city council for maintaining the health of the city in times of plague and pestilence.

Our gaze today is fixed on the first Public Health Act of 1848, on the men who formed the opinion which made it possible, and men who carried it through and the men whose administration of its provisions laid the foundation of the century-long struggle to provide a comprehensive service for the health of the people.

I do not even need to remind you of the appalling task which the reformers of 1848 faced.

Their labours were two-fold. One lay in the immensity of the practical problems themselves. The unpaved streets, the ordure-ridden water supply, the non-existent sewers, the hovels which served the people as homes, paralleled by the writers of the day only to the negro huts of the West Indies. These conditions led to an infantile mortality of 200 per 1,000; to a maternal mortality of 6 per 1,000. They led from time to time to the cholera epidemics of Asiatic violence which claimed their deaths not in hundreds as in the outbreak of poliomyelitis in 1947, not even in thousands as the influenza epidemics in living memory, but in tens and scores of thousands mounting, as in 1832, to national disasters only exceeded by the Black Plague of the Middle Ages and the Great Plague of 1666.

The second problem lay in the bitter opposition of many vested interests to reform. The Parish Officers, wrote Chadwick, “frequently oppose improved modes of paving and efficient cleansing, as they generally opposed the new police on the ground that it diminished the means of sustenance of decrepit old men as watchmen, for the avowed reason that it is expedient to keep up the means of employing indigent persons as street-sweepers and sweepers of crossings in removing it.”

No one thought public health a good investment. “The Great Plague of London will be revived and naturalised,” said The Times, “for the sake of saving half as many pounds as are found readily forthcoming for a German mine or a French railway.”

The task of rallying public opinion and getting anything done was, therefore, enormous. “Stench and smoke,” wrote The Times, “could not have preserved that which corn and sugar lost if they had been attacked with half the same determination.” It was from the pioneers – Edwin Chadwick, John Simon and William Farr – that the determination came.

Chadwick’s seminal work was the great report of his Royal Commission on the Sanitary Condition of the Labouring Population of Great Britain published in 1842.

(cont...)
For six years the cause of public health fought an apparently losing battle with the Corn Laws for public attention. Then at last in 1848, the first Public Health Act went through. The General Board of Health was finally set up but only lasted six years.

When, in 1854, it came to an end, one of the main reasons for this was personal antipathy to Chadwick. In Parliament, they saw him as a man fighting against private property and private interests. He was a danger to their comfort and prosperity. He was deposed.

Unfortunately, the disfavour which Chadwick had aroused attached itself to the whole movement of public health. In fact, the post of chief medical officer, first filled in 1855 by Sir John Simon, would have been abolished had not the Prince Consort intervened.

John Simon had been London’s first medical officer of health since 1848. The conception of a medical officer in an administrative post was then quite new. His annual reports for the years 1848-55, when he held the office of medical officer of health for the city, have become classics in the history of English sanitation.

Simon exposed all the degradation under which the masses were obliged to live. He showed the risks that arose from bad drainage in the spread of cholera and other diseases. He got in touch with the Registrar-General and made an arrangement with him by which punctually every Monday morning, the nine city registrars provided the Registrar-General with returns of deaths registered during the previous week and the causes of such deaths, and these papers were placed at Simon’s disposal. Gradually through his influence a weekly inspection in all the poorer parts of the city took place.

Yet when in 1855 Simon accepted the post of medical officer in the new Board of Health, he said: “None but the vaguest notions had been formed as to the work which the officer ought to do.” The general view was that a medical officer’s functions should be confined to fighting the dangers of the diseases when they occurred. This was not Simon’s idea.

His report on the Sanitary State of the People of England presented an unanswerable case for the establishment of a medical department of Government; and in 1859, after the passing of the Public Health Act of 1858, when the functions of the Board of Health were absorbed by the Privy Council, Simon was permanently appointed medical officer to that council.

In 1858 he published a Paper on the Constitution of the Medical Profession, and this was followed by the passing of the Medical Act by which the General Medical Council was established with a system of registration to enable persons requiring medical aid to distinguish qualified or unqualified practitioners.” Before this Act, Simon said: “The legal titles of medical practitioners were as various as the names of snuffs and sauces.”

