

## Auckland Regional Public Health Service

Rātonga Hauora ā Iwi o Tamaki Makaurau



Working with the people of Auckland, Counties Manukau and Waitemata

## Auckland Regional Public Health Service

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### Comments from the Auckland Regional Public Health Service on the draft Public Health Bill

1. Thank you for the opportunity for the Auckland Regional Public Health Service to provide comments on the draft Public Health Bill.
2. This submission represents the views of the Auckland Regional Public Health Service (ARPHS), which provides services on behalf of the three Auckland region district health boards (Auckland, Counties Manukau and Waitemata). This submission does not necessarily represent the views of all the district health boards.
3. ARPHS has, however, liaised with the DHBs during the development of this submission and Waitemata DHB's Community and Public Health Advisory Committee (CPHAC), on behalf of their Board, has strongly endorsed ARPHS's three key areas of concern identified below. In addition the Waitemata DHB CPHAC made further comment on the following:
  - Integration and co-ordination—given the number of public bodies/entities involved in promoting and protecting public health, Waitemata DHB requests that an integrated approach involving these diverse stakeholders be made explicit in the Bill. Key stakeholders would include DHBs, public health units, local and regional government, and Iwi/local Maori.
4. ARPHS understands that all submissions will be available under the Official Information Act 1982, except if grounds set out under the Act apply.
5. ARPHS would like to appear before the Select Committee to speak to this submission.
6. The primary contact point for this submission is as follows:  
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## **Introduction**

7. As the largest public health unit in New Zealand, the Auckland Regional Public Health Service (ARPHS) has a strong interest in the Public Health Bill, and agrees entirely with the identified need to modernise New Zealand's public health legislation.
8. As an organisation that works to improve the public's health in a wide variety of ways, however, ARPHS is disappointed with the current draft of the Bill. It considers that the opportunity to develop one of the key tools available for ensuring health gain has been incompletely realised.
9. The approach to public health has altered radically since the middle of the last century, when the previous Health Act was enacted. The sphere of interest of public health has expanded beyond environmental health and infectious diseases, and now encompasses other challenges to the health of New Zealanders: non-communicable diseases, health inequalities, and incorporation of a wider view of what makes a person healthy.
10. Accordingly, the tools, frameworks and techniques employed to improve public health have broadened. Health impact assessment is but one example of this. New ways of working, for example influencing decisions of local authorities on urban design issues, have taken on increasing importance as understanding has emerged that many factors affecting health lie outside the core health sector.
11. Despite the fact that there are references to many of these concepts in the preamble, there is a lack of follow through in the Bill. Instead, the Bill largely adheres to the framework of the previous fifty-two-year-old Health Act, with modifications and additional provisions to bring the legislation into line with other contemporary statutes, such as the Bill of Rights Act and the Privacy Act. Where new challenges to public health are recognised, they are generally addressed in such a way that effectiveness will be limited. This is particularly relevant for the section on non-communicable diseases.
12. ARPHS has identified three key lost opportunities in the Bill as it presently stands: to provide a statutory basis for an independent public health voice, to provide robust public health tools for non-communicable disease control, and to more strongly assert the role of local government in improving public health. Each of these is outlined in more detail below but also feature throughout ARPHS's comments.

### **The need for an independent public health voice**

13. ARPHS has noted in several places in this document the wide-ranging nature of public health, and the large number of actors that can influence it. ARPHS supports the role of the Director of Public Health to provide independent advice to decision makers on matters relating to public health.
14. ARPHS would like to see a similar mandate given at a district level. District health boards could be required to appoint local directors of public health who would act in an independent manner to provide advice on matters relating to public health. This advice should not be limited to chairs of the DHBs, but also be able to be provided to other organisations that impact on public health.
15. Public health is significantly affected by local-level decisions (both in and out of the health sector) and it is not reasonable to expect that a national Director of Public Health will provide advice at this level of detail. Therefore ARPHS considers it crucial

for there to be an authority in a district that can maintain an oversight of all activities and respond in a way that will improve, promote and protect public health.

