AUCKLAND WOMEN'S HEALTH COUNCIL

NEWSLETTER

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Progress among women towards the Smokefree 2025 goal

Two years ago I reported on New Zealand's smokefree status and progress towards reaching our Smokefree 2025 goal i.e. less than 5% of the population smoking. At that time around 21% of women were current smokers. That figure has now dropped to 16.4%.

However, smoking rates are still much higher for Māori women (41.8%), and somewhat higher for Pacific women (22.6%) than for NZ European/Other (14.3%) and Asian women (3%). Māori women are 2.9 times more likely to smoke than non-Māori women. In 2011 9% of NZ European women smoked during pregnancy compared to 37% of Māori women and 34.2% of under 20 year old pregnant women. Usually women who smoke during pregnancy have a partner who smokes and/or they come from a low socioeconomic area.

Rates for teenage girls (14-15 years) dropped from 17.1% in 1999 to 3.5% in 2013 but 18.4% of girls in low decile schools are regular smokers.

So the good news is Asian women and teenage girls are already largely smokefree and NZ European/Other women are probably on track to almost reach the 2025 smokefree goal. Smoking prevalence rates are on a general steady decline on the way to the planned 10% at around 2017 and under 5% by 2025, but the bad news is it is unrealistic to believe that Māori and Pacific people, Māori pregnant women and mental health consumers will achieve the goal. So what will the new government do to get us ***all*** there?

The problem with the Smokefree 2025 goal is it is aspirational and there is no government plan to achieve it. There has been no government tobacco control strategy in New Zealand since 2009. So how do we get there without a plan?

What is helping us on our way?

In July 2012 the display of cigarettes was banned with none of the very strange anticipated problems by the tobacco industry such as impeding competition, imposing significant costs and other burdens on retailers, encouraging price competition and fostering illicit trade. Banning the display of cigarettes was introduced to contribute to reducing the uptake of smoking among young people and to provide a more supportive environment for smokers to quit smoking. There is no reason to believe this has not happened.

The Government health target 'Better help for smokers to quit' now requires 95% of hospitalised smokers and 90% of smokers who are seen by a health practitioner in primary care to be given advice and help to quit. Most of the DHBs are achieving this target but the primary sector is lagging in its efforts. As with the banned display of tobacco products, these targets provide a supportive environment for smokers to quit smoking.

The Smoke-free Environments (Tobacco Plain Packaging) Amendment Bill passed its first reading by 118 votes to one. The Bill is being considered by the Health Select Committee. It was our great hope that the report on plain packs would be tabled in Parliament before the final sitting pre-election. However, this was not to be and even if it was, the Government is currently not prepared

to follow Australia's gutsy lead implementing plain packaging. Instead it is waiting until all challenges to the Australian Government have been overcome. This could take 20 years.

In Australia, there was a 78% increase in the number of calls to the Quitline associated with the introduction of plain packaging and it now has the lowest smoking rate in the world at 12%, with the highest rate of decline happening since plain packaging was introduced in 2010. Plain packaging is apparently a priority for the Government, but one that they are giving more lip service to than any real commitment. Meanwhile other countries such as Ireland, the UK, the Netherlands, and most recently France are committing to plain packaging and leaving New Zealand in their wake.

The price of cigarettes has increased 10% in January every year since 2008 and the final increase is planned for 2016. There have also been small inflationary price increases annually as tobacco is included in the Consumer Price Index. These price increases are helping to drive more smokers to try and quit but are not high enough to make a significant difference. In 2012 the tobacco control sector recommended a 40% tax increase for 2013 followed by 20% increases for the next 3 years. Unfortunately Government chose to ignore this recommendation.

The Health Research Council and the Ministry of Health have funded research through the University of Auckland to halve the prevalence rate of smoking by 2020. This has resulted in investigations into nicotine e-cigarettes, very low nicotine cigarettes, WERO a team based stop smoking competition targeting Māori and Pacific smokers, and other innovative studies to inform rapid smoking prevalence reduction. The research funding comes to an end in 2016.

In the 2012 Budget the Government allocated $5 million per annum to establish the Pathway to Smokefree New Zealand 2025 Innovation Fund to support innovative approaches to reduce smoking prevalence among Māori, Pacific people, pregnant women and young people. The fund has subsequently provided funding for evidence-based programmes such as WERO, Stoptober, a Quit Bus in South Auckland, incentives for pregnant women.

Tobacco representation in Parliament

With only 11 years until 2025, the Government needs to get serious about achieving its smokefree goal. The biggest worry with the new Government is it has lost two very strong tobacco control advocates and gained, for the first time in the history of New Zealand politics, not one but two ex-Philip Morris Corporate Affairs Managers, Chris Bishop and Todd Barclay. Both these MPs lobbied against plain packaging on behalf of Philip Morris and Chris Bishop against taxation increases. As the *Dominion Post* reported 'One tobacco lobbyist in the National caucus might be an accident. Two begins to make National look like a party whose anti-tobacco stance is hollow and hypocritical.'

