

Public Health Legislation

Promoting public health,
preventing ill health and
managing communicable diseases

Discussion Paper

2002

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MANATŪ HAUORA

Foreword

Public health requires information and action to ensure that optimal and equitable health status are attainable goals for New Zealanders. This discussion paper has proposals for a new legislative framework to help achieve these goals.

The Public Health Bill will replace the Health Act 1956 and associated legislation. While this legislation has served us well, it is now nearly half a century old. The Health Act has major gaps, is based on outmoded organisational and technological assumptions, and does not accord well with the human rights values of today's society.

This paper takes as its starting-point decisions made by Government to develop a new Public Health Bill, as well as proposals for new legislation set out in *Public Health Legislation Review: A new public health legislative framework discussion document* (Ministry of Health 1998).

The proposals in this paper provide details and options on implementing the Public Health Bill's objectives in relation to communicable diseases and related issues. The paper also suggests that public health legislation should explicitly recognise the significance of non-communicable diseases, and the importance of promoting public health in a positive sense. Underlying principles are made explicit.

Complex issues are inherent in many of the proposals. Some questions aren't easy to answer. A tension is recognised between some aspects of individual autonomy and the community good. We need to address these questions and decide what, as a society, we want.

This discussion paper is your opportunity to participate in this process, and I invite your submissions.

Your input will help guide the drafting of the Public Health Bill and will help ensure new public health legislation that addresses the needs of New Zealanders in this century.

Hon Annette King
Minister of Health

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How to Make a Submission

Please have your say on the topics covered in this discussion paper. There are three ways you can make a submission:

1. Write your comments in the submission booklet at the back of this paper and send the booklet to the Ministry by post.
2. Complete the submission booklet as a Word document and either email it to the Ministry or send it by post. The template document is on the Ministry of Health website at www.moh.govt.nz/forums.html and has the same questions as the paper.
3. Write your comments as a letter or as an email form and either email or post them to the Ministry.

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The email address is: phb@moh.govt.nz.

The closing date for submissions is Friday 28 March 2003.

Making a submission

Questions are set out for relevant topics to guide submissions. To assist with analysis of submissions please indicate, where possible, the specific chapter, topic, and the question number to which you are responding.

Factual information, and explanations to support your view, would help develop legislation that is reasonable, effective, clear, practicable, and in accordance with today's values.

We welcome submissions from both individuals and organisations. When sent on behalf of an organisation, it would be helpful to include details of the organisation.

What happens to your submission

Your submission will be acknowledged by the Ministry. A summary of submissions will be placed on the Ministry of Health website when completed.

Submissions will be available to the public. Any request for confidentiality will be subject to the Official Information Act 1982.

If you are an individual making a submission, the Ministry of Health can remove your personal details if you request.

Executive Summary

Chapter 1: Introduction. The purpose of this paper is to provide information and seek comments. This chapter reviews the development of the Public Health Bill, its policy objectives and legislative context.

Chapter 2: General framework. Elements of the proposed Bill that have already been agreed by Cabinet are outlined. The Bill would:

- provide for a responsible Minister and functions
- provide for designation of public health services by the Director-General
- enable effective management of all significant risks to public health that are not otherwise managed effectively
- provide for an explicit methodology for assessing risks to public health and possible actions in response
- provide that some activities and services with public health significance or risks must have ‘activity consents’ (or ‘licences’ to use present terminology)
- provide for what may happen in a public health emergency.

The provisions discussed in this discussion paper would slot into this general framework; hence this discussion paper does *not* provide details on organisational structures, roles and responsibilities of such organisations as public health units or territorial authorities, fees and payments or offences and penalties.

Chapter 3: Fundamental principles. The principles and considerations that underlie development of the Public Health Bill include rights and values, the Treaty of Waitangi, economic and social determinants of health, including reducing inequalities, and environmental, cultural, social, demographic change.

New Zealand’s legal and social context has changed considerably since the Health Act 1956 as a result, for example, of the enactment of new legislation such as the New Zealand Bill of Rights Act 1990, the Human Rights Act 1993 and the Privacy Act 1993. Legislation that is enacted today must include a greater number of safeguards, such as rights of review and appeal, where potential infringements of people’s liberties are involved.

Chapter 4: Information: Achieving public health objectives requires accurate and timely information. Some information provisions presently in the Health Act would be retained (with minor modifications). These include a duty to disclose ‘health information’ on request. Cabinet has also agreed that the Public Health Bill contain a ‘monitoring and reporting regime’ on the state of the public health.

The Public Health Bill would set out a framework for ‘notification of information – the power and duty to provide specified information’. This would be somewhat wider than the present idea of ‘notification’ in the Health Act. It is proposed that the term ‘condition’ would be used rather than ‘disease’. ‘Condition’ would include, as well as disease, clusters of symptoms and risk factors. The Public Health Bill would set out purposes of notification, ranging from monitoring and surveillance to enabling action to be taken in relation to particular people with conditions of risk to themselves or others. The Bill would also provide criteria for making conditions notifiable (to be then specified by regulation) and set out who must notify. The Bill could empower notification by laboratories as well as by general practitioners and others. Other issues, such as the authorities that notification should be made to and means of making notification, are also important. Privacy issues must be addressed in provisions on information; the Bill would indicate the limits on using the information (for instance notification need not always involve identifying details).

Chapter 5: Promoting public health. What role can legislation play in relation to non-communicable diseases and health determinants? The Public Health Bill could include a subpurpose in these areas and, in addition, regulation-making provisions aimed at influencing factors relevant to ill health could be included. The scope of such regulation-making provisions might relate to access to products, services and facilities, constituents of those products and the regulation of advertising. Any such regulations would require their own public health risk assessment and consultative processes before submission to Government.

Chapter 6: Preventing ill health and promoting child health. Immunisation and screening are two important strategies for managing communicable conditions and other conditions of public health significance. Optimum programmes for these purposes may require the establishment of registers. Preventive strategies such as immunisation may be particularly important for promoting child health. This chapter has ideas on the following provisions.

- *Generic provisions for registers*, to be established by regulation after consultation. These general provisions could also include the purposes of registers, issues about confidentiality and different types of registers – in terms of, for example, whether people can opt-on the register, or can opt-off after automatic enrolment.
- *Immunisation provisions* would refer to registers for immunisation, regulation-making, the powers of Medical Officers of Health for non-immunised children and emergencies. Regulation-making powers could be drafted so as to allow for several options, including the status quo and the requirement to give reasons for a child who is not immunised.
- *Screening provisions* could include regulation-making powers to enable, for instance, a power to screen specific populations for specific purposes (for example, new-born children or perhaps people working in specific occupations). More complex screening programmes could also be involved, such as the present cervical screening programme.

Chapter 7: Care, management and compulsory powers. Powers to be potentially included in the Public Health Bill relate to people in two categories: people with a communicable disease posing risk to others; and people who come under a ‘public health welfare’ category (an updated equivalent of the present section 126 provisions in the Health Act on ‘infirm and neglected’ persons). Although, ideally, legislation is not required for care and management of people in these categories in some circumstances a degree of compulsion or information disclosure may be warranted; for example, the power to require a person to undergo counselling, or supervision, or refrain from specified conduct (such as employment for a specified time in relation to food-borne illnesses).

The legislation would set out the rights and duties of a person with an infectious disease of significant risk to others and the duties of health professionals. A key question relevant to people with communicable conditions is ‘in respect of which communicable conditions might it be possible to exercise the range of compulsory powers?’. Options include:

- *any* communicable condition which the Medical Officer of Health considers appropriate in the circumstances in accordance with specified guidelines
- exercise of such powers *only* in respect of those communicable conditions specified by regulations.

The role of court orders with respect to those powers which most impinge on personal liberties (for example detention or isolation) is also discussed.

Criteria for the exercise of powers under the ‘public health welfare’ category are also discussed. The procedures relating to public health orders for such people would be the same as those applicable to people with communicable diseases. It would allow action to be taken, where other legislation such as the Protection of Personal and Property Rights Act 1988 does not apply, for people:

- who cannot, or do not, care for themselves (eg, to meet basic physical and housing needs)
- and as a result, their health and safety is endangered or an environmental risk is posed to others.

Chapter 8: Contact tracing. Contact tracing relates to people:

- who may have transmitted a communicable disease *to* the person with the condition
- who may be exposed to the condition *by* the person with the condition.

The purpose of such contact is to offer testing and treatment and to prevent, if possible, further infection. Ideally, contact tracing is undertaken by the person with the condition; that is, the person with the condition directly communicates with their contacts and encourages them to seek testing and, if necessary, treatment. The fundamental question is: does contact tracing require a legislative mandate? It may be appropriate if it is considered necessary to contact people without the authorisation of everybody concerned. The processes involved in contact tracing may come into conflict with privacy values in various situations.

If legislation is thought appropriate, there are several options for when contact tracing could be undertaken. It is proposed that the Bill make it clear that, to the greatest extent practicable, people should be asked to do their own contact tracing or to give their co-operation. The legislation should be explicit about those conditions for which contact tracing might be undertaken; options include *all* notifiable communicable conditions or only those specified by regulations as ‘contact-traceable’.

Chapter 9: Border health protection. This term is equivalent to the more traditional concept ‘quarantine’.

What can New Zealand feasibly do to protect itself from risk of diseases that come from other countries? And what role should health agencies have in relation to border health protection – should they play a role only in relation to incoming travellers who are sick? Or should they *also* have a role in relation to all animals, organisms and other pathogens that may be of risk to human health and which are carried by travellers? The chapter proposes that:

- the distinction in present law between quarantinable and non-quarantinable disease should be de-emphasised
- the main function of border health protection in relation to incoming travellers should be to gather information for a range of public health purposes, including that of enabling protective measures to be implemented when required. Health authorities would have the same powers in relation to incoming travellers that they would have for a person developing the communicable disease in New Zealand (except in emergencies).

If it is decided that the Public Health Bill should retain a role for border health protection as it relates to craft, goods, animals and plants, considerable discretion could be provided in relation to:

- whether risk management skills be employed to guide the level and focus of monitoring activities
- the extent to which monitoring and surveillance is undertaken by agencies other than health authorities.

1 Introduction

1.1 Purposes of this discussion document

The Public Health Bill (the Bill) will replace the Health Act 1956 and the Tuberculosis Act 1948. The purposes of this discussion document are to:

- provide information on the development of the Bill so far
- present and seek comments on a range of issues relating to communicable diseases and other conditions of significance for public health.

The discussion paper does not set out the Bill's framework in any detail, nor does it review specific topics such as environmental health or the organisation of public health services. These issues have already been canvassed in *Public Health Legislation Review: A new public health legislative framework discussion document* (Ministry of Health 1998).

On the basis of this previous consultation the Government has decided on the main principles and general proposals to be included in the Bill. These are summarised in Chapter 2. Ideas relating to communicable diseases and related topics, however, have not yet been developed in detail and therefore form the subject of this discussion paper.

1.2 Structure of the discussion paper

The discussion paper begins with a summary of work already done on the Bill and an outline of principles underlying the proposals in this paper. The following chapters each consider a separate topic – health information, health promotion, the prevention of ill health through such means as immunisation and screening, the use of compulsory powers and border health protection.

These substantive chapters begin with some context, provide a brief outline on current law and practice, discuss the issues involved and outline possible proposals and options for discussion. Each of these chapters concludes with a series of questions to help provide feedback on the paper.

1.3 Development of the Bill

Work began on a new Public Health Bill early in the 1990s. The 1998 *Discussion Document* was widely circulated and 117 submissions were received.

Following consideration of these submissions, and further development work in 2001, Cabinet approved policy proposals for the Bill. The Ministry of Health has begun preparing drafting instructions for the Bill.

It is hoped that the new Bill may be introduced into Parliament in 2003. All regulations made under the Health Act and the Tuberculosis Act would be continued under the new Public Health Act until later reviewed.

1.4 Policy objectives

The Public Health Bill will contribute to implementation of the general directions for planning and developing health and disability strategies set out in such key documents as the *New Zealand Health Strategy* and the *New Zealand Disability Strategy*. The Bill must also take account of more specific policy objectives for communicable diseases, particularly as set out in *An Integrated Approach to Infectious Disease: Priorities for action 2002–2006* (Ministry of Health 2001). This document is based on a broad, multisectoral view of infectious disease and control and identifies objectives, targets and agreed strategies for several disease groupings from 2002 to 2006.

The Bill will set a framework that extends well beyond 2006, but many of the key reasons for developing an integrated approach to infectious disease, as set out in *An Integrated Approach to Infectious Diseases*, are likely to remain relevant. They include the significant impact of infectious diseases, the probability of new and re-emerging threats and the fact that infectious diseases disproportionately affect disadvantaged and marginalised groups.

1.5 Associated draft legislation

Two amendments to the Health Act 1956 are proceeding independently and ahead of the new Public Health Bill. They will be incorporated into the Bill when it replaces the Health Act. They are the:

- Health (Drinking-water) Amendment Bill, which will require suppliers of drinking water to take all practicable steps to comply with the Drinking-water Standards for New Zealand 2000 and, except for the smallest suppliers, to institute public health risk management programmes
- Health (Screening Programmes) Amendment Bill, which will implement recommendations from the Gisborne Inquiry in 2001 relating to the operation and evaluation of the National Cervical Screening Programme.

Other draft legislation relevant to the Public Health Bill includes the Local Government Bill. The Ministry of Health is working with the agencies responsible to ensure consistency between the Bill and other draft statutes.

1.6 Other relevant legislation

The present Health Act and the Tuberculosis Act form part of a much larger statutory framework for public health, which includes the New Zealand Public Health and Disability Act 2000 and the Smoke-free Environments Act 1990 (administered by the Ministry of Health) as well as legislation administered by other agencies. Examples of legislation for which other agencies are responsible include the Civil Defence Emergency Management Act 2002, the Health and Safety in Employment Act 1992, the Hazardous Substances and New Organisms Act 1996, the Injury Prevention, Rehabilitation, and Compensation Act 2001, the Immigration Act 1987 and the Resource Management Act 1991. A new Public Health Bill will not affect the need for, or scope of, these Acts, although interface issues would require consideration. Possible overlaps would also require discussion so that the

Bill is clear on which statute (and agency) takes precedence in particular areas or provides for mechanisms to ensure clarity in particular situations.

1.7 Compliance costs

This paper does not analyse compliance costs, fees or payment of any costs associated with its proposals. These issues would be dealt with as proposals are further developed and as a result of comments on this paper. Comments are therefore welcome on compliance costs, fees and payments, as well as on any other implementation issues.

2 General Framework

Cabinet agreed in August and September 2001 to a general framework and some features for the new Public Health Bill. Some elements are outlined below.

The Bill will:

- become the primary statute for action by the Director-General of Health to protect public health
- enable effective management of all significant risks to public health that are not otherwise managed effectively, with its main focus being on communicable diseases and environmental health
- provide for enhanced co-ordination of all legislation which impacts on public health, particularly between public health services and local government
- provide an explicit methodology for the assessment of risks to public health and possible actions in response, having regard to alternatives, costs, benefits and the need for caution where information is uncertain or incomplete
- place a general duty on all people to prevent, remedy or mitigate risks to public health
- require that those responsible for ‘regulated matters’ (ie, whose services or activities are associated with public health risks, such as water supplies, camping grounds, possibly skin piercing services) demonstrate compliance with legislative requirements for inspection and certification by approved assessors as part of an ‘activity consent’ (operating licence). Compliance may be supported by reference to public health risk management plans
- provide for what may happen, and who has what powers, in a public health emergency
- provide for infringement notices (similar to instant fines) and compliance orders, among other enforcement mechanisms, to require the recipient to take specified measures to prevent, remedy or mitigate risks to public health.

Cabinet agreed that the special relationship between the Crown and Māori be recognised through inclusion of a reference to the Treaty of Waitangi, as well as specific references to Māori as appropriate throughout the Bill.

Cabinet also agreed that the Bill should contain a ‘monitoring and reporting regime’ to ensure that the Director-General of Health reports regularly on the state of New Zealand’s public health and is able to review and report on the performance of the health sector and other sectors in relation to public health outcomes. The concept of ‘health’ means a complete state of physical, mental and social wellbeing and not only the absence of disease, injury or infirmity.

Cabinet further agreed that some provisions in the existing Health Act, particularly those for health information, would be rolled over in the new Bill, perhaps with some modifications (see Chapter 4).

The Bill is therefore to be both comprehensive and relatively complex.

Two key issues must be kept in mind. The first is the need to ensure that the public health regime established by the Bill can be applied to a range of structures for delivering public health services. Any further health restructuring should not mean amendments to the legislation. At the same time, the Bill must ensure clarity of roles and accountabilities.

The second is that, because the Bill will potentially apply to all risks to public health, overlap with other statutes and agencies is possible (eg, in environmental protection and local government). The Bill will therefore make clear what legislation takes precedence in particular situations and provide mechanisms for co-ordination. It would also ensure that there is flexibility in which agencies at the local level deliver specific services (particularly in environmental health). The Bill will also require designated public health services, local government and Occupational Safety and Health (OSH) Regional Offices to enter into 'district protocols' to clarify their respective roles at the local and regional levels. In some instances a Memorandum of Understanding agreed at head office level can be used to guide relations between OSH regional offices and other agencies.

In summary, then, the Bill will provide for:

- a responsible Minister (and functions)
- a responsible department of state (and its functions)
- designation of public health services by the Director-General of Health
- the role of Director of Public Health
- co-ordination with territorial authorities and other agencies in overlapping legislation
- some activities and services with public health significance or risks to require activity consents
- public health emergencies
- compliance verification and enforcement.

The Bill will also provide for the prevention and management of communicable diseases and other conditions, as discussed in this paper. Some initial consultation on proposals in this area has been undertaken with key players such as Medical Officers of Health.

3 Fundamental Principles

3.1 Introduction

The Public Health Bill aims to promote and protect the public health. Public health is the health of both the whole population of New Zealand, and of specific groups within it. Within this broad framework, the Bill would provide appropriate legislative mandate for the effective management of all significant and emergent risks to public health that are not otherwise managed adequately. The parts of the Bill covered in this discussion paper focus in particular on communicable diseases, but are not confined to them.

Some principles and considerations that have influenced the development of these proposals are:

- rights and values in contemporary New Zealand
- the Treaty of Waitangi
- economic and social determinants of health, including the importance of reducing inequalities
- environmental, technological, cultural, social, demographic and organisational change.

3.2 Rights and values

Since the Health Act became law in 1956, New Zealand's legal and social context has changed considerably, as demonstrated by the passage of several key statutes. The New Zealand Bill of Rights Act 1990 sets out a list of specific protections in relation to, for example, the rights to refuse to undergo medical treatment, not to be arbitrarily detained, and to natural justice. These rights are not absolute: section 5 of the Bill of Rights Act states that the rights and freedoms may be subject only to 'such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society'. In addition, section 4 of that Act makes clear that a court cannot decide that a provision in any statute is ineffective because of inconsistency with the Bill of Rights.

