

Public Health Perspectives

Presenting the Ministry of Health's public health focus

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Time to test the waters

The Ministry of Health is currently consulting with small and rural communities on proposed changes to the Drinking-Water Standards for New Zealand [DWSNZ], and the Health (Drinking Water) Amendment Bill [HDWAB].

Safe drinking-water is a cornerstone of public health. Throughout the world pressure is coming on drinking-water resources. This has long been the case with the developing countries. The World Health Organization reports that 2.2 million people, mostly children, die every year from diseases related to poor sanitation, mainly from contaminated drinking-water.

In 2002, 22 percent of New Zealanders received water for which the quality was unknown. There were several reports of water-borne disease outbreaks.

To provide greater protection against water-borne disease, the Ministry is revising the drinking-water standards as part of a new drinking-water safety plan.

The intent of the drinking-water safety plan is to make the greatest possible use of multiple barriers to contaminants. These barriers cover all stages of the drinking-water supply from catchment to the user's tap. They operate within an overall risk management framework (quality assurance). The aim is to develop water quality management processes that are effective and affordable.

To promote the application of this 'catchment to consumer' plan, the Ministry is working with the Ministry for the Environment to develop a national environmental standard (NES) under the Resource Management Act 1991. The standard will apply to drinking-water in all its forms. The Ministry of Health, the Ministry of Economic Development, the Building Industry Authority and the New Zealand Food Safety Authority (NZFSA) are also focusing on the safety of smaller supplies and the user.

The proposed NES is a monitoring and reporting standard to better inform the community about the risks posed by its drinking-water source(s). In addition, the NES will bring about better Regional Council involvement in community water source planning and protection.

The HDWAB will cover all water supplies that are not subject to the Building Act 1991 or to New Zealand Food Safety Authority legislation. The HDWAB will provide risk management based procedures for all piped and tankered supplies, whether they are privately or publicly owned. It will authorise the Minister of Health to adopt public health standards for the quality of drinking water.

The DWSNZ, which were not designed to effectively cover tankered or individual water supplies serving fewer than 25 people, have been extended to cover these situations.

Editorial

Graeme Gillespie
Manager, Public Health Programmes



Acheson's definition of public health as the 'science and art of preventing disease, prolonging life and promoting health through organised efforts of society' has received general acceptance. Improving health outcomes through the collective efforts of society results from the degree of determinants of health that lie outside of the health sectors direct ability to change.

Building healthy communities and healthy environments through effective intersectoral collaboration and action is a fundamental principle of the Public Health Directorate's strategic plan to 2008. Achieving effective intersectoral approaches relies on taking maximum advantage of opportunities, as much as initiating and leading new initiatives. Two recent opportunities for generating intersectoral action have presented themselves. The first is at the policy end and the second at the community level.

Opportunity for All New Zealanders is the Government's high-level strategy for social development, and a response to social conditions reflected in *The Social Report*. It paints a big picture of what the Government is doing to improve the wellbeing of all New Zealanders. It is due for publication at the end of August.

Opportunity for All will have two parts. Part One describes what the Government is doing to improve social wellbeing and why it is doing it.

Part Two identifies a limited set of critical social issues for sustained interagency attention over the medium to long term, in order to improve outcomes further.

The development of *Opportunity for All* is being led by the Ministry of Social Development. The Ministry of Health is actively contributing to the project and is confident that the critical social issues identified in it will have direct implications for public health.

At the local level local government can play a leading role in improving health outcomes of its communities. The purpose for local government as stated in the Local Government Act 2002 is to promote the social, economic, cultural and environmental wellbeing of local communities. Local authorities also have a statutory mandate to promote and improve the health of their districts through section 23 of the Health Act 1956.

Long-term council community plans provide an excellent framework for co-ordinating intersectoral action at the local level. The health sector needs to look at how it can assist in this opportunity. A critical role is developing skills within local government to assist its development of long-term community plans and other planning activity. Imagine every local authority having someone with knowledge of the determinants of health and epidemiology skills and in key strategic positions.

