

# Public Health Perspectives

Presenting the Ministry of Health's public health focus

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## Achieving Health for All People

coming to a town near you

***Achieving Health for All People: Whakatutuki te oranga hauora mo ngā tāngata katoa, a framework for public health action for the New Zealand Health Strategy, has been completed and will provide the strategic framework for public health action for the next 3-5 years.***

Sincere thanks go to all those who have been involved in the development of this strategy. It is the result of two years of formal and informal consultation with the public health community including extensive consultation with Māori public health stakeholders.

Unlike many Ministry documents, the framework will not have a single launch. Providers will be sent a copy of the document before Christmas (and will be able to order more from Wickliffe [04 496 2277] or download copies from [www.moh.govt.nz](http://www.moh.govt.nz)). The formal introduction of the strategy will take place in a rolling programme of meetings and workshops with providers, DHBs and other stakeholders over the first half of 2004. Wherever possible the introductory session will be part of a larger meeting or workshop addressing aspects of public health action in order to support an in depth discussion of one or more elements of the strategy. Senior locality managers will be planning these events in response to local needs.

The central objective of Achieving Health for all People is to bring to life the 'organised efforts of society'. The strategy therefore has two audiences: The primary audience is the public health sector, that is, planners, funders and providers of public health services. The framework makes explicit the dual role of providers in carrying out public health services as well as supporting and informing the actions of others. A secondary audience is made up of the personal health sector, local government and non-health agencies whose work impacts on the determinants of health.



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# Editorial

**Don Matheson**  
**Deputy Director-General, Public Health**



This year represents the 25th anniversary of the Alma Ata declaration on primary health care. In 1978, there was a crisis in health care provision, particularly in the developing world, where large hospitals were being established to address the health needs of the people, despite the fact that most of the population couldn't access these services. Public health programmes were also in trouble, as communities were resisting some well intentioned but paternalistic and medically driven interventions to improve their health.

Alma Ata sought to address these issues. It was a key turning point in advocating a more comprehensive approach to health gain. It proclaimed health as a fundamental human right. It identified the need for society to address the social and economic determinants of health, and identified as unacceptable the inequalities that exist in health status both within countries and between countries. It saw promotion and protection of health of people as essential for sustained economic and social development. It provided the basis for the further development of

public health thinking – reflected in the Ottawa Charter.

Don't be misled by the term 'primary health care'. The principles of population health improvement and equity are the cornerstone of primary health care. It is important that public health practitioners see Alma Ata and primary health care as outlined in the declaration, as fundamental to public health practice, and that they do not reduce the scope of these principles to a level of care or a single discipline or approach to health. The principles of Alma Ata (and some of the presenting problems) remain as pertinent today as they did 25 years ago. To make progress we must continue to support actions that address the social and economic determinants of health. Our actions need to be evidence based, and that evidence must show the impact of what we do on people's health and on inequalities. Furthermore, that action needs to be taken with and by the people.

For text of Alma Ata see: [http://www.who.int/hpr/NPH/docs/declaration\\_almaata.pdf](http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf)





# Achieving Health for All People

coming to a town near you Continues from front page

The strategy is concerned more with the ‘how’ than the ‘what’ of public health and is designed to be used in conjunction with the New Zealand Health Strategy, the New Zealand Disability Strategy and He Korowai Oranga. Strategies such as Healthy Eating Healthy Action and the infectious diseases strategy provide guidance around specific programme areas. In response to sector feedback, half of the document is made up of action tables which outline specific actions and suggested outputs for all parts of the public health sector (policy makers, funders, providers, – both DHBs and NGOs), the personal health sector, local government and other community agencies. Actions to improve the health status of Māori are threaded through the five objectives and action tables and a companion action plan for Māori public health is currently in preparation.

## PHWAP

This is not the sound of a fly being swatted it is the name of the public health workforce strategy – now called the Public Health Workforce Action Plan.

The development of the plan is under way. Some of the key things that have happened so far are:

- a literature review has been carried out
- a needs analysis of the Māori public health workforce is under way
- work has been going on looking at issues around HPO recruitment for Māori
- some preliminary work to assess public health needs in the PHO workforce.

A ‘friends of PH workforce development’ database is being established and we will be sending regular updates to this group. We hope that this becomes an ongoing interactive group that can provide support and input to the process. If you would like to take part please contact Viv Head who is the project manager, or Maggie McGregor. Some work has begun on shared national initiatives with the public health leaders group that represents DHB-based public health services.

At present we are in the process of establishing a sector reference group – and planning a survey of the public health workforce. This is a ‘baseline’ survey as we currently have little comprehensive information about our workforce. There will be an ‘organisation’ survey and an individual one. In the first instance, the survey will cover those providers who have public health contracts. We also hope to carry out a pilot survey of the injury prevention workforce to assess the issues around surveying non-public health providers. The survey will be mainly carried out by phone and we hope that all providers will support the survey to ensure the best possible information on which to base the future plan.

