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Vol. VII No.3 JUNE 2004

GUEST EDITORIAL

Why New Zealand Should Increase Health Development Assistance to the Pacific

by Nick Wilson*, Osman Mansoor, and George Thomson* Wellington School of Medicine & Health Sciences

The New Zealand Government gives around \$NZ 250 million per year in overseas development aid. In 2001, New Zealand ranked only 15th out of 22 OECD countries in terms of aid as a proportion of GDP. This level was also less than half the United Nation's target of 0.7 percent of GDP and less than a quarter of the level provided by Denmark. New Zealand's development assistance has recently been reviewed and a new semi-autonomous organisation "NZ AID" has been established. The current major focus of development assistance is on poverty elimination, which includes health development. This article takes a public health perspective on the key arguments for increasing overall development assistance to the Pacific Island Countries (PICs), particularly for health development.

Reason one: Ethical issues

There is a strong case on ethical grounds for rich countries to assist developing countries in alleviating poverty and disease. The Solomon Islands, Papua New Guinea, and Vanuatu suffer from serious health problems, reflected in low life expectancy and high infant mortality. Infectious and vector-borne diseases are important contributors to the poor health outcomes (including malaria, diarrhoeal diseases and respiratory infections in many PICs). HIV/AIDS is spreading in the region and is of particular concern in Papua New Guinea. There are also problems with alcohol abuse, intentional and non-intentional injury, and increasing rates of diabetes and cardiovascular disease.

Another ethical issue is remediation of current and past harms imposed on PICs by activity allowed by New Zealand Government policy. For example, one estimate is that New Zealand's cigarette exports cause around 75 premature deaths per year in nine PICs. New Zealand also exports meat products high in saturated fat (eg, as 'mutton flaps') thus contributing to cardiovascular disease and diabetes in PICs. In the 1980s, New Zealand even provided 'development funding' to the construction of a cigarette factory in Samoa. This factory continues to supply cigarettes to Samoa and surrounding countries. Some of New Zealand's training of health professionals from PICs may also have contributed to a drain of nurses and doctors from these countries.

Reason two: Shared communicable disease control benefits

Globalisation and extensive air travel allow for the rapid spread of communicable diseases between countries, and border controls have incomplete capacity to prevent their spread. In

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order for New Zealand to achieve or maintain control of these diseases, control is vital in neighbouring countries with frequent reciprocal travel. New Zealand faces three types of communicable disease risk from PICs: importation of diseases (and their subsequent spread in New Zealand); infection of New Zealand travellers who then require treatment by New Zealand health services; and infection in Pacific migrants who then both require treatment by health services and who can spread disease in New Zealand.

There are a number of examples of communicable disease spread from PICs to New Zealand (eg, typhoid and Ross River fever). Dengue fever poses both risks to travellers from New Zealand, and there is also a potential risk of it becoming established in this country. Migrants from PICs to New Zealand also have relatively high rates of tuberculosis. Infectious agents in imported food from PICs have also caused health problems in New Zealand and the 1997 measles epidemic may have been started by an importation from the Pacific. Other diseases in which there is a potential risk of spread (from PICs to NZ or vice versa) include: HIV, pertussis, rubella, pandemic influenza, and SARS.

Fortunately, many communicable disease control interventions in developing countries are highly cost-effective. Tuberculosis control strategies in developing countries are estimated to save a disability-adjusted life year (DALY) for only \$US 3–5 (and \$US 12 per year of life saved). There are extensive international data on the cost-effectiveness of malaria control (eg, \$US 13 and \$US 43 per year of life saved in Guinea). In Melanesian countries, malaria poses a major and continuing threat and there is evidence from the Solomon Islands that permethrin-impregnated bednets are an effective and low-cost control strategy.

Immunisation programmes are also generally considered to be extremely cost-effective in developing countries (eg, \$US 12 – \$17 per DALY). A hepatitis B immunisation programme

(part-funded by NZ) was found to be successful in protecting infants from chronic infection in the Pacific – at an estimated cost of around \$US 190 per premature death prevented.

