

EDITORIAL

*Dr Gillian Durham,
Director of Public Health and
Deputy Director-General, Safety and Regulation Branch*

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Information for Action

The 10th annual Colloquium of the Spatial Information Research Centre held in Dunedin from 16 to 19 November 1998 included 12 papers on Health GeoInformatics. Many public health specialists attended this Colloquium. Public health information and research was identified as a key factor in strengthening the public health infrastructure to support *Strengthening Public Health Action* (Ministry of Health 1997c). It is useful to consider the contribution of Health GeoInformatics to public health action.

In 1996, the Ministry of Health published *Using Spatial Analysis to Improve and Protect the Public Health in New Zealand*. This report considered New Zealand and international experience with spatial analysis, analysed some methodological issues, looked at data sources and quality, and applied the method to teenage fertility in New Zealand. Two main uses for spatial analysis in New Zealand were identified:

- for investigating disease aetiology
- for investigating disease or risk factor distribution to assist in targeting preventive programmes or health services.

With respect to investigating disease aetiology, New Zealand has a number of features such as highly variable population density, high rates of mobility, and low intensity of industrialisation, which make such epidemiological investigations fraught with difficulty. In particular, the investigation of reported disease clusters in

New Zealand has either not confirmed an excess incidence or not found an aetiology (Ministry of Health 1997b). This experience apparently mirrors that overseas (Pershagen 1998). The meticulous environmental epidemiological studies undertaken in heavily industrialised countries take many years to complete, and may show a decline in risk with distance from the apparent source of exposure, but the lack of exposure data and the presence of confounding factors make interpretation difficult, and the studies rarely deliver conclusive answers. For example, cancer incidence around a pesticide factory in the UK was first reported on television in 1993, the study was not published until 1997, and its conclusions were that the study 'provides limited and inconsistent evidence for a localised excess of cancer in the vicinity of the ... plant. At present, further investigation does not seem warranted other than continued surveillance of

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Merry Christmas and Best Wishes

from the
Management and Staff of the
Safety and Regulation Branch



Introducing the Safety and Regulation Branch

In July 1998, Dr Karen Poutasi, Director-General of Health, outlined proposals for realigning functions and reporting lines within the Ministry of Health. The changes in the Ministry's structure were intended to realign roles so that different areas of the Ministry have a clear focus for their activity. The Ministry's structure is now consistent with its key functions of:

- providing policy advice to the Minister of Health
- monitoring the performance of the Health Funding Authority (HFA)
- ministerial servicing
- administering regulation.

Responsibilities of SARB

SARB is responsible for developing and implementing subordinate legislation for a modern, outcome-focused, risk-based regulatory framework, including for public health, and for mental health. SARB incorporates the Public Health Group, with statutory responsibilities for advising on public health matters.

Structure of SARB

SARB comprises three Groups, two Sections and two Teams. The three Groups are Public Health Group (PHG), Regulation Development Group (RDG), and Regulation Implementation Group (RIG). The two Sections are Licensing, and Consumer Protection. The two Teams are Mental Health and Branch Support. Currently, Consumer Protection, Licensing and Mental Health are in transition and their final status will be clarified over the next few months.

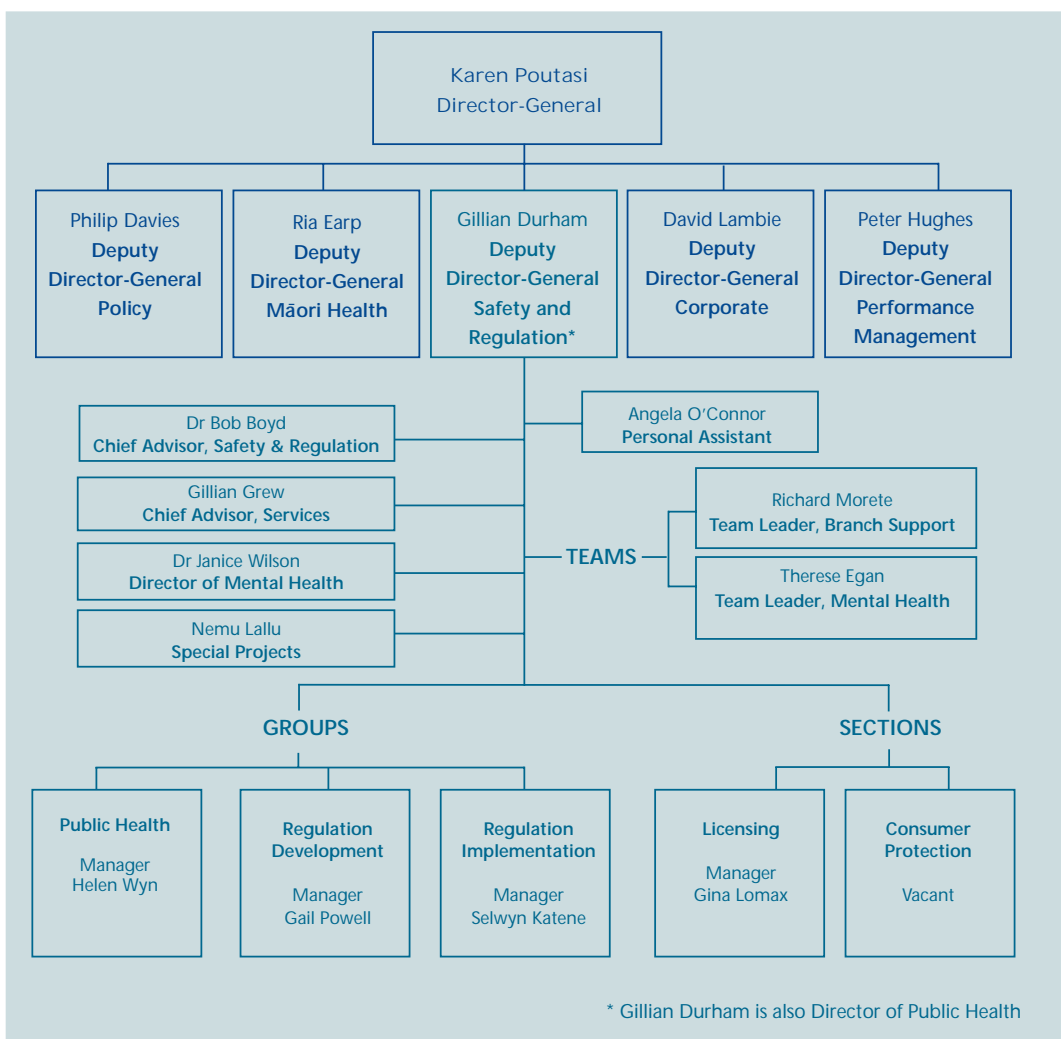
Two of the Ministry's Chief Advisors have also joined the Branch, Gillian Grew as Chief Advisor (Services) and Dr Bob Boyd, Chief Advisor (Safety and Regulation). The Director of Mental Health, Dr Janice Wilson, is also part of the Branch.

