

"The PHA - an informed, collaborative and strong advocate for public health"

PHA NEWS - JUNE 2006

Vol IX, No 3

■ PHA Post-budget breakfast

The need to invest in children and young people, and the issues posed by an aging population, were two of the themes at the PHA post-budget breakfast on Friday 19 May.

The breakfast, organised by the Wellington Branch of the PHA, attracted nearly 60 people – despite the 7am start!

Speakers were:

- Rod Oram (International financial journalist)
- Peter Harris (Economist)
- Debbie Te Whaiti (President of the Post Primary Teachers Association)
- Cindy Kiro (Children's Commissioner)

The theme was the wider determinants of health in relation to the budget. Presentations were based on the ten domains of the Social Report 2005 - www.msd.socialreport.govt.nz, starting with a broad overview, and finishing with a look at the impact on health. Those not able to make the breakfast can listen to the presentations by going to the Scoop website: <http://www.scoop.co.nz/stories/HL0605/S00308.htm>.



Rod Oram

Rod Oram went first, and described the budget as conservative, showing a government on 'cruise control'. He said this could be taken positively as it showed that the machine was coping, with the driver or pilot watching things carefully, but the overall flight plan was working. The government has good control of its finances, he said, and is steaming right ahead. He said that in years to come Michael Cullen might get more credit for his fiscal conservatism than is currently the case.

Mr Oram praised the useful increases in health – in particular the additional funding allocated to obesity – but said things could be done in a much more innovative way in the health sector. A major issue going forward is the need to use health money better – in a more innovative, creative way. He would like to see more things happening in preventative areas.

He said he had a huge overall reservation about the budget. While we've done very well economically and been through a great period of growth, about 85 percent of that growth has been driven by consumption not investment. And a large portion of that consumption has been driven by debt. New Zealand has the second most indebted households in the OECD (behind Australia), but we haven't fundamentally changed the way we earn our living in the world.

He said that while economic reforms had been painful, they did have some effect in making our old business model effective and efficient again for another couple of decades. However, we haven't fundamentally

INSIDE

>> Tobacco happenings	3
>> Notice of Annual General Meeting	3
>> PHA gives Budget 7 out of 10	4
>> National office round-up	4
> A word from Gay Keating	4
> Submissions and media	5
> Selling sickness: a summit on marketing and public health	6
> Email newsletter	6
> Council update	6
> Membership renewals	6
>> Positive result for fluoride referendum in Hamilton	6
>> PHA Wellington branch submission on Wellington LTCCP	7
>> PHA applauds government focus on prisoner treatment and rehabilitation	9
>> PHA Conference	9
>> Direct to consumer advertising	10
>> The rise and rise of Aukati Kai Paipa	10
>> Repeal of section 59 of the Crimes Act	11
>> Health Impact Assessment conference announcement	11
>> Findings of Decades of Disparity III	12

CONTACT INFO

Public Health Association
of New Zealand Inc.
P O Box 11-243, Wellington

Tel: (04) 472 3060
Fax: (04) 472 3059
E-mail: pha@pha.org.nz
Web: www.pha.org.nz

changed the way we earn our living out in the world, and we're starting to hit the buffers again.

In summary, he said that while the budget has a lot of positives in terms of the Social Report 2005, it doesn't fundamentally help us earn a better living out in the world. And this, at the end of the day, is the determinant of our wellbeing and how our Social Reports' statistics will track over the next 10 or 20 years.



Peter Harris

Peter Harris questioned how New Zealand was going to cope moving from a population structure of relatively few young people, relatively few older people, and lots of people of working age; to a structure of relatively few young people, relatively few people of working age and lots of older people.

He said that in a relatively short period of time we are going to move to a huge level of dependency on public support.

Added to this was the much greater costs of supporting older people – the state meets about 70 per cent of the cost of living for those who are over 65.

Peter Harris said the aging population had huge implications for the cost of New Zealand superannuation and the cost of healthcare. He said there were estimates that someone of working age costs on average about \$1300 a year in healthcare costs. Between ages 65 to 74 the healthcare cost is \$3600 a year, between 75 and 84 the cost is \$6800 a year, and from 85+ the cost of healthcare is \$13,500 a year.

He posed the question 'how much is enough?' In the last five years Vote:Health has gone up by 51 percent. He said that somehow, if we were going to deal with the labour force/dependency ratio, we were going to have to craft some sort of consensus about what is enough. This is because we cannot keep increasing the spend on health at the current rate – somewhere there has to be an acceptance of what is enough.

If we don't reach a consensus, he said, tax on working people will have to be unsustainably high. If this happens, people will go elsewhere.

He warned that if there was not a consensus, a correction would be imposed – and in his experience these corrections were usually imposed on the vulnerable and the inarticulate. They affect people who don't have the 'smarts' to get around the political system, don't have the jargon or the gloss.

In closing he said that this budget makes us ask what's next? And the answer is not 'more'.

Debbie Te Whaiti said that this was an important budget because it was putting money into the foundation of the education system, which is early childhood education.

She said that while highly effective schools played a huge part in helping students achieve qualifications, lead healthy and productive lives and pursue a life-long love of learning, they could not do it alone.

Funding that addresses social disparity is as important for improving health and educational outcomes for students as funding for the schools themselves, she said. Families must be supported to make ends meet and schools need

to be supported to provide children with the best learning opportunities they can, as free from disruption as possible.

She commented that it was important to view this budget from a wider perspective, as there is a strong link between good education and good health, and vice versa. By its emphasis on building stronger families, the money in this budget will in the long run potentially make the job of



Debbie Te Whaiti

schools and teachers in educating the children of those families much easier.

Debbie Te Whaiti then went over the five areas referred to in the Social Report 2005 under knowledge and skills as wider determinants of health: early childhood education, qualifications, educational attainment of adults, adult literacy and tertiary participation.