The survey is still at an early planning stage, however, we expect we will be asking who is doing what where, ethnicity of the workforce, which programmes you work in, your qualifications, what competencies you feel are needed, how you rate your own competencies, your training needs, recruitment and retention issues and so on. Although it will have quite a strong qualitative element, its main focus is to gain the baseline quantitative information. We recognise that more indepth work is likely to be required in some areas later. Viv Head, the project manager, is working to ensure we avoid unnecessary overlap with surveys that have already been carried out, for example, the health protection officer survey.

When the survey is analysed, all the information to date will be brought together, with help of the sector reference group, into a discussion framework. It will identify goals and objectives and broad areas for action over the next 3–5 years. The timeframe has not been finalised but we hope to consult on the framework and have a working draft completed by around September 2004. This is likely to include themes where more information or development is required as well as areas where we can start moving forward on delivery programmes

We are keen to work closely with the sector during the development of PHWAP so let us know if you’d like to be involved. Contacts:

Viv Head (project manager) [viv.jake@xtra.co.nz](mailto:viv.jake@xtra.co.nz) or

Maggie McGregor [maggie\\_mcgregor@moh.govt.nz](mailto:maggie_mcgregor@moh.govt.nz)



# Foodsafe campaign

**Foodsafe Week was from 1–9 December and the New Zealand Foodsafe Partnership is working hard to get its messages out to the public about safe food handling practices in the home.**

It's the second year the Foodsafe Partnership's campaign has been launched with a week dedicated to food safety and the campaign was highlighted in a number of different ways around the country.

It was launched in Wellington with a barbecue in Civic Square on 5 December hosted by celebrity chef Rick Rutledge-Manning and attended by sporting celebrities.

Public Health Units, which play a key role in promoting food safety, undertook a number of activities with many organising children's colouring competitions, mall displays or advertising in their local community newspapers.

The theme of the campaign this year is the importance of keeping

food covered. Resources – brochures, posters, fridge magnets, stickers and balloons – have been updated for this year's campaign making better use of the Partnership's mascot Foodsafe Freddie. A television advertisement featuring Foodsafe Freddie will appear on TV One and TV2 during December.

The New Zealand Foodsafe Partnership was set up in 1998 with a small group of representatives from the food industry, consumer groups, public health groups, MAF Food (now the New Zealand Food Safety Authority) and the Ministry of Health. Its purpose is to promote consistent and appropriate food safety messages to New

Zealanders. It was formed as a result of concern about high levels of foodborne illness in New Zealand and recognition that no matter how much care is taken to produce safe food, food handling by consumers at home plays a key role in preventing foodborne illness.

Visit the foodsafe website at [www.foodsafe.org.nz](http://www.foodsafe.org.nz)



## Progress continues on Meningococcal Vaccine Strategy

**Steady progress is being made to develop a vaccine to protect against group B meningococcal disease that has been at epidemic levels in New Zealand for 13 years.**

Pending analysis of clinical trial results, regulatory approval and vaccine availability, it is likely that the Ministry of Health's proposed MeNZB immunisation programme would begin mid-2004 in Counties Manukau District Health Board and the eastern corridor of Auckland District Health Board. The nationwide campaign

would roll out north to south in the North Island and then south to north in the South Island.

The proposed delivery model has been chosen to maximise coverage and enable vaccine to be carefully allocated and monitored to best control the epidemic.

The Ministry is working closely with a project team co-ordinated by Counties Manukau DHB to plan a campaign so it could be launched as soon as possible if regulatory approval is granted. DHBs

# Sexual health resources target school students

A range of sexual health resources for year 9 and 10 students (aged 13–15 years) were launched in November at Wainuiomata High School by Minister of Health, Hon Annette King. The education resources were developed by the Ministry of Health together with the Ministry of Education in consultation with students.



Minister of Health, Hon Annette King and students from Wainuiomata High. Displayed are the three sexual health education resources launched; a video, Compact Guide to Sexual Health booklet and a Teachers' Guide to Sexual Health.

The resources – A Compact Guide to Sexual Health, code 1438; a video titled *The Low-Down Up Front* and an A4 teacher's guide were developed to meet the needs of young people for up-to-date, relevant and accurate information about their sexual and reproductive health in a format they can relate to. The video features four young people discussing sexual issues which affect them including relationships, pregnancy and sexually

transmissible infections. The video is divided into three sections that covered in a teaching programme in the accompanying teacher's guide.

Copies of the resources have been distributed directly to schools through the public health services. The booklets can be ordered as individual items or can be viewed or downloaded from the health education website <http://www.healthed.govt>. The text of the teacher's

guide is also on the website.

Schools can order copies of health education resources from their nearest public health service or by ordering through the Ministry of Health's health education website – <http://www.healthed.govt.nz>

will be given 12 months' notice of the proposed launch in their area. An implementation plan will also be distributed widely through the health sector early in 2004 to promote strategies to deliver effectively to each local population. In particular, it is expected that specific strategies will be developed locally by DHBs to improve access for Māori and Pacific children and young people and for those less likely to be immunised.

