REVIEW OF THE Public Health Act 1991

Issues Paper

Better Health *Good Health Care*

NSW HEALTH

NSW HEALTH DEPARTMENT

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September 1999

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PART 1 INTRODUCTION

CHAPTER 1 BACKGROUND TO THE REVIEW

1.1 Introduction

Public health has long been an issue addressed by Government in part through legislation. Legislation has over time, adapted and changed to reflect the changing nature of society and risks to public health.

The current Public Health Act was introduced in 1991 following a review of the previous 1902 Act. The Act contains a series of legislative requirements governing a wide range of public health related issues. These range from general powers to respond to public health risks that may emerge from time to time, through to specific provisions dealing with identified risks associated with specific industries or arising from individual conduct.

1.2 The Current Review

The NSW Department of Health is undertaking a review of the Public Health Act 1991 and Public Health Regulation 1991. Terms of Reference for the review are set out in **Appendix A**. A number of factors have contributed to the need for a review of the legislation including the following.

- In 1995, all Commonwealth, State and Territory Governments committed themselves to the Competition Principles Agreement. Governments have agreed to review all legislation for the purposes of considering its potential anti-competitive effect. The guiding principle for these reviews is that legislation should not restrict competition unless it can be demonstrated that the benefits to the community as a whole outweigh the costs of restricting competition, and that the objectives of the legislation can only be achieved by restricting competition

- The Subordinate Legislation Act 1987 requires all Regulations to be reviewed, and if appropriate, remade every five years. The Public Health Regulation 1991 is scheduled for staged repeal on 1 September 1999. The Subordinate Legislation Act sets out the requirements which new regulations must meet. (These are detailed in Chapter 3 of the paper).

- The current Public Health Act and Regulations have been in operation for nearly eight years, with further piece-meal amendments occurring over that time. A number of specific problems with the current Act have been identified which require review. Further, consistent with general regulatory review principles, the Department is of the view that it is appropriate to consider and review the current Act and Regulations to

ensure that legislative and regulatory strategies remain appropriate for achieving public health objectives and are in the public interest.

- The National Public Health Partnership has established a Legislative Review Working Group to provide a national forum in which to discuss issues relating to public health law. While this body is advisory in nature, many of the issues identified for discussion in that forum relate to the current Act and Regulation.

The Department recently conducted a comprehensive review of the Tobacco Advertising Prohibition Act 1991 and as a result amending legislation has been passed by Parliament to consolidate the provisions of that Act within the Public Health Act 1991 and this will commence on 31 August 1999. Accordingly, the Department will not be revisiting issues which arose during the course of that Review.

During 1997, the Department wrote to key stakeholders in relation to the requirement to review the Public Health Regulation under the Subordinate Legislation Act 1989. In reviewing these submissions, it became apparent that a comprehensive review of the Act and Regulations would need to be undertaken concurrently. Pending this review, the staged repeal of the Public Health Regulation 1991 under the Subordinate Legislation Act 1989 has been postponed until 1 September 1999.

During 1998, the Department engaged Sydney University Faculty of Law to undertake a preliminary mapping exercise to assist with the identification of issues relevant to public health law in NSW. A number of issues identified by the consultants in their paper *Reform of Public Health Law in NSW* have been raised for formal consideration in this paper.[1]

1.3 This Paper

The Department has prepared this Issues Paper to facilitate community discussion of matters identified during the Review so far, in particular, those relating to the Government's obligations arising under the Competition Principles Agreement.

Copies of the legislation can be obtained from the NSW Government Bookshop (ph 02 9743 7200) or from the Australian Legal Information Institute Website at:
http://www.austlii.edu.au/au/legis/nsw/consol_act/pha1991126.

Submissions are invited from the public on issues identified for discussion in the following paper and any other matters within the terms of reference for the Review. Submissions will assist the Department to formulate

[1] Allars, Carney, Magnusson, McMahon and Opeskin December 1998 *Reform of Public Health Law in NSW* A report to the NSW Health Department, Faculty of Law Sydney University

recommendations (if any) to the NSW Government on amendments to the Public Health Act 1991. An assessment of the need for additional consultation will be made after submissions have been received.

It should be emphasised that one of the purposes of this review is to consider whether there is a continuing need to regulate certain matters affecting public health, and if so, the appropriate regulatory regime to achieve the objectives of the Act. Those making submissions should endeavour to provide material in support of their position, including the advantages and disadvantages of particular strategies.

To meet the requirements of the Competition Principles Agreement it may be necessary to prepare detailed assessments of regulatory options, including an assessment of the costs and benefits of different regulatory action. In relation to provisions of the Act relating to the Funeral Industry, the Department has engaged independent consultants, ACIL Consulting Pty Ltd, to undertake this work who will prepare a report for the Department. This material, and the submissions received, will be used in preparing the Final Report for consideration by Government.

1.4 Submissions

Submissions should be made to:

Legal Branch – Legal and Legislative Services
NSW Department of Health
Locked Bag No. 961
NORTH SYDNEY NSW 2059
Fax 02 9391 9604

The closing date for submissions is 16 December 1999. Inquiries should be directed to Anthony Lean, Legal Officer (Legislation), Legal Branch on ph (02) 9391 9626 or Kate Purcell, Principal Policy Officer, Public Health Legislation Project on ph (02) 9391 9258.

To assist with preparation of submissions a summary of discussion points is provided at Attachment D. To assist with analysis of submissions please indicate the specific section or discussion point of the paper that you are responding to.

Individuals and organisations should be aware that submissions might be made publicly available under the Freedom of Information Act 1988. To facilitate the review process, the Department may decide to circulate some or all submissions for further comment to other interested parties.

***Any information that is considered confidential should be clearly marked**.*

CHAPTER 2 PUBLIC HEALTH AND PUBLIC HEALTH LEGISLATION

2.1 Introduction to Public Health

The first NSW Public Health Act was introduced in 1896 largely in response to concern about the spread of infectious disease at a time when circumstances were very different from those today. Then, antibiotics were undiscovered, sanitation and working conditions were poor and most accommodation conducive to the spread of disease.[2] Early public health interventions focussed on issues such as sewerage, waste management, improved water supplies, improved nutrition and better housing. As vaccines were developed and antibiotics were discovered further advances were made in controlling disease and improving the health of populations. During the past century, it is public health programs that have played a vital role in achieving the dramatic improvements in health and life expectancy that have occurred.

During more recent times, public health programs have continued to address the traditional concerns of sewerage, clean water and safe food supplies as well as responding to the major health problems of our time, chronic diseases such as cancer and heart disease and emerging health problems such as HIV/AIDS.

Public health has substantially improved the health of the people of NSW through programs that have delivered reductions in tobacco use and related disease, declining rates of heart disease and stroke, reduction in road accident fatalities, early detection of breast and cervical cancers, increasing awareness of skin cancer prevention and improved control of infectious diseases.[3]

The distinguishing feature of public health is its focus on the health and well being of an entire population or community rather than an individual. Public health programs influence the well-being of the public and preserve quality of life in ways that people rarely notice unless a breakdown in the system occurs.[4]

2.2 What is Public Health?

Public health has been defined as "*the organised response by society to protect and promote health and to prevent illness, injury and disability*."[5]

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2 *Legislative Assembly Hansard* NSW Parliament 22 November 1990 p 60

3 National Public Health Partnership 1998 *Public Health in Australia- the Public Health Landscape* http://hna.ffh.vic.gov.au/nphp/broch/contents.htm

4 US Department of Health and Human Services and the US Public Health Service (Undated) *For a Healthy Nation: Returns on Investment in Public Health*

5 Definition of public health provided by the National Public Health Partnership MOU signed by all jurisdictions. http://hna.ffh.vic.gov.au/nphp/mou.htm

Public health strategies focus on improving, protecting and promoting public health by:

- preventing the spread of infectious diseases;
- protecting the environment, workplaces, housing, food and water;
- responding to disasters;
- reaching out to link high risk and hard to reach people to necessary services;
- monitoring the health status of the population;
- conducting research to develop new insights and innovative solutions;
- mobilising community action;
- promoting healthy behaviours[6];
- creating healthy environments such as healthy workplaces and healthy schools;
- establishing effective partnerships between government, non government organisations, industry and community groups to improve public health;
- developing health policies and programs to address both current and emerging public health risk.

2.3 The Purpose of Public Health Legislation

While law has always played an important part in public health practice, it is important to acknowledge that many gains in public health can be achieved without legislation. Legislation is just one component of the range of responses that governments use to implement policies to protect and promote public health.

For example both the National Tobacco Control Policy[7] developed in 1991 and the NSW Tobacco and Health Strategy[8] developed in 1995 identified a range of legislative initiatives (prohibitions on tobacco advertising, restrictions on under-age supply and labelling requirements) that work in tandem with programs such as health promotion campaigns, cessation support and pricing strategies to form a consolidated tobacco control strategy. There it was proposed that these initiatives all operate together, mutually supporting each other and directed to the one goal of reducing tobacco consumption.[9]

In certain situations it is necessary to legislate to ensure that appropriate measures are in place to safeguard and protect the health of the public. Legislation is necessary to underpin activities that infringe on the rights of others or require people to act in certain ways. Public health legislation focuses on managing high risk activities in the community, which have the potential to threaten public health and safety. The public expects that there

6 US Department of Health and Human Services and the US Public Health Service, op cit.
7 National Campaign Against Drug 1991 Abuse *National Tobacco Policy*
8 NSW Department of Health 1995 *NSW Tobacco and Health Strategy 1995-1999*
9 Reynolds C 'Ideas and Arguments about Public Health Law' in *Public Health Law in Australia – New Perspectives,* Australian Institute of Health, Law and Ethics 1998 at p 21

will be reasonable controls on these activities to protect their safety and well being, and to promote a high standard of public health in NSW.

2.4 Overview of the NSW Public Health Act 1991 and Regulations

The Public Health Act 1991 contains a series of legislative requirements governing a wide range of public health related issues:

- Managing public health risks through providing a power to make certain orders and give directions to authorities during a state of emergency and at other times in regard to the disinfection or destruction of items and the closure of water supplies and premises.

- Minimising the spread of infectious diseases through controlling the behaviour of affected persons, requiring their notification by medical practitioners and in providing a power to make public health orders requiring a person to be medically examined.

- Limiting the spread of vaccine preventable diseases by imposing on School Principals and Directors of Child Care Facilities certain duties and responsibilities to ensure that the immunisation status of each child in attendance is known. Additional responsibilities are also imposed to report the outbreak of vaccine preventable diseases.

- Controlling the growth of micro-organisms such as the Legionella micro-organism in air handling and hot and warm water systems.

- Preventing the incidence of and mortality from preventable cervical cancer through the establishment of the Pap Test Register.

- Ensuring that adequate standards are maintained within the funeral industry through the regulation of infection control requirements, cremation equipment, body preparation rooms, record keeping and associated requirements.

- Limiting the uptake of smoking through regulating the sale and advertising of tobacco products with specific prohibition on selling tobacco products to persons under eighteen years of age.

- Appointing medical officers of health to maintain standards of public health.

- Developing accurate surveillance systems for certain diseases by requiring any person who provides professional care or treatment at a hospital to a patient to advise of any patient that has a notifiable disease.

- Enabling the initiation of an inquiry into any matter relating to public health.

- Providing broad based regulation making powers to enable an adequate and timely response to public health issues as they arise.

2.5 Overview of Legislation Relevant to Public Health

In addition to the NSW Public Health Act there is legislation dealing with particular public health issues such as the Poisons and Therapeutic Goods Act 1966 and the Food Act 1989 which are also administered by the Department of Health. It is not intended to consider these Acts as part of this review.

Public health issues and concerns are in many cases managed by legislation outside the responsibility of the NSW Minister for Health. In fact, responsibility is spread through a range of Commonwealth, State and local authorities. While this legislation is too extensive to list in this paper, there are a number of general pieces of legislation worth mentioning because of their relevance to public health management:

- The *Local Government Act 1993* establishes that local councils and authorities have responsibilities for the enforcement of other legislation, including the Public Health Act 1991.

- The *Occupational Health and Safety Act 1983*, which is administered by the NSW WorkCover Authority, plays an important part in controlling health risks that arise in the workplace.

- Environment protection legislation such as the *Clean Waters Act 1970*, and the *Clean Air Act 1961*, control pollution emissions which may have an impact on public health. These include powers to direct that pollution be removed, dispersed, destroyed or mitigated.

- The *Environmental Planning and Assessment Act 1979* require issues affecting public health to be considered as part of the Environmental Impact Statement process for new developments. In addition, general planning and building control issues are dealt with under this legislation and the *Local Government Act 1993*.

Specific legislation that contributes to public health management includes the Commonwealth *Therapeutics Goods Act 1989*, the Commonwealth *National Food Authority Act*, and the NSW *Radiation Control Act 1990*.

CHAPTER 3 LEGISLATIVE REVIEW

3.1 Introduction

Legislation and regulations affect virtually every segment of the community including industry, owners of premises, service providers, consumers, and government. Few would dispute that most legislative initiatives are designed to achieve certain public interest objectives and many are effective in promoting the public good.

While most regulatory initiatives are generally designed to achieve a public benefit, it needs to be recognised that legislation and regulation can also impose costs on certain segments of the community. The imposition of such a 'burden' on the community, or a segment of the community, may be justified where it effectively redresses a problem that previously existed. However, in some cases, legislation and regulations may create a new problem for the community, or a sector of the community, which outweighs the benefit of the regulatory system. In other cases, regulatory initiatives may not be effective in addressing the problem they were designed to correct and simply impose an unnecessary burden on the community.

Government attention has in recent years focussed on "regulatory reform". This is not simply about 'deregulation' or minimising the burden on a segment of the community (such as business) to the detriment of the wider public. Clearly there is a community demand for government regulation, particularly to address and minimise risks to public health and safety and indeed the NSW Government recognises that serious, and often irreversible, adverse consequences may flow from conduct of individuals or businesses in an unregulated environment.

Underpinning all regulatory reform initiatives, such as the Competition Principles Agreement and the Subordinate Legislation Act 1989, is a desire to develop effective and targeted regulatory approaches that minimise the adverse consequences of regulation where possible.

3.2 Competition Principles Agreement

The review of anti-competitive legislation under the Agreement is aimed at removing unnecessary, cumbersome and costly impediments to conducting business in Australia. The guiding principle of the Agreement is that legislation should not restrict competition unless it can be demonstrated that the benefits to the community as a whole outweigh the costs of restricting competition, and that the objectives of the legislation can only be achieved by restricting competition.

The Agreement requires a number of matters to be considered. These are set out in detail in **Appendix B**.

As noted above, regulatory initiatives designed to promote the public good may have adverse consequences because they restrict competition. For example, a licensing system may restrict the number of people that can engage in a specific activity to ensure that only those that hold certain qualifications provide services. In many cases this will be an effective means of protecting consumers from harm. However, by restricting the number of people providing services, this could also lead to higher prices for individuals, or worse, a decline in standards (which the licensing system was designed to improve).

The goals of the Agreement are to assess whether provisions that restrict competition produce an overall benefit for the public as a whole, and to ensure that the least restrictive option is selected. Underpinning the Agreement is a view that unrestricted competition is an effective means of allocating community resources, and in general, regulatory intervention should only proceed where there are clearly identified problems in the unregulated environment (otherwise known as 'market failure'). However, the Agreement also recognises that not all legislation that restricts competition will be contrary to the public interest. In many cases it may be necessary to restrict competitive conduct to protect the public from harm. It is the NSW Government's policy to ensure that review processes take into account the full range of public benefits, including limiting risks to public health and safety.

It is important to stress that while the parts of the Public Health Act 1991 impact on competition, others do not and are not amenable to the application of competition principles, for example, the notification of disease. The principle areas of the current Act and Regulations that have been identified as requiring review under the Agreement are as follows:

- Requirements on operators of air and water handling systems to control the spread of disease;
- Requirements on operators of public swimming pools to limit the spread of disease;
- Requirements imposed on those that provide services which involve skin penetration;
- Regulatory requirements imposed on the funeral industry;
- Restrictions on the sale of tobacco products (other than advertising and marketing restrictions which have already been the subject of a separate review under the Competition Principles Agreement).

3.3 Subordinate Legislation Act 1989

The Subordinate Legislation Act requires all subordinate legislation, such as regulations and guidelines, to be reviewed, and if appropriate, remade every five years. The Subordinate Legislation Act sets out the requirements which new regulations must meet. These are essentially that the objectives of the regulation are reasonable and appropriate, accord with the objectives of the

Act under which it is made, are not inconsistent with other Acts or stated government policies, that the anticipated economic and social benefits outweigh the costs and alternative options to the regulation have been examined.

As a part of this process, the Subordinate Legislation Act generally requires that regulations being made be the subject of a Regulatory Impact Statement (RIS), examining the economic costs and benefits to the community of the regulation.

3.4 Principles for Best Practice Legislative Review

As noted in Chapter 2 much activity in the area of public health is non-regulatory. For example, information campaigns are designed to encourage people to improve their health by stopping smoking or engaging in more exercise. However, in some cases, regulatory intervention is necessary. It is essential when moving from non-regulatory to regulatory strategies that decisions are made with appropriate regard to principles of best practice regulatory reform, including the Competition Principles Agreement and the Subordinate Legislation Act 1989.

Even where legislative intervention is directed at addressing problems that are not a consequence of failures from the provision of goods or services by business, it is still necessary to properly assess the reasons for that intervention, and the likely impacts. For example, when considering legislation that regulates the conduct of individuals (such as provisions relating to the immunisation status of children enrolled in schools) or intervention which otherwise limits the protection afforded to individuals by other legislation (such as confidentiality requirements), it is necessary to properly assess and balance the rights of the individual against the interests of the community as a whole.

In any given situation determining the most appropriate legislative strategy requires consideration of a wide range of factors to effectively respond to the identified problem. These may be summarised as follows:

- The objectives of legislative intervention should be clearly specified, and outcome based as far as possible;

- Regulatory intervention through legislation and regulation needs to be appropriately assessed to ensure that it is directed towards correcting real and significant problems in an unregulated environment;

- The effectiveness of existing measures, including non-regulatory and legislative strategies (including general legislation such as fair trading requirements), need to be considered;

- Legislative strategies need to be assessed to ensure that they are appropriate and effective in achieving the objectives of the intervention. This should include an assessment of costs and benefits of the regulatory approach and, in the case of intervention that will impact on a competitive market, an assessment of the impact on competition. Similarly, the impacts on the rights of individuals need to be considered;

- A full assessment should be made of all regulatory options for intervention, including legislative and non-legislative options;

Other factors that should be considered in developing regulatory strategies include: the diversity of the practice, behaviours and commercial activities to be regulated in any situation; the need for transparency and consistency in decision making by those administering the strategies; the need for flexibility so that systems can respond to unforseen developments and evolving practice and community values; and the response (or penalty) should be commensurate with the materiality of the risk to humans or the environment that non-compliance generates.