Reason three: Shared non-communicable disease control benefits

New Zealand shares with PICs such problems as high rates of rheumatic heart disease, obesity, diabetes, and tobacco use among its citizens. Indeed, the increasing prevalence of adult obesity and type 2 diabetes are particularly major problems for both New Zealand and PICs. As Auckland has the largest single concentration of Pacific peoples in the world, many lessons learnt in the process of addressing these health problems (in both Auckland and in PICs) can be shared to the benefit of all. Examples might include the sharing of lessons in public health legislative frameworks, tobacco control policies, culturally-appropriate nutritional interventions, physical activity promotion programmes, and diabetes control programmes.

If future immigration from PICs occurs at high rates, then improved control of chronic diseases in these countries might ultimately lower health costs for New Zealand. This may especially be the case for low-lying island nations (eg, Tuvalu, Kiribati) that could be de-populated by rising sea levels attributable to global climate change.

Reason four: Enhanced regional stability

There are several areas of instability in the Pacific and some small states may also be at risk of exploitation by terrorist organisations and crime syndicates (eg, for money laundering, human smuggling, and drug trafficking). New Zealand has been involved in a number of successful stability-promoting initiatives (eg, peace-keeping activities) but these can be supplemented with actions to reduce poverty and improve health. For example, improving the health status of the

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Celebrating Achievements in Public Health

PHA Conference 2004

by Penny St John, Communications Manager, PHA

Almost 300 people are expected at the PHA's annual conference, starting 30 June in Christchurch. The conference theme is *Growing Our Own*, which refers to strengthening and developing capacity in public health.

Conference committee convenor, Vivien Daley, says the committee received 109 abstracts for this year's conference, which is a record for any PHA conference. These abstracts will be presented in a wide range of workshops, presentations and posters over the three-day conference.

"The huge interest in conference has meant we have expanded the number of planned workshops to accommodate the large number of presentations."

Topics include sudden infant death syndrome (SIDS, 'cot death'), breastfeeding in the workplace, refugee and migrant health care, road safety and walking school buses, the effectiveness of breast and other screening, the health of people in temporary housing, sun protection in schools, problem gambling, genetic testing, and school closures as a public health issue.

Pacific and Maori

Nga Manukura or leadership is the subject of a presentation by PHA president Marty Rogers. Marty will explore the traditional concept of leadership and explore how there is a different type of leadership emerging in the changing political and social environment.

Maori and Pacific coverage in screening programmes, Pacific nutrition training, Maori public health workforce development, Tamariki Maori coordination and reclaiming traditional values and practices to ensure Maori babies get the best start in life are some of the presentations on offer at Conference 2004.

2004 conference will provide opportunities to celebrate achievements in public health, and also to discuss ways of addressing new challenges

and emerging issues. She says emerging issues include the response to public health emergencies, integration of public health and primary care and supporting the developing of public health in other countries in the Pacific region.

Keynote addresses

As well as the wide variety of presentations, there will be high-profile keynote addresses from:

- Hana O'Regan of Ngai Tahu Development Corporation
- Dr Helen Leslie, Senior policy adviser with NZ Agency for International Development
- Dr Debbie Ryan, Chief Adviser Pacific Health, Ministry of Health
- Dr Lance Jennings, specialist virologist, Canterbury District Health Board
- Rachel Fonotia, coordinator of the Aranui Community Trust.

Christchurch –the Garden City

Surrounded by the Cashmere Hills, Christchurch is known as the garden city because of its many trees and gardens and the tree-lined Avon River. The city is considered the most English of New Zealand's cities and punting on the river is a favourite pastime during summer.

Cathedral Square is the heart of the city where you may find local celebrity the Wizard. There is a lively cafe and cultural scene. Make a circuit around many of the best known Christchurch sights in the historic trams.