### **Effectively dealing with non-communicable diseases**

16. Non-communicable disease control, particularly in relation to diseases caused by obesity, is a major challenge for New Zealand now and in the foreseeable future. Public health legislation can potentially be a key tool in helping to meet this challenge but this potential is not well realised in the current Bill. ARPHS has provided more specific comments on changes it would like to see under Part 3.

### **Better incorporating the role of local government in improving public health**

17. In the current Health Act local government plays an important role in environmental health protection. That function continues to exist today and ARPHS is pleased that this is retained in the Bill.

18. One key missed opportunity, however, is the chance to recognise that local government's role is much broader than it was fifty years ago. Under the Local Government Act 2002, local authorities have a duty to promote wellbeing in their communities; ARPHS views wellbeing as simply another term for public health. Therefore ARPHS suggests that much more consideration be given to integrating the provisions of the Public Health Bill with those of the Local Government Act.

### ***Layout of this submission***

19. ARPHS has laid out its comments using the same headings in the Bill. To aid those receiving this submission, it has addressed each section by focussing its comments under four groupings.

20. First, ARPHS would like to highlight areas that it sees as positive. Although the Bill has not realised its potential, progress has been made in some areas, particularly those that pertain to infectious disease risks and dealing with emergencies.

21. The second group of comments deals with some of the critical issues in the Bill. These are clauses, wording or intentions that will directly hinder ARPHS's ability, particularly those of its medical officers of health, to reduce health risks. These are changes ARPHS considers must occur, regardless of whether its desire to expand the scope of the legislation is realised.

22. Thirdly, ARPHS provides comments on areas that require substantial improvement. These refer mostly to the missed opportunities of the Bill. Where possible, ARPHS has provided specific examples of why improvement is desirable.

23. Finally, ARPHS highlights aspects of the Bill that could be improved, but if the changes are not made then the ability to improve, promote and protect public health will not be critically compromised.

### ***General comments***

#### **Other aspects that could be improved**

24. ARPHS notes that Part 3A of the Health Act is not present in this Public Health Bill. Some or all of the provisions in this Part seem to be now covered by the proposed Human Tissue Bill. Would a transitional provision be made to address this area, should this Bill become law prior to the passage of the Human Tissue Bill?

## **Part 1**

### **Aspects of the Bill that are supported**

25. ARPHS supports the inclusion of reducing inequalities in the purpose (clause 3(2)(c)), notwithstanding the comments made under Part 3.
26. ARPHS supports the role of the Director of Public Health (Subpart 4) and feels that independent advice on public health matters is critical. As described above, ARPHS would like to see this function extended to a district level.

### **Critical issues that must be addressed**

27. No comments.

### **Areas that require substantial improvement**

28. ARPHS is disappointed that there is no statement concerning the Treaty of Waitangi. As a Crown Agency, ARPHS acknowledges the special relationship between Maori and the Crown under the Treaty of Waitangi. This is expressed through our commitment to ensuring participation at all levels, partnership in service delivery, and protection and improvement of Maori health status.
29. The NZ Public Health and Disability Act 2000, Part 1, section 4 identifies that district health boards must work to improve Maori health gain through the provision of *"mechanisms to enable Maori to contribute to decision-making on and to participate in the delivery of health and disability services"*. This is reiterated in the Maori health strategy He Korowai Oranga, which states *"the Government is committed to fulfilling the special relationship between Iwi and the Crown under the Treaty of Waitangi"*. The review of the Health Act provides an excellent opportunity for the Government to demonstrate that commitment by including it in the proposed piece of legislation.
30. ARPHS recommends that there should be a requirement of DHBs to support areas of health gain and contribute to improved wellbeing using a framework that addresses inequalities and the determinants of health. Clause 19 ("Public health functions of DHBs") describes the need for DHBs to mitigate risks to public health. Given that this term also applies to non-communicable diseases, DHBs should be required under this Bill not to merely act in a regulatory manner but also to promote wellbeing, as per section 23 of the New Zealand Public Health and Disability Act 2000.

