



## PHA NEWS - NOVEMBER 2007

VOL X, No 3

### Reflections on conference 2007: Te Torino - Re-imagining Health

Public health workers and practitioners from around the country gathered at the 2007 Public Health Association (PHA) conference, held in Auckland 4 to 6 July.

Conference themes were urban design, food matters and voices. Topics included Kaupapa Māori, systems and structures, workforce, inequalities, determinants of health, and globalisation.

Convenor Kathrine Clarke looks back on a unique and rewarding conference.



Kathrine Clarke

Bringing you the 2007 conference – held at the Tamaki Campus of the University of Auckland – was no mean feat, as we (the committee) chose to explore different ways of providing an interesting experience for all who attended.

The committee was charged with meeting not only the demands of the public health workforce but also its diversity, and with threading the issues raised at the 2006 conference into our thinking. It is no wonder that, even some months later, we are still reflecting on the highs and not-so-highs of the event.

A definite high, and cause for huge celebration, was attracting not only the Governor-General, but the Public Health Association's (PHA's) life member the Rt Hon Helen Clark. Opening the conference in such a way paved the foundation for cementing a public health ethos at a policy level.

Diversity and the challenge diversity poses to us as public health practitioners was the theme on day two. The committee pulled out all stops to ensure the diversity that is 'the public' of Aotearoa was visible and heard, and reinforced the importance of policy decisions reflecting this diversity, while honouring our history including the place of te iwi Māori.

The gossip on the ground was heartening as many a participant expressed their enjoyment of day two. Just goes to show that despite the hard work, being daring enough to plan a conference that is not the "same" is well worth some time, pain and effort.

The committee would like to take this opportunity to thank all our guest speakers, our sponsors, and those of you who were brave enough to catch public transport to share with us at Te Torino – Re-imagining Health.

See also Fiona Imlach Gunasekara (page 2).

### IN THIS ISSUE

- 2 National office roundup
- 4 Round the branches



- 4 Tax cuts?
- 6 Problem gambling



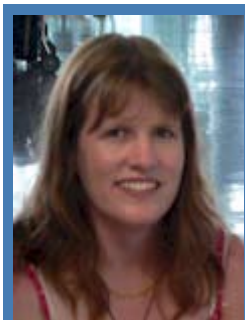
- 8 The benefits of insulation
- 9 Social determinants of health
- 10 Global spread of public health emergencies



- 11 800 million starving, 1 billion overweight
- 12 Public health a winner at Health Innovation Awards

“The PHA, an informed, collaborative and strong advocate for public health”

## Wellington Branch conference sponsorship recipient Fiona Imlach Gunasekara shares her thoughts about the PHA conference.



Fiona Imlach  
Gunasekara

PHA conferences are often notable for bad weather, a fair share of viral-laden participants (if not speakers) and technological impediments, but are always enlivened by the wonderful assortment of people who attend.

For me, the conference was a chance to catch up with colleagues and friends not seen for some time, to meet new people

who were exploring ideas I am also interested in, and to be immersed for a few days in the public health culture that we live and breathe and take for granted in our work and lives, but which for others may be a foreign concept, both challenging and even a little frightening.

It was a conference that celebrated unique individuals. Thursday's panel and dance performance challenged ideas about difference, how we conceptualise ourselves in relation to others, and how the realities of disadvantage work themselves out in the lives of children.

PHA conferences are distinctive in that dialogue and sharing of experiences are given equal prominence to presenting the results of quantitative, evidence-based research. For the discipline of public health in particu-

lar, both of these strands are necessary and valuable. Without an open and receptive exchange of ideas between public health workers and communities, our research will not be relevant or useful.

There was plenty of interesting research on offer. I learned that Asian adolescents are not as slim as generally assumed; that vitamin D is likely to be the next big supplement coming to our health stores; that you can make a health argument for a pleasant bus stop; that health impact assessment and persistence can change even recalcitrant regional councils and their transport plans. It was inspiring to see that busy public health people still find time to volunteer to work on issues they are passionate about, as seen from The Asian Network Inc and the People's Health Movement Aotearoa.