The **Public Health Group (PHG)** provides advice to the Director-General of Health on public health matters and on personal health and regulatory matters relating to public health. This Group will assess hazards and risks to human health through surveillance, risk assessment and a broad

array of environmental scanning techniques. The PHG will administer public health statutory responsibilities.

The **Regulation Development Group (RDG)** will develop subordinate statutory tools such as regulations, standards and codes of practice, where necessary, to implement policy and manage risks. The Group will strengthen existing relationships with other regulatory agencies through mechanisms such as memoranda of understanding.

The **Regulation Implementation Group (RIG)** will administer legislation. This will include interpretation on the application of legislation, development of guidelines and manuals, and training of regulatory field staff in



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Standards for Domestic Drinking-water Treatment Appliances

There is a great deal of public interest in knowing how to ensure that domestic water treatment appliances are suitable for the purpose for which they are intended. The Ministry of Health has received a number of requests for advice on this issue.

There have been claims that some home water treatment systems and office water coolers can be a health hazard because they act as a breeding ground for bacteria^{1,2,3,4}. Often it is not easy for consumers to evaluate the suitability of such an appliance for domestic and office use before they purchase it, because of inadequate information.

Standards Australia and Standards New Zealand have produced two standards which cover this situation:

- Australian/New Zealand Standard AS/NZS 3497:1998; *Authorization requirements for plumbing products – Domestic type water treatment appliances*

and

- Australian/New Zealand Standard AS/NZS 4348:1995; *Water Supply-Domestic type water treatment appliances – Performance requirements.*

To ensure that a domestic water treatment appliance will produce water that is safe to drink, the user should check that it meets the microbiological treatment performance criteria of AS/NZS 4348:1995. If in doubt, the vendor should be asked to certify the compliance of an appliance with these criteria.

Misleading demonstrations

The Ministry of Health's attention has also been drawn to the practice by some water distillation/purification

salespeople of demonstrating the 'unsuitability' of a water supply by means of a so-called 'electrolytic demonstration of water quality'. When the apparatus is switched on, an unpleasant-looking rusty brown

precipitate is produced which settles to the bottom. This gives a false impression that the brown material is an impurity from the water. In fact, it is produced by the demonstration apparatus, when some of the ions that are naturally present in the water react with the iron (Fe) electrode of the apparatus.

If any cases of the use of such equipment for demonstrating water quality come to your attention, please send details to:

Anne Reid
Fair Trading Division
Commerce Commission
PO Box 2351
WELLINGTON

Phone: (04) 471 0180
Fax: (04) 471 0771.



- ¹ Wallis C, Stagg CH, Melnick JL. 1973. The hazards of incorporating charcoal filters into domestic water systems. *Water Research* 8: 111–113.
- ² Geldreich EE, Taylor RH, Blannon JC, Reasoner DJ. 1985. Bacterial colonization of point-of-use water treatment devices. *Journal AWWA* February: 72–80.
- ³ Anon. 1996. Cool but not so pure. *Consumer* 351: 2–3.
- ⁴ Anon. 1996. Wonderful water? *Consumer* 354: 6–9.

Introducing the Safety and Regulation Branch

Continued from page 2

enforcement and investigations. RIG will also monitor compliance, undertake enforcement activities, and provide national co-ordination of statutory officers.

The **Licensing Section** is completing outstanding work until the changes to consumer safety legislation take effect and there is no longer a requirement to inspect and license hospitals and old people's homes.

Licensing will continue to undertake auditing, licensing and registration of premises during the transition.

The **Consumer Protection Section** implements policy decisions which require regulatory arrangements to

promote safe outcomes for patients and other consumers in the personal health sector. The section supports the work of the Assisted Human Reproduction Ethics Committee. It provides advice to the Minister on consumer safety issues.

The **Mental Health Team** administers mental health legislation and undertakes liaison with the mental health sector, particularly overseeing the implementation of the National Mental Health Strategy as well as co-ordination of the National Youth Suicide Prevention Strategy.

The **Branch Support Team** provides administrative services to the Branch.

A Time to Quit!

A number of exciting smoking cessation initiatives are currently under way, or in the planning stages. These include:

- a pilot quitline, jointly run by the Health Sponsorship Council, the Cancer Society of NZ and Te Hotu Manawa Māori, and which will be evaluated by the Health Funding Authority (HFA). The quitline was launched in September in the Bay of Plenty and Waikato regions. To date, there has been a very encouraging response, with an average of 80 callers a day. Quit-packs are posted to callers if requested and the caller can also speak to a quitline consultant.
- a nationwide 0800 manned quitline, funded by the HFA, which is to be operational by 1999. Self-help smoking cessation material will be available in association with the quitline
- a pilot nicotine replacement programme for Māori, in conjunction with counselling. This is likely to involve up to 2000 people

Smokefree enforcement update

Since enforcement of the ban on sales of tobacco to minors was stepped up in 1996, there is evidence that young people are finding it more difficult to purchase cigarettes. A number of controlled purchase operations carried out in the last few months resulted in very few sales – a great result, and an indication that retailers are asking for age and identification before selling cigarettes.

Latest prosecution figures are:

Total number of sales (to underage volunteers)	159
Convictions for selling tobacco to minors	84
Convictions for not displaying an under-18 sign	3
Discharges without conviction	12
Warnings	22
Cases dismissed	9

A number of cases are still to appear before the courts.

New *Why Start?* commercials

Two new commercials have been developed for the third year of the *Why start?* multimedia campaign bringing the total number of commercials to 20. The new commercials focus on smoking in movies and the marketing tactics of American tobacco companies. Both these issues have been

in the news lately, and are suspected to be linked to the increase of young people smoking.

The smoking in movies commercial features a Pākehā girl of about 14 saying:

‘Movies are making smoking look really glamorous and cool, but it’s not cool, because it kills you, and something that kills you, it can’t be very cool really.’

Voiceover: *Why start?* They’re trying to suck you in.