In this Issues Paper, the matters listed above are considered in the context of the area under review, with the exception of the "Objectives of the Public Health Act" which is discussed generally in Chapter 4. The remainder of this chapter provides general comments on the identification of public health problems (Section 3.5) and consideration of regulatory options (section 3.6).

3.5 Identification of Public Health Problems

Legislative intervention to achieve public health goals will often occur because a problem has been identified. Failure to address this problem could result in undesirable outcomes for society as a whole. As was noted in 3.2, public health legislation will often be directed at protecting the public from harm that may arise in an unregulated market for goods and services. Some examples of public health problems that might arise are as follows.

- ***Information problems*** – Consumers may not have sufficient information, experience or ability to make an informed decision when seeking goods or services. The inability to make an informed decision could lead to physical or financial injury or harm because an unsafe or inappropriate product or service is used. In other cases, the consumer could incur unreasonably high costs in seeking a service provider appropriate for their needs.

- ***Impact on third parties or the public generally*** – The provision of goods or services may result in a third party incurring a cost. For example, an unsafe product may be marketed and a consumer is injured. While the consumer could incur costs in seeking treatment for that injury, the Government may also incur costs because a need arises to provide the injured person with welfare and support. Alternatively, where a

consumer buys a product that is infected by disease, they may pass it on to others such as family members.

- ***Public Access to Goods/Services*** - Goods or services that the public requires may not be provided if they are left to the operation of a market.

- ***Natural Monopolies*** – Presence of a natural monopoly may mean that there are insufficient countervailing powers between producers and consumers in the market, leading to overpriced products and/or services and inefficient outcomes.

There are of course a range of other public health problems that might arise in circumstances that do not involve the provision of goods and services. These are too extensive to comprehensively list here, although a general overview of potential problems is identified.

- Individual conduct may expose others to the risk of injury or harm – for example, those infected by a specific disease may place others at risk if infection.

- Individuals may not have the skills and knowledge to assist them to make good health care choices (for example, there may be little understanding of the benefits of testing for certain conditions) and may require additional information;

- Government may not be able to obtain sufficient information to assist it in discharging functions or providing services that the public reasonably expects it to provide in an effective manner.

In assessing the need for legislative intervention, it is essential that the problems or rationale for legislative intervention be clearly identified.

3.6 Overview of Regulatory Models

A full assessment of appropriate options needs to be made to ensure that regulatory responses are targeted, effective and measured. This section provides an overview of different regulatory models that may be appropriate for responding to different public health risks or achieving certain public health outcomes. For any given problem, however, a range of measures, both regulatory and non-regulatory may be appropriate.

3.6.1 Non-legislative Strategies

To achieve an appropriate public health outcome, non-legislative approaches or existing regulatory approaches may be effective in achieving the desired outcomes. Where a problem is identified, consideration needs to be given to the issue of whether any or all of the strategies outlined below will be effective in securing public health objectives after considering issues such as the

significance of the problem and the nature of the industry. The following are examples of non-legislative options that may be fostered by Government, instead of or in conjunction with regulatory action.

- ***Information Campaigns*** - public health goals can be achieved using information campaigns or strategies. For example, programs to encourage parents to have their children immunised.

- ***Provision of information by Organisations*** - Government can encourage activities by organisations, such as industry associations or community organisations, which focus on providing consumers or individuals with material to assist them to make informed choices. For example, the Heart Foundation provides information to assist consumers to make healthy choices when purchasing food.

- ***Financial Incentives*** - Rather than directing individuals, businesses or organisations to take certain measures or comply with standards, an alternative option is to provide financial incentives to encourage such groups to undertake certain steps. For example, in recent years, the Commonwealth Government has provided a special payment to medical practitioners to encourage them to immunise children.

- ***Reliance on controls in other legislation*** - As was noted in section 2, other legislation can be effective in achieving public health goals. For example, under the current Public Health Regulation, medical and dental practitioners are exempt from regulations concerning skin penetration procedures because they have their own infection control standards set down under the relevant health professional registration Act.

- ***Voluntary Codes of Practice, Guidelines and Certification*** - Rather than requiring that certain standards be met by organisations or business, Government can provide assistance to encourage such organisations to develop and meet standards without legislation. Third parties, such as Standards Australia or the National Health and Medical Research Council publish standards or guidelines. For example, the Advertising Standards Board has established a voluntary code of practice in relation to the advertising of alcoholic beverages. Businesses or organisations will in many cases advertise that they comply with voluntary standards or Codes and may seek certification from a non-Government body.

- ***Litigation*** - The common law provides remedies for individuals, for example the law of negligence imposes a duty of care on individuals, businesses and organisations to exercise reasonable care to prevent injury to others. In many cases, litigation and its potential financial consequences may be a more effective means to prevent people from exposing others to the risk of injury of harm. Government intervention to improve access to such remedies, such as the establishment of advocacy services, facilitation of class actions or broadening standing requirements

so that organisations can sue on behalf of individuals may be an effective means of securing public health objectives.

3.6.2 Legislative Intervention

There are numerous options for legislative intervention.

- ***Mandatory Information Disclosure to the Public -*** Requiring providers to provide certain information can be an effective means of assisting the public to avoid products that may cause injury or harm. For example, the current Public Health Act 1991 and Regulations prescribe certain warnings that must be displayed on tobacco products concerning their risks. A variant on this approach would be the introduction of duties on individuals, organisations or businesses to disclose that a certain state of affairs has arisen which could be detrimental to public health.

- ***Information Disclosure to Government*** - Disclosure of information to the public by manufacturers or service providers may be of little assistance because consumers lack the skills, knowledge and experience to interpret that information. One regulatory option is to require businesses or organisations to provide certain information to the Government who can then decide whether or not to issue a warning or other information to the public. For example, the Public Health Act 1991 was recently amended by the Water Legislation (Drinking Water and Corporate Structure) Act 1998 to provide that the Chief Health Officer may issue advice for the benefit of the public on safety or drinking water and possible risks to health. The potential impact of a public warning should encourage suppliers to take reasonable measures to ensure a safe drinking water supply.

- ***General Prohibitions on Conduct -*** There are numerous provisions in the current Public Health Act whereby legislative objectives are achieved through the prohibition on certain specified conduct. For example:

    - Section 59 of the Act prohibits the sale of tobacco products to people under the age of eighteen years of age;
    - Section 6 prohibits exposing a person to an object which is infectious;
    - Section 61B prohibits the display of tobacco advertising for tobacco products in public places.

- ***Legislative Standards -*** The most common form of legislative intervention in response to public health problems is the setting of legislative standards that must be complied with. Failure to comply with the standards can result in imposition of a penalty. Under the current Public Health Act and Regulations, this approach is used in a number of areas, for example:

  - to control the spread of infectious disease the Regulations set standards that must be observed by those conducting procedures that involve skin penetration such as acupuncture, tattooing and ear piercing, and for swimming pools;
  - the Act and Regulations set installation, operating and maintenance requirements for air and water handling systems to control risks such as legionnella;
  - the Regulations set standards to be observed in the handling and disposal of dead bodies.

- ***Performance Based Regulation -*** Rather than specifying the manner in which companies are meant to achieve a certain goal or outcome, for example by mandating a process that must be used in preparing a good or when providing a service, legislation sets targets or 'performance standards' that must be met. The regulatory system is focussed on the end to be achieved, rather than the means.

- ***Voluntary Certification -*** Rather than specifying that all suppliers or service providers must meet certain standards, legislation would establish a system for certifying those that elect to meet the standards. While others can continue to provide the service, those that elect to be certified gain the right to use a specific title or accreditation symbol.

- ***Third Party Certification*** - Rather than relying on Government to certify that a product meets certain standards, legislation can provide that third parties may conduct the necessary inspections and issue a certificate specifying that the product or service complies. Again, this can be structured so that those that elect to be certified gain the right to use a specific title or accreditation symbol.

- ***Negative Licensing*** - Under this system, operators are required to meet certain legislative standards. Although no pre-approval is required before operation, where they fail to meet the standards they can be prohibited from engaging in the activity, either permanently or until they meet certain conditions.

- ***Registration*** - The requirement to meet certain standards can be supplemented by a requirement that all those wishing to provide the service or product **must** be registered. Although registrants are generally not required to establish that they can meet certain requirements before being registered, where they fail to meet the standards their registration can be cancelled and they are prevented from providing the service.

- ***Activity or Business Licensing*** - This is generally considered the most restrictive form of regulation, although there are no licensing systems under the Public Health Act 1991. Those wishing to provide a service must demonstrate to the relevant Government agency that they are capable of meeting the legislative standards. This is generally done by

specifying that only certain people may apply, by requiring detailed inspections, or by requiring that certain equipment be used. A variant of this approach would involve recognition of membership of a third party, such as a professional association or standards organisation, which has been assessed by Government as sufficient to protect the public from harm.

- ***Approval Processes -*** Products or plans are required to be submitted to a Government agency for formal approval before they may be used or marketed. For example, some therapeutic goods must be submitted to the Commonwealth Therapeutic Goods Administration before they may be distributed to the public.

- ***Self-Certification and Auditing -*** Under this arrangement, service providers would certify that their goods meet certain standards and provide certain information to Government agencies. The Government agency would then audit this information in appropriate cases to ensure that standards are being complied with.

- ***Market Based Regulation -*** Market orientated regulatory strategies place responsibility for the maintenance of standards with those making commercial decisions. In doing so the most cost-effective strategies are promoted, creating flexibility and the opportunity for innovation. For example, pollution credit systems introduced in the environment protection area are designed to reward those that pollute less, while making it less profitable for those that continue to pollute. While innovative approaches such as this are particularly common in environmental legislation, their application in the area of public health is less common.

PART II OBJECTIVES AND ADMINISTRATION OF PUBLIC HEALTH LEGISLATION

CHAPTER 4 OBJECTIVE AND STRUCTURE OF PUBLIC HEALTH LEGISLATION

4.1 Objectives of the Public Health Act 1991

The terms of reference of this review require an examination of the objectives of the Public Health Act 1991 and whether the terms of the Act are appropriate to secure those objectives. In addition, a recent review of public health legislation in Australia recommended that the Public Health Act in each jurisdiction should set out a philosophical framework for public health.[10]

The Act does not currently contain a statement of its objectives although the long title states that the Public Health Act is:

> "*An Act relating to the maintenance of proper standards of health for the public; and for other purposes.*"

As outlined in Section 2.3 of this paper, the Act contains measures to prevent and manage public health risks in relation to a wide range of issues including the management of infectious diseases, microbial control, drinking water, skin penetration and swimming pools and spas. The Act also regulates the funeral industry and the sale and advertising of tobacco products, mandates the collection of information in relation to infectious diseases and other specified conditions and provides broad regulation making powers to enable an adequate and timely response to public health risks.

When considering the purpose of public health legislation it is important to acknowledge the health protection, disease prevention and health promotion elements of the Act. *Health protection* has been defined as the enforced regulation of human behaviour to protect the health of the individual and fellow human beings. *Disease prevention* has been defined as interventions that build on the skills of public health and clinical medicine to reduce the incidence and prevalence of disease occurrence or injury in individuals and populations. *Health promotion* may be defined as the process of enabling people to increase control over, and to improve their health.[11]

Despite the narrow focus of the Act's long title, the broader scope and purpose of public health legislation was recognised at the time the Bill was

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10 Bidmeade and Reynolds 1997 *Public Health Law in Australia: Its Current State and Future Directions*

11 National Public Health Partnership op cit

introduced, with the Minister for Health of that time stating (in relation to scheduled medical conditions):

> "*Public health action may include education, prevention, medical treatment or notification*".[12]

This broader focus is perhaps more expressly recognised by more recent amendments. For example the Pap Test Register established under the Act has allowed the establishment of a screening program for the prevention and early detection of cervical cancer which is crucial in reducing death rates from cervical cancer. The Minister stated at the time of introducing the amending legislation to establish the register:

> "*Every year in NSW, approximately 350 women are newly diagnosed with cervical cancer. Every year, 100 women die from this disease. By earlier intervention through widespread screening, the incidence and mortality amongst these women can be reduced. The [pap test register] is fundamental to the successful implementation of an organised screening program, providing a seamless system for the prevention and early detection of cervical cancer…Put most simply, the Bill will save lives.*" [13]

In addition the data collections mandated under the Act play an important role in monitoring the health of the population, identifying risk factors and groups at risk and examining the causes of disease and the effectiveness of prevention activities, diagnosis and treatment interventions. Public health depends upon data collections, surveillance systems and the science of epidemiology to underpin the development of effective programs and strategies.

It may be timely to consider introducing a set of objectives for the Act which more accurately reflect the purpose of regulating in relation to public health and are consistent with modern public health concepts and practice. It has been suggested that the functions of the Act should encompass the following: reducing the incidence of disease, ill health and untimely death; health promotion; and future oriented health planning to achieve better health outcomes.[14]

Other States and Territories have also considered this question in recent reviews of public health legislation. For example, the Australian Capital Territory Public Health Act introduced in 1997 has the following detailed objectives:

> *(a) the protection of the public from public health risks including those associated with facilities, equipment, products and activities not adequately controlled by another law of the Territory or a law of the Commonwealth;*

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12 *Legislative Assembly Hansard* NSW Parliament 22 November 1990 at page 10398

13 *Legislative Council Hansard* NSW Parliament, 17 April 1996 at p 87

14 Allars, Carney, Magnusson, McMahon and Opeskin opcit p 37

(b) through the monitoring of health indicators, to provide the public with information about the health of the population and to design and implement appropriate policies and programs for the maintenance and improvement of the population's health;
(c) the provision of a rapid response to public health risks;
(d) the performance of functions under this Act in a professional and responsible manner;
(e) the avoidance of any undue infringement of individual liberty and privacy in the performance of functions under this Act.

Recently, the Queensland Health Department discussion paper on the review of the Health Act 1937 (Public Health)[15] proposed that both the objective and the mechanisms to achieve the objective should be summarised at the beginning of the Act. The proposed objective of the Public Health Act in Queensland is to:

"*Protect and promote the health of the Queensland public. This is to be achieved mainly through:*

- *controlling public health risks in the community and the environment;*
- *providing a legislative basis for the collection and use of certain health information and the use of health information for the purpose of research and studies.....*
- *preventing and minimising the spread of disease and illness*
- *responding to public health emergencies and inquiring into serious public health matters.*"

The Victorian Health Act 1958 commences with a series of objects, although the section containing these objects has never been proclaimed. They are:

- *To ensure equity in health.*
- *To help people live as full a life as possible no matter what their pre-existing level of health.*
- *To reduce the incidence of disease, disability, distress and symptoms of ill health.*
- *To reduce the incidence of untimely death.*

By way of contrast to the detailed objectives above, the Tasmanian Public Health Act introduced in 1997 has as its objective: "*An Act to protect and promote the health of communities in the state and reduce the incidence of preventable illness*" and the recent New Zealand Public Health Legislation Review[16] proposed that the purpose of the Act should be "*To improve , promote and protect public health".*

[15] Queensland Health Department February 1998 *Review of the Health Act 1937 (Public Health)*
[16] New Zealand Ministry of Health 1998 *Public Health Legislation Review : A New Public Health Legislative Framework Discussion Paper*

Other possible options could draw on the NSW Health Services Act of 1997 which recognises the role of Area Health Services in relation to public health and states that one of the purposes of an Area Health Service is "*to promote, protect and maintain the health of the community*" or the NSW Health Administration Act 1982 which sets out the functions of the Minister for Health and states that the Minister may formulate general policies "*for the purpose of promoting, protecting, developing, maintaining and improving the health and well being of the people of New South Wales to the maximum extent possible having regard to the needs of and financial and other resources available to the State.*"

Discussion Point 1 – Objectives of the Public Health Act

Submissions are invited on the desirability of including a statement of objectives in the Public Health Act, particularly a statement focussing on the outcomes sought to be achieved.

Submissions in favour of this proposal which identify the content of any objectives would be particularly welcome.

4.2 Structure of the Public Health Act 1991

It has been noted elsewhere in this paper that the previous Public Health Act was subject to piecemeal amendment over a number of years, resulting in legislation that appeared to lack a consistent philosophy or approach. The current legislation has been subject to amendment on a number of occasions in recent years which has tended to reinforce this problem.

One of the consequences of this 'piecemeal' development is that the Act and Regulations as a whole have lacked a coherent structure and approach. This is particularly evident in respect of the division of matters between the Act and Regulations. While some public health risk matters are dealt with exclusively by Regulation (for example skin penetration), other matters (where the risk would be appear to be broadly similar) are dealt with by both the Act and Regulations, for example, microbial control.

Modern public health legislation has tended to seek a more coherent legislative/regulatory structure to address public health problems. For example, the ACT has recently introduced new "over-arching" public health legislation that contains core public health provisions (such as general provisions to respond to unhealthy conditions and enforcement powers). The legislation also contains enabling provisions that allow specific public health risks to be dealt with through Codes of Practice or by way of Regulation.

Tasmania has taken a similar approach, although some specific public health problems continue to be dealt with by the principal Act (notably tobacco).

New Zealand is currently considering a similar approach whereby a core public health statute containing legislative provisions to address the following would be enacted:

- Public health regulatory infrastructure;
- A framework for public health risk management;
- Clarification of the interface with other public health legislation;
- Monitoring and reporting on the state of the population's health.

A shift to a core enabling public health statute, with targeted responses to public health problems contained in subordinate legislation, provides greater flexibility to respond to public health issues. However, the need for accountability to Parliament also needs to be considered. The existing regulatory review process established under the Sub-ordinate Legislation Act 1989 (as outlined in 3.3) may provide a degree of accountability.

Discussion Point 2 – Structure of Public Health Act

Is the current structure of the Public Health Act 1991 and Regulations appropriate. In particular, is the current division of matters between the Act and Regulations appropriate?

Should consideration be given to new public health legislation which contains "core" public health provisions and enabling provisions to respond to specific public health issues by Regulation?

4.3 Consolidation of Public Health Legislation

As was noted previously, there are a number of other Acts which deal with public health matters. An issue arises as to whether some of this legislation should be consolidated with the Public Health Act 1991.