She made the following points:

- investment in early education has a reach beyond the sector, with early childhood education making a difference to student achievement right into secondary school. Increased funding in early childhood has resulted in increased participation – overall, 94 per cent of four year olds now attend some form of early childhood education
- since the inception of NCEA, more students have left school with qualifications, giving them a wider range of options for higher education and future employment. It is pleasing that the Government has committed funding towards establishing a pilot scheme of senior subject advisors to support teachers to use and develop expertise in assessment. The additional \$7.6 million funding for quality careers advice in schools should help ease the transition for students from school to further training and employment
- in adult education, the extra funding allocated to the Gateway and Modern Apprenticeships schemes will provide pathways to employment and further training. These schemes are investing in young people and increasing their skill level. The \$33.5 million to improve the literacy, numeracy and language skills of the workforce is positive, but we should not underestimate the role that school-based courses play.

In conclusion, she said the budget needed to be seen as an outlay in our future human capital. The results would

not be seen for some time, as it takes more than a few years to reverse the dire economic consequences – increased crime, poor health, truancy and greater economic and social disparities – of under investment in people during the 1990s.

Cindy Kiro emphasised the need to invest in children and young people for the sake of our future, and said that the budget contained strong signals about looking to the future and Government priorities, and talk about the need to invest in children and young people.

She made the following points

- excluding Working for Families there is an additional

**"In a relatively short period of time we are going to move to a huge level of dependency on public support."
- Peter Harris**

\$1.04 billion for children and young people

- she was keen to see an over-arching plan that will drive decisions on spending for children
- disadvantaged children do not benefit significantly from this budget, although there are some investments, for example \$10m in South Auckland
- there is tension in spending on adults versus children – apparent in health spending especially with an increase of \$750 million to Vote:Health or increase of 7.5 percent, \$80.4 million for child health and \$76.1 million to fight obesity with \$126 million in one year going to home-based support care for the elderly
- we have an aging demographic, and need investment in the long term
- we need to invest in building capacity in non-government organisations. Limited with \$9.5 million to family violence providers
- family violence, there are 45,000 calls to police in year with 200,000 people directly affected by family violence each year – so it is a major and complex social problem – need everyone to come together.

Cindy Kiro said there was a lot of effort put into linking the budget announcements to what she thought would be a series of themes we would hear a lot about in the next few years. It was an attempt to point to the link between economic and social policy and the way these are inexplicably linked to each other. It was the beginnings of a Government attempting to find a vision that would create a home for the sprinkling of good initiatives that were signaled in the budget.

She stressed the need for agreement across the board about where we are going to spend our taxpayers' money, and the need to get a consensus from New Zealanders



Cindy Kiro

about the basis on which we make those investments in the future. There is good evidence about where money should be spent, but it is not happening. Areas greatly in need of funding include services for adolescents – such as mental health and sexual health.

She said it was vital that New Zealand understood the huge strategic choice that needed to be made. We need to become a society that seriously invests in children and young people. This would require cross party buy-in in our future potential.

She commented that she did not believe tax cuts would provide any positive investment for children. During the 1990s when tax cuts and benefit cuts were the primary policy levers for growth there was a substantial rise in child poverty rates. Child poverty is a sign that we are failing as a society to meet our obligations to nurture, protect and develop the next generation of children.

In summary, she said that New Zealand has to come to a consensus to make a strategic choice to invest in children and young people, in the interests of society. Demographic transition makes this investment imperative.

The talks were followed by a lively question and answer time, until it was time was the assembled company to go to their workplaces.

“We need to become a society that seriously invests in children and young people.”

- Cindy Kiro

■ Tobacco happenings

It has been the best of times and the worst of times on the tobacco control front.

On the positive side, we have a drop in tobacco consumption in the March 2006 quarter compared to the same quarter last year. And contrary to the dire predictions of some, the ban on smoking in bars appears to have had little impact on hospitality industry takings, with the continuation of strong retail sales from bars and restaurants in the March 2006 quarter. The third piece of good news is the seemingly imminent arrival of graphic picture health warnings on tobacco packets.

However, we've also had a very disappointing outcome in the Janice Pou case, with the power of addiction seemingly overlooked. Mrs Pou's children sought \$310,000 from British American Tobacco (NZ) and WD and HO Wills after their mother Janice Pou died of lung cancer in 2002. However, Justice Lang ruled against them, saying the tobacco companies did not have a duty to warn Janice Pou of the dangers of smoking. He said the dangers were common knowledge in 1968, when Janice Pou took up smoking and there was nothing to prove that the tobacco company caused her lung cancer.

The PHA echoes the sentiments of the Smokefree Coalition and ASH at this result. Janice Pou showed incredible courage and determination in spending her dying days seeking justice, even though she knew the case wouldn't be concluded in her lifetime. Her family are to be congratulated for carrying on the fight in her name, and continuing her stand against big tobacco, despite the ruling.

To all financial members of the
Public Health Association of NZ

Notice of Annual General Meeting

In accordance with Rule 11.1 of the Constitution of the Public Health Association of New Zealand Notice of the Annual General Meeting of the Public Health Association of New Zealand is hereby given.

Members are invited to attend.

Friday 7 July 2006
at 7.00am- 8.00am
Palmerston North
Convention Centre

PHA gives Budget 7 out of 10

The PHA has given the budget seven out of 10 for commitment to health, but says that the poorest children are still missing out.

The raft of health measures featured in the budget - cheaper doctors' visits; funding for obesity; investment in child health; improving the health of older people - will prevent many people from becoming sick in the first place. We're delighted to see Government has recognised that increased funding needs to go into prevention, because that is the only way we are going to reduce demand on hospital services.