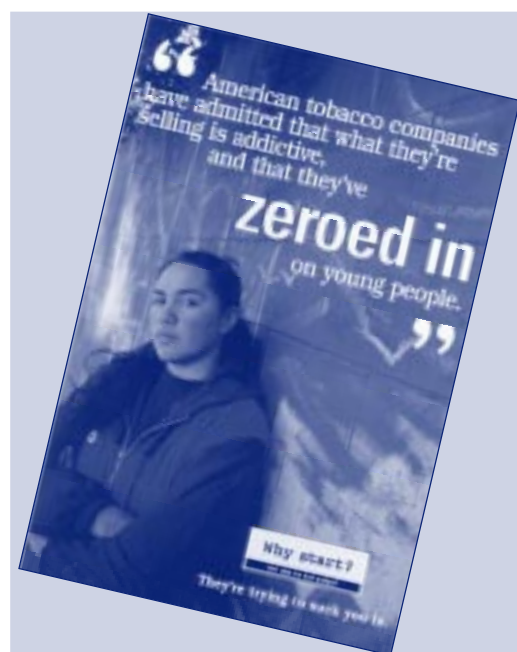
The industry manipulation commercial features a Maori girl of about 14 who says:

‘American tobacco companies have admitted that what they are selling is addictive and that they’ve zeroed in on young people. And young people are vulnerable enough to take the bait. So they’ll take it and the companies will be left with their money.’

Voiceover: *Why start?* They’re trying to suck you in.

In addition, two previously aired commercials will be replayed – *Not smoking means a healthier baby* and *Smoking is killing our culture*.

Previously managed by the Ministry of Health, the *Why start?* campaign is now being managed by the HFA. This is more in line with the respective roles of the organisations. For further information, contact Bridget Abernethy on (04) 801 2530.



World Smokefree Day 1999

Planning has already begun for World Smokefree Day 1999. The theme of the day is *Cessation of Tobacco Use*. The group that organised some national activities for the 1998 event has had its first meeting and has agreed to continue to work together again this year.

The team comprises:

Te Hotu Manawa Māori Moana Maniapoto Jackson

Cancer Society of NZ Helen Glasgow

Health Sponsorship Council Wendy Billingsley

Health Funding Authority (*Why start?*)

Bridget Abernethy (Hill and Knowlton) and Liz Price

For the 1998 World Smokefree Day, the planning team invested \$50,000 to raise the profile of the event, and smokefree issues in general. The result was an estimated national media return of \$280,000, not including coverage generated regionally.

In 1999, it is intended to again:

- involve all the smokefree agencies in planning for World Smokefree Day

- provide resources to build a higher awareness of the event and therefore of smokefree issues
- establish some nationally co-ordinated events involving a large number of schools, and thereby create media interest
- maximise the public relations opportunities associated with the event – with national media.

Poster competition

Another school poster competition is planned for 1999. There will be two prizes, one for the best auahi kore poster and one for the best smokefree poster.

The winners will spend a day in Auckland with Moana Maniapoto Jackson, taking part in a number of activities, including visiting the *Shortland Street* set and appearing on *Mai Time*.

More information about the poster competition will shortly be circulated to smokefree officers and health promoters by the planning team.

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mortality and cancer incidence in the locality' (Wilkinson et al 1997). In these situations, the media can produce visually powerful displays of potentially spurious relationships between environmental factors and health. Once careful investigations are undertaken, it is often clear that the original findings were over-interpreted (Elliott and Briggs 1997). Assessment of disease clusters in the New Zealand context clearly needs to utilise a number of complementary methodologies. We have to quickly evaluate and communicate to the public at large what we know and what we don't know.

On the other hand, the use of spatial analysis to investigate disease or risk factor distribution for targeting preventive programmes and health services really does seem to have potential, and we have a number of examples. These include teenage fertility in New Zealand (Ministry of Health 1996), road safety risks (Land Transport Safety Authority 1996), and the application of the NZDep96 index of deprivation (Salmond et al 1998). The road safety 'risk' of travel is defined as social cost per unit of traffic volume and includes assessment of driver factors (eg, alcohol,

speed, others), pedestrian, cyclist, road and vehicle factors. The mapping of NZDep96 has been used to identify pilot sites for Family Start, the prototype intensive home visiting programmes for families at risk, and the implementation of the National Drug Policy (Ministry of Health 1998). The other well-established use of this technology is mapping ground shaking hazards as a basis for our emergency management contingency planning. Those of us who live in Wellington are very familiar with these maps (Wellington Regional Council 1992).

A paper presented at the Colloquium demonstrated how public health services had used this information to support local prevention and control strategies in relation to the measles epidemic in Auckland (Jones et al 1998). There is also an opportunity to work with other sectors and use these technologies to assist work on influencing the determinants of health. One example is food security.

In 1995, the Public Health Commission identified food security, that is access to the food people need for a healthy life, as a priority area for research (PHC 1995). This research included health input to, and health benefits from, home grown food programmes. The analysis of the food security indicators in the National

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Youth Suicide – A Challenge for Government and Community

The death of any person by suicide is a tragedy. The tragedy is often compounded when the suicide is of a young person. In 1996, 143 young people aged between 15–24¹ committed suicide in New Zealand, equating to one of the highest suicide rates in the world. The Government alone cannot stop suicide, and needs the assistance of the whole community. However, the Government can take a lead in addressing youth suicide and, consequently, has developed the National Youth Suicide Prevention Strategy. The Strategy provides a framework for understanding suicide prevention and signals the steps government agencies, communities, services, whanau, hapu, iwi and Māori can take to reduce youth suicide.

The statistics

In 1996, youth suicide deaths represented 27 percent of total suicide deaths (26.7 per 100 000), while this group made up only 15 percent of the total population. This represents a doubling in the rate of suicide deaths since 1985 when the annual rate of suicide deaths was 12.6 per 100 000 (the rate has remained relatively stable since 1990). Males have the highest rate of completed suicides (39.1 per 100 000 compared with 14.3 per 100 000 for females). The rate of Māori youth suicide in 1996 was higher than non-Māori with a rate of 38.4 per 100 000. (1996 mortality rates by ethnicity cannot be compared with previous years because of a change to the definition of ethnicity.) While the figures on completed suicides are sobering, for each of these there are at least another eight or nine hospital admissions for attempted suicide.²

Development of a national strategy

With these statistics in mind, the Government set up an inter-departmental steering group to look at suicide among young people. In June 1994, the Ministry of Youth Affairs released the *Report of the Steering Group on Youth Mental Health and Suicide Prevention*. The report made a number of

recommendations to 13 government departments whose activities impact on youth mental health. Based on research and consultation within the mental health sector, the recommendations were designed to improve youth mental health and prevent suicide. A monitoring group was established led by the Ministry of Youth Affairs to monitor departmental responses to the recommendations.

Building on the report, the Government agreed to the development of a National Youth Suicide Prevention Strategy in 1996 to be led by the Ministry of Youth Affairs and supported by the Ministry of Health and Te Puni Kōkiri.

