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GUEST EDITORIAL

Cutting up the health funding cake- targeting vs universalism

by Peter Crampton, Researcher, Wellington School of Medicine

Population-based funding, ethnicity data and NZDep are currently some of the health sector's most powerful pro-equity tools. These tools are used increasingly to help us cut up the health funding cake. But we should be aware of the broader issues that lie behind the use of these pro-equity tools, particularly the universalism-targeting continuum.

The universalism vs targeting debate

While crucially important, there is sometimes a lack of clarity about the issues at stake. Our two major political parties are committed to universal approaches for hospital services (free access to everyone on the same terms), and a mixture of universal and targeted approaches for public health and primary care services. What are the benefits of universal approaches? How do we know which population groups to target? What mechanisms should we use to target health programmes, services and funding? Does targeting mean the same as needs-based resource allocation? This article discusses these questions and proposes a set of principles that could help guide health planning and health funding.

Universalism refers to providing health programmes, services and funding to all. Universal approaches have several potential advantages: they may promote a sense of belonging and entitlement amongst everyone thereby increasing social cohesion and inclusiveness, they usually avoid stigmatising minority groups, and they avoid the need for contentious and expensive targeting mechanisms. But universal approaches can lead to so-called 'middle-class capture' where relatively well-off and well-resourced people end up participating in and benefiting most from programmes. Univeralism also frequently suffers from the 'one-size-fits-all' problem where programmes are designed for the majority group and are less applicable to other groups. One of the most prominent examples of this problem, particularly historically, is the relatively frequent neglect of tangata whenua in the design and funding of health programmes.

Targeting, in general terms, means the directing of time, energy and resources to individuals and groups who have the greatest health need. Targeting therefore has great appeal because it addresses the needs of groups that are sometimes poorly served by universal approaches, and it allows funding to be used in a way that focuses on groups that stand to benefit most (the efficiency argument). For example, health programmes and health funding are sometimes targeted at the young or the elderly, or

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tailored for specific population groups such as by Maori for Maori health promotion programmes. Targeting is generally cheaper for the State. The disadvantages of targeting include its potential stigmatising effect and, when funding is targeted, the 'poverty trap' effect at the margins (the cut-off for eligibility creates a 'poverty trap' at the low end of the non-eligible population). Targeting approaches risk disadvantaging middle-income earners if funding eligibility criteria are very strict. If targeting is directed at individuals, using a mechanism such as the Community Services Card, other pitfalls arise. For example, people may be unaware of their entitlements, they may have difficulty engaging with the bureaucracy, or they may be reluctant to engage because of privacy concerns or because the amount of their entitlement is insufficient or trivial. Further, such individual targeting mechanisms tend to be expensive and cumbersome to administer both for government departments and for recipients.

Population based resource allocation explained

Population-based resource allocation refers to the allocation of health funding according to population needs. Population-based resource allocation is not the same as targeting in that it aims to divide funding fairly (not equally) across different population groups based on populations' capacity to benefit. That is, population-based funding is about dividing up the cake for maximum benefit, taking into account the needs of all main population groups. Population-based funding seeks to reverse unfair historically-based resource distribution patterns that develop over time in response to interest group lobbying, political expediency and institutional racism. The usual mechanism for population-based resource allocation is a population-based funding formula, such as the new funding formula for District Health Boards (DHBs). The key element in all population-based formulas is population. Over and above population, the DHB funding formula allocates extra money for high needs groups, such as the young and the elderly, Maori and Pacific populations, and people living in more socioeconomically deprived areas.

Dating back to the early 1980s, New Zealand has a tradition of population-based resource allocation for Hospital Boards, Area Health Boards and the Regional Health Authorities. The Primary Health Care Strategy now seeks to introduce a nationally consistent population funding formula (otherwise known as a capitation funding formula) for the funding of the new Primary Health Organisations. One of the effects of this approach will be to spread primary care funding more evenly across all groups in society, with extra emphasis on high needs groups.

How should we cut the cake?