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New Zealand Evidence-based Healthcare
Bulletin is available on-line at
www.nzgg.org.nz/bulletin/current.cfm

Indigenous Health Going Global a Maori Perspective on the IUHPE Conference

by *Damiane Rikihana, Maori Communications Adviser PHA*

The International Union for Health Promotion and Education (IUHPE) conference, in Melbourne sent a very clear message that health promotion for indigenous peoples must be led and controlled by indigenous people.

Delivered by Maori public health practitioners they told participants representing a huge range of countries across the globe, that this approach was fundamental to improvements in indigenous health and should be reflected in the structures and processes of the IUHPE.

The recommendations were derived from the Maori Health Promotion Gateway Hui held a week before the Melbourne conference. The Gateway Hui was a chance for more than 20 Maori health providers to showcase their innovations; share insights and learnings and prepare recommendations for the IUHPE conference.

Many Maori representatives at both conferences were PHA members, including representatives of the Maori caucus.

Validation of indigenous frameworks recognised

Megan Tunks said the IUHPE was reminded that if it was to engage in serious dialogue about indigenous people's health promotion issues then

it needed to recognise the validity of indigenous health promotion frameworks, models and concepts.

It also needed to pay particular attention to supporting capacity-building for indigenous health promoters.

"We were pleased that all these recommendations were passed by the Indigenous Caucus and the IUHPE World Assembly," she said. "The conference also confirmed for me how well we are doing in New Zealand and the strength we have in indigenous health promotion models and practice."

Keynote speakers from New Zealand at the international conference included Dr Papaarangi Reid, and Professor Mason Durie.

The International Union for Health Promotion and Education aims to promote global health and contribute to the achievement of equity in health between and within countries of the world.

The IUHPE fulfils this by building and operating an independent, global, professional network of people and institutions to encourage the exchange of ideas, knowledge, know-how, experiences, and develop collaborative projects, globally and regionally.

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Big Leap in PHA Maori Membership

by *Damiane Rikihana, Maori Communications Adviser PHA*

Maori membership of the PHA has witnessed a big leap this year to 17.36% of total PHA membership.

Maori caucus members attribute the rise in numbers to last year's conference at Ngaruawahia and the hugely successful Gateways Hui held in Auckland recently - which had a high level of input by caucus members. Though pleased with their results, caucus members said they were keen to push their numbers up even further. They expect Maori membership numbers could climb as a result of interest in the PHA conference in July.

18th World Conference on International Union for Health Promotion & Health Education

by Ann Shaw, PHA Executive Council

Nearly 3000 participants attended the international conference held late April in Melbourne. From the spectacular opening ceremony, held at the Melbourne Art Centre, to the Eberhard Wenzel Oration, (delivered by Dr Papaarangi Reid), it was all go; multi-streamed, multi-language, global and exciting! Papaarangi and Mason Durie did New Zealand proud with their presentations.

Conference of extremes

This was a conference of extremes. Representatives ranged from well-resourced USA Government organisations to community groups who rely on local support, to countries whose health and education budgets are not able to be adequately addressed because of huge international debts. All were able to come together and share experiences.

There was much discussion, debate, and pontification about the relationship between health promotion, primary health care and public health and the wide variation between those who are absorbed in the theory and those people at the flax roots was very evident.

The conference addressed *Valuing Diversity* by setting better solutions for everybody, with the greatest commitment to those with the worst health.

Reshaping power highlighted the importance of adding politics and art to the science of health promotion, while acknowledging that health inequities exist because some people make decisions that affect the life and health chances of others.

Exploring Pathways for Health & Wellbeing were discussed under a global umbrella acknowledging the interaction of academic, theory and practical dimensions.

NZ leading the way

! New Zealand can be very proud of its' diversity in practice. Events described as 'cutting edge'

were often those we have seen used by groups for many years, (especially in the fields of child health and tobacco).

I came away from the conference convinced every effort must be made to publish and acknowledge the excellent projects and strategies already in place in New Zealand. Many people working in health promotion, and the wider health sector in New Zealand, do not realise these initiatives are equal, if not better, than many from 'overseas.' In the words of a health promoter from the East Coast: "*It's an eye opener. We need to sing our own praises more because there are many things we can teach others*".