Consultation on the 1998 *Discussion Paper* on the Public Health Bill indicated widespread recognition of the importance of protecting human rights, but also agreement that giving greater value to protection of the public health was justified in some circumstances.

The Human Rights Act 1993 provides that no one may discriminate against others on a number of grounds (eg, race and sexual orientation). The Privacy Act 1993 also sets out principles that must be recognised in framing policies which affect people's privacy interests (eg, in relation to information about them held by others).

In general, these statutes, and the societal expectations they reflect, embody values such as the importance of personal autonomy, freedom, privacy and human dignity. The new Public Health Bill will recognise and give expression to these values.

At the same time, the Bill is a vehicle for implementing other rights and values. These are not articulated in the same way as the rights set out in the New Zealand Bill of Rights, but are implicit in the objectives of much social legislation. Such values relate to ideas about justice, equality (and minimising inequalities), community, wellbeing and interdependence. They concern the protection of health and wellbeing of people and communities, and are reflected in such instruments as the International Covenant on Economic, Social, and Cultural Rights (adopted in 1966, entered into force in 1976, 993 UNTS 3). Article 12 2(c), for instance, states (echoing the language of the World Health Organization) that the ‘States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’, and that steps to be taken to achieve this right include those necessary for the ‘prevention, treatment and control of epidemic, endemic, occupational and other diseases’.

To the greatest extent possible, the Public Health Bill will aim to implement both sets of values. Often they are synergistic – for example, giving expression to privacy and non-discrimination values can assist in the management of communicable diseases, as well as helping to fulfil goals of equality and wellbeing. In other instances, it may not be possible to give full expression to both sets of values. Any obligation to notify, for example, inevitably impinges on privacy, as well as on freedom of expression (which includes the right *not* to give information).

Several criteria must therefore be borne in mind when deciding whether, and to what extent, one value may be given fuller expression than another. Some criteria have been adopted by the New Zealand courts in interpreting the New Zealand Bill of Rights Act; others are set out in international guidelines or can be distilled from international and national experience. Examples include the:

- relative importance of the provision
- likely effects of the provision or policy in promoting or detracting from various values
- impact of any proposal in terms of the kind and degree of harm that may be involved – proportionality
- extent to which harms may be imposed on people involuntarily
- availability of options and their costs (to people individually, their communities and society as a whole)
- availability of means to mitigate the effects of giving less weight to a particular value.

3.3 The Treaty of Waitangi

Cabinet has decided that the Public Health Bill will follow the general approach of the New Zealand Public Health and Disability Act 2000. Hence the Bill will include a general clause relating to the principles of the Treaty. The Bill will elsewhere refer to Māori or the tangata whenua as relevant and appropriate.

In thinking through the topics covered by this discussion paper, it is therefore important to identify those issues where specific reference to Māori should be made. Examples could

include information collection and use, registers, and procedures and safeguards for people with conditions of public health significance.

3.4 Reducing inequalities

The *New Zealand Health Strategy* (Minister of Health 2000) and *Reducing Inequalities in Health* (Ministry of Health 2002) identify, as a general aim for public health, the reduction of inequalities. This is to be achieved by, among other things, focusing on underlying economic and social determinants of health. The theme of reducing inequalities is most relevant to issues concerning Māori and Pacific peoples.

The challenge is how to contribute to implementing this aim by statutory means. The Bill provides some mechanisms to facilitate the identification of information relevant to general health determinants – for example, the power to require information and the duty to provide it, as well as the monitoring and reporting regime (summarised in Chapter 4). It may also be helpful to enable the making of regulations to require the notification of a range of risk factors as well as such traditional matters as infectious diseases. In addition, a greater focus on preventive health strategies, such as immunisation and screening, may help to reduce inequalities.

3.5 Change and ‘future proofing’

The Bill must allow for needs, health concerns, health solutions and technologies that do not yet exist.

It must recognise that in the next 50 years New Zealand may:

- see changes in its climate and differences in its environment – for example, new disease vectors and diseases may become established and adverse environmental events such as floods or drought may become more frequent
- have increased proportions of Māori, Pacific peoples and immigrants from the Asia-Pacific region
- become even more closely tied to the Pacific region and the rest of the world through the impact of trade, international law, telecommunication and information systems and travel.

The Bill must therefore be ‘future-proofed’ as far as possible. This suggests that, while being clear about health outcomes, functional responsibilities and accountabilities, the Bill should generally aim to be enabling rather than prescriptive. Where provisions do need to be more specific, it may be possible to make them relatively easy to change (eg, by putting all such material in regulations).

Some matters in the Bill should be phrased in fairly general terms. For instance, it is intended not to refer to specific diseases or groups of diseases (unless absolutely necessary). This would not only avoid the problem of appearing to discriminate against people with certain types of disease, for example those which are sexually transmissible, but would enable the Bill to address diseases which have not yet emerged in New Zealand or anywhere. Some provisions should also ensure flexibility by enabling various options

in implementing them, such as who may be responsible for a particular task, while still being clear about objectives.

The development of future technologies would affect the diagnosis of disease, the tracking of disease through populations, and treatment. The Bill must facilitate these developments. It must also be amenable to modern telecommunication systems and take account of the issues posed by modern information systems (eg, data sharing, and confidentiality and privacy issues), as well as the opportunities they provide. Present trends that are likely to increase must also be addressed (for example, the growing ease, volume and speed of international travel may require changes to quarantine provisions).

4 Information

4.1 Introduction

Timely, accurate and comprehensive information is the key to implementing public health objectives and hence public health legislation. Information is needed on:

- the state of the public health
- the effectiveness of public and personal health services in improving population health outcomes
- environmental and social factors and determinants relevant to health outcomes
- disease trends and patterns.

Information is a two-way process. While most of the legislative provisions in this area focus on information given *to* health agencies, information should also be channelled *back* from agencies to the general public and specific communities. Information is required both for action by official agencies and for ensuring that individuals and communities are knowledgeable about, and able to participate in, promoting and protecting public health. These reciprocal information needs should be recognised in appropriate legislative provisions.

Information, at both population and individual levels, can assist in:

- monitoring and managing health status and factors relevant to health status
- improving delivery of services
- providing a means of accountability to communities
- informing and empowering people and their communities
- informing government policy
- fulfilling international surveillance and reporting obligations.

The Bill must therefore:

- specify the purposes of information collection
- provide for the authorisation of information collection and disclosure in specified circumstances
- ensure that specified people are obliged to provide certain information in specified circumstances (eg, diseases that have been specified for this purpose in regulations)
- protect privacy and confidentiality of information.

4.1.1 Structure of this chapter

This chapter backgrounds some of the context for considering legislation in this area. It sets out the current framework for health information in the Health Act and summarises those decisions that have already been made on provisions for reporting and information disclosure. The chapter then discusses issues relating to *information notification*. The current Health Act has a framework for information notification, but some modifications to this framework seem desirable. The form of any such changes is, however, provisional at this stage and submissions would help shape the final decisions in this area. The discussion on this topic is therefore fairly detailed. Some general headings include that of the purposes of notification, what should be notified, who must notify, the authorities to which notification must be made, details to be included in notification and issues relating to privacy and the use of notified information.

4.1.2 Some context

The tension between individual rights and the public good is highlighted in legislation relating to information. Not all provision of information requires the disclosure of details about identifiable individuals, but where such disclosure is required or permitted there is a need to protect individual privacy to the greatest extent possible. The issues are particularly complex where the need for comprehensive information is considered to require disclosure of information without the authorisation of the person concerned.

Health information provisions (both those in the present Health Act and those proposed for the new Public Health Bill) belong to a wider legislation framework relating to ‘personal information and privacy’. This framework includes the Privacy Act 1993 and codes made under that Act, as well as the Official Information Act 1982. Issues related to privacy assessment are discussed in more detail in chapter 6, with particular relevance to registers, immunisation and screening, but they also have general application.

Information often requires follow-up action in addition to that of surveillance of health trends and research into disease patterns. Subsequent chapters in this paper set out forms of public health action such as screening programmes, case management, and contact tracing that have information implications. One other form of follow-up action, not explored in detail in this paper, could also be included in the Bill. This would involve provision for regulation-making powers following reports from bodies (such as the National Mortality Review Committee) responsible for investigating issues relating to individual safety. Such individual cases may throw up concerns not foreseen by the legislation and point to the need to develop subordinate regulations.

4.2 The current framework for information in the Health Act

The present Health Act contains several categories of information provision. These include:

- a requirement for the Director-General of Health and the Director of Public Health to provide reports to the Minister (sections 3C and 3D)
- the ‘section 22 series’ relating to disclosure of, and access to, health information – for example, between government agencies and for financial audit
- notification obligations – in particular section 74, which states that medical practitioners must give notice of cases of specified notifiable diseases to Medical Officers of Health
- the cervical screening register (currently section 74A – these provisions may be amended in 2002).

It is proposed that the Public Health Bill retain these four general categories of information provision in modified and expanded form. In the longer term, health information and issues related to its collection and storage, and access to health statistics in the broader sector, may merit separate legislative treatment.

A brief summary follows of proposals for the general reporting provisions, and of the provisions that would replace the present ‘section 22’ series, which provides legislative support for the collection of health information and operates alongside the Privacy Act and the Health Information Privacy Code. There has already been consultation on these proposals and some general decisions have been made. The chapter then focuses in much more detail on the more provisional proposals for notification obligations. Proposals on registers and databases are outlined in Chapter 6.

4.3 Decisions already made on information

4.3.1 Decisions on a monitoring and reporting regime

The Government has agreed that there will be a monitoring and reporting regime. The Director-General will be required to develop and implement a system to collate and analyse information on the state of the public health. This system would be modelled on the existing section 3C of the Health Act, supplemented by a discretion for the Director-General to monitor the effectiveness of public health services, other health services, and other sectors whose responsibilities may be relevant to health outcomes.

4.3.2 Decisions on information disclosure

A Ministry of Health group has worked through the health information provisions in the present Health Act and its general recommendations have been accepted by the Government. Briefly, it is proposed that the Public Health Bill will retain both the general duty to provide information and the power to disclose information that exists in the present statute. Some minor amendments are also proposed.

‘Health information’ is defined in section 22B of the present Health Act as follows:

health information, in relation to an identifiable individual, means –

- (a) information about the health of that individual, including that individual's medical history;
- (b) information about any disabilities that individual has, or has had;
- (c) information about services that are being provided, or have been provided, to that individual;
- (d) information provided by that individual in connection with the donation, by that individual, of any body part, or any bodily substance, of that individual.

A similar definition would be included in the Bill, perhaps in an extended form. The Health Information Privacy Code has an additional provision:

- (e) information about that individual which is collected before or in the course of, and incidental to, the provision of any health service or disability service to that individual.

This would cover information about, for instance, people who are on operation waiting lists or who have subsidy entitlements. On the other hand, this extended definition may be considered too wide in terms of a duty to disclose information.

In this category of information provision, the Bill will provide that:

- information about an identifiable individual must not be disclosed to any other person or organisation except as provided in this legislation or other legislation
- identifiable health information may be disclosed only to specified people and organisations for specified purposes (see present section 22C)
- information must be provided by District Health Boards or other funders and providers of health services if the Minister of Health so requires. ('Health services' are defined in section 2 of the New Zealand Public Health and Disability Act 2000.) This cannot include identifying information unless the person concerned consents, or unless the information is essential for the purpose for which it is sought
- information must be provided if the Director-General of Health so requires by organisations in relation to services they have funded or provided where such services impact on public health, but this must not include personally identifiable health information
- subject to any regulations made under the Health Act (eg, the Health (Cervical Screening) (Kaitiaki) Regulations 1995), anonymised information about an individual may be disclosed to other people and organisations for purposes relevant to public health (eg, collecting aggregated statistical information) as in the present section 22H.

Two further provisions are proposed for discussion. First, it may be appropriate or even necessary for the Public Health Bill to ensure, at least in specified contexts, that electronic 'signatures' are as valid as those on traditional hard copy. This involves issues of authentication and security.

Second, it may be appropriate to provide that a person whose identifiable health information is disclosed under the 'section 22 equivalent' provisions is, in general, to be informed that notification is to be made. This could also provide an opportunity to correct

inaccurate information. Exceptions could be included (for example, if the information is relatively insignificant or routine, or its disclosure to the person concerned would involve significant difficulty or risk). In all cases the person would, of course, be informed that he or she has a particular condition.

4.4 Notification of information: issues and options

4.4.1 Scope

Notification is an important mechanism for obtaining information to identify, monitor and manage communicable diseases and other conditions of public health significance. It differs from ‘information disclosure’, which relates to the obligation to provide information when requested, as discussed in the preceding section. ‘Notification’ means that the person with the relevant information must initiate its provision to the specified authority. ‘Information’ for notification would be defined more broadly than ‘health information’ (as defined in the previous section). It would include:

- information about identifiable individuals (‘health information’)
- anonymised information about individuals
- aggregated anonymous information about groups of people
- information about factors and processes relevant to the health status of individuals or to general public health risks.

4.4.2 Notification provisions

The fundamental provision would be a general obligation that any condition, disease, risk factor or other matter of concern that is specified in regulations as ‘notifiable’ must be reported to the specified authority (usually the Medical Officer of Health). This part of the Bill would be drafted in an ‘empowering’ style. It would not identify the actual conditions to be notified. Instead, it would enable regulations to be made to specify the precise notification obligations (or, instead of regulations, an easily amendable schedule to the Bill).

The primary legislation would also:

- specify the purposes of notification
- provide criteria for making conditions notifiable by regulation
- allow for categories of notifiable conditions
- specify the range of people who may be required to notify and those to whom information should be notified (other than the Medical Officer of Health), and indicate what information must be provided, within what timeframe and the range of means by which it may be communicated (eg, to ensure it is clear that electronic communication is acceptable)
- indicate the limits on using the information.

4.4.3 Concept of ‘condition’

It is proposed that, in general, the term ‘condition’ would be used in these provisions rather than ‘disease’. Condition is a broader concept than disease and would include, as well as disease, pre-clinical changes that have not yet reached the disease stage, syndromes (clusters of symptoms) and post-disease abnormalities. It could provide for such conditions as burns in children, high blood-lead levels or adverse events following immunisation to be notifiable. Although the generality of this term could appear to encompass issues covered by other statutes (such as the Injury Prevention, Rehabilitation, and Compensation Act 2001), specific regulations made under the proposed Bill would ensure clarity on the application of the relevant statutes.

The term ‘condition’ could be defined as ‘condition, disease, risk factor or other matter of concern’. This general term would be used in the remainder of this paper, except where the sense suggests a more specific term such as disease or risk factor.

4.4.4 Purposes of notification

The fundamental purpose of notification is to enable the public health action that is required to achieve public health objectives by ensuring, through means that respect privacy as far as possible, the availability of:

- accurate, comprehensive and timely information on communicable conditions and other conditions of public health significance including risk factors
- factors contributing to trends in incidence of adverse health conditions.

Specific purposes would also be stated. Notification is to:

1. advise the relevant health authority of people who may transmit a condition to other people who may be directly or indirectly at risk as a consequence so that appropriate action can be taken, including care and management of the person concerned, case investigation, source identification and public health management
2. facilitate the identification and effective management of outbreaks or epidemics of communicable conditions
3. enable the timely identification of ‘clusters’ of particular conditions to enable appropriate investigation and public health management
4. monitor categories, incidence and trends relating to conditions of public health significance and enable evaluation and research to be done
5. identify and monitor risk factors which may contribute to trends in the incidence of adverse health conditions
6. monitor the health status of people in relation to specified risk factors or matters of concern so that appropriate action can be taken, including personal care and management, case investigation and public health management
7. identify and monitor exposure to risks which may contribute to trends in the incidence of adverse health conditions

8. assess the impact and inform the design and implementation of programmes or measures designed to improve health outcomes and status
9. fulfil international obligations for information notification.

4.4.5 What must be notified

The list of notifiable conditions would not be specified in the body of the Bill, which would simply state that whatever was specified in the schedule or regulations as ‘notifiable’ must be notified.

The notification criteria could be in two groups. The first group would include those criteria which, if fulfilled, would mean that a condition *must* be specified in regulations as notifiable; for example a condition for which notification is required to comply with international notification and surveillance obligations (in particular, the International Health Regulations of the World Health Organization (WHO)¹).

Are there other situations where specifying a condition as ‘notifiable’ should be required? Legislation administered by other agencies also have notification obligations relevant to health (for example, for occupational safety and health, biosecurity or hazardous substances). It may be useful to refer to the fact that statutes have such obligations.

The second group of criteria would include those to be taken into account in determining whether a condition *may* be specified in regulations or schedules as ‘notifiable’. Existence of one or more relevant criteria would not require any condition to be specified as notifiable, although once so specified, it would be mandatory to report the condition in accordance with the relevant regulations. Some possible criteria follow and the final legislation would focus on those considered the most significant.

1. The level and nature of the risk to the person with the condition or to people who may contract it, taking into account the seriousness of the condition and its ease of infectivity or outbreak potential. (HIV/AIDS and tuberculosis are examples of conditions that could meet this criterion.)
2. The extent to which having a condition specified as notifiable would inform, or enable, effective action for its prevention or management (for example, the effective response time might be relevant, so that notification would be favoured where a serious illness can be managed well only if swift action is taken). By contrast, a factor arguing *against* notifiability could be the perception that notification could deter people from seeking treatment, through fear of loss of confidentiality.
3. Whether the condition is relevant to the general immunisation schedule.
4. The nature or extent of socioeconomic impact.

¹ The purpose of the regulations is to ensure the maximum security against the international spread of diseases with a minimum of interference with world traffic. The regulations are at present being revised. New Zealand, like other members of WHO, must notify WHO when cases of specified diseases are diagnosed.

5. The relevance of any risk factor, or exposure to a potential source of harm, for contributing to the incidence of any significant condition, and the potential for avoiding or contributing to any significant condition by minimisation, control or management of the risk factor or exposure.
6. Whether the condition indicates:
 - a. environmental factors that may contribute to conditions or the existence of other public health risk factors
 - b. an issue or problem that, of itself or taken together with similar notifications, may require a response to minimise public health risks (eg, an adverse event following immunisation).

Feedback would be useful on which criteria are considered most relevant and meaningful. As the Bill would include general provisions requiring consideration of costs and benefits for significant proposals, such information would be relevant in deciding whether any particular condition should be notifiable.

The Bill could further state that a condition may be specified in regulations as notifiable if it indicates the likely development of a disease or condition which meets one or more of the criteria above. The Bill may also need to specify that notification for some conditions should relate to *confirmed* conditions only, while for others notification should be made even in cases that are only *suspected*.

4.4.6 Is a regime of specified notifiable conditions too inflexible?

Notification is at present required only with notifiable conditions already specified in schedules to the Health Act. Is this too inflexible? For instance, it may normally be appropriate that scarlet fever is not notifiable. But what if a medical practitioner has a large number of cases occurring in a short period? It is arguable that such cases should require notification, investigation and subsequent control as appropriate.