The epidemic's toll has now reached more than 5200 cases with 213 deaths. Cases involving

young people and adults attract significant media interest, however the groups most at risk are babies and preschoolers. About half of all meningococcal disease cases occur in this age group. Māori and Pacific children also bear a disproportionate burden of disease. On average, Māori contract meningococcal disease at double the rate of Europeans. Pacific peoples are affected at four times the rate of Europeans. People of other ethnicity make up a very low proportion of cases but everyone in New Zealand is at high risk.



# PHI update

## Update on activities in Public Health Intelligence

**Recently PHI released a collaborative publication with the Wellington School of Medicine, University of Otago, called *Decades of Disparity: ethnic mortality trends in New Zealand 1980–1999*.**

During the 1980s and early 1990s Māori and Pacific mortality was seriously undercounted. The undercounting occurred because ethnicity was recorded differently on death registration forms than in the Census. Until recently it was not possible to estimate the extent of this numerator–denominator bias in ethnic specific mortality rates, with the result that the ethnic mortality time series was unreliable.

The New Zealand Census Mortality Study (a joint project between Public Health Intelligence, Statistics New Zealand and the Wellington Medical School) is a record linkage study in which death registration data is linked anonymously and probabilistically to Census data. This study has finally allowed the ethnic numerator- denominator bias in the mortality time series to be unlocked. Using undercount adjusters derived from this study, we have recalculated ethnic specific mortality rates for the 20-year period 1980–1999. The undercount was found to be high throughout the 1980s and early 1990s, but low from 1996 on.

Ethnic groups were defined according to both sole and prioritised concepts of ethnicity. The key finding is that mortality rates declined steadily over the observation period for both sexes and at all ages for the European/Other ethnic group, whichever definition of ethnicity is used. By contrast, both Māori and Pacific ethnic groups showed significantly less improvement. The result has been a progressive widening of the gap in survival chances between the ethnic groups over the 20 years. For example, the gap in life expectancy at birth for females increased from 7.8 years at the beginning to 9.8 years at the end of the period, comparing Māori with European/Other ethnic groups (prioritised series) – an increase of 26 percent.

Most of this increase in inequality has arisen from widening differentials in chronic disease mortality in middle and old age. These two age

groups now contribute about equally to the ethnic disparities in life expectancy at birth.

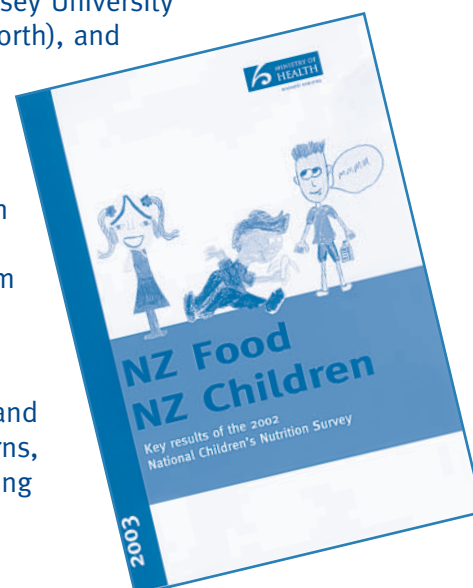
Among the chronic diseases, cardiovascular mortality has decreased over the 20 years for all ethnic groups – but more rapidly for the European/ Other ethnic group (especially for ischaemic heart disease mortality among males). This cause still ranks highest as a contributor to the total ethnic gap. However, cancer mortality is making an increasing contribution to the gap for both Māori and Pacific ethnic groups. Diabetes and chronic lung diseases also make a substantial contribution to the ethnic mortality gaps.

These mortality trends coincide with major structural changes in New Zealand society in the 1980s and 1990s, changes that impacted differentially on the three ethnic groups (as shown, for example, by their respective trends in unemployment rates). Differential access to health care, and disparities in the quality of the health care provided to patients, may represent additional explanations and provide further intervention points for policy.

### National Children's Nutrition Survey (CNS)

Results from the 2002 National Children's Nutrition Survey were launched by the Minister of Health, Hon Annette King, in Dunedin on 7 November. The Ministry of Health funded the survey that was carried out by the University of Auckland, Massey University (Palmerston North), and the University of Otago, and involved more than 3000 school children aged 5–14 years, and from 172 schools.

Questions included diet and exercise patterns, and the resulting



data formed the basis of a comprehensive report on food and nutrition intakes, eating patterns, levels of physical activity, dental health, and nutrition-related clinical measures.

Some of the findings from the survey are:

- 86 percent of females and 79 percent of males ate breakfast before they left home in the morning for school. The figures are lower for Māori and Pacific children.
- 78 percent of all children reported that their household could always afford to eat properly
- about 2 out of 5 children met the recommended number of serves of fruit (at least 2 per day)

- about 3 out of 5 children met the recommended number of serves of vegetables (3 or more times a day).