For example, Ministry of Health figures for 2002/2003 show that one in eight adults needed to see a GP in the last 12 months, but did not see one. The most common reason given was 'costs too much'. Cheaper doctors visits will enable people to go to the doctor when they first need to, not wait until they are really sick.

However we are disappointed the Government has chosen not to extend the *Working for Families* package to parents who are on benefits.

There is nothing in this budget for the poorest children - those with parents or caregivers out of work. Those families will fall even further behind - and it is the health of children that suffers.

And not increasing the taxation on tobacco products is another missed opportunity.

The extra funding for obesity is fantastic, and much needed. We challenge the Government to provide an equal funding boost next year to tobacco control. One way of doing this would be to increase taxation on tobacco products, and use this funding for smokefree programmes. Around 5000 New Zealanders die every year because of tobacco use - decent funding for this area would drastically reduce demand for health services.

However, overall, budget 2006 is socially-responsible and compassionate. There is no doubt that its provisions will improve the health of New Zealanders.

Evaluation course for health promoters/public health practitioners

An evaluation course, running over five days, is being offered in Auckland, 26-30 June 2006 by the Centre for Social and Health Outcomes Research and Evaluation (SHORE), and Whariki Research Group, Massey University. The course is designed for health promotion and public health practitioners with some initial training in evaluation and/or programme planning experience.

Participants are limited to 35 and places will be allocated according to email registration on a first come first served basis. Please contact Channel Lee (c.j.lee@massey.ac.nz; ph 09 3666136). As the course is supplemented by the Ministry of Health, the cost is just \$200.

National office round up

A word from Gay Keating



Gay Keating

We know that a large part of ill health lies outside of the health sector to solve. And most of the public discussion around the budget focussed on health services.

So let's think about health services from a public health perspective and see where we could have put the money. How would we reorient health services?

Think prevention

Health services are not well placed to promote good health - they are better placed to prevent sickness or to prevent a small sickness from turning into a life-threatening event. So looking at the Ministry of Health's reports on preventable hospital admissions and avoidable mortality the big things that stand out are infectious disease and asthma in Maori and Pacific peoples (children and adults) and cardiovascular disease in adults, again especially Maori and Pacific people.

Almost all infectious disease and cardiovascular disease can be prevented, and all of it can be treated early, before it gets to a dangerous state. That early detection and treatment is where health services can be really effective, and immunisation is a great example of where personal health services are effective at primary prevention (preventing the disease from happening to that individual).

Think life-course - think investment in children

What happens at one point in your life can influence you for the rest of your life - obvious really, isn't it? But it does mean that if we are to have healthy adults and older people we have to pay attention to our children and young people. Illness in childhood can irreversibly damage you so that you're never able to recover your full potential. So we need to focus **now** on children to get it right in thirty years time for our adults - to say nothing of the suffering and deaths of children in their own right.

**"We need to focus now on children to get it right in thirty years time."
- Gay Keating**

Think family and community

People (particularly children) are not isolated units, particularly when we are considering avoidable infectious disease and asthma. The risk factors for these conditions are things like poverty, overcrowding, poor nutrition and medical under treatment.

One person in a family who is exposed to these factors may become ill - but all are at risk. And one family may have someone ill but often these factors are common across a community. So a person who suffers an avoidable hospital illness is an index to a family and a whole community at risk.

Think intersectoral

Factors like poverty and poor housing are not easy for the health service to solve. But the health sector can partner with education and social development agencies. We know that poverty, poor education, underemployment, absent fathers and poor health in the family are all factors that increase the chance of bad health, low education, low job prospects, involvement in crime, and unplanned pregnancy for the children as they grow up. Health, education and social development agencies have all got a shared interest in working together to make sure all children get the best start possible

Think right-to-health

The Bangkok Charter for health promotion notes that the United Nations recognises that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without discrimination.

In a country that claims to provide free medical consultations to children there should be no reason for untreated and under treated infections that result in preventable multi-lobe bronchiectasis or subcutaneous abscess. But that's what's happening. Children here are being denied their right to health.

What's the health service that we need?

So what's the health service that can focus on infectious disease and asthma in children, particularly Maori and Pacific families, taking account of the family and community environment and medical under treatment?

We need whanau ora/well child services that are smart, engaged with their communities, acceptable to families, and extremely well linked to the local primary care services, the local health promotion services and the local education and social development agencies.

In fact, they should be a responsibility of PHOs – if the PHOs can demonstrate that they can work with other agencies and provide coverage to all families in their communities. If PHOs are unable to do that, funding should be withheld until the PHOs develop sufficient maturity to work collaboratively for the benefit of their populations.

The service needs to support the whole family. So it doesn't just focus on child immunisation, it also works the networks so Mum gets back into doing something about her education.

It needs to be a service that picks up families that are clearly at risk. The child who suffers from a severe, avoidable hospital admission, particularly an infectious disease or asthma, is an index case to an environment in which other children are at risk.

In short, we need an improved Family Start to move from being a few pilot sites to being a well-evaluated, evidence-based service available throughout the country.

What are my priorities?

- Quickly identify best practice from existing Family Start sites and other well child providers and researchers
- Expand Family Start across the country based on current evidence of best practice
- Enroll every family that has a child (of any age) ad-

mitted to hospital with infectious disease or asthma. Identify the communities these families belong to.

- Get every Maori and Pacific newborn in these communities linked into Family Start
- Evaluate and improve, evaluate and improve, evaluate and improve.

Submissions and media

Since the last issue of *PHA News*, PHA Director Gay Keating has:

- presented to the Health Select Committee conducting the inquiry into obesity and type 2 diabetes in New Zealand
- presented to the Law and Order Select Committee on the Sale of Liquor (Youth Alcohol Harm Reduction) Amendment Bill with particular focus on controlling the advertising and promotion of alcohol
- provided a written submission to the Ministry of Health on its consultation document that sets out options for the regulation of direct-to-consumer advertising of prescription medicines.