If it is agreed that additional flexibility is warranted, an additional trigger for notification could be included. This might be expressed as follows:

A condition that is not specified as notifiable in regulations (or a schedule) must nevertheless be notified by a health practitioner if, in the opinion of the practitioner, this is justified on public health grounds.

This criterion could be elaborated, for example, on the grounds of unexpected frequency or severity or other unusual features. Or there could be a *discretion* for the practitioner to notify an unusual condition, rather than an obligation to do so.

Another factor is whether an additional criterion for notifying normally non-notifiable conditions should be authorisation by the person concerned. Or there could be a requirement to notify non-notifiable conditions on grounds such as those discussed, but without identifying the person concerned. Disclosure of identifying details would be permitted only where the Medical Officer of Health considered this was warranted, preferably after advising the person.

Alternatively, or in addition, the Bill could provide for conditions to be ‘temporarily notifiable’ for a specific district or group of districts, as decided by the appropriate Medical Officer of Health with the agreement of the Director of Public Health (or perhaps by the Director of Public Health alone). For example, there may be concerns about the frequency of cases of a particular strain of influenza in a specific region and the Medical Officer of Health may consider that further information would be helpful in managing the outbreak. Under such a provision, he or she would have the power to require all practitioners in the region to notify new cases. The provision would specify a time limit for such temporary requirements – perhaps up to six months. There may need to be an official announcement of such a decision by, for example, a notice in the *Gazette* or relevant media.

4.4.7 Categories of notifiable conditions

The Bill is likely to provide for different categories of notifiable conditions relating to the different purposes of notification (eg, surveillance as against urgent case management). This would make it possible to classify a condition according to who must notify it, what information must be provided and other relevant circumstances, such as how notification should be made.

It may be useful for specifying who must notify particular conditions; for example, those conditions to be notified by health practitioners and those to be notified by laboratories.

4.4.8 Who must notify

The Bill would require people who are specified in regulations to notify the appropriate authority (usually the Medical Officer of Health) that a person has a suspected or confirmed notifiable condition.

The following could be included in the Bill as those with notification obligations, and as specified further in regulations or a schedule:

- a registered medical practitioner in primary health care, hospitals or other health care settings
- a chief executive or manager of a hospital or other relevant health care setting
- a manager of a medical laboratory
- a health practitioner other than a medical practitioner (registered or non-registered)
- a Medical Officer of Health
- an owner or occupier or manager of a health care facility or residential facility
- a manager, veterinarian or other responsible person of a veterinary clinic (for significant animal illnesses that are capable of transmission to humans)
- a manager or person in charge of an educational institution
- other occupational groups (eg, managers of food premises, camping grounds).

It may be appropriate to specify separately notification obligations with respect to a person who has died where that person had a possible or confirmed notifiable condition. For

example, these people may be specified in regulations as someone who has an obligation to notify in relation to a person who has died:

- a person responsible for autopsies
- a provider of funeral services
- a registered health practitioner.

4.4.9 Laboratory notification

There is reasonable agreement that a move to laboratory notification would be helpful (it is referred to in *Integrated Approach to Infectious Diseases* (Ministry of Health 2001), for instance). Notification by general practitioners to Medical Officers of Health is at present variable. A smaller list of conditions based on criteria such as urgency may be easier for health practitioners to comply with. However, with some conditions the regulations would be likely to require *both* practitioner and laboratory notification, because definitions could differ or because of the need for as much information as possible.

One possible problem is that some regions are comparatively under-served by laboratories, and relying on them for notifying some conditions may result in slower notification than by health practitioners (normally, laboratory notification would be faster). This issue could be addressed by allowing the Medical Officer of Health to modify who is required to notify in his or her area if laboratory notification proves unsatisfactory.

4.4.10 Which authorities should notification be made to?

Notification would be made to the local Medical Officer of Health. The Bill could also provide that regulations may specify some circumstances in which the notification should also be made to other authorities. In general, however, the Medical Officer of Health would decide whether other agencies should be notified. These could include:

- the Director-General of Health or the Director of Public Health
- the appropriate territorial authority or regional council
- others such as Occupational Safety and Health regional service centres, the Ministry of Agriculture and Forestry (for diseases communicated by animals), the Food Safety Authority or the Environmental Risk Management Authority
- international agencies (partly to fulfil international WHO obligations).

Regulations could also modify the requirement to notify a condition to the Medical Officer of Health with an obligation to notify one or more other agencies. This may apply when notification is necessary for obtaining comprehensive surveillance data and there is no need for personal health care or public health management and hence no need for identifying details.

4.4.11 Information to be included

The Bill is likely to specify what must, and what may, be included in any notification. As detailed on prescribed forms, the information would usually include: the condition, the name of the notifying person, whether the condition is suspected or confirmed, the name

and contact details of the person with the condition and the source or route of infection (if relevant and known).

4.4.12 Means for making notification

Regulations or schedules may set out the means and timeframe for making notifications. The Bill would further provide that, where no details are specified in regulations, notification must be made as quickly as possible and by the most convenient practicable means that allow the information to be accurately and verifiably communicated. This is likely to mean electronic or telephone notification. Again, this provision may apply to suspected or presumptive diagnoses as well as to confirmed cases.

4.4.13 Protection of privacy

The Bill would provide that people who are obliged to notify have a duty of confidentiality and a duty to protect the privacy of information about people with notifiable conditions. In particular, identifying information should be notified or disclosed only where relevant so that, if anonymised or statistical information is sufficient, only that information should be notified. Identifying details can be revealed or deleted at varying stages of notification. Further, when information is notified about an identifiable person, reasonable efforts should be made to inform that person that notification has been made. If the person cannot be contacted, however, that would not be a reason not to notify.

In the usual situation, where information is first notified to a Medical Officer of Health, all information would contain identifying details. The Medical Officer would then, on behalf of the Ministry of Health, forward that information to agencies responsible for disease monitoring, such as (at present) the Institute of Environmental Science and Research Ltd. In general, that information would not require identifying details, even though it would not usually be in aggregate form.

Questions for comment

- 1 It is proposed that the term 'condition' be used instead of 'disease' (in relation to notification and other topics discussed in this paper). This would include, as well as disease, clusters of symptoms and risk factors (para 4.4.3).

- Agree
 Don't agree

Please give reasons:

- 2 A range of purposes for notification is proposed, including the care and management of a person with a communicable condition, monitoring, identification of risk factors etc (para 4.4.4).

- Agree
 Don't agree

Comments and reasons; any suggestions for other purposes:

- 3 Do you agree with the proposed criteria for notification (ie, one group of factors for conditions which must be notified, such as those specified by the World Health Organization as quarantinable – yellow fever, cholera etc) and another group of factors to guide decisions on which conditions must be notified (para 4.4.5)?

Agree

Don't agree

Comments and reasons; other suggestions for criteria:

- 4 Do you have comments on, or suggestions for additions to, the four proposed categories of information to be included in the Bill (para 4.4.2)? The categories are:

- general reports
- disclosure, on request, of information about identifiable individuals
- notification of specified information
- registers and databases.

Comments and suggestions:

- 5 It is suggested that there could be provision for regulation-making powers following reports from bodies (such as the National Mortality Review Committee) responsible for investigating issues relating to individual safety (para 4.1.2).

Agree

Don't agree

Comments and reasons:

- 6 Do you have any comments on the proposed definition of 'health information' (the same as in the present Health Act) (para 4.3.2)? Should it be extended – if so, why?

Comments and reasons:

- 7 It is proposed that the Bill could include an obligation or discretion to notify non-notifiable conditions with unusual features (para 4.4.6).

Agree with obligation

Agree with discretion

Don't agree

Comments and reasons:

- 8 A concept of 'temporary notifiability' is proposed (para 4.4.6). Would this be useful?

Agree

Don't agree

Comments and reasons:

- 9 This chapter has proposals on who should be obliged to notify 'notifiable conditions' (para 4.4.8).

- Agree
 Don't agree

Comments and reasons:

10 It is proposed that laboratories be required to notify as well as, or in some cases instead of, medical practitioners (para 4.4.9).

- Agree
 Don't agree

Comments and reasons:

Do you have any comments on which conditions should remain the responsibility of general practitioners? Cost implications?

11 It is suggested that perhaps Medical Officers of Health could modify who is responsible for notification if, for example, laboratory notification is unsatisfactory (para 4.4.9).

- Agree
 Don't agree

Comments and reasons:

12 The chapter sets out some possibilities as to which authorities notification should be made (para 4.4.10). Comments and suggestions:

13 It is proposed that the Bill provide a number of ways in which the privacy of people who have had information about them notified could be protected (para 4.4.13).

- Agree
 Don't agree

Suggestions or comments:

14 It is proposed that people who are the subject of notification could be informed accordingly (para 4.4.13).

- Agree
 Don't agree

Suggestions or comments: Are there any circumstances in which this may not be practical?

5 Promoting Public Health

5.1 Introduction

Public health is about promoting wellbeing and preventing ill health before it happens. It focuses on keeping people healthy and improving the health of populations rather than on treating diseases, disorders and disabilities of individuals. Public health in this general sense requires recognition of all factors that contribute to health. These include housing, income, employment and educational opportunities, as well as more immediate risk factors such as nutrition and smoking (which in turn are influenced by income and education). This chapter focuses on some key influences on health status, while Chapter 6 presents proposals relating to more direct and traditional means of preventing ill health.

Statutes governing public health have usually focused on the factors of major relevance to the primary causes of ill health in the 19th century and first part of the 20th century. The emphasis has been on communicable diseases and environmental sanitation – for example, tuberculosis, water safety and good quality sewerage systems. Public health activities in these areas made huge contributions to health and enhanced the quality of life during the 20th century. They continue to be important and that is recognised in provisions envisaged for the Public Health Bill.

However, now that environmental sanitation and communicable diseases are generally managed effectively, the major causes of population ill health today are those broadly categorised as ‘non-communicable’. They include the chronic and major diseases, such as cardiovascular disease, cancers, diabetes, osteoporosis, respiratory disorders and oral ill health. Many such diseases are, in principle, preventable because of their relationship with such factors as smoking, inadequate physical activity, obesity, poor nutrition and lack of fluoridation. Another significant cause of ill health is injury (eg, burns, poisoning, adverse physical effects arising from products or services). In many cases other legislative frameworks would be adequate for addressing injury-related issues (eg, consumer safety legislation), but appropriate legislative safeguards may not always exist.

The *Ottawa Charter for Health Promotion* (World Health Organization, 1986) suggests a framework for developing approaches to these issues that has five components:

- building healthy public policy
- creating supportive social, physical and cultural environments for health
- strengthening community action for health
- developing personal skills so people can take action to improve their own health
- reorienting health services if necessary to make them accessible and acceptable to the population they serve.

An important question, therefore, is whether the Public Health Bill should include provisions aimed at reducing morbidity from non-communicable diseases and injuries. What is appropriate and feasible for legislation to achieve in this area and does the Ottawa Charter provide useful guidance for legislative action?

In relation to the most important, but usually more indirect, factors associated with health – income, education and employment – the role of health legislation seems relatively limited, especially as other agencies already provide a legislative framework for these sectors. The very nature of these factors requires an intersectoral response. Health policy could, however, provide for the following functions:

- information and reporting
- health impact assessment
- ensuring that health objectives are included in the policies of other sectors and that there is co-ordination between health and other sectors.

5.2 Information and reporting

Chapter 4 discussed the information and reporting provisions in the Bill to ensure, among other things, that health considerations figure in the development and implementation of policy in other sectors. This should enhance accountability and result in decisions and policies with better health outcomes.

5.3 Health impact assessment

Health impact assessment provides a formal way to assess the potential health effects of policies in sectors outside health. Health impact assessment is:

a combination of procedures, methods and tools by which a policy, program or project may be assessed and judged for its potential, and often unanticipated, effects on the health of the population and the distribution of those effects within the population. (European Centre of Health Policy)

An example of impact assessment relevant to health is inequalities assessment.

The Public Health Advisory Committee, a subcommittee of the National Health Committee (established under the New Zealand Public Health and Disability Act 2000), is developing tools to be used in assessing the impact on health of the policies of sectors other than health. The committee sees health impact assessment as an important tool for facilitating healthy public policy and is exploring options for its implementation. The committee may consider whether provisions for health impact assessment should be included in legislation and, if so, in what form.

5.4 Influencing risk factors associated with health status

Some statutes, in health and other sectors, aim to influence the possible adverse effects on health status of various products, services or facilities (for example, legislation relating to food, alcohol, tobacco, illicit drugs and gambling). The Smoke-free Environments Act 1990 provides for health warnings, regulates advertising and tobacco constituents and promotes supportive environments by requiring smokefree policies in workplaces and public places. The Responsible Gambling Bill, at present before a parliamentary select committee, aims to control the growth of gambling and to minimise or prevent its harm. That Bill's regulation-making powers (in the current draft) allow regulations for information provision, codes for advertising and the design and layout of specified gambling venues, as well as maximum stakes and prize limits.

How far would such approaches be effective or feasible with other products and aspects of our social and cultural environment (for example, alcohol and food)?

Alcohol is a significant source of illness and death in New Zealand. The possibility of health warnings for alcohol, as required in some other countries, has been raised in the past, but to date there has been no agreement to require warning labels.

Like many developed countries, New Zealand has an obesity epidemic to which the quantity and quality of food contributes. New Zealand regulates food safety through food safety and related regulations and through risk-based management plans. Legislation that contributes to improved nutritional status must be flexible in order to improve access of consumers to a range of healthy options and to ensure appropriate labelling and consumer information. Issues to do with the advertising and promotion of food – especially for children – could be considered. The scope and effects of the current codes on this topic, in particular the *Code for Advertising to Children* and the *Code for Advertising of Food*, administered by the Advertising Standards Authority, would need to be taken into account.

Access could also be relevant. Regulation of access could include the legal age of purchase; the number, size and placement of environments where it is possible to purchase and consume food; and the cost of particular items.

5.5 Legislative options for promoting public health

In conjunction with other appropriate measures, and within a general framework, legislation supporting intervention to promote public health by influencing specific risk factors is logical. It may not, however, prove easy to build support for legislation outside the traditional scope of health law. Often, and inevitably, the relationship between such risk factors and health outcomes is indirect and fairly long term. There can also be difficulties in providing evidence of that relationship. It may be for this reason that arguments from the health sector about the legal age for purchasing alcohol have failed. In addition, health status is generally multi-causal – for example, genetic factors may combine with poor nutrition to make adverse health outcomes more likely. In general, and partly because the issues have many causes, responses other than legislation can be considered for addressing such matters as smoking or nutrition or physical activity. Hence, a common argument used against the development of tobacco control during the 1980s was ‘education rather than regulation’. While education is certainly important in almost all health issues, often the ideal public health response is not ‘either/or’ but several complementary strategies.

Given the inherent difficulties, it is proposed that the Public Health Bill would *not* include any direct or substantive provisions at this stage. Instead, the Bill could include a reference to non-communicable diseases in its purpose and empower the use of regulations on a specific issue if that is considered appropriate at a later stage. Such regulations would be envisaged as one element of a general strategy, along with health education, workforce training, service provision and so on. Issues relevant to possible overlaps with responsibilities for other agencies would also be addressed at this regulation-making stage, in consultation with those agencies.

Hence, the Bill could state that one of its purposes is to:

promote public health and reduce preventable ill health from communicable and non-communicable diseases and accidental injury through recognition of the principles of the Ottawa Charter, and in particular by:

- a. creating supportive social, physical and cultural environments for health
- b. ensuring that information on factors relevant to social, physical and cultural environments for health is available
- c. empowering regulations relevant to products, services, facilities and other things associated with risk factors for ill health and accidental injury.

The Bill would make it clear that these purposes would be achieved only in collaboration with other agencies. Indeed, in many cases health authorities would not have the sole or even the principal responsibility for achieving such purposes (for example, information on factors relevant to social, physical and cultural environments for health is presently the responsibility of a number of agencies).

Regulation-making provisions, which would empower regulations after full consultation, could provide for matters relating to access, product composition, issues related to advertising and information, incentives and costs. Issues about the impact of these regulations, the interests affected, costs and benefits and relationships with other legislation, would be addressed in the course of consultation and policy development. Consultation procedures would involve provision of notice of possible proposals for regulations, a reasonable opportunity for submissions and appropriate consideration of submissions. Any regulations must come within the scope anticipated by the regulation-making powers that are set out in primary legislation, and which would be subject to scrutiny by the Regulations Review Committee.

Questions for comment

- 15 Do you agree that the Public Health Bill should refer in its purpose to public health promotion, the prevention of non-communicable diseases, as well as risk factors relevant to both communicable and non-communicable conditions (para 5.5)?

- Agree
 Don't agree

Comments, suggestions and reasons: Any ideas about wording of such a purpose statement?

- 16 Do you agree that the Bill should include regulation-making powers for promoting public health (para 5.5)?

- Agree
 Don't agree

If you do agree, do you have any suggestions for wording?

- 17 Should the Bill include a reference to health impact assessment (para 5.3)?

- Agree



Don't agree

If you think there should be such a reference, what form should an assessment take?
What kind of policies could it refer to?

- 18 If legislation is not the appropriate vehicle for health impact assessments, what other ways do you think may be helpful in encouraging them (para 5.3)?

6 Preventing Ill Health and Promoting Child Health

6.1 Introduction

Primary and secondary control of preventable illness and death are fundamental objectives of public health. Broader prevention strategies were discussed in Chapter 5. This chapter focuses on prevention through identification and management of diseases in their early stages.

Immunisation and screening are two of the main preventive strategies in the Bill for managing communicable conditions and other significant health conditions. Optimum immunisation and screening may require the establishment of registers or proactive programmes.

These preventive strategies therefore build on the information requirements set out in Chapter 4. Specified officials and agencies would be able, and in some circumstances required, to collect, use and disclose various categories of information.

Immunisation and screening can both raise issues about the relationship between privacy values and the aims of optimal public health outcomes and quality assurance. Policies on immunisation and screening can also raise issues about individual autonomy in relation to community wellbeing. In many cases measures to achieve autonomy may also further goals for the general good, given that one way of characterising autonomy is ‘having choices’. Most people would only willingly choose to participate in health services that are of high quality – even if ensuring such quality involves a modest cost to privacy.

An individual’s decision to participate in a health service should be based on information about any potential loss of privacy and other implications, as well as the likely benefits. People therefore need accurate and accessible information about all such relevant factors. Development of legislation for programmes such as those for screening and immunisation must recognise the range of views that people have on these issues and ensure that the implications for privacy in any health programme are able to be fully assessed. Ways of doing this are discussed at the end of this chapter.

Because both immunisation and screening services usually depend on registers, and may involve programmes, it is convenient to set out the Bill’s proposals for these ‘building blocks’, before specifying the uses to which they may be put in immunisation and screening.