Taking into account the points raised above, following is a list of principles for cutting up the health funding cake. The purpose of this list is to prompt further debate and discussion-responses to these points will be welcomed.

Both universal and targeted approaches are important and useful in the planning and funding of health services. The choice to use one or the other should be deliberative, and should take account of the pros and cons discussed above.

Population-based funding should be used as the main resource allocation mechanism for health services both at the level of DHBs and the level of Primary Health Organisations and their constituent member organisations, with population funding adjusted for high-needs populations (the young and the elderly, Maori, Pacific, high deprivation areas etc). Ethnicity data and NZDep are ideal pro-equity tools for use in population-based funding formulas because they relate to important socio-demographic characteristics of people and communities, are strongly associated with health need, and are relatively cheap to measure and administer.

When universal approaches to health programmes or funding are adopted then every effort should be made to tailor aspects of the programme to meet the needs of different population groups-Maori, low income, Pacific and so on. The best way to achieve this tailoring is

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Asthma and Allergens – Much ado about nothing?

by Neil Pearce, Centre for Public Health Research, Massey University, Wellington

Ten years ago we knew what caused asthma, and we knew how to prevent it. Asthma was an atopic disease caused by allergen exposure. The fundamental etiological mechanism was that allergen exposure, particularly in infancy, produced atopic sensitisation (which could be measured by skin prick testing) and continued exposure resulted in asthma through the development of eosinophilic airways inflammation, bronchial hyper-responsiveness and reversible airflow obstruction. The solution was therefore clear: to prevent asthma we needed to prevent exposure to allergens. If we fitted plastic covers to our mattresses, threw out our carpets, and killed enough cats, the problem would be solved.

In recent years it has become increasingly evident that "the emperor has no clothes", or at least that he is not as well-dressed as we have been led to believe. Bronchial responsiveness is a poor surrogate measure of clinical asthma and the current evidence is that it has lower validity than standard symptom questionnaires. Less than one half of asthma cases involve allergic mechanisms, and the other half appear to be due to non-allergic (neutrophilic) airways inflammation. Furthermore, although there are some clear cases of allergen exposure causing asthma in adults in the occupational environment, overall there is little evidence that allergen exposure is a major primary cause of asthma, and even some evidence that allergen exposure early in life may have a protective effect. In fact, trials have already been conducted in Europe of high allergen exposure early in childhood as a means of preventing asthma.

Why did we get it so wrong for so long?

The "established" risk factors for asthma, including allergen exposure, were "discovered" primarily on the basis of clinical studies and case reports of exacerbations in asthma patients. We know that allergen exposure may make asthma worse for some patients who already have the condition. Furthermore, there are some clear examples (from occupational studies) where allergen exposure causes asthma to occur in adults. It was therefore natural to conclude that because some adults get asthma in this way, that most or even all people (both children and adults) get asthma this way.

The dangers of such tunnel vision were brought home to me when I attended the World Asthma Meeting in Barcelona in 1998. At the end of the first day a group of us were sitting having a beer, when someone remarked "I've done a study which found that having a cat early in life protected you against asthma, but I haven't published it

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usually to have control and design of different aspects of the programme carried out by people who represent the different population groups.

When targeted approaches are adopted careful consideration should be given to the targeting mechanisms used, so that the programme (or funding) benefits the intended recipients. For example, NZDep is a small area-based tool that is very useful for targeting funding and programmes to areas and population groups, but cannot be used to target funding to individuals because of the frequently varied mix of people who live in small areas. The Community Services Card can be used for individual targeting but suffers a significant problem with non-uptake amongst eligible people, and has high administration costs.

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because it can't be true". Another colleague had found the same thing, but that particular finding had been removed from the published paper on the recommendation of a reviewer since "it can't be true". As we went around the table, between eight asthma epidemiologists, and about 16 pints of beer, we found five studies that showed that cat exposure was protective. Only one had been published, and that was as an incidental finding which had appeared in a table, but had not been commented on in the text. Now a number of studies showing a protective effect of cat exposure have been published, and those of us who work in the field can claim at least one important public health victory - despite years of research, we may not have prevented any cases of asthma, but we have saved the lives of a lot of cats.