So much for the work of Simon and Chadwick. But the administrator of today cannot write his bluebooks nor the medical officer of health his reports unless both can draw upon the bullion of statistically analysed experience.

Equally important is William Farr, son of a farm labourer, first became known through his freelance journalism in The Lancet and elsewhere on matters medical and economic. This self-taught mathematician who focused on medical statistics, was a true pioneer; he was original and courageous, a genius.

(cont...)
The answers to the questions in the 1851 Census of Great Britain provided a wealth of information which he used in his enquiry into the mortality of the English working man; the tool-grinder inhaling sharp particles of metal dust, the clerk poring over his ledgers in a stuffy office, the miner hewing at the coal-face, all these and many more became the objects of study and concern. And he was not content only with study. He was one of the first – far ahead of his time – to point out the advantages of a government system of health insurance.

Farr was no collector of facts for facts’ sake; it was not ink he had in his veins but good red blood. Throughout his life his aim was the use of medical statistics to reveal the causes of disease, to compare the value of various forms of treatment and to compel social and sanitary reforms. To him “prevention is better than cure” was not merely a truism – to him it was a constant challenge. Medical men, the guardians of public health,” he wrote, “never have their attention called to the prevention of sickness; it forms no part of their education. To promote health is apparently contrary to their interests.” In his unceasing efforts to change this attitude Farr was a great force in his day and he has been a source of inspiration to generations of our health workers right down to our own times.

I have spoken so far of Chadwick, Simon and Farr. Many others might be mentioned, particularly Delane, the great editor of The Times, and Dickens. But I should like to save my concluding words for a fourth figure – Lord Morpeth.

It is not enough for the social reformers to smell out abuses and bring them to light. It is not enough even for the administrator to have the knowledge and the ability to deal with the abuses once he is given power. In our method of government, no social reform can come to fruition and no new system of administration can be inaugurated until public opinion accepts, or is induced to tolerate, the reform. It is here that the politician becomes essential to give form to the idea; to modify it, if necessary, in such a way as to make it acceptable to the many interests affected; to keep intact the kernel of the matter and to place the new principle upon the statute book.

Morpeth gets the final credit for steering the first Public Health Act through Parliament. His popularity and his gift for compromise succeeded where the unyielding Chadwick would have failed. That, as I see it, is the essential function of the despised politician. He is the accoucheur of the public conscience. Not in himself the pioneer but yet in the final stages the catalyst by which the pioneers’ reforms are transformed into practical realities.

And so tonight, we remember Lord Morpeth as one who not only got the Act through, but who kept its principles alive during the first six vital and challenging years and, in so doing, paved the way to the development of the most effective Public Health Service in the world.
Five days in Rotorua

I did not travel to New Zealand for a holiday, but for the International Union of Health Promotion and Education 23rd World Conference on Health Promotion. The theme, Waiora: Promoting Planetary Health and Sustainable Development. Waiora translates as wellbeing.

Although there was lots of good work being demonstrated, three broad things emerged:

Firstly, the health promotion community, despite the title and theme of the conference, apart from Fran Baum, Trevor Hancock, Tony Capon, the Oceania Ecohealth group and a couple of others, just ignored the ecological dimensions that are strongly suggested by the idea of planetary health. Their socioecological model of health was entirely human-centric. Ecology is the sociopolitical, and maybe the built environment. There is no planet worth mentioning.

Apart from that major omission, there was a strong, vibrant Indigenous worldview permeating the conference presentations. This was perhaps best exemplified by Tamati Kruger of the Tuhoe iwi, whose described the community’s restoration and development pathway. That pathway is firmly placed in the notion that ‘we are from the land’. Restoring kinship between the land and families is the value basis of their approach. If it were everyone’s, humans would live more sustainably.

