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

Vol. VI No.5 OCTOBER 2003

GUEST EDITORIAL

# Energy and the Public Health

## – *research makes links*

*by Nigel Isaacs, Principal Scientist, BRANZ Ltd*

## Introduction

We spend much of our lives inside buildings, and the majority of this time is spent in our homes. Yet we know more about the conditions inside a space craft than we do about what goes on inside our homes. Warm or cold, damp or dry – the conditions in our homes have a critical impact on our individual and public health. These conditions are the result of a complex interaction between the building, the occupants, household appliances and the energy use.

The large majority of energy used in houses is used as heat – to warm the air, to provide hot-water for washing, to dry clothes or to cook food. Other important uses of energy include providing safety (e.g. lights), toys (e.g. TV, stereo) or tools (e.g. washing machine, dishwasher). Energy is the all pervasive, hidden servant that helps make our buildings healthy, safe and comfortable.

## The Project

The Household Energy End-Use Project (HEEP) is a major study investigating the energy use and conditions within New Zealand homes. It is funded by the Foundation for Research Science and Technology, the Building Research Levy, the Energy Efficiency and Conservation Authority, Transpower and a range of other government and private sources.

When monitoring is complete in early 2005, the database will contain information on more than 400 houses. The houses have been randomly selected on a population-weighted basis from around the country. Every house is different, every set of occupants is unique. Even so, common issues appear when a suitably sized sample is investigated.

The project monitors all fuels (electricity, natural gas, LPG, solid fuel, solar) and temperatures in at least three locations within the house at between one and 10-minute intervals. A detailed house audit and occupant survey provides physical and socio-demographic data for comparison with other statistical resources. This integrated, comprehensive set of data on the physical, social and energy aspects of housing provide opportunities for understanding our homes, and the relationship between occupants and their homes, that have not previously been available.

## Early Results

The HEEP Year 7 report will be released shortly, based on data from more than 200 houses. Some of the topics of obvious public health interest will include:

*Hot-water*

Too many people are admitted to hospital each year with serious hot-water burns. But how many homes have dangerously hot-water, and why? HEEP now has data on the following:

*continued on page two*

### Inside

Which Community?..............................3
Branch News.................................5 & 6
2004 Conference Announcement..........7

*continued from page 1*

## ...energy and the public health

- performance of electric thermostats – documenting how poorly many control water temperature, often delivering unsafe temperatures even though apparently set at a safe level
- hot-water temperature and cylinder size – smaller electric cylinders (135 litres or 30 gallons) on average have higher (and often dangerous) temperatures, but a significant number of larger (180 litre or 40 gallon) cylinders also have dangerously hot water
- physical hot-water system and occupants – although as house sizes increase the cylinder volume also increases (reducing the need for dangerously hot temperatures), the link between the number of occupants and measures such as cylinder volume, water temperature etc is not as clear. There may be a need to provide better guidance for the sizing of hot-water systems to meet current and future hot-water needs.

*Room temperatures*

How warm are New Zealand houses? New Zealand is a very egalitarian society – high income households are just as cold as low income households. Unlike many developed countries, only limited areas of our homes are heated, and then only for a limited time. Winter morning and evening heating are more common than all day heating – even if occupants are at home the entire day. About one-third of the houses in the sample have winter evening temperatures which average below 16 °C – the WHO recommended minimum. Houses with thermal insulation are warmer than uninsulated houses.

*LPG heaters*

Over the past 20 years, the increase in use of unflued, portable LPG heaters has been matched by a fall off in the use of portable kerosene and electric heaters. According to Statistics NZ's *Household Economic Survey* more than one-third of houses now have LPG heaters. The HEEP data shows that the majority of the LPG heaters monitored are used at low settings for less than five hours per week. HEEP also found that about one-fifth of houses without an LPG heater had a dehumidifier, while two-fifths of those houses with an LPG heater also had a dehumidifier.

Individual house data is confidential, but there are opportunities for a wide range of queries to be explored and, more importantly, for baseline data to be available for other research. Preliminary results from the HEEP analysis are leading to questions that will help improve the comfort and health of New Zealanders. The examples given here are not yet fully explored, and we look forward to providing more detailed analysis and understanding over the remaining four years of the project.