Healthy Eating – Healthy Action: Oranga Kai – Oranga Pumau Implementation Plan Launch

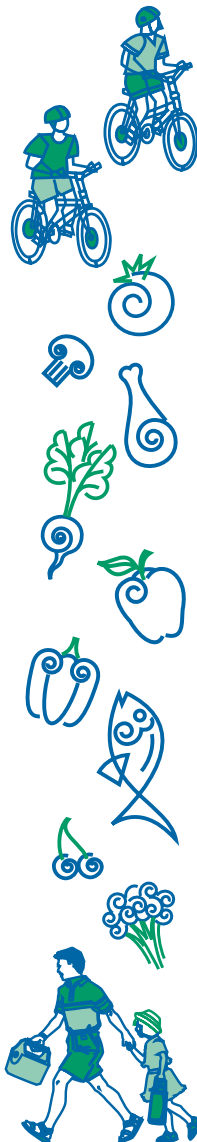
On 24 June the Minister will be launching the Healthy Eating – Healthy Action Implementation Plan at Parliament.

The launch is the culmination of over 18 months' work led by the Public Health Policy group. The strategy and implementation plan combine three of the population health objectives from the New Zealand Health Strategy – improving nutrition; increasing physical activity; and reducing obesity. This integrated strategy has been developed in parallel with the WHO Global Strategy on Diet, Physical Activity and Health, which was recently ratified by the WHA.

The Implementation Plan will provide further direction to the health sector and other sectors that will be involved in achieving the goals of the strategy.

Four different groups have contributed to the development of the Plan:

- an external advisory group made up of nutrition, physical activity and health promotion experts
- an interagency group made up of representatives from different government agencies
- an industry group with representatives from nutrition and physical activity industries



- an internal group with representatives from the Ministry of Health and (Sport and Recreation New Zealand) SPARC.

Twenty-six outcomes have been developed in the implementation plan and 87 actions identified in order to reach these outcomes. Some of the actions identified in the plan will require new funding to achieve progress and some actions are already occurring but will need increased funding in order for them to expand or be implemented nationally. Some of the actions identified can be completed within existing funding.

Actions identified in the 'Start Here' list of the plan include:

- promoting nutrition, physical activity and obesity issues in preschools and schools including Kohanga Reo and Kura Kaupapa Māori
- initiating and developing a range of social marketing strategies to facilitate behavioural changes supporting healthy eating, healthy action and healthy weight
- developing and implementing a strategy to increase the capacity and capability of trained Māori and Pacific health professionals and community health workers.

Health Research Council – Foxley Fellowship

The Foxley Fellowship is a prestigious award that will enable an individual with a minimum of five years' experience in the health sector to undertake a one-year research sabbatical within an academic institution.

The research undertaken by the applicant should be aimed at increasing the utilisation of health research results within the health sector. Information regarding the Foxley Fellowship can be found at <http://www.hrc.govt.nz/assets/pdfs/funding/foxleyfellowship.pdf>

Applications and forms

Applications must be made to the Council through the head of department and through the normal administrative channels of the applicant's intended institution.

Full information and application forms are available from the HRC website www.hrc.govt.nz

Closing date

5.00 pm Wednesday 1 September 2004.

National Immunisation Register

A website, resources, an education/training programme and significant progress on software development all signal that the National Immunisation Register (NIR) is just about ready to go live.



The NIR is a computerised information system that has been developed to hold immunisation details of New Zealand children. It is based on the successful Kidslink programme which since 2002 has recorded immunisation information on children in Counties Manukau, Westkids and the Eastern Corridor of Auckland. The NIR is designed for all New Zealand children.

Providers in DHBs where the NIR is going live first have been informed about what the NIR will mean to them and how it will affect their practice. Training is focused on all levels from DHB NIR administrators through to vaccinators and those who will provide education to parents. Ensuring accuracy and consistency of messages has been a key goal of the NIR teams.

