

EDITORIAL

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Funding Mechanisms for Public Health

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May is Budget month, which leads us to think of funding for public health. The health system is shaped by the way the funds to maintain the system are collected, allocated and distributed (Vienonen and Wlodarczyk 1993). In 1996/97 the estimated share of public funding was 77.3 percent. New Zealand's total health expenditure as a percentage of GDP was 7.8 percent. Public health's share of Vote: Health was 1.8 percent (Ministry of Health 1998).

Holland and Stewart (1998) have stressed the importance of public health practitioners influencing funding if the public health is to be improved:

'They have to be able to influence the budget for public health activities in order that the longer term issues are not omitted in favour of the clamant short-term demands. This is crucial as public health resource needs are always in competition with the needs of clinical services. The latter nearly always take precedence – treatment of individual patients seems far more immediate a priority than changes in health status for the future.'

That has been the experience in New Zealand. If we look back at area health boards, in 1991 dollars, a total of \$107.6 million per annum was transferred into the area health board allocation by 1989. This transfer was mainly for the devolution of district office functions to

area health boards which occurred between 1985 and 1989 (funding for one psychiatric secure unit was included in this transfer but it has not been possible to identify the specific amount). The monies were not tagged or designated for any express purpose. Boards were under no obligation to continue to spend that money in part or in full on public health services. By the 1990/91 financial year, expenditure on health promotion and health protection by area health boards was \$66.7 million (GST exclusive) and this reduced to \$57.2 million (GST exclusive) in 1991/92.

Definitions for the two service categories (health promotion and health protection) for area health boards were not changed between 1990/91 and 1991/92, and the reduction in reported expenditure was considered to represent a true reduction in expenditure. At that time, there were 11 national service categories, and only the intellectual handicap service experienced a comparable percentage fall in reported expenditure (NIPB 1992).

With the establishment of the Public Health Commission (PHC), funding for public health functions was unbundled from Vote: Health (NIPB 1992). The public health ring fence was established because of the problems described above and also because under previous arrangements, there had been a reluctance to spend money on less visible activities such as public health, and on activities where the benefits occur in the medium to long term.

Hazardous Substances and New Organisms Update

The Hazardous Substances and New Organisms (HSNO) Act 1996 aims to make New Zealand a safer and healthier place by maximising positive and minimising any negative effects of new organisms and hazardous substances on human health and the environment. The new organisms parts of the Act came into force last year, while the hazardous substances provisions are expected to be brought in later this year.

While HSNO is administered by the Ministry for the Environment, the Environmental Risk Management Authority (ERMA) is charged with assessing applications to approve new organisms and hazardous substances for import into or manufacture in this country.

Depending on how hazardous the substance or organism is, ERMA may place controls on the labelling, storage, transport, use and disposal in the interests of the safety and health of the community and the environment.

The Ministry of Health is one of a number of agencies, including Police, Occupational Health and Safety, Civil Aviation Authority and territorial local authorities, involved in the implementation and enforcement of HSNO.

At present, the Ministry is organising training for designated officers already working in the area of toxic substances, who will become a key part of the enforcement of HSNO alongside staff from other enforcement agencies. The Ministry is also working closely with ERMA,

Ministry for the Environment and other related agencies to ensure that health issues around the implementation and enforcement of HSNO are addressed.

Although the implementation of the hazardous substances part of HSNO is now behind the original timeframe, this legislation is a world first. It draws together environmental and health concerns making the controls on every aspect of the manufacture, use and disposal of hazardous substances and new organisms as comprehensive as possible.

You can find out more about HSNO at the Environmental Risk Management Authority's Web site: www.ermanz.govt.nz, or contact ERMA's communications staff:

Telephone: (04) 473 8426

Fax: (04) 473 8433

email: enquiries@ermanz.govt.nz

Postal address: PO Box 131, Wellington.

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The ring fence has been retained through the various institutional changes, but growth in public health funding may have been disadvantaged under the PHC which was excluded from central government processes. The average percentage annual growth of the public health ring fence for the two years the PHC could influence the Budget from outside the Government was 4 percent compared with 11 percent average annual growth for the Vote. This increased to an average 10 percent annual growth of the public health ring fence in the first four years that the Public Health Group (inside Government) was able to influence the Budget, which is in excess of the 6 percent average

annual growth for the rest of the Vote in the same time period.

Ring fencing is not the perfect solution because there is the risk of seepage out of the ring fence within providers whose funding comes from more than one ring fence. In addition, Māori have a commitment to personal and public health and have in the past experienced difficulty getting purchasers to recognise this, even when within the same organisation (PHC 1995).

Overall, ring fencing together with public health policy advice closely influencing the budgetary process, have been positive for public health.

World Smokefree Day

Each year, tobacco causes 3.5 million deaths worldwide – roughly equal to New Zealand's population. The aim of World Smokefree Day on 31 May was to highlight the terrible health effects of tobacco use, and to encourage smokers to quit.

In New Zealand, World Smokefree Day was promoted around the country by health workers, and by organisations such as the Cancer Society of New Zealand, Health Funding Authority, Te Hotu Manawa Māori, and the Health Sponsorship Council.

A national poster competition – open to standard three to form two children – was a focus this year. Entrants were asked to design a poster with the theme *Quit Smoking – Auahi Kore*.

The winning English language poster was designed by 10-year-old Casey Ferrier of Seatoun School, Wellington, while the winning Māori language



World Smokefree Day competition winners, Charley Eketane and Casey Ferrier. Casey is holding a t-shirt featuring his winning design.

poster was by 11-year-old Charley Eketone of Brandon Intermediate in Porirua.

The winning artwork appeared on the official 1999 World Smokefree Day

posters and t-shirts. The imagery will also be used on some smokefree resources produced for schools.