More findings are available from the Ministry of Health website <http://www.moh.govt.nz>

### 2002/03 New Zealand Health Survey

Preliminary findings of the 2002/03 NZ Health Survey were released by the Minister of Health, Honourable Annette King, on 3 December. Findings are available from the Ministry of Health website <http://www.moh.govt.nz>



## Screening Matters Programme day

**The National Screening Unit (NSU) hosted a Screening Matters Programme day on the 22 September 2003 for Auckland and Northland Primary Health Organisations (PHO).**

The one-day programme provided an informal, interactive opportunity for PHOs and the NSU to meet and develop networks for future collaboration.

A range of PHO personnel, including CEOs, health promoters, community health workers and business and clinical managers attended the day.

The purpose of the day was to assist PHOs to:

- gain a greater awareness of the role and function of the NSU
- hear information about the BreastScreen Aotearoa and the National Cervical Screening Programme for which the NSU has stewardship
- gain information about the support that is available from the NSU for the delivery of screening programmes

- discuss ways of incorporating screening and health promotion initiatives into the PHO environment.

Group Manager, Karen Mitchell and Public Health Leader, Ashley Bloomfield presented an overview of screening and the NSU.

NSU staff from the National Cervical Screening Programme and BreastScreen Aotearoa presented programme information on each programme and the NSU health promotion team facilitated workshops, which generated discussion and identified areas for future consideration.

Participant evaluations of the day were extremely positive and also provided the NSU with information about what future support and collaboration would support the PHOs in their work.

Based on the success of the day, the NSU is planning to host the Screening Matters Programme Days in other regions.

# Government response to cannabis inquiry

The Health Committee of the 47th Parliament presented its final report, *Inquiry into the public health strategies related to cannabis use and the most appropriate legal status*, to the House on 8 August 2003.

The Committee's report made 23 recommendations to the Government, and a further two recommendations to the House.

The Government response was tabled in the House on Thursday 30 October 2003.

A number of recommendations were made in regard to cannabis and youth, research, health programmes and education, legal status and policing and diversion. These recommendations will affect the policies and practices of a number of government agencies, namely the Ministries of Education, Health, Justice, Youth Affairs, the New Zealand Police, and Environmental Science and Research Limited.

Although there were some areas of the inquiry that the committee members could not agree upon, all members strongly supported protecting New Zealand's youth from adverse affects of cannabis use. A number of recommendations focused on promoting messages that young people should not use cannabis and that an all of Government approach was needed to enhance the quality, and ensure accuracy, of youth-appropriate health messages. Government was able to report back on work that is currently under way that directly addresses both the youth and other recommendations of the Committee. Most of this work is included in projects that already inform the policies and practices of the various government agencies that are involved in drug-related matters.

Full copies of both the Committee's report and the Government response are available on the National Drug Policy website <http://www.ndp.govt.nz>

# National Immunisation Register (NIR)

The National Immunisation Register (NIR) has continued to progress in its development over the past couple of months. The purpose of the register is to support the provision of immunisation services to children, and to enhance public health approaches (ie, monitoring and improving population immunisation rates).

The NIR is a complex project, and whilst there have been some delays in software development; supporting policies, processes and information resources are all progressing well. A key component of the register's development, the privacy policy, has received favourable comment from the Privacy Commissioner.

Manuals have been developed for the relevant maternity and well-child providers, vaccinators and NIR administrators. These manuals developed in consultation with future users of the NIR will form the basis of education packages for these providers. They have been edited and are almost ready for printing. The NIR team are developing information and education resources to ensure national consistency. However each DHB implements the plan and utilises the tools according to their local situation.

A brochure for parents and caregivers has also been developed. This brochure was pre-tested with a diverse group of parents and feedback was generally positive. Of those parents sampled 98 percent supported a register, and 85 percent were in favour of the register maintaining information for 'whole of life'. The brochure will be translated into Māori and some Pacific languages for distribution in hard copy. Other language translations will be available as PDF files for providers to print as required.

Northern region DHBs have developed project implementation plans that demonstrate extensive and robust stakeholder involvement through assessment of issues, identification of risks and strategies to address them. The lessons learnt from these DHBs will be useful for the rest of the country.

# Review of the National Drug Policy

**New Zealand's National Drug Policy (NDP) was developed in the mid-1990s mirroring similar developments in other countries. It focuses on intersectoral action to address and reduce drug-related harm, with an emphasis on harm minimisation. This includes but is not restricted to abstinence.**

The NDP sets national priorities and directions through strategies of supply control, demand reduction and problem limitation. Target groups include young people, Māori, people with co-existing drug use and other mental disorders, polydrug users, and pregnant women, and action settings of education, the community, workplaces and prisons are identified.