I am fortunate enough to work in an environment where public health values are normative, but for those in organisations with competing agendas, the conference can be an especially refreshing and fortifying experience. We are all fortunate in New Zealand to have a vibrant and diverse public health workforce and the PHA conference is a great place to celebrate achievements and plan for a better future.

*(Fiona Imlach Gunasekara is a public health physician, and now PhD student in social epidemiology with the Survey of Family, Income and Employment at the Wellington School of Medicine & Health Sciences)*

### PHA Conference 2008

#### Tapu and Noa – physical, environmental or both

Waitangi, Northland 1-4 July.

Put this date in your diary now – the 2008 PHA conference!

Hosted by the Tai Tokerau (Northland) branch at the Copthorne Hotel in Waitangi, the theme for the 2008 conference is based on Tapu and Noa, used as a health code by Māori for generations.

These finely balanced concepts have a practical application for public health. Tapu is linked to health risks, environmental hazards and protection. Noa is about safety and respect.

The location of Waitangi for the conference is significant: Te Tiriti o Waitangi is the founding document of Aotearoa-New Zealand and also a living document for public health practice.

More information about the conference will be put on the PHA website as it comes to hand.

## National office roundup

### PHA rebranding

The PHA's rebranding exercise continues, with several logo options being discussed by Māori Caucus. Once agreement is reached on the preferred logo, a recommendation will go to Council. The new logo needs to represent the PHA's multicultural focus, and work well across a variety of mediums.

### Report on Public Health Code of Ethics Project

Developing generic competencies for public health has highlighted the need for a code of ethics that identifies the key values and ethical principles underpinning public health practice in Aotearoa-New Zealand. A code would provide an ethical framework for all of public health as well as for the generic competencies.

At the 2006 PHA conference in Palmerston North a workshop organised by Louise Signal (Wellington School of Medicine, University of Otago) canvassed opinion on the development of national ethical guidelines for public health. A recommendation was made

## Media work

Since the last newsletter, 17 media statements have been released, many of them related to the PHA conference.

- 1 Oct PHA supports call for housing inquiry
- 18 Sep PHA applauds new cervical screening campaign
- 31 Aug National Party's response to obesity issues slammed by health groups
- 19 July Racism in health will continue if Treaty references removed
- 6 July Papaarangi Reid named 2007 Public Health Champion
- 6 July "Gimme Shelter" - Time to think fresh about the humble bus stop
- 6 July Study warns "safety first" over school travel
- 6 July 72 percent drive to dairy, 10 minutes walk away
- 6 July A revolutionary approach to health: reaching "the unreachable"
- 6 July Urban design impacts physical activity levels
- 5 July Call to act now to prevent global impact on New Zealand health
- 5 July Link between view of children as developing adults and support for physical punishment
- 4 July Asian adolescents an obesity timebomb
- 4 July Government must stay staunch in face of "hardball" junk food industry
- 4 July New Zealanders' chronic vitamin D levels expose them to killer diseases
- 3 July PHA Conference 2007
- 28 June PHA Conference 2007 details for media

There was wide coverage of the PHA conference, with particular interest in Papaarangi Reid being named Public Health Champion, Asian adolescent obesity, vitamin D levels and the shelter offered by bus stops.

for the PHA to pursue and lead such an initiative. This recommendation was tabled and accepted at the final conference session.

The generic competencies discussion document identified two codes of ethics with particular relevance to local public health practice: the Health Promotion Forum of New Zealand's Ngā Tikanga Manaki and the US Public Health Leadership Society's Principles of Ethical Practice of Public Health 2002. Using these codes and supporting literature, the PHA drafted a proposal document outlining a code of ethics for public health practice in Aotearoa-New Zealand.

An initial review of the draft proposal document has been carried out. This involved a number of Māori, other local and international public health experts providing comment. Also, at workshops during the recent Health Promotion Forum symposium on ethics and evidence in Auckland, the draft values, beliefs and ethical principles in the document were discussed. Response from this preliminary consultation was very positive about this initiative to develop explicit ethical principles for public health practice.