The prevention of ill health is important for everyone, but society has a special responsibility for children as recognised, for example, in the United Nations Convention on the Rights of the Child (UNCROC). It is proposed that the Bill recognise the importance of child health by, for instance, providing that one of the Bill’s purposes is to contribute to the promotion of child health and wellbeing through, among other things:

- prevention of vaccine-preventable disease and disability (both for individual children and for the contacts of children)
- the early detection, surveillance and appropriate management of diseases and disability that may occur in childhood or other conditions occurring in childhood that may result in long-term adverse health consequences
- other strategies relevant to the prevention and management of risks to child health.

Most of the specific provisions discussed in this chapter are not framed in terms of application to children although, in some cases, specific reference to children is made. Comments are invited on other issues related to child and infant health that have not so far been considered for inclusion in the Bill.

6.2 Registers

The Public Health Bill would have general provisions to empower regulations allowing registers to be established. Such registers may range from simple lists to comprehensive databases.

Some provisions relating to the National Cervical Screening Register and the National Cervical Screening Programme would also be included in the primary legislation rather than being empowered by regulations.

The Bill may also include some provisions relating to the National Immunisation Register. Alternatively, it may be sufficient for such a register to be established by regulation in accordance with the general register provisions.

6.2.1 General register provisions

The Bill would:

- authorise registers to be established by regulation following specified consultation procedures
- set out some general provisions for such registers.

The consultation procedures for establishing registers would be the same as those for all significant policy initiatives and regulations. As noted for the regulation-making powers proposed in chapter five, procedures for development of regulations involve ensuring adequate and appropriate notice of the intention to make regulations for a new register, giving a reasonable opportunity for interested people to make submissions and ensuring adequate and appropriate consideration of any submissions received. Any regulations made under such powers must come within the scope anticipated by the Act and would be subject to scrutiny by the Regulations Review Committee.

Possible general provisions follow.

The purposes of any register established under this Act may include the following:

- (a) enabling information to be collected in relation to the incidence, mortality rate, or other effects, of any health condition or disease, with the aim of reducing such incidence or mortality rate, or improving the quality of decision-making or management or both, at either the personal or population level, for that health condition or disease
- (b) enabling information to be collected in relation to health issues or disabilities for the purpose of improved management of the health issue or disability, or delivery of services to the people concerned
- (c) monitoring the health status of whole populations or segments of populations (eg, by age, gender or region) for the purpose of tracking delivery of health services to that population or population segment
- (d) monitoring the health status of people with a particular risk factor
- (e) ensuring that information is available to a population or population group for the purpose of facilitating the provision of one or more health services, or monitoring the results of such health service provision, or both (eg, immunisation or screening services).

Other provisions may be relevant (for instance, fulfilling international obligations).

6.2.2 Privacy and disclosure

The Bill would clarify the relationship of the Official Information Act 1982 and the Privacy Act to any register established by regulations. It may need to clarify what happens to information if a register is discontinued. The Bill might also address the role of regulations relating to the use of aggregate information, such as the Health (Cervical Screening) (Kaitiaki) Regulations 1995 and any other regulations relating to types of user or consumer groups.

The Bill would provide that information in any register established under this Act could not be disclosed except to:

- the person to whom the information relates or, if appropriate, that person's parent or guardian
- any person so long as the informed consent of the person to whom the information relates is obtained
- as otherwise provided in the Bill (eg, the equivalent of the 'section 22 series', including authorised providers)
- as otherwise provided for in the regulations.

The regulations would specify the other people or organisations to whom information from the register could be disclosed, as appropriate to the purpose of the register. Such people might include, as specified in the regulations:

- the relevant health or disability professionals and organisations
- people associated with any health or disability service to which the register relates

- assessors, auditors and evaluators associated with any health or disability service to which the register relates
- researchers studying any health or disability issue to which the register relates
- government agencies or government-funded bodies relevant to the issue to which the register relates (eg, educational providers if the register relates to immunisation).

The provisions could enable information from registers to be shared with other registers or databases for research or investigative purposes (eg, disease notification data for correlating trends in disease prevalence and the effectiveness of control strategies). Details might be included on the level of information to be made available to the various categories of people; for instance, researchers may need information about specific individuals, but not need details which identifies them. In some situations, aggregated information may be sufficient.

6.2.3 Types of registers and operational procedures

The regulations would specify whether a register is:

- ‘comprehensive’ (ie, all people to whom the register potentially relates are included on the register, with no choice not to be on it)
- ‘opt-off’ (ie, a person is automatically enrolled on the register unless the person declines or cancels enrolment)
- ‘opt-on’ (ie, a person is enrolled on the register only at the request of that person).

Depending on the type of register, the regulations would specify that a person or organisation must, or may, supply relevant information. With ‘opt-off’ or ‘opt-on’ registers, how a person may cancel or request enrolment would also be specified.

Registers could be specified as being either nationally or regionally based or administered by the Ministry of Health or other agencies (such as District Health Boards or primary health organisations).

The regulations could specify that all individuals whose details are recorded on the register are notified accordingly and that they have the right to request details about themselves (and to correct errors). Registers could include information on people who have died. If so, and if consent is required before information is placed on the register, the regulations must specify how such information is to be provided and who is authorised to give consent on behalf of the dead person.

The regulations could specify the sources of information to be used in compiling the register. The sources may include existing databases, the people whose details are to be recorded on the register, health professionals and organisations or laboratories that generate or record relevant information. The regulations could provide authority for registers to ‘backload’ data so that a register could capture information in other information systems. Provisions requiring information to be notified or disclosed for the purpose of maintaining the register may be needed.

6.3 Immunisation

The Health Act 1956 contains little on immunisation, although one relevant set of regulations has been made under the Act, the Health (Immunisation) Regulations 1995.

The vaccination of a child or adult against a disease by a suitable health practitioner does not in itself require legislative backing. That may become necessary, however, when measures are required to ensure that a national immunisation programme is effective in meeting general coverage goals and when some of those measures may impinge on principles in other legislation (eg, the Privacy Act) or other values.

Furthermore, legislation may be appropriate for immunisation given that children form the largest population group affected by immunisation programmes. The issue of consent in relation to children is different from consent in relation to adults, as it is the parents who consent on their child's behalf, and there may be differences of opinion between parents and health practitioners on what is best for the child.

New Zealand has low immunisation coverage rates at present, with resulting risks to child health. If coverage were improved to 95 percent or more of the relevant population, it would be possible to eliminate some vaccine-preventable diseases, such as measles, in New Zealand.

To improve and then maintain New Zealand's immunisation coverage it is proposed that the Bill could provide for:

- a register of those eligible for immunisation
- notification
- regulation-making powers (for matters concerning the registers or schools, as well as for matters concerning providers, such as the qualifications and competencies of vaccinators)
- powers of Medical Officers of Health and public health units in relation to non-immunised children
- emergency powers to deal with outbreaks of vaccine-preventable diseases.

6.3.1 Immunisation registers

The general provisions for registers are outlined in section 6.1.1. These may be sufficient to establish any immunisation register or to recognise one already in existence. However, it may be thought appropriate for the Bill to include specific provisions for a National Immunisation Register, in part because of its significance.

Either the Bill or regulations made under it could provide that the National Immunisation Register incorporate information already collected under other systems. Appropriate security safeguards would be needed for register information to be made accessible to different people and agencies, and to enable information to be shared with other registers or databases or information systems for research. For example, it may be essential to correlate immunisation information on the register with disease notification data, for monitoring trends in disease prevalence, disability, immunisation rates and the

effectiveness of control strategies or for notification of data on adverse events following immunisation. Policies and systems may be appropriate in relation to details of people who have died.

6.3.2 Notification

It may be useful to include in the information provisions (see Chapter 4) a provision that criteria for what must, or what may, be specified in regulations as notifiable include conditions that are relevant to the general immunisation schedule.

6.3.3 Regulations for immunisation

The Bill could include a range of regulation-making provisions for immunisation.

The provisions for immunisation status certification in relation to school and pre-school enrolment and attendance could be phrased generally to enable quite different regulations to be drafted. They could allow regulations to be made with any of the results set out below.

- Certification of immunisation status to be provided without any requirement that the child actually is immunised; that is, a simple record of whether or not the child is immunised. This is the status quo set out in the 1995 Immunisation Regulations.
- Certification of immunisation status to require either immunisation or a reason why the child has not been immunised. A reason may be a doctor's reasonable belief that the child may suffer an adverse reaction, or a child or parent's conscientious objection to immunisation, as recorded in a statutory declaration.
- Certification of immunisation status to be provided not only before a child's first pre-school or school enrolment, but also every time the child changes school, or periodically (say, every five years) throughout the child's school career, including primary, intermediate and secondary school. The rationale for this approach is the year 7 programme carried out in schools for most children and the need for outbreak control.
- Schools to be empowered to refuse a child's enrolment without certification (this option would not, however, be legally possible under section 3 of the current Education Act).

Regulations relating to child immunisation could refer to the evolving capacity of a child to make decisions without parental consent. The regulations would envisage that information on a register or database may, in time, supersede the school enrolment certification required by the present Immunisation Regulations. For example, the Bill may provide that parents or guardians must be able to provide immunisation status certification unless that information is on an immunisation register established under regulations made under this Act and available to the child's school and health professionals.

Other regulations relevant to child health may concern approved immunisation programmes, lists of vaccines, scheduling of vaccinations and training and approval of non-medical vaccinators. Some of these issues are at present addressed by the Medicines Regulations 1984.

Of relevance to adults, rather than children, could be regulation-making powers relating to immunisation and occupational health.

6.3.4 Powers of Medical Officers of Health and others

Medical Officers of Health would be empowered by the Public Health Bill, as at present, to exclude children from schools in cases of an actual or potential outbreak or epidemic of disease.

Although not relevant to immunisation, it may be convenient to include in this part of the Bill any provisions relating to the 'health examination of children'. This would replace current section 125 of the Health Act, which empowers testing where parental consent is not given.

6.3.5 Emergency powers

Emergency powers could include the power to vaccinate one or more people without their consent. Criteria for use of this power should be carefully specified. Declaration of a 'public health emergency' may not be sufficient, but the re-emergence of such an extreme threat as terrorist-introduced smallpox could justify compulsory vaccination. Consent may be a particular issue with children in that the parents' consent may be unobtainable or withheld. Criteria for the use of this power could be:

- a serious public health risk (ie, a risk to the community rather than to individuals)
- the likely efficacy of vaccination in preventing an epidemic or mitigating its effects
- efforts made to obtain consent have failed or obtaining consent is not practicable in the circumstances.

6.4 Screening

Screening initiatives current in New Zealand range from relatively simple screening tests to formal screening programmes. An example of the former is the Guthrie test given to all newborn babies. This screens for specific conditions that are amenable to treatment and which, if untreated at an early stage, can result in significant problems for the child, including irreversible intellectual disability or death.

An example of a formal screening programme is cervical screening. In addition to a register, this has proactive and service provision elements that justify the term 'programme':

- delineation of roles
- the powers and duties of programme staff
- procedures for follow-up and recall
- contractual arrangements with service providers
- evaluation of screening, diagnostic and treatment services.

There appears at present to be no need for the test given to newborn babies to be mandated by legislation, as almost all parents are happy for their babies to be tested in this way.

There is, however, no guarantee that this level of acceptance would remain or would apply to new screening tests. It may therefore be helpful for the Bill to provide for regulation-making powers for screening tests. The regulations could authorise screening and specify safeguards for the information collected.

Other regulation-making powers could relate to the screening of babies and children in health care facilities as well as educational and maybe even domestic environments. Powers relevant to adults could relate to the workplace.

The provisions could, in theory, cover genetic screening. This is a complex topic and the Ministry of Health considers that, if a legislative solution is appropriate, specific legislation should be developed. The Public Health Bill would therefore explicitly provide that any reference to screening does *not* include genetic screening.

6.4.1 Screening programmes

The distinction between simple screening tests and formal screening programmes is one of degree. It is not always necessary for screening programmes to have a legislative mandate – BreastScreen Aotearoa, the National Breast Screening Programme, for example, does not. On the other hand, the National Cervical Screening Programme is explicitly recognised in legislation. The provisions in the present Health Act relating to the cervical screening programme, and the proposed Health (Screening Programmes) Amendment Bill, provide a model for what may be included in other screening programmes on a similar scale. Elements that differentiate a screening programme from a register include the active provision of a service, including recall, provision of information to people enrolled in the programme and provisions for quality assurance.

The provisions of the present Health (Screening Programmes) Amendment Bill can be applied to other conditions by Order in Council. This mechanism for setting up screening programmes is expected to be incorporated into the new Public Health Bill. Alternatively, the Bill could provide for regulations to establish new screening programmes rather than using the Order in Council mechanism.

As with the National Cervical Screening Programme, general provisions for screening programmes could include:

- the objectives, procedures for enrolment and whether the programme is comprehensive
- whether the programme is ‘opt-on’ or opt-off
- the duties of those responsible
- the kind of information to be collected
- to whom the information can and cannot be disclosed
- the duties of other health providers involved
- retention of information
- provisions for quality assurance
- evaluation and research
- powers to require information.

6.4.2 Other programmes

The development of legislation for screening programmes raises the possibility of using registers for purposes other than screening programmes; for example, other preventive strategies.

6.4.3 Evaluation of privacy implications

In developing health programmes, such as those discussed in this chapter, it is important to understand the full privacy implications and to protect privacy to the extent possible in achieving the programme goals. A thorough assessment of privacy impacts should assist in achieving this understanding. As part of the process of developing regulations for a new register or for a programme with privacy implications, it is therefore proposed that the Bill could refer to the undertaking of a privacy impact assessment. Alternatively, administrative processes may include reference to privacy impact assessments. In addition to aiding development of policy, any such assessment may provide a basis for the later dissemination of information about privacy implications for individuals when deciding about their participation in relevant programmes.

Questions for comment

Child health

- 19 It is suggested that the Bill could specify as one of its purposes the importance of child health, possibly with a reference to the United Nations Convention on the Rights of the Child (para 6.1)

- Agree
 Don't agree

Reasons and comments on the proposed wording:

- 20 Are there any other issues relating to child health not covered in this chapter (or elsewhere in this discussion paper) that you think should be included in the Public Health Bill?

Suggestions and reasons:

Registers

- 21 It is proposed that there could be a set of general provisions to allow registers on specific subjects to be established by regulation following consultation (paras 6.2 and 6.2.1).

- Agree
 Don't agree

Comments:

- 22 Proposals are set out for possible register purposes, privacy and disclosure provisions, types of registers and operational procedures (paras 6.2.2 and 6.2.3).

- Agree
 Don't agree

Comments, reasons, alternatives, other wording:

Immunisation

- 23 It is suggested that the empowering provisions for making regulations on immunisation be drafted to allow for various options (paras 6.3 and 6.3.3).

Agree

Don't agree

Comments and suggestions:

- 24 One option that could be allowed by regulation-making powers is for children to be immunised unless a conscientious objection is stated or a reasonable possibility of an adverse reaction exists (para 6.3.3).

Agree

Don't agree

Comments (for example, on the evolving capacity of a child to make decisions without parental consent):

- 25 Should references to immunisation be focused mainly on child health (para 6.3)?

Agree

Don't agree

Comments and reasons:

- 26 Or should references to immunisation also extend to adults where appropriate (eg, workplaces) (paras 6.3 and 6.3.3)?

Agree

Don't agree

Comments and reasons:

- 27 It is suggested that the Bill could specify that a disease is notifiable if the vaccine for that disease is on the general immunisation schedule (perhaps with exceptions) (para 6.3.2).

Agree

Don't agree

Comments and reasons:

- 28 Should emergency powers envisage vaccinating people without their consent – adults as well as children – in situations of extreme risk such as terrorist-introduced smallpox (para 6.3.5)?

Agree

Don't agree

Comments and reasons:

Screening

29 Are powers for making regulations needed to specify circumstances in which screening would be appropriate (para 6.4)?

Agree

Don't agree

Comments (for example, on applying this to workplace settings):

30 Should the Bill contain general provisions, and regulation-making powers, to authorise the establishment of new screening programmes, as included in the Health (Screening Programmes) Amendment Bill (para 6.4.1)?

Agree

Don't agree

Comments and reasons:

31 Should the Bill provide for programmes for purposes other than screening (para 6.4.2)?

Agree

Don't agree

Comments:

32 Should the Bill include a reference to privacy impact assessments (para 6.4.3)?

Agree

Don't agree

Suggestions and comments (for instance, if legislation is not the appropriate vehicle for privacy impact assessments, what other ways do you think may be helpful in encouraging them?):

7 Care, Management and Compulsory Powers

7.1 Introduction

This chapter discusses the powers to be included in the Public Health Bill in relation to people in two categories:

- people with a communicable condition posing a risk to others
- people described in the Health Act 1956 (using the terminology of the day) as ‘infirm and neglected’.

These two groups of people have very different characteristics. They are both discussed in this chapter because the statutory powers that may be needed to provide appropriate assistance are similar. The associated civil rights issues are also comparable. The framework proposed is analogous to that in mental health legislation.

This chapter focuses on each group in turn.

7.2 People with a communicable condition

A person with a communicable condition may pose a risk to other people. Action to minimise or prevent such a risk can be considered from two perspectives:

- measures relating to the person (eg, treating the person so that he or she is no longer infectious)
- measures relating to other people (eg, identifying those with whom the infected person has been in contact so as to prevent or manage the further risk of infection).

Both sets of measures depend on the provision of information as set out in Chapter 4. For example, a general practitioner may notify a Medical Officer of Health that a particular person has a communicable condition that has been specified as ‘notifiable’. The Medical Officer of Health would then decide what, if anything, to do about the particular person, as well as about people with whom he or she may have been in contact. If, as a result of such measures, other people with the communicable condition are identified, information about them would be notified in turn.

This chapter deals with care of the person who has the health condition. Chapter 8 deals with the measures that can be taken to protect those with whom that person has been in contact; in particular, through contact tracing.

Legislative provisions as proposed in this discussion document would be implemented in conjunction with other policies, services and strategies aimed at preventing transmission of communicable diseases and protecting public health. Education and information for people with these conditions and those at higher risk are an essential first step, as are programmes to increase immunisation rates, and to increase efficacy of prevention in the community and institutional settings. For example, harm minimisation initiatives in prison settings (a project presently at the development stage) would assist inmates to protect themselves and others from blood-borne viruses such as Hepatitis B,

Hepatitis C and HIV, and from sexually transmissible infections such as chlamydia and HIV.

7.2.1 Rationale

The sole reason for having legislation relating to the care of a person with a communicable condition is the possible need for compulsion or information disclosure in caring for that person. If there were no need for powers to authorise actions contrary to the wishes of the person, the management of such conditions could be left to the ordinary relationship between health professional and patient.

