

EDITORIAL

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

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Global Action on Tobacco

Global action on tobacco is accelerating with the establishment of the Tobacco Free Initiative by the World Health Organization (WHO) in 1998 (WHO 1998b). A central part of this initiative is the development of a framework convention on tobacco control.

New Zealand was represented at a meeting of about 25 public health experts and international lawyers, convened by WHO in Vancouver in December 1998, to provide advice on WHO's role in the development of a convention, the structure and contents of the Convention and protocols, the special support required for developing countries, and methods to promote the adoption of the Convention.

Overall it is estimated that the current annual toll of 3.5 million tobacco-related deaths will increase to about 10 million deaths per annum in 2030 with 70 percent of these deaths occurring in developing countries (WHO 1998b). Speakers at the meeting presented data on the growing gap between exports of tobacco products by tobacco producing countries and imports, which is a measure of the growth in smuggling globally. They also graphically demonstrated the relationship between expenditure on tobacco advertising and smoking by young adults.

The meeting concluded (WHO 1998a) that WHO has clear legal and moral authority to convene working groups to draft the key elements of the Convention

for consideration of Member States. The Convention would establish a general system of governance with few or no major substantive obligations but with the guiding principles encompassing both national and transnational measures recognising that:

- tobacco is an important contributor to inequity in health in all societies
- as a result of the unique nature of tobacco products (addiction, health damage), normal trade practices are not applicable
- the public has a right to be fully informed about the health consequences of using tobacco products
- the health sector has a leading responsibility to combat the tobacco epidemic, but success cannot be achieved without the full contribution of all sectors of society.

The substantive obligations would be developed within a set of protocols which would allow states to proceed incrementally. Protocols are separate legal agreements and only parties to the Framework Convention can join the protocols. The meeting recommended that one or more protocols should be prepared for adoption concurrently with the Framework Convention. Protocols may include: protecting children and youth from tobacco products; maintaining the low level of smoking among women in developing countries; and controlling smuggling.

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Food Administration Review

– *Establishing the Food Regulatory Agency*

In our December 1998 issue, we featured an update on the Food Administration Review (Vol.2, 2:13). The review noted that at the time of writing, the Ministry of Health and the Ministry of Agriculture and Forestry (MAF), as joint leaders of the review, were preparing final advice for the Government.

On 18 December 1999 Cabinet agreed that the most effective way to provide an integrated food regulatory system in New Zealand, which would meet the Government's objectives for food reform, was to establish a single food regulatory agency within MAF. Cabinet directed that the agency be established by 1 July 1999.

Since this decision, work has been under way in both the Ministry of Health and MAF towards the establishment of the agency.

MAF has undertaken some internal restructuring, and has created a Food Assurance Agency and a Biosecurity Agency. These agencies will formally begin operations on 1 July 1999 and will be made up of current MAF Regulatory Authority staff and the Food Safety and Food Standards staff who will transfer from the Ministry of Health.

Following advertising in New Zealand, Australia, and a search process in the United Kingdom, Andrew McKenzie, currently Assistant Director-General/Chief of the MAF Regulatory Authority, has been confirmed as

Assistant Director-General/Group Director Food Assurance Agency.

Barry O'Neil, currently Chief Veterinary Officer within the MAF Regulatory Authority, will take up the position of Assistant Director-General/Group Director Biosecurity Agency.

MAF has established two teams to oversee the creation of the new agencies – an Establishment Team (dealing with mainly structural and technical issues) and a Change Management Team (dealing mainly with human resource and communications issues). The Ministry of Health is working closely with MAF during this transition period and has representatives on both teams. It is hoped that the structures of the agencies will be made available in early April 1999.

In the meantime, the Food Amendment Bill, which facilitates the establishment of the food agency by transferring most of the Ministry of Health's food administration functions to MAF, had its second reading in the House on 3 March 1999. The Bill has been referred to the Government Administration Select Committee for consideration and members of the public will have the opportunity to make submissions on the Bill to the Select Committee at this point. It is expected that the Committee will publish details of the Bill's submission process in major newspapers in the near future.

Progress on Health Outcome Targets

***Progress on Health Outcome Targets 1998* was released in December 1998 and is available on the Ministry of Health's Web site. It is the sixth annual report on the state of public health in New Zealand. It monitors New Zealand's progress toward specified health outcome targets.**

This report will be of interest to health professionals and other sectors, as well as the general public, as it provides the most up-to-date information available on a range of important health issues in New Zealand.