Immunisation providers will access the NIR information in three ways: electronic messaging of their updated PMS system, browser access via the Health Intranet, and through a manual process. To

ensure privacy and data security, only authorised users can use or disclose NIR information. Also, the level of access to the NIR is determined by the user's role in immunisation.

Once the NIR goes live in a DHB, all children born in that DHB will have their immunisation data recorded onto the NIR. These children are known as the 'birth cohort'. Older children will only have immunisation event data recorded onto the NIR if they participate in the proposed Meningococcal B Immunisation Programme either through the school-based campaign or the primary care campaign.

The NIR is due to kick off in the Counties Manukau, Waitemata and Auckland DHBs in mid 2004.

Public Health Workforce Action Plan – A big thank you!

The Public Health Workforce Action Plan is the first time anyone has attempted such a comprehensive workforce survey of the organisations and individuals who provide public health services in New Zealand. Consequently, both the Ministry and the research company have been on a steep learning curve.

The organisational level survey is now complete. We'd like to thank all managers for your patience and hard work. The individual survey, ie, a survey of all the individuals who work in the organisations, is now under way.

Please take the opportunity to fill in your survey form and get your information and your opinions into the 'pot'.

It will help develop the consultation document, be made available to the sector, and will be useful for planning at all levels.

With the help of the sector reference group, which is an amazing group of highly committed and dynamic thinkers, we aim to have a discussion document ready for consultation in September. Accompanying the discussion

document will be the first analysis of the survey. So keep your eye out for this.

If you'd like to have your name on a 'friends of workforce development' mailing list to stay in touch with this project, please contact Rockshan Creado (rockshan_creado@moh.govt.nz).

For more information or just to feed back on any aspect of the plan, please contact Viv Head (viv.jake@xtra.co.nz) or Maggie McGregor (maggie_mcgregor@moh.govt.nz).

Review of the International Health Regulations

The current International Health Regulations 1969 are the World Health Organization framework for preventing and controlling the spread of infectious disease around the world. Key components of the IHR have been incorporated into New Zealand's domestic legislation. They underpin the quarantine provisions governing infectious and quarantinable diseases.

However, the current IHR are rather prescriptive, and in particular are narrowly focused on the management and reporting of three particular diseases (cholera, yellow fever and plague). In 1995, the World Health Assembly (the member states that make up the supreme decision-making body of the WHO) asked the Director-General of WHO to revise the IHR.

Since the review process began, there have been a number of disease outbreaks of international significance. These include several avian influenza incidents and, of course, SARS in 2003.

The first substantial redraft was circulated to member states in January of this year. It kept many of the tried and true features such as *pratique*, a focus on disease vectors as well as diseases, and the expectations around sanitary measures for ships, aircraft, ports and airports. The redraft, however, also had some innovative new provisions.

These included:

- a deliberate focus on a broader range of threats to public health than just a short list of specified diseases
- explicit expectations that countries will develop and maintain the capacities for local and national surveillance and to mount co-ordinated responses to threats to public health
- a requirement to assess and then notify WHO of events which might constitute a potential or actual public health emergency of international significance, along with a flow chart (decision instrument) to assist countries make such assessments

- a mechanism for confidential consultations between member states and WHO in circumstances where a formal notification may be a marginal call
- recognition that WHO take into account information from unofficial as well as from official sources in forming its views about an emerging issue, and that WHO may seek to initiate investigations into matters (rather than just wait to be invited in).

The process from here is that WHO will consult with member states in each of WHO's six regions, finishing in June. After that, WHO will revise and reissue the draft. Member states will then have a further opportunity this coming November to discuss the detail of the proposals. Then, WHO will provide a final draft, which will be submitted to the World Health Assembly in May next year.

The Western Pacific Region was the first region to formally consult member states. This was through of a three-day meeting in Manila in late April 2004. The Western Pacific Region is a particularly diverse one, encompassing some of the smallest as well as the most populous countries in the world. It also includes some of the smallest economies, along with economic superpowers such as Japan. Overall, the Region expressed strong support for the general intent of the proposed IHR, in particular the focus on the effective detection of potential threats, improved response to such threats and a clear framework for international co-ordination.