My major realisation from the conference was that a related set of questions; ‘how do we do ... planetary health, ecological sustainability, reconnect with the land?’ Those questions focus down into very local action with people facing the crises of the Anthropocene. This is not a great revelation really; after all we have known this for some time. But all the high level talking and planning doesn’t change much unless and until it is happening on the ground.

So, for health promoters and public health professionals, our challenge is working this on-the-ground stuff into our daily lives, at home and work. The most inspiring stories at the conference were from those who were doing this.
What stops people from accessing a Primary Health Network?

By Amy Tyrell and Dr Orit Ben-Harush

The North Coast Primary Health Network (NCPHN) in NSW is one of 31 Primary Health Networks (PHNs) established by the Australian Government in 2015 to improve the efficiency and effectiveness of primary health care services across Australia.

Understanding its remit to improve patient outcomes, NCPHN recognised there was a gap in its evidence base, particularly around the perspectives of local people using primary health care services.

PHAA members Amy and Orit are a part of the Planning and Performance team who led the delivery of a large-scale community survey called Speak Up conducted in June 2018. Here, they share their approach and key findings.

The North Coast Primary Health Network’s community survey covered the region from Port Macquarie to Tweed Heads in NSW. The survey’s purpose was to gain unique information from community members to identify the barriers and challenges they experience when accessing and using local primary health services.

In total, 3,372 locals completed the survey. This response was possible due to the support and assistance of 148 local community organisations and individuals who promoted it. Survey data was collated, weighted (to match overall population distribution by age and sex), analysed and included in the 2018 NCPHN needs assessment report. Survey findings were presented to the public in a series of presentations and this information is now being used to inform planning and decision making when designing solutions to identified local health and service needs.

What did participants say about health services they access?

1. Access to general practitioners and other health services

In total, 97.8% of survey respondents had needed to access general practice services in the previous 12 months. Of this group, 28.3% found it difficult or very difficult to see a GP, with this result varying from 71.9% in the Kempsey Local Government Area (LGA) to 14.0% in Bellingen LGA.

Survey respondents were also asked about their level of access to local specialist doctors, allied health professionals, mental health services, alcohol and other drug services, and services for older people. Figure 1 shows the proportion of respondents reporting that access to each service type was ‘difficult’ or ‘very difficult’.

What stops people from accessing a Primary Health Network?

By Amy Tyrell and Dr Orit Ben-Harush

The North Coast Primary Health Network’s community survey covered the region from Port Macquarie to Tweed Heads in NSW. The survey’s purpose was to gain unique information from community members to identify the barriers and challenges they experience when accessing and using local primary health services.

In total, 3,372 locals completed the survey. This response was possible due to the support and assistance of 148 local community organisations and individuals who promoted it. Survey data was collated, weighted (to match overall population distribution by age and sex), analysed and included in the 2018 NCPHN needs assessment report. Survey findings were presented to the public in a series of presentations and this information is now being used to inform planning and decision making when designing solutions to identified local health and service needs.

What did participants say about health services they access?

1. Access to general practitioners and other health services

In total, 97.8% of survey respondents had needed to access general practice services in the previous 12 months. Of this group, 28.3% found it difficult or very difficult to see a GP, with this result varying from 71.9% in the Kempsey Local Government Area (LGA) to 14.0% in Bellingen LGA.

Survey respondents were also asked about their level of access to local specialist doctors, allied health professionals, mental health services, alcohol and other drug services, and services for older people. Figure 1 shows the proportion of respondents reporting that access to each service type was ‘difficult’ or ‘very difficult’.

What stops people from accessing a Primary Health Network?

By Amy Tyrell and Dr Orit Ben-Harush

The North Coast Primary Health Network’s community survey covered the region from Port Macquarie to Tweed Heads in NSW. The survey’s purpose was to gain unique information from community members to identify the barriers and challenges they experience when accessing and using local primary health services.