Copies of written submissions are available on the PHA website: www.pha.org.nz.

She is currently working on:

- a submission to the review of the Smoke-free Environments Regulations 1999 (health warnings on tobacco products)
 - a submission to the review of the National Drug Policy
 - the consultation document on core competencies for all public health practitioners.
- Media releases and letters to the editor have been distributed on the following issues:

- PHA calls for multi-party accord on obesity (23 May), the PHA calls on parties to work together to stem the obesity epidemic (oral submission to Health Select Committee)
- prisoner treatment and rehabilitation (12 May), congratulating the Government on its focus on the rehabilitation of prisoners, and their reintegration into communities
- PHA gives budget seven out of 10 (18 May), with the PHA applauding the Government's commitment to health in the budget, but pointing out that the poorest children are still missing out
- health groups support introduction of large, picture warnings on tobacco packs (10 May) - the Smokefree Coalition and PHA welcoming a proposal to place large graphic images on cigarette packets
- Pou case about tobacco industry lies (3 May) - PHA says the late Janice Pou's case against British American Tobacco (NZ) and W D & H O Wills was about making the tobacco industry pay for deaths caused by lies of the past
- letters to the editor on fluoride
- letters to the editor on a ban on alcohol advertising

**“Health, education and social development agencies have all got a shared interest in working together to make sure all children get the best start possible.”
- Gay Keating**

- letters to the editor on obesity.

Selling sickness: a summit on marketing and public health

The PHA co-ordinated a meeting on 17 May to look at the advertising and marketing tools and mediums used to promote the purchase of potentially-dangerous products and services.

The aim of the meeting was to consider common issues across the promotion of these products and activities and how promotional activities can be addressed.

Priorities for future action are currently being considered. Watch the next *PHA News* for more!

Email newsletter

To save on postage costs, some future issues of *PHA News* will be distributed electronically, via email. Electronic issues will be those distributed in October, December and February. The April, June and August issues will continue to be produced in hard copy, as they have information inserts relating to conference or Annual General Meeting.

Council update

The most important accountability meeting of the year for the PHA happens on Friday 7 July, 2006 – the Annual General Meeting. This is the time when the Council reports to you, the members, on their stewardship and governance in the past year. The notice of AGM and agenda for members is included in your envelope

In between the three Council face-to-face meetings a year (March, July and November) the work of Council happens in the various committees. Dallas Honey and Kathrine Clarke are carrying most of the work on the restructuring of the Director's role, as outlined in the last *PHA News*.

Over the past few months the Communications Commit-

tee has been looking at how we can improve the *PHA News* (as you can see!) and improving the targeting of the Maori media training.

The Executive Committee has been first having a great time on what we could do in the coming year, then agonizing over how to cut our plans so that we can live within our income and ways that we can improve what we do with our money and time. They've also been supporting staff as we look for new accommodation. The Wellington City Council is intending to quit the lease on the current Betty Campbell Centre in the coming year.

This is the busy time of year for the Awards Committee. This little group considers the applications for scholarships to attend conference that we are able to offer thanks to a grant from the J R McKenzie Trust and selects the Public Health Champion. It is also the group that recommends people for life membership of the PHANZ.

And of course the Conference Committee 2006 is working its socks off, while those hoping to host the 2007 conference are in that great early creative phase of vision and plans.

Membership renewals

It's that time again, membership renewals are due on 30th June. Included in the envelope of each member, along with this edition of the *PHA News*, is a lurid A4 membership renewal form. This form is personalised to each member. Please update for any changes and send back with your subscription to PHA, PO Box 11-243 or fax to 04 4723059.

For those of you who have been saying to yourself "I get too many emails from the PHA" this is the opportunity to get yourself taken OFF some of our email interest-lists.

Membership rates are going up this year for the first time since the 2002/03 year. Overall cost of living increase in that period has been approximately 3 percent a year.

Income	02-03 year	New Rate	% Increase	\$ increase
Over \$90K	\$160	\$175	9.3	15
\$50K - \$90K	\$120	\$130	8.3	10
\$30K - \$50K	\$80	\$85	6.3	5
Up to \$30K	\$35	\$40	14.3	5
Library Subscription	\$80	\$90	11.25	10

Table: New PHA membership rate information

Positive result for fluoride referendum in Hamilton

There is very good oral health news from Hamilton. The final result of a Hamilton City Council referendum has come out in favour of continuing with the fluoridation of the city's water.

The referendum was held by postal vote and had a voter turn out of 38 percent. Respondents voted 69 percent in favour of continuing fluoridation, with 30 percent voting against.

Waikato Branch PHA member Dallas Honey says that there is huge relief in the public health community about the outcome of the referendum.

"Those of us working in public health in the Waikato region were all too aware of the dire consequences removing fluoride from the water would have had for the oral health of our children.

"There is a large body of evidence showing that water fluoridation is a safe and cost-effective way of protecting teeth.

"Public health workers in this area really swung behind this issue – their work in promoting the benefits of fluoridation and countering misinformation had a big impact on the result of the referendum."

PHA Wellington Branch submission on Wellington LTCCP

Making submissions to councils' long-term community plans is an important way to influence local and regional government so they become partners in improving health and reducing health inequalities.

The Wellington Branch of the PHA recently made a submission to the Wellington City Council: Long-term Council Community Plan 2006/7 –2115/6. In doing this they used the guide on the PHA website <http://www.pha.org.nz/Advocacy.html>.

Because of space restrictions, we have only been able to reproduce parts of the submission in this newsletter. The full submission is available on the PHA website: www.pha.org.nz.