After wide consultation, the National Youth Suicide Prevention Strategy was published in March 1998. As part of a Cabinet decision, the Ministry of Health took the lead role for the ongoing overseeing, promotion, review and monitoring of government agencies' implementation of the Strategy.

Why a strategy?

A strategy was decided upon to promote a co-ordinated and collaborative approach to suicide prevention and to provide a recognisable and consistent strategy

at a national level. In addition, it was thought that a strategy could be used to identify existing interventions, to identify gaps and to establish priorities for action.

What's in the Strategy

The New Zealand Youth Suicide Prevention Strategy is actually made up of two separate but inter-connecting strategies presented within the same document. *In Our Hands: The New Zealand Youth Suicide Prevention Strategy* is the general population strategy and *Kia Piki te Ora o te Taitamariki: Strengthening Youth Wellbeing* has been developed for Māori.

In Our Hands presents a series of goals and objectives which range from promoting resilience factors such as strengthening and supporting families, and ensuring people have the skills to identify and help someone who is suicidal, through to supporting those who have been bereaved by suicide. The five goals are: promoting wellbeing; early identification and help; crisis support and help; support after a suicide; and information and research.

Kia Piki te Ora o te Taitamariki: Strengthening Youth Wellbeing is a similar strategy but with a community development approach which focuses on promoting resilience factors such as cultural identity and belonging. The five goals are: strengthening whānau, hapū and iwi; taitamariki development; cultural development; mainstream responsiveness; and information and research.

¹ 'Youth' is defined in the New Zealand Suicide Prevention Strategy and in statistics generally as persons aged 15–24 years.

² *In Our Hands: New Zealand Youth Suicide Prevention Strategy*, pp 28–29.

Both Strategy documents were accompanied by research papers: *In Our Hands: A Review of the Evidence* by Dr Annette Beautrais; and *Kia Piki: A Review of the Evidence* by Keri Lawson-Te Aho.

Implementing the Strategy

To signal the intersectoral nature of the Strategy a stocktake of the initiatives government agencies are currently implementing, or plan to develop, was undertaken.

Key tasks to be carried out include overall co-ordination of the Strategy, developing a communications strategy (including development of a Web page), compiling statistics, facilitating research into suicide, and undertaking evaluation and monitoring of the Strategy.

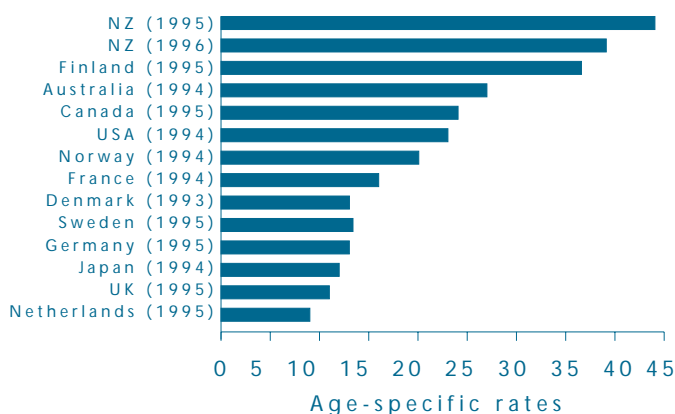
Forums such as *Public Health Perspectives* will be utilised to regularly update the sector on progress in implementing this important national strategy.

If you have any queries about *In Our Hands: The New Zealand Youth Suicide Prevention Strategy* please call either Grant McLean or Maria Cotter of the NYSPP Secretariat in the Ministry of Health on (04) 496 2000. For specific information about *Kia Piki Te Ora o te Taitamariki* call Arawhetu Peretini or Grant McLean on (04) 496 2000.

If you would like a set of the Strategy documents or any of them individually please contact Nadia Gate on (04) 496 2277 or Helen Wong on (04) 496 2375 at the Ministry of Health.



Figure 1: Male youth suicide rates, international comparison



Age-specific rates per 100,000 population
Youth is defined as age 15 to 24 years

Source: World health statistics Annual 1996, Mortality and Demographic Data 1995, provisional 1996 data.

Developing initiatives under the New Zealand Youth Suicide Prevention Strategy

A range of initiatives have been, or are being, developed to advance the Strategy throughout the community. Some examples include:

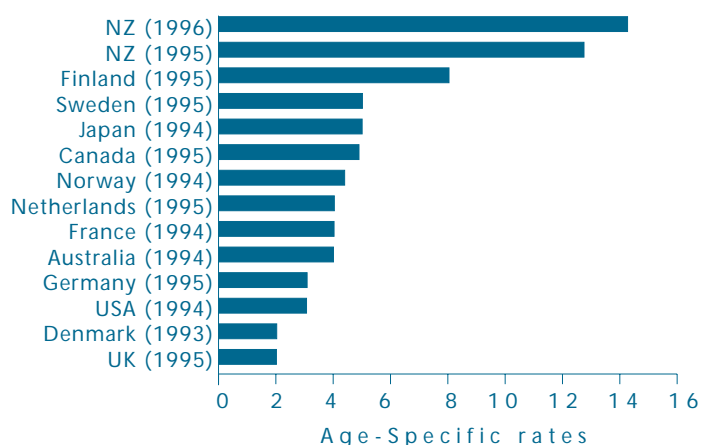
New initiatives

- suicide prevention clearing house/resource centre
- community youth development fund
- suicide prevention resource for Māori
- guidelines for primary health practitioners
- pamphlets for parents and young people.

Existing initiatives

- guidelines for schools
- CYPFS suicide risk assessment guidelines
- emergency department best practice guidelines
- media resource on the reporting and depiction of suicide
- HRC-funded research
- classification and recording of suicide work plan
- Strengthening Families initiatives including Family Start and youth mental health services
- suicide safe cells
- prevention strategies for schools.

Figure 2: Female youth suicide rates, international comparison



Age-specific rates per 100,000 population

Youth is defined as age 15 to 24 years

Source: World health statistics Annual 1996, Mortality and Demographic Data 1995, provisional 1996 data.

Public Health Legislation

Review Update

The public health legislation review is progressing according to plan. As well as input from the many consultation meetings held during July to September 1998, almost 120 written submissions were received on the Ministry discussion document *Public Health Legislation Review: A new public health legislation framework*.

Information and ideas obtained from consultation meetings and written submissions informed the development of policy advice on the scope and shape of future public health legislation. Many proposals outlined in the discussion document have been refined, added to, changed

or discarded in light of the analysis of consultation material. Working drafts of the summary/analyses of such material will be refined and should be available in early 1999.