In many cases, there may be little point in consolidating public health legislation such as that dealing with food or drugs and poisons as these have separate administrative and enforcement frameworks. However, where issues are already covered by the Public Health Act 1991 and other legislation also deals with these matters, it may be appropriate to consider consolidating that legislation to provide a more consistent basis for administration and enforcement purposes. A significant advantage of consolidation is that those businesses or individuals that are regulated will also have a single point of reference when seeking to identify regulatory controls.

Tobacco issues until recently were covered by four different pieces of legislation – the *Business Franchises (Tobacco) Act* (now repealed), the *Public Health Act 1991*, *the Tobacco Advertising Prohibition Act 1991* and the *Smoking Regulation Act 1997*. Enforcement officers have different powers under each Act resulting in considerable confusion. Parliament has now passed legislation to repeal the Tobacco Advertising Act 1991 and consolidate the provisions in the Public Health Act 1991.

Similarly, both the Public Health Act 1991 and the Fluoridation of Public Water Supplies Act 1957 deal with aspects of the regulation of the supply of water.

Discussion Point 3 – Consolidation of Other Legislation

Should other legislation be consolidated with the Public Health Act 1991?

What other legislation should be considered for this purpose?

CHAPTER 5 CO-ORDINATION OF PUBLIC HEALTH ACTIVITY

5.1 Introduction

Improving public health in Australia is a co-operative effort involving all levels of government, a range of government agencies, non-government agencies, industry and community groups.

However, the fragmentation of responsibility across a range of agencies can make coordinated management of issues difficult. Also, with a wide range of responsible organisations and authorities, it is difficult to ensure that certain issues receive the attention they deserve. The pervasive nature of public health means that there will always be legitimate overlap and interplay between public health legislation and that of other sectors.[17]

One of the major issues addressed by the review of the Public Health Act 1902 was the overlap in responsibility for public health matters between the NSW Department of Health, other specialist state government agencies (such as the Environment Protection Authority) and local government. The then Minister stated:

> "*The Public Health Act 1991 has long ceased to be the exclusive repository of public health provisions. For example, building control, nuisance control, air, water and noise pollution, planning and environmentally hazardous chemicals are now dealt with in specialist legislation. The growth and increased complexity of government has resulted in a multiplicity of legislative and regulatory controls with respect to public health. This process has caused much overlapping between public health and other legislation.*" [18]

The Public Health Act 1991 and cognate legislation sought to address this problem:

> "*In broad terms it is proposed that the problem of overlapping be addressed by transferring those provisions which deal with environmental matters to the Local Government Act or other specialist legislation which provides for environmental health. The role of the NSW Department of Health will be to oversee standards, monitor the performance of authorities and intervene selectively where any authority fails to carry out its functions and responsibilities. As the responsibilities to be transferred have public health implications, it is proposed that the Minister for Health will retain an overriding power to intervene in cases where he considers, on reasonable grounds, that the health of the public may be at risk.*"

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17 New Zealand Ministry of Health op cit

18 *Legislative Assembly Hansard* NSW Parliament 22 November 1990 at page 10398

The 'reserve authority' to which the then Minister referred is embodied in section 10 of the Public Health Act 1991.

> ***10 Direction to Exercise Statutory Function***
>
> *(1) If the Minister considers on reasonable grounds:*
>
> *(a) that a public authority has failed to exercise a function conferred or imposed on it (other than a power to make regulations or by-laws), and*
>
> *(b) that the failure is likely to endanger the health of the public,*
>
> *the Minister may, by written notice to the public authority, require it to exercise the function within a time stated in the notice.*

5.2 Improving Co-ordination Across Government

Although section 10 appears to be extremely broad in application, its usefulness as a co-ordinating mechanism to secure better public health outcomes is limited by practical considerations. In practice, administrative arrangements between the Department and other key stakeholders are likely to play an important role in securing desirable public health outcomes without the need for additional legislation. An example of this is the NSW Government's voluntary risk management program for controlling lead in the environment.

However the Sydney University Faculty of Law recommended in its Report to the Department that consideration should be given to legislative mechanisms to increase inter-sectoral co-ordination and improve management of diverse interests. Strategies to ensure that public health issues are appropriately considered by other organisations and to encourage better co-ordination of public health effort can include the establishment of strategic alliances, adequate resourcing, open communication, statutory requirements, mandatory reporting mechanisms and the presentation of strong arguments in support of public health interests.[19]

A number of states have adopted **statutory advisory councils** for public health at a statewide level including South Australia, Victoria and Tasmania.

The South Australian Public and Environmental Health Act 1987 provides for the establishment of the Public and Environmental Health Council which has both an advisory and an operational function. A major focus of the Council is to provide better co-ordination and accountability between the South Australian Health Commission and Local Government in relation to public

[19] New Zealand Ministry of Health op cit

health issues. Membership comprises a range of local government, community and public health experts.

The Council has a public charter to promote public health, hold inquiries, and keep the law and policy under review as well as responsibilities in environmental health and notifiable diseases. In particular the Council can examine cases where a local council has failed to discharge its statutory functions to "promote proper standards of public and environmental health in the State". If the Council believes that the issue will not be resolved it can "take such action as appears appropriate which may include withdrawing public health powers from a local council and transferring them to the South Australian Health Commission. The Council is also an appeal body in respect of orders and other requirements imposed under the Act which relate to the protection of public health. A further appeal may be made to the District Court".[20]

The Tasmanian Public Health Act 1997 establishes the Public Health Advisory Committee consisting of 5 people with appropriate expertise in the area of public health appointed by the Minister. The function of the advisory committee is to provide advice to the Minister and the Director of Public Health on any matter relating to public health.

Such bodies could play a planning role to achieve better co-ordination across government. Alternatively, they could play a role in managing individual public health issues or events should they arise.

Discussion Point 4 – Improving Co-ordination Across Government

Is the current division of responsibility (as established by the Public Health Act 1991 and cognate legislation) between the NSW Department of Health, public health units, government agencies and local councils operating to secure appropriate public health outcomes?

Are current administrative arrangements effective?

Is there a need for additional mechanisms to improve co-ordination of public health effort in NSW?

Submissions are invited on the costs and benefits of statutory advisory councils as a mechanism to improve, protect and promote public health in NSW.

[20] Bidmeade and Reynolds op cit p 26

5.3 Co-ordination between Health and Local Government

Chapter 5 of the Local Government Act recognises the broad responsibilities conferred on local councils by numerous pieces of legislation, including the Public Health Act, and states *that* "*a council has the functions conferred or imposed upon it under any other Act or law*". It should also be noted that Chapter 6 of the Local Government Act confers on councils their service or non-regulatory functions including the important role of Councils in the provision, management and operation of public health services and facilities.

Specific provisions of the Public Health Act 1991 and Regulations identify key council responsibilities. For example, the skin penetration provisions of the Public Health Regulation establish local councils as the responsible authority for receiving notifications of businesses conducting skin penetration provisions. The Public Health Act provides environmental health officers (EHOs) employed within local government with authority to exercise enforcement powers conferred by the Public Health Act in certain circumstances – for example, microbial control. EHOs employed by the Department of Health or an Area Health Service can also exercise these powers. In addition, local councils have enforcement powers under the Local Government Act 1993 (which in many cases are broader than those conferred under the Public Health Act 1991) which may be used for the purposes of carrying out functions conferred on local councils by other legislation (such as the Public Health Act 1991).

As noted above, a key reform intended by the 1991 Act was to more clearly divide responsibility between State and local government. While this was the intent of the legislation, a recent review of public health legislation in Australia[21] suggested that the current delineation of roles and responsibilities for public health in two separate acts within NSW is confusing and there would be benefits in clarifying roles and responsibilities of local government with respect to public health legislation within NSW. In some parts of the Public Health Act 1991, the role of local government is not clearly articulated and this has lead to inconsistencies in enforcement of the provisions of the Public Health Act between the 177 councils across NSW.

Further, many of the provisions under the Public Health Act have complementary provisions under the Local Government Act. For example, under the Public Health Act, infection control requirements are laid down for skin penetration activities that impact upon occupational groups such as hairdressers, beauty therapists, tattooists, acupuncturists and the funeral industry. Under the Local Government Act there are also public health requirements concerning the premises used as hairdressers shops, beauty salons and mortuaries which have to be read in conjunction with the Public Health Act requirements.

[21] Bideade and Reynolds op cit

It has been suggested that the opportunity should be taken to better clarify the respective roles of local government and NSW Health under the current Public Health Act. In seeking to do this, regard has to be had to the current role of local government and the resource implications for local councils of exercising such functions. A significant issue identified by the Local Government and Shires Association of NSW is the ability of councils to recoup their costs.[22]

Recognition of the Role of Local Government in Public Health Legislation

A number of Australian states have explicitly recognised the role of local government in relation to public health legislation. For example section 12 of the South Australian Public and Environmental Health Act states that it is the duty of a local council to:

- *promote proper standards of public and environmental health in its area;*
- *take adequate measures to ensure that the provisions of Part III (general sanitary requirements) are observed in its area; and*
- *to take reasonable steps to prevent the occurrence and spread of notifiable diseases and to prevent any infestation or spread of vermin, rodents or pests within its area.*

Section 29A of the Victorian Health Act 1958 charges local councils with a responsibility for disease prevention, prolonging life and promoting public health through organised programs, including the prevention and control of environmental health dangers, diseases and health problems of particularly vulnerable population groups through developing and implementing a range of specified strategies.

The Tasmanian Public Health Act 1997 states that a council within its municipal area must:

- *develop and implement strategies to promote and improve public health;*
- *ensure that the provisions of this Act are complied with;*
- *carry out any other function for the purpose of this Act the Minister or the Director determines; and*
- *carry out any function under this Act in accordance with any relevant guidelines.*

[22] Letter to the NSW Department of Health dated 14 February 1997

Establishment of Local Co-ordination Bodies

Another option to improve co-ordination could be to establish local co-ordination councils for designated geographical areas. Under this option, public health units and local councils within the area could meet to discuss public health priorities, and resources. This, in effect, is a local area version of the Public Health Council proposal discussed above.

Opportunities to share resources across council boundaries could be explored. Indeed some local councils already exploit such opportunities in non-public health areas through Regional Organisations of Councils (ROCs).

Municipal Planning

Under the Victorian Health Act 1958 (section 29B), councils are required, in consultation with the Chief General Manager of the Department of Health, to formulate at three yearly intervals a municipal public health plan which must:

(a) identify and assess actual and potential public health dangers in the municipality; and
(b) outline the programs and strategies which the council intends to pursue to prevent or minimise those dangers, to enable the people in the municipality to achieve maximum well being and provide for the periodic evaluation of those programs and strategies, as well as annually reviewing the public health plan.

In Victoria, councils are required to evaluate the programs and strategies set out in the plans and to review them annually.

Given the existence of public health units in NSW with a regional focus, it may be more appropriate to establish such arrangements at the public health unit level, but require the units to negotiate with local councils through the planning process. If responsibility for developing such a plan were to rest with public health units, it may be useful to introduce reporting requirements on local councils and public health units so that a proper assessment of enforcement activity of public health legislation (such as the Public Health Act 1991 or the Food Act 1989) can be made during the planning process. Planning requirements could also be linked to local co-ordination bodies if these were supported.

Discussion Point 5 – Co-ordination with Local Government

Submissions are invited on:

- the need to clarify the role of local government with respect to public health legislation;

- whether the current arrangements in relation to the local government's role in for the enforcement of the Public Health Act are adequate and appropriate
- mechanisms to improve co-ordination between health and local government in relation to public health including (but not limited to) those discussed above.

5.4 Establishing Links with the Planning System

Many planning decisions have the potential to impact on the health of the general community. Often, the link will be direct and obvious, for example the inappropriate siting of a preschool next to an industrial facility, or the siting of hazardous facilities adjacent to residential areas. However sometimes the mechanisms may be subtle or indirect and may not be apparent when assessing individual projects. Examples include decisions resulting in the greater use of private cars with ensuing impacts on air quality, the catchment effects of urban development on the water quality of oyster growing areas or the provision of adequate recreation facilities to encourage exercise. Both public health experts and the broader community have expressed concerns that these potential impacts are not being adequately addressed by existing planning systems. These groups have called for the development of better coordinated and comprehensive strategies to ensure public health issues are considered as part of the planning and development process.

The recently released report "*Environmental Assessment and Human Health: Perspectives, Approaches & Future Directions*" [23] identified social and health impact assessment as areas that are insufficiently considered or are inadequately treated in project environmental impact assessment. These concerns have prompted Tasmania, New Zealand and Canada to develop legislation to ensure Health Impact Assessments (HIA) are implemented as part of the Environmental Assessment .

The report previously mentioned, prepared by Davies and Sadler in 1997 for the Canadian Government, highlighted the significant socio-economic costs that are imposed by environmental damage and related health effects. While the health component costs of EA are difficult to quantify, they need to be compared with the eventual costs of remedial action and the curative and treatment services necessary to deal with effects on health. In particular it is difficult to quantify the adverse health effects prevented by EA (ie. effects that did not occur) and any positive health outcomes.[24]

[23] Davis K & Sadler B 1997 *Environmental assessment and human health: perspectives, approaches & future directions: a background report for the international study of the effectiveness of environment assessment* Canadian Health Department

[24] Davis K & Sadler B 1997 Op. Cit.

However, it is now widely accepted that the precautionary principle and a strategy of "anticipate and prevent" is far more cost effective than one of "react and cure". Preventing adverse effects on health is consistent with both the community's high expectation that public health is not jeopardised and the principles and practice of public health law.

HIA can be used in two ways to achieve these goals. In Tasmania, HIAs were introduced in 1994 for certain developments under section 74 of the *Environmental Management and Pollution Control Act 1994.* Since that time the Tasmanian Department of Health and Human Services have provided assistance to developers to specifically address those public health matters normally arising out of the environmental impact assessment process. HIAs can be required for any development that requires an Environmental Impact Assessment. In practice this means making sure that the existing checklist of environmental items address human health.

Health Impact Assessment can also be incorporated in a less formal way into regional and local planning processes. Since many health impacts result from the additive effect of multiple developments, Regional and Local Environmental Plans provide significant opportunities for improving and protecting public health.

Formal HIA seeks to ensure early, coordinated public and environmental health advice is available to relevant parties as part of the normal development assessment processes. The concept is based on the view that by addressing and coordinating public health matters early in the development cycle, expensive, time-consuming interventions at a later date are minimised.

It needs to recognised, however, that a process is already established in NSW for environmental impact assessment under the Environmental Planning and Assessment Act. There are a number of opportunities for input under the current Act including:

- providing input into the development of guidelines for the planning system such as the guidelines for the preparation of environmental studies, guidelines for the preparation of EIS, and guidelines for conducting hazard analysis under State Environmental Planning Policy (SEPP) No. 33;
- providing input to environment studies which are prepared during the plan making stage;
- providing input into the EIS of designated development and some development applications (particularly those relating to hazardous or offensive development under SEPP 33);
- providing input to rezoning where appropriate (such as changes from industrial to residential).

Including health concerns within this process minimises the need for separate health impact assessment processes and allows the health effects of development projects and policies to be considered in an integrated manner at the same time as environmental and economic issues.

Discussion Point 6 – Links with the Planning System

Submissions are invited on whether having regard to the existing mechanisms for assessing the impact of developments upon human health there is a legislative role for the Public Health Act 1991 in the assessment of the human health effects of development proposals.

CHAPTER 6 ADMINISTRATION OF THE PUBLIC HEALTH ACT

6.1 Current Arrangements

Within NSW, responsibility for administration and enforcement of the Public Health Act lies with the NSW Health Department, Public Health Units located in Area Health Services throughout NSW, and local councils.

The Public Health Division within the NSW Health Department has responsibility for developing statewide policies and strategies to prevent and manage risks to public health. The public health approach utilises a mix of health promotion, disease prevention and health protection strategies. Underpinning these strategies is epidemiological analysis and surveillance providing comprehensive up to date information on the health of the people of NSW, their access to and use of health services and the outcomes of programs and clinical practice. The Public Health Division in co-operation with the Legal Branch of the Department has oversight of regulatory functions relevant to public health. Legal Branch also has responsibility for the conduct of prosecutions under the Act.

The Public Health Units provide a regional source of public health expertise. There are 17 Public Health Units throughout NSW. While the functions of Public Health Units are broadly consistent throughout the state, Public Health Units are also required to also take account of the local needs and priorities within their area.

The functions of Public Health Units within their local area can be described as the:

- monitoring and surveillance of public health issues;
- identification of public health risks;
- investigating matters of concern regarding public health;
- provision of public health information and education strategies;
- coordination of public health strategies and research at an Area Health Service level;
- evaluating local health priorities;
- development of Area Health Service public health strategies.

It should also be noted that there is an additional Public Health Unit located within Corrections Health Service. This unit undertakes similar functions to those described above focussing on the correctional setting, for example, monitoring and surveillance of public health issues and the development of strategies to reduce public health risk within prisons are important functions of this unit.

Each Public Health Unit has at least one environmental health officer (EHO) who is a source of environmental health expertise and is authorised to

undertake regulatory functions. There are currently 31 EHOs located in Public Health Units across the State. It should also be noted that environmental health officers employed within local government have the same powers under the Public Health Act as EHOs employed by the Department of Health or an Area Health Service. The role of local government in enforcing the Act is discussed in chapter 5.

In addition, each Public Health Unit has a Medical Officer of Health (MOH) who has a broad ranging power to enter and inspect premises and make inquiries for the purpose of giving effect to the Act.

6.2 Issues Relating to the Role of Medical Officers of Health (MOH)

Medical Officers of Health have been a feature of public health legislation in NSW since 1896. Under the current Act, the MOH relates to specific local government authorities and is required to report to the Director General of the Health Department on matters affecting the health of the public in that medical district (and must send a copy of the report to the local authority where appropriate). The MOH may also inspect the registers kept under the Births, Deaths and Marriages Registration Act 1995 and require a copy to be made of an extract of the registers. Other specific powers of Medical Officer of Health under the Act are interpreted in the Public Health Delegations Manual of the Department of Health. Currently Medical Officers of Health and Directors of Public Health share 42 identical delegations under the Public Health Act and 17 identical delegations under 6 other Acts.

The current situation within many Area Health Services is that the Director of the Public Health Unit is a medical practitioner with substantial expertise in public health and is therefore also designated as the Medical Officer of Health. However, where the Director of a Public Health Unit is not a medical practitioner it is necessary to designate a MOH under the Act to undertake specific functions. It may be timely to consider whether there is a need to retain designated medical officers of health under the Act and whether the current statutory responsibilities of a MOH could be better undertaken by a Director of a Public Health Unit (noting that in the majority of cases they are one and the same officer).