In general terms, New Zealand supports the proposed revisions to the IHR and made a constructive contribution to the regional consultation process.

Biting back against the Mozzies

Southern Saltmarsh Mosquito Response Progress Report

The Southern Saltmarsh Mosquito is one pesky little varmint that experts are desperate to keep under control. In fact, their goal is to 'eradicate' this nasty breed of mozzie.

Certain mosquitoes – and the Southern Saltmarsh Mosquito is one of them – can transmit the Ross River Virus disease. For some people this disease causes painful aching in muscles and joints, a rash and even debilitate a person for five to six weeks.

The mosquitoes are just the carriers. The actual disease is sometimes brought into New Zealand by people who have been in Australia. The mosquito bites the traveller, picks up the disease, and then passes it on to the next person it bites. Even if you don't get the disease from the mosquito, just the bite can be pretty nasty!

Because this disease can affect so many people, the best approach is to target the carrier. Even this is not as easy as it sounds because eradicating this mosquito has not been done anywhere else in the world. The Ministry of Health takes advice from specialist scientists and technical experts. Experts have been contracted to run eradication programmes in all known 'hot spots'.

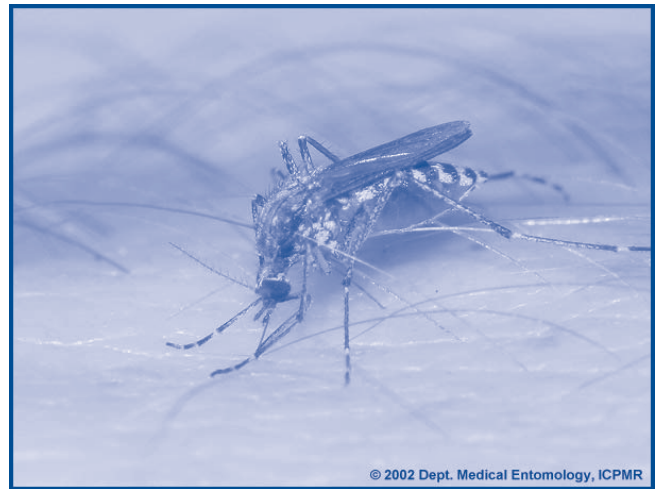
Eradication programme: Napier, Mahia

The eradication programmes in Napier and Mahia are now done. The local public health service will keep an eye on potential habitat¹ as part of their ongoing saltmarsh surveillance. No more southern saltmarsh mosquitoes have been found.

Eradication programme: Tairawhiti, Porangahau

The eradication plan for the remaining Hawke's Bay site (Porangahau) and Tairawhiti is being implemented. Applications of S-methoprene to sites in Porangahau and Tairawhiti were completed in April 2003 and June 2003 respectively, and surveillance is continuing.

The last adult trapped in Porangahau was in June 2002. The last larva was detected in August 2002. If no further larvae or adults are detected, eradication will be completed in September 2004. The last mosquito was detected in Tairawhiti in September 2002. If no further adults or larvae are found, eradication will be completed in October 2004.



Eradication programme: Kaipara

The Kaipara eradication programme is being fully implemented. Permanent sentinel surveillance sampling sites have been established at 31 locations including Mangawhai and Whitford. Staff visit the sites twice a week and sample for adults and larvae. They have picked sites to represent known positive areas, intermittently positive areas and known negative sites.

The last adult was trapped at a surveillance site in Kaipara in September 2003, and the last larvae in February 2004. Treatment of the habitat is due to be completed in June 2004. If no further evidence of SSM is found, eradication will be completed in February 2006.

The last adult trapped at Mangawhai since full-time surveillance began was in December 2002. Repeated surveys have not detected any larvae at Mangawhai at any time. If no further adults are found, eradication will be completed in December 2004. The last adult mosquito spotted in Whitford was in April 2002 and the last larva in November 2002. Since treatment has been applied for two summers and no further adults or larvae have been found, treatment in Whitford ceased in March 2004. Eradication will be completed in November 2004.

