Australian Goods and Service Tax (GST) Exemption On Food - Examining the Issue Through a Health Lens

By Dr Christina Pollard, PHAA Fellow and Jillian Abraham, PHAA WA Acting President

Food prices and food affordability are important determinants of food choices, obesity and diet-related non-communicable diseases such as diabetes, heart disease and some cancers. Food inequity is evident in Australia as people on low incomes experience financial stressors and struggle to make ends meet. Many are forced to buy cheaper, less nutritious food or go without. Reducing the price of healthy foods relative to unhealthy foods can lead to positive changes in consumption patterns.

Australia is one of a few countries in the world that applies a tax exemption to fresh food and basic items in an attempt to keep these foods affordable. The Australian Goods and Services Tax (GST), set at a rate of 10%, came into operation on 1 July 2000 with an exemption for fresh food and basic items. Decades later, commentators have asserted that the GST was a true tax reform rather than a revenue grab. Until recently there has been no political will to change the GST but the eminent Tax White Paper will examine all aspects of the Australian tax system, including the GST.

Discussions about increasing the tax to raise revenue have included broadening the tax base including suggestions to remove the fresh food exemptions. Estimates have shown that doing this could raise an extra $6 billion a year, a compelling economic argument in tough budget times. But at what cost?

Public health should be a central consideration of any decision making process regarding changes to the GST, particularly the exemption of fresh and basic food. The exemption aimed to reduce the price differential between healthy, nutritious foods and nutrient poor, energy dense discretionary foods. GST exempt foods include fruit, vegetables, breads and cereal foods, dairy foods, meat and other staple items. Categories of foods that are not exempt include unhealthy processed foods and beverages and take-away foods.

Nutritious foods cost more than unhealthy discretionary foods, even with the current exemption, and the cost of nutritious foods is increasing more rapidly than...
discretionary food. We know that most Australians do not eat a diet consistent with Australian Dietary Guidelines. Most do not eat enough fresh fruit and vegetables or basic food from the five food groups and eat too many discretionary foods. This dietary pattern is a leading risk factor for the burden of disease in Australia which is costing the government and our health system billions of dollars every year and showing no sign of decreasing.

There are three public health consequences of adding the GST to fresh and basic foods. Firstly, increasing the cost of the very foods we are trying to get people to eat more of will reduce their consumption. Estimates demonstrate a 10% GST on fruit and vegetables will decrease consumption by 5%. Secondly, the changes in consumption would increase disease burden, adding an additional 90,000 cases of heart disease, stroke and cancer, with a billion dollar health care price tag. It is thirdly, counter to taxation policy imperative to ensure any reforms are equitable, the greatest negative public health impact is likely to be on people already at risk of poor health outcomes. Aboriginal people, low income earners and people living in rural and remote areas are vulnerable to poor diet and diet related disease due to their economic circumstances. Reducing the affordability of food will exacerbate this.

Families earning a low income or relying on welfare would need to spend about half their disposable income to buy a healthy food basket consistent with the dietary guidelines. The impact would be even greater for people living in remote areas where despite remote area living allowances, the affordability of fresh food is particularly poor.

The PHAA has been campaigning for a couple of years to ensure the public health perspective is central to the debate. The public health impact of adding GST to fresh food would be to add additional pressure on those who are already suffering the poorest health in Australia. Any taxation revenue benefit would be overshadowed by increased health care costs due to reduced consumption of fresh, nutritious foods.

As public health professionals, let’s advocate against this proposition and say ‘NO!’ to GST on fresh food. References are available from the author at: jilli_anne@hotmail.com

Originally published in the PHAA WA Branch Intouch in WA newsletter March edition.
## Your health in their hands: time for a zero tolerance approach to hospital hand-washing?

By Marie McInerney, reprinted from the Crikey webpage, 18 March 2015

The latest statistics (see above, from Hand Hygiene Australia) show that doctors in Australian hospitals comply with hand washing requirements less than 70 per cent of the time. In the post below, ACT MP and former dentist Dr Chris Bourke asks whether or not it’s time we adopted a ‘zero tolerance’ approach on failure to comply. He points out a number of international policies and programs that have led to major improvements in hospital hygiene.