Overall there appeared to be strong support for the development of a new public health act which provides for a flexible, risk-management and outcome-focused legislative framework with clear responsibilities and accountabilities. There was also general support, albeit qualified in many cases, for the proposed purpose of the act and for many other key discussion items. The need to consider non-regulatory interventions (eg, health promotion and health

education) more fully was emphasised by a number of submissions. While not the focus of this round of consultation, many useful comments were also received on implementation issues. These comments have enabled a more detailed consideration of the transitional provisions that will need to be provided for in the new act.

During October/November 1998 the Ministry has worked with other central agencies to ensure robust policy proposals are prepared for Cabinet consideration in December 1998. Subsequent announcements on policy determinations will be the prerogative of the Government.

Change in the Case Definition of Hepatitis C

From 1 January 1999 the case definition for acute hepatitis C (HCV) will be changed.

The current definition requires a clinical illness consistent with hepatitis C and a positive blood test. Many cases of HCV are not associated with a clinical illness at the time the virus is acquired. The new case definition includes cases where there has been documented seroconversion to HCV, within the previous 12-month period, even if there were no symptoms. The new case definition will increase the sensitivity of the surveillance for acute cases of HCV. Chronic or prevalent cases of HCV are not notifiable in New Zealand.

The new definition was developed by the Communicable Diseases Network of Australia and New Zealand.

Case definition for acute hepatitis C (effective 1 January 1999).

Demonstration of documented seroconversion to HCV when the most recent negative specimen was within the past 12 months

OR

demonstration of an anti-HCV positive test, or HCV polymerase chain reaction (PCR) positive test, **and** a clinical illness consistent with acute hepatitis C within the last 12 months where other causes of acute hepatitis can be excluded.

Quality Assurance Activities Involving Medical Practitioners

It is generally accepted that there is at least some risk of an adverse patient outcome in all health care interventions. Effective robust quality assurance is seen as an important and positive way of reducing the incidence of adverse patient outcomes. Quality assurance embraces a wide range of activities which include hospital-based peer review processes, such as clinical audits into surgical mortality rates, incidences of adverse outcomes and the review of patient care.

Part VI of the Medical Practitioners Act 1995 operates on the underlying principle that quality assurance activities are in the public interest. For quality assurance activities to be successful, practitioners should be able to freely examine and criticise, in a constructive way, the actions and management of cases by their colleagues. Confidentiality of information and a measure of protection for participating practitioners is required. Two public interests are in conflict. On one hand the public generally benefits from open access to information. On the other hand,

without guarantees regarding confidentiality, it is unlikely that medical practitioners will participate in quality assurance programmes.

It is considered that the greater public good will be enhanced if information that arises from the result of a quality assurance activity is confidential. The purpose of providing such a protective framework is to encourage activities which will improve and maintain the quality of health care services provided to the public. The protection afforded is not intended to hide information of a non-identifying kind from the public. The publication and disclosure of non-identifying

information, particularly aggregated data, is crucial to ensuring the public receives full benefit from quality assurance activities.

Part VI of the Act provides that the Minister of Health may declare a quality assurance activity. The declaration:

1. protects the confidentiality of:
 - a. information that becomes known solely as a result of such activities
 - b. documents brought into existence solely for the purposes of such activities
2. gives immunity from civil liability to persons who engage in conduct in good faith in connection with such activities, and that conduct adversely affects any right or interest of another person who is a medical practitioner.

The Ministry assesses quality assurance applications and provides advice to the Minister of Health on whether to approve the applications.

The Evolving Epidemic: Second Australasian Conference on Hepatitis C

The global hepatitis C epidemic poses a major personal and public health challenge. As the epidemic evolves, so does our understanding of the virus, its effects on the body and the ways in which infection can be prevented and treated. Responses to the epidemic are also evolving through research, policy development, improved diagnosis and treatment, and through enhanced prevention and community support initiatives. However, there is still much we do not know and there are many challenges to be met and many opportunities to be seized.

The second Australasian Conference on Hepatitis C will provide a forum for all those involved with hepatitis C to present and discuss their perspectives on the evolution of the epidemic and responses to it.

The conference will be at the Christchurch Convention Centre from Tuesday 17 to Thursday 19 August 1999.

The programme will include keynote addresses as well as the opportunity for delegates to present in the form of papers, workshops and facilitated discussions under the following stream topics:

- basic sciences
- clinical sciences
- epidemiology and social research
- community support and self management
- prevention and public health.

If you would like more information on the conference, or would like to submit an abstract to present at the conference, please contact the Conference Secretariat:

Conference Innovators

PO Box 1370, Christchurch

Tel: (03) 379 0390 Fax: (03) 379 0460

E-mail: cindy@conference.co.nz

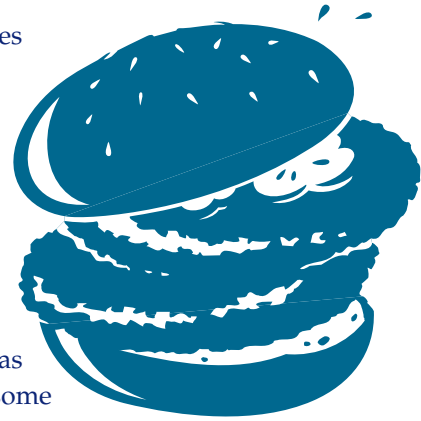
Successful Prosecution Warning to Unsafe Food Operators

A successful prosecution in October by the Ministry of Health of two Hamilton businesspeople for selling rejected meat patties for human consumption is a warning to others involved in similar practices. In the Otahuhu District Court, Christopher Stephen Cumings and Ross Alexander Williams were convicted and fined for selling, for human consumption, food that had been condemned as pet food. Ministry enforcement senior advisor Steve Anthony said it was the first prosecution under the Food Act 1981 where no actual harm had been caused by the food.

The frozen meat patties, originally destined for export, were condemned because they had defrosted and sat on a wharf for eight days before a power failure was detected and rectified. The defendants purchased the condemned patties as pet food before reselling them for human consumption at a significant potential profit. The goods were purchased for about \$3,000 and sold for a potential profit of \$35,000, although only \$6,000 was received due to the publicity surrounding the investigation.

The case was a landmark one as it allowed for prosecution under the new legislation, under which authorities only need prove there was a system failure and the sellers knew such a failure could create a risk to human health. In the past it was necessary to prove that harm was caused. As a result of the case, other prosecutions may also follow for others who have exposed people to risk through related unsafe practices.

The Ministry of Health takes risks associated with food very seriously which is reflected in the range of strategies it employs, including the introduction of food safety programmes, education, monitoring and compliance activities. It was of particular concern that some of the product sold by the defendants eventually went to a rest home where the potential for harm to a vulnerable population is even greater than to the general population.



