Public Health Association of New Zealand
PO Box 11-243, Wellington
Tel: (04) 472 3060 Fax: (04) 472 3059
E-mail: pha@actrix.co.nz, www.pha.org.nz

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GUEST EDITORIAL

Cycling for Health

by Dr Ralph Chapman, Maarama Consulting, Wellington; Stephen Knight, BikeNZ, Wellington; Des O'Dea, Wellington School of Medicine and Health Sciences.

Cycling extends your life, reduces the risk of obesity and associated illnesses, improves fitness and brain function, and generally makes for a healthier human being. Quantifying the link between cycling and health is becoming increasingly important. This is because decisions about transport options are now required to take cycling into account (New Zealand Transport Strategy 2002; *Land Transport Management Act 2003*; *Getting There – On Foot, By Cycle* 2005). The Government's new Urban Design Protocol (p21) states that quality urban design places a high priority on cycling as well as walking and public transport. Part of the justification is the claimed advantages to public health. Communities are increasingly aware that a lack of incidental exercise results from what past Heart Foundation head Dr Boyd Swinburn called 'obesogenic environments', that is, local conditions preventing cycling and walking (Egger and Swinburn,1997). Does this matter?

The short answer is yes! Physical activity does improve health (Prentice and Jebb 1995; UK Strategy Unit 2003; US Department of Health and Human Services 2003; World Health Organisation,1999). Benefits include a reduced risk of cardio-vascular disease, colon cancer, and Type II diabetes. For example, Hou et al's Shanghai study examined the effects of physical activity, particularly commuting physical activity, on colon cancer risk and found that risk was significantly reduced among subjects with high commuting physical activity. Given New Zealand's high colon cancer rate, this is a significant finding.

But cycling does have risks, and these put many people off. In 1992, the British Medical Association famously concluded in its book *Cycling Towards Health and Safety* that the overall health benefits of cycling well outweigh any risks from pollution or accident. However, such claims need to be treated cautiously. If you travel by bus to the gym and then work, you can be fit and avoid the extra risk of cycling, or, indeed, car travel.

Cycle and live longer study

The point was reinforced by a study in Copenhagen over 15 years involving 30,000 people. This found that cycling to work (an average of 3 hours cycling per week) did indeed decrease

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"Making the Links for Public Health"
PHANZ Conference
6-8 July 2005
Wellington Town Hall
The main information, education, and networking forum for the New Zealand public health workforce. *There is still time to register.*
website: www.pha.org.nz.

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the risk of mortality by about 40 per cent. But the control group was sedentary (Anderson 2000). Presumably if you are equally active, but take public transport, you may be both healthy and safe.

In some cities in New Zealand, for example Wellington, safety is a real issue, and one has to weigh relative risks. We don't have the advantage of the protection-in-numbers effect. Countries in Europe with the highest levels of cycling also have the lowest number of cyclist casualties and deaths per km (ECMT 2004).

Increasing the numbers of New Zealanders cycling will initially expose some participants to a greater accident risk. However, the past three years has seen a significant and real shift by central and local government to improving on and off road cycle facilities. The coming few years will see equal improvements in such things as road user education. The aim is to reduce risk exposure, hence increasing cycling rates. If a critical mass is reached, the safety-in-numbers affect should be also further reduce risks.

Advantages

The primary health advantage of cycling (and walking) is that it avoids the need to specifically undertake exercise separately from the daily routine of shopping, going to school, getting to work, and so on. This is arguably highly advantageous for those most at risk from a lack of exercise: the 39 per cent of New Zealanders considered 'inactive' by the standard definition. Introducing relatively easily-assimilated activity into this part of the population should have definite health and economic benefits, as demonstrated by unpublished data on the Green Prescription by Dr Raina Elley.

Identifying effective policies and measures will encourage more cycling is challenging. Favourable urban development is seen as a key, but the relationship is complex for both walking and cycling. The influence of increasing density may be non-linear - i.e. felt only "when a certain critical mass of people and destinations is reached. At this point, synergistic effects may begin to occur, wherein transit becomes more viable, walking and cycling are feasible, and driving may become much more expensive due to the cost of parking and other factors." (Frank et al, 2003, p148).