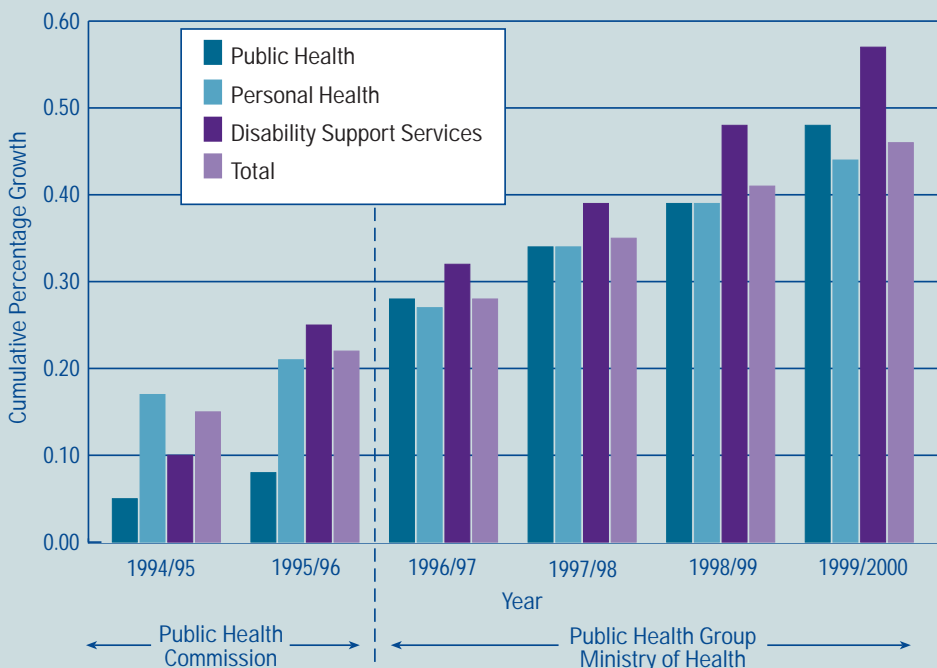
Encouraging houses and clubs to become smokefree was another focus for the day, with health promoters challenging these venues to 'get into the 90s' and become smokefree.

There was also widespread promotion of the Health Funding Authority's new national Quitline – 0800 778 778.

The Quitline was recently launched by Prime Minister Jenny Shipley, and is available all New Zealanders who are ready to quit smoking.

**For further information please contact Liz Price.
Email: liz-price@moh.govt.nz**

Vote Health Growth Comparison



References

Holland WW, Stewart S. 1998. Public health: where should we be in 10 years? *J Epidemiol Community Health* 52: 278–9.

Ministry of Health. 1998. *Health Expenditure Trends in New Zealand 1980–97*. Wellington: Ministry of Health.

NIPB. 1992. *Public Health Resource Identification Project: Volume 1, The Overview Report*. Wellington: National Interim Provider Board.

PHC. 1995. *1995/96 Purchase and Linkage Plan*. Wellington: Public Health Commission.

Vienonen M A, Włodarczyk W C. 1993. Health care reforms on the European scene: evolution, revolution and seesaw? *Wld Hlth Statist Quart* 46 166–9.

New Zealand Youth Suicide Prevention Strategy



Ministerial Committee formed to progress Strategy

To ensure that progress on the implementation of the New Zealand Youth Suicide Prevention Strategy is maintained and initiatives are well co-ordinated, the Minister of Health, Hon Wyatt Creech, recently established a Ministerial Committee for Youth Suicide Prevention.

The multisectoral nature of the Strategy is demonstrated by the make up of the group which includes the Ministers of Health (Chair), Education, Social Services Work and Income, Corrections and Police, Youth Affairs, Māori Affairs, and Internal Affairs.

This committee is, in turn, supported by an Inter-Agency Committee on Youth Suicide Prevention which has officials from the above Ministries and departments and also includes the Health Funding Authority, the Crime Prevention Unit, and the Ministries of Women's, and Pacific Island Affairs.

The Ministerial Committee is similar in make up to that set up for the National Drug Policy. Like the National Drug Policy, suicide prevention requires action from a range of government departments, service providers and communities so it is important that all the programmes are well co-ordinated.

Guidelines

In May, the Ministerial Committee agreed to a government priority work programme for the New Zealand Youth Suicide Prevention Strategy for the next year. Much of the focus of the work programme will be about consolidating recent initiatives, identifying areas not addressed, and disseminating best practice.

A strong focus will be on ensuring that all those who come into contact with vulnerable young people are equipped with the skills and knowledge to identify and respond appropriately should they be at risk of suicide. Guidelines are a key mechanism to enable this to happen and are effective tools to ensure that there is a consistent approach throughout the country.

A number of guidelines and resources have been produced or are still in development for:

- **communities and social service agencies** – (completed) Mental Health Foundation

- **emergency departments** – (in development) Australasian College of Emergency Medicine and Royal Australian and New Zealand College of Psychiatrists
- **primary health care providers** – (in development) Royal New Zealand College of General Practitioners; Ministry of Youth Affairs; HFA
- **Corrections prison officers** – (in development) Department of Corrections
- **Children's Young Persons and their Families Agency** – (in development) CYPFA
- **Media on the reporting and portrayal of suicide** – (being revised) Ministry of Health
- **Schools and school guidance counsellors** – (complete) Ministry of Education
- **Maori communities** – (in development) Te Puni Kokiri and Ministry of Health
- **mental health services** – (1993 guidelines being revised) Ministry of Health
- **schools and communities on traumatic incident planning** – (in development) Ministry of Education, Specialist Education Services and Department of Internal Affairs
- **Police and police youth aid workers on custodial practice** – (being revised) Police.

Obviously guidelines and training on suicide prevention are not all that is required. There are many other initiatives being progressed under the Strategy which do not involve guidelines. Guidelines do, however, provide the foundation for ensuring that as many key people as possible have a sound understanding of how to identify and respond appropriately to young people in distress.