- In New Zealand each year, about 10 000 cases of foodborne illness are reported to the authorities.
- Serious illness, or death, can occur as a result of unsafe food. In 1997, around 500 people were admitted to hospital with foodborne illness and, of these, 11 died.
- Many cases of foodborne illness are not reported. Most of those who suffer symptoms do not see a doctor, and if they do, not all doctors notify the disease.
- Various studies suggest that the true number of people who suffer symptoms of foodborne illness in New Zealand is probably between 300 000 and 700 000 a year.

For further information on the case, contact:

**Steve Anthony on (04) 496 2355
or Christine Simpson on (04) 496 2172
for internal inquiries.**

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Nutrition Survey should be available early next year (Ministry of Health 1997a) and should give us some national prevalence estimates of food insecurity, food inadequacy and coping strategies among adults 15 years and over. In addition to this, some knowledge of the distribution and health impact of home gardens for food production may be important to complement information on food insecurity and coping strategies, and socioeconomic deprivation (Salmond et al 1998).

Health GeoInformatics and associated technologies can assist our understanding of the determinants of health, and may possibly contribute to our understanding of disease aetiology. However, its major value is to

improve targeting of preventive programmes and health services, by using our knowledge of the geographical distribution of disease and health risk factors.

References

- Elliott P, Briggs D. Recent developments in the geographical analysis of small area health and environmental data. In G. Scally (ed) 1997. *Progress in Public Health*. London: FT Healthcare.
- Jones N, Bloomfield A, Rainger W, et al. 1998. Epidemiology and control of the 1997 measles epidemic in Auckland. Presented at the 10th Colloquium of the Spatial Information Research Centre, University of Otago, New Zealand, 16 to 19 November, 1998.
- Land Transport Safety Authority. 1996. *Road Safety Atlas*. Wellington: Land Transport Safety Authority.

Fifth National Disaster Medicine Training Course

The 5th National Disaster Medicine Training Course held at the Emergency Management Institute at Mt Macedon, Victoria, Australia was run from 29 November to 4 December 1998.

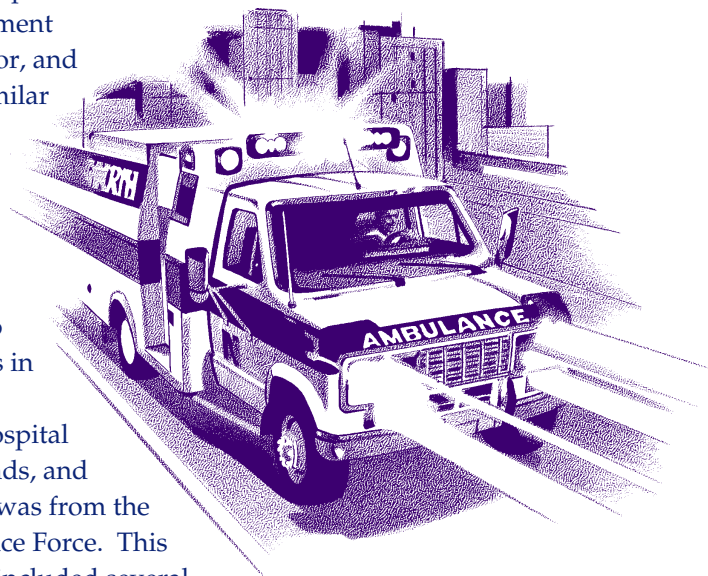
The course has been held annually since 1994 and each year someone from New Zealand has an opportunity to gain formal training for medical, nursing and ambulance skills related to a disaster situation.

Nominations were invited for a key person involved in disaster management and/or emergency services in New Zealand to attend this year's course. The Ministry was impressed by the high standard of applicants. After careful consideration, Robert Patton of Western Bay Health was selected to attend. Robert has been active in emergency management issues for some time, both in the Western Bay of Plenty, and across the Midland region. We are sure that Robert benefited from this opportunity, and that on his return, he will make further significant contributions to emergency management issues in the health sector.

Following his attendance Robert will report on the course (its nature, usefulness and applicability to New Zealand) to the Ministry's Emergency Management Operational Group. While no similar course is offered in New Zealand for the health sector, it is hoped that the skills brought back will foster the development of emergency management expertise in the sector, and that eventually a similar course can be developed here in New Zealand.

The Ministry of Health has been pleased to be able to support participants in the past. Previous participants have hospital planning backgrounds, and last year's attendee was from the New Zealand Defence Force. This year's nominations included several

people with public health backgrounds, and it is hoped that others will consider nomination next year in addition to attending some of the public health emergency courses already available in New Zealand.



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Action

for Health and Independence Conference

More than 200 participants attended the Action for Health and Independence conference at Te Papa on 15–17 October 1998. The conference aimed to identify the types of actions that can take place across the health and disability sector to improve health and disability outcomes for the communities we serve.



The conference proved to be an excellent melting pot where a wide range of people from across the health and disability sector spent time together considering how they could all contribute to achieving better health and disability outcomes for communities. Participants included disability support workers, GPs, chief executives, public health workers, specialists, researchers and representatives from Māori and Pacific health initiatives. One of the most striking developments was people discovering the benefits of sharing practical experiences and ideas, and learning from each other. This led to many people committing to networking and liaising more closely, both locally and on a national basis.

Public health service providers in the past have often been disappointed by the lack of attention paid to population health outcomes by personal services providers. The conference clearly demonstrated that this situation is now changing significantly, as demonstrated by programmes being implemented by a number of IPAs, disability support organisations, integrated care initiatives, hospital departments, Māori providers and initiatives for Pacific peoples. The challenge for public health services now lies in further encouraging and supporting local treatment services providers to implement outcomes-focused programmes, and building working partnerships with them.

Participants gave a striking commitment to community-development approaches to improve outcomes. They concluded that communities had many and diverse needs that could only be effectively met by diverse programmes oriented around people, rather than people being oriented around services. This means developing local solutions for local problems. This often means moving away from a medical perspective of illness to more holistic views held by different communities, including Māori and Pacific peoples, and hence more holistic programmes. This was clearly reflected in the conclusions concerning meeting the needs of people with disabilities, where quality of outcomes is defined by inclusion and empowerment. The challenge for public health services lies in recognising that disability is not synonymous with health status, and that

people with disabilities form diverse populations which should not be ignored.