**Dr Chris Bourke writes:**

When I was a young dental student the importance of washing our hands was hammered into us.

We all knew the story of Dr Ignaz Semmelweis, the Hungarian doctor at Vienna General Hospital in 1847 who dramatically reduced deaths by infection of mothers after childbirth by the simple act of getting doctors to wash their hands before delivering babies. I bet most medical students today also know this history. Yet there seems to be a disconnect after graduation when they are practising in hospitals. Astonishingly the Australian benchmark for hand washing by staff is only 70 per cent – unwashed hands for 30 per cent of the time seems to be OK for our health authorities. This data is collected by hand washing monitors who record failures to comply with the rules, therefore some staff fail to wash their hands despite knowing they were being observed.

Public health experts estimate that the failure rate is much higher when staff are not physically checked. It gets worse: when observations are broken down by staff category it is the doctors who fail the most. Some studies have found that doctors in hospitals wash their hands as little as 60 per cent of the time, while the latest statistics from Hand Hygiene Australia (HHA) put compliance at about 68 per cent.

In contrast hospital dental clinics record the highest rates of hand washing with 89 per cent compliance – well ahead of emergency departments, neo-natal intensive care and renal units. Dentists could be proud of this achievement but a failure rate of 11 per cent is still not good enough.

The WHO recommends five moments for hand washing; before and after touching a patient, before and after a
Your Health in Their Hands: Time for a Zero Tolerance Approach to Hospital Hand-Washing?

Continued from previous page

procedure, and after touching the patient’s surrounds. The US Centre for Disease Control estimates poor hygiene results in a whopping 1 in 25 patients with hospital acquired infections.

In Australia only the most deadly of hospital based infections, golden staph., is reported on the My Hospitals website. There are 1.35 staph infections per 10,000 patient bed days for major hospitals across the country. One estimate for hospital acquired infection in Australia is 180,000 per year causing an extra two million additional days in hospital.

Here in Canberra the story is no different to the rest of the country. The most recent audit period reported on My Hospitals website shows an estimated hand washing rate of 74 per cent for the June 2014 quarter at the Canberra Hospital. There were 41 cases of golden staph reported last financial year. ACT Health has responded to these outcomes by working to ‘educate health professionals that hand washing was just as important in preventing the spread of disease and illness as other hygiene practices’.

There are plenty of overseas examples of how to get doctors and other health workers to wash their hands. Cedars-Sinai Medical Centre is a not for profit tertiary hospital in Los Angeles, about one third bigger than the Canberra Hospital. In 2013 Cedars-Sinai recorded an organisation-wide hand washing compliance rate of 98 per cent, a dramatic increase from their 70 per cent rate in 2010. This resulted from a policy change that hospital acquired infections should be eliminated, not merely reduced, and by incorporating hand washing compliance into employee performance assessment.

In 2010 the Princeton Baptist Medical Center, a tertiary hospital in Alabama that is about half the size of the Canberra Hospital, implemented radio frequency identity badges for all staff including doctors to record hand washing. Messages on the device’s screen sent general and personal messages to reinforce hand washing. Hospital acquired infections fell 22 per cent in the first year.

UPMC Presbyterian in Pittsburgh, about the same size as Canberra Hospital, launched a ‘Just Culture’ initiative in 2012 to change hand washing behaviour through accountability. Within four months hand washing compliance increased from 70 per cent to 99 per cent.

Here in Australia a recent study of management attitudes at an inner Sydney 350 bed tertiary referral teaching hospital found that hospital managers still want to debate if hand washing non-compliance constitutes a patient safety error. Managers prefer not to confront non-compliers with consequences for their hand washing failure.

