Public Health Association of New Zealand Inc

PHA

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Fluoride debate rages on in Waikato

In the last *PHA News* we featured the fluoride debate currently taking place in Waikato. The Hamilton City Council held a workshop in November to consider whether fluoridation of the city's water supply should be discontinued. In February, an independent telephone survey of residents was conducted to assess public opinion.

The question asked was 'Hamilton has hydrofluorosilicic acid (commonly known as fluoride) added to the drinking water. Do you wish this to continue?'

Results were:

- 63 percent supportive of fluoridation
- 17 percent neutral or don't know
- 20 percent against (10 percent strongly against).

Despite these results, at a meeting on 20 February, the council voted in favour of a binding referendum on whether or not fluoride ought to remain in Hamilton's water supply. The referendum is to be conducted on 13 May 2006. If you live in the Hamilton area, please make sure you vote - and encourage others to do the same.

"Removing fluoride from Hamilton's water supply will have implications for dental services and the overall health of residents."

The Public Health Association is extremely concerned that the Hamilton City Council is seriously considering removing fluoride from the city's drinking water – even after a telephone survey showing strong support for its retention.

There is a huge body of evidence that shows water fluoridation is a safe and cost-effective way of protecting teeth from dental carries. Removing fluoride from Hamilton's water supply will have implications for dental services and the overall health of residents – including an increase in waiting times for hospital dental services.

The health of children, Maori, Pacific peoples and those on lower incomes will be particularly affected as these groups tend to have poorer oral health, and their increase in diseased teeth will therefore be greater.

The PHA has offered to support pro-fluoride groups in Waikato, as this matter goes to referendum.

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PHA urges total ban on alcohol advertising

On 29 March, PHA Director Gay Keating addressed Parliament's Law and Order Select Committee, and called for a total ban on alcohol advertising.

The committee was considering submissions on the Sale of Liquor (Youth Alcohol Harm Reduction) Amendment Bill.

Dr Keating said the Government needed to get serious if it wanted to change New Zealand's binge drinking culture.

"Alcohol advertising has a significant impact on the attitudes of people towards drinking, especially the attitudes of young people. Alcohol advertisements portray drinking as a sophisticated and desirable activity, and ignore the negatives of drinking – such as the risk of death, fetal alcohol syndrome, family violence, and crime."

She said young people are subjected to a barrage of alcohol ads on television from 8.30 in the evening – when over 25 per cent of 10-17 year-olds are watching.

"Advertisers pay hundreds of thousands of dollars for the funniest, quirkiest, most effective ads. It's all about encouraging people to drink more, more often."

> "Alcohol advertising has a significant impact on the attitudes of people towards drinking, especially the attitudes of young people."

Dr Keating said making a few changes here and there – such as requiring alcohol ads to be screened later at night – would have little effect. Decisive action was needed to help reduce alcohol-related harm.

"The PHA calls for a complete ban on alcohol advertising as part of a comprehensive package to reduce alcohol-related harm and change New Zealand's drinking culture."

She said in the meantime, the Advertising Standards Authority (ASA) should cease to have any jurisdiction over alcohol advertising.

"The ASA has shown that it is not an effective regulator. From 2000 to 2003, a total of 84 complaints about alcohol advertising were received, but only 30 percent upheld. This is always the risk when an industry regulates itself. Banning alcohol advertising completely would remove the need for the ASA. In the meantime, the independent Broadcasting Standards Authority should adjudicate on all alcohol advertising complaints."

Conference update

PHA Conference 2006

Online registrations are now open for this year's PHA conference – Sustaining Public Health – Pupuri Te Whare Tapa Wha. The conference, to be held in Palmerston North from 5 to 7 July, is a great opportunity for people with an involvement in public health to increase their knowledge and network with colleagues. The conference planning team is looking forward to making this a hands-on, interactive conference.

The conference programme has come together extremely well, and some exciting key note speakers are lined up. The full programme can be viewed on the PHA website from mid-April: www.pha.org.nz. Conference highlights include information on new initiatives such as the cancer control continuum, collaborative work in the area of population health, and the interaction of population health, primary healthcare and secondary healthcare. There will be a number of interactive workshops, and a focus on core competencies in public health.

New Office Hours

The PHA is now open Monday to Thursday: 9 am - 5 pm

McKenzie Scholarships 2006

Some limited funding is available to people who work for community organisations that do not have funding support from other sources, to attend the PHA conference in July. The closing date for applications is 19 May 2006.

The scholarships will pay:

- full conference registration
- accommodation at $40 per night (any difference to be made up by scholar)
- one ticket to conference dinner (extra tickets at scholar's own cost)
- 60 percent travel at the lowest economy airfare or other (ie, travelling by car or train), whichever is the lower amount
- one year's PHA membership.

See the PHA website for further details: www.pha.org.nz, or email pha@pha.org.nz, and put 'scholarship' in subject line.

National office happenings

PHA Director Gay Keating

It is hard to believe we are heading into winter; some of us are still recovering from the Christmas holidays!

At PHA HQ in Wellington we've been working on a number of issues, making submissions, planning for the conference, and keeping up our media presence.