Whilst conference participants saw value in diversity, they also agreed that services should be primarily focused on better outcomes for communities, and this required better co-ordinated programme development between providers. Many successful examples of such co-operation between community-based, primary, secondary and public health providers were showcased. It was also agreed that better, more practical and provider-focused information needed to be available to help direct action, and monitor progress towards better outcomes. This was a responsibility of all, and there was considerable need to share information on practical ways of collecting and utilising information to guide action.

Given the significant amount of local activity addressing population health and disability outcomes, the Ministry of Health has produced two newsletters to publicise innovative initiatives. The latest is enclosed for your information. It is also on our Web site. Would you find it useful to receive such information on a more regular basis? Would you like to contribute with details of your own population focused initiatives? Please let us know by faxing back the enclosed form and this will help us decide whether we should continue to spread the word on good home-grown population-focused programmes that we can all learn from.

If you are interested in accessing more information on conference papers and conference streams, visit our Web page on www.moh.govt.nz; news and issues; Action for Health & Independence.

Food Administration

Review Update

The joint Ministry of Health (MOH) and Ministry of Agriculture and Forestry (MAF) Food Administration Review involves developing an integrated food administration system. Key objectives are protecting health and safety, maintaining public confidence and facilitating access to markets.

The preferred structural option

The MOH/MAF project team examined several structural options for integration of food administration responsibilities before recommending a preferred structural option to the Government. In August 1998 Cabinet agreed in principle, and subject to consultation, to establish an integrated food regulatory agency in MAF, with relevant resources transferring from the MOH to MAF. Cabinet directed officials to report back in early December 1998 with firm proposals.

Consultation

Public consultation occurred over August and September 1998 with meetings held in Auckland, Wellington, Christchurch and Dunedin and a hui near Hamilton. Submissions were also called for on the discussion document *Assuring Food Safety: An integrated approach to regulating the food sector in New Zealand*.

One hundred and twelve written submissions were received on *Assuring Food Safety*:

- 38 percent from local bodies, environmental health officers and associated interest groups
- 23 percent from food industry interests
- 19 percent from the public health sector
- 20 percent from other groups and individuals.

Nearly half the submissions received supported establishing a single food agency, with the majority of those supporting the agency being located in MAF. Most of the other half did not offer a clear preference or state a clear view on a single agency, although a few clearly opposed the integrated approach.

Key strengths of a single agency in MAF identified in submissions included:

- a consistent, recognisable 'brand' for food safety
- an integrated regulatory system, single point of contact, and a clearer focus on food regulatory matters

- streamlining of auditing processes resulting in savings to industry
- access to technical expertise in certain aspects of food safety
- the structures that already exist within MAF are well designed to handle the complexity of food safety within the new environment.

Key weaknesses identified included:

- potential for conflict of interest by placing a public health function within MAF
- the inextricable link between foodborne infectious disease investigation and food safety, and the loss of a public health perspective in food safety matters
- the effect on 'critical mass' in smaller providers whose capacity to respond to other regulatory health matters will be seriously compromised if resources are shifted to other agencies
- the confusion the preferred option will generate for the public and industry
- compliance costs for small retail businesses should food safety programmes become mandatory
- the compliance cost of introducing the new system to the food industry and consequently to consumers.

Considerable input was received during consultation around implementation issues such as a move to mandatory food safety programmes (FSPs). While not part of the proposals of the Food Administration Review, this input will be useful in assessing any move to mandatory FSPs.

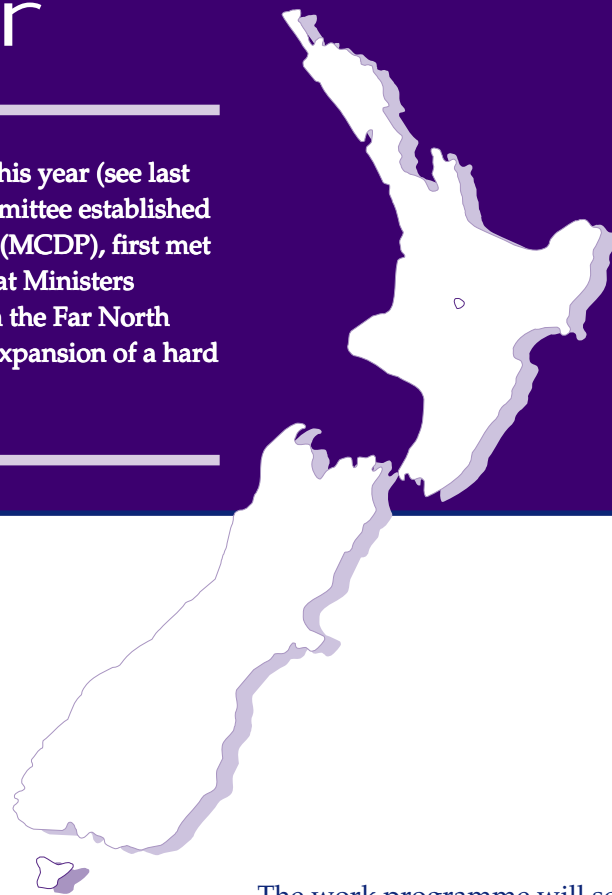
Final advice to Cabinet

The MOH and MAF are currently preparing final advice for the Government on the Food Administration Review proposals.



Cannabis Tour

The Government released the National Drug Policy in July this year (see last edition of *Public Health Perspectives*). The Ministerial Committee established under the Policy, the Ministerial Committee on Drug Policy (MCDP), first met in August and identified two areas of immediate concern that Ministers wanted to see addressed. These are the cannabis problem in the Far North and the East Coast of the North Island, and preventing the expansion of a hard drugs market in New Zealand.



Ministers charged the recently established Inter-agency Committee on Drugs (IACD) with developing intersectoral work programmes on these two issues. These programmes are to be developed by the end of the year.

As part of this work, Ministry of Health staff recently attended a series of meetings on cannabis in the Far North and the East Coast. Held in the week of 19 October, the meetings in Gisborne, Ruatoria, Whangarei and Kaikohe were an opportunity for local organisations concerned with minimising cannabis-related harm to present their views on what needs to be done to address the harm caused by cannabis to both individuals and communities.

Also attending the meetings were representatives from Te Puni Kōkiri and the New Zealand Drug Foundation. The meetings were organised by local Te Puni Kōkiri staff.

The meetings were very successful. Participants identified key concerns relating to cannabis use in their communities and shared a wealth of experience with their Wellington visitors. Those who attended the meetings generally supported a comprehensive approach incorporating local involvement in the development and

implementation of strategies to reduce the harm caused by cannabis.

The IACD is now working to draft a proposed work programme on cannabis, based on feedback from the meetings and submissions from government agencies, non-government organisations, runanga, youth agencies and other organisations with an interest in cannabis.