Whangaparaoa Peninsula

Staff conducted a survey of Shakespear Regional Park on 27 January 2004. This was after heavy rainfall combined with a spring tide of 3.4 m at Waitemata on 23, 24, 25 January 2004. Seventeen third instar² larvae from one site were identified on

28 January 2004 as being SSM larvae. Delimiting of the Whangaparaoa Peninsula and other potential habitat nearby identified a further two infested sites within 200 metres of the index site and within the same Park wetland. (Surveillance of these sites, undertaken shortly after the previous inundation event, on 8 August 2003, had detected *Culex pervigilans* and *Ochlerotatus antipodeus*.)

On the morning of 28 January a delimiting operation was launched to characterise the index site and to delimit the buffer zone. On 28 January 2004, the whole Peninsula was delimited and aerial surveys from Long Bay to Puhoi were undertaken to identify potential habitat. On 29 January 2004, all potential habitat from Long Bay to Puhoi was surveyed (although most was found to be dry). Potential habitat that was not inundated at the time of this initial delimiting was revisited after inundation. Staff then came back a third time when survey conditions were better (less windy and turbulent).

On 28 January 2004, staff noticed that larvae at the index location had matured to 4th instar. It became a priority to begin treatment whilst the larvae were still susceptible to S-methoprene. The same day, the Associate Minister for Biosecurity authorized (under section 7A of the Biosecurity Act 1993) a 20-working day exemption from Part III of the Resource Management Act. This made it possible for staff to apply XRG over 22 hectares of habitat at 3 o'clock that afternoon. This exemption has been subsequently continued by way of regulations, and treatment is continuing at around 21-day intervals to make sure a lethal dose of S-methoprene is maintained in the infested habitat.

Adults have never been found at this site, and the last larvae were found in March 2004. An eradication plan has been adopted for Whangaparaoa. That includes maintaining treatment of the index locations until April 2005, and surveillance for two years beyond the date of the last detection of SSM at the site.

Wairau incursion

SSM have been found in lagoons in the Wairau estuarine area near Blenheim. The mosquitoes were found after duck shooters reported being bitten by aggressive mosquitoes on the opening day of the duck season.

Nelson-Marlborough District Health Board's Public Health Service and New Zealand Biosecure investigated the area on the seaward side of the Wairau Valley. They found specimens at all stages of the mosquito's life cycle.

Initial delimiting surveys over approximately 2500 hectares of the lagoon area and habitat in the region have been completed. The SSM infestation has been found throughout the lagoon area, south of the Wairau Diversion. Surveillance identified areas of potential habitat that was dry at the time of the delimiting survey. These areas will be surveyed after heavy rain and/or high tides have inundated the habitat and encouraged any mosquito eggs that may be present to hatch. The upper estimate of infested habitat is around 800 hectares. A small, discrete positive site was also found at Lake Grassmere.

Consultation with landowners, residents, Council staff, iwi, Department of Conservation, and other interested parties is ongoing.

Public health services throughout New Zealand are also undertaking enhanced surveillance of saltmarsh habitat within their regions to identify if this mosquito is established anywhere else.

Once the information about the extent of the Wairau infestation, and nationwide surveillance is available, Ministry staff will discuss the information with scientific and technical experts. They will identify a range of possible options to respond to the Wairau incursion (including Lake Grassmere).

Whew! Aren't you glad you're not a mosquito?

¹ 'Habitat' here refers to a place (or places) where the mosquito lives.

² An instar is a phase between two periods of moulting.

Ready for Influenza 2004?

Each year New Zealand health services prepare themselves for the 'influenza season'. It can really take its toll.

In 2003, for example, surveillance estimated that influenza-like illness accounted for more than 46,000 visits to a general practitioner and a total of 586 hospitalisations. What can we do? So far this year, more than 670,000 vaccinations have been distributed to providers for the immunisation of New Zealanders.