Other key initiatives also being progressed in the next year include information for the community, options for restricting access to means of suicide, pamphlets for Māori parents, improvements in the recording of ethnicity data, and initiatives to build resiliency in Māori youth.

If you would like further information about the New Zealand Youth Suicide Prevention Strategy, or any of the initiatives described above, please contact Maria Cotter or Grant McLean at the Ministry of Health, Tel: (04) 496-2327.

National Drug Policy – Progress Report

In July 1998 the Government released the National Drug Policy (Ministry of Health 1998). It will run for five years (1998 – 2003) and sets out priority steps that can be taken to prevent and reduce drug-related harm in New Zealand. The Policy's goal is, as far as possible within existing resources, to minimise the harm to individuals and the community caused by tobacco, alcohol, illicit and other drug use.

The following national priorities for action have been selected for the first five years of Part 2 of the National Drug Policy:

Priority one: To enable New Zealanders to increase control over and improve their health by limiting the harms and hazards of drug use.

Priority two: To reduce the prevalence of cannabis use and use of other illicit drugs.

Priority three: To reduce the health risks, crime and social disruption associated with the use of illicit drugs and other drugs which are used inappropriately.

The Ministerial Committee on Drug Policy (MCDP) established under the National Drug Policy first met in August 1998 and identified two areas of immediate concern that Ministers wish 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 areas of concern.

The work programmes were released on 8 March 1999. Copies are available from the IACD Secretariat based at the Ministry of Health.

The work programmes outline initiatives that have been, or are being, implemented in five areas: information, research and evaluation; health promotion; treatment services; law enforcement; and policy development.

Information, research and evaluation

- In consultation with community groups developing a priority list of research topics, particularly with respect to cannabis use in the Far North and the East Coast, for sharing with research funders and providers.
- Establishing databases of service providers, resources and data for use by drug and alcohol workers (as a means of improving co-ordination and collaboration).
- Developing a framework for monitoring progress under the National Drug Policy.

- Intelligence gathering by Police and Customs with respect to illicit drugs.

Health promotion

- Developing guidelines for safe dance parties: for operators of dance parties, raves and nightclubs.
- Improving linkages with other intersectoral strategies such as the Youth Suicide Prevention Strategy and Strengthening Families.
- A review of drug education programmes in schools.
- Developing evidence-based guidelines on drug education.

Treatment

- A gap definition exercise: determining where there are gaps in current treatment services.

Enforcement

- Continuing Police and Customs efforts to reduce the supply of illicit drugs.
- Police Drug Strategy.
- Reducing inappropriate prescribing of controlled drugs.

Policy and legislative development

- Reviewing the classification of controlled substances, with a view to reclassifying Ecstasy as a Class A drug.
- Issuing a gazette notice to ban the importation and sale of cannabis pipes and bongs (*see article on page 8*).
- Reviewing the Alcoholism and Drug Addiction Act.

The IACD will be reporting back to the MCDP in mid-June on progress with implementing the National Drug Policy work programme.

References

Ministry of Health. 1998. *National Drug Policy Part 1: Tobacco and Alcohol. Part 2: Illicit and Other Drugs. A National Drug Policy for New Zealand 1998–2003*. Wellington: Ministry of Health.

Queries regarding the National Drug Policy or the work programme on cannabis and hard drugs should be made to the IACD Secretariat at the Ministry of Health:

Matthew Allen (04) 496 2192 or
email: matthew_allen@moh.govt.nz

Paul Marriott Lloyd (04) 496 2095 or
email: pmarriott@moh.govt.nz

Facsimile: (04) 496 2340

Cigars – Beyond the Smokescreen

Few people could fail to be aware of the recent media interest in the Ministry's approaches to several magazines it believed were promoting cigars. As can happen in these situations, some of the facts got lost in the media storm.

Contrary to some media reports, the Ministry did not require the burning or destruction of any magazines; the magazine distributors chose to do this themselves (in some cases after seeking their own legal advice). Nor did the Ministry 'seize' any material.

Last year, the Ministry wrote to a number of media outlining the advertising restrictions of the Smoke-free Environments Act 1990 (the Act) with regard to cigars. The only response to this low-key, educative approach was a continued burgeoning of cigar promotion.

Over the last eight months, the Ministry has approached (often as a result of complaints) several publications it believed were breaching the advertising restrictions of the Act.

The Ministry's actions were prompted by a desire to correct a public impression that cigar smoking isn't harmful, and an increase in the promotion of cigars in apparent breach of the legislation. A recent article in *Retail Today* states that cigar sales in New Zealand increased 9.2 percent in dollar terms in 1998. It goes on to say:

'Magazines like *Cigar Aficionado*, which features cover pictures of celebrities chewing on large cigars, have boosted the image of the cigar industry . . . The spate of cigar magazines now hitting bookstands is credited with the revival in cigar sales in the US.'

A study on cigar and pipe smoking states that, in recent years, cigar consumption has risen in the United States with cigar smoking becoming particularly popular with teenagers (Boffetta et al 1998).

The Ministry balances freedom of expression and speech issues alongside the need to enforce the law when it is breached. The law helps prevent the promotion of tobacco products which, when used as the manufacturer intends, kill half their consumers an average 14 years early, and harms non-smokers through exposure to environmental tobacco smoke.

Many media comments on this issue have centred on the freedoms inherent in the Bill of Rights Act 1990. The

Ministry notes that section 4 of the Bill of Rights Act contemplates that there will, from time to time, be legislation which is not consistent with the Act.

When the Smoke-free Environments Bill was considered by Parliament in 1989/1990, the significant health effects of smoking and the need to discourage its promotion were considered to override the right to advertise and promote tobacco products (Toxic Substances Board 1989). A similar stance is taken in relation to other issues such as the display of child pornography or the promotion of violent activity or racial hate material. In these cases Bill of Rights issues are considered secondary to protecting the population from harm.