Issues for Councils

This creates issues for councils such as Manukau City. The just-being-developed Flat Bush subdivision is promoted as cycle and walking friendly, but while conditions are friendly within the development, they are distinctly unfriendly once you get out of it. People still need cars for many daily activities, thus losing some of the synergy noted above. The need to create usable interlinked cycling networks is now a recognised part of increasing numbers of cycling strategies (including Manukau's).

The health benefits of cycling, how to avoid or reshape obesogenic urban environments, and how to encourage effective changes in travel behaviour, will be among the topics discussed at the up-coming New Zealand Cycling Conference, being held on October 14 and 15 in Hutt City. For more details, please visit http://www.can.org.nz/conference05/).

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Taking the lead - a public health code of ethics

by Louise Signal Senior Lecturer Wellington School of Medicine and Health Sciences

The recent debate about corporate sponsorship of the dental health service in Northland is a public health wake-up call, a public health call to action. I believe that public health should take the lead in the development and implementation of a public health code of ethics for the entire health sector.

For some time I have been concerned that public health has not had an explicit code of ethics to help shape its practice. I have been concerned that we have not explored the dilemmas that abound in public health nor determined as a profession what we are going to do about promoting ethical practice.

The uncovering of the "Unfortunate Experiment" at National Women's Hospital, and the subsequent Cartwright Inquiry, was a critical catalyst in medical ethics in this country. Let's not wait for such an unethical tragedy in public health before we get our house in order.

This is not to say that public health lacks an appreciation of its core principles. In fact, I think there is a lot of clarity about core principles. I also think that public health has other strengths upon which to build. For example, we have a strong commitment to planning and evaluation. This provides regular opportunities to reflect on what we are trying to achieve and whether we have been successful.

The Health Promotion Forum may well have led the sector with the development of a code of ethics for health promotion (Health Promotion Forum of New Zealand, 2000). This code begins the task of identifying some of the core values in the sector. These include commitment to do no harm, commitment to te Tiriti o Waitangi, commitment to social justice and equity, and commitment to collaborative ways of working.

Last (1987) argues that, "public health workers take it for granted that their activities are always morally and ethically impeccable" (p. 367). While I think this is an overstatement, I think there is a strong tenor of this in public health. Be assured – public health action can cause harm, and not just to individuals but to entire communities or society in general.

Contradictions

Fran Baum (1990) reminds us that there are contradictions inherent in health promotion, in public health. She argues, "it only takes a slight re-jigging of the rhetoric for it to become reactionary rather than progressive" (p.149). The Ottawa Charter's (World Health Organisation et al, 1986) support for enabling people to take control of their own health can, for example, be interpreted by conservative governments as justification for new right agendas of individual responsibility and withdrawal of state involvement in health promotion. Fran argues for self-reflection, for the need to recognise the problems; talk honestly about the dilemmas in trying to put rhetoric into practice; discuss errors of practice; accept that conflict is necessary to achieve changes in an entrenched system and that you cannot, if you want to maintain integrity, pretend that values do not matter (Baum, 1990, p. 149).

Call to action

So let's not wait. Let's get our house in order. Then let's move in from the margins of the health sector and provide real leadership across health. Public health, or population health as this current government calls it, is practiced in primary health organisations, in hospitals, and key health players such as district health boards are not immune from the ethical dilemmas that public health throws up. I challenge the Public Health Association, its members and everyone who works in public health to act. Let's use our public health skills to work in a coordinated way with all areas of the health sector, with managers and with the politicians to embed a public health code of ethics across the entire health sector. Then we will have a firm basis to decide about corporate sponsorship and much more besides.

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Leadership Training Programme for Mâori Public Health

by Denise Ewe & Kiri Leach, Hapai Te Hauora Tapui Ltd.