### **Other aspects that could be improved**

31. Consistent use of the terminology is required when discussing levels of action. For example, the current Bill uses the terms *"regional"* (clause 7(1)(a)(i)) and *"district"* (clauses 12(3) and 12(4)) to refer to the geographical unit within which a medical officer of health is regulatory powers: these two terms are not interchangeable and the inconsistency should be removed.
32. Is clause 14 ("Health districts") congruent with sections 19 and 20 of the New Zealand Public Health and Disability Act 2000? It would make sense for a link to be made between these two pieces of legislation.
33. Under clause 12(2) ("Health protection officers and medical officers of health") there should be a statement about factors the Director-General must take into account when considering the appropriate number of designated persons. This would include, among other things, the needs of the district.

## **Part 2**

### **Aspects of the Bill that are supported**

34. For clause 20 (“Interpretation”), ARPHS supports the extended interpretation of ‘health information’, as it is consistent with the Health Information Privacy Code (HIPC).

### **Critical issues that must be addressed**

35. Clause 21(3) (“Disclosure of health information”) is unnecessary as this is covered by Rule 11(1)(a)(ii) of the HIPC. This subclause, along with clause 22(4) (“Duty to provide health information”), appears to prevent a child under 16 years of age from consenting to disclosure of information, even where they are competent to do so, a position that is inconsistent with privacy law and well-established legal principles.
36. As with section 22F of the existing Health Act, clause 24 (“Duty to provide health information”) crosses the same territory as the Health Information Privacy Code and should be integrated into the latter. Disclosure of information is a critical aspect of clinical practice and the current mix of legislation is confusing to navigate. The HIPC is currently under review and this is the perfect opportunity to address this anomaly.
37. Under clause 26 (“Regulations as to retention of health information”) the reference to specimens should be removed. Management of tissue and substances is now governed by the Code of Health and Disability Services Consumers’ Rights 1996 and the proposed Human Tissue Bill.
38. There is no definition of ‘identifying particulars’ under clause 39 (“Duty of confidentiality and authorised disclosure of identifying particulars obtained from report of notification”). Would it extend, for example, to the name of the school or workplace the person with the notifiable condition attends?

### **Areas that require substantial improvement**

39. ARPHS recommends that provision be made in this Bill to require notification of cases with some notifiable conditions directly to an individual or agency with a national surveillance role, such as the Director of Public Health, the Ministry of Health, or the national surveillance centre (currently the Institute of Environmental Science and Research Limited, ESR), instead of the medical officer of health. At present (in clauses 32(2) and 33(1)), cases of all notifiable conditions must be notified to the medical officer of health. Not all conditions in schedule 1 of the proposed Bill have particular public health actions that the medical officer of health can (or should) implement in response to an individual case, and are notifiable purely for surveillance reasons (for instance, invasive pneumococcal disease). Retaining the requirement for cases with these conditions to be routed via the medical officer of health creates unnecessary information handling and is a poor use of resources.
40. Ethnicity should be included in the minimum dataset outlined in clause 32(3)(b) (“Medical practitioner or specified person must notify notifiable condition”) and clause 33(2)(b) (“Laboratory must notify notifiable condition”). This is necessary to improve surveillance and monitoring information and therefore allow a more appropriate public health response.
41. Clause 33(2)(b) should be amended to include the requirement to notify the name and contact details of the doctor who ordered the laboratory test. This will enable more efficient follow-up from the appropriate authority receiving the notification.

42. Under clause 39(2)(a) the words “*authorised by this Act*” should be replaced with ‘authorised by law’, because provisions in other statutes or regulations may also require or authorise disclosure.
43. Clause 39(3) should be removed, as it is unwieldy and places unrealistic obligations both the notifier (referred to in 39(1)(a)) and the medical officer of health. As worded, any medical practitioner who reports a patient with a notifiable condition to the medical officer of health will then need to seek the permission of the medical officer of health before discussing details of that person’s illness with a third party, such as a family member or employer, even if they have the patient’s consent to do so. This is unnecessary and adherence to this requirement is likely to be poor.
44. Why is Subpart 4 restricted to the cervical screening programme when there are other programmes to which the principles could apply, for example other screening, well child and immunisation? ARPHS recommends that this Subpart be redrafted to provide for all population-level health programmes.