The state of the public health is monitored for two reasons: to help us decide where we should be going, and to help us determine if we are getting there. Each public health target identifies a measurable change in health

status or health risk for a specific population group over a defined period of time.

Based on trend data over the last five years for which data are available, the areas in which progress has occurred include ischaemic heart disease, SIDS, road traffic injuries, alcohol-related harm, and cervical cancer. A trend in an objective toward health does not mean that all the targets within that objective will be reached by the set date, only that progress is being made overall toward achievement of the objective concerned.

For the other targets, no data are available or a plateau in rates is probable. Major exceptions are diabetes, rheumatic fever and youth suicide, for which rates have been increasing.

Toxic Fumes from Waterbed Contamination

An incident has been brought to our attention where a member of the public suffered acute respiratory distress as a result of adding the wrong chemicals to a waterbed. A commonly used conditioner, which contains quaternary ammonium compounds, had been used in an attempt to remove an odour, but when the odour persisted a bleach was added. The individual, who was asthmatic, subsequently developed breathing problems and required emergency hospital treatment.

The Institute of Environmental Science and Research warns that bleach should never be mixed with ammonia compounds in any situation because this results in the formation of chloramines. Inhalation of chloramines causes irritation and may result in breathing problems leading to hospitalisation.

Because of the potential problems associated with chlorine-based compounds, the Ministry recommends that public health services bring to the attention of waterbed vendors that bleach should not be used in waterbeds.

If public health services are aware that such incidences are occurring in their areas the Ministry should be informed so that we can consider further action.

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Developing countries would require technical and financial assistance to participate in the process of developing and promulgating the Convention. The meeting recommended that WHO should establish a separate multilateral fund for this purpose.

At the 103rd Session of the Executive Board of the WHO in January 1999, a recommendation for adoption by the Fifty-second World Health Assembly (WHA) in May 1999 of a resolution accelerating the development of the Framework Convention along the lines recommended by the meeting, was agreed. This timeframe provides for a working group to draft the Convention being established after the 1999 WHA, should the resolution be adopted. Subject to satisfactory progress, an intergovernmental negotiating body would be established in May 2000 and the target date for adoption of the Convention is currently May 2003.

References

WHO. 1998a. Main conclusions from the WHO meeting on the Framework Convention on Tobacco Control, Vancouver, 2 – 4 December 1998. Unpublished report.

WHO. 1998b. *Report by the Director-General. Tobacco Free Initiative*. EB 103/5, 8 December 1998. Geneva: World Health Organization, Executive Board, 103rd Session.

Polyurethane Condom Standard

In a world first, the Ministry of Health with the assistance of Standards New Zealand, the Institute of Environmental Science and Research Ltd and in consultation with industry has produced a new standard for the polyurethane condom. This standard applies to both the female and the male polyurethane condom. No other country has a standard for the polyurethane condom.

The standard, known as the New Zealand Standard 7106:1998 Polyurethane Condom, was gazetted by the Minister of Health on 28 January 1999 and it is now legal to sell this type of condom in New Zealand. New Zealand has specific legislation which requires the Minister of Health to gazette a standard before a contraceptive device can be sold so this is why a standard was produced for the polyurethane condom.

Polyurethane condoms can now be sold in New Zealand provided that they comply with the requirements of the standard. The standard has been designed to ensure that the polyurethane condom is of equal quality to the latex condom sold in New Zealand. Last year the Minister of Health updated the legal standard for the latex condom basing it on the latest international standard. As with the latex condom standard, the polyurethane condom standard includes specifications and a test for holes, an air burst test and labelling requirements. It is important to remember that both the latex and polyurethane condom standards allow 0.25 percent holes in the product. One hole in 400 condoms is a very low figure but not perfect.

It is the responsibility of the distributors to decide whether they wish to market this new type of product in New Zealand. It offers an alternative form of contraception and is especially important as an option for people who may have a latex allergy. Also the female polyurethane condom allows a greater choice of contraception for women in New Zealand.

Southern Saltmarsh Mosquito (*Aedes camptorhynchus*) Found in the Hawke's Bay

Introduction

The health sector is battling to rid New Zealand of a new mosquito that has found its way to our shores. The recent discovery in the Hawke's Bay of the exotic southern saltmarsh mosquito (*Aedes camptorhynchus*) has led to a containment exercise as the first phase of attempted eradication. Public health services have increased surveillance throughout New Zealand to determine whether the southern saltmarsh mosquito is anywhere else.