Reflecting on constructive feedback about the proposal

document itself, the PHA is now tasked with figuring out 'where to from here'. Inevitably the process will lead to wide reaching consultation within the public health sector and beyond, so watch this space!

### Introducing *Kawerongo*

PHA Senior Māori Analyst Kay Berryman is producing a bi-monthly PHA newsletter called *Kawerongo*. The newsletter highlights the importance of Māori being at the forefront of public health issues. It is available via the News and Events page of the PHA's website ([www.pha.org.nz](http://www.pha.org.nz)).

Please contact Kay at [kay@pha.org.nz](mailto:kay@pha.org.nz) if you would also like to receive each issue by email.



## Round the branches

### Local DHB Elections

**Local, regional and District Health Board elections have come and gone, and for many people were little more than a yawn. But the reality indicates it should not be this way.**

A mere 147 elected DHB members across the country help to govern the spending of \$8-9 billion dollars a year and since virtually every New Zealander has some contact with the health system in any one year, they influence our lives far more than we realise.

DHBs are charged with improving, promoting and protecting the health of communities so we need to know the views and priorities of our elected representatives.

The Otago/Southland Branch of the PHA collaborated with the Dunedin Council of Social Services to hold three public lunchtime forums: one for candidates standing for the DHB, one for city council candidates and a third for regional council hopefuls. All spoke on what they understood by the term "healthy community" and what they believed was important for health and social wellbeing. Local and national PHA president Richard Egan says the branch was very pleased with the media coverage it got from the forums.

Fifteen candidates spoke about their public health priorities at a meeting organised by Wellington PHA and South East PHO. A subsequent news release named

the candidates who showed a public health focus, but said most of the candidates did not hone in on issues around public health, their priorities being things like not privatising district health nurses or more money for cancer radiation therapy.

In Central Districts, a questionnaire was the focus of the pre-election campaign to get DHB candidates' ideas on public health issues. A list of questions, sent out for candidates' response included things like "What do you plan to do to increase the way your Board includes people in its decision-making processes?" and "Do you support the targeting of the provision of services to meet high needs groups?"

Answers were collated and sent to local newspaper the *Manawatu Standard* together with a list of those candidates who did not respond. Local president Jan Lockett-Kay says they got page three coverage.

A letter was sent to the editor of each of the main papers in the Waikato and Bay of Plenty regions, urging voters to get to know their candidates and particularly whether those candidates had a focus on supporting health and preventing illness, including avoidable hospital admissions.

### Tackling the Food Marketing Juggernaut – First Steps

**They came to Christchurch from Auckland, Palmerston North and all over the South Island. There were public health workers, people from the community, researchers and funders.**

It was the Canterbury PHA Seminar (June 2007) and people had come together to explore the collision between marketing and health and to think of ways of addressing the obesity epidemic.

The morning was all 'war stories' from the front line. Professor Janet Hoek gave the keynote address, reporting on how food marketing affects consumption.

Bronwen King spoke of her experience complaining about food advertising to the Advertising Standards Authority, and the frustration of such an unequal process. Marcia Annadale outlined the long history of duplicity and uncertain ethics from the infant feeding industry.

In the afternoon Kim Mundell, managing editor of the *Healthy Food Guide*, explained how ventures can be both ethical and commercially successful. A local school principal, Viv Butcher, showed how community action can encourage both good nutrition and better learning. Michelle Mako, from the Health Sponsorship Council, outlined the *Feeding our Futures* campaign.

## Tax cuts, but not at the cost of social services

From <http://www.scoop.co.nz/stories/BU0710/S00109.htm>

Nearly eight out of every 10 New Zealanders want a personal tax cut. But more than half would oppose tax cuts if they meant reductions in spending on health, education or welfare. And at the next election, most would be inclined to support the party which best balances these two positions.