The Leadership Training Programme for Mâori working in Public Health programmes was developed specifically for the Auckland Regional Public Health Service by Mauri Ora Associates and facilitated by the CEO, Tania Hodges. In conjunction with Hapai Te Hauora Tapui Ltd, an offer was extended to Mâori public health workers, within the Greater Auckland District Health Board region, to submit applications to attend the eight day training programme, consisting of four two day noho marae over a five month period. The wananga series began, for the fifteen successful applicants, on Monday 6th December, 2004 with a powhiri at Te Kohinga Marama Marae, at the University of Waikato campus in Hamilton.

Key themes

The Leadership programme contained four key themes, these were to increase participants' understanding of a broad number of 'cutting edge' issues in relation to the provision of Mâori public health services and programmes, to strengthen participants' networks across the greater Auckland region by fostering support, mentoring, strategy sharing, the retention of Mâori staff in the public health sector and finally to provide a safe – but challenging – environment for participants to explore issues related to Mâori public health. Tania's favorite comment "there are no sacred cows' took on a whole new meaning. Several small group projects, involving all participants, were also undertaken and completed. A bonus for all participants was the outstanding quality of invited speakers who lectured, shared their knowledge and supported the Leadership programme.

Over the ensuing months eleven modules were explored, debated, discussed and actioned. The work modules covered an array of topics that included Mâori leadership styles and the political dynamics, Mâori health in the context of wider Mâori development, Mâori health policies and strategies, research and evaluation, key management skills, health protection, indigenous health promotion in the global context and PHO developments to Mâori health.

The wananga series concluded with a graduation ceremony on the 15th April 2005. It was with a mixture of elation, at completing the programme and the increased specialist knowledge we had learnt, but tinged with sadness as we had become a public health whanau.

In total, thirty Mâori public health workers have completed the programme. The first intake involved fifteen Mâori public health workers from the Midlands District Health Board region.

Like all whanau we have grown in numbers and the Auckland 'graduates' have now combined with the Midland 'graduates' to formulate a strategy for the future growth and development of ongoing Leadership for Mâori in Public Health programmes. To fully utilise the collective synergies of both regions, a combined workshop was held on 26 – 27th May at Te Kohinga Marama marae to map a P.A.T.H. way towards the future. Mâori public health planning is vital in today's political climate of community development, shared accountability, collective action and collective responsibility.

The potential for this programme to develop Mâori public health workforce capacity to both lead and contribute to positive health outcomes for Mâori has only just begun. If the nature of leadership is one of playing a constructive and positive role in advancing the wellbeing and spiritual welfare of Mâori people (Mitaki Ra: 2004) then this programme should become mandatory for all who desire to work in the field of Mâori public health.

Finally I would like to take this opportunity, on behalf of the Auckland participants, to extend gratitude and thanks to Megan Tunks and Kathrine Clarke for their dedication and support of Mâori Public Health in the greater Auckland region.

Pai Marire.

Contact: denise@hapai.co.nz

Not just another acronym: NGOs in the health and disability sector

by Jo Fitzpatrick, Women's Health Action Trust

" Not Just Another Acronym" was the title of a strategic presentation from the NGO Working group to senior Ministry of Health staff in February this year. The well attended lunchtime forum started with a beginners' guide to NGOs and the work of the third sector before moving on to meatier issues. Key challenges raised by the Working Group included funding, contracting and compliance, the limits of Ministry consultation and our differing perceptions on partnership, the place of lobbying and advocacy and the role of NGOs in the new public/primary health sector. It was a lot to fit in to a lunch time but the presentation was lively, generated some interesting discussion, and was well received.

What is the NGO Working group?

The NGO Health and Disability Working group is the Ministry of Health and health NGO sector response to the 2001 Statement of Government Intent which envisages 'strong and respectful relationships between government and community, voluntary and iwi/Mâori organisations.' Membership of the Working Group comes from across the NGO health and disability sector with representatives from: Mental health, Mâori health, disability, personal health, Pacific health and public health. It also has representation from the Ministry of Health NGO desk. The Working Group aims to identify broad sector issues and take these to the Minister and the Ministry.