Trish Fraser
Global Public Health

Preventing Overdiagnosis

In September 2014 Oxford University hosted the second international conference on Preventing Over-diagnosis. The conference was attended by a number of New Zealanders, including three women from three women's health consumer groups, and two health professionals who gave presentations. Ben Hudson's cautionary tale was about screening for prostate cancer in New Zealand, and Erik Monasterio discussed the behaviour of the pharmaceutical industry in relation to the TPPA (Trans Pacific Partnership Agreement).

Crossing the border

The conference began with a keynote speech by Iona Heath, former president of the UK Royal College of GPs which set the scene for the following three days. Her presentation focused on overdiagnosis and the individual patient. The abstract for her talk states: "Susan Sontag's kingdom of the well is being absorbed into the kingdom of the sick, and clinicians and health services are busy ushering people across this important border in ever increasing numbers. The costs, personal, social and economic, are enormous. Working face to face with individual patients, what can clinicians do to stem the tide? Many feel helpless in the face of the increasing stampede but patients need clinicians courageous enough to reassert the border between the well and the sick so that people only make the journey across when medical care is appropriate and will produce more benefit than harm."

As with last year's Preventing Overdiagnosis at the Dartmouth Institute in Hanover, USA, one of the major issues to come under the spotlight at this year's conference were the harms caused by screening programmes. Breast cancer, prostate cancer and colorectal cancer screening programmes were the subject of many of the presentations.

Cancer screening

One of the many excellent workshops on offer at the conference focused on the need for a rational approach to cancer screening. "Cancer screening generates substantial overdiagnosis and overtreatment. The benefits of cancer screening are less than people believe, while its harms are greater than people think. Drivers of excessive cancer screening include consumer advocates, payers (who use cancer screening rates as quality metrics), and professional special interests, including clinicians and researchers. Promotion of screening is often based on the mistaken concept – and conventional wisdom – that early diagnosis is always beneficial," said Ronald Adler from the University of Massachusetts Medical School. His workshop demonstrated innovative communication strategies and techniques for re-educating and empowering clinicians and patients to engage in rational approaches to cancer screening that will reduce overdiagnosis.

Pre-diabetes

Another health issue of international concern is the overdiagnosis of diabetes and the epidemic of pre-diabetes. John Yudkin, Emeritus Professor of Medicine at University College, London, and author of "*Pure, White and Deadly*," gave a keynote address at the beginning of the second day of the conference. He described attempts to tackle the

increasing prevalence of diabetes which have focused on identifying and treating people with marginally elevated measures of glycaemia. "The definition of intermediate hyperglycaemia has expanded from impaired glucose tolerance to include people with raised fasting glucose or glycated haemoglobin (HbA1c) concentrations, and cut-off points have been lowered. While people in all the above categories have a raised diabetes risk, prediction is poorer for fasting glucose and HbA1c than for impaired glucose tolerance. Moreover the expanded categories dramatically increase the prevalence of intermediate hyperglycaemia by twofold to threefold, with over half of all Chinese adults so defined.

There is no evidence that treatment of people in these newly-defined categories with lifestyle advice or with drugs, will improve mortality and morbidity. A label of "pre-diabetes" as recommended by the American Diabetes Association brings problems with self-image, insurance, healthcare costs, and drug side effects. Diabetes prevention requires changes to societies and a concerted global public health approach. Diagnoses and thresholds for clinical application may unrealistically burden societies in exchange for limited value."

Anti-depressants

Overdiagnosis in mental health was also the subject of a number of work-shops and presentations at the conference. A workshop on the medicalisation of sadness in old age by Stefan Hjorleifsson described how among 40,000 patient living in nursing homes in Norway, around 15,000 were taking anti-depressants.

Gisle Roksund's workshop focused on the increase in psychiatric diagnoses in children and young adults in Norway which often serves to subsequently exclude them from contributing to society and sustaining themselves through work.

Dangerous caring

Dee Mangin's workshop on dangerous caring dealt with how the medicalization, overdiagnosis and overtreatment with multiple drugs can steal away healthy old age with the drugs frequently causing more death and illness than the diseases they're supposed to treat. On average the number of medications older people are on is seven. More people die from adverse drug reactions than from breast, lung and colon cancer combined.

There are a number of drivers behind this horrific statistic and they include the therapeutic imperative to do something, the distortion of evidence-based research, polypharmacy, and the problems surrounding complex co-morbidities and multiple medications. Many of the drugs involved in poly-pharmacy are for prevention and not cure, and there is now good evidence for discontinuing diuretic drugs and cholesterol drugs (statins).

Defining overdiagnosis

Other workshops dealt with the need to come up with a commonly agreed definition of overdiagnosis. While an article in the *British Medical Journal* in 2012 used two: "when people without symptoms are diagnosed with a disease that ultimately will not cause them to experience symptoms or early death" and "over-medicalisation and subsequent overtreatment, diagnostic creep, shifting thresholds, and disease-mongering, all processes helping to reclassify healthy people with mild problems or at low risk as

sick," there is a need to develop an understanding of the definition of overdiagnosis and the various types of overdiagnosis.