The ideal, clearly, is *not* to be obliged to have recourse to such powers and to choose the ‘least restrictive alternative’ first. Recognising this ideal in legislation should increase a person’s willingness to seek or accept treatment or appropriate care. When there is no conflict with the person’s wishes there would be no need to invoke the provisions discussed in this chapter.

These personal care provisions would be more detailed than in the present legislation.

7.2.2 Scope

The care provisions would cover:

- the rights and duties of a person with a communicable condition
- the duties of health practitioners
- the power to direct a person to take various actions.

7.2.3 Rights and duties of a person with a relevant condition

The Bill would specify that a person with a communicable condition (suspected or confirmed) would have the right to:

1. full information about the condition and its implications
2. protection of the person’s privacy to the greatest extent practicable
3. appeal procedures, including to the courts, in relation to specified orders
4. access to legal or other support (friends, whānau, and so on, who can act as advocates, provide advice or explain information independent of the health authority).

A person with a communicable condition would also have the duty to:

1. prevent or minimise the risk of transmission of the condition to other people
2. provide information to assist in protecting other people and the public health
3. co-operate with all people and authorities responsible for notification and case management of conditions.

There is an issue as to whether the duty to prevent or minimise the risk of transmission of a condition should have an offence attached. Options for dealing with this include:

- *no* specific offence or penalty, so that any sanction for putting another person at risk of infectious disease is left to the general criminal law
- providing an offence in the Bill for deliberately or recklessly infecting someone else with a specified disease or deliberately or recklessly putting someone else at risk of infection (probably with a defence of acceptance of risk)
- providing an offence in relation to deliberately or recklessly endangering the life or health of another person as a consequence of breach of a duty in the Bill (that is, omitting any reference to a specified disease).

There are arguments for and against criminalising behaviour which results in the risk of transmission of a communicable condition. Penalties need not involve imprisonment; for example a consequence of breaching the duty to prevent transmission of a specified disease could be an application for a public health order (the concept of ‘public health orders’ is discussed in section 7.2.7).

7.2.4 Duties of health practitioner

The Bill could provide that, for a person with a communicable condition, the health practitioner must:

1. advise the person of the possibility that he or she has a specified communicable condition to which this part of the Act applies
2. provide information on that condition and its implications
3. request the person to undergo further testing or examination to confirm whether or not he or she has the condition, after taking reasonable steps to determine that the person is at risk from the condition
4. recommend or offer appropriate treatment.

The Bill could state that, if the person wished, a medical practitioner (or other health professional) would provide information on:

1. the condition and how the person may best manage it
2. the means by which the person may minimise the risk of transmission of the condition to other people
3. the medical practitioner’s duties if the person is unwilling to minimise the risk of transmitting the condition to other people.

The Bill could further provide that the health practitioner must, in considering appropriate action in relation to a particular person, adopt the least restrictive alternative of the range of possible powers (unless there is good reason to believe this would be not justified).

These duties would sit alongside the professional duty of care to which health practitioners are subject.

7.2.5 Powers applicable to a person with a relevant condition

Where a person is not willing to fulfil their duty to minimise risks to others, and there are reasonable grounds to consider that he or she is, for that reason, likely to endanger the health of other people, the person may be directed by the Medical Officer of Health to do one or more of the following:

- undergo counselling by a specified person or occupational group
- agree to supervision by a specified person or clinic
- participate in a specified community or clinic programme
- refrain from doing certain things or do them in accordance with specified conditions
- refrain from employment or undertake employment in accordance with specified conditions
- refrain from visiting specified places or associating with specified people
- do any other action which would minimise risks to other people
- be detained or isolated in a suitable facility
- be treated (directions for this purpose would be triggered by extreme circumstances only).

Many of these powers impact directly on personal freedoms, such as the right to act and move freely, the right to refuse treatment and the right to have privacy safeguarded. Hence the following questions are important:

- to what conditions could these powers be applied?
- who should decide about the use of the powers?
- what powers could potentially apply?
- what should the decision-making process be?

7.2.6 To what conditions could these powers be applied?

The following approaches are possible.

- *Option 1:* The Medical Officer of Health could decide when it is appropriate to use the care powers, taking into account specified criteria, such as the presence of significant risk ('Medical Officer of Health discretion').
- *Option 2:* The care powers could be applied only with conditions that have been specified for that purpose in regulations (eg, tuberculosis or hepatitis A). The specified list could include all notifiable conditions that are communicable or all communicable diseases or one or more subsets of communicable diseases.
- *Option 3:* A combination of both approaches could be used – that is, a specified list in respect of which court orders would be required and a Medical Officer of Health discretion for the less 'coercive' powers for less serious (and not specified) conditions.

Whichever option is chosen, an additional criterion for the taking of any action would be reasonable grounds to consider that the person presents a significant health risk to the general public.

The options all have their advantages and disadvantages. The Ministry of Health does not favour the idea of a complete discretion for Medical Officers of Health, as suggested in Option 1, given that significant restrictions on people's freedoms are potentially involved.

If it were decided to have two categories or lists of communicable conditions the Bill could provide criteria for what may be specified by regulations for each category.

Criteria for specifying a condition on List A could include:

- any condition specified as quarantinable under WHO regulations
- a condition which is communicable, or may develop so as to be communicable, and which poses a significant risk to people to whom the condition may be transmitted, taking into account the mode and ease of transmission and the deleterious nature of the condition if transmitted.

Criteria for specifying a condition on List B would apply only to very high-risk infectious conditions (for example, tuberculosis or HIV). The criteria could specify:

- the condition is very serious in terms of illness or mortality
- the nature of the condition is such that the health of other people would be seriously endangered if measures were not taken by the person concerned to minimise the risk of transmission
- the ability of other people to protect themselves from the high-risk condition is limited.

Both Options 2 and 3 can be summarised as follows.

The use of the *more* coercive powers (eg, detention) would be possible only:

- for a more serious condition (List B conditions)
- with a court order.

Using *less* coercive powers (eg, requirement for supervision) would be possible for:

- both the more serious and less serious conditions
- by decision of the Medical Officer of Health.

7.2.7 Procedures relating to orders

Medical Officer of Health directions (or compliance orders) requiring that a person undergo counselling, agree to supervision, submit to testing, refrain from doing certain things or refrain from employment, would be time-limited. The person concerned would be able to appeal to the court.

The court would be able to make ‘public health orders’, which would include the same types of orders as Medical Officer of Health compliance orders, but also orders of a more restrictive kind: detention, isolation and, in the last resort, compulsory treatment. Procedures for these ‘public health orders’ would be modelled on the Mental Health (Compulsory Assessment and Treatment) Act 1992, which provides for compulsory treatment and detention. The Protection of Personal and Property Rights Act 1988 is also relevant.

Applications to the court for public health orders may be made by Medical Officers of Health. As in mental health legislation, this should perhaps require the signatures of two Medical Officers of Health. The orders would be time-limited but renewable. They should be able to be implemented flexibly – for instance, a person under a detention order could be moved from a closely supervised facility to a more independent living arrangement, but still be subject to the order. Decisions of the court would be able to be appealed to the High Court, but would be effective pending the appeal decision.

In addition, as with the Mental Health (Compulsory Assessment and Treatment) Act, provision for an emergency public health order may be needed. These orders would cover the same conditions and be able to impose the same restrictions as the court orders, but would be made by a Medical Officer of Health. They would be time-limited (72 hours maximum), but extendable after application to the Court. Criteria for using emergency powers would be stringent.

7.2.8 Which court?

Which court should be empowered to issue public health orders – the District Court or Family Court? There are more District Courts than Family Courts, hence they have the advantage of greater accessibility. Family Courts hear cases in private (which may be thought to be an advantage or a disadvantage). Family Courts have experience of the difficult ethical issues that are likely to arise in public health, given their involvement in the administration of the mental health legislation and the Protection of Personal and Property Rights Act. The Ministry of Health favours the Family Court at this stage.

7.3 Application of compulsory powers for public health welfare

7.3.1 ‘Infirm and neglected’

The Health Act 1956 has powers under section 126 in relation to people who are ‘aged, infirm, incurable or destitute’ and found to be living in ‘insanitary conditions or without proper care or attention’. A Medical Officer of Health may apply to the District Court seeking an order for the person to be placed in a hospital or other institution. These powers are further specified in the Health (Infirm and Neglected People) Regulations 1958.

It is proposed that the term ‘infirm and neglected’ be replaced in the Bill by the more general phrase ‘public health welfare’. Initial consultation has already been made on whether some form of the present section 126 of the Health Act should be retained in the Public Health Bill. Actual committals are fairly rare, but it appears that the section is referred to relatively frequently. It seems that the process of considering its use and engaging the various agencies and interested parties often leads to some beneficial outcome. For this reason, it is proposed that an equivalent to section 126 be included in the Public Health Bill. Clearly, however, the wording of section 126 must be updated and should avoid any possible discrimination. In addition, the procedures associated with court orders should be modernised.

7.3.2 Conditions for use of powers

It is suggested that the conditions for using the powers for public health welfare include the following:

- that other legislation does not apply (ie, the Mental Health (Compulsory Assessment and Treatment) Act 1990, the Protection of Personal and Property Rights Act 1988, and the proposed legislation for compulsory care of people with intellectual disabilities)
- that a person cannot or does not care for themselves and friends or family cannot provide that care (eg, to meet basic physical and housing needs)
- that, as a result, either
 - the health and safety of the person is endangered
 - or
 - an environmental health risk is posed to others.

Other conditions for using these powers need to be considered. In particular, the Public Health Bill would provide that the relevant health practitioner has a duty to adopt the ‘least restrictive alternative’ (as outlined in section 7.2.4) and to take all practicable steps to avoid the use of coercive powers. There would be the same duty on the health practitioner to provide relevant information, both to the person concerned and, if appropriate, to his or her family.

The person may be directed by the Medical Officer of Health to:

- agree to supervision by a specified person
- participate in a specified community or clinic programme.

If such directions do not prove helpful in a particular situation, the Medical Officer of Health could request the court to issue a public health order, under which the person could be ordered to:

- co-operate with health care or treatment
- be placed in a particular facility.

The procedures relating to public health orders would be identical to those proposed for people with communicable conditions – that is, orders would be time-limited but renewable and able to be appealed to the High Court. The person would be entitled to both protection of privacy and access to legal or other support. The court would be either the Family Court or the District Court, as decided for orders for people with communicable conditions.

Questions for comment

People with communicable conditions

- 33 It is proposed that the Bill would allow action to be taken in relation to people whose condition and behaviour creates risks for others. For which conditions might these powers be exercised and by whom (para 7.2.6)?
- **Option 1:** Medical Officer of Health discretion – that is, the Medical Officer of Health decides when, and in relation to what conditions, it is appropriate to use the specified powers, taking into account specified criteria.
 - **Option 2:** The full range of care powers could be invoked only for conditions specified for that purpose in regulations.
 - **Option 3:** A specified list of high-risk conditions for which the more restrictive powers may be exercised, but for which a court order would be required, while a Medical Officer of Health would be able to invoke the less restrictive powers to deal with any communicable condition.

Please indicate which option you prefer:

- Option 1
 Option 2
 Option 3

Reasons for your choice and comments, other suggestions:

- 34 Proposals are set out for possible rights and duties of people with communicable conditions (para 7.2.3).

- Agree
 Don't agree

Comments, other suggestions:

35 Should the Public Health Bill include offences for behaviour that involves infecting other people (para 7.2.3)?

Agree

Don't agree – this matter should be left to the general criminal law

Comments and reasons:

If you consider that an offence should be included in the Bill, should this be:

(a) for *deliberately or recklessly infecting* other people with specified conditions or

(b) for putting other people *at risk* of such infection

or

(c) for endangering the health and safety of other people (ie, no specific reference to *infection*)?

36 Some duties of health practitioners are proposed (para 7.2.4).

Agree

Don't agree

Comments and suggestions:

37 A range of powers is proposed (potentially for people with communicable conditions of risk to others) (para 7.2.5).

Agree

Don't agree

Comments and suggestions, reasons:

38 If lists of conditions are to be specified, on what criteria do you think such lists should be based (para 7.2.6)?

39 Do you agree that some powers should be exercised only by a court (paras 7.2.6 and 7.2.7)?

Agree

Don't agree

Comments and reasons:

40 Do you favour using the Family Court or the District Court for making public health orders (para 7.2.8)?

Family Court

District Court

Comments and reasons for your choice, cost implications?

41 Do you think an emergency public health order should be able to be issued by a Medical Officer of Health to have effect for a short period, but to be extendable after application to the Court (para 7.2.7)?

Agree

Don't agree

Comments and reasons:

Public health welfare

42 Do you agree that the Public Health Bill should allow action to be taken – where other legislation such as the Protection of Personal and Property Rights Act does not apply – for people (paras 7.3.1 and 7.3.2):

- who cannot, or do not care for themselves (eg, to meet basic physical and housing needs)

and

- as a result, their health and safety is endangered or an environmental risk is posed to others.

Agree

Don't agree

Comments and reasons:

43 Do you agree with the proposal that the term 'aged and infirm' – the current Health Act phrase – be replaced by a more general phrase, 'public health welfare' (para 7.3.1)?

Agree

Don't agree

Comments and reasons:

44 Do you agree with the proposed conditions, powers and procedures for using these powers (para 7.3.2)?

Agree

Don't agree

Comments and reasons:

8 Contact Tracing

8.1 Introduction

Chapter 7 noted that action to prevent or minimise risks posed by people with communicable disease can be considered from two perspectives:

- measures relating to the person
- measures relating to other people.

Chapter 7 discusses measures that relate to the person concerned. This chapter asks whether the Public Health Bill should provide for measures that relate to people other than the person with the original infection. Such measures are conveniently termed ‘public health management’, which includes steps to minimise not only the risk of the person infecting others, but also the risks in the environment that may contribute to infection. Preventive and remedial measures relevant to environmental factors are to be included in the environmental health provisions of the Public Health Bill. These could include cleansing orders or disinfection, for example. These provisions are not discussed in this discussion paper (as indicated in chapter 2, some proposals for the Bill are already agreed in general terms) so this chapter covers only measures impacting more directly on the person.

A prerequisite for such measures is information obtained through contact tracing.

8.2 Contact tracing

Contact tracing involves ‘identifying and seeking out those people who have been in contact with a person with a communicable disease, with a view to controlling spread of the disease by either diagnosing, and treating further cases, or providing protection such as preventive treatment or immunisation’ (Ministry of Health 1997). This involves contacting people:

- who may have transmitted a condition of public health significance *to* the person with the condition
- who may be exposed to the condition *by* the person with the condition.

Contact tracing helps to trace the source or outbreak of the condition through past contacts. In this context a ‘contact’ includes ‘carrier’ – that is, a person who may not be sick, but who has an infectious agent capable of transmission to others. Tracing allows identification of circumstances triggering an outbreak or cluster of cases and therefore leads to preventive, remedial or even enforcement action. It enables contacts to take advantage of treatment for themselves, if needed, and prevent transmission to others.

Contact tracing is ideally undertaken by the person with the condition. The health professional consulted by the person is likely to suggest such action in appropriate circumstances. The health professional may either ask the person to get in touch with possible contacts or help the person to do so. If contact tracing by the person with the condition is not feasible, the health professional may undertake to do so. This involves asking the person for details about possible contacts and then ensuring that someone contacts them, as far as possible preserving confidentiality about the person with the original condition (anonymity would not be possible if, for instance, the contact's only partner is the person with the condition). Once communication has been achieved with the original person's contacts, further contact tracing may be attempted with other contacts.

People who are found to be contacts may be counselled and provided with information and opportunities for testing, preventive management and, if appropriate, treatment. Testing and diagnosis may be encouraged or required by various means. The provisions outlined in chapter 6 may be relevant. Non-compliance may result in other action, such as follow-up with the person's employers in the case of food-borne illness, for example.

8.2.1 Partner notification

This term is often used to mean the same as contact tracing. Here the concept of 'partner notification' is used to focus on whether health professionals should have a duty, or power, to notify known partners. The aim of such notification is to ensure that partners are informed of foreseeable risks and can, if necessary, protect themselves. While contact tracing may be done by public health staff (for example, after notification to a Medical Officer of Health by a general practitioner) it may also be reasonable in some circumstances for the general practitioner to contact known partners directly. Clearly, a prerequisite for such action would include failure by the person concerned to advise their own partner.

Legislative provisions for this purpose could permit the health practitioner to breach what would otherwise be their duty of confidentiality.

8.3 Present legislative background

The Health Act 1956 does not make explicit provision for tracing contacts of those with communicable diseases, but a few elements are set out in regulations.

Regulation 10 of the Health (Infectious and Notifiable Diseases) Regulations 1966, made under the Health Act, provides for the examination and treatment of contacts and carriers for specified infectious diseases as the Medical Officer of Health may direct. These are not necessarily *notifiable* infectious diseases. Under regulation 7 of the Venereal Diseases Regulations 1982, a medical practitioner must advise the Medical Officer of Health if a person with a venereal disease in communicable form fails to attend for treatment. A Medical Officer of Health may then, under regulation 8 of the Venereal Diseases Regulations, require a person who is believed to be suffering from venereal disease to submit to examination.

The Tuberculosis Act 1948 makes explicit provision for contact tracing (section 7), although this is not set out in great detail.

8.4 Present service delivery

Contact tracing is done in New Zealand now by various means. Public health units conduct contact tracing for notifiable diseases (which generally do not include sexually transmissible infections). General practitioners and sexual health clinics carry out some contact tracing for non-notifiable diseases – in particular, sexually transmissible infections. The latter appears to rely more on consent by the parties concerned than the former.

8.5 Is legislation needed for contact tracing?

As with many public health strategies – for example, immunisation and screening – most contact tracing is done without any need for legislative mandate. Hence, an initial question is whether provisions for contact tracing should be included in the Bill or whether it can be left to good practice.

Ideally, if it is thought desirable to communicate with the contacts of a person with a communicable condition, that person would either themselves encourage their contacts to seek testing and treatment or ask for authorisation from contacts to give their names and details to a relevant health practitioner. Justification for legislative provision arises where contact tracing is thought desirable or necessary for public health management but where authorisation from all parties is not forthcoming. An example is where the condition is connected with a breach of the Crimes Act 1961.

Contact tracing may conflict with privacy values in the following situations.

- A person with a condition involving risks to others may willingly disclose to a health professional the details of people from whom he or she may have contracted the condition, or to whom he or she may have given the condition, but makes that disclosure without authorisation from their contacts.
- A health professional may obtain the details of contacts of a person who has a condition involving risks to others where the person is reluctant to give that information.
- A health professional may independently communicate with contacts of a person who has a condition involving risks to others (such as a partner) without authorisation from, and perhaps not having informed, the person with the condition.

It is therefore important to be clear on whether contact tracing *without* full authorisation is helpful and whether it outweighs possible conflicts with privacy values.