Once the allergen theory became established it was easy to find "verifications" of the allergen hypothesis ("if I hadn't believed it, I wouldn't have seen it"). Everybody "knows" that New Zealand has the highest asthma prevalence in the world, and it is easy to find features that are unique to New Zealand such as the high pet ownership, damp housing, wall-to-wall carpets, high pollen levels, etc. In fact, all of the English-speaking countries (New Zealand, Australia, United Kingdom, Ireland, USA, Canada) have about the same (high) levels of asthma prevalence, including some countries and centres that have much lower house dust mite allergens levels than ours. We have wasted 15 years trying to find out what is unique about New Zealand, when we should have been trying to find out what it has in common with these other countries. More generally, it is becoming increasingly clear that allergen exposure does not appear to account for global patterns of asthma prevalence, or the striking increases in asthma prevalence over time.

So why does this matter? Surely, avoiding allergen exposure doesn't do any harm, and may do some good? This may be true for secondary prevention, i.e. if you already have asthma and you are allergic to something (e.g. house dust mites) then it may be worth avoiding exposure (if you can). Some randomised trials have shown benefits of allergen avoidance in this situation, although the benefits are not large, and these studies have usually only followed people for a few months (anecdotally, the benefits from avoidance may wear off after a year or so - if you are "programmed" to be allergic and you remove one exposure, then after a year or so you become allergic to whatever other allergens are still around).

However, the situation is quite different with regards to allergen avoidance as a means of primary prevention of asthma, e.g. by daily vacuuming, fitting plastic covers on mattresses, avoiding pets, changes in domestic design, etc. In particular: (1) the evidence of potential benefits is weak and inconclusive; (2) allergen avoidance early in life may even increase the risk of asthma in some instances by delaying the first heavy allergen exposure to an age where it may be more hazardous; (3) there can be considerable financial costs to families of allergen avoidance (and a considerable "allergen avoidance industry" has built up); (4) there may also be social costs in terms of the difficulties involved, and the time required, for parents to follow strict allergen avoidance regimens (parents complain of less time to spend with the children, arguments about who should do the daily vacuuming, feelings of being "a bad parent" because they are unable to follow strict allergen avoidance regimens, etc). This doesn't mean that allergen avoidance should never be done. Probably it will benefit some people. However, on a population level, we just don't know whether it will prevent asthma, have no effect, or increase the risk of asthma, and the substantial economic and social costs involved mean that cannot be justified as a public health priority.

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Moving forward with the Population Health Manifesto

by Gay Keating, PHA director

Before I say anything else, Dunedin in June was a great place to be, as the PHA conference was buzzing. - wonderful work by Peter Burton and team, and I hope that all of you who came enjoyed yourself as much as I did. See you in Ngaruawhahia next year for another great Conference.

Three years ago the PHA and the New Zealand Committee of the Australasian Faculty of Public Health Medicine produced our first Population Health Manifesto. It covered the key public health issues of the time.

The PHA conference in Dunedin this year was the launch place for the revised Population Health Manifesto. The previous Government didn't consult with us, and so put our conference into the middle of an election campaign. In the office here, we have used the election to highlight aspects of the Population Health Manifesto. The Manawatu-Wanganui branch also drew on the themes of the manifesto for their wonderful candidates forum (see branch news).

"...but what next on our Population Health Manifesto issues?"

Eliminate childhood poverty

Politicians must commit on the ways to end poverty for our children. We have been very active in supporting the call of the New Zealand Council of Christian Social Services that political parties commit to a summit to end poverty. Child Poverty Action has laid out some specific actions that can be taken which will assist the 1 in 3 children that the Ministry of Social Development say live in poverty (see PHA News April 2001 Is it time for our children yet?). The new government has to take action for our children, and a Summit is an important first step. A very positive step has been the Nelson-Marlborough DHB calling upon DHBNZ to work with other agencies to hold a forum to end poverty in New Zealand. Congratulations Nelson-Marlborough, and I challenge the other DHBs to support the call.