The poster presentations were mind blowing. Not only were there different posters each day, but their diversity and the depth of the research involved made the poster hall an exciting, if noisy place to linger.

My sponsorship at the conference involved the PHA, Manawatu Cancer Society and BreastScreen Coast to Coast so I managed to attend areas of interest to all. Australian PHA played a big role in the organisation of the conference.

Speakers

Fran Baum spoke about the principles of global solidarity acknowledging the failure of WHO leadership, the need for a global format that does actually put people ahead of economic decisions, the link between war and oil, and the failure to de-medicalise health care.

Lawrence Green spoke about the need to move from evidence-based practice to practice-based evidence, stating, "*Evidence as we know it for controlled trials will never surface as the sole source for best practice. Best practice is often confused with best processes*".

Common themes running through plenaries and presentations included: the misuse of power, integration of public health, primary healthcare

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....18th World Health Promotion Conference

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and health promotion, social justice, *the* importance of theory and practice; singing from the same song sheet and the need for health promotion to start where the people are.

I attended one session on '*Education, Training and Workforce Development*' where the wide diversity of a global view of health promotion was evident.

Peter Sainsbury's '*rant*' included the cry for new skills without the loss of the old skills and enthusiasm, while John Lowe questioned the need for the world to have the same competencies. A gentleman from Laos reminded us that the majority of his workers did not have secondary education.

Linda Burney (the first Aboriginal Woman to get a Diploma of Teaching) highlighted the huge gap between indigenous Australians and the rest of the population. She stated that '*equity means opportunity to participate in society wrapped soundly in a blanket of culture*', as well as the perceived '*sea gull*' phenomenon: '*White fellows fly in, shit on you and fly out!*'

Jay Wortman, who is a First Nation Canadian, used himself as an example for the need for indigenous peoples to return to the foods of their ancestors in the fight against obesity, type 2 diabetes and heart disease. He showed a TV programme in which he starred highlighting the changes it had made to his health by returning to the low carbohydrate, hunter/gatherer diet of his forebears. He warned of the counter advertising and articles from bread, pasta and orange juice manufacturers whose income is threatened as this idea catches on across North America.

Antanas Mockus, former mayor of Bogata, described how social pressure was harnessed to assist in the prevention of road accidents and homicide in his football crazy city where the presentation of a red card caused embarrassment and shame and resulted in changed behaviour.

Ideas between people

The Rev Andrew Mawson advocated 'people before structure' and to begin with the micro not

the macro. He described his experience in an inner London church centre, advising practitioners to go for partnerships, (ideas between people), not representative committees; stating that new ideas do not come out of universities and experts leave behind a dependent culture. He feels solutions to problems lie with practical micro details and to this end advocates '*an inside out approach, not bottom up, as equity principles can be destructive.*'

Antoinette Ntuli, Chair of Health Global Equality Gauge Alliance, urged participants to go beyond description of equity to action. "*Watch what's happening globally and shift the paradigm to targeting wealth distribution*". She said, "*Equity is about unfair process not just outcomes or technical issues*".

Cost of 90's experiments

Many speakers referred to the global decline in trust of governments and the 'marketisation' of the individual.

The cost to the world and subsequent health outcomes of the 90s' experiments in privatisation were only too evident in many presentations. One third of the world workforce is unemployed or under-employed in a vicious circle of poverty.

ILO estimates that work related accidents world wide equate to four percent of global GNP.

Comparisons were made with the late nineteenth century in use of precarious employment and fragmentation of the workforce. Examples of how this had often followed Free Trade agreements with USA were numerous:

- de-skilling in the Canadian forestry,
- trade in people from the Philippines, and
- 'whether New Zealand had a definite policy of keeping Medical Practitioner training twenty percent below requirement to take advantage of cheaper imports.' All were part of the lively discussions between global policies and health.