What do they do?

In March, the Health and Disability Working group met with Director General of Health, Dr Karen Poutasi. The meeting followed up an earlier meeting in December 2004 where the Ministry's statement on lobbying in NGO contracts was discussed. Once again, the unresolved lobbying instruction was up for discussion but so too were:

- The results of a study the group had commissioned on NGO relationships with PHOs
- Current financial pressures on NGOs
- The results of an NGO survey on relationships with the Ministry of Health.

The PHO study

The Working group commissioned the PHO study in response to rising concern within the NGO sector about their role in the new primary health care strategy. While many NGOs endorse the philosophy of the strategy, they are finding themselves increasingly alienated by the rise and rise of Primary Health Organisations. At the NGO forum in September last year, the Working Group communicated this concern to the Minister of Health and pointed out that the PHO Steering Group did not have an NGO representative. The Minister responded by inviting the Working group to appoint a representative and this was swiftly done.

The PHO study explores and identifies issues raised by eight NGOs who are working to develop relationships with PHOs and to carve out a place for themselves in primary health. It demonstrates just how difficult this process is and highlights the fact that there is no funding or policy support for the process. It also sounds a warning: if these issues are not resolved there are major concerns about the future viability of NGOs and the health and wellbeing of the communities they serve. Clearly NGOs and PHOs are not on a level playing field and NGOs are face major challenges and are seriously under resourced as they divert resources into establishing relationships with PHOs.

Financial pressures

This issue is related to the one above but goes further in identifying issues for NGOs with a service delivery component. It covered the following:

- Transaction costs and collaboration with

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........not just another acronym

PHOs
- The impacts on NGOs of pay parity and related workforce issues including the impacts of the nurses MECA and the health practitioners Competency Assurance Act
- Compliance costs
- Reduction of inequalities as an NGO goal but without funding recognition
- The impacts of the NZ Information Strategy (where we are also represented on the Steering Group)
- Regional differences in funding formulae
- Costs of workforce development

The Working group indicated that they would be willing to work with the Ministry on solutions to these.

Survey

In November 2003, the Working group carried out a survey on NGO relationships with DHBs and there were so many comments on relationships with the Ministry that this survey was commissioned in October last year. The Public Health Directorate had the second highest number of survey responses and the most consistently positive responses across the board. It should be noted that responses were completed before the restructuring of the Directorate late last year.

Some clear themes emerged from the survey overall and five suggestions were put forward by NGOs as ways forward to achieve excellence in the relationship. These were:
- The Ministry response to NGO reports needs to include feedback and appropriate discussion and action, where necessary
- The Ministry should develop a process for constructive and meaningful engagement with NGOs about policy and project implementation, particularly where these impact on NGOs
- Action to build Ministry understanding of the role and work of NGOs in communities is needed, including site visits
- Funding for NGO infrastructural and administrative development is necessary
- More flexibility in NGO contracts and longer term contracts are needed.

At the time of the survey, the Public Health Directorate had established good relationships with sector NGOs in key areas of communication and building relationships. The recent restructuring has been unsettling for the directorate and its NGOs and the period of transition has been accompanied by the perception of slippage in some areas.

What you can do

The Working Group relies for its effectiveness on active NGO participation. Forums are held twice a year to provide the Working Group with the opportunity to report back to the NGO sector and for the sector to raise the issues with the Working Group. There are a number of ways to be linked.
- Be sure to sign up to the NGO mailing list at ngo@moh.govt.nz. This mailing list keeps you informed on the Working Group forums and activities but also provides you with a wealth of interesting sector information
- Find out about the NGO Health and Disability Working Group and its current work programmes. Put http://www.moh.govt.nz/ngo into your favorites.
- Attend a forum. Find out about the forums (past and future) at: http://www.moh.govt.nz/moh.nsf/238fd5fb4fd051844c256669006aed57/ef4e2d6a3bce2e47cc256efa000b5ae5?OpenDoc
- Contact the public health representatives on the Working group. They welcome your thoughts on sector issues. Please contact them:

Dr Kawshi de Silva , National Heart Foundation, PO Box 17-160, Greenlane, Auckland. Telephone: 09 571 9191. Fax 09 571 9190. email: kawshid@nhf.org.nz.