Strategies will be developed under three key headings:

- education and community development initiatives designed to reduce the demand for drugs
- law enforcement and other activities to limit the supply/availability of drugs
- initiatives to reduce the harm that is caused by drug use to both individuals and the community.

The work programme will set directions rather than be an A-Z of what will be done. This will come later and may very well require further input from the experts: the people in the field who are working with people and communities with drug-related problems on a day-to-day basis. It is important too that initiatives under the National Drug Policy fit in with initiatives under other intersectoral programmes such as the Strengthening Families framework and the Crime Prevention Strategy.

Feedback will be provided to those who attended the meetings or made submissions to the IACD.

The work programmes will be presented to the MCDP for consideration in the near future.

Any queries regarding the National Drug Policy should be directed to the IACD Secretariat, based in the Ministry of Health:

Matthew Allen (04) 496 2192

Brigid Wilson (04) 496 2282.

Extending Prescribing Rights to Nurses



At present, only medical practitioners, dentists and midwives are able to prescribe medicines in New Zealand. In other countries, such as the United States, prescribing rights are given to a much wider range of health professionals. The Ministry of Health has released a number of discussion documents over the last few years regarding the extension of prescribing rights to other health professionals in New Zealand.

On 12 May 1998 (International Nurses Day) the Minister of Health, Hon Bill English announced that the Government would be introducing legislation to enable the extension of prescribing rights to nurses and other health professionals. This announcement involves two phases of work. First, an amendment to the Medicines Act 1981 to provide for a regulatory mechanism to enable the introduction of prescribing rights to nurses and other health professionals, at such time as this is approved by Government. Secondly, the policy work on the practicality of extending prescribing rights to nurses in particular areas.

With regard to the second phase, the Minister has asked the Ministry of Health to begin policy work on the extension of limited prescribing rights to nurses working in the areas of aged care and child/family health. In August 1998, the Ministry established two expert working groups to undertake some developmental work on nurse prescribing. Each group comprised five nurses, two medical practitioners and a pharmacist, appointed on the basis of their clinical knowledge and the expertise they brought in their particular areas of practice.

Representatives of the Nursing Council and Pharmac also attended the working group meetings as observers. The groups were asked to:

- define the parameters of the scopes of practice
- compile a list for each scope of practice of the generic classes of medicines which it may be appropriate for nurses to prescribe.

The two Ministry working groups have completed identifying:

- the benefits and risks of extending prescribing rights to nurses in aged care and child/family health
- the parameters around each scope of practice, such as the age of the client group, the location of the clients, and nurses' role in providing treatment and care for the client group

- the potential list of generic classes of medicines that nurses may prescribe within each scope of practice
- the diagnostic tools that nurses will need to access in order to form a consumer's clinical assessment and make a prescribing decision
- principles of prescribing for all prescribers.

In undertaking this work, the working groups have taken the view that if there is no justification or benefit to the consumer from being able to prescribe a particular medicine, the medicine should be excluded from the range available to nurses. The groups have also recommended restrictions on the dosage of particular medicines, or suggested that some medicines be restricted to nurse specialists practising in particular areas, for example, asthma.

Alongside the Ministry working groups, the Nursing Council has been looking at the competencies and education requirements that nurses would need to successfully meet before being granted prescribing rights.

Now that the working groups have compiled the potential list of generic classes of medicines suitable for nurses to prescribe, the Ministry of Health will work with the Health Funding Authority and Treasury to determine the costs and benefits arising from extending prescribing rights to nurses practising within the aged care and child/family health scopes of practice.

At this stage, the Ministry hopes to circulate a consultation policy paper to the sector later this year. The paper will outline the proposed regulatory framework for nurse prescribing, and detail the conclusions of the working groups.

It is hoped that the Medicines Amendment Bill, which will enable the making of regulations to allow designated classes of health professionals to independently prescribe medicines, will be introduced in the current parliamentary session.

Health and Disability Sector Standards

The Government has decided to review the current safety legislation for hospitals, rest homes and homes for people with disabilities. New legislation will be introduced into Parliament in the near future.

sector. The process to be used is following that used to set standards in other sectors, which includes:

- a management committee, to oversee and approve the development of the health and disability sector standards
- expert committees to develop standards for the safe delivery of services, and for contract specification
- a facilitation service, contracted by the Ministry and the HFA, to support the work of the committees.

The problems with the present licensing legislation are that it:

- is focused on only some of the elements that constitute a risk to patients/residents
- has low benefits/moderate compliance costs
- is duplicated in terms of outcomes by other safety legislation introduced since 1993
- lacks clarity as to who is responsible for safe services
- doesn't focus on management of significant safety risks
- doesn't provide a basis for addressing significant risks arising from new services or impact of new technology in the delivery of existing services.

The new legislation will change the current requirements. The legislation will require rest homes, hospitals and homes for people with disabilities to either have a Health Funding Authority (HFA) contract or, if not, to be accredited by an agency designated by the Minister of Health. The Government has requested the Ministry of Health to facilitate the development of national safety standards for the services covered by the present legislation.

The new regime will require the HFA and designated agencies to audit providers to determine compliance with national safety standards. This arrangement will replace the current licensing requirements. The HFA and the Ministry of Health have agreed on a framework for the development of standards across the health and disability

The committees are made up of provider and consumer representatives.

The initial standards will focus on outcomes and will be for services covered by the present safety legislation – hospitals, rest homes and homes for people with disabilities. They will be generic standards that can be applied across the health and disability sector but, where appropriate, service specific standards will be developed for each area.

The Ministry's primary interest in the development of standards is in implementing the Government's decision to repeal the present consumer safety legislation and replace it with new legislation. The HFA has a wider perspective which is concerned with developing nationally consistent purchasing approaches for health and disability services. The jointly established framework will address both of these interests.

Regular newsletters to keep the sector and consumers informed of progress to date are being circulated. Draft standards will be available from:
<http://www.standards.co.nz> or phone David Waters on (04) 498 5906 or e-mail david@standards.synet.net.nz

Lead-based Paint Warning

David Speedy, Health Protection Officer (HPO), Nelson Marlborough Health reports that at an early childhood centre in Blenheim he found seven out of eight cots were painted with lead-based paint. He had been invited to check them after giving a talk on the subject.

This highlights the possibility that despite previous poisoning incidents (including a death) and associated publicity and health promotion work by public health agencies, there is still likely to be some hazardous furniture or toys being handed down to the latest generation.

Licensing officers, HPOs and public health nurses who visit early childhood centres, or indeed private homes, should be aware of the possibility of lead-based paint on old or recycled timber, toys and furniture and keep a look out for situations that may need investigation.