David Tipping (UN Habitat) reminded all that health is central to economic development and market factors are at the lower end of the spectrum. The cost and results of poor health in
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epidemics, poor sanitation, loss of fisheries and famine far outweigh market efficiencies. Health issues come under the wider umbrella of human rights 'diseases' such as hunger, poor drinking water, slums, smoking, AIDS, alcoholism, drugs and the abuse of children.

Fiona Stanley reminded us about the importance of early childhood development, '*while genes are important the crucial thing is how they are switched on and off*'. She illustrated the effects that colonisation had had on Aboriginal children 'child health diseases and sound influences are a personal and powerful predictor of health outcomes'. Implications for health promotion are to focus on child development. The gap between statistics for Aboriginal and non-indigenous Australians was painfully evident throughout the conference.

The session on Primary Health Care was chaired by Don Matheson and Canadian and New Zealand experiences illustrated that the fifth Ottawa Charter principle is the hardest to implement.

I came away from the conference with a better global perspective, convinced that one size for health promotion does not fit all and that international structures such as IUHPE, WHO, IMF, and World Bank sometimes become so intent on their own survival they forget their reason for being.

The huge global gaps, not only in services, but also in the recognition of basic human rights, and acknowledgment that there is much still to be accomplished, makes one very humble about living in Aotearoa/New Zealand.

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Your membership renewal form/invoice is enclosed. We look forward to receiving your membership for another exciting year of public health action.

A membership survey recently carried out by masters student Geoff Stone indicated over 82 per cent of members are satisfied with our services. We aim to do even better this year!

What are the Essential Functions of Public Health?

by Dr Gay Keating, director, PHA

Some countries and regions have been considering this question. Here is one answer that Western Australia has tried. What do you think?

1: Health situation monitoring and analysis

The measurement, monitoring and analysis of changes in health status, including inequalities.

2: Epidemiological surveillance/disease prevention and control

This contributes to safeguarding the public's health and reducing the burden of disease.

3: Development of policies and planning in public health

This enables coherent service development.

4: Strategic management of health systems and services for population health gain

Making the necessary changes in services happen.

5: Regulation and enforcement to protect public health

Development and compliance with regulation, safeguards and protects the public's health, and reduces the burden of disease.

6: Human resources development and planning in public health

To provide the workforce needed.

7: Health promotion, social participation and empowerment

Make communities healthier by advocating for health and empowering citizens.

8: Ensuring the quality of personal and population-based health services

To improve health status, reduce health inequalities, safeguard and reduce the burden of disease.

9: Research, development and implementation of innovative public health solutions

Innovation is needed for solutions to hard problems.

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WFPHA Congress – All the Same, But Different

by Gay Keating, director, PHA

I attended the World Federation of PHAs' tenth congress in April which was held conjointly with the UK PHA meeting. The UK sessions had a whole lot of similar issues to ours – overarching concern about inequalities, focus on specific issues such as obesity, tobacco, public health workforce – the same, but different.

Similar issues

The WFPHA sessions also had a whole lot of similar issues to ours – overarching concern about inequalities, focus on specific issues such as obesity, tobacco, public health workforce – the same, but different.

I can think of no better way to bring the essence of the Congress to you than to quote from the keynote Leavell Lecture, provocatively titled *“The end of public health as we know it: - constructing global health in the 21st century”*. It was presented by Professor Ilona Kickbusch, Special Advisor, Pan American Health Organisation and Faculty, Yale University School Of Medicine.

Public health rarely works through magic bullets – and public health professionals need what the poet Adrienne Rich has called *“wild patience”* combining ingenuity, evidence, common sense, passion, a sense of urgency and above all a sense of justice. *“The two public health revolutions that changed the face of health and disease in the industrialised countries in the 19th and 20th century were the results of often harsh political and ideological battles spread out over decades which always accompanied the professional and scientific progress and economic and social; therefore its remedies must also be economic and social.”*

At present, it is the poorest countries that are paying the price for this negligence – but we have mounting signals that a new health divide is in the making in the developed world. Indeed it is becoming more and more difficult to define the rich and the poor of this world at the level of the

nation state as a large global underclass spreads out around the globe and defies the old definitions of vulnerable groups.