Structures to channel intersectoral action include the Ministerial Committee on Drug Policy (MCDP) and an officials committee – the Interagency Committee on Drugs (IACD). Both of these committees have membership drawn from all government sectors with an interest in drug policy.

However, much has changed in the last 5–8 years. For example health inequalities are not specifically addressed, drugs such as methamphetamine are much more prominent now, and the Government itself has specific objectives that it wishes to put into place. As the NDP is due to end in 2003 it is a good time to consider the approach to be taken on the future of New Zealand's drug strategy.

Three options were considered by Ministers. The current policy could have been tweaked and endorsed for a further five years; the idea of a National Drug Policy could have been dispensed with in favour of informal mechanisms for encouraging intersectoral collaboration to reduce drug-related harm; or a review of the current NDP

could be undertaken in order to develop a new strategy for the next five years. Ministers considered these three options and decided that a full review of the NDP should be undertaken.

The idea is to:

- evaluate the successes and failures of the current National Drug Policy
- review the concepts of harm minimisation, abstinence, drug education, treatment, enforcement and other approaches in the New Zealand context
- consider where emphasis should go over the next five years (ie, what drugs, what initiatives, what approaches to reducing harm, and so on)
- identify the important groups and settings that deserve particular attention as national policy, and specific initiatives, are developed
- review current mechanisms for facilitating collaboration to reduce drug-related harm.

A steering group has been established as a sub group of the Inter-Agency Committee on Drugs. The project will be in four stages: a review of the current National Drug Policy, development of a consultation document, a consultation phase; and preparation of the new policy.

Consultants Allen and Clarke Ltd have been contracted to undertake the first phase and are already interviewing key informants. This phase is expected to be completed by March 2004.

Consultation is planned for May and June 2004 with a report to Ministers in August. The new Strategy will be prepared and confirmed by Cabinet by October 2004.

Visit the National Drug Policy website at [www.ndp.govt.nz](http://www.ndp.govt.nz)



# Ministry publishes *Food and Nutrition Guidelines for Healthy Adults*

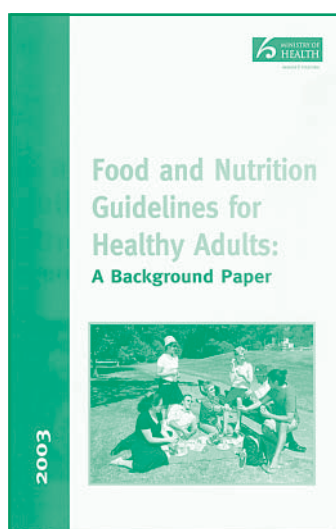
***Food and Nutrition Guidelines for Healthy Adults: A Background Paper* has been developed for health professionals to use as a technical background paper for the promotion of New Zealand's new Food and Nutrition Guideline statements. Good nutrition, physical activity and maintaining a healthy body weight are fundamental to reducing the burden of chronic diseases in New Zealand.**

The document brings together the latest evidence and advice on food and nutrition, physical activity and healthy eating for adult New Zealanders. Practical advice is given for following the guidelines, such as how to reduce fat intake and increase physical activity.

The Ministry publicly consulted on the discussion document in April/May 2002 and received 46 submissions – 31 on behalf of organisations and 15 from individuals. Revisions have been made to address issues that were raised in the submissions, where appropriate.

The New Zealand Food and Nutrition Guideline statements are:

1. Maintain a healthy body weight by eating well and by daily physical activity. (At least 30 minutes of moderate intensity physical activity on most if not all days of the week and if possible add some vigorous exercise for extra health and fitness.)
2. Eat well by including a variety of nutritious foods from each of the four major food groups each day.
  - Eat plenty of vegetables and fruits.
  - Eat plenty of breads and cereals, preferably wholegrain.
  - Have milk and milk products in your diet, preferably reduced or low-fat options.
  - Include lean meat, poultry, seafood, eggs or alternatives.
3. Prepare foods or choose pre-prepared foods, drinks and snacks:
  - with minimal added fat, especially saturated fat



- that are low in salt; if using salt, choose iodised salt
  - with little added sugar; limit your intake of high-sugar foods.
4. Drink plenty of liquids each day, especially water.
  5. If choosing to drink alcohol, limit your intake.
  6. Purchase, prepare, cook and store food to ensure food safety.

A recent Ministry of Health and University of Auckland study estimated that up to 40 percent of all deaths

(11,000 deaths in 1997) were due to nutrition-related risk factors. These risk factors were high blood cholesterol, high blood pressure, overweight and obesity, and inadequate vegetable and fruit intake. Deaths attributable to these risk factors included 85 percent of coronary heart disease mortality, 70 percent of stroke mortality, 80 percent of diabetes mortality and six percent of cancer mortality. The potential benefits from following the guidelines are therefore, considerable.