#### **Other aspects that could be improved**

45. Some provisions in section 74AA of the current Health Act have not been transferred into clauses 33 (“Laboratory must notify notifiable condition”) and 34 (“Laboratory must notify notifiable contaminants”) of the proposed Bill. ARPHS recommends that the following provisions in section 74AA of the Health Act be reinstated in the proposed Bill:
- *“The person in charge of a medical laboratory must take all reasonably practicable steps to ensure that there are in place in it efficient systems for reporting to him or her [test results for notifiable diseases]”* (Health Act 1956 section 74AA(1))
  - *“The person for the time being in charge of a medical laboratory...must immediately tell the health practitioner for whom the test or other procedure concerned...”* (Health Act 1956 section 74AA(2))
46. Note that the wording in clauses 33(1)(a)(i) and 33(1)(a)(ii) in the Bill is preferred over that of the current section 74AA of the Health Act.
47. ARPHS is concerned that the provision for regulations to be made under clause 43 (“Regulations”) may have an unintended consequence when applied to clause 36 (“Notifiable conditions in animals”). Large numbers of notifiable conditions may be detected in animal populations, e.g. campylobacter, tuberculosis, and not all of these will be of risk to humans. This could create an unnecessary burden on both those making the notifications and those receiving them. It is not clear that clause 43(1)(c) will allow for a requirement that consideration to be given to the risk to human health. ARPHS would like to see this clarified through an additional subclause either under clause 36 or under clause 43.

### **Part 3**

#### **Aspects of the Bill that are supported**

48. ARPHS supports the inclusion of the non-communicable diseases section. Non-communicable diseases are an increasingly large burden for New Zealand and this Bill is one means to meet some of the challenges.

#### **Critical issues that must be addressed**

49. No comments.

#### **Areas that require substantial improvement**

50. ARPHS would like to see a purpose for this part of the Bill. We would suggest wording similar to that used on page 26 of the discussion document *Public health legislation: promoting public health, preventing ill health and managing communicable diseases* (Ministry of Health, 2002):

- The purpose of this section is to promote public health and reduce preventable ill health from non-communicable diseases and intentional and unintentional injury through the recognition of the principles of the Ottawa Charter, and in particular by:
  - creating supportive social, physical and cultural environments for health
  - ensuring that information on factors relevant to social, physical and cultural environments for health is available
  - empowering regulations relevant to products, services, facilities and other things associated with risk factors for ill health and intentional and unintentional injury

51. Although local authorities are considered in the Public Health Bill, they are done so in the limited way originally set out in the Health Act 1956. The role of local government in influencing public health has grown with the passage of legislation such as the Local Government Act 2002. Local government now has a responsibility to promote the social, economic, environmental and cultural wellbeing, all of which are key determinants of public health (more comments are made about this under Part 5).

52. Therefore, ARPHS would like to see greater recognition of the role that local government can and does play in improving, promoting, and protecting public health. One way to do this is to include in the Bill a requirement that local authorities must consider the density of fast food outlets, gambling/gaming establishments, liquor outlets and any other premises likely to increase the prevalence of risk factors when developing, reviewing and implementing their regional or district plans. Not only would this requirement enable local government to address the clear link between the density of some of these risk factors and harm (e.g. liquor outlets), it would also allow local government to factor in the inequalities that exist (e.g. gaming machines are far more likely to be located in low socioeconomic areas). ARPHS recognises that this may impact on existing legislation such as the Sale of Liquor Act 1989.

53. ARPHS suggests that this section could be greatly enhanced by ensuring that public health best-practice models such as the Ottawa Charter and Te Whare Tapa Wha frameworks form the basis of all codes of practice and guidelines.

54. One of the key flaws in this section, and indeed in the wider Bill, is the lack of focus on inequalities. Despite the fact that inequalities are mentioned twice in the explanatory note, and equitable outcomes is one of the Bill's main purposes, no further regard seems to be paid to this topic. If equitable outcomes are truly desired then action must not solely focus on addressing the social determinants of health, but also on tackling the unequal distribution of factors that lead to ill health.

55. One way to ensure that inequalities are given more consideration would be to insert an additional principle under section 80, which would oblige the Director-General to take inequalities into account when considering actions to reduce levels of non-communicable diseases.