Effective DHBs

Nelson-Marlborough has shown how a DHB can put the health of their population as top priority. All DHBs need to build on their health needs analyses to collaborate with other sectors. A major question for each DHB is how they intend to improve access to early intervention for everyone, especially groups with known poorer health. PHA members can help by keeping me informed of local priorities and DHB actions.

Healthy public policies

We are having some success in that some of the smaller political parties had health impact assessment as part of their policies. The direction of the transport strategy considers health and safety. We now need to get healthy public policy more widely accepted in other areas, particularly with local bodies.

Improved Maori health

The Maori Caucus has developed a work programme to be implemented over the next year (see item this newsletter). Improving PHA action on Maori health is the responsibility of all PHA members, and the leadership of the Maori Caucus on this will take us to new heights. The PHA Conference 2003, being organised by the Caucus, will be spectacular.

Increasing funding for effective preventive and first line treatment services

The PHA is concerned to see improved health for the people of Aotearoa. Looking at the data in the Ministry of Health's Our Health, Our Future the two big ways to this are more effective prevention and effective primary care.

The workshops Different Drummers, Same Rhythm - Public Health and Primary Care working together at the conference were very successful, and we are exploring ways we can work together with primary care organisations to improve collaboration at district level. We will continue to advocate for increased funding in these areas, but we need also to be exploring ways that collaboration can result in more effective results for communities at the district level.

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MAORI CAUCUS

Maori Caucus in Action

by Marty Rogers, PHA Vice President, and Maori Caucus

Wow! What an exciting time for Maori Caucus 2002-2003 is going to be. The PHA conference in Dunedin gave two new and wonderful members to caucus, Adrian Te Patu and David Tipene Leach along with Chris Webber and Marty Rogers.

Tinorangatiratanga in Public Health: Conference 2003

At the conference we issued our invitation and wero to participants for the 2nd, 3rd and 4th of July, 2003 in Ngaruawahia.

We will be calling a national hui on the 12th September for all Maori caucus members who would like to contribute to the development of the national conference. The hui will be held in Hamilton and further information will be sent out via the email tree. Watch this space!

Maori caucus would also like to acknowledge the Waikato branch who are supporting our efforts as well. Tena koutou to Dallas and the team.

Maori Caucus Workplan

We also committed to developing a workplan for 2002-2003. Full caucus identified some key issues to be included. The intention is to ensure a planned and co-ordinated approach to highlighting Maori issues in the media, participation in and influence of PHA policy developments and processes, and also to look to building on strengths available to whanau from individual mahi at a local and regional level.

Issues include: smoking, Tamariki Ora, Kai Tika - Wai Ora, Maori public health leadership, to name a few. In the media to date we have highlighted Oral Health and the issues facing our whanau.

If you would like to contribute to this mahi please contact either Marty Rogers: rogersm@waikatodhb.govt.nz, or Chris Webber: chris.webber@bopdhb.govt.nz.

Contact: *rogersm@waikatodhb.govt.nz*

BRANCH NEWS

PHA issues challenge at pre-election forum in Palmerston North

by Noeline Holt, PHA manager

17th July - 10 days before the election Manawatu-Wanganui branch pulled out all stops and invited six local candidates to attend a forum on public health policies. More than 50 people crowded the venue at the Palmerston North Library. Nan Kinross directed the action from the chair.

The candidates had been asked to address some specific questions:

- funding for public health
- the impact of economic policies on health such as removing subsidies on milk
- international issues that impact on health such as global warming
- issues for older people, and
- issues for children.

The evening provoked vigorous debate and some challenging questions from the floor.

Gay Keating highlighted two policies in the PHA Manifesto - eliminating child poverty and the role of DHBs in ensuring improved access to healthcare. She then challenged the candidates to commit to an *Eliminating Poverty Summit* within six months of the election.

Congratulations to the Manawatu/Wanganui branch on their quick action in organising a forum (including catering) within a very short timeframe before the election.