These views have been released as the interim results of nationwide research undertaken by ShapeNZ for the New Zealand Business Council for Sustainable Development. The research has been conducted ahead of the Business Council's Business Budget Summit 2007 on 1 November where 80 chief executives and Government ministers will discuss personal tax reform.

The day was enlivened by 'Walking the Talk' discussion groups, great (healthy) food and by the creepy presence of the Cancer Society's Colossal Colon (3 x 1.5m) with appropriate sound effects!

Some great ideas came about, focusing on workplaces supporting healthy eating and physical activity, including:

- management showing leadership in changing norms
- discussions with staff
- have policies about funding and sponsorship
- have policies about catering, vending machines and tuck boxes
- take a positive approach (don't be the 'health police').

Along with one of our co-sponsors Healthy Christchurch, Canterbury PHA is seeking funds to move forward some of the ideas from the discussion groups. This includes work to develop local guidelines to assist the more than 200 Healthy Christchurch signatories to become healthier workplaces, and to work with them to achieve this. This will be our branch project for 2008.

Canterbury PHA and Healthy Christchurch thank co-sponsors Partnership Health Canterbury PHO, the Canterbury District Health Board and HEHA for financial and other support.

Pauline Barnett, Christchurch PHA



Bronwen King explains the ways of the Advertising Standards Authority.



Participants experience the Cancer Society's 'Colossal Colon' at Tackling the Food Marketing Juggernaut.

## Problem gambling - where to from here?

**What is the way forward for problem gambling prevention and harm minimisation? Dr Kawshi De Silva, Director Public Health of the Problem Gambling Foundation, argues the public health paradigm used to tackle health risks such as smoking, alcohol and obesity can also be used for problem gambling.**

The argument has been that if products are neutral, or beneficial in their effect, there is no problem. But if, as with tobacco, the product is lethal in itself, or is engineered to cause addiction as with gambling, we have to act. Food and alcohol are other examples of what in moderation may have a beneficial effect but excessive use of which can cause harm.

The fundamental question is how social and health policies should be formulated when it comes to unhealthy products. Products such as alcohol, tobacco, and pokie machines have economic and social gain to a country but there is political bias towards their control. However, we are aware that sustained legislative and regulatory presence is important for meaningful policy change for tobacco, alcohol and gambling. Change in environmental social factors that support unhealthy and unsafe practices are also an important milestone toward prevention and harm minimisation.

Tobacco, alcohol and gambling are legal within the free market economy. Their industries stand for profit supply, marketing to increase demand, minimal regulation to curtail use, purchase or use age restrictions in some cases and location restrictions being implemented to demonstrate social responsibility.

George Thomson states an 'industry focus' approach helps move responsibility from smokers to the tobacco industry. Industry 'denormalisation' has been the theme used within comprehensive tobacco control strategies and has needed continued political commitment for its effectiveness. In considering the industry focus a number of principles have been recommended to keep in mind. These are: to include a comprehensive approach for tobacco control; the need for political defences; and the need for periodic new approaches to the use of the focus.<sup>1</sup>

The tobacco industry uses a range of strategies to survive and prosper. They include the denial of or deception about health and addiction risks, deception about the true nature of the product, damaging the credibility of industry opponents, and delaying and defeating attempts to regulate the industry.<sup>2</sup>

It has been shown that the reduction of the prevalence



Dr Kawshi De Silva, Director Public Health of the Problem Gambling Foundation

of obesity is more likely to come from policy-related changes to the environment than from medical interventions targeted at individuals. The perceptions and beliefs in society about obesity can profoundly influence behaviour change and resistance to it. Industry marketing has a huge influence on individuals' perceptions and behaviour. The social determinants of obesity and cultural aspects are important factors contributing to the situation.

Recognising the role of food supply, its influence in the food chain and the food choices for individual and communities is important before intervening. The rights of the consumer to know what they are eating and its effects on them have been stated strongly within this debate. This means clear, informative, accurate and scientifically proven labelling of food and its benefits or the potential harmful effects of the food being disclosed. The personal choice has to be made in an environment where consumers are fully informed.