Jo Fitzpatrick, Women's Health Action Trust, PO Box 9947, Newmarket, Auckland. Telephone: 09 520-5295. Fax 09 520-573, email: jo@womens-health.org.nz.

As representatives of public health, we welcome your views and your active participation.

Corporate sponsorship - a public health paradox?

by Shane Kawetana Bradbrook, Auahi Kore/Maori Smokefree Coalition

"If a business is managing products which pose risks to health, we believe it is all the more important that it does so responsibly". – Michael Prideaux, British American Tobacco (BAT).

This is a rather paradoxical quote as it comes from a BAT executive talking about BAT being a responsible corporate citizen. Commendable? Hardly!

BAT like its other tobacco industry cronies has undertaken a global strategy to attempt to convince the public that they are taking responsibility for the 'risk' that this 'legal product' poses. They however do not want to be responsible for the death and destruction that tobacco creates.

As Shakespeare reminds us. "Assume a virtue, if you it not". In Aotearoa/New Zealand the major 'beneficiary' of this corporate responsibility are Mâori. Of course BATNZ are particularly keen to assist Mâori with the issues surrounding tobacco addiction. In the latest BATNZ social report they recognised, "…that smoking incidence among Mâori … is high". I am sure that they have been aware of that for some time, especially as Maori have also contributed heavily to their profit margin!

Another quote says that BATNZ, "…have not sought to explore issues or initiatives particular to Mâori …we believe that Mâori are best placed to tackle issues particular to them". A nice sentiment that Mâori are able to tackle the issues themselves. But one can so easily point out that the issue is actually BAT!

BAT also feels that they need to 'learn more' and consult with Mâori if "Mâori – specific initiatives" are to be undertaken. Later in the report they see an opportunity to make a '"commitment" to supporting the use of Mâori role models and examining the "greater social context" of Mâori smoking.

The first signs of infiltration

The Corporate Sponsorship of the programme for at risk youth is the first public sign that BATNZ is now sponsoring programmes that will infiltrate the Mâori community via a role model that has no connection with the auahikore/smokefree community or the wider public health community to deliver an unevaluated programme to Mâori.

This self-serving programme for BATNZ and delivered by a former All Black allows for the following outcomes:

1. BATNZ gets to say they are working responsibly with Mâori via a well known and respected sportsman. Who will criticise such a responsible and commendable act?
2. Support for a programme that will never be evaluated – our sports star is happy because he gets financial support for his social redemption programme. Who will question such a motive?

The questions are of course rhetorical as it should be the place of the public health community to answer this issue of corporate sponsorship.

That the corporate responsibility angle is a global strategy by the tobacco industry is not news. The industry pays good money for programmes that essentially fail to be effective tobacco control programmes. Why would you pay for something that will undermine your sales to youth? Simply you pay for failure to assist sales with a "Say No To Drugs" programme. Sadly this former All Black may be light on his toes but what does he know about tobacco control?

BATNZ's attempts to engage with Mâori are highly problematic. It does not take a rocket scientist to recognise that Mâori are one the most vulnerable populations in this country. One only has to look at the ongoing health disparities discourse to confirm this. The vulnerability to 'cash incentives' and 'no strings attached' scenarios is a battle that the auahi kore/smokefree community will struggle to compete with.

Here is one scenario. You are an under-funded Mâori health provider who is approached by the tobacco industry with a 'no strings attached' offer such as a new computer, vehicles for immunisation workers, cash in exchange for your cessation programme etc. You then have a public advocacy message saying 'don't take the money,

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.... corporate sponsorship

the industry is evil, and it addicts and kills Mâori. Despite all the supporting evidence of the tobacco industry's deceptive practices it will be a struggle to stop this incursion.