Further information, including papers and report summaries are available from the BRANZ web site: www.branz.co.nz

Contact: *NigelIsaacs@branz.co.nz*

## PHA Diaries a first

Earlier in the year we were approached by Academy Publishing (Christchurch) asking if our members would be interested in a free 2004 diary. "Do bears etc", we said and placed an order. We have been working with Academy Publishing since then approving advertising and setting out. The result is enclosed. We have a few spares so if you would like another, please contact this office *pha@actrix.co.nz.*

## A Name Change - but still the same great branch

The Manawatu/Wanganui Branch of the PHA, realising that its membership encompassed a much wider geographical area than described in their present name, has solved the problem by renaming itself the **Central Districts** Branch of the PHA.

Contact: *ann.shaw@midcentral.co.nz*

# Which Community?

*by Neil PearceCentre for Public Health ResearchMassey University Wellington Campus*

You have to be in favour of "community". It's an idea that everybody can feel good about. The concept of "community" has become so central to public health that in some instances it has been renamed as "community health". The New Zealand Health Strategy has an objective to "promote healthy communities and health environments." The "community approach" seems to provide a way forward for public health, since tackling structural inequalities is "too hard" and the country is too big. Furthermore, trying to get individuals to change their behaviour doesn't work very well. But "communities" are somewhere in between. All we need to do is to find the "deprived communities" and get them to change their lifestyles and increase their social capital, as well as "targeting" them for delivery of primary health care.

## Which community?

There is just one small problem. Which community are we talking about? This question is rarely discussed because to do so would be to open a can of worms. In most instances, when people in the health services use the word "community" they mean geographically defined communities. This is understandable because health services, for logistical reasons, usually serve specific areas (e.g. DHB areas or smaller areas served by PHOs), and they are increasing being encouraged to take a "population health" approach to the health of "their" "communities." It is natural that this approach should spill over from health service delivery into public health. It also sounds more democratic, with more potential for "local control".

## Defining "community"

The point of this article is not to argue against the concept of "healthy communities" (how could I?), but to argue that such communities should not necessarily be defined geographically. People do live in communities. They are communities defined by ethnicity, by gender, by occupation, by country-of-birth, by age, and by many other factors. They are Tongan communities, Chinese communities, gay communities, communities of workers in particular jobs, etc. They network through their extended families, their hapu and iwi, their churches, their workplaces, their unions, and a multitude of other organisations. When we focus on geographic communities we tend to ignore all of the other communities in which people live, work and organise themselves. It's easy to assume, without meaning to, that "we are all one people", at least if we define the geographical areas small enough.

A second reason for being sceptical about approaches based on geographical communities is that most deprived people do not live in deprived (geographical) communities. Any intervention that focuses on just a few geographical areas will only reach a minority of deprived people no matter what other measure of deprivation you use (Blakely and Pearce, 2002). There may (or may not) be good logistical reasons for "targeting" funding for health service delivery to specific areas, but it does not follow that public health interventions should also be primarily area-based.

A third reason for being sceptical about approaches based on geographical communities is that often they do not lead to greater democracy. To take an extreme example, the United States has one of the greatest levels of devolution and local control in the developed world, to the extent that even judges and police chiefs are locally elected. It was this local autonomy that enabled small Southern towns to maintain segregation and discrimination (which incidentally, may have increased the social capital of the white majority in these towns), and federal government intervention (together with the grass-roots civil rights movement) was required to over-rule "local democracy" and defend human rights. In the

*continued page 4*

## ....which community?

*continued from page 4*

international context, the development of the European Union involving a partial centralisation of authority has encouraged a flourishing of ethnic, cultural and regional diversity which was previously restricted by national governments. Currently, in some areas of New Zealand local democracy too often means that Treaty rights are ignored and racism flourishes. Once again, central government has a key role to play.

### Reasons against area-based approaches

There are also good practical reasons for not adopting area-based approaches to public health. It is essential that data systems and definitions be standardised nationally, and that a central core of resources and expertise is available for monitoring population health and for developing national strategies (including national strategies for specific "communities",) even if they are then implemented with local variations.