The Ministry of Health has a statutory obligation to administer legislation for which it is responsible, and to investigate clear breaches of this legislation. Failure to carry out this duty can result in judicial review. The risk of review is of particular significance in legislation like the Smoke-free Environments Act 1990 where the ordinary citizen is unable to initiate prosecution action. The appropriate officer (Director-General of Health) charged with that obligation is at least obliged to consider prosecution action. *Gallen J. 1989.*

Section 22 of the Act prohibits the publication of any tobacco product advertisement in New Zealand. Tobacco product advertisement is defined as:

'any words, whether written, printed, or spoken, including on film, video recording, or other medium, broadcast or telecast, and any pictorial representation, design, or device, used to encourage the use or notify the availability or promote the sale of any tobacco product or to promote smoking behaviour . . .'

Books, magazines or newspapers printed outside New Zealand are exempted, unless their principal purpose is the promotion of tobacco products.

References

Boffetta P, Jockel K-H, Forastiere F et al. 1999. Cigar and Pipe Smoking and Lung Cancer Risk: a multicentre study from Europe. *Journal of the National Cancer Institute of Europe*. 91: 8 614-9.

Gallen J. 1989. *Hallett v. Attorney General*. 2 NZLR 87-105.

Toxic Substances Board. 1989. *Health or Tobacco: An end to tobacco advertising and promotion*. Wellington: Toxic Substances Board.

For further information please contact Liz Price at the Ministry of Health.
Email: liz-price@moh.govt.nz

Biosecurity

The Development of a National Pest Management Strategy

Biosecurity is a topical issue. The recent infestation of southern saltmarsh mosquitoes in Napier certainly caught the media's attention. The series of interceptions of other exotic species, the gypsy or tussock moths, which forced the Ministry of Agriculture and Forestry (MAF) to conduct a series of containment and eradication operations around the country, has sustained this awareness. The health sector is conducting its own eradication programme in Napier in an attempt to eradicate the southern saltmarsh mosquito infestation that was discovered there in December 1998.

The recent conviction and imprisonment of two individuals under the provisions of the Biosecurity Act 1993 for importing bee pollen has demonstrated the seriousness that the courts are viewing infringements of the Act, and underlines the seriousness of the threat of exotic pests becoming established in New Zealand.

The Ministry of Health is in the process of developing a National Pest Management Strategy (NPMS) for the control of exotic mosquitoes of public health significance. A project team whose members are Sally Gilbert, Paul Baigent, Andrew Forsyth and John Gardner has been formed. Consultation is ongoing with the various stakeholders, for example, Ministry of Agriculture and Forestry, Ministry of Fisheries, Department of Conservation, Health Funding Authority (HFA), public health services and local government. It is anticipated the draft discussion document will be completed by 30 June 1999 and delivered to the Minister of Biosecurity on that date.

Following Government's agreement that the discussion paper may be

released, it is expected that it will be released for a two-month consultation period. Following the analysis of submissions the NPMS will be finalised and will undergo the statutory processes for notification. This is expected to take at least a further year, and following notification an operational plan must be prepared to give effect to the strategy.

As well as the strategy paper there is to be a review of the contingency plans of all the public health services with the intention that a generic framework be developed. This measure will ensure that a common operational standard will be followed nationwide when surveillance and response activities occur. An assessment of the training requirements needed to prepare staff for their roles once the NPMS is adopted is also in hand.

Changing economic, social and climatic conditions have been the factors that have made exotic organisms a much more serious threat to New Zealand. The Biosecurity Act reflects the Government's concern for the potential hazards that exotic pests

pose to indigenous fauna and flora, to our agricultural industry, or to the health of the public.

The threat to the nation's economy if agricultural pests are allowed to enter New Zealand is well known. Less appreciated are the dangers to public health that exotic insect vectors could pose to New Zealand. The Ministry of Health has identified that one major risk to public health is the threat of exotic mosquitoes becoming established in New Zealand. If a suitable disease vector does gain a foothold, these insects can transmit viruses or other parasites from infected hosts to susceptible people.

The NPMS will enable the Ministry of Health to implement a sustainable programme for the exclusion, eradication and management of exotic mosquitoes of public health significance.

For further information please contact John Gardner at the Ministry of Health.
e-mail: john_gardner@moh.govt.nz

Banning Drug Paraphernalia

As one of the initiatives agreed to by Ministers, the National Drug Policy work programme includes the issuing, by the Minister of Health, of a gazette notice under section 22(1A) of the Misuse of Drugs Act 1975 (as amended 1997), to ban the importation and sale of certain drug paraphernalia. The work programme, released in March 1999, states:

'The visibility and availability of paraphernalia, in particular pipes and bongs, which are designed specifically to be used in illicit drug-taking activity, have the potential to send conflicting messages to young people about the appropriateness or safety of drug taking.'

The work programme also acknowledges that there is difficulty in defining drug paraphernalia because many innocuous or 'everyday' items can be adapted to facilitate the use of illicit drugs. Therefore:

'... the Gazette Notice will be confined to items which only have an illicit drug-taking purpose. The notice will concentrate on certain classes of pipes and "bongs" allowing the Government to prohibit the importation and sale of the most visible and blatant forms of drug paraphernalia.'

The draft gazette notice was prepared by the Ministry of Health in discussion with the Ministry of Justice, the Parliamentary Counsel Office, Customs and the Police. On 8 and 15 May 1999 public notices were placed in newspapers in the main centres advising the public of the proposal and seeking feedback, particularly on the scope of the notice and a transition time for importers and retailers, by 6 June 1999.

It is proposed to brief the Ministerial Committee on Drug Policy on the outcome of consultation in mid-June.

International Narcotic Drugs Meeting

Matthew Allen of the Ministry of Health has just returned from a trip to Vienna where he represented New Zealand at the 42nd Session of the United Nations Commission on Narcotic Drugs in March. Also attending for New Zealand were Michael Webb, formerly of the Ministry, and Merv Smith, a New Zealand Customs officer based in Brussels.