We need not only forceful public health action at nation state level in both the developed and the developing world – we also need nothing less than a new global social contract on health.

Europe needs to take the historical step to make public health a priority within its borders and in terms of its global responsibilities. A forceful and well funded global health strategy is the most ethical and forward looking way of paying back what Europe received during a long period of colonialism and empire.

The messages for Aotearoa/New Zealand are clear:

- Public health gains come only with harsh political and ideological battles spread out over decades
- Public health gains depend on the wider context of social reforms and investments, plus the development of strong and sustainable public health systems
- Poverty in our country is now beginning to merge with poverty in other countries
- Our country has been both colonised and coloniser, and the shadow of that legacy hangs over the health of people in this country and the wider Pacific.

Public health in our country is clearly now inextricably interwoven with the rest of the world. We need both national and international public health linkages and networks to help us maintain and build good health for people here, and contribute to the same task internationally.

The full text of the Leavell Lecture can be found on the WFPHA site at <http://www.apha.org/wfpha/TranscriptOfLeavellLecture.pdf>.
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Child Poverty and the Budget

by Dr Gay Keating, director, PHA

For some years now the PHA has been highlighting child poverty as an underlying determinant of health. Budget 2004 had been predicted to be the opportunity for Government to make significant changes to alleviate child poverty, and the budget was billed as “one for families”. After the event it seems to be a very mixed bag.

Yes, the Prime Minister DID acknowledge that there is child poverty in New Zealand. But no, there is no target date to achieve Government’s own goal from *New Zealand’s Agenda for Children* of eliminating child poverty. There is also a lack of an overall strategy.

Yes, many children will be lifted from poverty. By 2007 the government estimates that the number of children in poverty will be reduced by 30 per cent. But no, there is no indication of any plan for the lives of more than twice that number of children who will still be financially impoverished.

Yes, over two thousand million dollars will be spent that will benefit children. But the reason it will be spent is not to benefit the lives and life chances of children. It is to incentivise parents to join the paid workforce – to make work pay.

Yes, there has been an increase in tax credits lifting them to about the level they would have been if updated for inflation, and there will be future indexation of benefits. But it is quite unclear how this will affect eligibility for special benefits.

The package is very complex, and many questions about it are still unanswered. What is clear are the following:

- Government does not place high priority on having an adequate safety net for those with children who cannot work take paid work, such as super annuitants, invalids and the sick. Returning these benefits to levels they should have been if they had been indexed is welcome but insufficient.
- Government does not place high priority on parenting by single parents with infants and children, preferring to give greater Government funding to those parents if they are in paid employment than if they look after their own

children.

- Government does not expect employers to pay a living wage, as the increased funding in the budget is targeted at the working poor - those who cannot adequately feed, shelter and clothe their family on a full-time wage.

Fair-minded New Zealanders still do not understand the extent and depth of poverty, nor the impact on children in this country. We need to continue to build awareness of the issue and build outrage at the damage that this is doing to the health and prospects of children - our futures.

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Health Research Council Foxley Fellowship

The Foxley Fellowship is a prestigious award that will enable an individual with a minimum of five years experience in the health sector to undertake a one-year research sabbatical within an academic institution. The research undertaken by the applicant should be aimed at increasing the utilisation of health research results within the health sector. Information regarding the Foxley Fellowship can be found at <http://www.hrc.govt.nz/assets/pdfs/funding/foxleyfellowship.pdf>.

Application and Forms

Applications must be made to the Council through the head of department and through the normal administrative channels of the applicant’s intended institution.

Closing Date

5.00 p.m. Wednesday 1st September 2004.

Full information and application forms are available from the HRC website www.hrc.govt.nz.