Immediately prior to Christmas 1998, the Napier City Council received a number of complaints about unusual nuisance mosquito biting. The Council sought advice from the local public health service, Healthcare Hawkes Bay. Mosquito specimens were subsequently collected and identified by experts contracted to the Ministry of Health.

Aedes camptorhynchus is a mosquito species of public health significance to New Zealand. It is cool tolerant and is normally found in coastal areas of Australia due to a preference for saline or brackish water habitats. In Australia, *Aedes camptorhynchus* has a reputation as a 'vicious' biter and is thought to be the main carrier of Ross River virus disease in southwest Western Australia. It is also a potential vector of the rare, but potentially fatal, Murray Valley encephalitis.

Ross River Virus Disease

Ross River virus disease is notifiable under the Health Act 1956 as an arboviral (arthropod-borne viral) disease, and there are established surveillance mechanisms for the investigation and reporting of notified cases of this disease. Only two cases of Ross River virus disease have been reported in New Zealand since the disease became notifiable in the late 1970s. The most recent case was notified in November 1997 and the previous one in 1980. Both cases were investigated and found to have been acquired overseas.

The incubation period for development of Ross River virus disease symptoms is three to eleven days. Symptoms are characterised by arthritis, primarily in the

wrist, knee, ankle and small joints, which lasts from days to months. In many patients, the arthritis is followed in one to ten days by a rash, mainly on the trunk and limbs, which may last seven to ten days. Fever is usually present but may not be.

Before mosquito transmission can occur, the mosquitoes must have bitten a viraemic person or other animal host. In the absence of known cases of Ross River fever in the Hawke's Bay area, the risk of disease is considered to be relatively low at this time. However, medical practitioners in the area have been advised of the finding of *Aedes camptorhynchus*, and the signs and symptoms of Ross River virus disease. It is possible that tourists from Australia or residents returning from holiday in Australia, for example, may carry the virus.

The Size of the Problem

A health impact assessment prepared for the public health service at Healthcare Hawkes Bay by the University of Otago, Wellington School of Medicine states that:

'the current risk is an irreversible hazard to the Hawkes Bay region if *Aedes camptorhynchus* populations are left unchecked and allowed to consolidate and spread. Future risk exists for the introduction and transmission of [Ross River] virus into Hawkes Bay leading to a 'virgin soil' epidemic of [Ross River] virus disease ...'

There are no strong leads on how the mosquito arrived or when it established. However, it seems that it has been present for more than one breeding season.

Significant rainfall at the beginning of December, after a long drought period, was almost certainly the cause of large numbers of mosquitoes hatching. *Aedes* species lay their eggs above low water levels in pools or in dry craters subject to inundation during spring tides or heavy rainfall.

Southern saltmarsh mosquitoes have been found within a 50 km² area (5000 hectares) to the north of Napier and in a smaller area to the south. Within these areas it is estimated that the mosquitoes are breeding in about 650

hectares of saltmarsh, estuarine margins, waterways and other suitable aquatic habitat.

Responding to the Problem

The Ministry of Health and Healthcare Hawkes Bay public health staff established a response centre in Napier and have been spraying infested habitat with an aqueous formulation of the biological control agent *Bacillus thuringiensis* var. *israelensis* (*Bti*). *Bti* is specific to mosquitoes, blackflies (often called sandflies in New Zealand) and gnats and is considered by the World Health Organization to be one of the safest pesticides in use today. Spraying has been undertaken to contain the mosquito establishment as the first phase of attempted eradication, subject to the collection and analysis of further information by the Ministry of Health and its technical advisors.

Application of sprays in the affected area is not a permitted activity under the regional air quality or water quality plans. However, Section 7A of the Biosecurity Act 1993 provides for the responsible Minister to exempt actions taken in an attempt to eradicate an organism, from Part III of the Resource Management Act 1991 for a limited time. Hon John Luxton (Minister for Food, Fibre, Biosecurity and Border Control) granted such an exemption and Healthcare Hawkes Bay then applied for the necessary resource consents to allow spraying to continue beyond the exemption period.

As at the end of February 1999, the mosquito establishment looked to have been successfully contained by environmental factors and the spray programme. If it is determined that ongoing eradication efforts are warranted, the marsh areas of concern are readily accessible and control is relatively straightforward (eg, application of larvicides by helicopter, four-wheel drive vehicle or backpack). Alternative controls would include habitat elimination (eg, draining) of these and some other areas around the margins of brackish ponds in the area.

National Surveillance

In addition to the containment and monitoring of the southern saltmarsh mosquito in the Hawke's Bay, public

health services throughout New Zealand have intensified surveillance of potential habitats in their regions to determine the likelihood of the mosquito being established elsewhere in New Zealand.