If provisions on contact tracing are included in the Public Health Bill, they could make it clear that, except in specific circumstances (such as the commission of a crime that is connected with the condition), contact tracing without authorisation from all people concerned is possible only if other avenues have been tried first and not been successful. These avenues are:

- asking the person with the condition to do their own contact tracing
- obtaining authorisation from the person with the condition that contact tracing be done by a health service.

The rest of this chapter outlines possible legislative approaches.

8.6 Provisions for contact tracing

The most important legal issue concerns the prerequisites for contact tracing: what justifies the breach of confidentiality where contact tracing is done without authorisation?

Other issues are:

- duties of people with risk conditions
- procedures for contact tracing
- what information may be required
- how information may be used: the limits of contact tracing and protection of confidentiality.

8.6.1 Prerequisite conditions

Three options for determining the conditions in which contact tracing could be permitted without authorisation from all relevant people are discussed below, ranging in order from the most limited to the most discretionary. All options would be supplemented by a requirement in the particular case that contact tracing is needed on the grounds of public health risk.

Contact tracing could be permitted under the following options.

- *Option 1:* for notifiable communicable conditions that are specified in legislation as ‘contact traceable’.
- *Option 2:* for notifiable communicable conditions and also for non-notifiable communicable conditions where there is significant public health risk *and* the court has given an appropriate order.
- *Option 3:* for any notifiable communicable condition
- *Option 4:* for any communicable condition, whether or not notifiable, where a Medical Officer of Health has reason to consider that this is justified on the grounds of very significant public health risk.

In addition, the legislation could allow contact tracing in relation to any condition associated with an offence under the Crimes Act.

8.6.2 Duties of people with risk conditions

The Bill would provide that a person who has, or may have, a relevant condition, or who is a contact of such a person, must provide information to his or her medical practitioner or to the Medical Officer of Health, about the people with whom he or she has been in contact and who for that reason may have been exposed to the condition. The Bill could further specify that the person may be asked to co-operate with testing for diagnosis.

8.6.3 Procedures for contact tracing

Contact tracing that has the authorisation of all concerned, and is done either by the person with the condition or, with permission, by the person's health practitioner – including a practitioner from a sexual health clinic – needs no further legislative reference. The procedures outlined in the following paragraphs are based on the need for some tracing or disclosure without the authorisation of all concerned. In such circumstances it is appropriate to involve a statutory officer – that is, a Medical Officer of Health or other officer of a public health service – rather than the person's own health practitioner.

The only exception may be partner notification. Should the person's own health practitioner be permitted to advise a known partner of the possibility of exposure to a serious health condition, where the person refuses to do so of their own accord, without involving the Medical Officer of Health?

The Bill would specify the duties and powers of Medical Officers of Health and public health services in relation to the procedures and information required for contact tracing. An example of such provisions (with explanations in brackets) follows.

- (1) A Medical Officer of Health and or relevant public health unit may, when advised that a person in their area has a relevant condition for which contact tracing would be helpful because of its public health significance:
 - (a) request the person to:
 - i. advise possible contacts of risks associated with the condition, and
 - ii. ask them to provide information to health services and to seek testing and treatment as appropriate;or, if this is not feasible or ineffective:
 - (b) request information from the person with the condition; and
 - (c) request that person's authorisation to obtain information from other sources (eg, the person's medical practitioner and hospital, and workplace in the case of food-borne illness).
- (2) The information requested by the Medical Officer of Health or public health unit may include the following:
 - (a) the name and address or whereabouts of any person who may have transmitted the condition to the person, or to whom the person may have transmitted the condition; and
 - (b) any other information relevant to the circumstances in which the person may have acquired, or been exposed to, the condition, or may have exposed others to the condition or transmitted the condition to others.
- (3) The Medical Officer of Health or public health service may not disclose to the contacts of a person with a relevant condition details that identify that person, except in cases where it is not feasible to undertake contact tracing without providing this information.
- (4) The following information may be requested from a person who is a contact of a person with a condition:
 - (a) the person's name and address;
 - (b) the name and address or whereabouts of any person to whom the contact may have transmitted the condition;

- (c) information concerning the circumstances in which the person may have been exposed to the condition or may have exposed others to the condition.
- (5) Before requesting information as above, the Medical Officer of Health or the public health unit must inform the person of the reason for the request.

These provisions would apply only to conditions which are prerequisites for contact tracing (as discussed in section 8.6.1 above) and where the person with the condition has refused the request of a Medical Officer of Health or public health service to undertake contact tracing themselves or to allow health services to do so.

The Medical Officer of Health or public health service would then advise the person that he or she is required to provide the information necessary for contact tracing, and that he or she has a duty to comply with this requirement. If the person still does not comply, the legislation would enable the Medical Officer of Health or public health service to take reasonable steps to ascertain information relating to any contact of the person, having regard to:

- the degree of risk of the contact having contracted, or contracting, the condition
- the desirability of preserving as far as possible the privacy of all people affected
- any other relevant factors.

The contact could then be advised of his or her possible risk of exposure to the condition, or possible responsibility for the condition.

8.6.4 Limits on disclosure of information

The Bill would specify that no person other than the health professional, Medical Officer of Health or public health service would be entitled to disclose information obtained through contact tracing, except in specified circumstances. These would include the obligation to notify information in relation to any notifiable disease (in accordance with provisions in Chapter 4).

The Bill could also provide that the Medical Officer of Health or public health service must provide information on the condition to the person who has the condition, if that person is not aware of the information. Information should also be provided to the primary health care practitioner of the person with the condition, if authorised by the person and if the practitioner is not already aware of the person's condition.

Questions for comment

45 Do you think legislative provision for contact tracing is needed (paras 8.2 to 8.5)?

Agree

Don't agree

Reasons and comments (eg, on resource and service implications):

46 If you do agree, for which of the following conditions should contact tracing be permitted (para 8.6.1)? Please indicate which option.

- Option 1:* A notifiable communicable condition specified in legislation as 'contact traceable'.
- Option 2:* A communicable condition whether 'notifiable' or not (on a court order).
- Option 3:* A communicable condition specified as notifiable (but no requirement for a separate specification as 'contact traceable').
- Option 4:* A communicable condition whether notifiable or not.

Comments and reasons:

47 Do you think the Bill should provide for contact tracing where the condition is associated with an offence under the Crimes Act (para 8.6.1)?

- Agree
- Don't agree

Comments and reasons:

48 Are there any other options for which conditions might justify contact tracing?

Please give reasons:

49 It is proposed that the Bill should specify the duty of people with risk conditions to provide information and assistance (para 8.6.2).

- Agree
- Don't agree

Comments and reasons:

50 Should the Bill make specific provision for partner notification (eg, where a person's health practitioner knows the identity of the person with the condition) and allow for that partner to be advised by the health practitioner of possible exposure (paras 8.2.1 and 8.6.3)?

- Agree
- Don't agree

Comments and reasons:

51 Do you agree with the procedures proposed for contact tracing, which emphasise first obtaining authorisation and then invoking powers to require information where this is not possible (para 8.6.3)?

- Agree
- Don't agree

Reasons and comments (eg, on specific aspects of this approach as well as costs and service implications):

9 Border Health Protection

9.1 Introduction

In this chapter the term ‘border health protection’ is used in a sense similar to the traditional term ‘quarantine’ in describing a domain of health law. Border health protection is a broader concept than quarantine, as it includes protection measures before as well as after a person has crossed the border, and conveys more of the aims of the provisions. This chapter sets out possible objectives for border health protection, and then discusses *how* such objectives should be implemented.

The fundamental question is: what can New Zealand, a small country that is relatively isolated but increasingly open to the rest of the world, feasibly do to protect itself from risks associated with communicable conditions that may be imported from other countries?

Subsidiary questions are: What functions relevant to border health protection should be set out in the Public Health Bill? Should any roles and functions be transferred from health legislation to legislation administered by other agencies, in particular the Biosecurity Act 1993 and the Hazardous Substances and New Organisms Act 1996?

9.2 Background

The Health Act 1956, and regulations made under it, contain a range of provisions dealing with quarantine issues. The related functions and activities are a traditional responsibility of public health staff. The development of proposals for the Public Health Bill provides an opportunity to revisit first principles of border health protection and decide what is appropriate for the 21st century.

This is a complex task. Border health protection law is implemented by several agencies with their own statutory frameworks and purposes distinct from, but overlapping with, health purposes. The main agencies are the New Zealand Customs Service (Customs) and the Ministry of Agriculture and Forestry (MAF), as well as immigration authorities. Border health protection is also directly relevant to trade and tourism and, clearly, must fulfil international obligations.

9.3 Purposes and objectives of border health protection

The overall purpose of border health protection is to prevent the transmission of disease to people in New Zealand either by people from overseas (returning travellers, visitors and immigrants) who have been infected or by animals, vectors, organisms or other pathogens carried to New Zealand by people, craft or goods.

Possible objectives of border health protection are described below. For convenience, transmission of disease by people infected with the disease has been separated out from transmission of disease by animals or other organisms (eg, rats or mosquitoes) or other goods (eg, anthrax spores on imported animal hair). Some of these objectives could relate to intentional introduction and transmission, as well as non-intentional.

- *Objective 1:* Preventing the introduction and transmission of diseases to people in New Zealand by people arriving in New Zealand who are sick or who show symptoms of sickness or who have been exposed to a particular source of infection – in particular, diseases that are new to New Zealand or which have major public health significance.
- *Objective 2:* Preventing the export of infections that may be transmitted through people who are sick, or through animals or organisms or pathogens capable of causing ill health or infection, from New Zealand to other countries.
- *Objective 3:* Ensuring that international craft, and humans, animals, vehicles and goods transported by such craft, minimise the risk of entry into New Zealand of animals, vectors, organisms or other pathogens which are capable of posing a threat to human health and which may be communicated through food, water or other means, or carried by humans, animals, vehicles or goods. ('International craft' includes all craft which can travel internationally, including ships, boats, aircraft, balloons, submarines and so on.)
- *Objective 4:* Ensuring that ships meet minimum environmental health standards in order to minimise illness in their crew and passengers.
- *Objective 5:* Ensuring that goods from other countries, including goods sent through postal systems, do not contain animals, vectors, organisms, plants or any source of infection or substance of risk to public health that may harm the health of people in New Zealand.
- *Objective 6:* Fulfilling international health obligations.

9.3.1 Discussion

Various issues arise from the above comprehensive list. Not all of the objectives are implemented by New Zealand's health authorities, and some only to a very limited extent. In particular, border protection authorities such as Customs and MAF have the main responsibility for ensuring that unwanted animal vectors and other organisms do not enter New Zealand. While such prevention of unwanted vectors is aimed at objectives that, in principle, are not about human health, but rather about protection of the environment or animal health, human health objectives may indirectly benefit.

Should the Public Health Bill omit reference to such vector-prevention objectives, given that these may be met by other agencies under other legislation or should they be retained to give health authorities a formal mandate for a last resort or default role in vector prevention? This issue is discussed below in relation to Objectives 3 and 4 (see section 9.7).

Objective 1, minimising the introduction and spread of infection, is at present focused in legislative terms on ‘quarantinable’ diseases. These are defined in New Zealand’s legislation as those specified in the International Health Regulations (World Health Organization) – at present yellow fever, cholera and the plague.

It may be considered that Objective 4, minimising ill health in the crew and passengers of ships from overseas, is not appropriate for New Zealand border health protection. There are, however, two rationales for including such an objective. First, unsatisfactory insanitary conditions that cause ill health in ships’ crews or passengers may have indirect health consequences for New Zealanders. In addition, it may be reasonable to acknowledge explicitly the value, as an end in itself, of protecting the health interests of foreign crews, some of whom may be vulnerable to exploitation.

At present there is little legislative mandate for Objective 5 under health legislation. The only example is the Anthrax Prevention Regulations (1987) under the Health Act, which relate to anthrax spores on such items as hairbrushes. If legislative provisions of this kind are to be included in the Public Health Bill (rather than being transferred to the Biosecurity Act), it may be helpful to generalise this responsibility to include other products transported by post, taking into account international movement in bio-hazardous substances and laboratory specimens. This could raise issues relating to bioterrorism and the question of whether it is appropriate that health legislation has a supporting role in that area.

Quarantine legislation at present is focused almost entirely on communicable diseases. Some of the above objectives are, however, capable of covering harm that extends beyond such diseases – they could apply to people who have been poisoned by snakebites, for example. It may be important to have legislative mandate for ensuring that such poisonings can be notified – to ensure that an agency such as MAF checks the person’s luggage for pests, for example.

Objective 6 relates to fulfilling international legal obligations. These are contained in the International Health Regulations, most of which are concerned with restricting the global spread of communicable diseases. These requirements form a minimum to be implemented by New Zealand law, although our law may expand on these requirements for our own purposes. The International Health Regulations are being revised at present. The Public Health Bill need not use the same concepts or provisions as in the present or proposed WHO International Health Regulations, but must be consistent with them.

Discussion is needed on whether the objectives outlined here are appropriate and relevant, and whether any others should be developed. Assuming that, in general, they are along the right lines, it then needs to be decided whether all or just some should be included in the Public Health Bill or whether some should be transferred to other legislation.

If included in the Public Health Bill, the provisions could recognise that at least several of these functions may be implemented largely or partially by other agencies, but still leave the door open for public health action as necessary.

9.4 Legislative strategies

Are the present means and strategies provided in the legislation for implementing border health protection objectives effective, fair, humane, reasonable and efficient? And how far could they be improved in developing the Public Health Bill?

The remainder of this chapter summarises key provisions for the objectives set out above, then assesses how they could be improved.

It is convenient to distinguish between provisions which directly affect people (that is, those who are, or may be, ill or who have symptoms of some kind) and provisions which relate more to things (that is, craft and the range of pathological agents that can be transported by those craft). Issues relating to people clearly have very different legislative implications than those for vehicles and goods, particularly with regard to rights.

9.4.1 Quarantine and pratique

Internationally recognised concepts that are fundamental to border health protection are:

- quarantine (and liability to quarantine)
- pratique (and grant, or denial, of pratique).

These terms are not formally defined in New Zealand legislation, although their contexts indicate their meaning.

‘Quarantine’ can be taken to mean a lack of entitlement to ordinary freedoms, such as freedom of movement, which may be applicable to craft and people entering a country. Its purpose is to prevent possible communication of disease. The concept is related to ‘pratique’, which is similar to ‘licence’. A craft or person does not have a ‘right’ to enter New Zealand unless a licence (ie, pratique) is granted. Until pratique is granted, the craft or person is liable to quarantine and whatever conditions are set out in quarantine law may apply for that time.

While it is reasonable to ask whether these concepts and terms are still relevant to border health protection in this century, they are well understood and internationally used. The twin concepts of quarantine and pratique can provide an effective mechanism for achieving at least some border health protection objectives – that is, people or craft cannot enter New Zealand unless the relevant requirements are fulfilled to the satisfaction of the relevant health authority.

9.4.2 Current provisions

The current provisions, in simplified form, are as follows.

- Section 96 of the Health Act provides that ships and aircraft arriving in New Zealand from any place outside New Zealand are liable to quarantine.
- Section 97 provides that a person is liable to quarantine if on board a ship or aircraft that is liable to quarantine.

- Section 98 provides that a ship or aircraft continues to be liable to quarantine until pratique is granted and that a person continues to be liable to quarantine until released from quarantine under regulations made under the Act.
- Ships subject to quarantine must accordingly have a visibly recognisable signal on the ship.

It is proposed that provisions similar to these remain in the Public Health Bill.

9.5 Legislation to implement Objective 1

The Health Act provides that:

- a person liable to quarantine may not leave a ship except with authorisation
- if a person on a ship or aircraft that is subject to quarantine is suffering from any infectious or quarantinable disease, the Medical Officer of Health may examine that person, subject to regulations (section 101)
- if a person on a ship has a quarantinable disease, or is reasonably believed to be suffering from or to have been exposed to a quarantinable disease, the Medical Officer of Health or Health Protection Officer may do anything, including give directions, as prescribed by regulations (section 108)
- the person in charge of the ship must ascertain the state of health of everyone on board and then complete a maritime declaration (section 102)
- a ship with someone on board who has a confirmed or suspected quarantinable disease (ie, yellow fever, plague or cholera) must berth only at a 'place of inspection' unless otherwise instructed
- the captain of an aircraft must assess whether a person on board has become ill and whether any condition on board may lead to the spread of disease. If so, the captain must notify the airline agent, who must notify the Medical Officer of Health.

The Health (Quarantine) Regulations 1983 specify the procedures for people suffering from, or reasonably believed to be at risk of, a quarantinable disease. The Medical Officer of Health may:

- detain the person for examination
- place and keep the person with the suspected quarantinable disease under surveillance for up to six days
- remove the person to hospital to be detained until no longer suffering from disease.

The Health (Quarantine) Regulations also specify the following duties for people who have, or may have, a quarantinable disease. They must:

- give such information as their name, address, destination and movements during the preceding six days to the Medical Officer of Health or Health Protection Officer
- comply with all directions or conditions imposed by the Medical Officer of Health
- if placed under surveillance, present themselves for examination and provide information and reports as required by the Medical Officer of Health.

Potential immigrants, that is people who have applied for permanent residence in New Zealand, are also subject to the Immigration Act 1987 and Immigration Regulations 2000. All applicants intending to be in New Zealand for two years or more must under immigration policy undergo a formal medical screening (and such screening may be requested of any other applicant).

9.5.1 Discussion

The emphasis on ‘quarantinable’ diseases restricts the scope of these provisions. Quarantinable diseases must include, although need not be limited to, those diseases which are termed quarantinable by the World Health Regulations. It could be argued that the distinction in New Zealand law between quarantinable and other communicable diseases, though traditional, is not justifiable in terms of the respective public health risks. At present it seems that most people who come into the country with communicable diseases are not identified.

Since New Zealand’s quarantine legislation originated, there has been an ‘enormous increase in both speed and volume of international movement of people for the purposes of migration, business and tourism. It is now possible to travel the globe in less time than the incubation period for most diseases’ (Human Quarantine Review, Commonwealth Department of Health and Aged Care). Travel by sea was the only possibility when quarantine legislation was first developed but now, of course, most people travel by air. These changes have meant that, on the one hand, the need for border surveillance and control of communicable diseases has become more important while, on the other, effective border control has become more difficult.

9.5.2 Proposals

It is suggested that provisions in the Public Health Bill be based on the following ideas.

- The present distinction between quarantinable and non-quarantinable diseases should be de-emphasised, so that the provisions apply to a greater range of conditions (while including the conditions specified by WHO).
- Some of the powers available to the Medical Officer of Health – in particular, the powers to detain, place under surveillance and remove to hospital – may not be appropriate or justifiable, particularly in light of the Bill of Rights Act, without procedural safeguards and provisions to make it clear that they are measures of last resort.
- Notification of possible risk conditions should be the main aim of border health protection in relation to people who have, or may have, infectious diseases of public health significance. Notification would then allow decisions to be made about appropriate case management and public health management.