Matthew Allen

Matthew said that the meeting was extremely worthwhile. In particular, the increased commitment on the part of the United Nations Drug Control Programme to demand reduction initiatives (for example, drug education, treatment services) was well received by many countries and supported by New Zealand.

In the past there has been considerable emphasis on law enforcement but with the 1998 UN Declaration on the Guiding Principles of Drug Demand Reduction, most countries now believe that demand reduction is as important as Police and Customs efforts to reduce the supply of drugs.

The meeting is held each year. Next year is a reporting year meaning that countries will be required to formally report on progress in reducing drug-related harm.

Matthew said that this year New Zealand circulated a report to all delegations on New Zealand's efforts to date in reducing the supply of, and demand for, illicit drugs. This was well received. The release of the National Drug Policy (June 1998) and more recently the Government's work programme to reduce the harm caused by cannabis and other illicit drugs (see related article on page 5), puts New Zealand in a very good position to be able to report real progress in 1999.

Nurse Prescribing

Update



In December 1998 the Ministry of Health released a consultation document entitled *Nurse Prescribing in Aged Care and Child Family Health* (Ministry of Health 1998) to the health sector. The consultation document sought the health sector's comments on a proposed regulatory framework for introducing nurse prescribing in aged care and child family health, and further scopes of practice in the future.

The document also sought comment on the conclusions of two expert working groups which were established to:

- define the parameters of the aged care and child family health scopes of practice
- compile a list, for each scope of practice, of the generic classes of medicines which it may be appropriate for nurses with the appropriate education and training to prescribe. This was further expanded to include the diagnostic tests which it would be necessary for nurses prescribing in aged care and child family health to access in order to make a clinical assessment and a prescribing decision.

The closing date for submissions was 26 February 1999, although an extension was given for many respondents. One hundred and fifteen submissions were received on the consultation document. Approximately 50 submissions were received from nurses or nursing organisations, and 15 from medical practitioners or medical organisations.

The key themes raised included:

- general support by the majority of respondents for the proposed regulatory framework
- the need to implement the nurse prescribing proposals in tandem with changes to the Nurses Act 1977 to empower the Nursing Council to review the ongoing competence of nurse prescribers
- the need for medical practitioners and nurses to work collaboratively, otherwise there could be a risk that patient care could become fragmented
- support by nurses for nurse prescribing education to be set at advanced pre-entry post-graduate level
- concern that having an additional prescriber in the health sector may increase antibiotic resistance
- the need for a pilot to be established and evaluated prior to implementing nurse prescribing nationally.

These issues are being followed up by the Ministry of Health. In particular:

- the Ministry is seeking legal advice as to whether regulations made under the Medicines Act 1981 could provide for the Nursing Council to review the ongoing competence of nurse prescribers
- the New Zealand Nurses Organisation has volunteered to facilitate a meeting with key nursing and medical organisations to further discuss issues regarding collaboration between nurse prescribers and medical practitioners
- the Ministry has sought suggestions from nursing and medical organisations regarding the sorts of issues that should be covered in a post-implementation review of nurse prescribing in aged care and child family health
- the Ministry is meeting with members of the Antimicrobial Resistance Working Group to discuss concerns that antibiotic resistance may increase by having an extra prescriber in the health sector.

The Nursing Council has almost completed its work on developing the competencies needed by nurses to safely prescribe. As a result of the analysis of submissions on the consultation document by the Ministry of Health and the expert working groups, the Ministry has written to the Nursing Council asking the Council to:

- establish a multidisciplinary team to scrutinise the proposed education programmes for nurse prescribers. The multidisciplinary team should include a medical practitioner, a pharmacist, and practising clinicians from the relevant scopes of practice
- ensure that the education programmes include the use of diagnostic tests, vaccinations, and antibiotic resistance.

The Ministry of Health, Treasury, Health Funding Authority (HFA) and PHARMAC are continuing work on funding issues for nurse prescribing.

The Ministry will be providing final policy advice to the Minister of Health on extending prescribing rights to nurses in aged care and child family health, at the end of June 1999.

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Eradicating the Southern Saltmarsh Mosquito

In the previous issue of *Public Health Perspectives*, an article described how the health sector is battling to rid New Zealand of the southern saltmarsh mosquito (*Aedes camptorhynchus*). At that time, containment was under way as the first phase of attempted eradication.

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.

Government agrees to eradication

On 26 April 1999, the Government agreed to proceed with phase two of the response to the southern saltmarsh mosquito. The eradication programme is based on use of s-methoprene for 13 months in the mosquito habitats in the Hawke's Bay, followed by a 24-month surveillance programme to confirm success, and supported by national surveillance.

The eradication plan

The eradication plan involves the initial application of appropriate s-methoprene products over the known habitat (approximately 650 hectares) including areas currently dry or with falling water levels.

Repeated blanket applications of s-methoprene over the known habitat is undertaken 21 days later, or when the level of s-methoprene falls below

20 times the concentration that is known to kill the mosquitoes. S-methoprene residues will be maintained for 13 months.

Although the eradication plan allows for s-methoprene applications over the whole habitat, applications may only be required over restricted areas of the habitat because of limited water events (perhaps only around 150 hectares).

Bti will be used for spot treatment on detection of untreated breeding areas.

Ongoing monitoring of larvae and adults will continue as it is important that the pre-eradication surveillance is adequate, and to be confident that the infestation is limited to the known habitat of around 650 hectares surrounding Napier.

Ongoing environmental monitoring of other species in the area will show that the eradication programme is meeting the requirements of the resource consent, provide data for the application for full registration of s-methoprene, and be useful for informing environmental and community groups about any environmental impacts from using the control agent.