Wellington City Council role and health

City councils are obliged by the Health Act (1956) to “improve, promote and protect public health” (s 23). This is reinforced by the views of the residents that a safe and healthy community is one of the key desired outcomes for the City. To achieve this, Council needs to collaborate with others and to take specific actions itself.

The Public Health Association Wellington Branch is delighted to see that Wellington City Council is committed to working with other agencies to achieve the desired community outcomes. However the PHA believes that there are actions that the Council itself should be taking to achieve the health role of Council.

One of the most desired community outcomes for Wellington City is a safe and healthy community. Public health acknowledges that the context within which people live impacts upon their health status - access to education, adequate income, warm, dry and low-cost housing, meaningful work and access to nutritious and affordable food.

There are many Council activities that have an influence on health. Many have an immediate, obvious contribution to health (such as providing a clean water supply, and cemeteries). Others, such as housing, transport and community development also have a strong influence on health, although it is less direct in some cases.

It is now widely accepted that the factors that have the greatest effect on people's health lie outside and beyond the control of the health sector. Income, housing, education and employment are factors that play a major part in the ill-health people experience during their lifetime.

Assessment of the health impact of policies

Because so many areas of Council responsibility have health impacts, it is important when the Council is considering all policies that they consider the potential health impact of the policies.

Health Impact Assessment (HIA) can be used to assess the potential effects of Council policies, programmes and plans on community health and wellbeing.

Health Impact Assessment has strong links with the new Local Government Act 2002 that requires local bodies to



Health Impact Assessment has much potential for use in Wellington

use a sustainable development approach and to consider the well-being of their communities.

Health Impact Assessment has been used successfully by Auckland City (Avondale and Mt Albert urban intensification plans), Greater Christchurch on its urban intensification strategy, and Counties-Manukau on the potential impact on obesity of an urban design for Mangere.

Health Impact Assessment has much potential for use in Wellington. The Public Health Advisory Committee has developed a resource to assist organisations to use Health Impact Assessment

Detailed comments on LTCCP

We have organised our comments along the lines of the Council's outcomes. We have grouped together “health” and “safety” This is because safe food, air and water result in good health.

More livable

- The plan must acknowledge and allow for the aging population, eg, provision of suitable, accessible accommodation for older people in the urban intensification process.
- There must be an adequate supply of affordable and healthy housing for people in Wellington. Any intensification or new development must cater for people in lower socio-economic groups.

“It is now widely accepted that the factors that have the greatest effect on people's health lie outside and beyond the control of the health sector.”

- We oppose the introduction of market rentals for 5 percent of Council housing stock. Council housing areas should be improved and made more “livable” for those already there and priority given to those currently on waiting lists.
- There needs to be increased inspection and extension of housing provided by WCC. Families living in houses that are not weatherproof, or which are damp and crowded are more likely to suffer from meningitis, asthma, chest and skin infections.
- There needs to be purpose-built housing in the community for people with special needs (eg, those liv-

ing with psychiatric, intellectual, physical disabilities etc). The Council can act alone to meet this need, or can work with others.

- All road development or changes should incorporate ways to support safe walking and cycling and incorporate effective public transport. These modes promote the capacity for all members of our community to move from place to place. Many households in Wellington do not have access to a car (13.1 percent), and those households with just one car often leave other people in that household with no other options (such as women, children, older people). These inequalities lead to inequalities in employment, income, housing and health status.
- We are pleased that the three-year priorities include travel demand management and improvement of passenger transport systems. These are critical. However, we fear that the other options also of priority (investment in the state highway network and new roads) will soak up the lion's share of the available funding.
- The Council must commit to altering the proportion of funding spent on 'network investment': 'TDM and passenger transport solutions' by 3 percent per annum (favoring a shift towards increased share of funding for TDM and passenger transport solutions). This is a shift of funding, not an increase in overall funding.
- All major transport options being investigated must undergo a health impact assessment, as protecting public health is now a requirement of the Land Transport Management Act. The current assessments for 'health impacts' do not cover, or do not go any distance in protecting public health. Suggested wording includes 'We'll also work to influence the design of the proposed Petone-Grenada link road and take part in studies of key transport routes such as the Ngauranga-to-Airport corridor to ensure that public transport, road safety and public health are protected and enhanced'. One of your outcomes is to make Wellington 'healthier', and health impact assessment is a way to achieve that outcome – at the moment the council is not paying adequate attention to delivering this outcome via its transport portfolio.

Safer and healthier

Collaboration

- Council must create safer environments through enhanced collaboration with Police, regional public health staff and other agencies in planning, inspection and enforcement services relating to alcohol; smokefree environments; hazardous substances; waste disposal; food, air and water safety and intentional child injury.

Skilled staff

- Council must ensure that our own public health staff are skilled and up-to-date.

Alcohol

- Council must actively work towards a reduction in alcohol-related harm (eg., road crashes, violence, disorderly youth, unsafe sexual activity) through improved liquor licensing services.

Crime-related injuries

- Council must support community safety using all the elements of crime prevention design techniques.

Food safety

- Council must improve planning, inspection and enforcement services of commercial food premises to help reduce the high incidence of food-borne illness in Wellington.

Environmental hazards

- Council must increase investment in initiatives to maintain and improve healthy air, water, waste disposal and environmental toxins.

Intentional child injury

- Council must collaborate with other agencies and actively provide support to prevent deaths and severe injury to children from family violence.

Physical activity, leisure and recreation

- Recreation, including physical activity, is also important for wellbeing. It will be important that the Council monitors the impact of rising fees on the use of recreation facilities to ensure that cost does not restrict use of facilities. Number and type of users should be reported in the performance measures.