One of the standout presentations on the final day was a summary by Helene Irvine, consultant in public health of the National Health Service in greater Glasgow and Clyde, of a study she undertook on the national allocation formula in Scotland. Contrary to her expectations she found that "in a health board that is famous for concentrated social deprivation, the rising activity and costs were increasingly disproportionately attributed to elective activity in the most privileged which included screening-related overdiagnosis and overtreatment for the worried well."

The conference ended with a number of excellent keynote presentations. Alexandra Barratt outlined the 45-year history of overdiagnosis in screening. It has taken decades for this shadowy idea of overdiagnosis to be accepted in the mainstream of medical awareness, she said. Along the way it's been the subject of vitriolic debate, professional division and public confusion, misunderstanding and disbelief. As a researcher working in the field for 20 years, she reflected on the long journey of overdiagnosis from an outlandish idea to an acknowledged reality.

Many of the keynote presentations will be placed on the Preventing Overdiagnosis website in due course: www.preventingoverdiagnosis.net/

Preventing Overdiagnosis 2015
Next year's Preventing Overdiagnosis conference will be held on 1st – 3rd of September 2015 in Washington, DC USA.

A NEW WAY TO FIGHT BREAST CANCER?

It's October and the pink ribbon blues are upon us once again. One advertisement in particular has reached an all-time low in its misguided and misleading fundraising efforts for the New Zealand Breast Cancer Foundation.

Under the heading "A New Way to Fight Breast Cancer" the ad features a pink tube of "breast cream" strategically placed in front of a very young, naked woman with her hands covering her breasts.

The ad urges women to regularly apply the "nourishing moisturiser" to their breasts in this "new beauty routine that could save your life."

$2 from every pack sold goes to the NZ Breast Cancer Foundation.

The ad claims that applying breast cream "regularly to your breasts helps you get to know what your normal feels and looks like, so if you ever notice any changes, you can tell your doctor straight away."

This is just another version of the discredited "breast self-examination"

routine which was abandoned years ago after research revealed it made no difference to the death rate from cancer. Two large studies looking at a total of more than 388,000 women found that death rates from breast cancer were the same among women who rigorously self-examined as those who did not, while there were almost twice the number of biopsy operations in the self-examination group. (1)

Despite the research findings, breast self-examination continues to be advocated in numerous sources of health promotion information. In addition to the lack of efficacy of breast self-examination, there is also no evidence that "breast awareness" is any better as it has never been scientifically tested. (2)

The ad also conveys the idea that breast cancer is something that young women should be concerned about, which is another unacceptable scaremongering trend in ads about breast cancer. They rarely mention that half of all cases of breast cancer are identified in women over the age of 65. Instead the sinister message conveys that this young woman's breasts are ticking time bombs.

Finally there is utterly ridiculous idea of a beauty routine that involves young women rubbing breast cream into their breasts. And goodness knows what is in this new breast cream and whether the ingredients are totally safe for breasts.

References

1. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD003373/pdf/abstract
2. http://www.vidyya.com/vol6/v6i113_7.htm

AWHC GENERAL MEETING 16 October 2014

Detailed minutes of this meeting are available on request. Matters discussed included:

- Financial reports
- Non-consensual clinical trials
- Northern A ethics committee
- Preventing Overdiagnosis conference
- Consumer rights

Further information on some of the topics listed above is contained in this issue of the AWHC newsletter.

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UP AND COMING EVENTS

DISTRICT HEALTH BOARD meetings for October/November 2014:

Waitemata DHB (Website address: www.waitematadhb.govt.nz)
The Waitemata Hospital Advisory Committee meeting starts at 11am on Wednesday 5 November 2014 and will be followed by the DHB Full Board meeting which starts at 1.30pm. Both meetings will be held in the DHB Boardroom, Level 1, 15 Shea Terrace, Takapuna.

The **combined Waitemata DHB and Auckland DHB** Community & Public Health Advisory Committee meeting starts at 2pm on Wednesday 15 October 2014.

Auckland DHB (Website address: www.adhb.govt.nz)
The Hospital Advisory Committee meeting will be held at 9.30am on Wednesday 29 October 2014 followed by the Full Board meeting at 2pm. Both meetings will be held in the A+ Trust Room in the Clinical Education Centre, Level 5, Auckland City Hospital.

Counties Manukau DHB (Website address: www.cmdhb.org.nz)
The Hospital Advisory Committee meeting will be held at 9am on Wednesday 1 October 2014 at Ko Awatea and will be followed by the Full Board meeting at 1.30pm.

The Community & Public Health Advisory Committee meeting will be held at 1.30pm on 22 October 2014 at 19 Lambie Drive, Manukau City.

ETHICS COMMITTEE meetings – dates for the four new ethics committees are at:
http://www.ethics.health.govt.nz/about-committees/meeting-dates-venues-minutes

The Postnatal Distress Support Network Trust will be holding a Charity Fundraising Dinner at 7pm on Friday 7 November 2014 at the Royal NZ Yacht Squadron Ballroom, Auckland

With Robyn Malcolm as the MC and Annah Stretton as the guest speaker and lots or amazing items for auction.

$140 per ticket or $1200 for a table of 10.

To purchase tickets contact PND Support Network Trust on: pnd.org@xtra.co.nz .