Maybe, instead of a punitive approach, an opportunity exists to apply the restorative practice philosophy that has worked so well in education and juvenile justice. Restorative practice focuses on using shame within a continuum of respect and support to induce behaviour change (see Van Stokkom, B. 2002, "Moral emotions in restorative justice conferences: Managing shame, designing empathy", Theoretical Criminology, vol. 6, no. 3, pp. 339-360).

Elements of restorative practice have already been successfully tried to improve hand washing; one US hospital appointed medical students as hand washing champions to remind senior doctors to wash their hands – doctor compliance improved from 68 per cent to 95 per cent within 6 months with senior doctors readily accepting the reminders. Another study found that nurses’ hand washing intentions were influenced by peer pressure from doctors and administrators.

We must take action now to change attitudes and behaviours at our major public hospital to improve patient safety and quality of care otherwise we can expect more deaths and permanent disability from hospital based infections.

Dr Chris Bourke was elected to the ACT Legislative Assembly in 2011. He was the first Aboriginal Australian to complete a dental degree and has postgraduate diplomas in public health and clinical dentistry. He is a former President of the Indigenous Dentist’s Association of Australia, member of the Campaign for Indigenous Health Equality (Close the Gap), chairman of the Australian Dental Association (ACT Division) and Treasurer of the Public Health Association of Australia (ACT).
Volcanic Ash/Fumes Associated with a Volcanic Site at Hakone – Owakudani [大涌谷] - Japan
[Are Facial Masks Required]?

By Deborah Hilton Statistics Online

In September/October 2014, our family had the opportunity to visit Japan. I was able to present work at the ICSA 2014: XII International Conference on Statistics and Analysis.

Sometime before this conference, we had the wonderful opportunity to visit Hakone – Owakudani (大涌谷) in Japan. This is the area around a crater created during the last eruption of Mount Hakone some 3000 years ago. Today, it is an active volcanic zone with sulfurous fume’s, hot springs and hot rivers. A ten minute walking path leads from the ropeway station into the volcanic zone to a number of steam vents and bubbling pools. There was a board of warnings and these included those related to respiratory symptoms. I had pre-packed disposable facial masks. I hadn’t read comprehensively enough and was not aware that there would be so many fume’s. Nor had we planned to visit this site before we left Australia. In fact I didn’t know anything about this area, I had purchased the masks as I noted many people wearing basic cloth masks in the city.

One or more of our family of four do at times get asthma symptoms triggered by various factors, and on this trip we had a fifth friend accompanying us. Three of our group went off, keen to look at the sites, without masks, while I and my younger daughter Natasha – 12 years old decided to put the masks on as a precautionary measure not really knowing whether or not they would be of use. I bought these from a local pharmacy in Tokyo a few days prior and I had asked the Japanese shop assistant about why people were wearing these, but she didn’t understand me, nor did I understand her so I just purchased them. The writing on the pack was in Japanese except for a couple of lines giving dimensions. Luckily we were all healthy with no URTIs at the time and none of us, after walking through the area that day, experienced any shortness of breath, coughing or wheezing, irrespective of whether or not we were wearing masks.

In terms of research, on PubMed there is one study published in the British Medical Journal which recommended usage of masks. A population-based study/survey of early health effects of the Eyjafjallajokull 2010 eruption in Iceland. The survey followed an explosive eruption of around 6 weeks, one which injected approximately 8 million tons of fine particles into the atmosphere. The survey period was from 31 May to 11 June 2010. After physician examination, spirometry testing, questionnaires relating to physical and mental health and the use of equipment it was determined that the adults surveyed reported upper airway and eye irritation symptomology and also worsening of asthma in those with pre-existing conditions. The author concluded that wearing of protective glasses and face masks was considered beneficial in protecting the eyes and upper airways.

After our return, I’ve discovered a website; The international volcanic health hazard

Continued on next page
network which has a webpage titled; recommended dust masks for protection from volcanic ash.