The background paper will be the basis of updating the accompanying health education pamphlet for the public *Healthy Eating for Adult New Zealanders / Nga kai totika ma te hunga pakeke o Aotearoa* (Code 6036) in the near future. Hard copies are available from your local health unit or provider network or electronically from [www.healthed.govt.nz](http://www.healthed.govt.nz)

*Food and Nutrition Guidelines for Healthy Adults: A background paper* is available on the Ministry of Health's website at [www.moh.govt.nz](http://www.moh.govt.nz)

For further information contact  
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Public Health Policy

# Amendments to sanitary works subsidy criteria

**The Government announced a sanitary works subsidy scheme (SWSS) in May 2002 that came into effect in July 2003. The SWSS was fully described in the September 2002 edition of the Public Health Perspectives.**

So far the scheme has attracted more than 70 applications for community sewerage schemes. To date the Minister of Health has provisionally approved 15 applications for sewerage works worth over \$30 million.

One of the conditions of the scheme was that any subsidy from the Crown had to be matched by the local authority from funds obtained from across the district. This condition had caused concern for a number of local authorities that would have had to review their district rating policies. Following representations from LGNZ and a number of local authorities, the Minister of Health set up a working party of mayors, local government officers and government officials to review the condition and recommend alternative wording.

The Minister has approved the revised condition, which is in two parts. There is a high level principle and a new definition of the requirement for the relevant local authority (RTA) to provide an 'equivalent contribution'.

## Principle of SWSS

'The Sanitary Works Subsidy Scheme will be a partnership between local government and the Crown, aimed primarily at enabling disadvantaged small and medium-sized communities to achieve good environmental outcomes and safe sanitary

conditions. While the provision of the local share of funding is a matter for the Relevant Territorial Authority (RTA) to decide, the RTA is expected to provide additional subsidy to the extent necessary to make eligible sewerage schemes affordable for the benefiting community.'

## Commitment from the RTA to provide an 'equivalent contribution'

'This equivalent contribution is to be raised by funds from across the whole district, including other local government funding. The equivalent contribution can be any combination of funds, including the region, whole of district, reticulated communities, participating community and any other basis considered appropriate by the RTA. All such funding is to be in accordance with the Revenue and Financing Policy of the RTA.

'In making this decision, the local authority needs to consider:

- the promotion of community outcomes
- the distribution of benefits (particularly health and environmental) between the community as a whole and the participating community
- the overall cost impacts on the current and future social, economic, environmental and cultural wellbeing of the community.'

The updated *Report on Detailed Criteria and Processes* containing the amended condition is now available on the Ministry's website <http://www.moh.govt.nz> under Publications.



# Rising to the challenge

Rising to the Challenge, the theme of the Samoan Nurses Association's (SNA) 15th Annual National Conference aptly described the culmination of effort leading to the official launch of the *Pacific Nurses and Nursing Students National Survey Report* by the Hon Annette King on 30 October this year.

Initiated by the SNA of New Zealand, and funded by Ministry of Health, the survey was designed to scope the numbers, characteristics, areas of speciality and current status of employment and training needs of Pacific nurses and current nursing students in New Zealand. The report is an essential step in developing a long-term planned approach to building the skills and numbers of the Pacific nurses workforce, and will inform the development of the Ministry's Pacific Health Workforce Plan.

The Minister identified as a significant issue the need to support and train a large workforce of non-active Pacific nurses with overseas qualifications unable to practise in New Zealand. Of the many recommendations, she highlighted the need for recruitment and barriers to progressing a Pacific nurses workforce to be addressed and the recommendation that a single Pacific nurses body be established to represent the interests of all Pacific nurses.

Before the launch, there was a formal handover of the report by the SNA and the lead researcher, Dr 'Ana Koloto.



From right to left: Dr 'Ana Koloto (lead researcher for the research project); Fuao Stowers (member of the Wellington based research interview team); Josephine Samuelu (member of the research project); Elizabeth Powell (Ministry of Health).

Dr Koloto noted that a unique feature of the survey was that Pacific nurses initiated the research topic, were involved in the Advisory Group, formed the research team and were involved as research participants. This approach is an example of a Pacific Governance model of research. Chief Advisor, Nursing, Dr Frances Hughes, spoke of the need to honour the work, and those who will deliver and benefit from it. Dr Hughes described the research methodology and consultation framework as highly innovative and credible and said that the biggest challenge would be to translate the recommendations into meaningful action.

Anna Bailey (SNA) says that the support and presence of representatives and leaders from Pacific ethnic communities; Pacific health providers, PACIFICA, DHBs;

Pacific PHOs; government agencies together with pioneer nurses, the Pacific nursing sector and their families contributed a 'medley of joyful celebrations and thanksgiving'. A further cause for celebration was the acceptance by Luamanuvao Winnie Laban, MP to be the patron of the Association.

An important outcome for Dr 'Ana Koloto was that the Survey was an opportunity to train and work with 45 Pacific nurses and nursing students as researchers. 'Building the capacity and capability of Pacific nursing researchers is critical to the development of Pacific health researchers. The Health Research Council Guideline on Pacific Health Research [launched on 5th December], talks about Pacific governance research.'