#### **Other aspects that could be improved**

56. There are some amendments and additions that should be made to the list under clause 80 ("Principles"):

- Subsection (f) should be altered to read 'promoting, maintaining, enhancing and protecting the health status of the general population and communities' so as to be consistent with the purpose of the Bill.
- There is no definition of 'primary health' under subsection (h). This could be reworded to primary health care to be more consistent with terminology used in other legislation and Ministry of Health documents.

## **Part 4**

### **Aspects of the Bill that are supported**

57. If it will lead to faster resolution of applications and appeals, ARPHS is supportive of the move to use Family Court Judges to hear matters under clause 94 ("Proceedings under this Part in District Courts to be heard by Family Court Judges, if practicable"). ARPHS is interested in understanding the anticipated impact of this change.
58. ARPHS supports the inclusion of a legislative framework for managing contacts (clauses 137 to 149) and considers that this is an important improvement to the legislation.
59. ARPHS is supportive of the requirement to accept treatment (clause 115(f)) as a possible result of an order.

### **Critical issues that must be addressed**

60. To secure medical investigation and treatment of non-residents suffering from infectious diseases (primarily tuberculosis), medical officers of health can currently use sections 9 and 10 of the Tuberculosis Act 1948 to make an order for investigation/treatment, which then allows the patient to be exempt charges (under the Minister's eligibility direction). This is necessary to ensure that inability to pay is not a barrier to obtaining investigations (and thereby treatment) for conditions that would otherwise represent a public health risk. If clauses 95 ("Directions that may be given to manage health risk posed by condition to which this Part applies") and 97 ("Direction for medical examination") are to be the equivalent sections in the proposed Bill, ARPHS recommends the following:
- a. That the eligibility directive will need to be reissued to countenance orders made under this legislation when enacted.
  - b. That a provision be made, either in the Public Health Bill or in the eligibility directive, to specifically enable medical officers of health to require DHBs to exempt charges for individuals with conditions representing a public health risk, to enable appropriate management of that risk. At present, a coercive power is exercised for the sole purpose of facilitating access to publicly funded treatment and investigation services, and this is not the intended use for these provisions.
61. ARPHS recommends that the Public Health Bill includes a provision requiring DHBs to support health risk orders for detention (made under clause 114(1)(a)), as the proposed Bill does not contain such a responsibility. The current Tuberculosis Act (under section 16(8)) requires *"the medical officer or other person in charge of any institution or other place to which any patient is ordered to be removed"* to receive the patient and arrange for their medical treatment. ARPHS considers that this is an important provision to retain as the Service has had several examples in Auckland where the medical officer of health has wanted to detain someone who represents a public health risk, but the hospital authority has been very reluctant to act as a site for detention.

### **Areas that require substantial improvement**

62. Consistent with the comments made above, there is no explicit purpose for this part. Although there is a general purpose set out in clause 3, having a purpose at the beginning of each part will aid readers to understand for what purpose certain provisions are made.
63. ARPHS considers that the wording of clause 146 (“Duty of confidentiality”) is too restrictive and does not allow for situations where the individual who may have communicated the condition has given his or her consent, or when the public health risks are such that disclosure is necessary.

#### **Other aspects that could be improved**

64. Clause 95 (“Directions that may be given to manage health risk posed by condition to which this Part applies”) enables medical officers of health to give direction to individuals who pose a health risk. ARPHS considers that medical officers of health should have equivalent power to disclose information to individuals or agencies to reinforce the direction to the individual. For instance, clause 95(4)(b) enables medical officers of health to give direction to an individual to refrain from carrying out travel within and out of New Zealand. This could be best supported if the medical officers of health were also able to disclose health information to Immigration officials. This group, however, is not identified as a permitted recipient of health information in clause 21(2) (“Disclosure of health information”).
65. The penalties under clause 126 (“Person must not recklessly spread notifiable disease or other notifiable condition”) do not seem to align with the penalties under sections 145, 188(2) and 201(1) of the Crimes Act. It is these sections that have been used in situations where someone has been deemed to be recklessly spreading a notifiable disease, but presumably they will be superseded by Subpart 4.
66. The objective of clause 152 (“Medical practitioner may consult with medical officer of health”) should be clarified. Does this clause simply require medical officers of health to provide a collegial opinion, or is the formal approval of the medical officer of health being sought by such consultation?