Cold hard cash versus stickers and posters

Trying to convince Mâori that this is tainted money and a buy-out will fall on deaf ears. Essentially the 'have-nots' will 'get-some' and protestations by advocates offering the moral and ethical high ground with a few stickers and posters will not replace cold hard cash! The reality for providers, both Mâori and non- Mâori is simple – it is money that is needed to help our organisation deliver its kaupapa. A question should be placed at the door of central government, "When are you going to prioritise and then fund tobacco control commensurate to the issue?"

Prioritising and funding based on evidence will assist in curbing this unwanted attention by the tobacco industry. With Mâori providing over $250 million each year in tobacco taxes and receiving a paltry $5 million in targeted cessation programmes there is work to be done.

BATNZ is looking at forming a 'relationship' with Mâori. The relationship to date has been one in which Mâori hand over money for a product that kills and incapacitates. It will be a sad day when Mâori accept this modern form of blankets and beads and forgives the industry. Resistance is the path that will have to be walked if this paradox is to be overcome. The tobacco industry may want to take responsibility for the 'risk' posed by their product but they never take responsibility for the death and destruction that they create. Doing good is merely a thin veneer for corporate greed.

I will finish with this disturbing statement by BATNZ:

"…we are committed to engaging in dialogue with a broader cross-section of the Mâori community and will endeavour to ensure that our dialogue model is conducive to greater Mâori attendance. We see consultation with Mâori as a necessary precursor to any involvement we might have in addressing Mâori issues…"

Contact: atak@xtra.co.nz

Conference 2005 - challenging, informative, exciting

by Noeline Holt, manager PHA

Making the links for public health conference promises to be a conference of education, information, networking, and action!!

The programme has evolved into an eclectic mix which will appeal to everyone.

Topics under the main conference themes include a presentation on a programme called High on Life, which is centred around partnerships between schools and outside agencies to look at ways of dealing positively with alcohol and other drug related issues.

Iwi tobacco intervention project

Learn about He Arorangi Whakamua - A Partnership for Sustainability of an Iwi Tobacco Intervention Research Project developed to reduce the uptake of tobacco smoking in the tamariki/rangatahi population of Ngati Hauiti.

Prisoners rights to healthcare

Hear the results of a review of a regional prison clinic to assess the extent and quality of its services against expectations derived from existing healthcare quality standards. The review arose out of concerns about the quality of healthcare in correctional institutions.

Environmental health issues

A public health unit has been working with other stakeholders for over four years to examine and deal with sites contaminated by timber treatment chemicals. What are the conflicts in dealing with environmental contamination?

Wellington - city of action

Each morning there will be walks to Balaena Bay - an opportunity to enjoy the brisk Wellington air and wonderful harbour sites, (there's also Mt Victoria for the more fit people). And we are hoping to have some yoga sessions – yet to be confirmed. Information on other walks around the city will be included in your conference satchels. You will leave this conference better informed, with new friends, and feeling fitter.

Contact: pha@actrix.co.nz

Observations and lessons

by Gay Keating, PHA director

"The German government is putting through a law on prevention. The World Federation of PHAs has been talking with their Ministry of Health and they would like to have an international workshop on legislation and prevention. So if the German Ministry of Health pays, will Gay write a paper on health, legislation and prevention and come to Bonn to be part of the meeting?" I said "yes" (wouldn't you?)

The participants were members of the current Executive Board of the World Federation of PHAs, plus a few people from countries specifically invited by the German Ministry of Health. We were to look at best practice in relevant legislation, ongoing activities, intentions and strategic issues.

We covered a lot of the world. Western Europe (Finland, Switzerland and of course Germany) and Eastern Europe (Russia and Serbia-Montenegro). Most of Asia from Bangladesh to China and South Korea. North America (Canada, USA) and South America (Costa Rica and Brazil). And of course the Western Pacific with New Zealand. But not Africa. The African delegate had such significant delays getting a visa that there was not time to pre-pay his air travel. He was not in a position to be able to pay for his airfare and be reimbursed later.