In total, 3,372 locals completed the survey. This response was possible due to the support and assistance of 148 local community organisations and individuals who promoted it. Survey data was collated, weighted (to match overall population distribution by age and sex), analysed and included in the 2018 NCPHN needs assessment report. Survey findings were presented to the public in a series of presentations and this information is now being used to inform planning and decision making when designing solutions to identified local health and service needs.
Based on the survey data, the Australian Institute of Health and Welfare (AIHW) were engaged to develop a model showing the odds of an individual reporting that access to general practitioners was difficult. As shown in Figure 2 (right):

- Older and younger people were less likely to report difficulties accessing GP services
- Females and people who identified as non-binary or being transgender were also found to have higher odds than males
- Those who reported that they require assistance for self-care activities were more likely to report difficulty accessing GP services (61% higher odds)
- Persons who were unable to access funds at short notice ($2,000 within a week) were more likely to report difficulty accessing GP services, with odds 2.7 times those of people who do have access to funds.

2. Specialist doctors that participants found hard to see in their community

Participants were asked to select which of 15 specialists they found hard to see. The most commonly-reported specialists that were difficult to access on the North Coast were psychiatrists (23.8%), cardiologists (19.2%) and general surgeons (15.1%). Additional specialists that were most commonly reported as hard to access are presented in Figure 3 (below right).

To view the results to questions about access to allied health, mental health, alcohol and other drugs and services for older people, check the ‘General Population Needs Assessment Report’ at: [https://ncphn.org.au/needs-assessment](https://ncphn.org.au/needs-assessment)

For survey key findings as well as information sourced from national and state statistical collections, you can view the NCPHN Local Government Areas (LGAs) fact sheets here: [https://ncphn.org.au/needs-assessment](https://ncphn.org.au/needs-assessment).

Contact

If you are thinking about undertaking a similar exercise in your region, feel free to contact Orit by email at: [oben-harush@ncphn.org.au](mailto:oben-harush@ncphn.org.au).
Sponsors of PHAA 2019 events

The PHAA would like to acknowledge and thank all sponsors for their support and contribution to PHAA events in 2019.

Justice Health Conference 2019

- NHMRC Centre of Research Excellence in Offender Health
- Kirby Institute
- Australian Government Department of Health
- GILEAD
- Intrahealth
- armchair medical
- UTS

Public Health Prevention Conference 2019

- The Australian Prevention Partnership Centre
- VICTORIA Health and Human Services
- WOMEN VICTORIA
- VicHealth

Unhealthy Marketing to Kids Forum 2019

- fare Foundation for Alcohol Research & Education
PHAA Office Bearers

The PHAA Board:

President
David Templeman
Vice President - (Policy)
Christina Pollard
Vice President - (Development)
Rohan Greenland
Vice President - (Finance)
Richard Franklin
Vice President - (Aboriginal & Torres Strait Islander Health)
Summer May Finlay

SIG Convenors’ representatives
Kathryn Backholer
Lea Merone

Branch Presidents’ representatives
Kate Kameniar
Devin Bowles

Student and Early Career Professionals Representative
Aimee Brownbill

Chief Executive Officer:
Terry Slevin: ph (02) 6285 2373
tslevin@phaa.net.au

ANZJPH Editors:
Editor in Chief
John Lowe: jlowe@usc.edu.au

Editors
Priscilla Robinson: priscilla.robinson@latrobe.edu.au
Anna Ziersch: anna.ziersch@flinders.edu.au
Melissa Stoneham: M.Stoneham@curtin.edu.au
Bridget Kool: b.kool@auburn.ac.nz
Roxanne Bainbridge: roxanne.bainbridge@jcu.edu.au

SIG Convenors:
Aboriginal & Torres Strait Islander Health
Yvonne Luxford: yvonne.luxford@gmail.com
Michael Doyle: michael.doyle@sydney.edu.au

Alcohol, Tobacco and Other Drugs
Mike Daube: M.Daube@curtin.edu.au
Julia Stafford: j.stafford@curtin.edu.au

Child Health
Jane Frawley: Jane.Frawley@uts.edu.au
Ruth Wallace: ruth.wallace@ecu.edu.au

Diversity, Equity and Inclusion
Brahm Marjadi: b.marjadi@westernsydney.edu.au

Ecology and Environment
Peter Tait: aspetert@bigpond.com
Lea Merone: lea@doctors.org.uk