## **Part 5**

#### **Aspects of the Bill that are supported**

67. Notwithstanding the comments below, ARPHS supports the fact that there is a clear and defined role for local authorities in improving, promoting and protecting public health.

#### **Critical issues that must be addressed**

68. Sections 10 and 11 of the Local Government Act 2002 show that a main role of local authorities is to give effect to “*promoting the social, economic, environmental, and cultural wellbeing of communities*”. The minor alterations to the Health Act presented in this Bill do not reflect the reality of this widened responsibility, nor a modern view of what constitutes public health (which includes these types of wellbeing). Local authorities have a large amount of influence on the determinants of health (e.g. urban form, sustainability, social connectivity) and this is not well recognised in the Bill.
69. There is a lack of clarity over the terms used in this part, and the Bill more generally, as they apply to local authorities, territorial authorities and local government. Local authorities include both territorial authorities (i.e. city or district councils) and regional councils. Therefore, all types of council have a responsibility for aspects of the public health of their communities. For example, regional councils take the lead as an enforcement agency in resource management and air quality. There is inconsistency

in requiring territorial authorities to appoint environmental health officers (clauses 153(1)(a) and 157) but not regional councils.

70. ARPHS has concerns about the definition of a nuisance under clause 166 (“Nature of nuisance”), which has shifted from the Health Act. The use of the wording “*injurious to public health*” has two implications: the nuisance must affect multiple people (using the definition of public health in clause 4) and that physical harm must occur. ARPHS supports retaining the existing wording of ‘offensive or injurious to health’.

#### **Areas that require substantial improvement**

71. Further to the comments above about the role of local authorities, why is a distinction made between who may request reports from a regional council (clause 154) and who may request a report from a territorial authority (clause 155)? It would make more sense for these clauses to be combined and the term ‘local authority’ used.
72. Regional councils also have the ability to make bylaws under the Local Government Act (section 149) and the matters upon which they may do so has the potential to impact on public health. ARPHS considers that Subpart 4 should also apply to these authorities and that the term ‘territorial authorities’ should be replaced with ‘local authorities’.
73. ARPHS considers that clause 185 (“Consultation required before territorial authority makes public health bylaw”) should be altered to require a local authority to consult with the relevant district health board upon renewing or amending bylaws.
74. ARPHS recommends that the use of health impact assessments (HIAs) be strengthened in this Part. ARPHS recognises that local authorities may not have the public health expertise necessary to conduct a HIA and therefore advocates for a partnership approach with the DHBs. One way to do that would be to add a paragraph under clause 153(1) (“General powers and duties of territorial authorities in respect of public health”) that requires local authorities to work in partnership with DHBs to conduct health impact assessments on all proposed plans, policies or activities that may impact significantly on the community.

#### **Other aspects that could be improved**

75. Clause 167 (“Duties of territorial authority”) seems repetitious of clause 153(1)(b) (“General powers and duties of territorial authorities in respect of public health”) and clause 153(1)(c).
76. ARPHS has some concerns about clause 183, in particular that it could allow permitted activities to cause a nuisance, which seems contradictory to the Bill’s purpose. The test that would allow an activity to be stopped if health risks were not foreseen is too limiting. A health risk may often be foreseen but the scale of this risk may not be evident until the activity begins.

## **Part 6**

#### **Aspects of the Bill that are supported**

77. ARPHS supports the use of public health risk management plans as a way to proactively protect public health.

#### **Critical issues that must be addressed**

78. It is not clear from either this Part or Schedule 3 when a DHB is the relevant consent authority and when that duty falls to the territorial authority. Clause 203(1) (“Consent authority to obtain report and respond to application within 20 working days”) defines

them both as a consent authority but uses the conjunction 'or', implying that only one will be the consent authority for any given application. DHBs do not currently receive consent applications for regulated activities and if this is to change under the Public Health Bill then the resource implications must be considered.

#### **Areas that require substantial improvement**

79. Schedule 3 contains a list of activities that have classed as regulated for somewhat historical reasons and should be updated. For example, ARPHS considers that activities such as tattooing and operating beauty parlours carry a greater risk to the public's health than hairdressing.