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First Maori Public Health Leadership Course Completed

by Chris Webber, PHA Maori Caucus

A shot in the arm for Maori Public Health was delivered last month with the completion of the pilot Maori Public Health Leadership Programme in Hamilton.

In four months, over a series of two-day waananga, participants were exposed to a wide range of topics and speakers deemed to be the "crème de la crème of Maori Public Health", according to facilitator Tania Hodges. Topics ranged from approaches to health promotion and protection, through tools like epidemiology and project management, to strategy for health policy and checking leadership styles and being on the right kaupapa.

The Ministry of Health contracted Mauri Ora Associates to deliver the programme to a group of fifteen participants drawn from Waikato, Taranaki and Bay of Plenty. It is hoped a successful evaluation and support from key stakeholders will push the programme to continue developing the leadership needed to achieve our aspirations in Maori Public Health.

"Cool, awesome, inspiring" are but few of the words repeated about the programme from graduates. Outcomes included both individual learning plans as well as group efforts like a submission on the Maori Public Health Strategic Action Plan. The group has already resolved to reconvene in future and continue developing a voice and opportunities for others in Maori Public Health Leadership.

Graduates stand outside Te Kohinga Marama Marae (left to right), Irene Walker, Kingi Turner (facilitator), Evelyn Bennett, Hana Harawira, Eugene Davis, Josephine Smith, Pania Ruakere, Joanne Aoake, Kathey Webster, Luana Te Hira, Manaki Pake, Raewyn Hawera, Donna Leatherby, Angeline Perry, Avy Gardiner, and Chris Webber

Contact: *Chrisweb@pacifichealth.co.nz*

NATIONAL NEWS

PHA appoints Communications Adviser

Penny St John has been appointed communications advisor for the PHA and will be working 20 hours each week on public health issues.

Penny has a background in radio and print journalism and more recently has worked for a range of public health organisations, including the Smokefree Coalition. Penny lives in Seatoun, Wellington with her family, including an inherited geriatric springer spaniel.

Media Training

The PHA will also be organising media training. In the meantime, ring Penny if you are visiting or live in Wellington and want some free media training.

Feel free to ring Penny through the PHA office if you need help with press releases or advice on communicating specific issues.

Contact: *Penny St John, pha.office@actrix.co.nz*

New PHA Policies at the AGM

by Gay Keating, PHA director.

Four policies were considered and adopted by the Annual General Meeting of the PHA in Dunedin on 27 June, 2002.

Policies were adopted on breastfeeding, and family/whanau violence. Inequalities in health in our standard format replaced the shorter statement we had previously adopted,and the gun control policy was refreshed to bring it up to date.

The PHA now has policies on 14 issues - advertising of prescription drugs, alcohol, breastfeeding, climate change, disability access, environmental health, family/whanau violence, gambling, gun control, inequalities, nuclear weapons, road safety, tax, tobacco, and water fluoridation.

PHA policies provide an excellent evidence-based resource for the PHA and others in our communities to understand issues, risk factors and diseases from a public health perspective. They provide a strong basis for PHA advocacy. All PHA polices are on our website - www.pha.org.nz.

Policy sponsors wanted

In the coming year we will be looking to refresh (or retire) several of these policies - Access for people with disabilities, alcohol, fluoride, gambling, tobacco, and several members are looking to develop new policies.

Each new policy (or policy revision) needs one or more PHA members to do the policy development, including ensuring that the policy is relevant for Maori. The draft is then peer reviewed, and circulated to all members before consideration at the conference round table. The opportunity for all members to have input to the policy development process means that improvements and issues of contention should be all resolved prior to the Annual General Meeting.

If you are interested in developing or refreshing a policy, contact Gay at the office (04) 472-3060, pha.gay@actrix.co.nz.

Policy Committee members wanted

The PHA Executive Council has a standing committee on policy. The committee advises council on draft policies and also on implementation. It is also available to assist policy sponsors in the formulation of policies and in quality assurance. Member, Daniel Williams, retired at the June AGM, and we are looking for someone who is interested in moving evidence to action to be part of this committee.