In either case, it has been suggested that it may be useful to describe the function and role of a Director of a Public Health Unit or MOH within the Public Health Act. It has been suggested that their responsibilities could be defined as the identification of public health risks and the coordination of appropriate responses within a specified area.

Discussion Point 7 – Medical Officers of Health

Submissions are invited on the need to retain and/or clarify the role of Medical Officers of Health.

6.3 Issues Relating to the Role of Public Health Units

At present, the basis of Public Health Units is administrative only. The Act does not recognise any role for Public Health Units across NSW. It may be useful to consider whether there is a need to formally recognise the role of Public Health Units or that of a Director of Public Health Unit within the Act. As discussed above, the relationship between MOH and the Director of a Public Health Unit also requires consideration.

Currently, the Director of each Public Health Unit is accountable to the Chief Executive Officer of his/her respective Area Health Service. It is recognised that Public Health Units, while formally part of Area Health Services have a close operational nexus with the Department of Health through the Chief Health Officer, Public Health Division and Legal Branch, concerning enforcement of the Public Health Act and Food Act.

Periodically situations emerge in which it is desirable for the Chief Health Officer to coordinate and direct the health system response to public health issues. It has been suggested that the relationship between the Chief Health Officer and the Director of a Public Health Unit (and/or Medical Officers of Health) should be recognised within the Public Health Act to ensure that a timely response to a public health issue can be coordinated directly by the Chief Health Officer across Area Health Services.

Discussion Point 8 – Public Health Units

Submissions are invited on:

- the need to describe the role of Public Health Units and/or the Director of a Public Health Unit under the Act;
- whether the relationship between the Public Health Units and the Department in relation to public health activities requires formal recognition under the Public Health Act

PART III MONITORING & IMPROVING PUBLIC HEALTH

CHAPTER 7 COLLECTION OF PUBLIC HEALTH INFORMATION

7.1 Information and Public Health

Policy makers, health practitioners and consumers need access to timely, high quality public health information to plan, implement and evaluate health services and public health interventions and to make informed decisions. Ensuring better health for the people of NSW, enabling equity of access to a comprehensive range of services and improving the quality of service are three principal goals of the NSW Health Department. Public health surveillance is a key element of the Department's role in monitoring progress towards these goals.[25]

Section 8(2) of the Health Administration Act 1983 provides that one of the functions of the Director General of the NSW Department of Health is to:

> *(a) to initiate, promote, commission and undertake surveys and investigations into:*
> *(i) the health needs of the people of New South Wales;*
> *(ii) the resources of the State available to meet those needs; and*
> *(iii) the methods by which those needs should be met.*

Public health information informs health policies and actions that are aimed at:

- the determinants of a population's health and causes of illness rather than symptoms;
- the health of a population, and groups within it, as opposed to the individual;
- the promotion and protection of health and prevention of illness rather than treatment alone; and
- the relationships among these elements.[26]

Information systems are necessary to identify risk factors, risk groups, the causes of disease and, importantly, the optimal methods of intervention not only within the context of clinical medicine but during the course of public health practice which incorporates prevention, education, diagnosis and management of risks to public health.[27]

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25 Jorm L, Puech M December 1997 *Strategy for Population Health Surveillance in NSW Discussion Paper* NSW Health Department

26 NPHP op cit

27 Allars, Carney, Magnusson, McMahon, Opeskin op cit

7.2 How is information gathered?

Information can become available through many different aspects of public health practice: as part of patient management, as part of gathering and investigating population based data on disease incidence (through surveys or studies), and in the course of carrying out routine public health functions.[28] It must also be recognised that because public health action is broad based, encompassing many government and non government agencies, community and industry groups, important public health information is often found outside the health sector. For example important information relevant to public health is found in information systems related to road safety campaigns, coronial inquiries, crime statistics, environmental data and vital statistics on births such as those held by the Registry of Births, Deaths and Marriages.

While the collection of public health information has clear public interest objectives, it must also be recognised that the community places a high degree of emphasis on the maintenance of individual privacy and confidentiality. The common law and legislation impose duties on medical practitioners and other health professionals to maintain the confidentiality of information obtained in the course of their professional practice. Similarly, legislation such as the Health Administration Act and the Public Health Act impose obligations on Government agencies and their employees to maintain the confidentiality of information obtained about individuals during the delivery of health care services, or in the course of administering or executing public health legislation.

This value the community affords to the maintenance of privacy is perhaps most clearly embodied in the recent Privacy and Personal Information Protection Act 1998. The Act sets out information protection principles for public sector agencies and section 8 of the Act requires that a public sector agency must not collect personal information by any unlawful means and that personal information must not be collected unless :

- the information is collected for a lawful purpose that is directly related to a function or activity of the agency, and
- the collection of the information is reasonably necessary for that purpose.

The collection of public health information with its broad public interest objectives must therefore proceed in this context. As a consequence, information which may be of assistance to public health practice, including information about individuals, can be gathered in two general contexts:

- with the consent of the individual concerned; or
- without the consent of the individual, but only with clear legislative or other legal authority.

[28] Australian Institute of Health and Welfare under the auspices of the National Public Health Information Working Group 1998 *National Public Health Information Development Plan* Draft Discussion paper at Http://hna.ffh.vic.gov.au/nphp/nphidp/index.htm

The Public Health Act 1991 is an important source of statutory authority for the collection of health information where the interests of individual confidentiality are sought to be balanced with the broader objectives of public health. The material collected under the Public Health Act 1991 and the purposes for which it is collected is detailed in section 7.4.

7.3 Privacy Protection

The protection of personal information is an important element of public health practice and is one of the key elements of patients' rights. As stated in a recent review of public health law in Australia[29], the importance placed on privacy protection has varied between communities and over time, and it should be acknowledged that early public health laws paid little attention to the protection of privacy. As communities became increasingly concerned about the collection and flow of information in bureaucracies, both governments and the courts have imposed checks on information gathering and its use. Consequently, modern legislation, including public health legislation, contains explicit privacy protection measures.[30]

The NSW Health Department has developed stringent policies and procedures relating to use of data and privacy protection. There are detailed privacy protection measures relating to public health existing today including the Health Administration Act, the Private Hospitals and Day Procedure Centres Act, which ensures the confidentiality of records for private hospital patients, and the Day Procedure Centres Regulation which contains the same provisions for day procedure centre patients.

Under section 75 of the Public Health Act a person who discloses information obtained in connection with the Act is guilty of an offence, unless a court is satisfied that there is a lawful excuse for disclosure. The Public Health Regulation 1991 allows as a lawful excuse the release of epidemiological data where there is written approval from the Chief Health Officer.

Section 17 introduces additional confidentiality arrangements in respect of information about persons that have contracted HIV/AIDS. These provisions are much more specific and prevent the name and address of a person living with HIIV/AIDS being provided to the Department of Health as is the case with other scheduled medical conditions. The Act provides for a penalty of a fine of up to $5,000 for unauthorised disclosure.

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29 Bidmeade and Reynolds op cit

30 Reynolds C *Confidentiality and privacy provisions in Public Health: the transfer of information between Australian jurisdictions* National Public Health Partnership *at* http:\\hna.ffh.vic.gov.au/nphp

The Privacy Protection and Personal Information Act 1998 provides for the development of Privacy Codes of Practice to regulate the collection, use and disclosure of personal information by public sector agencies and requires that a Privacy Commissioner and a Privacy Advisory Committee be appointed. The Act also requires that all public sector agencies must prepare and implement a privacy management plan by the end of 1999 and that the annual report of each public sector agency must include a statement of the action taken by the agency in complying with the requirements of the Act

The NSW Health Department has had an Information Privacy Code of Practice since May 1996. The NSW health system code of conduct contains requirements for all employees to observe the confidentiality of personal and sensitive information. The Code also includes detailed requirements relating to the use of data collections (including data linkage) which is covered in section 8 of the document. The Department's Information Privacy Code of Practice may be accessed on the NSW Health Website *www.health.nsw.gov.au/iasd/ information-privacy*.

A review of public health law in Australia[31] identified two main issues relating to privacy protection and public health

- "*There needs to be adequate privacy protection for patient data. Successful public health practice requires co-operation rather than coercion. People are more likely to co-operate if they trust the system, and in the case of infectious disease control in particular, the protection of patient privacy is the most important element around which trust needs to be built.*

- *There also needs to be effective access to data for epidemiological studies. Many large scale retrospective analyses of exposures and disease require access to named patient data. Often these patients cannot be found in order to give consent or it is logistically impossible for the researchers to try to obtain it. Here the breaches of privacy need to be measured against the public health benefits that can flow from the identification of new causes of disease.*"

Discussion Point 9 – Privacy Protection

Submissions are invited on whether the current arrangements for privacy protection under the Public Health Act and related legislation provide an appropriate balance between privacy protection and ensuring that information can be collected and analysed for public health purposes.

[31] Bidmeade and Reynolds op cit

7.4 Collection of Information under the Public Health Act 1991

The Public Health Act 1991 establishes a list of scheduled medical conditions, divided into five categories and certain practitioners and organisations such as pathology laboratories are required to notify the incidence of disease. The conditions are listed in Table 7.1 along with the practitioners or organisations who are required to provide information to the Department where they identify individuals that are affected by the condition. The identity of a person suffering from a category five medical condition (HIV/AIDS) is not to be revealed unless:

- the person has consented to the disclosure,
- there is some lawful reason for doing so,
- a court has ordered the disclosure in order to examine a witness,
- to enable information to be provided to a person providing care, treatment or counselling to the subject person, or
- the person is a patient in a public hospital, private hospital or a day procedure centre and the disclosure is necessary for the care and treatment of the patient.

The lack of a restriction upon the identification of a person with a category five medical condition when being treated in a health care facility comes about through the need to ensure that the identity of the person is clearly established when providing treatment. It should be emphasised, however, that other restrictions apply to disclosure of category 5 information to individuals not connected with the patient's care. There are also other primary obligations on such facilities to maintain confidentiality including the Health Administration Act 1982, the Private Hospitals and Day Procedures Centres Act 1988 and the common law.

In addition, section 68 places an obligation on hospitals to notify the incidence of certain conditions. While the conditions are broadly similar to those listed in Schedule 1, Category 3, there are some variations. A list of diseases notifiable by hospitals is provided in **Appendix C**.

More recent amendments to the Act have established a Pap Test Register which provides for the notification of screening results to a central register managed by the NSW Cancer Council. Women have the right to elect to not have their results forwarded to the register, however, those that are on the register will receive a reminder notice that they are due for another screening test after a certain period of time.

Table 7.1 - Scheduled Medical Conditions

Category	Required to Notify	Condition	Information to Be Collected
1	Medical Practitioners	Birth	The particulars for the Midwives Data Collection Form
		Perinatal Death	Identifying details of the mother and baby, and details of the death.
		Sudden Infant Death Syndrome (SIDS)	Identifying details concerning the mother and baby, including birth and place of death.
2	Medical Practitioners	AIDS	AIDS Notification form (Identifying information about the patient is not collected)
		Acute Viral Hepatitis Adverse events after Immunisation Food borne illness in >2 related cases Gastroenteritis among persons in an institution Leprosy Measles Pertussis (Whooping Cough) Syphilis Tuberculosis	Doctor/Hospital Notification Form (including identifying information)
3	Pathology Laboratories	Aboviral infection Botulism Brucellosis Cholera Cryptosporidiosis Diptheria Gonorrhoea *Haemophilus influenza* type B Hepatitis A,B,C,D & E Lead Poisoning *Legionella* Infection Leptospirosis Listeriosis Malaria	Form approved by the Director General including identifying information

Category	Required to Notify	Condition	Information to Be Collected
		Measles Meningococcal Mumps Mycobacterial infections Pertussis Plague Poliomyelitis Q Fever Rabies Rubella Salmonella infections Syphilis Typhus Verotoxin producing E Coli infection Viral Haemorrhagic Fevers Yellow Fever	
		HIV	Form approved by the Director General, but not including identifying information
		Cancer	Form approved by the Director General including identifying information
		Neonatal Birth Defects	Form approved by the Director General including identifying information.
4	See category 2 and 3	Tuberculosis Typhoid	N/A
5	See Category 2 and 3	AIDS HIV	N/A

7.5 Why is Information Collected Under the Public Health Act 1991?

Traditionally, the collection of public health information has focussed on certain infectious diseases and cancers. In relation to infectious diseases, the collection of information about the incidence of certain conditions is necessary

to monitor the outbreak of diseases or prevent and control their outbreak. Identifying data assists the Department and Public Health Units to conduct follow up interviews with individuals and to identify sources of infection and those at risk. Early intervention to prevent the widespread outbreak of the disease may produce significant benefits for the community. The specific action that may be taken in relation to Scheduled Medical Conditions and the obligations that are placed on individuals under the Public Health Act 1991 are discussed in more detail in Chapter 8.

Notwithstanding the traditional focus on the collection of information relating to infectious diseases, in more recent years the legislation has provided for the collection of information in relation to other conditions for other purposes, unrelated to 'disease control'. The Public Health Act 1991 sought to recognise the broader purposes for which information may be collected including research and education:

> *"Public Health action may include education, prevention, medical treatment or notification requirements…*
>
> *Category 1 comprises non-communicable medical conditions which require notification to the Director-General and may be subject to voluntary public health action, such as education campaigns."*

The recently released report by the Cancer Council, *Cancer Incidence in NSW*, was prepared based on information collected under the provisions of the Public Health Act 1991 and provides valuable information concerning variations in the rates of cancer across NSW.

Conditions for which information is collected primarily for research and planning purposes includes; adverse events following immunisation, SIDS, cancer, neonatal birth defects, perinatal death and birth defects.

7.6 Issues for Consideration

7.6.1 *The Role of the Department in the Collection of Data*

Although it is specified in the Health Administration Act, it has been suggested that the Public Health Act should specifically recognise the Department's responsibilities for monitoring health through the use of health data.[32] This has been implemented to varying degrees in other jurisdictions. For example, the Victorian Health Act requires the Chief General Manager to *"establish a comprehensive information system encompassing the causes and nature of illness in Victoria, and the utilisation of health services in that state."*

[32] Allars, Carney, Magnusson, McMahon and Opeskin op cit

7.6.2 *Introduction of new Notification Requirements*

The Schedules of the Public Health Act 1991, which specify the conditions that must be notified, can be amended by Regulation. It has been suggested that in circumstances where conditions are identified for which it may be appropriate to require notification, the process for adding a condition can be very cumbersome and slow. For example, prior to the recent contamination of Sydney's water supply, *giardia* was not a scheduled medical condition. Although the legislation was subsequently amended, the routine availability of information concerning its incidence throughout the event would have been of assistance.

However the requirement to amend the schedules through a publicly promulgated Regulation may be appropriate given the issues of personal privacy involved. One alternative that might be considered could include amendment of the lists by Ministerial order, rather than regulation.

Another option that may be appropriate to consider is the inclusion of provisions in the Act that would allow the Minister for Health, the Director-General or the Chief Health Officer to require the notification of certain conditions by medical practitioners or pathology laboratories during a specified period. The use of such provisions would be limited to situations where an outbreak of a condition raises significant public health concerns, and notification on a temporary basis is required to assist the Department and/or public health units in making decisions on appropriate action.

7.6.3 *Identifying Information*

A number of comments have been received suggesting that the reporting of Hepatitis C and sexually transmitted infections should be undertaken on the same basis as the notification of persons newly diagnosed with HIV, that is on a non-identifying, need to know, basis. It has also been suggested that the current provision of data on a person diagnosed with Hepatitis C or sexually transmissible disease is inadequate. Presently the only data collected are the person's name, age and sex. This does little to contribute towards gaining a better understanding of the condition, how long, prior to diagnosis, a person was infected, and the social environment in which it was transmitted. It has been suggested that a data profile similar to that collected on persons diagnosed with HIV be considered to enable services to be better targeted.

The question has also been posed as to whether, in addition to the reporting requirements for scheduled medical conditions, medical practitioners should be mandated to report any observations of the emergence of geographic clustering of communicable diseases. While the incidence of such conditions is reported on a case by case basis, the emergence of a cluster from data analysis can take some time to emerge. Requiring medical practitioners to report observations of clusters of communicable diseases may speed up the cluster identification process enabling a more timely response to emerging

situations. However, the value of such a mechanism has to be assessed against the additional workload that such a requirement imposes upon medical practitioners and the enforcability of such a requirement.

7.6.4 *Major Data Collections*

It has been suggested that the compulsory collection of major data sets that play a role in public health practice, though not necessarily related to infectious disease control, should have a clear and more transparent statutory foundation. Establishment of new registers, such as those related to the collection of data relating to birth defects and cancer has proceeded through the provisions relating to scheduled medical conditions, which have traditionally focussed on infectious disease control. This has sometimes proved difficult with unnecessary duplication occurring (and some conditions requiring multiple notification).

Further, an argument can be made that the establishment of separate stand alone registers for specific conditions should occur with due regard to transparency and accountability measures.

Under the Tasmanian Public Health Act 1997, the Director of Public Health has a generic power to set up information registers. The Act states that:

> *"The Director may establish registers containing information which the Director considers may assist in facilitating, protecting, promoting or maintaining public health. The Director may require any person, public authority or agency to provide information for inclusion in an information register. The Director may require a council to establish registers containing any information the Director determines."*

The Act could set out an operational framework to govern the conduct of information registers. Careful consideration of a range of issues is required to identify those elements most appropriately included in legislation and those issues that may be appropriately subject to administrative policies and procedures. Relevant issues requiring consideration include: the nature of the data to be collected, transparency of the process, approvals required to collect and use data, confidentiality issues, the use of data for planning and research purposes, public access to information, reporting requirements, destruction of data, the use of identifying data and whether the cross referencing of identifying data from other sources should be permitted.

7.6.5 *Monitoring Outcomes*

As the health care system places greater emphasis on the population health outcomes of health care services, the scope of public health information has broadened. For example, mammography screening aims to decrease deaths due to breast cancer, but any reduction in mortality will be achieved through a partnership between effective screening programs and effective treatment

programs. In order to evaluate the effectiveness of screening in terms of death rates, information concerning treatment may be required.

Section 20 of the Public Health Act 1991 provides that where a person dies from a scheduled medical condition the Registrar of Births Deaths and Marriages is to arrange to have sent to the Department the name, address, age of the deceased and other information. While this provides some material, it may not be effective in its current form.

The establishment of stronger links between screening and treatment raises important issues. Clearly individuals may not wish to have their ongoing treatment monitored, notwithstanding the important public health benefits. Any proposals in this area would need to establish an appropriate balance between the interests of the individual and those of the public at large. Indeed options for resolving this balance may include stronger privacy safeguards, an opt-off register (as provided for in provisions establishing the pap test register) or an opt on register where patients can elect if they want information recorded.