#### **Other aspects that could be improved**

80. Although additional provisions have been made since earlier drafts for a reviewer to be independent under clause 216 ("Appointment of reviewer and conduct of review"), ARPHS still has some concerns about a potential conflict of interest. Where a reviewer is chosen who is employed by the consent authority there seems likely to be in some circumstances pressure for that person to rule for the consent authority and against the person who sought the review.

## **Part 7**

#### **Aspects of the Bill that are supported**

81. ARPHS supports the inclusion of provisions for dealing with emergencies.

#### **Critical issues that must be addressed**

82. As they are currently worded, clauses 271(4) ("Powers of medical officer of health to requisition things") and 272(3) ("Power of entry and inspection") seem to imply that the medical officer of health, or any other person who exercises power under those sections, will be required to notify the Civil Aviation Authority and Maritime New Zealand, regardless of whether or not they are affected by the exercising of that power. This needs to be reworded so that these authorities are only notified if the exercising of the power affects them or something under their jurisdiction or this will create an unnecessary burden of reporting for the medical officer of health.

83. For surveillance and epidemiological purposes, ARPHS would like to see gender and date of birth added to the list of information that may be requested from a person under clause 286(4) ("People liable to quarantine to comply with directions and supply information").

#### **Areas that require substantial improvement**

84. ARPHS has some general concerns around some duties on health protection officers to make clinical assessments, for example as seems to be implied in clause 289 ("Powers and duties of medical officer of health or health protection officer in relation to quarantinable conditions"). Health protection officers do not have the training required to make decisions on clinical matters. ARPHS notes that the wording in the existing Health Act (section 97D) is similar but sees an opportunity to improve the legislation.

#### **Other aspects that could be improved**

85. ARPHS would like to see an additional paragraph under clause 268(2) ("Emergency power relating to redirection of aircraft") with wording such as 'he or she is satisfied that the redirection will not threaten the safety of the aircraft or anyone aboard'.

86. ARPHS would like assurances that regulations made under clause 322 (“Regulations about risks to public health at border”) will be made in line with the International Health Regulations so as to exempt officers from boarding all ships liable to quarantine (as per clause 305(1)) (“Medical officer of health or health protection officer may order craft to another port or airport”).

## **Part 8**

### **Aspects of the Bill that are supported**

87. ARPHS recognises that health impact assessment (HIA) is a valuable tool for improving and protecting public health in a pre-emptive manner and therefore supports the inclusion of HIA in the Bill. It does, however, have some serious concerns about the provisions that have been made for its use.
88. ARPHS supports aspects of clause 374 (“Regulations about public health generally”), though would like some clarification on their application (see below). In particular, ARPHS considers that subsection (x) goes some way to correct the weaknesses of Part 3, though it would like some of the same principles to be considered as per clause 80.

### **Critical issues that must be addressed**

#### *Health impact assessments*

89. ARPHS questions whether or not this subpart contributes to the Bill’s purpose to “*improve, promote and protect public health in order to help obtain optimal and equitable health outcomes*”. For example, there is no statutory requirement to undertake health impact assessments, unlike assessments of effects on the environment in the Resource Management Act, nor is there a requirement to act on the requirements (or at least review them).
90. As commented under Part 5, ARPHS would like to require that local authorities be required to make use of HIAs. Additionally, ARPHS notes that under Western Australia’s proposed Public Health Bill there are provisions for a senior government public health official (the equivalent of the Director-General of Health) to require public health assessments. ARPHS considers that provisions granting public health officials (either the Director-General or medical officers of health) the power to require HIAs could contribute greatly to achieving the Bill’s purpose.
91. As currently written, there are likely to be disincentives to undertake a HIA, especially in terms of uncertainty over criteria and the requirement to submit a copy to the Director-General.
92. Whilst ARPHS supports a best-practice approach to HIAs, the criteria that could be set by the Director-General (as per clause 324(2)) (“Health impact assessments”) are at this stage unknown. ARPHS instead advocates for the inclusion of guidance on undertaking a HIA as a schedule in the Bill, in the same way assessments of effects on the environment are provided for under Schedule 4 of the Resource Management Act 1991.
93. The Bill appears to only focus on the state sector not the private sector. The presumption in the legislation is that “*the purpose of health impact assessment is...to enable departments of State, Crown entities, and local authorities to identify and assess whether proposed actions have a positive or negative effect on public health*”. HIA have, however, been undertaken by a range of non-state organisations and individuals in New Zealand and internationally. ARPHS considers that the purpose as

written is too restrictive. It is also not clear whether the provisions in this Bill (principally clauses 324(2) and 325) apply to non-state organisations or individuals.