In particular, we have been working with other agencies, and developing media releases, opinion pieces, articles and letters to the editor on the following issues:

- the Hamilton City Council's referendum to determine whether or not fluoride should stay in the city's water supply
- repeal of section 59 of the Crimes Act – this is the Bill from Green MP Sue Bradford, which seeks to remove the 'reasonable force' defence currently available to parents who seriously assault their children
- the Janice Pou case against British American Tobacco (NZ) and WD & HO Wills
- the Select Committee inquiry into obesity and type 2 diabetes in New Zealand.

Gay Keating has made the following submissions:

- to the Finance and Expenditure Committee on the 2006 Budget Policy Statement
- to the Justice and Electoral Select Committee on the repeal of section 59 of the Crimes Act (physical punishment of children)
- the Law and Order Select Committee on the Sale of Liquor (Youth Alcohol Harm Reduction) Amendment Bill (oral submission was heard on 29 March)
- Ministry of Health public health workforce development project.

Upcoming submissions include to the:

- Health Select Committee on the inquiry into obesity and type 2 diabetes in New Zealand (submissions close 26 April)
- Ministry of Health on its consultation document that sets out options for the regulation of direct-to-consumer advertising of prescription medicines (submissions close 28 April)
- Government-led review of regulations controlling the advertising and promotion of alcohol.

Core Competencies Project

Work is continuing on the Core Competencies Project – a 16-month initiative which evolves from the Public Health Directorate of the Ministry of Health's Public Health Workforce Development Plan.

It progresses previous reports on the development of public health core competencies with the goal of establishing and advising on the implementation of generic competencies that will form the basis of training and qualification frameworks.

The first draft will be ready for consultation in May.

Changes in Council structure

The current president of the PHA - Marty Rogers - has notified council that due to personal circumstances she intends having some time off from her council role until the July 06 AGM. She will be available as president again following that meeting.

In the interim, we have made some changes to council roles so that we can progress some of the work that is pending.

Dallas Honey will act as president, with Michelle Mako acting as vice president. Kathrine Clarke will look after human resources matters.

The biggest piece of work is the completion of the PHA review paper, and the implementation of some of the outcomes/recommendations. As a result of the review process, there will be communication with the branches and at the AGM regarding future PHA structure.

One of the agreed outcomes of the review that will be implemented as soon as possible is the redesigning of the Director's role by the development of a National Executive Officer (NEO) position (the exact title of this position has not been completely decided at this stage).

The position will be scoped and offered to Gay Keating (existing Director, who has been involved with the discussions leading to these decisions). Further configuration of staff will then be carried out by the NEO.

A day in the life…

Multitasking is something PHA Director Gay Keating has become very good at over the past five years. It's an essential skill when your tasks in any one day can include talking to decision-makers, being interviewed by the media, tracking down items in the budget, training staff, drafting a policy document, and taking your turn making the coffee.

Here's a report from Gay on a typical day in the PHA office.

Wednesday was a relatively quiet day for me because I spent so many hours sitting in Select Committee. While there I talked to a journalist from Select Committee News – we want to ensure he is on our media database. I listened to the other oral submissions on the Sale of Liquor (Youth Alcohol Harm Reduction) Amendment Bill, and then, with Dr Helen Bichan, presented for the PHA.

Back in the office I had to review staff arrangements – office manager Bella has to change her work days because of new childcare arrangements.

Then onto some paperwork – planning the countdown to the AGM in July, and for the selection of the 2006 PHA champion. Time to put my computer skills to the test now, and put the latest PHA media release up on the website.

Make Liz (Communications Manager) a cup of coffee.

An email comes in from a governance group member on draft core competencies – I send around an email to set up a meeting. A journalist rings wanting to follow up on our press release calling for a complete ban on alcohol advertising. I accept an invite from the Minister to the launch of a report, and pass on to Liz to consider whether the PHA should put out a media statement to coincide with the launch.

"I contact the journalist and wonder what to wear. And Liz wants ANOTHER coffee."

I respond to a member's request for the PHA submission on the budget policy statement 2006, and wrestle with a problem with the office computer back-up system. Another email goes out, this time confirming the time for the Communications Committee meeting. I make a start on the agenda.

There is a follow-up meeting planned on New Zealand's interpretation of the WHO code of compliance for breast milk substitutes, and I liaise with the Ministry of Health, and PHA Council member who will be attending.

Time to turn my attention to the conference. I sort out a problem with a mis-match of submitter contact details and abstract – the wrong person got the "pleased to tell you that your paper has been accepted" message. Make a note to discuss these issues with the developer of the on-line submission site.

I need to review the text for the PHA News, and comment on an op-ed piece on housing that has been developed - I put both in my 'to do' pile.

I forward a number of emails addressed to me to the relevant people in the office. Then receive a call from an Australian public health advocate about a proposed NZ television programme – would the PHA NZ be prepared to go out on that topic? I contact the journalist and wonder what to wear. And Liz wants ANOTHER coffee."

Supporting a public health perspective in local and regional government

The PHA has developed a package with information on influencing local and regional government so they become partners in improving health and reducing health inequalities.

To help track when local and regional councils are calling for public input to their plans and processes, we've gathered together a list of the council websites, and prepared a template letter.

The information is on the PHA website – www.pha.org.nz, or contact the office (04 472 3060 or pha@pha.org.nz) for advice and assistance.

The benefits of health impact assessment

'Health impact assessment' is a concept with the potential to make a big difference to the health of New Zealanders.