We also think of the bigger picture. As part of a global initiative, New Zealand participates in international influenza surveillance. General practices here collect the data. It is then used in international vaccine strain selection.

The Ministry of Health and the National Influenza Immunisation Strategy Group (NIISG) support the promotion of influenza vaccination for those at high risk of contracting the disease. This includes people aged 65 and over, as well as adults and children with certain chronic medical conditions. NIISG, which is made up of medical and nursing health professionals as well as representatives from the vaccine manufacturer, provides education about influenza to health professionals. It also develops and provides free resources for distribution to consumers.

Each year NIISG supports an influenza vaccination campaign at the national level, and supports a number of regional and local promotion initiatives. Key messages for the 2004 influenza season are:

- Influenza is serious and can affect anyone.
- Influenza immunisation is your best protection.
- You need an influenza vaccination each year – get vaccinated early.
- Influenza vaccination is free for those at greatest risk.

For further information, talk to your health care provider or visit the webpages: www.moh.govt.nz/influenza.html

More choice in District Health Board elections

vote!
2004 Local+DHB Elections

This year's District Health Board (DHB) elections will feature not only a new voting system but also the chance to vote for members across the whole district.

Voters in October's DHB elections will be given the opportunity to rank all the candidates who stand in their district rather than just selecting a limited number of candidates on a constituency basis. The new voting system is the Single Transferable Vote (STV) and it replaces the First-Past-the-Post system used in the first District Health Board elections in 2001.

Instead of putting a tick beside candidates' names, voters in October's DHB elections will put a number showing their degree of preference for the candidate. For example, if a voter liked Candidate A best, they would put a '1' beside Candidate A's name. If the voter liked Candidate B next, they would put a '2' beside Candidate B's name, and so on. You can rank as many or as few candidates as you like.

This year's elections will also be held 'at large': all votes cast in a district will contribute to electing all seven board members. In contrast, voters at the 2001 elections could only vote for a limited number of board candidates, on a constituency or ward basis.

Health Minister Annette King says the new system gives voters more choice and power to determine the total make-up of the boards. It also means that boards better reflect the regional nature of health service provision.

Up to 11 members sit on each DHB board. Seven are elected every three years at the time of local government elections, and up to four can be appointed by the Minister of Health.

Nominations for candidates open on 23 July and close on 20 August. Postal voting in local and DHB elections closes at noon on 9 October.

For more information, visit www.moh.govt.nz/dhbelections

Harkness Fellowship to Elana Curtis

Dr Elana Taipapaki Curtis has been awarded a Harkness Fellowship in Healthcare Policy for 2004/05. In September she will leave her role as Public Health Medicine Specialist with the National Screening Unit (NSU) and head to the US for a year.

Elana's Harkness research proposal will extend the work she has been doing at the NSU for BreastScreen Aotearoa. She has been examining the epidemiology of breast cancer in Māori and non-Māori women. Her Harkness project is titled 'Ethnic Disparities in Breast Cancer Mortality and Survival: Understanding the role of access and quality in breast cancer screening and treatment'. Elana's chosen topic supports her passion for researching ethnic disparities in health. She is looking forward to applying the knowledge and experience she will gain in the US to Aotearoa when she returns.

The specific aims of her research proposal are to:

- identify the ways in which the US has examined the causes of ethnic disparities in breast cancer mortality and survival and determine the applicability of these findings to New Zealand.

A specific focus will be on ethnic differences in access to and quality of breast cancer screening and treatment services



Elana Taipapaki Curtis

- perform a quantitative analysis of routinely collected data investigating differences in an aspect of breast cancer screening and/or treatment quality between ethnic groups in the US
- present recommendations for further research and interventions that should be considered in order to investigate and address ethnic disparities in breast cancer mortality and survival in New Zealand and the US.

Elana is currently discussing placement options with Mount Sinai Medical School (New York City) and UCSF (University of California, San Francisco) to undertake her project.