Defining eradication

Defining the zero population level (ie 'probable' eradication) is crucial as it won't be acceptable to apply s-methoprene continuously after the mosquito has been eradicated. The

zero point may be set at the equivalent of a December 1998 inundation level which shows no evidence of egg hatching or no larvae or adults or eggs after three water events and one generation, or two years, whichever is the longer.

After numbers of larvae and adults drop to zero, monitoring and surveillance will continue. Adult trapping will continue for at least six months to increase the detection capacity for 'strays' but thereafter trapping would be instituted after inundation events only.

Eradication will be confirmed after two years of surveillance with no evidence of eggs, larvae and adults. This is the World Health Organization's definition of eradication.

Reassessment rules

The technical advisory group advising the Ministry on the response to the mosquito has reviewed the eradication plan and believes that eradication is technically feasible. However, the technical advisory group has advised that should any of the following occur, the eradication plan would need to be immediately reviewed:

- the southern saltmarsh mosquito is found at another site in New Zealand
- the mosquito spreads beyond the known habitats in the Hawke's Bay

Nurse Prescribing

Update

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Medicines Amendment Bill

The Medicines Amendment Bill, which would put in place the framework to allow nurse prescribing, is currently being considered by Parliament's Health Committee. The Medicines Amendment Bill enables the making of regulations to:

- information on egg desiccation rates, instalment hatching, and the life cycle of the southern saltmarsh mosquito is found to be incorrect
- the concentration of s-methoprene falls below the concentration needed to eradicate the mosquito in any of the known habitats
- s-methoprene is found not to be effective and environmentally sustainable against the southern saltmarsh mosquito
- after 13 months of applying s-methoprene, there are still larvae, pupae or adults being found.

Conclusion

Eradication of the southern saltmarsh mosquito is believed to be technically feasible and the Government has agreed to the eradication plan being implemented. Application of s-methoprene will be carried out for 13 months in an attempt to eradicate the mosquito from the Hawke's Bay. This will be supported by surveillance in the Hawke's Bay, and nationally to ascertain that the mosquito has not spread further.

For further information please contact Sally Gilbert at the Ministry of Health.
e-mail:
sally_gilbert@moh.govt.nz

- extend prescribing rights to defined classes of registered health professionals (eg, nurses, pharmacists, physiotherapists, chiropractors, podiatrists, optometrists)
- designate health professionals who are able to select and administer specific prescription medicines, for particular classes of patients, in accordance with standing orders prepared by a medical practitioner, dentist or midwife.

Regulations promulgated under the proposed Medicines Amendment Bill would set out the details of to whom prescribing rights would be extended, and how, and details governing the use of standing orders. The Medicines Amendment Bill amends a number of provisions in the Medicines Act 1981, including those relating to the administration of medicines, restrictions on the possession of prescription medicines, and the regulation making powers of the Act.

The Health Committee has received 25 written submissions on the Medicines Amendment Bill, and is in the process of hearing oral submissions.

There is support for the Medicines Amendment Bill to enable the designation of health professionals to select and administer specific prescription medicines, for particular classes of patients, when acting in accordance with standing orders prepared by a medical practitioner, dentist or midwife. There is, however, mixed opinion about the extension of prescribing rights to other health professionals. Medical organisations consider that unless nurses, or other health professionals, have the same training and education as medical practitioners, they will not have the diagnostic skills to adequately prescribe. They also have concerns that nurse prescribing may fragment general practice. The Medicines Amendment Bill is, however, supported by those professions who consider that the extension of prescribing rights will benefit health and disability consumers, whilst at the same time advancing professional practice.

It is hoped that the Medicines Amendment Bill will be passed during the current parliamentary session.

Reference

Ministry of Health. 1998. *Nurse Prescribing in Aged Care and Child Family Health*. Wellington: Ministry of Health.

If you require further information regarding the nurse prescribing project contact Helen Lockyer, Regulation Development Group, Ministry of Health tel: (04) 496 2231) or e-mail: helen_lockyer@moh.govt.nz

The Government's Medium Term Strategy

The Government recently released its Medium Term Strategy for health and disability services which sets a pathway for the future.

The strategy outlines the Government's medium-term direction for health by presenting the broad policy settings within which the health sector will be working over the next three to five years. It is relevant to both health service providers and the general public.

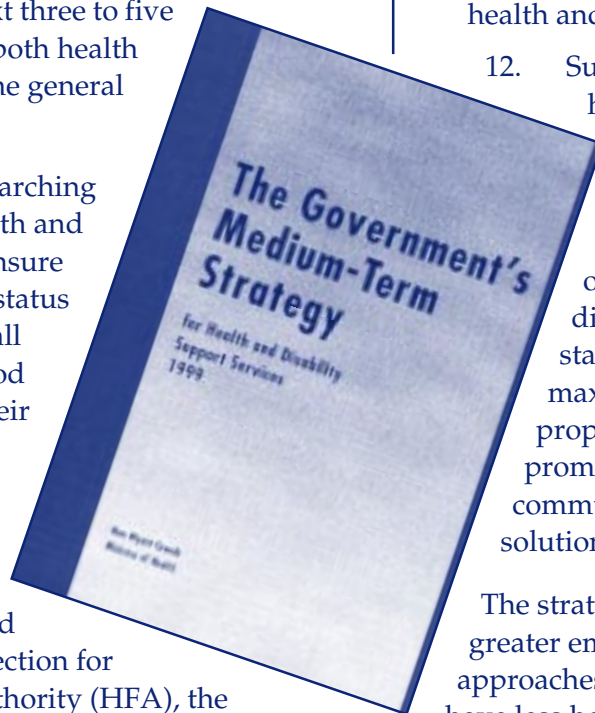
The Government's overarching policy objective for health and disability policy is to 'ensure real gains in the health status of New Zealanders, so all enjoy the benefits of good health and maximise their potential to live a full life'.