“Recreation, including physical activity, is also important for wellbeing. Council must increase and improve leisure and recreation areas throughout greater Wellington to better encourage physical activity and social interaction for youth and adults.”

- Physical activity policies and programmes should promote changes to the built environment that advantage all citizens, and take into account the needs of lower socioeconomic groups, older adults and other sectors of the population currently at risk of not getting enough physical activity.

- Wellington City Council takes pride in the fact that there is a continuing upward trend in the use of Council swimming pools (AC Nielson report on 2006 Survey of residents, page 15) yet proposes to reduce public holiday opening hours for pools from 15 to eight hours per day. This move will discriminate

against families who have to take advantage of holidays to recreate together because of long working hours throughout the year. Reductions in the hours of opening for the Khandallah and Thorndon outdoor pools have the potential to further increase the barriers to residents carrying out leisure or recreational activities as stated in the AC Nielson report.

- Council must increase and improve leisure and recreation areas throughout greater Wellington to better encourage physical activity and social interaction for youth and adults, including improve maintenance and increase numbers of safe outdoor public playgrounds for children to encourage more physical activity.
- Council must monitor the impact of rising fees on the use of recreational facilities and ensuring that costs do not restrict usage of these facilities.

Emergency preparedness

- the community should be informed about WCC's emergency preparedness (including pandemic flu plan) to ensure people are well informed of the Council's preparedness strategy for Wellington.

Access to treatment services

- The Council must work closely with Capital and Coast DHB to ensure equitable access to health services, particularly in areas of high need
- PHA supports continuation of fluoridation of water as a means to improving dental health, and looks to the Wellington City Council maintaining fluoridation.

PHA applauds government focus on prisoner treatment and rehabilitation

PHA Director Gay Keating has applauded Corrections Minister Damien O'Connor's willingness to look for long-term solutions to New Zealand's high imprisonment rate.

In a speech delivered on 12 May, Mr O'Connor emphasised the need to focus on the rehabilitation of prisoners, and their reintegration into communities. As well as needing offenders to repay society in order to serve justice, a healthy and safe society needs them to be given every opportunity to acknowledge their failures and mistakes and become constructive members of our communities.

He said those prisoners who wanted to grasp opportunities such as working, receiving training, or getting a place on a drug and alcohol course must receive the full support of the Department of Corrections.

"They need to be able to move through a series of progressive steps – treatment, skills-training, work experience, to qualifications – and finally, towards the end of their sentence, they will have the opportunity to earn employer trust and find worthwhile and sustainable jobs."

**"New Zealand's high imprisonment rate has dire consequences for the health of many inmates."
- Gay Keating**

Gay Keating says New Zealand's current high imprisonment rate has dire consequences for the health of many inmates, and moves to reduce the number of prisoners were long overdue.

Money is best spent on treatment and rehabilitation programmes. Offending is often linked to drug and alcohol issues, and by imprisoning people you make it more difficult for them to access treatment services.

Our high imprisonment rates also lead to overcrowding, which increases the risk of infectious diseases such as preventable lung and skin infections and gastroenteritis.

The Government's commitment to an increased focus on treatment and rehabilitation will impact positively on inmates' physical and mental health.

The PHA fully supports this emphasis on programmes that prevent people from entering prison in the first place, alternative sentencing, and rehabilitation.

PHA conference 2006

We're entering the countdown to the PHA conference – Sustaining Public Health/Pupuritiai Te Whare Tapa Wha – to be held in Palmerston North from 5 to 7 July.

Organising committee member Ann Shaw says the conference provides a great opportunity for new and experienced public health practitioners to network and share their experiences.

"The conference will include papers from Maori and Pacific public health practitioners, and from people working on public health issues that have emerged more recently, such as problem gambling.

"But it also continues a focus on the core public health areas such as providing a healthy environment for children to grow up in, and developing the right infrastructure to sustain public health – particularly in the area of housing."

Ann says this mix provides an opportunity for primary health and public health workers to learn from each other, and develop complementary strategies that address issues from both perspectives.

"The conference will have something for everyone – people who work at a very strategic level, researchers and academics, service providers, and community workers."

Topics covered include:

- Whanu ora
- Maori models for health
- Young people and alcohol
- Maori approaches to problem gambling
- Asian models of public health
- Maori working with PHOs
- Building the Maori public health workforce
- Using sport for health
- Wellbeing of Samoan families
- How can you be healthy living in a caravan?
- Tokelauan approaches to housing
- Tongan community action
- Rural perspectives of public health
- The health of gay populations
- Health impacts of school travel plans
- Challenges of public health nursing
- Putting fathers back into families
- What determines a healthy workplace?
- Growing well, healthy children
- Using special measures to achieve equality
- Harm minimisation in the gambling industry
- Maori health workforce development
- Tobacco control.

The full programme can be viewed on the PHA website: 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 developing skills across the workforce in public health.

Direct to consumer marketing

The promotion of prescription medicines raises special ethical and regulatory difficulties. In fact New Zealand and the United States are the only countries that have not banned the practice.

The PHA National Office and Christchurch Branch of the PHA recently provided separate written submissions to the Ministry of Health on its consultation document that sets out options for the regulation of direct-to-consumer advertising of prescription medicines (DTCA).

The Christchurch branch submission responses to question one and five, are reproduced below.

Question 1: Are you concerned about DTCA in New Zealand? OR Are you supportive of DTCA in New Zealand?

We are extremely concerned about DTCA in New Zealand and do not support it. We are persuaded by comprehensive reviews of research, both from New Zealand (Toop et al 2003) and elsewhere (eg Gilbody et al 2005) that DTCA leads to inappropriate use of prescription medicines, can compromise public safety, distort resource allocation and increase the risk of providing misleading information to the public.