Rising to the Challenge celebrates a vision that has come to fruition for many people and begun journeys for many others. A final word from Reverend Aotofaga Lemuelu. Quoting Helen Keller he asks, 'What is worse than being blind? To have sight but no vision.'

Soifua.





# Taking a fresh look at emergency management in the health sector

**Operation Virex, SARS, white powder incidents and issues concerning counter-terrorism preparedness have prompted the Ministry of Health to take a fresh look at health sector preparedness for emergencies. The Ministry of Health is embarking on a number of new projects to address this issue.**

Firstly the Ministry has contracted Business Research Centre to carry out a review of New Zealand's SARS response. Some of you may have been interviewed or offered an opportunity to complete a questionnaire. This review will help ensure the lessons from the SARS response can be incorporated into future planning and programme development.

As part of the SARS response, the Communicable Diseases team will be redeveloping the Pandemic Plan. The original plan enabled New Zealand to mount a more rapid response to SARS than many other comparable countries. Clinical Services Directorate will develop the treatment services component of the Pandemic Plan, taking into account the lessons learned from SARS, to better enable a response by DHBs to emerging novel infectious diseases. ESR will be completing its work on trialling an online form for collection of data and a reporting interface to facilitate rapid communications during future novel infectious disease outbreaks. ESR will also assess and validate new tests for the detection of SARS, and ensure its own laboratory staff is trained to operate in high containment laboratory facilities.

The Ministry has also initiated a new project to identify priorities for improving health sector preparedness for a terrorist event threatening health. Whilst the threat of such activity is low, it is important to consider how the sector can be better prepared to respond to a chemical, biological or radiological event.

The National Radiation Laboratory will be reviewing its emergency management plans, and policies and procedures for waste management and compliance monitoring in the light of new international guidelines.

Public Health Programmes will lead other aspects of the Ministry's work on counter terrorism preparedness including reviews of health sector



*Chief Auditor Steve Brazier*

workforce capability and capacity to deal with unusual emergencies; critical supplies and equipment; high level containment laboratory facilities; real-time surveillance; triage at incident sites; legislative barriers or anomalies to effective public health action; and developing policies concerning smallpox vaccine utilisation.

Overarching all these activities, the Risk and Assurance Unit, led by Chief Auditor Steve Brazier, will develop a National Emergency Management Plan for the health sector to sit alongside the National Civil Defence and Emergency Plan. This will be a resource for those involved in the preparation for, mitigation of, response to, or recovery from a health emergency. It will clarify the roles and responsibilities of different parts of the health sector to enable effective, consistent and joined-up responses. As part of the plan, health emergency management planning standards will be developed. The intention of these standards is to assist emergency planners with the development of their emergency plans and identify what is expected of them.

It is anticipated that these reviews will reveal gaps and anomalies that will need to be considered and prioritised in order to provide advice to the Minister of Health on options for enhancing emergency preparedness.

So the next six to 12 months will be a very busy time for Ministry staff, and you will undoubtedly hear more and, in many instances, be invited to comment on or be involved in identifying solutions to the issues.



# Decision-making on water fluoridation

**In September 2002, the Ministry of Health released a report on *Identification and assessment of factors impacting upon council decision-making in relation to fluoridation of public drinking-water supplies*. This report was prepared by ESR for the Ministry of Health. It contributes to the Ministry of Health's fluoridation policy by identifying and assessing the importance of factors impacting on local body decision-making on the fluoridation of public drinking-water supplies.**

Fluoridation of public drinking-water supplies continues to be a controversial topic and/or experience – for health professionals, for local government decision-makers, for anti-fluoridation campaigners, and others who participate in public discussion. There are a number of strategies and processes that health professionals can carry out in relation to local government and communities which may contribute to fluoridation of public drinking-water supplies. The following principles were identified by Ann Winstanley, (ESR) in consultation with Debbie Jeffery (Hutt Valley Health), Martin Lee (School and Community Dental Service, Canterbury District Health Board), Councillor Chrissie Williams (Christchurch City Council), and reviewed by Cassandra Hinton (ESR).

## Relationship building when fluoridation is not a public issue

In order to promote fluoridation of public drinking-water supplies it is advisable for health professionals to invest in spending time to build relationships with local government councillors and engineers, community groups and other health professionals.

## Promoting appropriate forms of public consultation and/or participation in decision-making

Through establishing relationships with local government councillors, health professionals can promote the use of surveys in relation to gauging public support for fluoridation and/or the use of tribunal settings for presentations and decision-making protocols. Health professionals could also suggest that the whole council reads submissions, hears presentations and makes the final decision in order to avoid questions about council processes. If other forms of public consultation/participation are used, health professionals should know whether or not the council is bound by the

results of these consultative methods (polls, referenda).