Details of these proposals follow.

9.5.3 Conditions

Border health provisions would apply to:

- all notifiable conditions as discussed in chapter 4. This would include all WHO ‘quarantinable’ diseases and take account of any new WHO criteria
- any other condition which, though not notifiable, is communicable and of public health significance – that is, a condition which fulfils the criteria for making a condition notifiable even though New Zealand regulations may not yet recognise it as such because, for example, the condition is relatively new or re-emerging.

Should non-communicable diseases also be included? For instance, would it be useful to be able to identify temporary visitors with significant health issues who may require significant assistance during their stay in New Zealand?

What time period, if any, should be associated with notification of conditions covered by the second criterion? The incubation period of the condition might be relevant.

9.5.4 Notification obligations and consequences

The provisions would be reasonably broad in relation to notification obligations. They could simply state that a person must, as specified in regulations, notify the appropriate authority with information concerning a person at the border, including (as specified in regulations) both passengers and crew. Regulations would specify the information to be notified, what the appropriate authority is, and the means by which information should be notified.

This permissive approach could enable different requirements for notification, either as a general obligation or ‘by exception’ (eg, if a passenger has specific symptoms). It may be desirable to recognise that established international liners owned by recognised companies need report only if they have someone with symptoms on board, whereas other vessels would be obliged to report in all cases.

The Bill would then set out the consequences of notification. In general, no consequences would occur at the border for a person diagnosed or provisionally identified with a relevant condition. Nothing would depend on whether the person was diagnosed at the border or later on arrival at their destination (except perhaps for emergencies). There would be no difference between what a Medical Officer of Health may do, as outlined in chapter 6, in respect of such people compared with those who have been infected with the same condition within New Zealand. Hence, if a person arrives in New Zealand with a serious infection, the Medical Officer of Health could decide, if appropriate, that the person should be referred for a visit to a general practitioner or counselled or placed under supervision. Decisions about using a more restrictive power (such as detention) could be made only by a court (if that is what is decided in relation to the options set out in chapter 6). The same review and appeal rights as set out in that chapter would apply.

One exception to this general scheme would apply to travellers who do not have New Zealand or Australian citizenship. Such travellers identified at the border as not having an acceptable standard of health (in terms of immigration policy) could be denied entry into New Zealand under immigration law.

9.5.5 Border health protection emergencies

It may be desirable to define a ‘border health protection emergency’. This would be an emergency having potential adverse public health effects, which may be:

- a health emergency of international concern – that is, an emergency affecting the population of one or more countries other than New Zealand, with potentially significant effects for countries other than the originating country
- a health emergency arising in New Zealand or part of New Zealand which may affect the populations of one or more other countries
- the arrival, or anticipated arrival, in New Zealand of a group of people who, on account of their health status, or some other factor, pose a risk to the public health of New Zealand that cannot be managed by the ordinary provisions.

A health emergency arising in a specific part of New Zealand, and which may affect New Zealanders in other parts of New Zealand, would not be dealt with under border health protection provisions but under provisions for public health emergencies elsewhere in the Public Health Bill.

A declaration of a border health emergency would permit the availability of more restrictive powers than would be possible in normal circumstances. These could include the power to detain, treat or isolate without a court order and for a period longer than the 72-hour emergency orders.

9.6 Legislation to implement Objective 2

In the present legislation there are few explicit mechanisms for meeting Objective 2 (that is, preventing the export of infectious agents *from* New Zealand). Some general provisions in the Health Act are relevant, including those on water supplies, sanitary works and nuisances. While these provisions are not aimed at preventing export of sources of infection, the emphasis on safety for internal consumption reduces the possibility of exporting infectious agents. The Food Hygiene Regulations 1974 are also relevant. The general power given to Medical Officers of Health to restrict movement could arguably be used to stop or delay a person travelling from New Zealand. This is important for New Zealand’s capacity to act as a responsible member of the international community.

It is proposed that the present provisions for export of pathogens from New Zealand, whether via people, goods or craft, should either be broadened in the Public Health Bill and made more explicit or possibly transferred to the Biosecurity Act. Regulation-making powers would also be needed.

9.7 Legislation to implement Objectives 3 and 4

The present legislative scheme related to managing risks of entry into New Zealand or animals, vectors, and other pathogens capable of harming human health is framed around the duties of people in charge of ships and aircraft (and their crew and passengers) when arriving in New Zealand. In addition, the legislation sets out the powers of Medical Officers of Health and Health Protection Officers in relation to people, their craft and

things on board the craft (such as baggage and vehicles). More general provisions in the Health Act relating to nuisances are also relevant.

The present provisions in simplified form are as follows.

- Subject to regulations, the person in charge of a ship liable to quarantine may not, except with authorisation, do such things as bring the ship to berth, let any person on shore, or let any goods be transhipped (section 99).
- The Medical Officer of Health has the power to board and inspect any thing.
- The Medical Officer of Health or Health Protection Officer may do anything or give any directions (as prescribed by regulations) if in their opinion any quarantinable disease is likely to be spread by baggage, linen or bedding (section 109).
- If the Medical Officer of Health or Health Protection Officer considers that a ship is in an insanitary condition ('insanitary' is not defined), or in a condition favourable to the outbreak or spread of any notifiable infectious disease, they may (whether the ship is in quarantine or not) serve an order that the ship be cleaned (section 110).
- If an aircraft arrives somewhere other than at a Customs airport, no one may leave the aircraft until permitted by the Medical Officer of Health.
- Spraying may be done to get rid of animal hosts and other causes of diseases borne by water and air.

The main issue in relation to these objectives is, as noted, whether health services should have any involvement in border issues relating to organisms or things capable of threatening human health, rather than only in relation to border issues concerning people who are sick or symptomatic. The present statutory framework (including the Health Act, the Biosecurity Act and the Hazardous Substances and New Organisms Act) does not provide a clear division of responsibilities or allocation of roles. Although there are practical ways of resolving the difficulties created – by memoranda of understanding between the agencies involved, for instance – it may be helpful to clarify the different roles in legislation. On the other hand, it may be useful for health authorities to retain a formal mandate for vector prevention which may be used in cases where deficiencies develop, from a human health point of view, in the way services are provided by other agencies.

The Ministry of Health is not committed to either option at this stage, and accordingly invites discussion. The choice is either:

- a statutory division of responsibilities, with the Public Health Bill providing for matters relating to people arriving in New Zealand who appear to be sick or to have symptoms of various sorts, and the biosecurity and hazardous substances legislation addressing all other issues concerning potential risks to human health as well as more general risks
- or
- the Public Health Bill allowing, but not requiring, public health services to have a role in all issues with potential risks to human health, with the details of who does what being worked out at agency level according to what seems most sensible at the time and confirmed by such mechanisms as memoranda of understanding.

This choice also applies to Objective 5, as discussed below.

9.7.1 Issues and proposals for the broader role

This subsection discusses what provisions should be in the Public Health Bill on the assumption that it is decided to keep a potential or default role for health services at the border for matters relevant to organisms, vectors and pathogens.

Some issues raised are described below.

- Are there any risk-management approaches that could be recognised in legislation – for example, in relation to the responsibilities of incoming craft. Should the legislation make, or at least enable, a distinction between ‘regular’ commercial craft and private craft or between craft with a good compliance record and others?
- Legislation may also allow the Medical Officer of Health or Health Protection Officer to apply risk-management or prioritisation principles as a basis for decisions on whether to inspect and monitor incoming craft. Should criteria for using such discretion be provided?
- The present provisions are restricted in that they refer to specific types of animal vector or causes of illness. How could they be made more general?
- Primary legislation should include the authority, if prescribed by regulations, to require international craft to produce proof of their sanitary status (eg, deratting certificates), but is there a need to mention specific types of certificate in primary legislation?
- The Medical Officer of Health has the power to require the captain of a ship to take such steps as are necessary to prevent the spread of infection, destroy insects and vermin and remove conditions likely to convey infection. Are these powers broad enough?
- Should the legislation provide for appeals? To which areas should this provision apply?
- Should the Bill explicitly provide for cross-references to other agencies being able to take on any or all of the above functions under other legislation? Should a role for inter-agency agreements be mentioned?

It is proposed that the Bill allow for wide potential powers of inspection and action and that it provide considerable discretion in:

- whether these powers are used
- whether risk-management systems be employed to guide the level and focus of monitoring activities
- the extent to which monitoring and surveillance activities are carried out by agencies other than health authorities.

The Bill could allow for, but not require, ‘pratique by exception’ or self-reporting to be available to all craft, including ships. It is proposed that, in such cases, the Medical

Officer of Health or Health Protection Officer would continue to have the power to make inspections.

The Bill would have no specific focus on the WHO quarantinable diseases in relation to environmental health. Instead, the Medical Officer of Health or Health Protection Officer would have wide powers to require reports, to inspect and to take actions in respect of any organism or pathogen or other indicator of insanitary conditions that may pose a threat to public health.

The legislation would provide for appeals against the actions of the Medical Officer of Health or Health Protection Officer and possibly compensation (where an employee acts in bad faith or without due care, for example).

9.8 Legislation to implement Objective 5

The main enactment to meet Objective 5 is the Anthrax Prevention Regulations 1987, which prohibit the import into New Zealand of hairbrushes made from animal hair or bristle without the approval of a health authority. In addition, the Minister of Health may, by notice in the *Gazette*, prohibit the importation of a good produced from animal products if anthrax is likely to be conveyed. Other provisions relate to disinfection.

The same issues relating to Objectives 3 and 4 apply here in the choice of an appropriate legislative vehicle for preventing the entry of unwanted organisms through goods. It is possible that the power to search mail for anthrax-contaminated brushes was included in the Health Act because, at the time, the Biosecurity Act did not exist.

If it is decided, following consultation, that the Public Health Bill should retain the function of preventing the entry of pathogens on goods, no matter how such goods are transported into New Zealand, it is proposed that this be explicitly recognised in appropriate regulation-making powers. The scope may need to be extended so that powers relating to imported goods are not confined to organisms, but include any substance with a public health risk (ie, hazardous materials not covered by the Hazardous Substances and New Organisms Act) (for example, graphic materials which may present a risk of poisoning).

Questions for comment

52 Do you agree in general terms with the outlined objectives for border health protection (para 9.3)?

Agree

Don't agree

Comments, reasons, any deletions, amendments or new ones to suggest:

53 Two options for legislation on border health legislation are proposed. They are that the Bill should (paras 9.3 and 9.3.1, also para 9.7):

Option 1: cover only issues relating to returning New Zealanders and incoming travellers who are sick or symptomatic – so that issues concerning pathogens and

infectious agents carried by animals, vehicles, goods or other things would be dealt with other legislation

or

- Option 2:* also include potential or default powers, and hence a role for health agencies, on pathogens and infectious agents carried by animals, vehicles, goods and other things.

Please indicate which option you favour. Comments and reasons:

- 54 It is proposed that the main aim of border health protection in the Bill – as it relates to returning New Zealanders and incoming travellers – should be to provide opportunity for notification, and hence follow-up, of any significant communicable disease. Health authorities would have the same powers that they would have for a person developing the communicable disease in New Zealand (except in emergencies) (paras 9.5.2 and 9.5.4).

- Agree
 Don't agree

Please give reasons for your answer:

- 55 Do you agree that the concepts of quarantine and pratique should be retained and applied much as at present (paras 9.4.1 and 9.4.2)?

- Agree
 Don't agree

Comments and reasons:

- 56 Do you agree with reducing the present emphasis of the Health Act on quarantinable disease and focusing instead on a much wider range of diseases and conditions (including, but not limited to, those which are currently quarantinable) (paras 9.5.2 and 9.5.3)?

- Agree
 Don't agree

Comments and reasons:

- 57 Should there be some provision for border health protection to apply to non-communicable conditions in order, for example, to inform health agencies of potential resource demands (para 9.5.3)?

- Agree
 Don't agree

Comments and reasons:

- 58 Do you agree that the Bill should allow for more restrictive powers to be available in border health emergencies than would be available under normal circumstances (para 9.5.5)?

- Agree
 Don't agree

Comments and reasons:

59 Should the Bill make more explicit recognition of the duty to prevent the export of pathogens *from* New Zealand to other countries (para 9.6)?

Agree

Don't agree

Comments and reasons, resource implications:

60 Do you agree that the Bill should allow for wide potential powers of inspection and actions in relation to craft, but that it should also allow for considerable discretion in the use of these powers (para 9.7.1)?

Agree

Don't agree

Comments and reasons:

61 Do you think there should be more explicit provision (whether in the Public Health Bill or other legislation) for border health protection to apply to items sent through the post and that this should include substances as well as organisms and pathogens (para 9.8)?

Agree

Don't agree

Comments and reasons, resource implications:

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Glossary

Acquired immunodeficiency syndrome (AIDS)	A serious disease of the immune system, caused by infection with the human immunodeficiency virus (HIV), allowing the establishment of particular diseases which may cause the death of the affected person.
Adverse event following immunisation	Any adverse event that follows immunisation (all such events are not necessarily caused by the vaccine).
AIDS	See acquired immunodeficiency syndrome.
Chronic	Of a disease, lingering or lasting; having an effect over a prolonged period of time.
Communicable disease	See infectious disease.
Condition	A term proposed in this paper as a general concept to include disease and, in addition, any physical change or abnormality of concern or injury or risk factor. The term would include pre-clinical changes which have not yet reached the disease stage, as well as clusters of symptoms (see ‘syndrome’).
Contact tracing	Identifying and seeking out those people who have been in contact with a person with a communicable/infectious disease with a view to controlling spread of that disease by either diagnosing and treating further cases or providing protections, such as preventive treatment or immunisation or advice and information.
Determinant (of health)	The range of personal, social, economic and environmental factors that determine the health status of individuals or populations.
Director-General of Health	The chief executive or acting chief executive of the Ministry of Health.
Director of Public Health	Appointed by the Director-General of Health under section 3B of the Health Act 1956 to advise on matters of public health.
District	A geographical area specified under the Health Act 1956 (and in future under the Bill) which has a Medical Officer of Health (and in future relates to a designated public health unit). These districts are based on districts of territorial local authorities mandated under the Local Government Act 1974.
District Health Board	An organisation established under the New Zealand Public Health and Disability Act 2000 to have objectives and functions set out in that Act relating to improving, promoting and protecting the health of the people in its district. At present public health units are located in, or associated with, District Health Boards.
ESR	The Institute of Environmental Science and Research Ltd, a Crown entity which provides services relating to communicable diseases, food safety, population and environmental health and water quality (among other things).

Food Safety Authority	The New Zealand Food Safety Authority, a semi-autonomous body attached to MAF, was established on 1 July 2002.
Gazette	The <i>New Zealand Gazette</i> published under the authority of the New Zealand government. It provides official notice of such matters as the making of a regulation or rule.
Health impact assessment	A combination of procedures, methods and tools by which a policy, programme or project may be assessed and judged for its potential, and often unanticipated effects on the health of the population, and the distribution of those effects within the population.
Health Information Privacy Code	The code promulgated in 1994 under the Privacy Act 1993. The code is a regulation under the Act.
Health protection officer	An officer designated by the Director-General of Health to undertake statutory public health functions and the exercise of statutory powers and responsibilities attached to that position.
HIV	See human immunodeficiency virus.
Human immunodeficiency virus (HIV)	The virus that, by infecting and killing cells of the immune system, weakens the resistance of the body making it susceptible to a number of particular diseases. When a person infected with HIV develops one of those diseases, the diagnosis of AIDS is established.
Immunisation (synonym: vaccination)	Protection of susceptible individuals from communicable disease by administration of a living modified agent, a suspension of killed organisms or an inactivated toxin (see vaccine).
Immunisation schedule	The National Immunisation Schedule which is set out in the Immunisation Handbook 2002.
Incidence	The number of new cases or events, such as deaths, that occur in a given period in a specified population.
Infectious disease (synonym: communicable disease)	An illness due to a specific infectious agent or its toxic products that arises through transmission of that agent or its products from an infected person, animal or reservoir to a susceptible host. It may be transmitted directly, or indirectly through an intermediate plant or animal host, vector or the inanimate environment.
International Health Regulations	Regulations of the World Health Organization which aims to ensure the maximum security against the international spread of diseases. Contains provisions relating to ‘quarantinable diseases’ for example the plague, yellow fever, cholera. These regulations are being revised.
Intersectoral	Involving various sectors of the community. The sectors would vary according to the context of discussion, but could include various government agencies, non-governmental organisations, and private interest groups, businesses and organisations.
Kaitiaki Regulations	The Health (Cervical Screening (Kaitiaki)) Regulations 1995 govern access to, use and publication of Māori women’s aggregate data from the National Screening Programme Register. ‘Kaitiaki’ means caregiver or guardian.

Medical Officer of Health	An officer designated by the Director-General of Health to undertake public health statutory functions and to exercise the statutory powers and responsibilities attached to that position within a specified health district, and who holds the requisite medical professional qualifications.
Morbidity	Illness, sickness.
Mortality	Death.
National Cervical Screening Programme	A programme operated by the Ministry of Health; established in 1990/91 to organise cervical screening with the aim of reducing the number of women who develop cervical cancer; relevant legislative provisions in section 74A of the Health Act 1956.
National immunisation register	This refers to a project to establish a register to increase immunisation coverage in New Zealand. This project is (at November 2002) still in the process of development.
Non-communicable disease	A disease which is not communicated from one person to another; for example, diabetes. The term is usually used in reference to major and chronic non-communicable diseases, including many cancers, cardiovascular disease, diabetes, osteoporosis, arthritis etc.
Notifiable disease	Under present New Zealand law, a disease that is notifiable under section 74 of the Health Act 1956 and specified in the First Schedule or under section 3 of the Tuberculosis Act 1948. Proposals in this paper would, if enacted, supersede the present legal regime in a new Bill.
Notification	An obligation specified in law to notify a specified authority (in health law, usually the Medical Officer of Health) in relation to information about a person. This information usually concerns a disease (see notifiable disease), but this paper proposes its extension to include conditions.
Ottawa Charter	The charter developed and adopted by the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986. This charter defines health promotion as the process of enabling people to increase control over, and to improve, their health. Health promotion action means: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services.
Pathogen	Disease-producing micro-organism or material.
Population health	Often a synonym of public health, sometimes also used to describe services that straddle the boundary between public health and personal health (eg, immunisation or screening programmes).
Pratique	The Health Act 1956 refers to a certificate or grant of pratique, which has the effect that quarantine restrictions and other measures no longer apply.
Prevalence	The number of instances of a given disease or other condition in a population at a given time. Prevalence includes both new (incidence) and existing instances of a disease.