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workforce may contribute to stronger economic development and therefore reduce the risk of state instability. Family planning programmes can assist in lowering population pressures in island nations that have limited natural resources. Family planning is also a very cost-effective way to improve child and maternal health (at \$US 20-30 per DALY). Child health programmes may also contribute to population control, since as child survival improves, maternal fertility tends to decline.

A more stable South Pacific would facilitate mutual economic development (including more trade and tourism) and reduce New Zealand requirements for expensive peacekeeping operations. It would also lower the long-term risk of New Zealand having to accept refugees from local conflicts. Similarly, enhanced stability may increase the resilience of PICs to the impacts of climate change and, therefore, future numbers of environmental refugees.

Summary

New Zealand is a relatively poor contributor of financial aid to developing countries – with a rank of 15th in the OECD. Given the poverty and poor health status within some Pacific Island Countries (PICs), there is an ethical imperative to do more. This imperative is strengthened by the need for the remediation of current and past harms to the health of Pacific peoples (eg, from New Zealand tobacco exports). Development aid can also lead to direct and indirect health (and other) benefits

for New Zealand. These benefits are most obvious for communicable disease control (eg, for tuberculosis, measles, pandemic influenza, and vector-borne diseases). These benefits will apply more broadly to any health intervention of relevance to the Pacific Island community in New Zealand (eg, diabetes prevention programmes). The reduction of poverty and population stabilisation in PICs may also enhance regional stability. Such stability would benefit New Zealand in terms of trade, reduced needs for peacekeeping, and a lowered risk of refugees arising from internal conflicts.

Call to Action

PHA members are encouraged to write to their MP and to the relevant Minister (Hon Marian Hobbs) to urge an increase in the amount as well as more effective use of New Zealand's development budget to promote health and peace in the region.

Acknowledgement

*A more detailed and fully referenced version of this article was published in the *New Zealand Medical Journal* in April 2004 (1). The authors gratefully acknowledge the *NZ Medical Journal* editors for permission to reproduce parts of this publication.

(1) Wilson N, Mansoor O, Thomson G. Key arguments for increasing New Zealand's health development assistance in the Pacific. *NZ Med J* 2004;117(1191).

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FORTHCOMING EVENTS

Immunisation at the Crossroad Challenges and Strategies

9th National Immunisation/1st PHAA Asia
Pacific Vaccine Preventable Diseases
Conference
Cairns Convention Centre
Queensland, Australia
19-20 August 2004
website www.phaa.net.au

Making a Difference - Celebrating 40 Years of La Leche League in New Zealand

Date: 24-26 September
Venue: St Pats Silverstream
Upper Hutt
Contact: LLLNZ
Tel/fax: 04 471 0690
Email: llnz@clear.net.nz
www.lalecheleague.org/LLLNZ

Taking Care of Our Children – post budget breakfast a great success

by Julia Stuart, Wellington

Marmite today

Post-Budget breakfasts traditionally provide more food for the already well-fed who want to know what goodies Government is putting their businesses' way. The annual PHA/CPAG (Child Poverty Action Group) breakfast has taken an alternative approach however, with speakers focusing on how others – particularly poorer people – might possibly benefit.

The breakfast itself has had its own journey. Its venue has spread from down-town Wellington to academic Auckland and to third-sector Wellington in the last three years. Its sponsorship too has changed. Initiated by the Public Health Association, it has been increasingly underpinned by the growing Child Poverty Action Group coalition. This year CPAG was the host, with PHA in a supporting role – the child growing up and taking over from the parent, in effect.

This year's event was a bit more celebratory than usual, too, because one family in five, and usually the one at the lower end of the five, is clearly going to find life a little easier – even though not quite yet. One commentator described this year's Budget as *'jam tomorrow – and a bit of Marmite and peanut butter today'*. So the Minister of Social Services, the Hon Steve Maharey, was almost jubilant as he spoke to a coffee-sipping, muffin-munching crowd in the Loaves and Fishes hall in Wellington on Friday 28 May.