Question 5: Which of the options outlined in Section 6, 'DTCA Regulatory Options', do you support? Why?

We support the component of Option 3 that proposes a complete ban on DTCA. We are opposed to disease state advertising, even if regulated. Experience of disease state regulation in both Canada and Australia demonstrates that this is not a satisfactory option, and other research shows that regulation of advertising generally is ineffective (eg Coney 2002; Kaphingst and DeJong, 2004).

We strongly support the provision of independent consumer information, on both disease states and prescription medicines, provided as a public service by an organisation without conflicts of interest.

We further support public health campaigns by government and non-profit organisations for the management and prevention of specific disease conditions (eg diabetes, heart disease) and the promotion of healthy lifestyles (eg nutrition, exercise).

References

Coney, S (2002) Direct to consumer advertising of prescription pharmaceuticals: a consumer perspective from New Zealand. *Journal of Public Policy and Marketing*, 21(2): 213-23.

Gilbody, S., Wilson, P., Watt, I. Benefits and harms of direct to consumer advertising: a systematic review. *Quality and Safety in Health Care*, 12: 246-50.

Kaphingst, K., and DeJong, W. (2004) The educational potential of direct to consumer prescription drug advertising. *Health Affairs*, 23(4): 143-158.

Toop, L., Richards, D., Dowell, A., et al (2003) *Direct to Consumer Advertising of Prescription Drugs in New Zealand: For Health or for Profit.* University of Otago.

The rise and rise of Aukati Kai Paipa

The Aukati Kai Paipa Programme was piloted from 1999 – 2001, in an attempt to test the viability of an internationally proven smoking cessation model within Maori settings.

Because smoking among Maori women is so high the programme was designed for wahine; based around a model combining nicotine replacement therapy with counselling.

The development of the programme involved some of the stalwarts of Maori tobacco control. People like Mary McCulloch, Marewa Glover, Anaru Waa and Joe Puketapu worked with a western template, adopting it for training for Maori providers who were awarded the initial contracts.

"It was about marrying traditional concepts like manaakitanga, with this new model," explains Sue Taylor who co-ordinated the pilot.

"I can remember in training we'd say your clients are like manuhiri on your marae. Treat your clients with the same kind of care, that's what it's all about."

Sue also says that like any Maori health issues, all of the providers involved in the pilot talked about working holistically with their whanau.

"When these quit coaches walked into these homes, they often saw a whole lot of other issues. They told us that they had to take account of these other influences, if they were serious about getting their clients to quit."

During the early stages providers adapted the programme to suit their local environments in quite remarkable ways.

"It was about adopting local situations to suit the programme, which gets quite complex. Take an organisation like Poutiri Trust in Te Puke for example. This NGO supports around 28 iwi affiliates, each with their own kawa."

"What really made the pilot work was the passion which all providers had for Maori health, and the sense of whanaungatanga that developed among us."

The Ministry of Health evaluation of the pilot found the programme achieved a high quit rate, and that it was accessible and acceptable to Maori.

The programme is still going strong. Angilla Perawiti from Ngati Whatua Health Services explains how it has developed for this iwi provider.

"It's about working with smokers to identify their triggers. We develop an action plan for them which we help monitor."

It's the contact with counsellors that is the key to the success of the programme, Angilla says. "We help clients understand that they are the key to quitting, not the NRT."

Success can be measured in ways other than quitting. During the pilot providers decided they would work with people wanting to reduce their smoking as well as those who wanted to quit completely. "Or it could be working with a whanau to make their home smokefree. All of that is positive change and keeps our tamariki healthy and safe."

Sue says that a lot of it is just common sense.

"As Maori we already have a lot of concepts and knowledge that has been passed on from generations before, so why reinvent the wheel?"

Repeal of section 59 of the Crimes Act

Green MP Sue Bradford's bill to repeal Section 59 of the Crimes Act (the section that allows parents the defence of "reasonable force" in disciplining their children) is now before the Justice and Electoral Select Committee for hearings.

The Select Committee is due to report back to Parliament by October 2006. This is an issue that always has the talkback running hot, with claims by opponents that the repeal of section 59 will criminalise parents who give their children a light tap on the arm.

The bill has support from many child and family welfare and advocacy agencies, including PHA, Child Abuse Prevention Services New Zealand, Plunket, Barnardos, Save the Children New Zealand, Parent Help, UNICEF, The Office of the Children's Commissioner, and Women's Refuge.

The Children's Commissioner, Dr Cindy Kiro, recently gave an oral submission on the bill to the Justice and Electoral Select Committee. Following are some of her key points.

- Section 59 says that parents are justified in "using force by way of correction of a child if the force used is reasonable in the circumstance". It allows parents arrested for assaulting their children to use section 59 as a defence by saying that the assault was justified, reasonable or carried out to discipline the child.
 - The United Nations has been critical of New Zealand because section 59 is seen to violate the United Nations Convention on the Rights of the Child (UNCROC) of which New Zealand is a signatory.
 - Repeal is a fundamental and necessary step to ensure that children in New Zealand grow up in secure environments free from all forms of violence.
 - Parliament has an opportunity to demonstrate moral and political leadership on behalf of our children as demonstrated by the hundreds of community-based organisations who are supporting repeal, not amendment. They have reached this decision after carefully considering all the evidence. I strongly oppose any attempt to amend the Crimes Act to define reasonable force.
- "Parliament has an opportunity to demonstrate moral and political leadership on behalf of our children."**
- This would send a message that some degree of violence is acceptable. It is not.
 - Although most incidents of physical punishment do not lead to child abuse, research has shown that most incidents of child abuse arise from physical punishment. Moving the parenting 'norm' away from negative discipline to more positive approaches will shift all of our statistics in a more positive direction.
 - Removing a statutory defence to assault of a child by parents does not create an offence of physical punishment for which parents can be prosecuted.
 - Research commissioned by my office in April 2006, showed that baseline public support for repeal was



Green MP Sue Bradford

that they will not be prosecuted for minor technical assaults.