The strategy contains 12 goals to achieve the overall objective, and these set a common direction for the Health Funding Authority (HFA), the Crown Company Monitoring and Advisory Unit (CCMAU), Hospital and Health Services and other service providers.

The 12 medium-term goals are:

1. Public certainty about access, quality, and security of services.
2. Timely, equitable and nationally consistent access to elective services.
3. Acknowledging the special relationship between Māori and the Crown.
4. Decreased longstanding disparities in health status.
5. Improved mental health.
6. Improved child health.
7. Improved disability support services.
8. Greater emphasis on population health approaches.

9. Well co-ordinated, integrated services that contribute to better health and disability outcomes.
10. Intersectoral collaboration between agencies and providers to achieve social policy objectives.
11. Improved capability and adaptability of the health and disability sector.
12. Sustainability of the publicly funded health system.



The Government's 12 medium-term goals aim to build certainty and confidence in the security and stability of the New Zealand health and disability system; give equity of health status to all New Zealanders; and maximise the benefits of early intervention, proper integration of services, health promotion, and the involvement of communities in developing their own solutions to local health issues.

The strategy signals that the Government seeks greater emphasis on population health approaches, particularly for those groups who have less healthy outcomes. The document highlights further progress on immunisation rates, healthier lifestyles, less smoking, better diets and screening and health promotion programmes, as important. The Government will be monitoring progress through its focus on public health outcome targets.

The strategy gives considerable attention to improving health outcomes, and increasing our performance on health status measures, particularly for Māori. It builds on national frameworks and strategies already familiar to the sector, such as the Child Health Strategy, and the national strategy for mental health *Moving Forward*. The recently released *Hospital Services Plan*, *Roadside to Bedside* plan and the *Rural Health Policy* also underpin the Medium Term Strategy. The Strategy consolidates and brings together these strategies.

The Government continues to seek 'sector-led evolution'. It wants to see participants in the health

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sector take an increasingly prominent role in developing solutions to health issues, working with local communities to initiate and lead change. This is to be done with increased focus on health outcomes.

Collaboration between agencies, intersectoral collaboration, co-ordination between providers and integration of services are seen as significant drivers of improvements to overall outcomes for people and communities. Strengthening Families is presented as a key intersectoral initiative.

The strategy highlights the need to be prepared to deal with pressures facing the health system: technological advances; demographic change, especially ageing; epidemiological change; and growing consumer expectations.

The Government is working to modernise legislation to enable adaptability while continuing to ensure safe, quality outcomes. An example of this is the work under way in relation to public health and safety in the form of the Public Health Bill and the Health and Disability Services (Safety) Bill currently under development.

The Government wants a high-performing, quality system at all levels. All agencies in the publicly funded health sector are expected to focus on achieving the goals of the Medium Term Strategy to achieve real gains in health for New Zealand.

During early March to early June 1999 the Government Administration Select Committee considered the Food Amendment Bill. The Bill facilitates the transfer of food administration functions and staff from the Ministry of Health to the proposed Food Assurance Authority in the Ministry of Agriculture and Forestry (MAF), originally planned to be established by 1 July 1999.

This proposed action arises from Cabinet's decision of 18 December 1998, that the most effective way to provide an integrated food regulatory system in New Zealand, which would meet the Government's objectives for reform, was to establish a single food regulatory agency in MAF.

The Government Administration Select Committee deliberated on the Bill on 3 June 1999, but were unable to reach agreement by majority that the Bill proceed. The Government is therefore considering options for progression of the Bill.

Course in Health Program Evaluation by Distance Education Melbourne

The Course in Health Program Evaluation by Distance Education is offered by the University of Melbourne's Program Evaluation Unit at the Centre for Health Program Evaluation (CHPE) within the Department of General Practice and Public Health.

The Course in Health Program Evaluation aims to provide participants with the knowledge and skills essential for designing, implementing and overseeing evaluations of public health programmes.

Professionals who are involved with the planning, development or implementation of health programmes, or who are intending to measure the impacts and outcomes of health programmes would find this a valuable course.

The course begins late July 1999 and runs for 16 weeks.

Fees are A\$950 / \$1050 (International)

For a brochure and application form please contact
Helen Jordan: h.jordan@gpph.unimelb.edu.au

Taking the Pulse

Taking the Pulse: The 1996/97 New Zealand Health Survey is a new publication by the Ministry of Health, launched at the end of May. *Taking the Pulse* is an overview of the results of the most recent national health survey of the health status and health service utilisation of New Zealanders.

The 1996/97 survey is the second such survey, the first having been in 1992/93. The current survey sampled nearly 8000 adults, and 1000 children. Information was obtained on three main areas:

- health-related risk factors (smoking, alcohol use, physical activity, high blood pressure)
- health status (asthma, diabetes, injuries/poisonings, self-reported physical and mental health status)
- health service utilisation (GP use, use of other health professionals, prescription use, hospital use).

The 1996/97 survey extends the scope and improves on the methodology and analysis of its predecessor. Māori and Pacific people were oversampled to improve the reliability of estimates for these groups. Internationally standardised questionnaires were included to measure alcohol use (the Alcohol Use Disorders Identification Test), and self-reported health status (the SF-36 questionnaire). Information on injuries and poisonings was collected for the first time. Data collection was carried out by Statistics New Zealand in face-to-face interviews (the previous survey used telephone interviews). The analysis was carried out by Ministry of Health staff using specialised software to allow the accurate calculation of estimates and confidence intervals.

Taking the Pulse includes an analysis of all the major content areas of the survey by key sociodemographic variables (age, sex, ethnicity, family income, education, area deprivation index (NZDep96)), together with information on important relationships between variables such as the number of people with asthma who smoke, or the rate of injuries among people who drink alcohol. Although only a limited number of the tables of results were able to be included in the report, additional tables are published on the Ministry's Web site (www.moh.govt.nz). The report itself is also available on the Web site.