The harm minimisation approach has been adopted toward tobacco, gambling and alcohol. One of its key strategies is to decrease demand and increase control of supply. Availability and accessibility directly influence the control of supply. The liberalisation and deregulation of outlet density has been shown to increase alcohol-related disturbances to public order, the costs of which have to be borne by the taxpayer. Increased access to alcohol within or in close proximity to universities has been associated with an increased number of binge drinkers.<sup>3</sup>



“Industries producing harmful products will portray their social responsibility, downplay addiction, play tricks with language... and attempt to offload responsibility.”

The public health approach to drug control can help develop policies to reduce harmful use of substances, minimise negative health effects on the individual and limit secondary drug-related harms to society. It has been observed that the goal of the public health approach, which is to minimise harm, often puts public health in conflict with different interest groups whose main activity is increasing supply and demand through marketing and PR strategies.<sup>4</sup>

The public health approach to issues such as tobacco, alcohol and gambling focuses on health promotion, prevention and minimisation of harm. It incorporates individual and societal health protection measures through protecting and promoting physical environments and social policy frameworks that maximise health and minimise individual and community harm. The guiding principle should be “First do no harm”.

This principle should be applied to all services (health, social, enforcement etc), as well as to new and existing policies so as not to exacerbate problems introduced by industry products.<sup>5</sup>

In summary, industries producing harmful products will portray their social responsibility, downplay addiction, play tricks with language, try their best to form formal relationships with politicians, build networks of relationships with individuals and groups within society, demonstrate good intentions to the economies of both the country and local communities, and attempt to offload responsibility.

We should rise above all such strategies and advocate for society’s right to be free of dangerous addictions such as gambling. The ethical argument and human rights used in many social movements globally can be used effectively for products such as alcohol and gambling that generate social and health inequities.

The success of strategies in areas like tobacco control gives confidence that similar strategies using models which target industry, environment and population policies can generate social change.

1. Thomson G (2003). Focusing on the Tobacco Industry: A report to New Zealand NGOs. Department of Public Health, Wellington School of Medicine.
2. Thomson G (2005). Trust Us We’re Socially Responsible: The truth behind British American Tobacco NZ’s Corporate Social Responsibility reports. Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago.
3. Chaloupka JF, Wfchsler H (1995). The impact of price, availability, and alcohol control policies on binge drinking in college. National Bureau of Economic Research, Cambridge.
- 4, 5. Health Officers Council of British Council of British Columbia (2005). A Public Health Approach to Drug Control in Canada: A discussion paper. Health Officers Council, British Columbia.

## The benefits of insulation

**A stocktake and mapping project of insulation retrofits enhances community outcomes says Dr Polly Atatoa-Carr of Waikato District Health Board.**

Increasing evidence identifies housing as a key determinant of health and health inequalities, with an impact across the life course.

Effective insulation is an important component of housing and health, yet over two-thirds of housing in New Zealand was built before the 1977 Building Code required minimum insulation standards.

Retrofitting insulation to houses results in increased indoor temperature, decreased relative humidity and a number of benefits for the householders and the community. Recent New Zealand research has shown that retrofitting insulation to houses results in reduced episodes of wheeze, fewer days off school and work, and reduced GP visits.

Installation of an insulation package is also cost-effective, with the opportunity for significant cost and energy savings over the lifetime of the components. In addition, many insulation schemes in New Zealand currently involve the employment of local agencies such as the Huntly Energy Efficiency Trust (HEET) to undertake the retrofit.

Nationally, there are a number of projects involved in retrofitting insulation into older houses. As a member of the Waikato DHB Healthier Housing Group, I have led a recent project that identified and mapped (in combination with deprivation, age of housing stock, and outdoor

air quality) more than 3,000 houses in the DHB region which have had insulation retrofitted.

This project has found that 10 percent or less of potentially eligible uninsulated houses, or of those that are occupied by low income householders, have been insulated within the 10 districts of the DHB region.

From north to south within the region, fewer households have received insulation packages despite reducing ambient air temperature and a generally increasing age of housing stock.