This website/webpage describes why a mask/respirator should be worn and the specifications you need to look out for when choosing and purchasing respirators/masks. There are guidelines and quality standards that require codes and markings on the masks that specify efficiency and that certain standards have been met. They also describe the hazards that relate to both short and long term exposure of ash/fumes. This website also states that the cheap disposable lightweight masks often known as ‘nuisance dust masks’, ‘comfort masks’ or ‘hygiene masks’ have no markings and that these should not be used for protection from volcanic ash. That day however there was not a lot of ash, only some fumes present. Hakone, the tourist site we visited obviously was not a volcano spewing hot lava and copious fumes/ash, as it would be closed if that was the case. Hakone - (Ōwakudani 大涌谷) is a destination that tourists visit for a pleasant day of sightseeing. The board that was on display in the picture on previous page stated that sulfulous acid gas [sulfur dioxide] has a strong stimulus against respiratory organs and breathing the gas can be fatal. Hydrogen sulfide has a strong stimulus against both eyes and respiratory organs. It causes conjunctivitis and a fit of coughing. In fact it states that a person with asthma and a delicate bronchus are forbidden to enter [I actually think there was a mis-spelling on the board and this should read ‘delicate’ and sulfulous should read sulfurous]. None of us had asthma symptoms, so we ventured along the path enjoying the sights. All in all it was a nice day out, a pleasant scenic place to visit and we took some amazing photos and survived the trip.

http://sites.google.com/site/deborahhilton/
Overconcentration of People on Disability Support Pension in Disadvantaged Areas

By Dr Timothy Ore, Department of Health and Human Services, Victoria

For many Australians with disability, the Disability Support Pension (DSP) is the principal source of income. As at March 2014, 832,533 Australians (3.5% of the population) were on DSP, compared with 602,280 in 2000, representing a compound annual growth rate of 2.3%. The cost of DSP in 2013-14 was over $16 billion.

Are people on DSP concentrated in certain areas of the country or are they randomly distributed? To investigate this question, I analysed the March 2014 data on DSP for each of the 561 Local Government Areas (LGA) in Australia, looking at any association with socio-economic status (SES). SES was measured using the Australian Bureau of Statistics Index of Relative Socioeconomic Disadvantage, derived from the 2011 Census. The lower the Index for an area, the lower the area’s SES.

The analysis shows that people living in the most disadvantaged LGAs (lower quartile) are approximately three times more likely than those in the least disadvantaged LGAs (upper quartile) to be on DSP, 6.8% compared with 2.4%. In twelve LGAs, more than one in ten residents are on DSP. These are, by state, Western Australia (Murchison 15.7%, Sandstone 11.4%, Halls Creek 11.4%, Cue 10.4%), Northern Territory (Tiwi Islands 12.3%, Belyuen 12.2%), Queensland (Wujal Wujal 10.4%, Cherbourg 10.2%), South Australia (Maralinga 15.1%, Peterborough 12.6), Tasmania (Tasman 10.6%) and New South Wales (Walgett 11.0%). At the other end of the scale, less than one in a hundred residents in ten LGAs are on DSP: Western Australia (Carnamah 0.2%, Ashburton 0.5%, Cambridge 0.8%, Cottesloe 0.9%), Queensland (Weipa 0.5%, Isaac 0.9%), New South Wales (Ku-ring-gai 0.7%, Mosman 0.7%, Woollahra 0.9%) and South Australia (Roxby Downs 0.4%).

Figure 1: Association between Rates of Disability Support Pension and Socioeconomic Status, by Local Government Area, Australia, March 2014
Overconcentration of People on Disability Support Pension in Disadvantaged Areas

Continued from previous page

There is a statistically significant negative correlation (Spearman’s Rank Correlation Coefficient = -0.789, p < 0.01) between the percentage of population on DSP and SES (see Figure 1).

Targeting policies at the ‘catchment of disadvantage’ could help reduce the burden of DSP on tax payers and the community more generally. Those policies could target improving health outcomes, acquiring higher educational qualifications and skills, boosting employability with tax incentives for employers and timely and effective provision of psychological and psychiatric services. Indeed, approximately seven in ten sources of disability for people on DSP are psychological/psychiatric (31.3%), musculoskeletal and connective tissue (26.1%) and intellectual/learning difficulties (12.4%). Therefore, there is scope for preventability. Population ageing could compound the burden of DSP, as the probability of a person with a disability being on DSP increases with age.