Discussion Point 10 – Information about Public Health

Submissions are invited on:

- the adequacy of the current arrangements for the collection of data under the Public Health Act;
- the need to specifically recognise the Department's responsibilities in monitoring health through the use of health data;
- procedures for introducing new notification requirements;
- the types of data collections that should be mandated under the Public Health Act;
- the issue of introducing a generic registers power within the Act;
- the need to improve arrangements for monitoring disease outcomes.

7.7 Public Health Reporting Mechanisms

Currently, the Department of Health provides information about public health measures through the release of the Chief Health Officer's report "*The Health of the People of NSW*". This report provides a detailed account of available measures of health for the population of NSW. The report includes more than 200 health indicators and is intended for policy makers, health professionals, academics, administrators, students and interested members of the general

public. It may be timely to consider whether there is a need for the Public Health Act to mandate reporting on the health status of the people of NSW. It has been suggested that a formal requirement to publish this type of information is likely to enhance accountability for performance in the area of public health.[33]

Currently, the New Zealand Health Act 1956 requires the Director General of Health to provide the Minister with an annual report on the state of public health to be tabled in Parliament and a comprehensive report on population health status and on the major determinants of health outcomes every 5 years. This is seen as a measure of accountability for public health.

This approach to formal reporting as required by legislation has also been utilised in the area of environmental protection, with section 10 of the Protection of the Environment Administration Act 1991 requiring the Environmental Protection Agency to publish a report on the state of the NSW environment every 2 years. These reports provide an assessment of the condition of the environment, the pressures on the environment and the response of the environment to those pressures. The reports also analyse trends, evaluate the effectiveness of policies and establish a bench mark from which future environmental changes can be assessed.

Discussion Point 11 – Reporting Requirements

Submissions are sought on the need for the NSW Public Health Act to mandate reporting requirements in the health status of the people of NSW.

How often should reports be required?

[33] Queensland Health Department February 1998 *Review of the Health Act 1937 (Public Health)*

PART IV RESPONDING TO PUBLIC HEALTH AND ENVIRONMENTAL RISKS

CHAPTER 8 GENERAL POWERS

8.1 Emergency Powers

The NSW *State Emergency and Rescue Management Act 1989* provides for the development of the State Disaster Plan (*NSW DISPLAN*). *NSW DISPLAN* details preparedness, response and recovery from major incidents/disasters. Under the *NSW DISPLAN* the roles and responsibilities of NSW Health are clearly identified as follows:

"to co-ordinate and control mobilisation of all health responses to emergencies and this includes medical, nursing, first aid, pharmaceutical supplies, public health and mental health services."[34]

The *NSW HEALTHPLAN* details the arrangements to co-ordinate the health response to, and recovery from, major incidents and disasters including the public health response.

In addition, **Section 4** of the Public Health Act 1991 provides that where a "state of emergency" has been declared under the *State Emergency and Rescue Management Act 1989*, and the Minister for Health (in consultation with the Minister for Emergency Services) decides on reasonable grounds that the emergency could result in a situation where the health of the public is or is likely to be at risk, an order may be published in the Gazette by the Minister directing that certain actions be taken to deal with the risk. Where an order is in place, the Minister may take action to avert the risk. This may include directing persons in a specified area or group to submit to medical examinations.

Section 5 provides that where no state of emergency exists, and the Minister considers on reasonable grounds that a situation has arisen in which the health of the public is at risk or is likely to be at risk, the Minister may take such action, and by order published in the Gazette, give directions to deal with the risk and its possible consequences. Before the Minister may take action under this section the approval of the Premier must be obtained.

Action that may be taken includes any measures the Minister considers necessary to reduce and remove the risk in an area, to segregate or isolate inhabitants and prevent or restrict access to an area.

Neither provision has been used since the Act commenced.

[34] NSW Health Department *NSW HEALTHPLAN* Functional Area Supporting Plan 1996

Up until 1998, section 7 contained similar general powers that permitted closure of the water supply. This provision was repealed and replaced because it was found to be inadequate and cumbersome for responding to the recent contamination of the water supply in Sydney. Under the amending provisions, new arrangements were introduced which provided for a broader range of responses in the event of an emergency involving water supplies, including powers to obtain information and issue warnings.

There is a need for emergency powers within the Public Health Act 1991 to respond to unforeseen emergencies and events. However, it is imperative that the provisions can be used in an effective and timely manner to enable immediate response to emergencies such as food contamination or an outbreak of a serious disease. That said, given the potentially intrusive nature of the provisions on the rights of individuals, adequate safeguards need to remain in place to ensure that they are only used in appropriate cases.

Discussion Point 12 – Emergency Powers

Submissions are invited on the adequacy of section 4 and section 5 of the current Public Health Act 1991 for responding to emergencies.

8.2 Premises that Pose a Risk to Public Health

Currently section 8 of the NSW Act contains provisions that permit the Minister for Health to order closure of premises that present a threat to public health. The Act states:

> *(1) If the Minister considers on reasonable grounds that any premises on which the public, or sections of the public, are required, permitted or accustomed to congregate should be closed in order to preserve the health of the public, the Governor may, by order published in the Gazette, direct that the premises be closed, and kept closed, in accordance with the order while it is in force.*
>
> *(2) If:*
>
> *(a) a direction given under this section is in force in relation to premises that are not under the control of a Minister, and*
>
> *(b) a person who controls, or is involved in the control of, the premises is notified of the direction, the person must take such reasonably practicable action as may be necessary to ensure compliance with the direction.*

> *(3) A person who, after being notified under subsection (2) of a direction given under this section, fails to comply with that subsection is guilty of an offence.*

It should be noted that the Public Health Act 1991 does not deal with public health risks that emanate from premises (nuisances). These provisions were rationalised with provisions under environmental protection legislation in 1991 as discussed earlier in the report.

Clause 82 of the Public Health Regulation requires an occupier of premises to take reasonable measures to keep the premises free of vermin such as fleas, disease-carrying insects, rats and mice (except any such animals kept as pets). The Victorian Health Act 1958 contains similar provisions to those in NSW, with section 87 of the Act permitting regulations to be made regarding rats and mice. Regulation 36A of the Victorian Health (Infectious Diseases) Regulations 1990 provides that the owner or occupier of premises can be given reasonable directions to destroy any rats or mice on those premises or take steps to remove or rectify any conditions on the premises which are conducive to the breeding of rats and mice.

The current provisions are applicable to premises that are deemed insanitary and present a risk to health. Section 8 might also be used in circumstances where a public gathering might occur where an infectious disease might be spread, notwithstanding the premises themselves are satisfactory. However, they do not permit any alternate action other than closing the premises. It may therefore be useful to consider the approaches adopted by South Australia, and the ACT in regard to this issue where 'clean up' notices can be issued.

The South Australian Public and Environmental Health Act 1987 states that if premises are in an insanitary condition, the local council may issue a notice to the owner of the premises or any other person who is apparently responsible for causing or allowing the insanitary condition to occur. This notice specifies the necessary action to improve the condition of the premises or requires the owner/proprietor to cease a specified activity that is causing the insanitary condition. If residential premises are, by reason of their insanitary condition, unfit for human habitation, the council may require that the premises must not be occupied until:

(a) specified action to render the premises fit for human habitation has been taken; and

(b) the authority is satisfied that the premises are fit for human habitation.

In addition, the scope of Section 8 of the Public Health Act 1991 would appear to be confined to situations where "the public, or sections of the public, are required, permitted or accustomed to congregate". The use of this

wording is vague and may not be adequate to respond to all public health risks. For example, a member of the public may visit premises to receive particular services or purchase goods and be exposed to a significant public health risk, but not necessarily "congregate" with other members of the public.

Alternatively, the premises may not of themselves be insanitary, although the gathering of people may result in a risk to public health in situations where a highly contagious disease

It should also be recognised that general requirements such as those contained in section 8 may result in costs for occupiers of premises as they endeavour to meet the 'reasonable' standard required by the legislation. This may result in barriers to entry for new operators where the costs of meeting the reasonable standard are significant.

Discussion Point 13 – Unhealthy Premises

Submissions are sought on the adequacy of section 8 of the Public Health Act 1991 and clause 82 of the Public Health Regulation for responding to health risks on premises.

8.3 Exposing Others to Contaminated Articles

Section 6(3) provides that a person is guilty of an offence where, without reasonable excuse, she/he;

- transfers an article to another person,
- exposes an article to another person, or
- removes an article,

knowing it to be an article that;

- has been in contacted with a person suffering from an infectious disease that is transmissible by contact with article;
- is verminous, or is likely to be verminous, dangerous or prejudicial to health because it has been used by a person infested with vermin.

Section 6(2) provides that the Director-General may authorise a person in writing to enter premises to seize any such article if they have reasonable grounds for suspecting that there is such an article on premises. The article may then be disinfected or destroyed.

These provisions are intended to provide a means of ensuring that individuals and businesses that provide services do not expose others to the risk of harm. A general provision such as section 6 could be important in regulating emerging services such as "colonic irrigation" that are not subject to specific

regulatory controls. However, the Department has found them to be difficult to enforce even in cases where the possible transmission of serious diseases, such as hepatitis or HIV/AIDS, may have occurred as a result of inadequate infection control procedures. Further the provisions give no recognition to strategies that may be put in place to minimise the risks associated with infected articles.

No prosecutions have occurred under this section, however, the provisions have been used on one occasion to authorise the seizure from a service provider of equipment where inadequate infection control procedures were being used.

Discussion Point 14 – Infection Control

Submissions are sought on the effectiveness of section 6 of the Public Health Act 1991 in minimising risks to public health such as the spread of serious medical conditions.

8.4 Directions to Public Authorities

Section 9 provides:

> *(1) If the Minister considers, on reasonable grounds, that the health of the public is, or is likely to be, endangered because of an action by a public authority, the Minister may direct the public authority to rectify any adverse consequences of the action by taking other specified action.*
>
> *(2) It is the duty of the public authority to comply with any direction given to the public authority under this section.*

With the increase in the contracting out of Government services to the private sector, risks that previously may have been presented by public authorities may now be shifted to the private sector. An issue arises as to whether these sections should be extended to cover these circumstances.

Discussion Point 15 – Directions to Public Authorities

Comments on the adequacy of section 9 of the Public Health Act 1991 are sought.

8.5 Responding to New Public Health Risks

In addition to the powers outlined above in sections 9.1 to 9.4, section 82 of the Public Health Act 1991 has a broad regulation making power for dealing with new and emerging public health risks. The power provides that the Governor may make Regulations for "the prevention, mitigation and eradication of risks to public health". This provision has been used for developing new regulatory structures for minimising risks to public health and safety in specific industries, such as skin penetration requirements.

Reviews of legislation in other jurisdictions have raised for consideration whether a more comprehensive approach to public health risk management should be adopted in legislation. Concerns that have prompted consideration of this issue include:

- the potential for gaps in existing public health legislative frameworks,
- the wide variety of factors that may influence public health;
- the limited scope for proactive responses to public health risks under traditional public health legislation.

New Zealand is currently giving extensive consideration to this issue. In a recent discussion document *Public Health Legislation Review* the option of creating a general duty not to cause risks to public health has been identified for consideration. In addition, that jurisdiction is considering adopting within their legislation a framework for responding to hazards to health that recognises the importance of estimating the significance of a risk presented by a hazard, and ensuring that the level of control is appropriate to the nature, scale and significance of the activity. The Act could also specify a hierarchy of interventions for responding to risks, which should be considered where action is considered necessary, for example:

- the making of regulations, standards, or by laws,
- the enforcement of rules through infringement notices, compliance orders or prosecutions,
- provision of information to the public, including the disclosure of non-compliance,
- the taking of direct action by a public authority,
- monitoring a health risk,
- non-regulatory intervention, or
- audit arrangements such as a formal examination of the risk involved.

Controls, such as regulations, would only be imposed where the risk is significant. Other options such as standards, guidelines or codes of practice could also be considered depending on the degree of risk. The option of performance standards and alternative compliance arrangements would also be considered.

The exercise of powers might also be guided by a "precautionary principle" similar to that which exists in environmental protection legislation.

In South Australia, if an activity gives rise to a risk to health, the Health Commission may, by notice in writing to the person responsible for the activity, require that they stop the activity or observe certain requirements in relation to it. Failure to comply with an order is an offence.

In the ACT, the Minister can declare an activity to be a risk activity and require various things to be done in respect of it, including compliance with a particular code of practice or accreditation standard or the obtaining of a licence.

Having regard to the provisions of the existing NSW Public Health Act 1991, one option might be to improve or expand the existing ' duties' imposed under sections 6 and 8 relating to premises and articles to create broader duties relating to public health. The Minister or the Department could then consider the need for specific action to respond to an identified risk within the context of a risk management framework such as that set out in the New Zealand legislation. Interventions that could be considered, having regard to the level of risk, might include:

- conducting a formal inquiry or investigation;
- the issuing of guidelines;
- the issue of warnings to the community;
- recognition of voluntary industry codes of practice;
- mandatory standards;
- introduction of performance standards;
- issuing of clean up or mitigation notices;
- closure powers;
- establishment of licensing or other accreditation systems through legislation.

Obviously wherever such broad ranging powers were considered it would be necessary for there to be adequate safeguards in place to minimise inappropriate use.

Discussion Point 16 – Emerging Public Health Risks

Is there a need for more general powers to respond to public health risks that may emerge in the future? If so, how should decisions regarding the exercise of the powers be guided by legislation?

8.6 Inspections and Inquiries

Section 70 enables the Minister to inspect the records of a public authority while section 71 enables the Director-General to inquire into any matter relating to the health of the public or any matter that requires action by the Minister or Director-General. This provision is coupled with enforcement powers and inspection provisions.

This provision has been used on a number of occasions to conduct inquiries into specific incidents where concerns have been raised that the public may have been exposed to infectious diseases. For example, an inquiry was established to investigate the case of patient to patient transmission of HIV in a doctor's surgery in Sydney. Through the inspection of patient records, the Department was able to identify patients that may have been infected with HIV and enabled advice to be provided to these patients to undergo testing. Counselling could also be provided to the patients. In addition, it assisted the Department in identifying possible modes of transmission. The provisions have been used in other similar incidents.

It is the Department's view that this power has been useful in undertaking its functions.

Discussion Point 17 – Inquiry Powers

Submissions are sought on the adequacy of section 70 and 71 of the Public Health Act 1991 for conducting inquiries.

CHAPTER 9 SCHEDULED MEDICAL CONDITIONS

9.1 Introduction

As discussed in Chapter 7, scheduled medical conditions cover a wide range of disorders and diseases and are divided into five categories. Included are conditions such as AIDS, Measles, all forms of Hepatitis, Tuberculosis and Typhoid. The inclusion of conditions in each category is based on the type of action that may need to be taken to protect public health. Category 1 comprises non-communicable medical conditions. Category 2 consists of medical conditions to be notified by medical practitioners. Category 3 medical conditions are those to be notified by laboratories, while category 4 is composed of communicable medical conditions that may require involuntary public health action. Category 5 medical conditions are those that are communicable, may lead to a premature death and in respect of which there is presently no curative treatment.

The Act imposes a number of specific obligations on medical practitioners that provide treatment to individuals affected by conditions listed in certain categories. In addition, certain obligations are imposed on those individuals suffering from conditions in certain circumstances. In the case of category 4 or 5 conditions, the Act provides for Public Health orders to be made under which individuals may be detained for treatment or in other circumstances specified in the Act.

9.2 General Precautions Against the Spread of Scheduled Medical Conditions

Section 11 requires a person suffering from a category 2, 3, 4 or 5 medical condition, when in a public place, or some other place frequented by the public, to take all necessary precautions to avoid spreading the medical condition.

South Australia, Tasmania and Victoria take broadly similar approaches to that taken in New South Wales. All Acts provide that persons infected with notifiable diseases have certain obligations to ensure that they do not infect others.

Section 12 of the Act provides that in regard to sexually transmissible conditions, medical practitioners are required to provide a person affected with prescribed information concerning the nature, progress and treatment for the condition.

Section 13 provides it is an offence for a person to engage in sexual activity without first advising the other person of the condition, or to allow such sexual activity to occur on premises for the purposes of prostitution.

The absence of a definition of what constitutes a sexually transmissible condition has led to considerable debate over whether particular conditions, such as Hepatitis C, should be considered sexually transmissible conditions. This would suggest that either the term needs to be defined, or that a determination be made regarding which conditions are sexually transmissible and listed in a schedule.

The AIDS Council of NSW has proposed that the requirement for a person with a sexually transmissible condition to advise another person of this fact prior to engaging in sexual activity is too generalised. The Council is of the view that oral sex, due to the low risk factors and sexual intercourse per vagina and anus involving the use of a condom should be excluded. In any event, the Council is of the view that the use of a condom should be cited in the legislation as a defence in any prosecution.

The AIDS Council has further proposed that in regard to category 5 medical conditions that medical practitioners ordering such tests should be obliged to offer the person to be tested pre and post test counselling.

Discussion Point 18 – Scheduled Medical Conditions

Submissions are invited on:

- the need to define the term "sexually transmissible condition" and/or identify by way of a schedule those conditions that are sexually transmissible;
- whether persons with sexually transmissible conditions should have to advise any sexual partner in advance is restricted to sexual activity other than oral sex or sexual intercourse involving the use of a condom;
- whether medical practitioners when ordering diagnostic tests should be required to offer pre and post test counselling;

9.3 Public Health Orders

The purpose of public health orders is to minimise the spread of infectious diseases by ensuring controls may be placed on the behaviour of a person who is behaving in a way that is endangering, or is likely to endanger the health of the public.

Under section 22 of the Public Health Act, the Director-General can require a person suffering from a category four medical condition (Tuberculosis or Typhoid), or a category five condition (AIDS or HIV infection) to undergo a medical examination carried out by a medical practitioner of the person's choosing.

The Chief Health Officer or a medical practitioner authorised by the Director-General may make a public health order under the Act if they are satisfied that a person is suffering from a category four of five medical condition and is behaving in a way that is endangering the health of the public because the person is suffering from the condition. The order can direct the person to refrain from a specified activity, undergo specified treatment, counselling or submit to the supervision of particular persons and can be in force for up to twenty-eight days. In addition, an affected person can be detained at a specified place for the purpose of receiving treatment. In respect of a category five medical condition, a person may also be detained at a specified place while the order is in force without the requirement that the detention be for the purposes of receiving treatment.