It was clear that public health is truly international. Sometimes we struggled with understanding language, but we never struggled with understanding the social determinants of health, communicable disease, or injury prevention.

Governments, laws and health

Lawmaking is government business. The extent to which there are laws that protect and promote health is a key indicator of the priority that governments place on health. For example Brazil is explicit in their constitution that health is a right for all and a duty of the state.

The most common theme was managing public health issues in a decentralised or devolved political environment. Irrespective of the aspect of prevention, managing the tension between centralised consistency and local autonomy featured in every country. This was because most of the countries represented had a federal structure with considerable decision making at the local level. It made New Zealand look very centralised and integrated. For example Germany needed to create legislation to fund preventive activities because there is no health-related funding at all at the national level; it is all at the local or regional level.

Some countries had a totally hands off devolution approach of "you sort it out – do what you like if you can find a way to pay for it" while others had a decentralised view - "you do it and here's the money".

The German Proposal

The proposed German legislation has a clever approach to managing decentralisation. They propose a framework for joint decision making on priorities for prevention and funding programmes at the most decentralised level. The stakeholders -city councils and other parties - must develop a Common Council on Prevention with shared priorities, concrete objectives and benchmark indicators within a year. If they do not then the decision defaults to a more centralised level.

The German constitution includes the principle of subsidiarity. Matters should be submitted to the next highest authority if (and only if) the previous one is not as well equipped to handle them. Embedded in this is the view that there is no need for government intervention when other systems are working well; there is also the view that the government at the highest level has a duty of care. Individuals and communities should not be left to suffer simply because their local authorities cannot reach an agreement.

It reminded me of explanations I have heard from some Mâori on the traditional principles of whanaungatanga – if an individual is not managing then the whanau will support. If the immediate whanau cannot support, then the wider whanau

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steps in, and so on.

It seemed to me that New Zealand could benefit from having principles such as subsidiarity in government spelt out and applied. It could make clear what has to happen to have housing for all. It could clarify the processes between local government and health boards. And it could identify what is needed to fulfill the right to health.

Representative and participative democracy in law

Brazil has built in social control and citizen participation into its health legislation. In addition to having elected politicians, all levels of government must have health councils which are composed of equally of the state and of civil society, and the civil society representatives must be accredited by NGOs and community institutions. Perhaps it is because they have relatively recently emerged from military rule that makes Brazil so careful in building in checks and balances from civil society.

Globalised trade, economies and health

Global trade and the impact on economies was another common theme, with tobacco the most common example. The German government opposed the Framework Convention on Tobacco Control: closing down their cigarette manufacturing factories would pose an unemployment burden that their government was not prepared to face.

"Hey, you're an Eastern European country in transition. We'll help you get your economy and employment rate up – we are going to build you a cigarette factory with aid money!" In the absence of widespread adoption of the FCTC small or economically vulnerable countries are easy picking for "sponsorship" and "aid".

There was an explicit plea (and challenge) to countries that have ratified the FCTC. The view from the PHAs in countries that have not ratified was that the biggest support that can be given to help get law smokefree laws introduced globally is hard economic data on health care costs saved by FCTC ratification and implementation.

A further aspect of globalised trade imperiling health was touched on - Brazil is challenging international trade agreements where they block access to affordable necessary drugs.

Considering the health impacts of economic policies produced my least expected alliances - Russia and Serbia. Our similarities came from the health effects of massive economic transition with inadequate social safety nets. While New Zealand does not have 45% unemployment we have had extreme unemployment in Mâori communities and spiraling housing costs with families unable to afford adequate food and clothing.

Communicable diseases

SARS and AIDS were much talked of, particularly in the context of the strengthening needed for countries to cope with rapidly emerging infectious diseases. Canada, which had had a plane load of people exposed to SARS, has just renewed their communicable disease regulations. The delegate brought several CDs of their new regulations which were eagerly received. I've passed my copy along to our Ministry of Health.