Potential habitats were identified by the presence of saltwater marshes, saline soils, and saline-tolerant vegetation. Areas that are tidally flushed each day are not of concern but, for example, estuaries which may be inundated only on spring tides may be of significance. Public information was also used to identify mosquito activity.

After identifying habitats, public health staff have investigated them, focusing on areas near ports and airports and population areas as a priority. Heightened levels of surveillance will continue to come for some time, particularly as many areas are currently suffering drought and will need to be re-checked after rainfall as the southern saltmarsh mosquito's eggs may survive drying out for many months.

Specimens of larvae and adult mosquitoes are being forwarded to taxonomists for identification but to date no southern saltmarsh mosquitoes have been found anywhere other than the known habitats in the Hawke's Bay.

Once more complete data is available, including that from national surveillance, the Government will determine whether the move to phase 2, that is full eradication, is feasible and warranted. Decisions are expected by May 1999. In the meantime spraying will continue to contain or even reduce the area of infestation.

Conclusion

This establishment of an exotic mosquito of public health significance serves as a timely reminder of the need for vigilance by public health and Ministry staff alike. Only with our combined efforts, and close co-ordination with other agencies such as local government, the Department of Conservation and the Ministry of Agriculture and Forestry, will ongoing exclusion measures have a significant likelihood of success against the constant threat of unwanted organisms.

Cigarette Test Purchases Slash Sales to Minors

Test purchases of cigarettes by under-18-year-old, volunteers appear to be slashing illegal sales to minors. Provisional figures from the Ministry of Health show that the sale rate to volunteers has fallen to under 5 percent for the period July 1998 to end of January 1999.

Director of Public Health, Dr Gillian Durham, believes that the drop off in sales is due to growing awareness among retailers of the controlled purchase operation (CPO) programme.

'As more and more test purchases are carried out, it is increasingly likely that retailers will know someone who has been visited in a CPO. There has also been considerable media coverage of the programme and education of retailers, most of whom are aware that a CPO could be carried out on their premises at any time,' said Dr Durham.

Since CPOs began in late 1996, over 2000 retailers have been visited, resulting in 165 sales. Sale rates for the first two years of the programme were around 10 percent of total visits, however this figure has fallen considerably over the past six months.

The test purchases are carried out all around the country by smokefree officers from regional public health services. During a CPO, an under 18-year-old volunteer enters a retail outlet and attempts to purchase cigarettes. If a sale is made, the volunteer returns to the car, and the smokefree officer enters the shop to interview the retailer. A file of events is sent to the Ministry of Health where the Health

Legal team and the local Crown Solicitor decide whether a prosecution will be taken.

To date, over 80 retailers have been successfully prosecuted for selling tobacco to minors. The assistance of an underage volunteer is the only reasonable way that has been found to ensure that enough evidence is gathered to prosecute a retailer who sells to a child or young person.

As well as the test purchases, smokefree officers have spent a considerable amount of time educating retailers about the law relating to sales of cigarettes. In addition, in August 1997, the Ministry of Health sent a pamphlet to every tobacco retailer emphasising that tobacco should not be sold to minors.

Dr Durham believes that the knowledge that a shop's compliance could be tested at any time is a big deterrent to retailers who might otherwise be tempted to sell tobacco to a minor.

There have been few defended hearings as a result of sales of tobacco products to minors during a CPO, as the majority of retailers plead guilty. Of the recent hearings, entrapment has been used as a defence three times (that is, the retailer argued that they were 'entrapped' into doing something they would not otherwise do). In all three cases this defence did not succeed.

Making it more difficult for minors to obtain cigarettes raises the age of use of, and addiction to, tobacco products.¹ The younger a person starts to smoke, the less likely they are to quit and the more likely they are to become heavy smokers, suffer smoking-related health problems, and die prematurely.²

¹ Altman DG, Foster V, Rasenick-Douss L, et al. 1989. Reducing the illegal sale of cigarettes to minors. *JAMA* 26: 80-3.

² Clark L, Wood L, Markham P, et al. 1994. *Choking the Supply: Restricting the sale of cigarettes to children in Western Australia*. Perth: Health Department of Western Australia.

Public Health Perspectives Survey

Enclosed with this issue of *Public Health Perspectives* is a readership survey.

The information gained from this survey will help decide content for future issues and find out what you think of current issues.

We would appreciate it if you could complete the survey and return it in the reply paid envelope by 30 April 1999.