Previous Ministry of Health Harkness fellows have included Dr Colin Tukuitonga, John Hobbs, Dr Frances Hughes and Dr Sue Crengle.

Secondhand smoke a killer

You wouldn't leave arsenic, ammonia, carbon monoxide, methane, formaldehyde and naphthalene under the sink for your children to drink so why smoke around them?

All these chemicals are in cigarette smoke that children are exposed to.

To get the message across a new hard-hitting advertising campaign has been funded by the Ministry of Health. The advertisement shows cigarette smoke 'morphing' into the poisonous chemicals found in tobacco smoke, highlighting the dangers of secondhand smoke. The new campaign focuses on the dangers of smoking around children, particularly in the house and car.

The *British Medical Journal* recently published a study that shows that adults who have never

smoked and who live with smokers have a 15 percent higher risk of death than those living in a smokefree household. It is the biggest study of its kind and adds considerable weight to the existing evidence of harm caused by exposure to secondhand smoke.

Adults may not realise just how dangerous tobacco smoke is. It contains a large number of noxious poisons that can make children, with their small and delicate lungs, extremely sick.

Smoking in a different room, or blowing your smoke away from children is not enough. You need to smoke outside the house or car.

Those who are ready to take the next step and quit smoking should call the freephone Quitline on 0800 778 778.

Emergency of national significance

Imagine this. It's a Friday afternoon in a provincial New Zealand city. People start to get sick with severe gastroenteritis. Over the weekend health care workers start to catch the illness as well. Primary care, hospital emergency department and public health services are quickly overloaded and are unable to cope.

Then it gets much worse. A terrorist organisation contacts the news media and claims responsibility.

This is the scenario that was faced by Medical Officers of Health and senior public health medicine registrars at a recent two-day emergency risk communication workshop in Rotorua.

The aim of the workshop was to walk Medical Officers of Health slowly through the practical risk communication issues of an emergency of

national significance. Issues covered during the workshop included psychology of a crisis; audiences and messages; choosing the right communication channel; choosing the right spokesperson; facing the news media; pre-event planning; crisis management; and terrorism and bioterrorism challenges.

One of the highlights of the workshop identified by attendees was the media training. All the Medical Officers of Health were interviewed and videotaped on both days by an experienced health reporter. Individual feedback and tips were provided.

The workshop was funded by the Ministry of Health and organised as a 'group effort' by Drs Jonathan Jarman, Phil Shoemack, Derek Bell (Medical Officers of Health), Frances Ross and Peter Abernethy (Communications advisors from the Ministry of Health) and Judith Parnell (Australasian Faculty of Public Health Medicine).

Awareness Campaigns

July to December 2004

11 July	Dyspraxia Awareness Day	10 Oct	World Mental Health Day
	World Population Day	15 Oct	World White Cane Day
August	Disability Pride Month	16 Oct	World Food Day
1-7 Aug	World Breastfeeding Day	18 Oct	International Day of Tolerance
9 Aug	International Day of Indigenous People	24 Oct	United Nations Day
12 Aug	International Youth Day	3 Nov	Eating Disorder Awareness Day
1 Sept	World Deafness Day	9 Nov	Push Play Day
9 Sept	International Fetal Alcohol Syndrome Day	12 Nov	Disability Mentoring Day
10 Sept	World Suicide Prevention Day	14 Nov	World Diabetes Day
19 Sept	Women's Suffrage Day	20 Nov	Universal Children's Day
21 Sept	International Day of Peace	1 Dec	World Aids Day
21 Sept	World Alzheimer's Day	3 Dec	International Day of Disabled Persons – Equal opportunities, equal participation
23 Sept	World Retina Day	5 Dec	International Volunteer Day
25 Sept	World Deafness Day	7 Dec	International Human Rights Day
1 Oct	International Day of Older Persons		

Update on National Drug Policy Review

Government Ministers have approved a review of the *National Drug Policy 1998 – 2003*. The NDP outlines the Government's intentions regarding drug issues in New Zealand over a five-year period. It provides the framework for encouraging the development of strategies and programmes which prevent and reduce drug-related harm.