Complementary Medicine - Evidence, Research & Policy
Jon Adams: jon.adams@uts.edu.au
Jon Wardle: Jon.Wardle@uts.edu.au

Food & Nutrition
Kathryn Backholer: kathryn.backholer@deakin.edu.au
Penny Love: penny.love@deakin.edu.au

Health Promotion
Carmel Williams: Carmel.Williams@health.sa.gov.au
Aziz Rahman: aziz.rahman@y7mail.com

Immunisation
Angela Newbound: Angela.Newbound@yahoo.com
Michelle Willis: michjwills@gmail.com

Injury Prevention
Richard Franklin: richard.franklin@jcu.edu.au
Lyndal Bugeja: lyndal.bugeja@justice.vic.gov.au

International Health
Jaya Dantas: jaya.dantas@curtin.edu.au

Justice Health
Tony Butler: tbutler@ncchcr.unsw.edu.au

Mental Health
Fiona Robards: fiona.robards@sydney.edu.au
Samantha Battams: sam.battams@flinders.edu.au

One Health (Zoonoses)
Van Joe Ibay: vanjoebay@gmail.com
Andrea Britton: andrea.britton@ue-c.net

Oral Health
Tan Nguyen: tan.nguyen@dexcl.net.au

Political Economy of Health
David Legge: D.Legge@latrobe.edu.au
Deborah Gleeson: d.gleeson@latrobe.edu.au

Primary Health Care
Russell McGowan: lazarus@bigpond.com
Gwyn Jolley: gwyn.jolley@flinders.edu.au

Women’s Health
Angela Dawson: angela.dawson@uts.edu.au
Mearon O’Brien: mearonob@gmail.com

Branch Presidents:
ACT | Devin Bowles: caphiaed@gmail.com
NSW | Patrick Harris: patrick.harris@sydney.edu.au
NT | Suzanne Belton: Suzanne.belton@menzies.edu.au
QLD | Letitia Del Fabbro: phaaqlbranch@gmail.com
SA | Kate Kameniar: kate.kameniar@southerncrosscare.com.au
TAS | Kim Jose: Kim.Jose@utas.edu.au
VIC | Anna Nicholson: phaa.vic@gmail.com
WA | Hannah Pierce: hannah.pierce@curtin.edu.au
PHAA Welcomes New Members

PHAA is very pleased to welcome **197 new members** since the February edition of InTouch!

*In the ACT*
Kefyalew Addis Alene  
Myfanwy Bailey  
Zi Siong Chow  
Katja Everson  
Gerard Fitzsimmons  
Algreg Gomez  
Ingrid Hunter  
Patrick Wells  

*In New South Wales*
Oluwatosin Akinya-Ojo  
Ed Annand  
Elena Argirovska Stojkovikj  
Lydia Baker  
Vaishaliben Bhuva  
Ishka Bless  
Alecia Brooks  
Jane Burn  
Samantha Carlson  
Brendan Clifford  
Jody Clouten  
Jo Cochrane  
Barbara Davis  
Sharon Duncan  
Bronwyn Eisenhauer  
Imogen Evans  
Cathryn Forsyth  
Karen Gainey  
Nicole Gonzaga  
Anne Grunseit  
Ure Ihekanandu  
Kalissa Inshaw  
Jelena Kopcic  
Sarka Kynclova  
Rohan Lal  
Rebecca Liackman  
kerri lucas  
Kanchan Marcus  
Michelle Marshall  
Karina Martin  
Lisa Maunsell  
Carolyn Mazariego  
Georgina Mulcahy  
Lanika Mylvaganam  
Richard Ofiabodhe  
Anna Pickles  
Alina Rana  
Scarlett Smout  
Liam Tegg  
Paige Todd  
Helen Tran  
Ian Trevallion  
Nicole Weavers  
Kurnia Wijayanti  
Peter Wnukowski-Mtonga  
Alessia Zen  
Sameera Zini  