These provisions represent a staged approach to the management of people who have an infectious disease who may transmit the disease to others. The Act clearly envisages that the least restrictive option must be considered first and must be inappropriate, or attempted and have been unsuccessful, before a more restrictive order is made. The most restrictive provisions, providing the power to restrict a person's behaviour or movements are viewed as a last resort to protect public health and have been used only rarely.

To ensure that a person's civil liberties are protected, a public health order for a category five medical condition has to be confirmed by a Local Court within three days of it being served on a person and a copy of the application to the Local Court given to the person named in the order. The Local Court has to be satisfied as to the need for the order, or revoke it. The Court may also vary the order by adding or substituting requirements as provided for within the Act.

Public health orders may only be made for 28 days. The District Court, upon application, may extend an order for a period not exceeding six months. The District Court, if it extends an order, may vary the order by adding or substituting requirements as provided for within the Act. A person who is the subject of a public health order may appeal to the District Court, challenging the making of the order.

Failing to comply with the terms of a public health order is an offence punishable by a fine of up to $5,500 or 6 months imprisonment. Such a prosecution may only be commenced by the Director-General or a police officer. To secure compliance with an order, a police officer may also obtain a warrant to apprehend a person who fails to comply with the terms of a public health order for the purpose of bringing them before the appropriate court. A warrant may only be issued after an authorised medical practitioner has certified that a breach of the order has occurred. The court, if satisfied that the person has contravened the terms of an order, may require a person to comply with the terms of the order and confirm or vary the terms of the order.

In hearing a matter the court can make orders suppressing all or some of the details of the proceedings to ensure that identifying details on the person are not released. An appeal may also be made to the Supreme Court on a point of law.

In summary these provisions aim to strike an appropriate balance between the rights of an individual, as opposed to the interests of the community who may be adversely affected by conduct of persons infected with Category 4 or Category 5 conditions.

It is appropriate to consider whether the current provisions strike an appropriate balance between the rights of individuals and the interests of the community. Those professionals required to consider the making of orders have highlighted some practical problems with their use. For example:

- the procedure for breach of an order requires a patient to be taken before a court. (This would require the person to remain in police custody possibly without necessary treatment.) The question has been posed as to whether such persons should in the first instance be taken to a hospital and detained there through a 'scheduling' procedure similar to that used in the Mental Health Act 1990, until such time as the matter can be reviewed by a court.

- where a person suffering from a Category 5 condition is detained under an order, the local court must confirm the order within three days. In the case of Category 4 conditions this does not apply. While this obligation to confirm the order is designed as a safeguard because the individual's civil liberties are compromised, it is likely that the '3 day rule' would deny the patient the opportunity to obtain legal assistance, while creating practical difficulties for the Department.

On the other hand, concerns have been expressed that there are inadequate safeguards in place.

- It has been suggested that less restrictive measures should be tried before detention is ordered.

- It has also been suggested there should be greater consistency in issuing detention orders.

- Authority to issue an order should rest exclusively with the Chief Health Officer acting on the advice of an assessment panel.

It has also been suggested that consideration should be given to broadening the application of these provisions to include other medical conditions such as Syphilis and viral haemorrhagic fevers. The current arrangements for issuing a public health order under the Act cannot be utilised for these conditions even if a person is behaving in a way that is endangering, or is likely to endanger the health of the public.

Discussion Point 19 – Public Health Orders

Submissions are invited on the effectiveness of current arrangements for public health orders.

Is it necessary to retain the provisions? What alternatives are there to the current arrangements?

Should the current provisions be extended to include category 3 medical conditions?

9.4 Responding to Notifications of Scheduled Medical Conditions

Although Public Health Units receive notifications concerning scheduled medical conditions and other notifiable diseases, the Act is relatively silent on the action that may be taken by public health units where they receive a notification. In general, action is guided by the Department's Infectious Diseases Manual. While in practice Public Health Units undertake a range of actions including providing counselling, contact tracing and issuing warnings, it has been suggested that it may be appropriate to set out more clearly the action that should be taken in the legislation.

Discussion Point 20 - Notifications

Should the Act set out the procedures to be followed where disease notifications are received under the Public Health Act 1991?

9.5 Medical Examinations

Section 22 of the Public Health Act 1991 enables the Director-General by written notice to require a named person to undergo a medical examination if the practitioner believes on reasonable grounds that the person is suffering from a category 4 or 5 medical condition (HIV, AIDS and tuberculosis). The provision provides that the person named in the order can select a medical practitioner to perform the examination.

There is a difficulty with the provision in that the ability to require an examination can be impeded where the person refuses to select a practitioner, or fails to do this within a reasonable period of time. Further, the persons ability to select an appropriate practitioner may be limited where complex tests are required to determine the patient's actual condition. This is a particular problem with drug resistant tuberculosis as many practitioners will not have the ability to perform the tests.

Discussion Point 21 – Medical Examination

Comments are invited on the adequacy of the existing provisions relating to the power of the Director-General to direct that a medical examination be carried out.

CHAPTER 10 REGULATION AFFECTING THE CONDUCT OF SPECIFIC INDUSTRIES

10.1 Skin Penetration

The objective of regulating in relation to skin penetration is to reduce the risk of the transmission of blood borne pathogens such as HIV and Hepatitis B and C as well as infections due to bacteria such as staphylococci. The requirements in the Act apply to acupuncture, tattooing, ear piercing, hair removal activities and any other activity involving the penetration of the skin and therefore impact upon occupational groups such as hairdressers, beauty therapists, tattooists, acupuncturists and chemists. A medical practitioner, dentist or person acting under their instruction is exempted from these requirements, as they are already covered under professional registration legislation.

The regulation sets out basic infection control requirements to prevent the incidence of infection and cross infection and provides a power to publish guidelines. In the event of a person being prosecuted in relation to an activity captured by the regulation, a defence is provided if it can be demonstrated that the act or omission was in compliance with published guidelines. Matters of detail, such as appropriate sterilisation procedures, are covered by the guidelines.

All jurisdictions in Australia with the exception of the Northern Territory regulate skin penetration activities. Most other states require service providers to be licensed. Every jurisdiction has standards set by regulation for the conduct of skin penetration businesses including standards for premises. By way of contrast Tasmania's Public Health Act 1997 and the ACT's Skin Penetration Procedures Act 1994 make provision for the minimum acceptable standards to be published in codes of conduct relating to skin penetration procedures. Most other jurisdictions are fairly prescriptive in the standards that are set, which is different to the approach adopted in NSW as outlined above.

In accordance with the requirements of the Competition Principles Agreement and the principles outlined in Chapter 3 of this Paper, it is necessary to clearly identify the rationale for intervention and the impacts of such interventions. For example, are the current arrangements necessary or effective in controlling the spread of disease? Can less restrictive options also control the spread of disease?

If it is demonstrated that there is a continuing need for some form of statutory regulation, the appropriate regulatory model needs to be identified. A number of specific issues have been raised in respect of the current provisions:

- Two of the largest industry groups affected by the regulation, hairdressers' shops and beauty salons are also affected by complementary requirements under the Local Government Act. Because local

government health inspectors administer both of these requirements, industry players have difficulty in distinguishing between the requirements of the two Acts.

- Similarly, it is also observed that while notices of compliance can be served under the Local Government Act, there is no equivalent power under the Public Health Act when breaches of the Skin Penetration Guidelines are detected. It would seem timely to consider whether the Public Health Act should have an equivalent power. Consideration should also be given to whether the requirements currently contained in the Local Government and Public Health Acts in relation to skin penetration activities should be integrated.

- The current provisions rely on prosecutions to gain compliance. As noted previously there is no licensing requirement in NSW. As a consequence, in the event of repeat breaches, no action can be taken to exclude inappropriate operators from the market. A negative licensing system may be appropriate to address this problem.

- The coverage of the current provisions is unclear, particularly in relation to hairdressing procedures that do not involve skin penetration. Similarly colonic irrigation (an invasive procedure) is not subject to the provisions.

- Health professionals, such as podiatrists, are subject to skin penetration requirements of the Public Health regulation and also to infection control requirements under professional registration legislation. This can create confusion.

Discussion Point 22 – Skin Penetration

Submissions are invited on:

- the advantages and disadvantages of regulating skin penetration activities, and in particular, the specific options for regulation;

- If some form of statutory regulation is maintained, whether other strategies such as third party accreditation, negative licensing strategies or compliance orders should operate in additional to or in lieu of the present statutory requirements;

- any difficulties being encountered by having separate but complementary requirements under the Public Health and Local Government Acts.

- the exemption of health professionals from the requirements;

- the scope of the current provisions.

10.2 Microbial Control

Requirements for microbial control were introduced into the Public Health Act in response to outbreaks of Legionella, specifically Legionnaires' Disease associated with air and water handling systems in buildings. Being a naturally occurring microorganism, its hazard potential cannot be eliminated completely, but it can be controlled. Control rests on the fact that it only becomes a hazard under certain circumstances, such as when the count exceeds safe levels or through airborne or aerosol (spray) transmission. Therefore the focus of regulation is on restricting the microorganism count to acceptable levels.

The legislation specifies design standards and installation, operational and maintenance requirements for equipment on regulated premises concerning:

- air handling systems;
- evaporative cooling systems;
- hot water systems;
- humidifying systems;
- warm water systems; and
- water cooling systems.

Regulated premises include all types of buildings, except for dwellings.

NSW, Western Australia and Queensland are the only states to prescribe standards for the control of Legionella micro-organism, however in Western Australia and Queensland the extent of regulation is limited to the adoption of AS/NZS 3666. In Tasmania local government has the power to approve regulations and guidelines for the maintenance and cleaning of systems. While industry generally supports the need for some form of regulation, it criticises the operating and maintenance costs associated with the present regulatory regime. A further point of contention is the nature and frequency of the cleaning and disinfection procedures required. The growth of the Legionella organism is as much affected by the frequency with which equipment is used, as it is the design of equipment and the prevailing climate in which the equipment is used. It is also noted that NSW while having the most prescriptive regulations of any Australian state also has the highest incidence of the disease, although the incidence has been steadily falling over the last three years.

To minimise the costs, industry favours the development of performance based standards or the adoption of AS/NZS 3666 which has been adopted in Queensland, the ACT and Western Australia. This standard sets out the requirements for the design, installation and commissioning of air handling systems and for the heating and cooling of water employing a performance based approach. Were NSW to follow this path it has been estimated that the

present regulatory regime could be significantly reduced without affecting public health.[35]

While variations to the legislative requirements can be approved, the only agency authorised to approve or vary the regulatory requirements, or authorise inspections (which are usually undertaken by local council officers), is the Director-General of the NSW Department of Health. As an alternative it may be useful to consider whether third party accreditation could be employed and competent authorities permitted to determine suitable standards and/or undertake inspections, with costs being borne by industry and building owners.

Discussion Point 23 – Microbial Control

Submissions are invited on the benefits and costs of the regulation of Legionella hazard and in particular, on the specific options for regulation.

In the event of statutory regulation being considered necessary, submissions are invited as to whether:

- AS/NZS 3666 of its own is a sufficient standard to regulate for the control of Legionella;
- provision should be made for both outcomes based performance standards and prescriptive requirements within the legislation;
- whether third party accreditation systems could be adopted

10.3 Swimming Pools and Spas

Section 82(2) of the Act provides the power to make regulations to facilitate the prevention, mitigation and eradication of risks to public health. This power has been used to regulate swimming pools and spas to which the public has access.

The regulation requires that pools and spas to which the public has access have to be disinfected and the pool surrounds, toilets and change rooms kept clean to prevent the spread of infectious diseases.

Standards of disinfection to be observed are set out in guidelines provided for in clause 17 of the regulation. The regulation also provides a defence against any prosecution if it can be demonstrated that the act or omission was in compliance with published guidelines. The regulation also provides for a

[35] Clive Broadbent and Associates Pty Ltd 1996 *Management of Legionella Hazards in NSW, a review of the risks, rules and roles*

power of entry, inspection, testing, removal of water samples and the closing of public swimming pools and spas if considered to be a risk to the public.

The regulation of swimming pools and spas impact upon local councils as well as commercial interests such as motel and hotels, tourist resorts, sporting organisations and clubs, health and fitness clubs and a range of recreational venues.

Swimming pools and spas to which the public has access are also regulated in the Australian Capital Territory (ACT) and Western Australia which takes a similar approach to NSW legislation. The Western Australian Health Act (Swimming Pool Regulation) 1964 regulates, amongst other things, the cleaning of pools and facilities, maintenance and design, the closure of pools and the exclusion of people with infectious diseases. The Tasmanian legislation takes a slightly different approach by providing for the licensing of premises, including public swimming pools, by the relevant local government body. Guidelines for licensed premises can be issued under the Act giving a high level of flexibility to regulatory bodies in addressing public health risks associated with these activities. The ACT legislation is similar to that of Tasmania.

In NSW, while neither the Act or regulations impose any restrictions upon who may operate pools and spas, the regulation imposes requirements to be observed by operators thereby imposing costs upon business. This may create a barrier to entry, although this may be necessary to prevent the spread of disease. Therefore consideration is required of the present regulatory requirements for public swimming pools and public spas. If it can be demonstrated that continued regulation is necessary then consideration should be given to determining the most appropriate compliance strategy. Comments therefore are sought on whether alternative compliance strategies to statutory regulation can be used and the extent to which the industry is able to self regulate .

A number of specific issues have been identified for consideration:

- It has been observed that individuals using these facilities rely upon the diligence of the pool operator to maintain the water quality in swimming pools and spas in accordance with the prescribed guidelines. To make the process more transparent and beneficial to the public it has been suggested that the operators be required to display a notice advising of the last date and time the pool or spa was tested, the result obtained and the recommended level to be achieved.

- The current arrangements rely on public health units conducting inspections. It has been suggested that an alternative system might be used whereby operators are required to conduct regular testing subject to requirements they notify the Department if a breach of guidelines is detected (self-certification). This would be subject to monitoring or auditing by public health units.

Discussion Point 24 – Regulation of Swimming Pools and Spas

Submissions are invited on:

- the benefits and costs of the regulation of swimming pools, spas, and in particular, on the specific options for regulation.
- should some form of statutory regulation be maintained, whether provision should be made for third party accreditation and negative Licensing strategies; whether this should be additional to, in lieu of or complement the present statutory requirements.
- the need to make the water quality testing process more transparent by requiring the operators of pools and spas to display test results.

10.4 Drinking Water

The purpose of the current legislation in relation to water quality is to ensure that the health of the community is not jeopardised through the use of contaminated water. Water is an excellent medium for spreading infectious diseases and other conditions, such as blue-green algae, which may threaten the health of the public.

Recent amendments to the Act have codified the powers of the Director-General and Chief Health Officer in regard to the issuing of "boil water advices" and were introduced to improve the quality of responses by the heath system to drinking water health risks. In severe cases, the Director-General may order the closure of a water supply under section 10I. These amendments arose out of a formally established inquiry with the final proposals receiving bipartisan support in Parliament and are similar to the powers under the South Australian, Tasmanian and Victorian Public Health Acts that provide for action to close or restrict the use of a water supply.

In view of the recency of these amendments, the Department does not propose to review the adequacy of these provisions at the current time.

10.5 Crematorium Equipment

There are presently 24 crematoriums in NSW with a further two under construction with each cremator having a life span of ten to fifteen years. The establishment of a crematory requires approval under the Local Government Act for the premises and the Public Health Act for the cremator. Section 52 of the Act makes it an offence for a person to conduct a crematory unless the equipment and apparatus used in or in connection with the crematorium have been approved of by the Minister. The Act and regulations are silent as to

what criteria are to be employed when considering an application for approval.

Central to the approval process adopted is the need for the approving authority to be satisfied that the operating temperatures of the unit are sufficient to burn all soft and hard tissue, leaving only an ash residue. As there is no independent means of verifying the capacity of a new cremator design to meet this objective, the approval process relies upon the validity of the manufacturer's specification and the equipment being used in accordance with the manufacturer's instructions.

In addition, clause 41 of the regulation provides that the Minister for Health can issue a notice of closure for a crematory, however, it is silent as to the grounds upon which the Minister might act, nor is there any power of entry provided. If a crematory intends closing, notice of the intended closure must be given to the Minister and all registers and documents sent to the Director-General, or otherwise disposed of as directed by the Director-General. In considering the need for regulation it is also noted that NSW is the only Australian State to regulate for the supply and use of crematorium equipment.

Among the Australian States and Territories, NSW is the only State which regulates crematoria equipment. To maintain the present regulatory regime requires a demonstration that the benefit to the community outweighs the cost of the statutory requirements. In view of the reliance placed upon the supplying manufacturer's specifications and operating instructions by regulatory agencies in approving equipment, is there a continuing need to regulate for the approval and use of cremator equipment?

If it is considered that there is a continuing need to regulate for the use of crematoria equipment, should a cremator which has been approved for use in another country, be accepted for use in NSW? Could either a negative licensing model or a statutory, performance orientated outcomes based approach, as occurs with incinerators licensed under the Clean Air Act, be adopted to govern the installation and operation of cremators? If there is a demonstrated need to continue to regulate for the use of equipment used in crematoria, would it be more appropriate for this activity to be undertaken by the Environmental Protection Agency (EPA) as the approvals given employ identical criteria to that employed by the EPA when approving of incinerators.

If it is determined that a capacity to direct the closure of a crematorium should be retained should the grounds for such a decision be specified and any right of appeal set out? Similarly, consideration is required of who should be notified if a crematory intends closing and to whom all registers and documents should be sent, or be able to direct how they are to be disposed. The principal issues appear to be ensuring that the location and accessibility of registers and documents relating to the crematorium remain known and the alternative arrangements made concerning the advance sale of urns. Which government agency is the most appropriate authority to address such matters?

Discussion Point 25 - Cremations

Submissions are invited on:

- the benefits and costs of regulation of crematoria equipment and apparatus and in particular, on the specific options for regulation and which government agency should give any such approvals;
- the need for and the grounds on which a crematorium might be closed and associated rights of appeal;
- which government agencies should be involved in the regulation of cremators.

10.6 Preparation for and Burial or Cremation of Bodies

Section 82(2) of the Act provides for the making of regulations for "the prevention, mitigation and eradication of risk to public health". A significant part of the Public Health Regulation concerns infection control requirements surrounding the preparing and transporting of deceased persons. In particular special requirements are imposed in clauses 26 and 27 concerning the use of body bags and protective clothing for funeral industry workers which can lead to increased costs. Other requirements are imposed concerning the handling of bodies infected with medical conditions and diseases as set out in List A and List B as per appendix C. Bodies infected with List A and B conditions cannot be embalmed, meaning that they cannot be placed in a vault, but can only be buried or cremated. List A contains conditions such as all types of Hepatitis and AIDS, while List B contains diseases such as Anthrax, Smallpox and the viral haemorrhagic fevers such as the Ebola fever.