It is widely accepted that the factors that have the greatest effect on people's health and wellbeing are beyond the control of the health sector. They include income, housing, education and employment. Health impact assessment helps to predict the potential effects of policies being made in all these areas on health and health inequalities.

An example given in the Public Health Advisory Committee publication *A Guide to Health Impact Assessment* is the introduction of market rates to state housing rentals in the 1990s. If the health impacts of this policy had been assessed, it may have highlighted the implications of overcrowding, which is linked with infectious diseases such as meningococcal disease.

"Health impact assessment is an important tool that should be used widely by local, regional and national policy makers…"

A more recent example was the introduction on 1 April of the 'in work' payment, part of the *Working for Families* package. While the *Working for Families* package will make a huge difference to the health of many children in low-income families, any additional financial support needs to be extended to all children who need it, not just those with parents in work.

These caregivers often have a smaller income than those in paid employment, and are less able to afford essentials like healthy food and adequate housing. This in turn affects the current and future health of their children.

By considering the impact of a policy on the health of children and families, the Government could be alerted to any unintended negative consequences of that policy, such as some groups slipping further into poverty, and experiencing poorer health.

The Public Health Association believes that health impact assessment is an important tool that should be used widely by local, regional and national policy makers. It should be used over a range of issues, including housing, education, welfare, employment, transport, taxation and health.

For further information on health impact assessment, see the Public Health Advisory Committee publication *A Guide to Health Impact Assessment: A policy tool for New Zealand* on the NHC website:

http://www.nhc.govt.nz/phac.htm.

New voices in Maori public health

The infrastructure and expertise of Maori public health has developed remarkably quickly. Not so long ago there were few workers in the industry. Now there is a network of providers around the country, offering services, education and training in a whole range of areas.

A new breed of educated younger Maori professional is also becoming much more visible. They are rising through the ranks, and have interesting new perspectives. In this issue of the *PHA News* Anton Blank profiles Peter Thomas and Skye Kimura.

Peter Thomas (Te Rarawa/Nga Puhi)

At 28 years old, Peter Thomas calls himself young.

"That's the thing about us. We're passionate and enthusiastic about what we do but we're still young." Peter laughs.

That may be so but Peter could almost be called a veteran. He's been in the trade since he was eighteen. Peter was born and raised in Moerewa and later returned to Panguru in the Hokianga Harbour, and his first job was as Sexual Health Liaison Officer at Hokianga Health Trust.

"Apart from sexual health, I worked in alcohol and drug education as part of a pilot programme CAYAD established in five communities around the country."

"It was difficult being such a young worker because you had to work with older Maori who were dictating how things should be done. I felt I knew what those young people needed. I knew how to talk to them about healthy choices."

It was in the Far North that Peter also began his academic training. He completed three year training in Maori Theology and Philosophy with Kura Tikanga o Ngapuhi nui tonu.

"Later on I completed a post graduate Diploma in Public Health at the University of Auckland. I also have a certificate in Performing Arts and Adult Education, and at the moment I'm working on my Masters in Public Health."

Peter is gay and lives in a gay relationship, and he thinks this adds another dimension to his skills and work.

"I'm used to being different, and it gives me a passion to keep working in health. I was also raised within whanau so I have a really good idea of how a family functions and dysfunctions."

Peter's second job was with Ngati Hine Health Trust, working in areas like diabetes education, food and nutrition, Hepatitis B and smoking cessation. After that he moved to Wellington to work for The Family Planning Association.

"That was a very different experience working within a Pakeha organisation. I did a year there and then I moved to my current role as Mental Health Policy Manager, for Whakapai, which is part of Capital and Coast District Health Board."

"Our role is to offer advice to mental health services on tangata whaiora mental health outcomes. We contribute at all levels: policy, strategy and operations."

"Some of the work is difficult. Mental health clinicians have to be clinically safe, and it's hard for them think about things like Maori spirituality in the context of their work. What I find is that we rely very heavily on Mâori staff to work with tangata whaiora."

Peter's got some strong thoughts on how the sector is developing.

"We still lack good training. There are so few of us who have been tertiary trained and trained in the Maori community. We also need to be careful in our work that we don't end up demonising our people. Sure they have a raft of issues to deal with but we must also remain a happy population.

"Bombarding Maori with health messages can make them feel like sinners. Our work should be about healthy human relationships not disease."

Skye Te Rangi Kimura (Ngati Raukawa/Ngati Tuwharetoa/Ngati Maniapoto/Taranaki/Ngati Rarua)

Twenty-seven-year old Skye Kimura recently moved from a job in sexual health with Te Puawai Tapu to a role as youth advocate for Te Reo Marama (Maori Smokefree Coalition). She has a Diploma in Health Studies from Te Wananga-o-Raukawa.

It's a move back to tobacco control for Skye who started life in public health as an Auahi Kore health promoter for the Mid Central District Health Board.

"That job was a real learning curve for me because it taught about the importance of looking at the big picture and the determinants of Mâori health. If you acknowledge those and factor them into your work, you'll get better outcomes." Skye says.

This was a major shift for Skye who says she went into the role expecting to tell Maori people not to smoke.