*In the Northern Territory*
Priya Janagaraj  
Rachael Turner  

*In Queensland*
Jocelyn Abernethy  
Emmanuel Olorunleke Adewuyi  
Amy Anderson  
Grace Baxter  
Orelia Bello  
Scott Brown  
Zoe Calleja  
Andrea Casasola  

Articles appearing in intouch do not necessarily reflect the views of the PHAA but are intended to inform and stimulate thought, discussion and comment. Contributions are welcome and should be sent to:

*intouch, PHAA*  
email: communications@phaa.net.au

How to join PHAA  
ONLINE MEMBERSHIP is available at: www.phaa.net.au  
or enquiries to:  
Public Health Association of Australia  
PO Box 319, Curtin ACT 2605  
Tel 02 6285 2373 Fax 02 6282 5438  
email: phaa@phaa.net.au  
twitter: @PHAA
In Tasmania
Justine Bevilacqua
Benjamin Granger
Rob Hill
Nicola Stephens
Annika Wilson

In Victoria
Dima Al Tarsha
Birgit Beisner
Stephen Bendle
Philippa Buckingham
Stuart Clarke
Rebecca Conning
Natasha Davidson
Alexandre Drigo
Gabrielle Fegan
Miranda Gartside
Melanie Gibson-Helm
Kristen Glenister
Michelle Gooley
Miriam Hachem
Emily Harris
Marie Heloury
Kate Hind
Victoria Hobbs
Timothy Holloway
Negar Jamshidi
Jenny Aleyamma John
Helen Jordan
Ameera Katar
Bandana Khadka
Michelle King
Janelle Lay
Wen Liu
Amelia Lowe
Alison McAleese
Elyse McDonald
Berni Murphy
Christine Murray
Judith Myers
Catherine Nguyen
Stephanie Odoi
Patience Ndidi Onuogu
Jayme Pavloff
Elizabeth Peach
Michelle Pritchard
Beth Scholes

In South Australia
Osman Ali
Liana Bellifemini
Sean Cridland
Yuan Gao
Tara Guckel
Jessica Judd
Mah Laka
Zhidong Liu
Hero Moller
Shannon Packer
Sarah Reece
Sarah Schwetlik
Eliza Scrymgour
Rachel Swift
Tegan Tiss

In Western Australia
Colin Barnard
Melissa Boglis
Joseph Carrello
Kane Deering
Bhargavi Desai
Karishma Doolabh
Isabel Dunstan
Isabelle Fisher
Kate Fitzgerald
Amanuel Gebremedhin
Apu Karajagi
Natalie Kippin
Katherine Landwehr
Jessica Matthews
Kahlia McCausland
Rebecca McLevie
Alison Mills
Emily Moore
Palak Patel
Larissa Perry
Jackie Smith
Kaila Stevens
Helen Tanner
Tracy Waddell
Rory Watts

Other new members
Vikas Bhatia
Bianca Caputi
Chris Enright
Michael Hale ● Auckland
Kym Lang
Eric Layland
Amber Abid Malik ● Pakistan
Sally Pitson

PHAA Welcomes New Members (cont.)
Membership Benefits

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
• 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
• Discounted rates for advertising or for placing inserts in our current publications intouch and the Australian & New Zealand Journal of Public Health (does not apply to job vacancies and event promotional e-campaigns)
• (*All of the benefits of individual membership also apply to the individual nominated representative for an organisational member.)

Advertising Rates

<table>
<thead>
<tr>
<th>Format</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/4 page</td>
<td>$175</td>
</tr>
<tr>
<td>1/2 page</td>
<td>$250</td>
</tr>
<tr>
<td>Full page</td>
<td>$330</td>
</tr>
<tr>
<td>PDF format</td>
<td>preferred</td>
</tr>
</tbody>
</table>

Conference listing (5cm column)

<table>
<thead>
<tr>
<th>Lines</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>up to 5</td>
<td>$35</td>
</tr>
<tr>
<td>up to 10</td>
<td>$58</td>
</tr>
</tbody>
</table>

If further information is required please contact PHAA via email: communications@phaa.net.au

Email and Webpage adverts
email phaa@phaa.net.au

For more information click here