A final reason for being sceptical about area-based approaches is that they tend to move problems between areas rather than actually solve them. For example, when there are major structural inequalities in wealth and income, then improving facilities in one area leads to "gentrification" with less advantaged people being forced out. This doesn't mean that we shouldn't try and improve community facilities; however, it does mean that local solutions are not enough unless we can also look at the "big picture" and address structural inequalities nationally. We need to act (and think) globally as well as locally.

I realise that many people will object to my arguments because they will feel that there is no contradiction to taking an area-based approach while strongly supporting approaches specific to particular communities (e.g. Mâori health initiatives) within their areas. Of course, this is a good thing, but when we focus on geography, and make it the starting point for policy, we are choosing not to focus on other things, or at least to relegate them to second place. The value of local initiatives doesn't remove the need to have national public health strategies, e.g. for Mâori health, Pacific health, environmental health, occupational health, etc. In fact national strategies are essential if the health needs of the communities in which people really live are to be addressed.

### References

Blakely T, Pearce N. Socioeconomic position is more than just NZDep. NZ Med J 2002; 115: 109-11.

Contact: *n.e.pearce@massey.ac.nz*

EXECUTIVE NEWS

# Public Health Association - Pacific Caucus

*by Aumia Herman, PHA, Pacific Caucus*

Kia orana, Talofa, Malo lelei, Fakaalofa atu, Taloha ni, Bula Vinaka.

Earlier this year, the PHA consulted with Pacific members, Pacific Reference Group (Advisory group to the Ministry of Health) and the Pacific Health Community on how the PHA could best work with Pacific people on relevant public health issues. Momentum was continued during the July Annual PHA conference held in Ngaruwahia where several Pacific health members met to discuss this issue.

In September, Dr Debbie Ryan (Ministry of Health – Chief Advisor Pacific Health) conveyed the wider Pacific Health Community's support for the move to strengthen the relationship between Pacific health workers and the PHA. This information has been warmly received by both parties. Faafetai Sopoaga and Aumea Herman will lead the development of the Pacific Caucus.

Contact: *Hermana@tapasefika.org.nz*

## Otago/Southland Branch in action with seminars and membership drive

*by Kate Morgaine, Otago/Southland PHA*

Otago/Southland branch members have been keeping busy this year with a varied series of seminars hosted jointly by the branch and the Department of Preventive and Social Medicine, University of Otago.

Dr Susan Jick kicked the year off with an enlightening look into oral contraceptive usage, pregnancies and pregnancy terminations, following the October 1995 warning about third generation oral contraceptives.

Dr Bob Hancox presented research on a topic that touches almost everyone: TV watching and health.

In April members shifted gears with Professor Jack Dowie's seminar on evidence based medicine in practice?

The next topic under fire was health information systems and the impact of decentralisation and nationalism with research on the New Zealand case presented by Dr Robin Gould.

Visiting again the area of contraception, Dr Brian Cox and Dr Mary Jane Sneyd shared their findings on vasectomy and prostate cancer.

Finally in the depths of winter Dr Tony Blakely presented his seminar on *Decades of Disparity; ethnic mortality trends in New Zealand – 1980-1999.*

The seminars, which are run regularly throughout the year, always spark lively debate and give branch members the opportunity to explore many different facets of public health.

### Student membership drive

The Otago/Southland branch has also been actively trying to encourage student membership and one action towards this was to sponsor a student, Helen Tane to the National conference this year. Helen is currently undertaking a Masters in Public Health and in her report back to the branch conveyed how much she gained from the national conference.

Contact: *kate.morgaine@stonebow.otago.ac.nz*



## 8th Public Health Summer School 2-20 February 2004

The summer school, run by the Department of Public Health at the Wellington School of Medicine and Health Sciences, provides an environment where individuals can learn for the first time about basic principles of public health, or where those with public health experience can further develop their knowledge and skills. The School's modularised design enables interest-specific enrolment from a range of 16 courses over the three weeks.

Most courses will be held in the University of Otago Stadium Centre, Waterloo Quay, Wellington, with specialised courses taught in the Wellington School of Medicine and Health Sciences computer facility, and at Victoria University of Wellington. *Social Epidemiology* will be also be taught by video-conference link at (introductory and advanced levels), handling and analysing data, health economics, the New Zealand health system, Mäori health, ethnic disparities in health, health promotion action to tackle inequalities, social epidemiology, globalisation and health, using geographic information systems in health, population screening and public health and primary care.