## Presentations – oral or written submissions, public meetings, council presentations

Presentations provide both opportunities and challenges in relation to content, style, the range of presenters, and the ways in which fluoridation is framed.

## Scientific content

When giving presentations it is important to acknowledge the part that science plays in fluoridation as an oral health strategy, without relying on scientific evidence to produce a decision in favour of fluoridation.

Scientific information can include how fluoride works in relation to tooth development; relationships between fluoride intake and dental caries; incidence and implications of dental fluorosis; relationships between fluoride intake and the incidence of bone fractures, sarcomas and other health problems; and the chemical properties and sources of different forms of fluoride.

It must also be recognised that 'debates' around the science underpinning fluoridation do not exist in isolation from other public debates, and the ways in which science, governments and industries interact.

## Values

It is worthwhile to recognise that the values underpinning fluoridation initiatives as well as the arguments by anti-fluoridation campaigners are not dissimilar. These include:

- do no harm.
- water as a valued (natural) resource.





## Ethics

Those campaigning against fluoridation and also decision-makers often refer to the ethics of 'individual rights' or 'individual choice'. Health professionals may frame the collective responsibility health equity outcomes also as an ethical issue.

## Health equity

The health equity argument is based on the premise that for those with limited access to resources (education, money, alternative fluoride treatments, time); fluoridation of public water supplies is the most effective protection against tooth decay (and attendant oral health problems). Another way to approach the issue of health equity is to demonstrate the relationship between the costs of implementing or maintaining fluoridation and the costs of dental care in a given region or locality. These costs would include the direct costs of dental care as well as morbidity rates associated with oral health problems. The effectiveness of the health equity approach is improved through using locally relevant data through which members of the public and councillors are made aware of social, economic and ethnic disparities in their region (also see section 'local contexts' below).

There is a danger that drawing attention to relationships between ethnicity and socio-economic factors will promote a 'victim blaming' response, whereby differences in health outcomes are attributed to ('ethnic') individual or family behaviour, rather than societal causes such as discrimination and differential access to resources. One way to combat this tendency is to get disadvantaged groups to present their own experience.

## Individual rights

The individual rights approach used by those opposing fluoridation is based on the freedom to choose whether to have fluoride or not as well as the freedom from authoritarian decision-making. The freedom to choose argument is countermanded by the concept of individual responsibility to others (see above), while the freedom from argument can be countermanded by the principles underlying democracy and how we select and/or elect certain people to make decisions on behalf of others.

The democratic principles argument also endorses the council mandate to make decisions on behalf of the communities they serve, rather than opting for less appropriate methods of public participation.

Most decision makers accept that health professionals can talk on behalf of their patients – especially children. It is important therefore that when presenting information or making submissions that the audiences are convinced that concern for others is the driving force behind maintaining or initiating fluoridation. Passion on behalf of others is important.

## Local contexts

Statistical data, photographs, and anecdotal experiences are all part of producing a local 'story'. Anecdotal experiences include those of health professionals, community organisations and individuals, for example, anecdotal evidence of older people who are able to compare their own dental health with that of their children.

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# Helping WHO prepare for the re-emergence of SARS

From July to September 2003 Douglas Lush, Acting Director of Public Health, worked on secondment with the Communicable Disease Surveillance and Response (CSR) team of the World Health Organization (WHO) in Geneva. Here is his report.

CSR systematically gathers official reports and rumours of suspected outbreaks from a wide range of formal and informal sources. These reports are then verified and their public health significance assessed. WHO offers assistance to affected state(s) in the form of technical advice, supplies and, in a number of cases, by mounting co-ordinated international investigations/responses. In March 2003, CSR recognised the emergence of a new and potentially devastating disease now known as SARS. CSR co-ordinated the global response to the emergence of SARS, including regular web-based updates, travel advisories, establishing global datasets and providing clinical and control guidelines. Once SARS was brought under control the tasks within CSR turned towards learning more about the origin and control of SARS in order to be able to respond to any future re-emergence of the disease.

My tasks within CSR included establishing the SARS Research Advisory Committee to determine



Douglas Lush

the global research priorities for the future public health control of SARS. Committee members included international leaders in the fields of epidemiology, disease modelling, economic impact, risk communication, and psychology as well as clinicians and public health physicians who had been involved in managing the outbreaks within the affected countries. The Committee met on 20 and 21 of October in Geneva and determined a preliminary list of research questions for global research agencies and funding institutions.

Other work within CSR included assisting in the process of updating the International Health Regulations (IHR) that are expected to be approved by the World Health Assembly in 2005. The updated IHR are designed to allow for better recognition and response to future global public health threats while minimising the effects on trade. National, regional and global consultation on the new IHR will take place over the next 18 months.

I appreciated the extraordinary opportunity to work within WHO, gaining many insights into the capacity and the mandate of WHO in responding to global threats to health. I am grateful to WHO for hosting my secondment and to the Ministry of Health for supporting me.

## Public Health Perspectives Mailing List

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