He told them that, depending on which poverty measure you took, the Budget would mean between 30 and 70 per cent of New Zealand children would no longer be living in families below the poverty line. *"It's the most significant Budget since 1973,"* he said. (1973 was the

Budget which expanded access to benefits beyond people who were unemployed, invalid or old.) *"Yesterday we did a biggie and I'm extremely happy."*

The reality

Professor Bob Stephens of Victoria University brought the Minister down to earth a bit by noting that the Budget was mainly 'a return to pre-1986 levels of income' for families. It did however counter Bob's previously-publicised statement that... *'New Zealand's family support is rather mean and nasty'* and he was happy to be contradicted. *'If it were not for this Budget, comparative figures show that New Zealand would have slipped even further in the world rankings,'* he said. He marked the Budget 9.5 out of 10 (compared with the National Party leader's mark of 2.5/10).

Cautious thumbs-up

"A cautious thumbs-up for commitment," was the verdict of Murray Edridge, CEO of Barnardo's. *"The vast majority of families want to do the very best for their children, but have been defeated by successive governments,"* he said. *"People provided with a secure early childhood future very quickly become productive providers."*

"Care is needed not to discriminate between children whose parents work and those whose can't," he warned. *"Also needed is a commitment not to let people slip back. The stakes are high but our kids are worth it."*

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Have your say on what is read!

The PHA News editor would like your public health news for publication in the PHA News. Please send copy for next issue by **August 2nd 2004** to the manager at PHA, email pha@actrix.co.nz or telephone (04) 472-3060 for further information.

“Growing our Own - strengthening the public health workforce”

PHANZ 2004 Conference
 Date: June 30-July 2, 2004
 Venue: Christchurch
 Contact: Conference Office, University of Canterbury
 Tel: (03) 364-4162/(027) 436-4167
 email: m.brown@cont.canterbury.ac.nz
 Vivien Daley, conference convenor
 email pha@cont.canterbury.ac.nz

“Sex Matters”

New Zealand Family Planning Association conference
 Date: 29-31 October 2004
 Venue: Wellington, New Zealand
 Contact: Tricia McKendry
 Tel: (04) 479-8616/(027) 671-9060
 email: tricia@cwl.nz.com

PHANZ Conference 2004 has been endorsed by RNZCGP and is approved for up to 20 hours (= up to 40 credits), for Advanced Vocational Education (AVE) and Maintenance of Professional Standards (MOPS) purposes.

THE COMMONWEALTH FUND

Harkness Fellowships in Health Care Policy

The Commonwealth Fund is pleased to announce the 2005-06 Harkness Fellowships in Health Care Policy. The Fellowships provide a unique opportunity for mid-career health policy researchers and practitioners from the United Kingdom, Australia, and New Zealand, to spend up to 12 months in the United States conducting a policy-oriented research study, working with leading U.S. health policy experts, and gaining an in-depth knowledge of the U.S. health care system. Under a new partnership between The Commonwealth Fund and The Health Foundation, the program includes two additional U.K. fellowships targeted at health care practitioners and supported by The Health Foundation.

Applicants must demonstrate a strong interest in health policy issues and propose a research study that falls within the scope of The Commonwealth Fund’s national program areas which include improving health insurance coverage and access and improving the quality of health care services. Its quality programs focus not only on general issues but also on the needs of specific groups, including underserved populations, young children, and frail elders.

The deadline for receipt of applications is September 1, 2004. In order to apply, applicants must be **citizens of the United Kingdom, Australia, or New Zealand** and submit a formal application. Each fellowship will provide up to \$85,000 (U.S.) in support. A family supplement is available to fellows accompanied by families.

To obtain further information about the Fellowship program, including a List of Suggested Projects, please see The Commonwealth Fund’s webpage at www.cmwf.org. Application materials and instructions are available in electronic form on the webpage. For further questions regarding the program, eligibility, or the research proposal, contact Robin Osborn at The Commonwealth Fund, One East 75th Street, New York, NY 10021, U.S.A. (tel: 001 212 606 3809 or email: ro@cmwf.org).

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