Communicable Disease Control Manual *1999 Review*

The Ministry of Health is reviewing the *Communicable Disease Control Manual* (CDCM). The review will be completed by 30 May 1999. Revisions will be published and distributed by 30 June 1999.

The CDCM was developed to:

- provide information on the prevention and control of communicable diseases in New Zealand
- provide national protocols for communicable disease control
- help public health staff respond to communicable diseases.

For each disease, a response protocol – specifying the minimum actions that should follow notification or reporting – has been developed.

The CDCM was published in June 1998 with the intention that sections of the manual would be revised as practices in disease control and prevention change. Major revisions of the CDCM are not intended until the current public

health legislation review has been completed and various changes in legislation passed.

However, it is acknowledged that due to the long gestation prior to publication (it was originally conceived in 1993!) it is inevitable that there will be some changes required in the short term. The CDCM is currently being reviewed to assess the practical application for public health staff and how short-term improvements can be made.

A number of helpful comments and suggestions have been received on the content and format of the manual. These will be considered in the review that is currently taking place.

NOW is the time to provide any further **comments and suggestions** for improvements. If there are any significant suggestions concerning control practices, the Ministry will have these reviewed by external infectious disease physicians.

If you wish to discuss any aspects of the CDCM review, please contact Nicola Chapple, Analyst, Social Environment Team, Regulation Implementation Group (tel: (04) 496 2031, e-mail: nicola_chapple@moh.govt.nz).

Chiropractor Poser Prosecuted

Michael Dawson appeared in the North Shore District Court on 29 January 1999. He entered guilty pleas to 25 charges under the Chiropractors Act 1982, which were laid by the Ministry of Health.

After hearing that Dawson was not in the position to pay a fine, the Judge sentenced him to three months' periodic detention.

The charges arose as a result of Dawson taking over the practice of a registered chiropractor who had left New Zealand. In so doing Dawson held himself out as a registered chiropractor when not so registered.

There were 24 charges in relation to nine patients in Te Puke and Matamata to whom he provided treatment over the period 1 June to 31 July 1997 and one charge relating to a doctor at Te Puke who referred patients to him.

These charges are representative of the overall offending as it is estimated that he was dealing with as many as 60

patients during the period between 10 June 1997 and 5 August 1997.

Patients who had been referred by their doctors for ACC-subsidised chiropractic treatment continued to attend these clinics.

New patients were also referred for chiropractic treatment. One doctor in Te Puke estimates that he referred 20–30 patients during the period in question.

Non-doctor referred patients were also attracted to the practice through advertising that had been arranged by the previous chiropractor, prior to his departure.

At the clinic and over the phone, Dawson introduced himself to the patients and advised that he was either a locum or a therapist there to fill in while their usual chiropractor was overseas for a couple of weeks completing immigration paper work.

Dawson then gave the patients treatment which they believed to be consistent with chiropractic treatment.

The Ministry of Health treats this type of offending seriously. The principal purpose of registration is to protect the health and safety of members of the public by providing a mechanism to ensure chiropractors are competent to practise. Incorrect chiropractic practice can pose significant risk to the consumer, including paralysis or death from inappropriate spinal manipulation.

Proposal to Establish a New Zealand Food Safety Group

In New Zealand, and worldwide, the incidence of foodborne illness continues to increase. Recent estimates suggest there may be between 300,000 and 700,000 cases each year in New Zealand. Media coverage of serious foodborne illness outbreaks in developed nations, including the United States, Great Britain, Japan and Australia has damaged local and export-based food business, and eroded consumer confidence in the safety of their food supply.

To reduce the incidence of foodborne illness, we must employ a range of interventions covering all elements of the 'paddock to plate' continuum. Several countries have tackled the 'plate' end by developing education programmes to increase public awareness of food safety and promote safe food handling practices. In December 1998, a group of industry, health promotion and government agencies met in Auckland to consider the possibility of establishing a partnership to provide co-ordinated food safety education to the general public of New Zealand. A working objective was developed for this Food Safety Group:

'To co-ordinate the development and implementation of an education strategy for New Zealanders to reduce the incidence of foodborne illness'.

The following parameters were suggested for the group's activities:

- initial research and needs analysis
- establishing target audience(s)
- timing of activities
- appropriate use of mass media.

Following the main meeting, a smaller group convened to work on the structure of the Food Safety Group and to draft a proposal and action

plan for consideration by interested parties. A further meeting was planned for February 1999 to agree on the way forward.