International benchmarking

While the WHO does much described as "best practice" it is usually in technical fields. The WHO is an organisation of member countries, and as such it is constrained by the views of member countries.

The World Federation of PHAs Executive Board was clear that internationally, as within countries, there is an important role for NGOs to critically assess the effectiveness of governments in enabling their citizens to be healthy. This was the first attempt that the World Federation of PHAs has made at international benchmarking. The meeting is yet to be fully written up and published.

The lessons that I drew from our deliberations

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contact:louise@wnmeds.ac.nz

INTERNATIONAL NEWS

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were that best practice in legislation for public health includes:

- Comprehensive frameworks

- Establish principles
- Forward looking
- – Impact assessment
- – Avoid gaps in issues
- – Integrate levels of government
- – Manage implementation, incentives and penalties

- Explicitly cover community values

- Balance rights
- Participation

- Health not trade comes first!

Contact: Gay Keating pha.gay@actrix.co.nz

GUEST EDITORIAL

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.....cycling for health

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C*ontact: Stephen@bikenz.org.nz*

Membership renewal for 2005/2006

Your yellow membership renewal form/invoice is enclosed for the 2005/2006 membership year which begins 1st of July.

We look forward to receiving your membership for another exciting year of public health action.

With membership numbers increasing and over 82 per cent satisfaction with our services, we aim to do even better this year!

FORTHCOMING EVENTS

2005 International Conference on Problem Gambling – Living with Gambling – A Global Community Response

27-28 July 2005. Hyatt Hotel, Auckland, New Zealand.
This conference will look at the impact of gambling from the perspectives of treatment, the community, government, public health and diverse cultures.
For more information visit our website – www.pgfnz.co.nz/2005conference contact Cynthia Orme on (09) 369 0623 or email cjorme@pgfnz.co.nz

Cycling Conference: Health and the Transport Sector

The inter-relationship between health and transport goals is one of a range of topics being tackled in the 2005 NZ Cycling Conference. Cycling is a critical part of the active transport movement, which also promotes the health benefits of incidental exercise as a driver for good urban design.
The conference includes discussion on the associated implementation issues such as land use planning, road user education, the legal situation, travel planning, good (and bad) road designs, and accident prediction modeling.
The keynote speaker is Danish traffic planner Troels Andersen.
Troels is closely involved with European sustainable transport initiatives.
Venue: Little Theatre, Hutt City.
Date: October 14 and 15 2005
For further information and a registration form, contact, Stephen Knight, email ,stephen@bikenz.org.nz. BikeNZ, PO Box 1057, Wellington, +64 4 916 1873, (021) 599 102, +64 4 473 1616 (fax).or visit http://www.can.org.nz/conference05/

"Making the Links for Public Health"
PHANZ Conference

6-8 July 2005,
Wellington Town Hall
email: tricia@cwlnz.com
website: www.pha.org.nz

36th Public Health Association of Australia Annual Conference Successes in Public Health

Sheraton Perth Hotel, 25-28 September 2005
The Douglas Gordon Oration will be held on Tuesday, 27 September.
Further information about PHAA conferences can be obtained by visiting the PHAA website http://www.phaa.net.au

IPNANZ Injury Prevention Conference 2005
"Living and Playing Safely in Aotearoa/Ne w Zealand"

2- 4 November 2005
Themes:

- Getting in behind - working together
- No 8 wire - Kiwi ingenuity and new ideas
- The long haul - lasting results

James Cook Grand Chancellor
The Terrace, Wellington
Contact: Valerie Norton
email: v.norton@ipn.org.nz,
telephone: 04 472-2562
website: www.ipn.org.nz

The PHA News editor would like your public health news for publication in the PHA News. Please send copy for next issue by **end July 2005** to the manager at PHA, email *pha@actrix.co.nz* or telephone (04) 472-3060 for further information.

DISCLAIMER: The views expressed in this newsletter do not necessarily reflect those of the PHANZ.