"It was also about adapting the stuff my parents taught me. I was brought up a pa girl through and through – in Ngati Raukawa. I'm bilingual and I feel really privileged. I know that I can make a real contribution to te ao Maori."

Skye describes a stint in Australia with her partner as a culture shock.

"We lived in Port Douglas. I was really shocked at how they treated their indigenous people and how I was treated as a person of colour. They assumed I was uneducated."

Sexual health was a shift that Skye enjoyed, and a different kind of health promotion.

"It's different because you're trying to warn people about issues that actually stem from something enjoyable. It's also way down the list of national health priorities, so we also had to battle for resources the whole time. It was awesome to work for an organisation that was kaupapa driven."

Looking ahead at her work with Te Reo Marama, Skye echoes some of Peter's philosophies.

"We need to be careful that we don't demonise our people in the work we do. We must always remember that this issue is about the tobacco industry and the way they exploit Maori people."

"We must always remember that this issue is about the tobacco industry and the way they exploit Maori people."

Flipping the gaze: Pakeha privilege

Timmy lives in his Auntie's ~~house with two bedrooms,~~ ~~a treehouse and a~~ garage. This morning he got up and he had ~~a bowl of coco-pops,~~ two pieces of toast ~~with jam and watched cartoons~~ before his ~~mum and~~ dad got up.

Then he went and played football with his dad. He had a cough, so his dad wrapped him up warm ~~and spent fifty dollars taking him to the doctor~~ which made him feel ~~a lot~~ better. He then played ~~with his toys~~ for a while.

His shoes had holes in them so his dad had to decide whether to ~~walk into town or drive~~. ~~They took the car because they were going to~~ buy groceries ~~for dinner and then his dad took him to the sports shop to~~ buy him ~~new~~ shoes.

He was a bit sick ~~of shopping~~ so they went back home and had some dinner and then he said good night to his dad ~~and then he went to his room~~. He put on ~~some music and took off~~ his hoodie ~~and jeans~~ and went to bed ~~snuggled up under his massive duvet~~ because it was ~~a bit~~ cold.

How do you sleep at night? One in three children in Auckland are sleeping in poverty. Please call 0900 4 2825 to give an automatic $20 donation to the Auckland City Mission Winter Appeal and make every kid's story complete.

Jenni Moore from Northland Urban Rural Mission shares her thoughts on Pakeha privilege.

"Whiteness is not visible to the powerful, because they themselves are white. They notice black, brown, other bodies and the differences of those imaginations. But whiteness, to the white is the norm. It has the normative status in the same way that 'man' has a normative status. The able body is the neutral body. The marked body is outside what is regarded as the norm: it is too thin, it is too fat, it is crippled, it is mad, it is unpredictable". Susan Hawthorne

As a Pakeha woman, my life may well have been very different if I had been born into a poor Maori family than that of my real life experience: born to a well-resourced farming family in mid-Canterbury, even if a Methodist veneer of austerity was laid over that experience. I have led an easy life on the face of it, give or take a few minor crises or two. I've sailed through school, work training and numerous interesting and relatively well-paid jobs. Lucky old me. Lucky? Or how much of that 'ease of passage' was because I was Pakeha, and not Maori?

The debate of Pakeha privilege was raised at the 2005 PHA conference in the context of health services. The challenge was laid that we need to speak about it - and stop pussy footing around this ever so sensitive topic. Pakeha privilege is the flip side of Maori faring poorly, in health status and utilisation of health services. So if Maori are receiving less than their fair share of (for example) angioplasties, the flip side is that Pakeha are receiving more than their fair share. This stark equation can be replicated in every unequal health-utilisation statistic.

So in a fair and just society are we happy to acknowledge not only that Maori are badly off, but Pakeha are correspondingly well off? This is an issue of conscience and a further personal incentive for Pakeha to move to address the myriad of inequalities that benefit Pakeha. The implication of this reality is that we need to accept the unpalatable fact that our potential to benefit may be getting in the way – consciously or subconsciously – of how we support the cause of reducing inequalities. Because of the structure of privilege over disadvantage, our current responses are not addressing the problem because those structures and mechanisms that support Pakeha privilege remain in place. It is possible that improving Maori health may mean less resources for Pakeha and those in funding positions of power need to have a clear analysis of how privilege works, to be able to act to make the changes that we are all charged with achieving.

To the left is one of a series of advertisements from the Auckland City Mission and is reprinted with its permission. It illustrates the realities of the above article.

Using underage tobacco sales money to enhance youth health

Each year, $18-24 million dollars in tax is gained from sales of tobacco to underage New Zealanders. Rob McGee, Tony Reeder, and Helen Darling from the Social and Behavioural Research in Cancer Group, University of Otago have some ideas on how that money could be used.

The proposal

We propose that the tax monies gained from the sales of cigarettes to underage young New Zealanders be used to directly sponsor efforts to enhance their health in its broadest sense. It is morally appropriate that this money is returned from whence it came in the form of assistance to improve the health of all New Zealand youth. There is a real need to fund prevention efforts to reduce high rates of adolescent health compromising behaviours such as tobacco smoking, binge alcohol drinking, other substance use, unsafe sex, depression and violence.

The need

In the past, not a lot of information has been available about the health of young New Zealanders. More recent surveys, both nationally[1] and in Dunedin[2], provide a good snapshot of adolescent health. What is life like for young people in New Zealand? Most believe that they are in good health and by and large, they feel that they are supported by adults around them; their teachers are fair; and their neighbourhoods are safe.