A 2010 OECD Report, Sickness, Disability and Work: Breaking Barriers – A Synthesis of Findings across OECD Countries, shows that some countries have higher employment rates for people with disability than Australia. Among 29 countries, Australia ranked 21, with a 39.8% of people with disability in employment, compared with 62.3% in Sweden, 61.3% in Iceland, 54.9% in Switzerland, 52.3% in Denmark, 50.4% in Germany, 46.9% in Canada and 45.3% in the United Kingdom. The OECD average was 53%.

Increasing the employment rates of Australians with disability to the OECD average would be helpful. The 2015 Intergenerational Report shows that the Australian economy will grow at a slower rate (an average of 2.8% annually) over the next forty years than over the past 40 years (3.1%). The projected slower growth is partly due to declining participation rate for Australians aged 15 years and over, falling from 64.6% in 2014-15 to 62.4% in 2054-55. As noted in the Foreword to the OECD Report “many people with health problems can work and indeed want to work in ways compatible with their health condition, so any policy based on the assumption that they cannot work is fundamentally flawed”. There is a need for greater promotion of labour market participation by people with disability, in addition to women and older workers. In OECD countries, including Australia, employment rates of people with disability are on average 40% below the overall level, and unemployment rates are twice the overall level. A reasonable balance is needed between providing adequate and secure income for those who cannot work while providing good incentives and support to work for those who can.

CALL FOR NOMINATIONS

PHAA Public Health Mentor of the Year Award 2015

Nominations for the PHAA Public Health Mentor of the Year Award 2015 are now open!

This award is made to a senior member of PHAA who has made a significant contribution to mentoring early-career professionals/practitioners/students to acknowledge a public health professional who has demonstrated outstanding dedication to mentoring students/early career professionals/practitioners.

Its purpose is to formally acknowledge the importance of mentoring in career development and in recognition of the time commitments and other sacrifices that are involved for mentors.

Mentoring plays an important role in developing proficiency and increase the capacity of the objects of the Association.

Nominations for this award close on Friday 19 June 2015

For further details about this award and the nomination process, please visit the PHAA website at this link: http://phaa.net.au/awards.php
Rural ECOH Improving Oral Health in Rural Australia

By Dr Virginia Dickson-Swift

As part of a 3 year NHMRC grant the Rural ECOH team with partners from James Cook University, La Trobe University, Bendigo, Dental Health Services Victoria, the Royal Flying Doctors, and Medicare Locals (Townsville Mackay Medicare Local and Loddon Mallee Murray Medicare Local) are improving oral health in rural communities across communities in Victoria and QLD.

The research teams based in Victoria and QLD have spent the last 12 months working with rural communities in Bowen, Hughenden and Ingham in QLD and Gannawarra Shire, Swan Hill and Kyabram in Victoria. Using a participatory approach based on the award winning Remote Services Futures (RSF) model developed in Scotland the team have worked with communities to develop local ideas to improve oral health status.

The ideas developed by the communities are simple and innovative and involve local oral health experts, local communities and service providers working together on oral health improvement. In QLD the team have worked on developing infographics for oral health service pathways and toothbrushing and education programs for children at the local high schools. In Victoria the team have developed some pilot guidelines for a toothbrushing program in a local primary school and the provision of oral health information for young children and families through the council-run immunisation sessions. With support from the public clinic at Swan Hill and Colgate we are piloting some toothbrushing activities within the schools, and through a partnership with the Royal Flying Doctors (Vic) undertaking some screening in the local primary schools within the Gannawarra Shire.

It has been a busy 12 months in the six communities but we have oral health on the agenda and are looking forward to the next part of the project as the communities implement the activities.