Premises that can be used for the preparation of bodies for burial or cremation, including embalming, for the placing of bodies in coffins for burial or cremation and the use of holding rooms are regulated. The regulation requires the approval of the Director-General before using premises for such a purpose, subject to the applicant providing a vehicle reception area, hand washing facilities, various items of furniture, refrigeration facilities and storage containers under clause 22. Undertakers are also required to have at least one hearse and one body collection vehicle. Restrictions are also imposed upon where in a vehicle a body may be carried, and that the part of the vehicle used for transporting a body be kept separate from that occupied by a person.

Provision is made to ensure that each cemetery and cremation authority maintains a register of all burials and cremations to ensure that the details of persons buried or cremated are recorded in a standardised format. Provision is also made for the inspection of mortuaries, crematoriums, cemeteries and any premises that are suspected of being used as a mortuary by environmental health officers who may also inspect and take copies of any register, document or record.

The exhumation of a body is prohibited unless the subject of an order by a coroner or approved of by the Director-General. When an exhumation is carried out an officer of the Department or an environmental health officer must be present.

To ensure that the body of a person is not cremated against the wishes of the person expressed while they were alive, is adequately identified prior to cremation, to ensure the cause of death is known prior to cremation and is not the subject of or associated with other investigations, the process of approving of the cremation of a body, who may apply, under what circumstances, who can approve and the restrictions upon giving an approval are all set out in the regulation.

Restrictions are also imposed by clause 34 upon where a person may be buried, this being limited to a public cemetery or other place on public or private land approved of by a local authority. The burial of a body in a vault is prohibited under clause 35 unless it has been embalmed and hermetically enclosed with a material approved of by the Director-General. No matter how a body is to be disposed of, it must be enclosed in a coffin and the lid secured, unless otherwise approved of by the Director-General.

Following the cremation of a body the ashes may be given to the person who made the application for cremation, disposed of in a burial ground or land adjacent to the crematorium set aside for the burial of ashes or otherwise retained or disposed of in accordance with clause 54.

Approvals required to be given by the Director-General which may restrict competition in this area have been summarised in Table 10.1.

TABLE 10.1 ACTIONS REQUIRING APPROVAL BY THE DIRECTOR-GENERALUNDER PART 5 OF THE PUBLIC HEALTH REGULATION

Clause	Matter
19(1)	to use premises other than a mortuary for the embalming or other preparation of bodies for burial, cremation or placing in a coffin
19(5)	to use the facilities at a hospital for the business of an undertaker or operator of a mortuary transport
21	the manner of disposal of solid waste arising from the preparation of a body for burial or cremation
24	to retain a body for more than five working days since the issue of a death certificate or coroners burial or cremation certificate
25	an institute to provide a person with a certificate of proficiency to embalm a body
26(1)	the conditions under which a person may remove a body from a place
26(2)	the alternative methods of sealing the outer bag in which a body is to be stored if infected with a List A or B disease
26(2A) 26(3) 26(3)(b)	the method for handling a body infected with an infectious disease
28(2)	the method for removing a body infected with a List A disease to prepare the body for viewing, transport, burial, cremation or transfer to a coffin
31	to bury or cremate a body other than in a coffin with the lid securely sealed
35(1)	the materials used to hermetically enclose a body
35(2)	the conditions, other than those prescribed under which a body may be placed in a vault

Clause	Matter
35(4)	the method of disposal of a cemetery register
37(1)	to exhume a body
56(3)	the method of disposal of the register of cremations and prescribed documents

As per the regulation of crematoria equipment, NSW is alone amongst the States and Territories in having regulations governing funeral industry practices and the handling of bodies. The present regulation prescribes requirements to be observed by undertakers, which are additional to those to be observed by persons (who may not be undertakers) when handling bodies, concerning:

- the burial or cremation of a body within five days following death;
- the embalming of a body,
- the need for a body to be placed in a body bag,
- the wearing of protective clothing when handling a body that may be infected with an infectious disease,
- the need to refrigerate any body that is kept on a premises for more than forty eight hours,
- the placing of a body in a coffin prior to cremation or burial,
- the transporting of a body infected with an infectious disease,
- the places at which and the manner in which a body may be buried.

The requirements for premises used for the preparation of bodies are very similar and complementary to those in the Local Government (Orders) Regulation 1993 concerning mortuaries. If they are to be maintained, in noting the inter-relationship of mortuaries and body preparation rooms should consideration be given to locating the requirements in the one regulation? Similarly, the requirements governing the disposal of waste also have some complementarity with the Local Government Regulation concerning waste disposal.

Anecdotal evidence suggests that on occasions relatives themselves collect the body of a deceased person from a hospital, nursing home or a domestic residence and transport it to another location, or to a cemetery for burial. As reported, the manner in which this is being done is in contravention of the Act through failing to use body bags, retaining the body for more than forty eight

hours without refrigeration and not having the body cremated or buried within five days of death.

However, to limit the removal and transportation of a body to Undertakers would be hard to justify on the grounds of public health or under the National Competition Policy. Such a limitation may also cause cultural conflict and in addition, such practices occur infrequently. To restrict the removal of a deceased person from premises to an Undertaker would in effect provide undertakers with a protected market. In addition under such circumstances it would not seem an appropriate response to prosecute a grieving family member for breaches of the Public Health Regulation. This suggests that the legislation needs to better reflect the public health issues, while at the same time accommodating the reasonable wishes of a deceased person's family.

As earlier noted there is also a restriction upon the embalming of bodies with List A or B medical conditions. This means that such bodies cannot be placed in a vault, as only an embalmed body can be so placed. However, as other Australian States do not have such a restriction this has led on occasions to families taking the body of a relative interstate for embalming. In view of the lack of a restriction in other states consideration of the continued need for such a restriction is required. Are there any public health or occupational health and safety issues, and if there are, why have they been discounted in other states?

The Funeral Industry Council (FIC) has submitted that there is a need for some form of regulation of the industry additional to that presently provided to address poor standards amongst current operators and prevent substandard operators from entering the market.[36] The FIC believes that regulation is required to ensure that:

- the health of the public is protected through standardised operating practices informed by infection control requirements;
- satisfactory standards of service are maintained;
- services provided reflect community expectations;
- the handling, transportation and storage of deceased persons is carried out in an appropriate manner; and
- the health and safety of workers in the industry are protected.

The FIC has proposed a system of registration administered by an independent Funeral Industry Registration Board to be funded by way of annual registration fees to be met by the imposition of a levy on each funeral and service provided by registered service providers.

[36] Funeral Industry Council 1998 Submission to the Minister for Health for the establishment of a Funeral Industry Registration Board

The proposal is based on the establishment of minimum standards for registration. The Board would have the power to refuse an application for registration, for transfer of a business and be able to cancel a registration. As such mechanisms constitute barriers to entry to the market place, they have to be subject to a cost benefit analysis in accordance with the Competition Principles Agreement. In addition, the increased cost to the community through the establishment of a registration board, application process and ancillary requirements has to be justified.

The FIC is of the view that leaving standards of service to market forces to determine is ineffective as there are few benchmarks available to the community by which to judge service providers. The FIC argues that this is compounded by the fact that most people are in some form of crisis when arranging a funeral which needs to be organised in an expedient manner. As a result people purchasing services from an undertaker are considered to be more vulnerable, with little time to shop around and make enquiries.

If the funeral industry is to be regulated the question arises as to the extent to which this should occur, as no other Australian State or Territory does so. If the industry was to be regulated which government agencies are the most appropriate ones to administer the legislation? While the Department of Health clearly has responsibilities for infection control issues, the WorkCover Authority is responsible for occupational health and safety issues, a factor identified by the funeral industry in their argument for some form of regulation. In addition, local government agencies also have a statutory role in the regulation of premises, while the protection of the public from unscrupulous operators is a matter of concern to the Department of Fair Trading.

The Department has engaged an independent consultant (ACIL Consulting) to prepare a report on the options for the regulation of the funeral industry. The consultant has been asked to assess the costs and benefits of alternative regulatory approaches. This report will be considered by the Department along with the submissions received in response to the Issues Paper in preparing a Final Report.

Discussion Point 26 – Disposal of Bodies

Submissions are invited on:

- the need to regulate for the handling of bodies;
- the benefits and costs of the regulation of premises used for the preparation for bodies for burial and cremation;
- the need for infection control requirements;
- the need to impose limitations upon where a person may be buried;

- the need, if any, to impose restrictions upon who may handle bodies, and the basis of such restrictions;
- whether the present regulatory requirements under the Local Government Act and Public Health Act should be merged;
- whether the current restriction on the embalming of bodies with List A or B medical conditions should be removed;
- the need for and benefits and costs of regulating the funeral industry and in particular, on the specific options for regulation and which government agencies should be involved; and
- are the opportunities to use performance based regulatory models in this area, rather than prescriptive approaches.

10.7 Tobacco Sales

Part Six of the Act deals with the sale of tobacco products. The Act prohibits the sale of unpackaged tobacco products, the packaging and sale of tobacco products without a health warning, the sale and packaging of tobacco products with wording suggesting that the product is not harmful and the sale of tobacco products to persons under eighteen years of age.

All Australian jurisdictions regulate tobacco products both in terms of labelling and sales of tobacco products to children. In addition all jurisdictions, with the exception of Queensland and the Northern Territory, have controls over the advertising and promotion of tobacco products. The Commonwealth Tobacco Advertising Prohibition Act 1992 applies in all jurisdictions and provides some limited controls where there are no state restrictions. The current review needs to identify and assess the effectiveness of the existing provisions in reducing smoking related diseases.

The Public Health Amendment (Tobacco Advertising) Act 1997 inserted provisions to control the advertising of tobacco products in view of the recency of these amendments the department is not considering these matters in the current review. The amending Act was considered in accordance with the requirements of the Competition Principles Agreement and was found to produce an overall community benefit, notwithstanding its impact on competition.

Overall, smoking imposes costs on the Australian community totalling $12 billion. Material from the United States highlights the reluctance of tobacco manufacturers to disclose information concerning the risks of smoking. Tobacco control legislation generally is directed at discouraging people, particularly young people from smoking, providing information about risks of smoking and assistance to quit.

A number of specific issues have been raised in respect of the current provisions:

- Concerns have been expressed at the relative ease with which persons under eighteen are able to obtain cigarettes through a third party, usually a friend.[37] A response to this problem of "third party supply" may be to consider prohibiting the purchase of tobacco products on behalf of or for a person under eighteen years of age.

- Another issue for consideration is the need to have in NSW legislation, specific requirements for tobacco products to carry health warnings in view of Commonwealth law. Industry and consumer groups who responded to the preliminary invitation to identify issues for inclusion in this paper pointed out the requirements of the Commonwealth Trade Practices (Consumer Product Information) (Tobacco) Regulations made under the Trade Practices Act 1974. It has been suggested that as this regulation requires all consumer products to carry prescribed information there is no need for a state law. As there is some duplication between State and Commonwealth requirements it is necessary to consider whether NSW requires legislation concerning health warning labels on tobacco products.

- Tobacco manufacturers and retailers have consistently argued that an offence should be introduced for purchasing, or attempting to purchase cigarettes while under the age of 18 years. The Department however has concerns with subjecting young people to criminal sanctions for attempting to purchase tobacco.

Discussion Point 27 - Tobacco

Submissions are invited on:

- the benefits and costs of regulating the sale of tobacco products and on the specific options for regulation (n.b. the advertising restrictions in Division 4 do not form part of the current review);

- if it is considered that some form of statutory regulation should be maintained, the costs and benefits of limiting the purchase of tobacco products for minors by a third party;

- the need for NSW to maintain the present regulatory requirements governing the application of health risk warning labels on tobacco products in view of the Commonwealth requirements.

[37] Usually described as third party supply

10.8 Sleeping Rooms

Clause 83 of the regulation sets out the special requirements to be observed by the occupier of any premises for any room or cubicle used for sleeping purposes based on a formula of 5.5 square metres of floor space per person. The objective of the regulation is to ensure that health risks are minimised through reducing overcrowding of rooms used for sleeping. While the principal application of the clause is to buildings under the control of local government, it also has some application to premises in national parks and other similar areas administered under the National Parks and Wildlife Act 1974, for example, ski lodges. While it has a general application, its use is primarily associated with new buildings and the approval of buildings for particular purposes as a health and hygiene issue. It is also noted that the enforcement of the regulation is more likely to be carried out by local government environmental health officers rather than an officer of the Department of Health.

While neither the Act or regulation impose any restriction upon who may provide overnight accommodation, in limiting the number of people that may occupy a room for sleeping purposes, a variety of costs are imposed upon commercial activities relating to the design and size of sleeping rooms. Consideration is therefore required as to whether the benefit of the regulation outweighs the cost, and if so, how to best achieve the desired outcome from the available regulatory options.

In the event that it is determined that some form of statutory regulation is necessary, the question also arises as to whether the requirements would be better relocated to the legislation under which building development and use is regulated. Therefore, submissions are also sought on whether this regulation would be more appropriately located under the Environmental, Planning and Assessment Act, Local Government Act and National Parks and Wildlife Act.

Discussion Point 28 – Sleeping Rooms

Submissions are invited on:

- the benefits and costs of regulating the spatial requirements associated with rooms used for sleeping and the specific options for regulation; and
- whether the regulatory requirements for "sleeping rooms" would be better located under the Environmental Planning and Assessment Act 1979, the Local Government Act 1993 and the National Parks and Wildlife Act?

CHAPTER 11 IMMUNISATION

11.1 Introduction

Immunisation has proven to be one of the safest and most cost effective procedures in modern medicine. However, to be effective, immunisation rates should generally be in excess of 95%. Within Australia, where such rates have been achieved, diseases such as smallpox, poliomyelitis and diphtheria have been effectively controlled.

Due to falling immunisation rates, the incidence of diseases such as mumps, measles and rubella began to increase. In response, legislation was introduced in 1992 to minimise and control outbreaks of certain "vaccine preventable diseases" in children. These vaccine preventable diseases are defined by the Act to include measles, diphtheria, whooping cough, poliomyelitis, tetanus, mumps and rubella. When introducing the amending legislation, the Minister for Health of the time acknowledged that "*Immunisation programs have prevented more suffering and saved more lives than any other medical intervention this century.*" [38]

The amending legislation introduced provisions which aim to limit the spread of vaccine preventable diseases by imposing on School Principals and Directors of Child Care Facilities certain duties and responsibilities to ensure that the immunisation status of each child enrolled in the school or child care facility in attendance is sought. Additional responsibilities are also imposed to report the outbreak of vaccine preventable diseases to medical officers of health in the local area. The mechanism by which this is achieved involves requiring the principals of schools and directors of child care facilities to request of parents, prior to a child commencing at a school or child care facility, proof of the child's current immunisation status, the details of which have to be recorded in an acceptable format. Parents are not required to provide this information, however, if they decline the child is taken to be unimmunised.

The requirements are such that a child who is not shown on the records of the child care facility or school as being immunised may be excluded from attending a child care facility or a school in the event of an outbreak of a vaccine preventable disease being notified. However, apart from excluding a child during an outbreak, children who are not immunised must not be discriminated against.

Both the Tasmanian Public Health Act 1997 and the Victorian Health Act 1958 take a similar approach to that taken in New South Wales. Both those Acts also contain provisions that require local government to take action to develop local immunisation programs.

[38] *Legislative Assembly Hansard*, NSW Parliament, 17 November 1992 at 9236

Part 2A of the regulation gives effect to the provisions in the Act concerned with the control of vaccine preventable diseases by:

- Applying the requirement to record the immunisation status for all children who enrolled in either a kindergarten class of a school or a child care facility, being a playgroup affiliated with the Play Group Association of NSW or a child care service, as defined in the Children (Care and Protection) Act, for preschool children with effect from 1 January 1994. (Children not so immunised may be excluded from attending during any outbreak of a vaccine preventable disease).

- Requiring principals of schools to retain a child's immunisation certificate and directors of child care facilities to maintain an entry of the child's immunisation details in a register for two years after the child has left the school or facility (unless a request is received from another school or child care facility to transfer the record).

- Specifying the occasions on which the director of a child care centre is obliged to request of a parent of a child in attendance at the centre, evidence of the currency of the child's immunisation program.

The current provisions seek to strike a balance between the interests of the community as a whole in achieving high immunisation rates, with the rights of individuals who have concerns with the risks of immunisation. Not all members of the community consider it appropriate to have their child immunised, perceiving the risk of adverse reactions to vaccination to be as, or more dangerous, than the disease itself. However, it is appropriate to consider whether the current balance between the two is adequate.

11.2 Issues for Consideration

A number of specific issues have also been raised:

- On occasions it may be more practical and effective to exclude from a school or child care facility a child that has acquired a vaccine preventable disease in addition to, or as an alternative to, excluding children who have not been vaccinated. Where there has been the early detection of a child who is still in the infectious stage, the exclusion of that child may be of greater benefit.

- The current provisions only apply to children enrolled in school since 1994. Older children are not subject to the provisions limiting their effectiveness. An issue arises as to whether the provisions should be extended to cover older children.

- The last issue to be raised concerns adverse event suffered by some children following immunisation. While the legislation provides for the reporting of adverse reactions to vaccines, some concern has been

expressed regarding difficulties members of the public may have in readily accessing this data. This poses the question as to whether information concerning adverse events should be made available from time to time, in a manner readily accessible by the public.

Discussion Point 29 - Immunisation

Submissions are sought on the:

- advantages and disadvantages of regulating for vaccine preventable diseases.
- the appropriateness of the current regulatory regime.
- the value of amending the Act to provide for a discretionary power to exclude from a child care facility or school a child that is suffering from a vaccine preventable disease.
- whether the provisions should be extended to cover older children enrolled in school.
- the proposal to increase public access to data regarding adverse reactions to vaccines used to prevent certain diseases and what constitutes an adverse reaction.

PART V COMPLIANCE ISSUES

CHAPTER 12 GENERAL ENFORCEMENT ISSUES

12.1 Powers of Entry and Inspection

An important consideration in the review of the Public Health Act is to ensure that the Act contains appropriate provisions to allow the government to monitor public health risks and respond quickly and effectively to protect public health. These provisions include enforcement powers, power to grant delegations and powers of entry and inspection.

The NSW Public Health Act provides for a range of powers for officers to enable them to enforce its requirements. These powers are provided to environmental health officers who are an officer of the Department of Health, an employee of an Area Health Service or an employee of a local authority/council. Currently, however these powers are spread throughout the Act, reflecting the evolution and development of the Public Health Act. Problems of inconsistency and confusion have arisen because there are variations in the powers of entry and inspection in relation to each issue regulated under the Act. Subject to the Act being remade it is proposed to review all the powers of entry to ensure uniformity and consistency.