Included in the draft proposal

were suggestions for the group framework and main objective, educational objectives and primary and secondary target audiences. The group would aim to raise awareness of foodborne illness risks in the home, to provide information to educate and empower consumers and to educate 'influencers' who could aid in disseminating messages. The proposal clearly defined the scope of the group's activities so as to avoid any perception that the group would 'take over' initiatives of other agencies or organisations.

Effective communication was highlighted as important, especially the development of an appropriate visual identity and logo for use on all printed material. Messages must be consistent, exciting and interesting, conveyed through a variety of media and networks, and constantly reinforce key food safety points. The ideal, as proposed in the draft, was a small number of core messages that are regularly and repeatedly communicated to consumers and which are designed to encourage them to change their attitudes and behaviour. Independent, credible spokespeople were seen as essential to the success of media campaigns. The proposal also emphasised the importance of a programme evaluation framework.

Before embarking on specific activities or media campaigns the group would:

- carry out research to establish benchmark levels of food safety knowledge and awareness
- develop key messages
- demonstrate the value of any campaign.

The group structure could look like this:

- the main food safety group consisting of all interested parties
- a steering committee of about eight members to drive and oversee implementation of agreed activities
- an independent, credible chairperson
- a director
- a secretariat to cover administration
- spokespeople with relevant knowledge, media training and independent of any particular food or brand (some spokespeople may come from outside the steering committee)
- a patron who is a well-known New Zealander with a high profile in the food area.

Feedback on the draft proposal was presented at the February meeting. Most participants emphasised the importance of recognising the many food safety promotion activities already in place. Staff of public health services, the Ministry of Health and other organisations have, for many years, produced and distributed resources and mounted campaigns to alert the public to the dangers of foodborne illness. The value of the Food Safety Group lies in its ability to harness and co-ordinate these efforts and combine them with industry

Public Health Legislation Review Update

initiatives to provide consistent and innovative messages.

The meeting agreed to set up a steering committee (eight to ten members) with an independent chair. Participants directed this committee to carry out a review of current programmes and resources used in New Zealand and overseas, assess consumer views, identify gaps and, based on this information, recommend a future structure and activities for the group. These tasks are to be completed by the end of April 1999. The group relies on contributions in cash or 'kind' from members to fund its activities.

Both the Ministry of Agriculture and Forestry and the Ministry of Health support the proposed Food Safety Group. The Health Funding Authority sent a representative to the February meeting, as did two public health services. With co-operation among these agencies and a wide variety of industry organisation, we can look forward to greater clarity and consistency in the New Zealand approach to promotion of safe food practices.

The public health legislation review is progressing according to plan. Government policy determinations were made in December 1998, in light of public consultation held earlier that year. The Ministry of Health has been active during January/February 1999 in preparing drafting instructions for a Public Health Bill. Precisely when the Bill will appear for public scrutiny depends on the priority it receives on the legislative programme and other demands on Parliamentary Counsel time.

Publication of the summary analysis of submissions on the discussion document *Public Health Legislation Review: A new public health legislative framework* has been delayed by the diversion of key staff members to deal with emergent issues (eg, exotic mosquitoes in Napier). However, working drafts will be refined and made available as soon as practicable.

Plans for a number of important related projects are nearing completion with a view to them being undertaken during the 1999/2000 financial year. Many will include working groups and further opportunities for consultation. These projects include development of preferred approaches for:

- the risk management methodology (including sections on cost-benefit analysis and taking into account the need for caution where there is scientific uncertainty)
- Māori issues related to a public health risk management framework
- competencies, training accreditation and appointment of public health officers and approved auditors
- a public health service delivery infrastructure under the new legislation.

Introducing

Dr Anthony Duncan

Dr Anthony Duncan recently joined the Ministry of Health as Deputy Director of Mental Health. Having worked in hospitals for the last 11 years, he said the idea of working in an open plan area threw him at first, but he's getting used to the idea.

Anthony is a psychiatrist and member of the Royal Australian and New Zealand College of Psychiatrists. He completed his postgraduate training in psychiatry in Dunedin, qualifying in 1987, and then worked at Concord Hospital in Sydney.



Returning to Wellington in 1995, he worked as a psychogeriatrician first for Capital Coast Health and then for Hutt Valley Health.

'My role has two main components, the regulatory side, including the smooth running of the Mental Health Act and various project work, including development of the Ministry's policy blueprint for mental health services for the elderly.'

Anthony is pleased to be involved in a team environment and working towards co-ordinated development of comprehensive consumer and community focused mental health services. When working in an area as complex as mental health where there are a number of variables, team work is essential, he says.