Primary legislation	An Act. It is ‘primary’ because it is the authority under which secondary or subordinate, legislation can be made (regulations) and also tertiary legislation (such as some rules, codes or bylaws).
Primary prevention	This aims to limit the incidence of a disease, condition or injury by influencing causes and risk factors.
Privacy impact assessment	A systematic process for evaluating a proposal in terms of its impact upon privacy and for identifying how any detrimental effects might be lessened.
Public health	As defined in the New Zealand Public Health and Disability Act 2000, means the health of all of the people of New Zealand or a community or section of such people. Another definition, among many others, is the science and art of preventing disease, prolonging life and promoting health through organised efforts of society.
Public health order	A concept proposed in this paper for the Bill. It would mean an order issued by a court requiring a person to take specified action or empowering action to be taken in respect of the person on public health grounds.
Public health services	Goods, services and facilities provided for the purpose of improving, promoting or protecting public health to prevent population-wide disease, disability or injury (see New Zealand Public Health and Disability Act 2000).
Public health unit	Funded by the Ministry of Health, these units provide local or regional public health services, particularly those relevant to legislative requirements, and also general health protection and health promotion services. The units employ Medical Officers of Health and Health Protection Officers among others. There are at present 12 public health units (or 13, depending on criteria) based in district health boards.
Quarantinable disease	These are defined in the Health Act as those specified in the World Health Organization’s International Health Regulations (at present yellow fever, cholera and the plague). People with a quarantinable disease may be subject to quarantine. This paper proposes that the Bill provide that quarantinable diseases include more than those presently specified by the Health Act.
Quarantine	In a general sense, quarantine means measures (in particular, restrictions on movement, but also other measures) relating to vehicles, goods, and people to which quarantine applies (generally, craft coming to New Zealand and incoming travellers). The aim of quarantine is to prevent or control the introduction or spread of diseases or pests. In some contexts quarantine refers more specifically to segregation of people with a confirmed or suspected infectious disease.
Register	Record containing details of a person and relevant information as appropriate to the purpose of the register. The registers envisaged in this paper would usually include contact details as well as information such as test results relating to a specific health issue.

Regulation	Used in this paper to mean subordinate or secondary legislation (that is, legislation made under the authority of an Act (primary legislation)). The term is sometimes used in a wider sense as equivalent to legislation.
Risk factor	An aspect of personal behaviour or lifestyle, an environmental exposure, or an inborn or inherited characteristic that is associated with an increased risk of a person developing a disease.
Schedule	Part of an Act (or regulation), usually at the back of the Act or regulation, and similar to an appendix. It usually contains material too detailed to be conveniently included in the main body of the Act or regulation; often set out in tabulated or list form.
Screening	Testing people for a particular disease or condition when they do not have symptoms of the disease or condition but may, for any reason, be at risk of its development.
Secondary prevention	Aimed at early detection of a disease or condition, and prompt and effective intervention and treatment, with the result that the more serious, consequences of the disease are avoided.
Sexually transmissible infection (or disease)	Infection, or disease spread by the transfer of organisms from person to person during sexual contact.
Surveillance	Ongoing scrutiny, generally using methods distinguished by their practicability, uniformity and, frequently, their rapidity, rather than by complete accuracy. Its main purpose is to detect changes in trend or distributions in order to initiate investigative or control measures.
Syndrome	A set of symptoms which occur together.
Territorial authorities	District, city or unitary councils
Vaccinate	To inoculate with a vaccine with the aim of providing immunity to a corresponding infectious disease.
Vaccine	An immunobiological substance used for active immunisation by introducing into the body a live modified, attenuated or killed inactivated infectious organism or its toxin.
Vaccine-preventable disease	A disease that is preventable by vaccination (that is, immunisation). For example, measles, rubella and pertussis (whooping cough).
Vector	A living carrier (generally an insect; for example, a mosquito) which transfers an infectious agent from an infected individual (or its wastes) to another individual or its food or immediate surroundings.
Venereal disease	This term, now outmoded, is the equivalent of sexually transmissible disease. The Venereal Diseases Regulations (1982) are made under the Health Act 1956.

Submission Booklet

Public health legislation

Promoting public health, preventing ill health and managing communicable diseases

Please have your say on the topics covered in this discussion paper. Completing this booklet is one way to make your submission – a template for the booklet is also available electronically on the Ministry of Health website www.moh.govt.nz/forums.html.

If you need more space than is provided here, please attach additional pages.

The postal address is:

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WELLINGTON

The email address is: phb@moh.govt.nz.

The closing date for submissions is: Friday 28 March 2003.

Making a submission

Factual background and reasons would be helpful in explaining your views. Please also indicate information about costs and resource implications where appropriate.

Please fill in the following details:

This submission was completed by: _____ (name)

Address: (street/box number): _____
(town/city): _____

Email: _____

Organisation: (if applicable) _____

It would be helpful to include some details about your organisation.

What happens to your submission

Your submission will be acknowledged by the Ministry. A summary of submissions will be placed on the Ministry of Health website when completed.

Submissions will be available to the public. Any request for confidentiality will be subject to the Official Information Act 1982. If you are an individual making a submission, the Ministry of Health can remove your personal details from the submission if you check the following box:

I **do not** give permission for my personal details to be released to persons under the Official Information Act 1982.

Questions

Chapter 4

- 1 It is proposed that the term 'condition' be used instead of 'disease' (in relation to notification and other topics discussed in this paper). This would include, as well as disease, clusters of symptoms and risk factors (para 4.4.3).

Agree

Don't agree

Please give reasons:.....
.....
.....
.....
.....

- 2 A range of purposes for notification is proposed, including the care and management of a person with a communicable condition, monitoring, identification of risk factors etc (para 4.4.4).

Agree

Don't agree

Comments and reasons; any suggestions for other purposes:.....
.....
.....
.....

- 3 Do you agree with the proposed criteria for notification (ie, one group of factors for conditions which must be notified, such as those specified by the World Health Organization as quarantinable – yellow fever, cholera etc) and another group of factors to guide decisions on which conditions must be notified (para 4.4.5)?

Agree

Don't agree

Comments and reasons; other suggestions for criteria:.....
.....
.....
.....

- 4 Do you have comments on, or suggestions for additions to, the four proposed categories of information to be included in the Bill (para 4.4.2)? The categories are:
- general reports
 - disclosure, on request, of information about identifiable individuals
 - notification of specified information
 - registers and databases.

Comments and suggestions:.....
.....
.....
.....
.....

- 5 It is suggested that there could be provision for regulation-making powers following reports from bodies (such as the National Mortality Review Committee) responsible for investigating issues relating to individual safety (para 4.1.2).
- Agree
- Don't agree

Comments and reasons:
.....
.....
.....

- 6 Do you have any comments on the proposed definition of 'health information' (the same as in the present Health Act) (para 4.3.2)? Should it be extended – if so how and why?

Comments and reasons:
.....
.....
.....

- 7 It is proposed that the Bill could include an obligation or discretion to notify non-notifiable conditions with unusual features (para 4.4.6).
- Agree with obligation
- Agree with discretion
- Don't agree

Comments and reasons:
.....
.....
.....

8 A concept of 'temporary notifiability' is proposed (para 4.4.6). Would this be useful?

- Agree
- Don't agree

Comments and reasons:.....

9 This chapter has proposals on *who* should be obliged to notify 'notifiable conditions' (para 4.4.8).

- Agree
- Don't agree

Comments and reasons:.....

10 It is proposed that laboratories be required to notify as well as, or in some cases instead of, medical practitioners (para 4.4.9).

- Agree
- Don't agree

Comments and reasons:.....

Do you have any comments on which conditions should remain the responsibility of general practitioners? Reasons:

.....

11 It is suggested that perhaps Medical Officers of Health could modify who is responsible for notification if, for example, laboratory notification is unsatisfactory (para 4.4.9).

- Agree
- Don't agree

Comments and reasons:.....

12 The chapter sets out some possibilities as to which authorities notification should be made (para 4.4.10).

Comments and suggestions:.....
.....
.....
.....

13 It is proposed that the Bill provide a number of ways in which the privacy of people who have had information about them notified could be protected (para 4.4.13).

- Agree
- Don't agree

Suggestions or comments:.....
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14 It is proposed that people who are the subject of notification could be informed accordingly (para 4.4.13).

- Agree
- Don't agree

Suggestions or comments: Are there any circumstances in which this may not be practical? .
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Chapter 5

15 Do you agree that the Public Health Bill should refer in its purpose to public health promotion, the prevention of non-communicable diseases, as well as risk factors relevant to both communicable and non-communicable conditions (para 5.5)?

- Agree
- Don't agree

Comments, suggestions and reasons: Any ideas about wording of such a purpose statement:
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16 Do you agree that the Bill should include regulation-making powers for promoting public health (para 5.5)?

- Agree
- Don't agree

If you do agree, do you have any suggestions for wording?

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17 Should the Bill include a reference to health impact assessment (para 5.3)?

- Agree
- Don't agree

If you think there should be such a reference, what form should an assessment take? What kind of policies could it refer to, and what resource implications may be involved?

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18 If legislation is not the appropriate vehicle for health impact assessments, what other ways do you think may be helpful in encouraging them (para 5.3)?

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Chapter 6

Child health

19 It is suggested that the Bill could specify as one of its purposes the importance of child health, possibly with a reference to the *United Nations Convention on the Rights of the Child* (para 6.1).

- Agree
- Don't agree

Reasons and comments on the proposed wording:

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20 Are there any other issues relating to child health not covered in this chapter (or elsewhere in this discussion paper) that you think should be included in the Public Health Bill?

Suggestions and reasons:.....
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Registers

21 It is proposed that there could be a set of general provisions to allow registers on specific subjects to be established by regulation following consultation (paras 6.2 and 6.2.1).

- Agree
- Don't agree

Comments:
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22 Proposals are set out for possible register purposes, privacy and disclosure provisions, types of registers and operational procedures (paras 6.2.2 and 6.2.3).

- Agree
- Don't agree

Comments, reasons, alternatives, other wording:.....
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Immunisation

23 It is suggested that the empowering provisions for making regulations on immunisation be drafted to allow for various options (paras 6.3 and 6.3.3).

- Agree
- Don't agree

Comments and suggestions:.....
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24 One option that could be allowed by regulation-making powers is for children to be immunised unless a conscientious objection is stated or a reasonable possibility of an adverse reaction exists (para 6.3.3).

Agree

Don't agree

Comments (for example, on the evolving capacity of a child to make decisions without parental consent):

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25 Should references to immunisation be focused mainly on child health (para 6.3)?

Agree

Don't agree

Comments:.....

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26 Or should references to immunisation also extend to adults where appropriate (eg, workplaces) (paras 6.3 and 6.3.3)?

Agree

Don't agree

Comments:.....

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27 It is suggested that the Bill could specify that a disease is notifiable if the vaccine for that disease is on the general immunisation schedule (perhaps with exceptions) (para 6.3.2).

Agree

Don't agree

Comments:.....

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28 Should emergency powers envisage vaccinating people without their consent – adults as well as children – in situations of extreme risk such as terrorist-introduced smallpox (para 6.3.5)?

Agree

Don't agree

Comments and reasons:
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Screening

29 Are powers for making regulations needed to specify circumstances in which screening would be appropriate (para 6.4)?

Agree

Don't agree

Comments (for example, on applying this to workplace settings):.....
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.....

30 Should the Bill contain general provisions and regulation-making powers to authorise the establishment of new screening programmes, as included in the Health (Screening Programmes) Amendment Bill (para 6.4.1)?

Agree

Don't agree

Comments and reasons:
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31 Should the Bill provide for programmes for purposes other than screening (para 6.4.2)?

Agree

Don't agree

Comments:
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32 Should the Bill include a reference to privacy impact assessments (para 6.4.3)?

- Agree
- Don't agree

Suggestions and comments (for instance, if legislation is not the appropriate vehicle for privacy impact assessments, what other ways do you think may be helpful in encouraging them?):.....
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Chapter 7

People with communicable conditions

33 It is proposed that the Bill would allow action to be taken in relation to people whose condition and behaviour creates risks for others. For which conditions might these powers be exercised and by whom (para 7.2.6)?

- **Option 1:** Medical Officer of Health discretion – that is, the Medical Officer of Health decides when, and in relation to what conditions, it is appropriate to use the specified powers, taking into account specified criteria.
- **Option 2:** The full range of care powers could be invoked only for conditions specified for that purpose in regulations.
- **Option 3:** A specified list of high-risk conditions for which the more restrictive powers may be exercised, but for which a court order would be required, while a Medical Officer of Health would be able to invoke the less restrictive powers to deal with any communicable condition.

Please indicate which option you prefer:

- Option 1
- Option 2
- Option 3

Reasons for your choice and comments, other suggestions:.....
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.....

34 Proposals are set out for possible rights and duties of people with communicable conditions (para 7.2.3).

Agree

Don't agree

Comments, other suggestions:
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35 Should the Public Health Bill include offences for behaviour that involves infecting other people (para 7.2.3)?

Agree

Disagree – this matter should be left to the general criminal law

Comments and reasons:
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.....

If you consider that an offence should be included in the Bill, should this be:

(a) for *deliberately or recklessly infecting* other people with specified conditions
or

(b) for putting other people *at risk* of such infection
or

(c) for endangering the health and safety of other people (ie, no specific reference to *infection*)?

36 Some duties of health practitioners are proposed (para 7.2.4).

Agree

Don't agree

Comments and suggestions:.....
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37 A range of powers is proposed (potentially for people with communicable conditions of risk to others) (para 7.2.5).

Agree

Don't agree

Comments and suggestions, reasons:

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38 If lists of conditions are to be specified, on what criteria do you think such lists should be based (para 7.2.6)?

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39 Do you agree that some powers should be exercised only by a court (paras 7.2.6 and 7.2.7)?

Agree

Don't agree

Comments and reasons:.....

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40 Do you favour using the Family Court or the District Court for making public health orders (para 7.2.8)?

Family Court

District Court

Comments and reasons for your choice, cost implications:

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41 Do you think an emergency public health order should be able to be issued by a Medical Officer of Health to have effect for a short period, but to be extendable after application to the Court (para 7.2.7)?

Agree

Don't agree

Comments and reasons:
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Public health welfare

42 Do you agree that the Public Health Bill should allow action to be taken – where other legislation such as the Protection of Personal and Property Rights Act does not apply – for people (paras 7.3.1 and 7.3.2):

- who cannot, or do not care for themselves (eg, to meet basic physical and housing needs)
and
- as a result, their health and safety is endangered or an environmental risk is posed to others.

Agree

Don't agree

Comments and reasons:
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43 Do you agree with the proposal that the term 'aged and infirm' – the current Health Act phrase – be replaced by a more general phrase, 'public health welfare' (para 7.3.1)?

Agree

Don't agree

Comments and reasons:
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44 Do you agree with the proposed conditions, powers and procedures for using these powers (para 7.3.2)?

- Agree
- Don't agree

Comments and reasons:.....
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Chapter 8

45 Do you think legislative provision for contact tracing is needed (paras 8.2 to 8.5)?

- Agree
- Don't agree

Comments and reasons (eg, on resources and service implications):.....
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46 If you do agree, for which of the following conditions should contact tracing be permitted (para 8.6.1)? Please indicate which option.

- Option 1:* A notifiable communicable condition specified in legislation as 'contact traceable'.
- Option 2:* A communicable condition whether 'notifiable' or not (on a court order).
- Option 3:* A communicable condition specified as notifiable (but no requirement for a separate specification as 'contact traceable').
- Option 4:* A communicable condition whether notifiable or not.

Comments and reasons:.....
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47 Do you think the Bill should provide for contact tracing where the condition is associated with an offence under the Crimes Act (para 8.6.1)?

Agree

Don't agree

Comments and reasons:
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.....

48 Are there any other options for which conditions might justify contact tracing?

Please give reasons:
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.....

49 It is proposed that the Bill should specify the duty of people with risk conditions to provide information and assistance (para 8.6.2)?

Agree

Don't agree

Comments and reasons:
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50 Should the Bill make specific provision for partner notification (eg, where a person's health practitioner knows the identity of the person with the condition) and allow for that partner to be advised by the health practitioner of possible exposure (paras 8.2.1 and 8.6.3)?

Agree

Don't agree

Comments and reasons:
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51 Do you agree with the procedures proposed for contact tracing, which emphasise first obtaining authorisation and then invoking powers to require information where this is not possible (para 8.6.3)?

- Agree
- Don't agree

Reasons and comments (eg, on specific aspects of this approach, as well as costs and service implications):.....
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Chapter 9

52 Do you agree in general terms with the outlined objectives for border health protection (para 9.3)?

- Agree
- Don't agree

Comments, reasons, any deletions, amendments or new ones to suggest:.....
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53 Two options for legislation on border health legislation are proposed. They are that the Bill should (paras 9.3 and 9.3.1, also 9.7):

- Option 1:* cover only issues relating to returning New Zealanders and incoming travellers who are sick or symptomatic – so that issues concerning pathogens and infectious agents carried by animals, vehicles, goods or other things would be dealt with other legislation

or

- Option 2:* also include potential or default powers, and hence a role for health agencies, on pathogens and infectious agents carried by animals, vehicles, goods and other things.

Please indicate which option you favour. Comments and reasons:.....
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.....

54 It is proposed that the main aim of border health protection in the Bill – as it relates to returning New Zealanders and incoming travellers – should be to provide opportunity for notification, and hence follow-up, of any significant communicable disease. Health authorities would have the same powers that they would have for a person developing the communicable disease in New Zealand (except in emergencies) (paras 9.5.2 and 9.5.4).

- Agree
- Don't agree

Please give reasons for your answer:

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55 Do you agree that the concepts of quarantine and pratique should be retained and applied much as at present (paras 9.4.1 and 9.4.2)?

- Agree
- Don't agree

Comments and reasons:

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56 Do you agree with reducing the present emphasis of the Health Act on quarantinable disease and focusing instead on a much wider range of diseases and conditions (including, but not limited to, those which are currently quarantinable) (paras 9.5.2 and 9.5.3)?

- Agree
- Don't agree

Comments and reasons:

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57 Should there be some provision for border health protection to apply to non-communicable conditions in order, for example, to inform health agencies of potential resource demands (para 9.5.3)?

- Agree
- Don't agree

Comments and reasons:

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58 Do you agree that the Bill should allow for more restrictive powers to be available in border health emergencies than would be available under normal circumstances (para 9.5.5)?

- Agree
- Don't agree

Comments and reasons:.....
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59 Should the Bill make more explicit recognition of the duty to prevent the export of pathogens from New Zealand to other countries (para 9.6)?

- Agree
- Don't agree

Comments and reasons, resource implications:.....
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60 Do you agree that the Bill should allow for wide potential powers of inspection and actions in relation to craft, but that it should also allow for considerable discretion in the use of these powers (para 9.7.1)?

- Agree
- Don't agree

Comments and reasons:.....
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61 Do you think there should be more explicit provision (whether in the Public Health Bill or other legislation) for border health protection to apply to items sent through the post and that this should include substances as well as organisms and pathogens (para 9.8)?

- Agree
- Don't agree

Comments and reasons:.....
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