Nevertheless, individual behaviours that might compromise the health of young people were commonly reported. These included binge drinking of alcohol (four in ten young New Zealanders binged on alcohol in the last month); drink driving (over one quarter had been a passenger in a car with a drunk driver); cannabis use (one in seven had used cannabis three or more times in the last month) and violent behaviours (a quarter had been involved in two or more fights in the last year). Mental health also was a cause for concern; depressive symptoms were common (one in five girls, one in ten boys), and one third of girls and one sixth of boys thought about killing themselves in the last year; one in ten girls and one in twenty boys engaged in self-harming behaviour.

> "One aspect of smoking that receives relatively little attention is 'who profits from youth smoking?'"

In terms of behaviours that are health protective, one in four boys and one in three girls who were sexually active did not use a condom at last intercourse. About three in ten boys and four in ten girls did not engage in regular physical activity, yet many strived for reduced weight. Only one in three reported eating five or more servings of fruit and vegetables per day.

We believe that the explanation for these high rates of problematic behaviours needs to go beyond simplistic notions of peer pressure, impulsivity, youthful risk taking or poor self-esteem. We cannot disengage these behaviours from the wider society in which they occur. By and large, adults make the rules. They market and sell (and in some cases buy) the alcohol and tobacco that young people consume. They control the media and thereby any sexual and violent imagery to which young people are exposed and that many want to copy.

More importantly, perhaps, adults control the resources that determine the availability and accessibility of health services and health promotion programmes that address the sorts of behaviours outlined above. It is this issue that this proposal addresses.

Under-age sales of tobacco

After rising in prevalence during the 1990s, tobacco smoking among young New Zealanders seems, thankfully, to be on the decline[3]. However, tobacco smoking remains a highly important health issue because of the associated short- and long-term serious health effects. Furthermore, the burden of smoking among young people falls disproportionately upon the disadvantaged and young Maori. One aspect of smoking that receives relatively little attention is "who profits from youth smoking?" Young people smoke primarily because adults sell them cigarettes. Nearly one of every two secondary school students who smoke daily buys their cigarettes from a shop; a further one in six gets someone else to buy them[4]. It can be estimated that, on average, students who smoke tobacco buy about one packet of cigarettes per week or 52 packs per year. This translates into government taxes and GST of between $18-24 million accruing from these sales[4-5]. The retailers, usually depicted as the bad guys, only get about $8 million split between about 8,600 of them.

What should be done with this money?

We believe that this money should be returned in the form of directed aid to those who generated it in the first place. There are good moral reasons for this. There is a need for sustained high quality health promotion efforts to reduce the health compromising behaviours engaged in by many NZ adolescents, and to increase the health promoting ones. There are already programmes in existence that might serve as models of good practice. In Dunedin,

for example, we can point to the Otago Youth Wellness Trust, the Dunedin Kids on Bikes Programme and the Youth Mental Health Expo as innovative programmes for young people. Doubtless there are many others throughout New Zealand. However, resourcing and consequent difficulties in sustainability are often problems for these types of programmes. More work is also needed to develop innovative ways of reaching youth.

The idea of using money obtained from tobacco tax to address health issues is not new. For example, an appropriate model is Healthway, established in Western Australia under the Tobacco Control Act 1990[6]. The purpose of Healthway is to not only discourage tobacco smoking but also to promote good health and prevent illness. Children and young people are identified as the major target group. Mental health and physical activity are also identified as priority areas. Apart from health promotion programmes and research activities, funding is also provided for sports and arts sponsorship.

In NZ a comparable organisation would be the Health Sponsorship Council. One possibility is that the additional funding from tax on under-age sales could be distributed through this organisation, and specifically targeted towards improving the health of young people.

It could be argued that these young smokers are financing the Quit programme for adult smokers in NZ and that if adults quit, then children will be less likely to take up smoking. We believe the evidence to support this is not strong. At the moment, smoking among young people is falling at a time when the prevalence of smoking in adults has remained steady at around 25 percent. The prevalence of youth smoking rose dramatically in the 1990s and there is no reason to suppose that these kinds of dramatic upswings in smoking might not happen again. Furthermore, current levels of smoking remain unacceptably high, especially among disadvantaged youth and young Mâori.

A better way for New Zealand young people

Richard Eckersley, an Australian social commentator on the place of young people in Western society, argues that behind the bald statistics associated with youth behaviour lies a failure of our societies to provide young people with a sense of meaningfulness, a sense of connectedness to the wider society, and a sense of being valued for themselves. If this is true, governments have a responsibility to lead the way in providing the means to help address these issues. Increased funding would allow greater innovation in addressing issues of concern to young people. While New Zealand does well in developing broad social marketing approaches to health, in the case of young people these need to be backed up by strong community level programmes and action. We believe this proposal would allow the development and exploration of other models of action such as community development approaches, and the use of information technology.

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Public Health Champion Award 2006

Do you know someone who has made a special contribution to public health? The PHA is currently calling for nominations for the public health champion award. The purpose of the award is to identify outstanding individuals, profile the issue or work of the individual, and raise the profile of the PHA.