Combatting Antibiotic Resistance – A Co-ordinated Effort Needed

By Dr Bob Boyd

Antibiotics are vital for the treatment of severe bacterial infections in both humans and animals. They have also become increasingly used in the agriculture sector for enhancing sustainable livestock production through use as growth promotants and for prevention of bacterial diseases in animal herds. Administration has been by routine supplementation of animal feed.

Until recently the problem of antibiotic resistance has been mainly perceived as a medical problem which was capable of being overcome by newer products arising from the pharmaceutical industry.

Several incidents have heightened public concern and caused regulatory agencies to rethink current policies about identifying and managing the risks.

Antibiotic resistance isn't a new problem. Resistant strains began emerging soon after the introduction of penicillin over 50 years ago, but the trend is accelerating at an alarming rate. For example, ESR reports that the proportion of *E Coli* isolated from urinary infections which are resistant to Amoxicillin/Clavulonate rose from 6.7 percent to 11.4 percent between 1991 and 1997. In the same period non-urinary *E Coli* resistance leapt from the same 6.7 percent to 21.6 percent.

An excellent summary of the international concerns can be found in the *British Medical Journal* edition which was wholly devoted to antibiotic resistance six months ago (*BMJ* 1998, 317: 609–74).

Recent Issues about Resistance

Within the last year, four cases of vancomycin-resistant staphylococci have been reported in Japan and the USA, the latest case being fatal despite administration of a combination triple-antibiotic therapy which had cleared the other three infections.

On 14 December 1998 the European Commission voted to ban the addition of four anti-microbial agents to animal feeds as a growth promotant. These are zinc bacitracin, spiramycin, virginiamycin and tylosine

phosphate, the first two are used or have been used in human medicine in New Zealand.

The World Health Organization published a review on the hazards of antibiotic use in animals in 1998 which called for a reduction in the use of antibiotics as growth promotants.

New Zealand general practitioners in several independent practice associations around the country used the media last winter to publicise their intentions to limit the use of antibiotics for winter respiratory infections.

In Australia a Joint Expert Technical Advisory Committee on Antibiotic Resistance (JETACAR) is soon to report to the Australian Health Ministers Advisory Council, on which the New Zealand Ministry is represented.

Between them, the Ministries of Health and of Agriculture and Forestry have established three working groups to examine and make recommendations on different facets of antibiotic resistance.

There is a degree of common membership between the groups to ensure consistency. Their recommendations will form an important part of future risk management.

The Antimicrobial Resistance Working Party, convened under the chairmanship of Rod Ellis-Pegler, has already met once and made several recommendations to the Ministry of Health.

The working party has recommended:

- improved surveillance of human pathogens in New Zealand, to act as a barometer for picking up antibiotic resistance



*Dr Bob Boyd
Chief Advisor, Safety and Regulation*

Progress on New Public Health Legislation

- improved surveillance of antibiotic prescribing, including data on antibiotic use not just cost
- co-ordinated monitoring of human and animal pathogens to look for possible paths of developing resistance
- increased public and professional awareness of antibiotic resistance
- better communication between GPs and patients about expectations of receiving an antibiotic backed up by clear best-practice guidelines when antibiotics are a treatment option
- the regulatory agencies should investigate the permitted level of access by the public and farmers to antibiotics and should investigate the registration criteria for antibiotics to be used in human, veterinary and agricultural use.

A second group has been convened by the Ministry of Agriculture and Forestry to advise on the issues surrounding in-feed antibiotics for enhancement of animal production (which includes both growth promotion and routine prophylactic use).

The Ministry of Health has requested ESR to convene a meeting of experts to advise on the risks related to antibiotic residues in food, with particular reference to the setting of maximum residue levels (MRLs) of antibiotic in meats for human consumption.

There will obviously be a considerable amount of work for those involved in communicable disease control, medicine regulation, agricultural compound registration and food administration, the health funder and personal health services providers arising from the recommendations of these three groups.

A number of policy changes approved by Cabinet during 1998 are nearing introduction.

Three new Bills which will promote different aspects of public health are currently being considered by Select Committee.

The Health and Disability Services (Safety) Bill reforms the present arrangements for the regulation of health sector providers (primarily hospitals and residential care providers) which currently are required to be registered. The Bill is expected to come into effect in the middle of the year and will require that providers of these services adopt standards of care. A six-month transitional period will follow the introduction of the new legislation.