The Waikato DHB has a significant percentage of people living in high deprivation and within these, Māori and Pacific people are over represented. Therefore, there remains significant need within the Waikato DHB region to improve the quality of the housing stock, particularly in areas of high deprivation and degraded outdoor air quality.

This existing stocktake and the maps that have been produced in order to highlight areas of need are likely to be important tools to improve future co-ordination of service delivery, enhance community wellbeing and reduce inequalities.

### Acknowledgements:

- The other members of the Healthier Housing Group, particularly those that provided information for this stock take (including HEET, Housing NZ, EECA, WEL Energy Trust)
- Environment Waikato GIS Services (Howard Ettima).



**Inset:** Polly and husband Rob with their children Mereana (5), Lydia (12) and baby Maeva

# Social determinants of health - Achieving Health Equity: from root causes to fair outcomes

The Public Health Association's policy on reducing health inequalities notes "Social and economic factors are fundamental determinants of health inequalities."

Key social and economic determinants of health inequalities that have been identified in research include: income, education, employment, occupation, housing and racism".

These determinants were also reflected in messages to the World Health Organization (WHO) Commission on Social Determinants of Health, developed at a recent meeting of senior New Zealand social service and health officials gathering in Auckland with Pacific researchers, NGO representatives and public health leaders. The Commission will report to the World Health Assembly in Geneva next May.

Dr Don Matheson, Director, International Relations at the Ministry of Health said the meeting focused on New Zealand and Pacific experiences of health inequalities, and practical work to improve the health of our peoples.

"It's essential that recommendations from the Commission reflect our experiences and needs. We have made some real gains in reducing disparities, in improving health outcomes for the most vulnerable groups. New Zealand and Pacific lessons can be shared to improve health outcomes in other countries too".

A WHO Commissioner, Dr Fran Baum of Flinders University and the Foundation Director of the South Australian Community Health Research Unit will carry the messages from the Auckland meeting to the Commission.

Key messages from the participants to Dr Baum were:

- the region's concern that global warming will become a very important future determinant of health, with some island communities facing the fact that their islands will become uninhabitable within decades and the consequences of that
- the important role of the health sector in economic development for marginalised groups, but also the need to take a whole-society approach, as impacts come not just from the health sector
- the need to deal with complexity - human systems are complex, hence the importance of shared values such as equity, and effective relationships so that marginalised groups have a voice
- the importance of the "isms" that pervade human society - racism, sexism, able-ism, sexual orientation etc. These "isms" shift with culture

and setting, but society can influence as we have experienced with stigma and discrimination against the mentally ill

- the important role that WHO plays in progressing the social determinants, when it presents it as a normal part of the approach to health, backed by authoritative, and well-argued policy
- 'privilege' and 'deservedness' need a focus, within and between services; support for a rights-based approach and a clear articulation of values
- importance of structures in society, for example the role of legislation, research, strategy and policy, the shape of health system
- how does a population take this forward, as opposed to how does a government take this forward. There is need for short-term success, as well as long-term commitment
- look at local vs central roles – how to encourage enthusiasm without being prescriptive. There is incredible diversity in the region, what is the role of the centre and how much autonomy is going to get the best results at the periphery? This region is unique in the degree of remoteness and what does this mean for tiny isolated communities?
- vulnerability around economic, environmental and trade change, and yet extraordinary resilience; there needs to be clarity on trade and broader public health issues. Pacific nations noted that difficulties of access to pharmaceuticals needed particular attention
- endorsement of the importance of primary health care
- traditional medicine and traditional responses should be valued.

[www.pha.org.nz](http://www.pha.org.nz)

Did you know the PHA site contains several regularly updated sections?

- *From the journals* contains excerpts from recent public health related journals, both locally and from overseas.
- *Coming events* lists coming conferences and seminars
- Our *job vacancies* page contains a list of current situations vacant.

If you haven't had a good browse around the site for a while, we invite you to come and look again!