The NDP was designed to provide a single strategic cohesive national policy that brought together cross-government strategies and interventions. Specifically it was intended to:

- form a basis for coherent policy development across a wide range of settings and agencies
- assist co-ordination of strategies and delivery through identification of any gaps and overlaps, and through establishing key linkages and co-ordination mechanisms
- provide for the development of measurable outcomes against which the impact of the strategies may be assessed.

The overarching goal of the current NDP is to minimise the harm caused by tobacco, alcohol, illicit and other drug use to both individuals and the community, as far as possible and within available resources. This approach recognises that there is a continuum of harm associated with drug use which cannot be addressed by a single set of strategies or approaches. Harm can be minimised through supply control measures, demand reduction measures, or problem limitation measures.

In order to determine how effective and collaborative the existing NDP framework has been in minimising harms arising from drug use in New

Zealand, Allen and Clarke Policy and Regulatory Specialists has recently completed a qualitative assessment of the implementation of the NDP. This scoping exercise identifies the basis for a public consultation in mid 2004 on what a future National Drug Policy will look like. It is hoped that the sector and the community in general will contribute

to the development of a forward-looking, workable and generally agreed approach for the next five years.

Some of the questions that need to be addressed at the consultation phase are:

- What sort of document should it be – high or low level, general or specific, fixed or flexible?
- Should harm minimisation remain the overarching principle for drug policy in New Zealand?
- What are the priorities and how should they be established?
- Should tobacco, alcohol, illicit and other drugs all continue to be dealt with under the policy?
- Is it more important to address different substances than target groups within society?
- How can an emphasis on outcomes be assured?
- What resources will be required?
- What mechanisms should there be to co-ordinate views and action across the sector?

The consultation process should be completed by August. A new National Drug Policy will be ready for consideration by Government in November 2004.

'Towards a Healthy Nation' conference

The impact on the health sector of new information management technologies in the areas of workforce development, primary health care and population-based health, will form the key theme at the Health Informatics New Zealand 'Towards a Healthy Nation' conference to be held in Wellington over 27-29 July 2004.

The conference will be opened by the Minister of Health, the Hon Annette King, and is being hosted by the New Zealand Health Information Service.

Over 300 delegates are expected to attend the three-day conference and exhibition. Delegates will be informed by an exciting array of speakers aiming to increase sector knowledge around information management and information technology as being an essential component of health care in New Zealand.

Keynote speaker Mike Rillstone, Ministry of Health Group Manager for the New Zealand Health Information Service will outline a direction of how Information Management Technologies will support population-based care.

'This is an important event for all stakeholders who have an interest in health IT, the focus is firmly fixed on collaboration and connectivity, and on the need to develop a service built around the needs of the patient,' he says.

'Information-enabled health services can streamline workflow, speed up and improve the delivery of patient care, reduce errors and use resources more effectively, but it cannot do these things alone. Buy-in from clinicians and administrators will be a critical part of the equation.'

Pre-conference workshops on Tuesday 27 July include a session provided by Women in

Technology titled 'Do you have the right stuff for an IT career', where participants are encouraged to explore their existing skills and their ability to transfer those skills into health information management.

Also on Tuesday will be a satellite link-up to a health informatics conference occurring simultaneously in Australia. IMIA President-elect Nancy Lorenzi will deliver a keynote presentation titled 'IT and Change Management in Health', via the satellite link.

Other speakers will address issues such as privacy and security, the transfer of clinical information from general practice to the new Primary Health Organisations and the implications of clinical performance indicators.

The joint Ministry of Health and HINZ 'Sharing Excellence in Health and Disability Information Management' 2004 awards finalists will be announced at the conference opening cocktail party.

District Health Board Chief Information Officers will have their own forum for discussing how changes are best implemented within their organisations.

The conference will be held at the Wellington Convention Centre.

Further information and registration is available through www.hinz.org.nz

Ministry of Health Publications

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