The recipient will have made an outstanding contribution to public health in the past 12 months and may:

- be well known in a local public health community.
- be a well-known national public health figure
- have been regularly in the news on a major public health issue.

For further information see the PHA website – www.pha.org.nz.

Closing date for nominations is 30 May 2006.

The American Public Health Association conference

Kristen Berger, Policy Analyst, Women's Health Action Trust, reports on the American Public Health Association (APHA) conference in Philadelphia, 10 to 14 December 2005.

I was lucky enough to attend the American Public Health conference as a representative of the New Zealand Public Health Association through the World Federation of Public Health Associations. This was a wonderful opportunity to learn about the some of the important universal issues in public health and to gain content knowledge from the individual scientific presentations.

Over eleven thousand public health professionals descended on the cold and snowy streets of Philadelphia, Pennsylvania for five days in December to attend the American Public Health Association's 133rd Annual Meeting and Expo. With over 1,000 scientific presentations and over 500 exhibitors there was something for everyone

Evidence-based policy and practice

The theme of this year's meeting was "evidence-based policy and practice". The pressing need, particularly in the American context, to focus on evidence-based policy and practice was emphasised throughout the conference. Mr. Tsou, the APHA president, opened the first general session by discussing the joys and wonder of working in public health, declaring that it is one of the most rewarding jobs anyone could ever have because "public health professionals get to do two virtuous things - public service and health care" and concluded that the common goals of public health workers are to fight inequalities. This rousing speech, delineating the APHA's opposition to the war in Iraq and the need for universal access to health, brought thousands of people to their feet stamping and applauding.

American public health priorities: war, woe and the moral right

Senator John Kerry gave the key note speech which outlined the three main themes of the conference. First, the overriding import and influence of the fact that the US is currently at war. The second and universal theme was the need to address inequalities in health. Thirdly, the overarching theme of evidence-based policy and practice with attention to the current crisis facing health care in the US, what he termed "the attack on science" when evidence is ignored for political and ideological purposes.

In addressing the war, Kerry highlighted the way it affects not only the hundreds of thousands of people in Iraq but the way it has allowed the US Government to ignore pressing issues at home. On the deep inequalities apparent in the US healthcare system Senator Kerry outlined his current "Kids Come First" bill which aims to expand government-funded health insurance for children in poverty (Medicaid).

The US is facing a crisis in health care. Kerry stated "we need to be in battle - because science is under attack". Senator Kerry cited recent events such as the suppression of research on mercury and the current administration's refusal to believe evidence from the Federal Research Board. In appeals to morality, on which he supposedly lost the US presidential election, Senator Kerry concluded that "we need to make America a reality-based community, that's what morality and real values are about".

> **"We need to be in battle - because science is under attack."**
> - Sen. John Kerry

Something for everybody

Scientific sessions addressed everything from abortion to Zidovudine. The range and scope of papers, the number of streams and special sessions were endless. It is impossible to do them justice either on the spot – as you select from the wide array of topics on offer - or here later looking back.

Keeping with the theme of evidence-based policy and practice, many sessions examined the ways in which evidence is or should be used to determine practice. Special sessions included "sequestered science: the public health consequences of undisclosed knowledge", "evidence in the policy process" and "the realities of evidence-based public health".

Politics and public health: in/action!

Kerry's keynote speech reflected the overwhelming concern amongst participants over the misuse of scientific evidence for political purposes. This concern was perhaps best illustrated by the popularity of a late session called by the Union of Concerned Scientists on the last night. With little notice and no mention in the programme, hundreds of people turned up to hear Susan Wood and others discuss "Defending science from political interference: Public health scientists forced to alter data?" The sheer numbers in attendance overwhelmed the original room this session was scheduled for, and as participants decided to take over a large auditorium, a feeling of rebelliousness was in the air.

Dr Wood who stepped down from her position as Director of the FDA's Office of Women's Health in August in protest of the agency's refusal to issue a decision on emergency contraception was joined by four federal scientist and academic staff who have all stepped down from "good" public service jobs over frustration with bad policy and ignoring scientific evidence. This session served as a rallying cry to public health professionals as all of the presenters discussed the various means by which scientific evidence is undermined. Dr. Wood concluded that political pressure from outside of Washington DC and the force of civil society is the only way to get the US federal scientific agencies back on track.

Although the focus was largely on public policy and government interventions in science and health, it should be noted that the clear need for integrity around scientific evidence and data needs to explore corporate sponsorship and responsibilities as well. At the beginning of every session presenters informed the audience of any conflicts of interest that may exist. Sessions related to commercial interest in public health included topics such as international trade and public health and critical perspectives on pharmaceutical corporations.

The implications for NZ

Dr Wood underlined a salient point: No matter how much we may trust our elected officials or democratic processes, it crucial that we maintain robust and healthy civil society organisations. Only by providing alternate voices to the evidence selected in the policy-making process can the integrity of evidence be evaluated. The US example shows what can happen when a political ideology is allowed to overshadow evidence. The accumulating examples of suppression and willful ignorance of scientific evidence for political purposes must remain a live concern for public health workers throughout the world.

Public health the Canadian way

Bay of Plenty-based Medical Officer of Health (MoH) Phil Shoemack recently swapped jobs with a Canadian MoH, and spent four months living and working on the Sunshine Coast, just north of Vancouver. He tells *PHA News* of his experiences.