### Contact

Further information and enrolment forms are available from the Summer School administrator, Linda-Jane Richan, at Wellington School of Medicine and Health Sciences, PO Box 7343, Wellington South Phone 64 4 385 5999 (ext 6052) Email *linda-jane@wnmeds.ac.nz.*

### Pssst! A Word in Your Ear!

Is your PHA membership up to date? If not, time is running out and we would love to hear from you.

A membership renewal form/invoice was enclosed with the June issue but you may have missed it. If you would like another form please contact this office *pha@actrix.co.nz.*

# Putting Public Health into Primary Health Care

## Canterbury PHA Annual Seminar

*by Pauline Barnett, Canterbury Branch PHA*

The link between public health and primary health care was the topic of the annual Canterbury PHA Branch Seminar 20th August. The theme was chosen because of the relevance of public health to emerging PHOs, and widespread uncertainty about how PHO development could properly incorporate population health and health promotion. About sixty people attended form all parts of the health sector and from across the Upper South Island.

### Potted history

Understanding the historical context is important, and the seminar began with a presentation by Public Health Champion Dr George Salmond. George was one of few New Zealanders present at the Alma Ata Conference in 1978 that launched the Health for All movement and the broader concept of primary care that is now so widely endorsed. George pointed out that much of the Alma Ata initiative came from a New Zealander, Ken Newell, who was then with WHO and later became the first Professor of Community Health at the Wellington School of Medicine.

### Examples of current developments

An important part of the seminar was the sharing of information on current developments. Much of the morning was spent on examples of the link between public health and primary care. From the largest local IPA, Pegasus Health, Mary Anne Stone and Dr Kim Burgess presented details of work both in community health projects and in enrolling and registering their patient populations. Work on diabetes on the West Coast was outlined by Dr Alistair Humphrey from Community and Public Health. That project includes three aspects: population-based analysis, clinical intervention and a family/whanau approach. We also had reports from two primary health teams that are now part of the first PHO in Canterbury. The Union and Community Health Centre is a well-established service in Christchurch, with a long tradition of meeting the needs of disadvantaged groups. Lib Edmonds, the Centre's social worker, presented a profile of the Centre's outreach work. In addition, Linda Ngata, from a recently established service, Te Amorangi Richmond, outlined the way in which the primary care team there uses whanau workers to reach out into the community and includes other agencies on site (eg WINZ) as part of its 'one-stop shop'.

In the afternoon, Susan Noseworthy from the Canterbury District Health Board discussed the national policy framework that the CDHB had used to support PHO development. Eve Nissen from the Canterbury Community PHO told us about the establishment of the new organisation and the ways in which the public health and health promotion aspirations might be fulfilled.

### Optimism for the future

Throughout the day there were opportunities in discussion groups to address some of the key issues for linking public health and primary care. The groups highlighted the potential in bringing together traditional population health and newer community development approaches within a primary care setting. Although barriers remain, there was optimism that with time and goodwill these could be overcome.

George Salmond finished the day by drawing the themes together. While reminding us of how far we had to go, he also confirmed how far, since Alma Ata, we have come.

Contact *pauline.barnett@chmeds.ac.nz*

CONFERENCE 2004

# 'Growing Our Own'

# Strengthening Capacity in Public Health

*by Vivien Daley, PHA 2004 Conference* Convenor

The Canterbury Branch of the PHA is excited to host the 2004 PHA conference.

The theme the branch has chosen 'Growing Our Own - strengthening capacity in public health.

The theme includes:

***Growing our own infrastructure*** - examining the way the health system adapts to changing public health needs, including global threats such as SARS and more local issues such as developing the public health workforce in Aotearoa New Zealand.

***Growing public health in the community*** - The conference will continue themes from the 2003 conference in Ngaruawahia which used the **TE PAE MAHUTONGA** model for Maori health promotion as a framework. For the Conference Committee,

***Helping others 'grow their own'*** - here we explore the relationship between Aotearoa New Zealand and the countries of the Pacific in supporting the development of public health in our region.