Students in Hugenden (QLD) learn about oral health
Targeted Health Screening with Health Navigator

By Simon Brooks, Metro North Brisbane, Medicare Local

An analysis of results from the use of a Medicare Local web application designed to assess chronic disease risk has shown more than half of all users are at risk of chronic kidney disease.

Health Navigator is a mobile-enabled app which guides the user through a basic health assessment using questions and clinical evidence validated by the National Vascular Disease Prevention Alliance.

Users receive a comprehensive report detailing their risk levels for chronic conditions, including cardiovascular disease, diabetes and chronic kidney disease. It also provides recommendations for engaging with local primary care providers and healthy living programs.

Health Navigator was launched in April 2014 and by February this year, more than 1,500 health assessments had been completed. Over half (51.4 per cent) of these assessments indicated risk of chronic kidney disease.

Earlier results from January, based on 1,451 assessments, showed just over 10 per cent of users had a high risk of cardiovascular disease, 17 per cent had high blood pressure and over 30 per cent had a high risk of diabetes. Of the people assessed, 39 per cent indicated they were a current smoker and over 70 per cent reported being insufficiently active.

While Health Navigator is available to anyone with an internet-enabled device, Metro North Brisbane Medicare Local has been using it as part of an outreach health screening strategy targeting vulnerable and disadvantaged population groups. This financial year the Medicare Local has contracted four local organisations to provide outreach screening to people who are homeless or who are vulnerably housed, people from culturally and linguistically diverse backgrounds, and Aboriginal and Torres Strait Islander communities. Manager of outreach health screening Ms Jeanelle Gibson said the Medicare Local had distributed nine iPads to nurses and staff from partner organisations to carry out Health Navigator assessments.

"Assessments are carried out in community settings, such as caravan parks, community centres and at community events," Ms Gibson said.

"As an example, multicultural health workers from the Ethnic Communities Council of Queensland used Health Navigator to screen 107 people from four different ethnic community groups.

"Anglicare Southern Queensland is another partner using this tool. Workers at the Kilcoy Pastoral Company and visitors to the Reconnect Homeless event in Caboolture were among those screened by Anglicare nurses last year," she said.

There is no cost to use Health Navigator, which was funded by the Australian National Preventative Health Agency. To access the app, visit: www.healthnavigator.org.au.
Higher Mental Health Burden for Mothers of Children with Autism

By Jenny Fairthorne, Telethon Kids Institute, Perth

Our research at the Telethon Kids Institute in Perth has shown that mothers of children with autism have higher rates of psychiatric disorders after the birth of their child than other mothers.

The results were recently published in the journal *Autism* (http://aut.sagepub.com/content/early/2015/02/03/1362361314566048.full.pdf+html)

With the support of Dr Helen Leonard, Dr Nick de Klerk, Dr Peter Jacoby and Jenny Bourke, I analysed hospitalisation and out-patient treatment records for more than 250,000 women who had a child between 1983 and 2005 in Western Australia.

Our results showed that apart from alcohol and substance abuse, mothers of children with autism spectrum disorder had more episodes of all categories of psychiatric disorders than other mothers.

We looked at women who had no psychiatric history and compared those whose eldest child had autism with those who didn’t have a child with autism or intellectual disability.

We found that mothers with no psychiatric history and a child with autism without intellectual disability were two to three times more likely to have a psychiatric disorder with an onset after the birth of their child than other mothers with no previous psychiatric history.

Mothers of children with autism face many more challenges in raising their children than other mothers and this could explain why these mothers have a higher rate of new onset psychiatric episodes after the birth than other mothers. Many of these mothers face self-blame and criticism regarding the behaviour of their child.

We suggest more help for the more vulnerable mothers of children with higher functioning autism including one-to-one counselling sessions and parental respite generated by the provision of special educational and recreational activities for their children. Group workshops aimed at helping the management of difficult situations arising as a result of their child’s disability, either socially, at school, or in the general community, would be likely to assist these mothers to improve their health.