Section 72 of the current Act provides uniform accountabilities for authorised officers and core powers of inspection, with requirements specific to the exercise of powers of individual regulatory areas being set down in the appropriate parts of the Act and regulation. The current safeguards in the Act include requirements to produce identification, to only use the powers at reasonable times, to give reasonable notice, provision for compensation and a prohibition on the use of unreasonable force.

It has also been suggested that there is a need for express powers to seize articles for the purposes of conducting prosecutions. In the area of skin penetration, for example, it has been suggested that it would be impossible to determine whether an unsterile article had been used without a power to seize and test the article.

Broad powers of entry, inspection, search and seizure are provided for in the ACT, South Australian and Tasmanian legislation. Note also the provisions of Chapter 8 part 2 of the Local Government Act 1993 (NSW) which gives council inspectors broad powers of entry and inspection.

Discussion Point 30 – Enforcement Powers

Submissions are sought on the powers of entry and inspection into premises regulated under the Public Health Act 1991.

12.2 Self Enforcing Infringement Notice Scheme

The traditional enforcement strategy available when a breach under an Act or Regulation is detected is to prosecute the offender in the courts. Self Enforcing Infringement Notice Scheme (SEINS) was introduced to reduce the cost to government and defendants of enforcement action and to minimise the time it takes to have a matter heard. The scheme is also aimed at easing the burden on the court system for offences of a minor nature. Under SEINS, referral of an offence to a court only occurs if the defendant wished to contest the matter.

A good example of the operation of SEINS occurs under the Motor Traffic Act. Under this Act the police are able to issue on-the-spot fines for a wide range of traffic offences, such as exceeding the speed limit.

Further benefits arising out of the use of SEINS are:

- because of the opportunity of finalising a matter administratively there is no need for the defendant to spend time at court and the expense of retaining legal representation is reduced;
- if the penalty is paid no criminal conviction is recorded;
- the defendant is not disadvantaged as the option to defend the matter remains;
- the array of options provided to respond to regulatory breaches is enhanced, meaning that more appropriate responses can be made;
- matters which previously had to wait for months before being heard are able to be disposed of quite quickly; and
- the scale of investigations and the time taken to conduct them can be reduced producing savings for business and government.

Operationally, when an offence is detected, evidence would be collected in the normal way (in the event that the matter is contested) and submitted to a senior officer with a recommendation that an infringement notice be issued. If issued it would then be up to the defendant to either pay the fine or defend the matter.

The Tasmanian Public Health Act utilises infringement notices as an enforcement option for some offences. Another option may be to consider an approach adopted by the ACT, where improvement notices and prohibition notices may be issued which require a person who carries out a public health risk activity to either improve an aspect of the activity or to cease the activity.

Discussion Point 31 – Self Enforcement Infringement Notices

Submissions are sought on whether SEINS should be adopted for offences under the Public Health Act and Regulation.

If supportive, in what circumstances or for which offences would this approach would be appropriate?

12.3 Penalties under the Public Health Act

If a prosecution under the Public Health Act is successfully undertaken, the present penalties are relatively low compared to the penalties contained within environmental health legislation and occupational health and safety legislation. For example, breaches of the environmental legislation can attract penalties of up to one million dollars in the case of a corporation and up to $250,000 or 7 years imprisonment or both in any other case. Current penalties under the Public Health Act are much lower. Should penalties for causing a risk to public health be more significant in order to reflect community views of the seriousness of this behaviour? If greater penalties are deemed appropriate, what kinds of offences should attract a higher penalty under the Act?

In addition, some public health and occupational health and safety legislation has penalties that allow for a daily fine where the offence is continuing. The Occupational Health and Safety Act 1983 also provides for a greater penalty to be imposed where the offence is not a first offence and provides for greater penalties to be imposed on corporate bodies compared to individuals.

Discussion Point 32 - Penalties

Should penalties for causing a risk to public health be more significant in order to reflect community views of the seriousness of this behaviour? If greater penalties are deemed appropriate, what kinds of offences should attract a higher penalty under the Act?

Should there be provision for higher penalties where the offender is a body corporate?

Should there also be higher penalties for subsequent offences under the Public Health Act?

Submissions are also sought on additional regulatory strategies that could result in a more flexible and responsive approach to protecting and promoting public health

12.4 Capacity to Enforce Public Health Legislation

The effectiveness of public health legislation is dependent on the level of enforcement activity. This paper has already explored in some detail the options for improving the administration of public health legislation, including possible strategies to co-ordinate activities across government agencies and sectors. Improvements in these areas will assist in increasing the level and quality of enforcement activity.

However there may be other innovative strategies that could be utilised to improve the enforcement capacity of the health system and others with responsibility for public health. For example, the Local Government Act 1993 confers extensive authority on local councils to charge fees for inspections and other activities. More innovative strategies may be available to improve the efficiency of existing enforcement arrangements, which would allow resources to be targeted more effectively.

Discussion Point 33 – Other Enforcement Issues

Submissions are sought on strategies to improve or increase the capacity of the health system and others to achieve the objectives of the legislation.

PART VI APPENDICES

APPENDIX A TERMS OF REFERENCE

1. The Public Health Act 1991 is to be reviewed in accordance with the Council of Australian Government's Competition Principles Agreement. In particular, the review will consider the following areas to assess whether: (i) the costs of restricting competition are outweighed by the benefits, and (ii) the objectives of the legislation can only be achieved by restricting competition:

    (i) the regulation of skin penetration procedures;

    (ii) microbial control;

    (iii) swimming pools;

    (iv) tobacco (with the exception of provisions relating to tobacco advertising);

    (v) the disposal of bodies; and

    (vi) other miscellaneous regulatory controls.

2. The review provides an opportunity to consider and address other issues relating to the Public Health Act 1991 including:

    (i) the objectives of the Public Health Act 1991;

    (ii) assessment of the need for statutory intervention to regulate current identified health risks - for example, water quality.

    (iii) review of the existing provisions of the Act in relation to: responding to health risks; disease monitoring; and control of vaccine preventable diseases;

    (iv) Adequacy of current enforcement and compliance arrangements including the interface between local government and health authorities.

APPENDIX B REQUIREMENTS FOR THE COMPETITION PRINCIPLES AGREEMENT

Guiding Principles of the Review

The Competition Principles Agreement provides that the guiding principles of each review are that "legislation should not restrict competition unless it can be demonstrated that:

a) the benefits of the restrictions to the community as a whole outweigh the cost; and
b) the objectives of the legislation can only be achieved by restricting competition." (clause 5(1), CPA)

Content of the review

"Without limiting the scope of the individual review, each review should:

a) clarify the objectives of the legislation;
b) identify the nature of the restriction on competition;
c) analyse the effect of any identified restriction on competition on the economy generally;
d) assess and balance the costs and benefits of the restrictions;
e) consider alternative means for achieving the same results including non legislative approaches." (clause 5(9), CPA)

Public benefits

"Without limiting the matters that may be taken into account, where this Agreement calls:

a) for the benefits of a particular policy or course of action to be balanced against the costs of the policy or course of action; or
b) for the merits or appropriateness of a policy or course of action to be determined;
c) or for an assessment of the most effective means of achieving a policy objective;

the following matters shall, where relevant be taken into account:

d) government legislation and policies relating to ecological sustainable development;
e) social welfare and equity considerations, including community service obligations;
f) government legislation and policies relating to matters such as occupation health and safety, industrial relations and access and equity;

g) economic and regional development, including employment and investment growth;
h) the interests of consumers generally or a class of consumers;
i) the competitiveness of Australian businesses; and
j) the efficient allocation of resources." (clause 1(3) CPA)

APPENDIX C NOTIFIABLE DISEASES

Acquired immunodeficiency syndrome (AIDS)

Acute viral hepatitis

Adverse event following immunisation

Botulism

Cancer

Cholera

Congenital malformation (as described in the "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death" published by the World Health Organisation, Geneva) in a child under the age of 1 year

Cystic fibrosis in a child under the age of 1 year

Diphtheria

Food borne illness in two or more related cases

Gastroenteritis among people of any age, in an institution (eg among persons in educational or residential institutions)

Haemolytic Uraemic Syndrome

Haemophilus influenzae type b

Hypothyroidism in a child under the age of 1 year

Legionnaires' disease

Leprosy

Measles

Meningococcal disease

Paratyphoid

Pertussis (Whooping cough)

Phenylketonuria in a child under the age of 1 year

Plague

Poliomyelitis

Pregnancy with a child having a congenital malformation (as described in the "Manual of the International Statistical Classification of Diseases, Injuries, and Causes of Death" published by the World Health Organisation, Geneva), cystic fibrosis, hypothyroidism, thalassaemia major or phenylketonuria

Rabies

Syphilis

Tetanus

Thalassaemia major in a child under the age of 1 year

Tuberculosis

Typhoid

Typhus (epidemic)

Viral haemorrhagic fevers

Yellow fever

APPENDIX D SUMMARY OF DISCUSSION POINTS

Discussion Point 1 – Objectives of the Public Health Act

Submissions are invited on the desirability of including a statement of objectives in the Public Health Act , particular a statement focussing on the outcomes to be achieved.

Submissions in favour of this proposal which identify the content of any objectives would be particularly welcome.

Discussion Point 2 – Structure of the Public Health Act

Is the current structure of the Public Health Act 1991 and Regulations appropriate, in particular, Is the current division of matters between the Act and Regulations?

Should consideration be given to new public health legislation which contains "core" public health provisions and enabling provisions to respond to specific public health issues by Regulation?

Discussion Point 3 – Consolidation of Other Legislation

Should other legislation be consolidated with the Public Health Act 1991?

What other legislation should be considered for this purpose?

Discussion Point 4 – Improving Co-ordination Across Government

Is the current division of responsibility (as established by the Public Health Act 1991 and cognate legislation) between the NSW Department of Health, public health units, government agencies and local councils operating to secure appropriate public health outcomes?

Are current administrative arrangements effective?

Is there a need for additional mechanisms to improve co-ordination of public health effort in NSW?

Submissions are invited on the costs and benefits of statutory advisory councils as a mechanism to improve, protect and promote public health in NSW.

Discussion Point 5 – Co-ordination with Local Government

Submissions are invited on:

- the need to clarify the role of local government with respect to public health legislation;
- whether the current arrangements in relation to the local government's role in for the enforcement of the Public Health Act are adequate and appropriate
- mechanisms to improve co-ordination between health and local government in relation to public health including (but not limited to) those discussed above.

Discussion Point 6 – Links with the Planning System

Submissions are invited on whether having regard to the existing mechanisms for assessing the impact of developments upon human health there is a legislative role for the Public Health Act 1991 in the assessment of the human health effects of development proposals.

Discussion Point 7 – Medical Officers of Health

Submissions are invited on the need to retain and/or clarify the role of Medical Officers of Health

Discussion Point 8 – Public Health Units

Submissions are invited on:

- the need to describe the role of Public Health Units and/or the Director of a Public Health Unit under the Act;
- whether the relationship between the Public Health Units and the Department in relation to public health activities requires formal recognition under the Public Health Act

Discussion Point 9 – Privacy Protection

Submissions are invited on whether the current arrangements for privacy protection under the Public Health Act and related legislation provide an appropriate balance between privacy protection and the ensuring that information can be collected and analysed for public health purposes.

Discussion Point 10 – Information About Public Health

Submissions are invited on:

- the adequacy of the current arrangements for the collection of data under the Public Health Act;
- the need to specifically recognise the Department's responsibilities in monitoring health through the use of health data;
- procedures for introducing new notification requirements;
- the types of data collections that should be mandated under the Public Health Act;
- the issue of introducing a generic registers power within the Act;
- the need to improve arrangements for monitoring disease outcomes.

Discussion Point 11 – Reporting Requirements

Submissions are sought on the need for the NSW Public Health Act to mandate reporting requirements in the health status of the people of NSW. How often should reports be required?

Discussion Point 12 – Emergency Powers

Submissions are invited on the adequacy of section 4 and section 5 of the current Public Health Act 1991 for responding to emergencies.

Discussion Point 13 – Unhealthy Premises

Submissions are sought on the adequacy of section 8 of the Public Health Act 1991 and clause 82 of the Public Health Regulation for responding to health risks on premises.

Discussion Point 14 – Infection Control

Submissions are sought on the effectiveness of section 6 of the Public Health Act 1991 in minimising risks to public health such as the spread of serious medical conditions.

Discussion Point 15 – Directions to Public Authorities

Comments on the adequacy of section 9 of the Public Health Act 1991 are sought.

Discussion Point 16 – Emerging Public Health Risks

Is there a need for more general powers to respond to public health risks that may emerge in the future? If so, how should decisions regarding the exercise of the powers be guided by legislation?

Discussion Point 17 – Inquiry Powers

Submissions are sought on the adequacy of section 70 and 71 of the Public Health Act 1991 for conducting inquiries.

Discussion Point 18 – Scheduled Medical Conditions

Submissions are invited on:

- the need to define the term "sexually transmissible condition" and/or identify by way of a schedule those conditions that are sexually transmissible;
- whether persons with sexually transmissible conditions should have to advise any sexual partner in advance is restricted to sexual activity other than oral sex or sexual intercourse involving the use of a condom;
- whether medical practitioners when ordering diagnostic tests should be required to offer pre and post test counselling.

Discussion Point 19 – Public Health Orders

Submissions are invited on the effectiveness of current arrangements for public health orders.

Is it necessary to retain the provisions? What alternatives are there to the current arrangements?

Should the current provisions be extended to include category 3 medical conditions?

Discussion Point 20 - Notifications

Should the Act set out the procedures to be followed where disease notifications are received under the Public Health Act 1991?

Discussion Point 21 – Medical Examination

Comments are invited on the adequacy of the existing provisions relating to the power of the Director-General to direct that a medical examination be carried out.

Discussion Point 22 – Skin Penetration

Submissions are invited on:

- the advantages and disadvantages of regulating skin penetration activities, and in particular, the specific options for regulation;
- If some form of statutory regulation is maintained, whether other strategies such as third party accreditation, negative licensing strategies or compliance orders should operate in additional to or in lieu of the present statutory requirements;
- any difficulties being encountered by having separate but complementary requirements under the Public Health and Local Government Acts.
- the exemption of health professionals from the requirements;
- the scope of the current provisions.

Discussion Point 23 – Microbial Control

Submissions are invited on the benefits and costs of the regulation of Legionella hazard and in particular, on the specific options for regulation.

In the event of statutory regulation being considered necessary, submissions are invited as to whether:

- AS/NZS 3666 of its own is a sufficient standard to regulate for the control of Legionella;
- provision should be made for both outcomes based performance standards and prescriptive requirements within the legislation;
- whether third party accreditation systems could be adopted.

Discussion Point 24 – Regulation of Swimming Pools and Spas

Submissions are invited on:

- the benefits and costs of the regulation of swimming pools, spas, and in particular, on the specific options for regulation.
- should some form of statutory regulation be maintained, whether provision should be made for third party accreditation and negative Licensing strategies; whether this should be additional to, in lieu of or complement the present statutory requirements.
- the need to make the water quality testing process more transparent by requiring the operators of pools and spas to display test results.

Discussion Point 25 – Cremations

Submissions are invited on:

- the benefits and costs of regulation of crematoria equipment and apparatus and in particular, on the specific options for regulation and which government agency should give any such approvals;
- the need for and the grounds on which a crematorium might be closed and associated rights of appeal;
- which government agencies should be involved in the regulation of cremators.

Discussion Point 26 – Disposal of Bodies

Submissions are invited on:

- the need to regulate for the handling of bodies;
- the benefits and costs of the regulation of premises used for the preparation for bodies for burial and cremation;
- the need for infection control requirements;
- the need to impose limitations upon where a person may be buried;
- the need, if any, to impose restrictions upon who may handle bodies, and the basis of such restrictions;
- whether the present regulatory requirements under the Local Government Act and Public Health Act should be merged; (*cont*….)

- whether the current restriction on the embalming of bodies with List A or B medical conditions should be removed;
- the need for and benefits and costs of regulating the funeral industry and in particular, on the specific options for regulation and which government agencies should be involved.

Discussion Point 27 – Tobacco Products

Submissions are invited on:

- the benefits and costs of regulating the sale of tobacco products and on the specific options for regulation (n.b. the advertising restrictions in Division 4 do not form part of the current review);
- if it is considered that some form of statutory regulation should be maintained, the costs and benefits of limiting the purchase of tobacco products for minors by a third party;
- the proposal to have tiered fines for repeat offences involving the sale of tobacco products to minors;
- the need for NSW to maintain the present regulatory requirements governing the application of health risk warning labels on tobacco products in view of the Commonwealth requirements.

Discussion Point 28 – Sleeping Rooms

Submissions are invited on:

- the benefits and costs of regulating the spatial requirements associated with rooms used for sleeping and the specific options for regulation; and
- whether the regulatory requirements for "sleeping rooms" would be better located under the Environmental Planning and Assessment Act, Local Government Act and the National Parks and Wildlife Act?

Discussion Point 29 - Immunisation

Submissions are sought on the:

- advantages and disadvantages of regulating for vaccine preventable diseases;
- the appropriateness of the current regulatory regime;
- the value of amending the Act to provide for a discretionary power to exclude from a child care facility or school a child that is suffering from a vaccine preventable disease; (*cont*…)

- whether the provisions should be extended to cover older children enrolled in school;
- the proposal to increase public access to data regarding adverse reactions to vaccines used to prevent certain diseases and what constitutes an adverse reaction.

Discussion Point 30 – Enforcement Powers

Submissions are sought on the powers of entry and inspection into premises regulated under the Public Health Act 1991.

Discussion Point 31 – Self Enforcement Infringement Notices

Submissions are sought on whether SEINS should be adopted for offences under the Public Health Act and Regulation.

If supportive, in what circumstances or for which offences would this approach would be appropriate?

Discussion Point 32 - Penalties

Should penalties for causing a risk to public health be more significant in order to reflect community views of the seriousness of this behaviour? If greater penalties are deemed appropriate, what kinds of offences should attract a higher penalty under the Act?

Should there be provision for higher penalties where the offender is a body corporate?

Should there also be higher penalties for subsequent offences under the Public Health Act?

Submissions are also sought on additional regulatory strategies that could result in a more flexible and responsive approach to protecting and promoting public health.

Discussion Point 33 – Other Enforcement Issues

Submissions are sought on strategies to improve or increase the capacity of the health system and others to achieve the objectives of the legislation.