The Health and Disability Sector Standards have been developed by Standards New Zealand in consultation with the health sector. The public consultation meetings on the Standards, held throughout the country during January and February, were very well attended in all centres.

The Medicines Amendment Bill is also currently before Select Committee. This Bill provides an opportunity to extend prescribing rights to nurses and to other registered health professionals such as optometrists and physiotherapists.

Finally, public consultation on the Mental Health Amendment Bill has closed and submissions are now being assessed. Key changes include additional powers for compulsory

assignment and treatment of patients, the need to consult with families as part of the assessment and treatment process, and clarification of the powers of officials to use force when taking or returning a patient to hospital. The Ministry of Health will report back to the Select Committee by the end of March 1999, taking the analysis of submissions into account.

A number of other pieces of legislation have either been introduced into the House, or are nearing this stage.

The Food Amendment Bill transfers most of the food administration functions of the Ministry of Health to the Ministry of Agriculture and Forestry to assist in the establishment of a food regulatory agency within MAF. Read the article on page 2 for more details on this!

The Healthcare and Therapeutic Products Bill will replace the current Medicines Act 1981 with legislation regulating medicines, medical devices and dietary supplements.

Finally is the new Public Health Bill. This Bill represents a major milestone in improving, protecting and promoting the public health in New Zealand by replacing the previous 'cornerstone' of public health, the Health Act 1956, and also the Tuberculosis Act 1948. Intended for introduction into the House by September 1999, the new Public Health Bill will provide a modern, risk-based regulatory framework for public health (see page 9).

Food Irradiation

Food irradiation is a tool that can be used to significantly reduce or eliminate harmful bacteria, including ***Campylobacter*** and ***Salmonella*** in certain foods. For example spices such as dried paprika and pepper (of which New Zealand imported 87 tonnes in 1997) can carry the bacteria that cause salmonellosis if left untreated. New Zealand is experiencing unprecedented levels of foodborne illness (1998: 11,503 cases of ***Campylobacter***; 2069 of ***Salmonella***; in 1997 there were 8848 ***Campylobacter***; 1169 ***Salmonella***).

New Zealand may have food irradiation as a new tool to help control foodborne illness. On 27 January 1999 the Australia New Zealand Food Authority (ANZFA) released a draft standard on food irradiation for consultation in New Zealand. Submissions close on 26 March 1999.

Copies of the consultation document (which is accompanied by a factsheet prepared by the Ministry of Health and the Ministry of Agriculture and Forestry) can be obtained from:

Information Officer
Australia New Zealand Food Authority
PO Box 10559
WELLINGTON

Ph: 04 473 9942
Fax: 04 473 9855
Web site: <http://www.anzfa.govt.nz>

Since 1989 the Government has had a policy to not permit irradiated food to be sold in New Zealand except in exceptional circumstances on a case-by-case basis. The Government has agreed that the New Zealand policy on food irradiation be reviewed. The development of a standard on food irradiation by ANZFA is the process for providing advice to the Government on a new policy.

Worldwide, at least 40 countries permit the irradiation of food and it is accepted by three international agencies (World Health Organization, the Food and Agricultural Organisation and the International Atomic Energy Agency) as a safe treatment for food. Based on overseas experience it is not expected that there will be a significant number of foods which will be irradiated. They would most likely be some spices (to control foodborne illness) and some tropical fruits and vegetables (to control pests).

Benefits of Food Irradiation

Food irradiation will add to the range of tools available to help control foodborne illness. To rid high-risk foods of harmful bacteria, some form of treatment is required.

Based on overseas experience, food irradiation is considered as particularly suitable for the treatment of some spices. The only other acceptable method of treating spices, such as paprika, is the use of ethylene oxide gas (ETO), which can leave undesirable chemical residues in food. The temporary permission to use ETO in New Zealand will expire on 21 April 1999. The Ministry of Health is currently evaluating the

health risk from ETO use in spices.

Food irradiation is also a viable method for reducing the risk of importing exotic insect pests, such as fruit fly, on certain imported foods. The most widely used fumigant, methyl bromide, is being phased out as it is an ozone-depleting gas.

Draft ANZFA Standard on Food Irradiation

The proposed standard would permit entry into New Zealand and Australia of foods treated with irradiation only after they have undergone a scientific, case-by-case safety assessment by ANZFA, which includes public consultation. The standard proposes that all irradiated food be clearly labelled.

The Ministry of Health and the Ministry of Agriculture and Forestry have published a factsheet to accompany the release of the ANZFA consultation document. It is available on the Ministry of Health's Web site: www.moh.govt.nz

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