The work load is not heavy (except for March when there is need to read and think about all draft policies). If you would like to join Dallas Honey and Chris Laurenson on this committee, tell Gay. Or you might like to volunteer a colleague.

Contact: *pha.gay@actrix.co.nz.*

HAVE YOUR SAY

Let's debate the issues

As a way forward we are keen to encourage debate. Selected members will be contacted in a week or two following the publication of the August issue of the PHA News and asked for their comments on different articles. We will be asking them what they liked/didn't like, and what they think should happen next. Feedback will be published in the October issue of the PHA News.

However, don't wait for us to call you, if you have something to say about a burning issue contact us at pha@actrix.co.nz.

NZ NEWS

Update on National Public Health Compliance Audit Protocol and Processes

by Janet Gafford Ministry of Health, Dunedin

The Ministry of Health has updated the National Public Health Audit Protocol and from early August will begin seeking registrations of interest from potential auditors, in order to set up a panel of auditors.

From 2002/2003 the Ministry will begin to undertake the first audits of public health providers.

The focus of the audit process will lie in assessing whether or not the services that are being delivered comply with those contracted for and, if they do not, how the Ministry can provide assistance in remedying any non-compliance issues. The intended process may also help District Health Boards (DHBs) with their quality improvement processes.

Where it all began

During 1999 the Health Funding Authority developed a national public health audit protocol after wide consultation with providers including Hospital and Health Services Public Health teams. The draft protocol was generally very well received and the HFA was encouraged to begin using it as an important quality improvement tool.

Representatives from a wide range of independent providers were also consulted. Other interested bodies including the Public Health Association, Health Sponsorship Council and the Australasian Faculty of Public Health were invited to comment and/or attended the consultation meetings which were held in Dunedin, Christchurch, Wellington, Hamilton and Auckland. The 1999 Public Health Association Conference in Wellington was also used as a forum for consultation.

The proposed requirements and the processes outlined in the draft protocol were then amended to incorporate the views emerging from the nation-wide consultation resulting in the draft.

For further information please contact Janet Gafford, Ministry of Health, Dunedin, janet_gafford@moh.govt.nz

EXECUTIVE NEWS

New members welcomed to the PHA Executive Council

by Noeline Holt, PHA manager

At the PHA AGM President Fran McGrath was delighted to confirm that Marty Rogers of the Maori Caucus was the newly elected Vice President, Rebecca Williams (Auckland branch) and Louise Croot (Otago/Southland branch) were successful nominations to the Council.

The Maori Caucus announced that the two new caucus representatives to Executive Council would be Adrian Te Patu, and David Tipene-Leach.

Farewells and thanks were made to retiring members John Waldon (Vice President), Trish Fraser (Auckland), and Geoff Bristowe (Maori Caucus).

Retiring Auckland representative Trish Fraser spoke to her report in the Annual Report advising the meeting of the specific and very significant public health issues the Auckland branch was facing, and recommended to the council that it looks at ways an Auckland based advocate could be employed or contracted.

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People and Place - 2002 Conference wrap up

by Marion Poore, 2002 Conference Organising Committee

The Conference Organising committee for 2002 is now tidying up all the loose ends that such a large event inevitably leaves behind. However, the good feeling created by such positive Conference energy remains, and the Otago Southland branch plans to build on that to keep public health alive and well in the south.

Expectations exceeded by a country mile

In the end 340 people registered. Day 2 was especially popular with four keynote speakers and workshop sessions on 'Shared decision making in the public health sector' and 'Different drummers same rhythm' - exploring the primary care public health interface. It was great to have people from a variety of backgrounds (DHBs, health promotion, general practice, community groups to name a few), getting actively involved in some hearty and healthy debate.

All keynote speakers generated great interest from the audience and the breakfast conversations (a first) gave delegates the opportunity to talk further in a more informal way. Concurrent papers generated a lot of interest as well. Many delegates commented on how hard it was to pick which paper session to attend - a testimony to the excellent programme put together from such a variety of papers submitted.