Public health is the same where ever you go, right? Well sort of. While most of the issues I got involved with during my four months working in Canada were amazingly similar to home, there were exceptions.

Within weeks of arriving I had responded to three separate inquiries about rabies. In each case the caller had been exposed to a bat. The local Canadian protocol in instances where bat exposure is even a possibility is to advise for post-exposure administration of rabies immune globulin (RIG) and five weekly doses (ie, five doses over four weeks) of rabies vaccine; the cost for the product alone of about $1000, which is borne by the health system.

One day a lab technician rang from Bella Coola, one of the more remote townships I covered (Bella Coola is a 1300km drive from Vancouver). She said a local hunter had brought in some moose meat worried about the small popcorn-sized white balls he had seen in the raw meat. I arranged for a sample of the meat to be sent to the provincial public health lab for identification. It turned out to be a tape worm that commonly infests moose.

Mosquito surveillance is a recent activity for public health units in British Columbia (BC); due to the slow but inexorable westward spread across North America of West Nile Virus (WNV). As at the end of the 2005 autumn surveillance season, BC is the only jurisdiction in Canada or the contiguous 48 states of the US that has not identified WNV activity. Surveillance activity includes mosquito trapping, and disease surveillance in corvids (the crow family), cervids (the deer family), horses, and humans (including monitoring of donated blood).

One evening while running home from work I noticed a man out the front of his property holding a large rake. As there were bright yellow leaves around the base of the numerous maple trees I assumed he was about to start the daily battle of clearing the leaves that had fallen that day. As I ran past he said he needed to warn me that there were two bears in the neighbourhood. I considered stopping for a while to watch him battle the bears with his rake, but decided I needed to keep warm and get home before it got too dark.

Definition and funding of public health

In Canada the definition of public health is very fluid compared to New Zealand, and includes public health nursing and many other services which are delivered to individuals, such as community dental services and occupational therapy. Services are broadly funded rather than contracted and in general there appears to be more money to go around although public health remains a 'Cinderella' service receiving about 2 percent of total health spending; the same as in New Zealand. Canada spends 9.9 percent of GDP on health compared to 8.7 percent in New Zealand. However, when the level of GDP is taken into account Canada spends about 50 percent more per head than NZ does on health.

Phil Shoemack

While I was there sufficient funding was received to issue a laptop computer complete with a wireless card and portable printer for each public health office to use in any emergency situation (ie, four for the unit I was working in). Each office also has a satellite phone and fully-stocked emergency kit.

Canada has $300 million of medical equipment in eight warehouses around the country ready for use in an emergency. On the Sunshine Coast there are two 80 foot containers and one 40 foot container with all the equipment needed for a field hospital. This is on site at the local high school. Unfortunately it dates from the cold war era and expert opinion is that it is outmoded at best. It would also take 80 people to deploy.

Travel is a major issue within British Columbia, let alone across Canada. Parts of the area I covered are only reachable by plane or boat. While Vancouver was only 35kms away, it took close to two hours to reach due to the ferry.

Many meetings are conducted by teleconference. The Public Health Department at the University of British Columbia has regular seminars. It is possible to hook into many of them via the internet and a toll free phone link.

General health service issues

I attended the monthly Medical Advisory Committee meeting at the local hospital. Issues discussed usually followed a similar line to what can heard at the same fora in New Zealand with topics such as:

- review of laboratory services with centralisation of some testing procedures, problems with specimen delivery times, and result reporting times
- opening of new acute mental health unit with ongoing problem of recruiting and retaining staff
- pressure on hospital beds with patients often being admitted to 'corridor' beds
- over-budget status of large hospitals resulting in financial squeeze on all health services, including public health
- clinical protocols being developed for many different interventions
- local people questioning the accuracy of official population projections, believing they under-estimate reality
- issue of end of shift patient handover (between doctors)
- long time frame for getting new buildings
- inefficient "administration"
- hospital is built on Indian band land, but band members feel uncomfortable in hospital premises and have difficulty accessing care
- problems with drug seekers in ED.

General practitioners work in privately owned clinics, often with no nursing support. Their services are free to all patients. The use of community-based midwives is increasing but they are still responsible for less than 10 percent of births. Most general practitioners have hospital privileges, so when they admit a patient to hospital they continue to be involved, and in some cases, responsible, for their care.

As a result GPs are definitely more involved with hospital management issues and clinical decision-making. Most vaccinations are delivered by public health nurses in community clinics, many of which are located on the public health unit premises. Vaccination coverage rates are not known with any accuracy but surveys suggest they are reducing and are probably less than 75 percent at two years of age and on time coverage is about 65 percent. Vaccines are therefore stored in large quantities in vaccine fridges in public health units. Written consent is not required for children to receive vaccines at school and children as young as twelve are able to give verbal consent if a nurse assesses them as being competent to do so. The PHNs also do most of the antenatal classes and well baby checks.

> "Written consent is not required for children to receive vaccines at school and children as young as twelve are able to give verbal consent..."

This was an amazing opportunity for me to sample the delights of living and working in another country. I would like to thank the management of Toi Te Ora Public Health and the Bay of Plenty District Health Board for allowing me to arrange this unique swap and thanks also to all my colleagues in New Zealand who one way or another 'covered' for me in my absence. I would encourage each of you to entertain the possibility of doing something similar. If you are interested please get in touch with me as I know there are several staff of Vancouver Coastal Health who are keen on coming to New Zealand.