## New rules to prevent the global spread of public health emergencies



WHO Member State representatives convene in Geneva for the International Working Group on the Revision of the International Health Regulations.

### June 15 marked the coming into force of the new International Health Regulations (IHR) which aim to prevent national public health emergencies spreading internationally.

The regulations are the world's first legally binding agreement in the fight against public health emergencies of international concern such as those caused by new and re-emerging diseases with epidemic potential, as well as those associated with acute chemical or radionuclear events. They establish practices and procedures for prompt notification to the World Health Organization (WHO) of global health risks.

Chernobyl, Ebola virus, variant Creutzfeldt-Jakob disease, severe acute respiratory syndrome, and more recently avian influenza, have all highlighted the inadequacy of the old regulations (IHR 1969), which required countries to raise the alarm in emergencies involving only three diseases – yellow fever, plague, and cholera.

New Zealand's Director of Public Health Dr Mark Jacobs, said under the new IHR, each country had to nominate a "national focal point" to communicate to the WHO the details of any public health emergency which might be of international concern. These details included case definitions, laboratory results, number of cases and deaths, and conditions affecting the spread

of disease. The WHO would then be responsible for validating whether the threat was of international concern – declaring emergencies, recommending containment measures, and co-ordinating an international response. In New Zealand, that national focal point is the Office of Public Health.

"In order to assess whether a public health emergency is of international concern," said Dr Jacobs, "a new 'decision instrument' – which is basically a flow chart – would be used by officials in the Office of Public Health to quickly evaluate whether an outbreak of disease domestically could spread internationally."

Dr Jacobs also said the new IHR oblige countries not just to notify WHO in the event of an outbreak of disease that may cross borders, but to actively prevent that outbreak moving overseas. "For instance if people are assessed as likely to be incubating a disease, they would be prevented from taking an international flight." He said New Zealand already had good surveillance and response processes in place but for other countries who may not have the same capacity, the new IHR would make a big change to the way they do things.

For more information, see "International Health Regulations: the challenges ahead", *The Lancet*, Volume 369, Number 9575, 26 May 2007 <http://www.thelancet.com/journals/lancet/article/PIIS0140673607607880/fulltext>.

## 800 million starving, 1 billion overweight

**Dr Raj Patel, author of *Stuffed and Starved – Markets, Power and the Hidden Battle for the World Food System*, swept through New Zealand in late September speaking in Christchurch, Wellington and Auckland. He offered insights into how the world's food supply is controlled.**

Dr Patel said that for the first time in history overweight and obese people worldwide (1 billion) outnumber those who are starving (800 million). But that, he said, is not a sign that more people are becoming better fed.

Many people are obese, particularly in the west. Dr Patel believes this is because the nutrition-poor, energy-rich foods processed with salt, sugar and fat are the cheap foods.

Dr Patel told Radio New Zealand National's *Nine to Noon* programme: "United States research on obesity in different postal codes indicated that more people in lower socioeconomic postal codes were overweight and obese than those in higher socioeconomic areas. The researchers believed that this was not just because of the accessibility and low price of processed food but also because of the lack of 'farmers' markets' and green spaces in which to exercise, in the poorer areas".

He said that while western supermarkets appeared stuffed with a huge variety of foods, in fact consumers have very little food choice. He said what western supermarkets mostly stock is endless variations of a small amount of highly processed food.

He said this has come about because standing between millions of food producers and billions of consumers are just a handful of giant food companies, who follow market principles by buying cheap, adding what they have to, to make their product attractive, and then selling at a high profit margin.

The prices these food giants pay producers, particularly in developing countries, are so low that even with a high profit margin and the addition of sugar, salt and fat the food appears in western supermarkets at a comparatively low price.

He said supermarkets had become the new global food gateways and were so powerful they controlled the lives of farmers (particularly in developing countries) from whom they bought the raw material, and influenced the lives of consumers who bought the finished product.

For every dollar spent on promoting nutritious food, \$500 was spent on promoting junk food. But Dr Patel said supermarkets cannot be blamed, they are just following the rules of good business.