There was plenty for people to look at with the poster displays, the Public Health Units' exhibition of the work they do in their regions (congratulations to Northland which was judged the best), and other work displayed from a whole range of groups. Celebrating diversity would have to be the catch-phrase. There was wide media coverage - TV radio and press over the whole conference period and for a short time after.

Southern hospitality enjoyed to the max

It was a real buzz to see everyone enjoy the wine-tasting, fruit juice, beer and cheese from the Otago region while listening to a string quartet and catching up with friends and colleagues at the Welcome Function. The museum provided a perfect setting. The Conference dinner held in the Dunedin Art Gallery got off to a wonderful start with the announcement of Louise Croot as Public Health Champion. She and all previous public health champions were displayed in huge 'cartoon' paintings in the Art Gallery. The evening reached a natural high with everyone dancing the night away to 'Jazzies Groove'.

Popular choice for 2002 PHA Champion Award Louise Croot with son James and, from Auckland, 2001 co-winner Judy Reinken

Believe it or not but the 7am start to the AGM didn't put too many people off and the meeting was well attended with policies debated and passed on breastfeeding, health inequalities, gun control update, and family and whanau violence.

Thanks to all those who completed their evaluation forms giving us lots of useful feedback to hand on to Maori Caucus. Congratulations to the five people who won the draw. They are Sandy Brinsdon, Lynne Pere, Robin Law, Mary-Ann Carter, and Chris Stephens - your gifts are in the mail.

Conference Committee thanks all involved with organising the Conference and to those participating for their contribution. We had a great time and hope you did too! We look forward to Conference next year at Ngaruawahia and wish Maori Caucus all the best in their planning.

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DIRECTOR'S COLUMN

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Other PHA policies

Two of the new policies adopted by the PHA AGM have already been areas for action - breastfeeding, and family/whanau violence. Both are typical public health issues in that the "presenting symptoms" may be seen as matters of individual choice, but are in fact issues tied closely with our social and economic structures. Both are issues in which the whole range of Ottawa Charter strategies must be brought to bear, so that as a society we can make healthier choices, easier choices.

The PHA is enthusiastically giving our support to other agencies in relation to both World Breastfeeding Week, and to the repeal of section 59 of the Crimes Act (which gives parents legal defence for physical punishment of children).

I urge PHA members to support both these issues in your local area.

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FORTHCOMING EVENTS

"AEA the only conference in NZ & Australia devoted to Epidemiology"
Date: 5-6 September 2002
Venue: Te Papa Museum, Wellington
Contact: Conference Secretariat. AEEA Conference, c/- health Services Research Centre, P O Box 600, Wellington

"Clearing the air - What's next" National Smokefree Conference 2002
Date: 9-10 September 2002 (additonal - researchers workshop 11 September)
Venue: Wellington Town Hall and Michael Fowler Centre
Contact: Health Sponsorship Council
Tel: 04 472-5777, Fax: 472-5799
email: christine@healthsponsorship.co.nz

"Mobilising Public Health" PHA Australia 34th Annual Conference
Date: 29 Sept - 2 Oct 2002
Venue: Adelaide Festival Centre, Adelaide, Australia
Contact: PHAA Secretariat
Tel: 0061(02) 6285-2373
email: conference@phaa.et.au
www.pha.org.au/conferences

"Eighth RCMI International Symposium on Health Disparities"
Date: December 8-11 2002
Venue: Sheraton Waikiki Hotel, Honolulu
Contact: Richard Yanagihara, M.D., or Marilyn Dunlap, Ph.D., Phone: (808) 956-6151, Fax: (808) 735-7544, email: yanagiha@pbrc.hawaii.edu, website: http://www.pbrc.hawaii.edu/rcmi/symposium

"Putting the Public back into Public Health" America PHA 130th Annual Conference
Date: 9-13 November 2002
Venue: Philadelphia, PA, USA
Contact: Registration Bureau
Tel: US (514) 228-3009
Fax: US (514) 289-9844
email: APHA@Laser-Registration.com
website: www.apha.org/

Next issue October, **copy due September 27th.** Please send your article to the editor, email: pha@actrix.gen.nz.

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