"We want to link the **TE PAE MAHUTONGA** themes of the 2003 conference into the 2004 conference. We see developing community capacity in public health as reflecting *Mauri ora* (access to Te Ao Maori), *Waiora* (environmental synergy), *Toiora* (healthy lifestyles), *Te Oranga* (participation in society), *Te Mana Whakahaere* (autonomy) and *Nga Manukura* (leadership)," says conference spokesperson Wendy Dallas-Katoa.

**Close date for Call for Papers**
**20 March 2004.**

Call for Papers details and Registration information will be on the website from December (www.pha.org.nz) and in the December issue PHA News.

For further information contact our Conference Co-ordinator, at the Conference Office, University of Canterbury, *m.brown@cont.canterbury.ac.nz.*

Join us in **Christchurch 30 June – 2 July 2004 at the Hotel Grand Chancellor**

NATIONAL OFFICE NEWS

# PHA Membership Survey

Thank you to all PHA members who have renewed their membership. We are pleased to welcome new members and farewell one or two who are moving on.

We are fortunate to have the services of Geoff Stone, a Social Science Masters student from Victoria University who is assisting the office with a membership survey as part of a practical placement.

The aim of the survey is to check out what members need and expect from PHA to help your PHA Executive Council make sure that it can deliver on your expectations.

At this stage it is envisaged that a web-base questionnaire will be available to fill in within the next month. Each member will be notified when the survey has gone "online" and invited to take a little time to fill it in.

We'll make every effort to ensure this exercise is straightforward and respects your time. By responding you will automatically enter a draw for a prize that will make filling in this form more worthwhile!

Conducting a membership survey is one demonstration of the executive's intentions for the PHA to be a learning organisation. Thank you in advance for your participation.

Contact: *pha@actrix.co.nz*

## FORTHCOMING EVENTS

***"Social Marketing for Social Profit"***
Date: 16-17 October 2003
Venue: Hotel Intercontinental, Wellington
Fax: (04) 472-5799
email: christine@healthsponsorship.co.nz

***"Weaving the Strands"***
Injury Prevention Network of Aotearoa New Zealand Conference
Date: 29-31 October 2003
Venue: Te Papa Tongarewa
Contact: Conference Works Ltd
email: robyn@cwlnz.com
website: www.ipn.org.nz

***"Spread the Word – TB"*** Tuberculosis Conference, Auckland, New Zealand Conference for Health Professionals.
Date: 13-14 November 2003
Venue: Barrycourt Conference Centre, Parnell, Auckland
Contact: Bette Swan ph 012 894-582 or Jill Miller (09) 262-1855
Fax: (09) 630-0051
Email: tbassn@xtra.co.nz

***"Aotearoa/New Zealand fit for us"*** National Children's Rights Conference
Date: February 11-12 2004
Venue: Victoria University, Wellington, New Zealand
Contact: Conference Coordinator, Office of the Commissioner for Children
Tel: 0800 22 44 53
Email: l.defriez@occ.org.nz

***"Vision to Action"*** World Federation Public Health Associations 10th Annual Congress. Hosted by United Kingdom PHA
Date: 19-22 April 2004
Venue: Brighton, England
Contact: WFPHA, c/- American PHA, 800 1 Street,, N, W Washington D>C, 20001-3710, USA
Tel: +1 (202) 777-2506
Website: www.phaworldcongress.com

***"Health 2004"*** 18th World Conference on Health Promotion & Health Education
Date: 26-30 April 2004
Venue: Melbourne Convention and Exhibition Centre
Contact: Kim Stevenson
Tel: +61 (3) 9417-0888
Website: www.health2004.com.au

***"Growing our Own - strengthening the public health workforce"***
PHANZ 2004 Conference
Date: June 30-July 2, 2003
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: vivien_d@pegasus.org.nz

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

### Let's debate the issues

Do you have a comment to make about any articles in this issue? Send your comments to the editor *pha@actrix.co.nz.*

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

### 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 **23rd November 2003** to the editor *pha@actrix.co.nz* or *pha.media.co.nz* or telephone (04) 472-3060 for further information.