- In addressing concerns about criminalisation of parents, a key consideration should be the best interests of the child. Repeal is consistent with a legislative and policy context which prioritises a whole child approach and working for improved outcomes for children.
- I encourage our politicians to have the courage to act to make childhood safer, with more positive outcomes and to contribute effectively towards children in our society. This Bill provides them with a real opportunity to do so.

Health Impact Assessment conference announcement

**An idea whose time has come
8:30am-5:00pm 27th June 2006
Intercontinental Hotel, Grey St, Wellington**

Ten years ago Health Impact Assessment (HIA) UK academic Alex Scott-Samuel gave an address entitled "Health Impact Assessment – an idea whose time has come?" For New Zealand that time is right now!

Health Impact Assessment is a practical approach for promoting wellbeing and public health through a participatory process that assesses proposed projects, policies or programmes for their broad health impacts. It assists policy makers and planners who are working towards a healthy and well population.

The HIA one-day conference is an opportunity to:

- critically review progress to date within transport, energy, urban design, housing, environment, social and local government sectors
- discuss the future of HIA in New Zealand.

We hope you will join planners and policy makers across central and local government, along with public health and HIA practitioners and others from around the country to explore ways of promoting HIA into the future.

The Minister of Health, the Hon. Pete Hodgson, will open the conference, which will include case studies, interactive workshops, and panel discussion.

**For more information contact Quigley & Watts:
jane@quigleyandwatts.co.nz
Phone: 04 472 0134**

The conference is supported by the Public Health Advisory Committee, University of Otago, and Quigley and Watts.

Findings of Decades of Disparity III

The latest Decades of Disparity report shows that about half of the gap between Maori and non-Maori mortality rates at any one point is due to socio-economic factors, and that about half of the widening mortality gap over the 1980s and 1990s was due to widening inequalities in socio-economic resources between Maori and non-Maori.

Co-author Associate Professor Tony Blakely from Otago University's Wellington School of Medicine and Health Sciences takes a look at Decades of Disparity III.

The University of Otago and the Ministry of Health recently jointly released the third and final Decades of Disparity report written by Jackie Fawcett (lead author), Tony Blakely, Bridget Robson, Martin Tobias, Ricci Harris, and Natalie Pakipaki. It shows that approximately half of the over two-fold difference in death rates between Maori and non-Maori is due to the greater socio-economic advantages of non-Maori.

Inequalities in socioeconomic resources are an important cause of inequalities in mortality between Maori and non-Maori. However, things other than socio-economic resources are also important determinants of ethnic inequalities in health.

In the first Decades of Disparity report released in 2003, myself and co-author Bridget Robson argued that increas-

Decades of Disparity III - Key findings

- Maori were disproportionately represented in lower socioeconomic strata (eg, lower income, no qualifications, no car access) during the 1980s and 1990s, however measured. As a consequence, Maori are disproportionately affected by the health consequences of lower socioeconomic status.
- However even among groups with similar socioeconomic resources non-Maori have lower mortality rates than Maori. For example even among people in high income households there are substantial disparities in mortality rates between Maori and non-Maori.
- Among both Maori and non-Maori populations, those with low income and no qualifications experience higher rates of mortality compared to high income groups and those with tertiary qualifications.
- The different socioeconomic resources or positions of Maori and non-Maori ethnic groups account for at least half of the ethnic disparities in mortality for working-age adults and one-third for older adults.
- During the 1980s and 1990s the socioeconomic resources of Maori, relative to non-Maori, worsened. This widening socioeconomic inequality explained about one-third to one-half of the widening gap in the mortality rates between Maori and non-Maori – at least for people of working age.

ing Pakeha advantage in access to and power over socioeconomic resources is the primary cause. Though this statement generated a lot of debate at the time, the results of this latest report largely support that argument.

Regarding explanations for widening gaps in mortality between Maori and non-Maori during the 1980s and 1990s, we found that employment

was a key explanatory variable. This fits with the large increases in unemployment in the late 1980s and early 1990s that impacted disproportionately upon Maori.

Based on the report findings, we are calling for a sustained long-term commitment from Government to help reduce socio-economic inequalities between ethnic groups.

We need to take the longer view because, quite frankly, improvements in health and mortality don't just happen over night – it takes time for improved socio-economic circumstances to have an impact. That's why we're looking for a sustained political commitment not just from the present Government but from successive governments to ensure that both ethnicity and socio-economic status continue to factor in the funding of health programmes.

**"We're looking for a sustained political commitment... from successive governments."
- Tony Blakely**

About half of ethnic disparities in mortality were not explained by socio-economic status as measured by this study. Possible factors behind this component of the

disparities include:

- unequal access to, and access through, health services
- different exposures to healthy or disease producing environments (such as good quality housing, stressful situations, smoking, exercise), and
- early childhood and early life experiences.

Disparities in these factors, and in socioeconomic status itself, are underpinned by historical and social processes that systematically disadvantage Maori (ie, colonisation, discrimination and racism).

As ethnicity is not a measure of genetics, individual genetic risks are unlikely to directly explain a substantial proportion of differences in all-cause mortality between Maori and non-Maori at the population level.

Decades of Disparity III is a joint report between the researchers at the University's Wellington School of Medicine and Health Sciences and the Ministry of Health. The New Zealand Census Mortality Study (NZCMS), from which the work arose, was previously funded by the Health Research Council of New Zealand and now funded by the Ministry of Health and University of Otago. The NZCMS is conducted in collaboration with Statistics New Zealand.



Tony Blakely