"For the first time in history overweight and obese people worldwide outnumber those who are starving." - Raj Patel

Well, what can we, as consumers, do about it?

Dr Patel said there are many "subsidies" in food bought in supermarkets which are not in the price: environmental subsidies (such as CO<sup>2</sup> emissions) and social subsidies (low wages) among them. We should be prepared as individuals and as a nation to pay a bit more to place a value on those unacknowledged subsidies.

"On an individual level, we can also cut out supermarkets by shopping at farmers' markets and the local butcher and the local greengrocer. We can find out who grew the produce, where and in what circumstances. We can buy seasonally for price and for health.

"We need to learn to enjoy food, to connect more with its taste, with the environment that produced it and with the people who grew it."

He said that in India, a huge co-operative of 20 million farmers was dealing directly with consumers under the motto "one rupee more for the farmer, one rupee less for the consumer" – in other words, cutting out the middle person benefits both ends of the food cycle.

## Public health a winner in Health Innovation Awards

### Mangere Healthy Kai

**A programme which tackles obesity in Auckland's Mangere town centre has won the Supreme Award at the 2007 New Zealand Health Innovation Awards (HIA).**

Since the Mangere Healthy Kai programme began in 2003, retailers have been selling more filled rolls, sandwiches, grilled fish and stir fry – and less high-fat food. The programme has been changing eating habits to combat obesity, type 2 diabetes and heart disease.

The programme, from Auckland Regional Public Health Service, is supported by Auckland DHB, Mangere Community Health Trust, National Heart Foundation of New Zealand, Bader Drive Healthcare, Te Kupenga O Houturoa, Procure Network Manukau, Manukau City Council and Otara Health Incorporated.

Judges described the programme as “an innovative and collaborative approach within the broader community”.

### Asian Smokefree Communities

**Asian Smokefree Communities (ASC), a project helping Asian smokers on the North Shore to quit, has been highly commended in the 2007 New Zealand Health Innovation Awards.**

“This programme reflects everything positive the Primary Health Care Strategy sets out to do,” says Clinical Services Manager of Harbour Health PHO, Janice van Mil. “It gives us links with the community, it gives access to a vital health service for a group who previously did not have that access and it engages the community in managing their own health.”

Mrs van Mil said 2005 research conducted in the Wait-

emata District's Asian community showed 10 percent of its population smoked and did not have equitable access to smoking cessation programmes or resources.

Asian smokers told researchers they did not feel comfortable using standard smoking cessation services, like the Quitline, mainly because of the language barrier. They also felt the available resources did not meet their needs in either language or content.

So, in a first for New Zealand, three health organisations combined to do something about it.

Waitemata DHB, Harbour Health PHO (one of the largest in the country, representing 150,000 people) and Auckland Regional Public Health collaborated under the Primary Health Care Strategy to co-fund a programme to help Asian smokers to become smokefree.

The community was asked what the new programme should look like. From this came the idea of home visits by female co-ordinators to support both the households and smokers becoming smokefree.

In another New Zealand first, ASC combined a smoke-free environments programme with a smoking cessation programme.

An evaluation of the first six months operation of ASC (May-November 2006) found 42 percent of people in the programme had quit. The national average of quitting success in any one year is less than 10 percent.

--

The Health Innovation Awards, run by the Ministry of Health and ACC, recognise excellence in innovative projects that improve health services to New Zealanders. They are an opportunity to showcase some of the cutting-edge developments and improvements within the health service. This year there are category winners from Auckland, Hawke's Bay, Waikato, Canterbury and South Canterbury.

The Supreme Award winner receives \$13,000 while category winners receive \$4,000. The People's Choice winner also receives \$4,000.

The 22 finalists, chosen from 190 entries, presented their ideas during an expo at the Wellington Town Hall before the evening awards ceremony.

This year's judges were Mary-Anne Boyd, who has been associated with innovation in health services for the past three decades; independent health consultant Karl Puloto-Endemann; and award winning journalist Martin Johnston.



The winning Healthy Kai team with Health Minister Pete Hodgson