Call for nominations

The Tony McMichael Public Health Ecology and Environment Award

This award is bestowed on a person who has made a significant, discernible contribution in the combined domains of public health and ecology or environmental health, which is consistent with and has contributed to fulfilling the aims of the Public Health Association of Australia and the Ecology and Environment Special Interest Group.

Nominations for this award close Tuesday 30 June 2015 and may be sent to the Ecology & Environment Special Interest Group Convenor, Peter Tait, via email to aspetert@bigpond.com

To view the selection criteria and further information on this award please click on this link

11
Call for Nomination and Guidelines 2015 for the AILEEN PLANT MEDAL

Professor Aileen Plant was a great friend to Public Health, locally, nationally and internationally. Aileen was known to, and loved and respected by, so many of the public health family. As a medical epidemiologist and professor of international health at Curtin University of Technology and the Deputy Chief Executive Officer of the Australian Biosecurity CRC for Emerging Infectious Diseases, she was one of the World Health Organization’s leading experts in outbreak investigation.

Within her extensive experience in outbreak investigation, her main interests were in the applied research and policy aspects of infectious disease control. She was passionate about her work and travelled extensively, often with great risk to herself, to help people and countries in need of her expertise. She was an amazing teacher and mentor and those who were fortunate to have experienced her teaching and academic supervision bear testament to her perennial encouragement, her humour; her commitment to excellence and above all to her reflected joy in her students’ achievements.

Professor Plant has been described as a leader in her field and a person of great compassion. She was committed to all aspects of public health. Aileen Plant’s contribution went beyond communicable diseases and across all areas of population health, including but not restricted to international health.

She had a passion for teaching, mentoring, and the application/translation of research to make a difference. It is therefore fitting that the four peak Australian public health organisations have come together to strike a medal, “The Aileen Plant Medal” to be presented at every national Population Health Congress. The inaugural medal was first presented at the Population Health Congress in 2008.

Eligibility for nomination

A person must be nominated by a 2nd party. Any early career population health practitioner can be nominated for the Aileen Plant Medal, provided they have made a significant contribution to the field of population health and are not a current member of the Population Health Congress Organising Committee or sub-Committees.

For Guidelines and Nomination Form click here
We are delighted to announce that the Population Health Congress 2015 will be held in Hobart, Tasmania, Australia from 6-9 September 2015 at the Hotel Grand Chancellor, situated in the heart of Hobart on its beautiful waterfront location.

The pre-eminent population health event in Australasia, the Population Health Congress is expected to attract over 1000 delegates from Australia, New Zealand and the Asia-Pacific regions, from a range of population health backgrounds, including health promotion, epidemiology, public and environment health, public health medicine and primary health care.

**TOPICS OF INTEREST**

The theme for the 2015 congress is “One Vision, Many Voices”. This theme will be explored and discussed through the following six sub themes:

- **ENGAGEMENT AND ADVOCACY ACTION**
- **RESEARCH AND KNOWLEDGE TRANSFER**
- **GRAND CHALLENGES AND WICKED PROBLEMS**
- **HEALTHY PLACES AND SPACES**
- **VULNERABLE POPULATIONS**
- **ADVANCING PUBLIC HEALTH POLICY**

**CALL FOR ABSTRACTS & WORKSHOPS**

Authors are invited to submit their abstracts online at: [www.populationhealthcongress.org.au](http://www.populationhealthcongress.org.au)

Abstracts may be submitted for one of several presentation formats:

- **Long Presentation**: 12 minute oral presentation + 3 minutes Q&A
- **Snapshot Presentation**: 5 minute oral presentation, focused on a single finding or message
- **Oral Poster**: A0 in size, portrait page orientation, presented with 3 minutes to discuss
- **Poster (traditional)**: A0 in size, portrait page orientation (no oral component)
- **Workshops**: Up to 120 minutes for a self-contained session

**KEY DATES**

- Workshop submission deadline: Friday 13 February 2015
- Abstract submission deadline: Friday 13 March 2015
- Author notification of outcome: Mid-May 2015
- Author registration deadline: Monday 15 June 2015

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