Phil Shoemack
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Second International Asian Health and Wellbeing Conference

"Prevention, Protection and Promotion" is the theme of the second International Asian Health and Wellbeing Conference which will be held at The University of Auckland's School of Population Health on 11 and 13-14 November 2006.

The conference is being co-ordinated by the Centre for Asian Health and Research Evaluation (CAHRE), and follows the successful staging of the Inaugural Asian Health Conference in 2004.

Keynote speakers will include Professor K. Srinath Reddy, Head of the Department of Cardiology at the All India Institute of Medical Sciences, and Chair of the World Heart Federation's Scientific Council on Epidemiology and Prevention.

Professor Reddy will be joined by Professor Paul B. Pederson from the Department of Counselling and Human Services at Syracuse University in New York, Professor Edmond Chiu, Chairman of the World Psychiatric Association Section in Old Age Psychiatry, along with Associate Dean (International) Faculty of Medical and Health Sciences and Director of CAHRE, Dr. Samson Tse.

Attendees to the conference will also have the opportunity to listen to speakers and delegates from a variety of disciplines such as medical and health sciences, social services and cultural studies who will come together to discuss recent advances and issues in Asian Health in New Zealand, and the global context for Asian health.

Please browse the website: http://www.health.auckland.ac.nz/population-health/cahre/ for more information

The obesogenic environment

The Health Select Committee is holding an inquiry into obesity and type 2 diabetes in New Zealand. Obesity Action Coalition Executive Director Celia Murphy considers some of the initiatives that would help address the obesogenic environment we live it.

Celia Murphy

We live in an environment in which the easy choice is often the most unhealthy choice. It is easier to hop in the car than to walk to the railway station, easier to buy takeaways than to cook dinner, easier to give in to your child and buy fizzy drink than to insist he or she drink water. So it's no wonder that, as a nation, our weight keeps increasing.

There is no single magic solution and no single individual or group that will reverse this trend. However, as a community there are things we can push for that will go some way to making a difference.

Here are 20 things which will help to reduce obesity. None of these steps alone will combat obesity but added together they will make a difference.

1. Less advertising of high fat, high sugar foods. The ads fuel the "pester power" of the kids and influence their parents. The advertising of high fat, high sugar foods and drinks should be restricted to protect the vulnerable and gullible.
2. Smaller portion sizes in restaurants, cafes and takeaway food outlets. Large portions encourage people to eat more than they want or need. The responsibility for reducing portion size belongs to chefs, the hospitality industry, food manufacturers and retailers.
3. Stop "up-selling" takeaway and snack foods, ie, a much bigger portion for very little extra cost and the "Would you like a chips, a drink etc with that". People buy and eat more than they want or need because of the pressure and/or the value.
4. Helpful food labels. Presently some health claims, especially "% fat free" lead people to believe foods are low in energy when they may not be. Some reduced fat foods have extra sugar added to maintain palatability and contain as much energy as their higher fat counterparts.
5. Nutrition labelling on fast foods and more information in cafes and restaurants so high energy foods can be easily identified.
6. Mandatory food policies in schools to ensure healthy food is sold in tuck shops and canteens. This not only reduces consumption of poor foods but reinforces the messages taught in classroom health lessons.
7. The removal of soft drink and snack food vend ing machines from schools and their environs.
8. Appropriate sponsorships in schools. Sponsorship arrangements with companies selling high fat, high sugar foods and drinks are not appropriate. They identify and reinforce the idea that these foods are a part of a "normal" lifestyle in children's minds. They are daily reminders of high fat, high sugar foods suitable only as occasional treats.
9. Appropriate fund raising schemes in schools. Foods used for fund raising projects should be healthy.
10. A greater selection of affordable healthy foods and fewer high fat/high sugar foods to choose from in supermarkets, cafes, restaurants and fast food outlets.
11. Incentives and/or legislation to encourage manufacturers to reformulate food products to reduce the fat, sugar and energy content.
12. Safe, accessible, pleasant, well maintained places for children to play and adults to exercise. Affordable physical recreation opportunities – low cost use of swimming pools, tennis courts, sport grounds etc to encourage active leisure.
13. Cycle ways, footpaths, shopping and urban areas designed to encourage walking and cycling rather than driving.
14. Building design that encourages stair use and active living.
15. Transport systems that encourage walking and active commuting.
16. Physical education programmes in schools that encourage active play and daily, habitual, lifestyle activity.
17. Walking school buses or cycle trains to get children out of cars, more active and accustomed to "active" transport options.
18. Controlled pedestrian crossings, reduced speed limits and other road safety measures to increase the safety of roads near schools so children can walk to and from school.
19. Appropriate sponsorship of sports activities. Linking physical activity with high fat, high sugar foods and drinks is counter productive.
20. Adequate funding for health promotion activities in the community.

> "We live in an environment in which the easy choice is often the most unhealthy choice."

Making these sorts of changes requires commitment at a political, community, family and individual level. Talk about these issues in your communities, talk to your MP, your local school, local councillors, community leaders - anyone who can make a difference. Take action now.