The results of the survey highlight a number of areas of public health importance and indicate where programmes need to be targeted. Smokers, for example, are more likely to be men, except in the 15–24 year age group where young women outnumber men. Māori are much more likely to smoke than other ethnic groups, and



*Kate Scott
with copies
of Taking
the Pulse.*

across all age groups Māori women are more likely to smoke than Māori men. The overall prevalence of smoking (25%) has not reduced since the previous health survey.

The survey also shows areas of concern for alcohol consumption, where 'hazardous drinking' is much more prevalent among young people, and among men. Those in lower socioeconomic status groups, and Māori and Pacific peoples, were both more likely to not drink at all, and also, among those who did drink, to drink hazardously.

The analysis of diabetes prevalence suggested that the overall prevalence of diabetes in the population (3.7%) has increased significantly since the last survey (although this may in part be an increase in the reporting/diagnosis of diabetes rather than an actual increase in prevalence).

The survey found high levels of satisfaction with GP and other health services among respondents, but also identified a degree of self-reported unmet need for GP services that was cost-related (about the same level as reported in the previous survey). Māori, Pacific, and low income groups were more likely to report unmet need.

Taking the Pulse: The 1996/97 Health Survey is available from libraries and medical institutions, and on the Ministry of Health's Web site. It can be purchased by individuals at a cost of \$30.00. To order the publication:

tel: (04) 496 2277

fax: (03) 479 0979

or mail: Ministry of Health,
C/- Wickliffe Limited
P O Box 932
Dunedin.

Inquiries about the survey can be directed to Kate Scott, Ministry of Health, (04) 496 2237.

Customised results of the survey are available from Statistics New Zealand's Information Consultancy Group. Researchers wishing to obtain access to the dataset should contact Statistics New Zealand's data laboratory.

Introducing Gill Grew

Chief Advisor, Services



Patient safety is the focus of new standards for hospitals and rest homes. As Chief Advisor, Services, Gill Grew's latest challenge is leading the project to replace outdated licensing laws.

Gill Grew certainly likes challenge. She has undertaken a variety of policy, managerial and advisory roles within the Ministry, but is probably best known for setting up the National Cervical Screening Programme.

A New Zealand citizen, and raised in Hong Kong, Gill began her extensive nursing career in London, emigrated to New Zealand and has spent a number of years in nursing education here.

Gill has been a member of the Nursing Council of New Zealand and was Frances Hughes' predecessor as Chief Advisor Nursing.

Gill is currently leading the project to make fundamental changes to the way hospitals and rest homes are regulated.

The Health and Disability Services (Safety) Bill will repeal the legislation that underpins the licensing of hospitals and homes. The Health & Disability Sector Standards are to replace the licensing regime and are scheduled to come into effect in July 1999 after consideration by the Health Select Committee.

She believes the old licensing regulations were outdated and sometimes ludicrous.

She says they covered things like the number of toilets or the size of rooms but didn't necessarily ensure patient safety.

'Under the new system, hospitals and rest homes will have to meet safety standards rather than follow

'We want a safe, appropriate standard of health care in New Zealand and we think this is the best way of doing that.'

rigid regulations which may or may not be appropriate.'

Gill says staffing levels are a good example of how the new standards will make a positive difference. She says previous regulations set out nurse to patient ratios using outdated levels of care needed for particular patients.

She says the old requirement may have been okay for a geriatric hospital that had a low level of acuity but not appropriate for hospitals with much frailer patients with more complex health requirements.

'Most hospitals exceed the standards set out in the regulations otherwise they wouldn't be providing an appropriate level of care.'

She says the new standard ensures the skill mix is appropriate to the level of complexity of care.

'For example, outcomes will be measured against infection rates, fall rates and re-admissions.'

Gill says half the battle is bringing public hospitals into line with their private counterparts. Although private hospitals and rest homes have always been subject to audits, public

hospitals only had to do so after legislation was introduced to establish Crown Health Enterprises in 1993.

'The private sector has always been subject to audit, and they just see it as another discipline. To a degree public hospitals are either unused to

being audited or more recently have signed up to accreditation under the auspices of Quality Health. So the discipline of ensuring regular audits as part of "business as usual" is relatively new to most public hospitals.'

Gill says some health and hospital services do have to work within the constraints of older buildings but she says managers should be thinking about how to meet standards, not just now, but in the future.

'Hospital management will have something concrete to negotiate with.'

She says change will happen over time and many hospitals and rest homes will have to operate under the old regulations while they make the transition to the new standards, but she believes the outcome will be good in the long term.

'We want a safe, appropriate standard of health care in New Zealand and we think this is the best way of doing that.'

Getting New Zealanders Active

The Government has released a joint policy statement on physical activity that underpins the Hillary Commission's \$2 million 'Push Play' campaign. The Minister of Health Wyatt Creech and the Minister of Sport, Fitness and Leisure Murray McCully said the statement sets out their common agenda for the promotion of physical activity.

Push Play wants people to think about the amount of activity they get, whether it's a lot or a little, and finding ways of increasing it. Thirty minutes on most days of the week is all it takes to maintain good health.

While the Hillary Commission does a good job in promoting physical activity, the Push Play campaign will provide a further 'kick-start' by emphasising the benefits of including 10 minutes' physical activity into people's everyday lives. The new message is 'snactivity', small amounts of physical activity done frequently.

If just 10 percent more adults became physically active, about \$55 million could be saved each year from New Zealand's health bill.

Thirty minutes on most days of the week is all it takes to maintain good health.

New Zealanders will be given the Push Play message through a series of television commercials and through events organised by regional sports trusts around the country. There will be a toll-free

phonenumber, 0800 ACTIVE, which will give people advice on ways to get active.



Thank You

Public Health Perspectives Survey

Thank you to everyone who made the effort to complete and return the *Public Health Perspectives* survey.

We have had many replies and are now in the process of analysing the results.

These will be published in the next issue of *Public Health Perspectives*.

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