94. ARPHS is uncertain what the requirement to supply a copy of a HIA to the Director-General (clause 325) will achieve. Decisions and actions of government that may be linked to the HIA could be reviewed or overturned should the HIA process be held to be inadequate. In any event, HIA would usually (if not always) be publicly available, and would be available via an Official Information Act request. If the purpose is about making the results of HIAs publically available, and it covers HIAs conducted by non-state organisations that would not be subject to the Official Information Act, then perhaps this clause should be reworded to that effect.
95. Furthermore, what mechanisms are there to identify HIAs and ensure that they are supplied to the Director-General? What are the penalties for state and, more particularly, non-state organisations and individuals for non-compliance?
96. Generally, the inclusion of clauses 323 to 325 adds nothing. It does not change the status quo, and in fact the provisions could act as a disincentive for anyone undertaking a HIA. The wording is confusing (see comments above). In addition, “proposals” are included in the definition of a HIA (clause 4), but not included in clause 324.

#### *Examination of children*

97. It is unclear when clause 328 applies and when it does not. What is the purpose of these provisions? Is it to update section 125 of the existing legislation?

#### *Compliance orders*

98. ARPHS has concerns that if clause 329(4)(b) (“Medical officer of health or health protection officer or environmental health officer may issue compliance order”) remains as it is currently written, environmental health officers will have no part to play in monitoring regulated activities (Part 6 of the Bill). As it is already unclear who is the consent authority for regulated activities (see comments above) this limitation further complicates the issue.
99. ARPHS is also concerned that if responsibility for issuing compliance orders in relation to regulated activities solely rests with medical officers of health and health protection officers there will be a lack of capacity in the workforce to effectively address this area.

### **Areas that require substantial improvement**

#### *Regulations about public health generally*

100. How do regulations made under clause 374 fit in with other standards, regulations and pieces of legislation? For example, how would subsection (s) relate with import health standards issued under section 22(1) of the Biosecurity Act 1993? How would subsection (v) related to the Food Act or associated legislation?

### **Other aspects that could be improved**

#### *Related amendments to other enactments*

101. Clause 396(3) should be altered to read ‘the management of any publicly owned organisation providing *or funding* any public health services’ (emphasis added).

#### *Regulations about public health generally*

102. ARPHS notes that under clause 380 (“Regulations and other enactments having effect under this Act”) all existing regulations are due to expire on 1 July 2012.

ARPHS suggests that rather than a fixed date, a period such as five years should be provided to allow sufficient time to replace those regulations that do need to remain.

## **Schedule 1**

### **Aspects of the Bill that are supported**

103. ARPHS is generally supportive of the reviewed schedule notifiable conditions, as it is important to keep the list of conditions for surveillance and public health action up-to-date and relevant in an environment where the challenges and issues for public health response are ever changing.
104. In particular, ARPHS supports:
- Inclusion of tuberculosis in the notifiable disease schedule to the Public Health Bill
  - Replacement of highly pathogenic avian influenza with the more inclusive novel strain influenza.
  - Apparent recognition that the requirements for disease notification may vary between diseases and conditions: i.e. that a 'one-size-fits-all' notifiable disease schedule may not be appropriate. However, this new approach to disease notification has not been fully realised, as described below.

### **Critical issues that must be addressed**

105. No comments.

### **Areas that require substantial improvement**

106. ARPHS recommends that the notification requirements for conditions listed in Schedule 1 of the draft Bill are given careful consideration on a condition-by-condition basis. ARPHS recommends that the notification requirements for each configured are configured according to the primary surveillance needs (i.e. to inform policy and/or operational response) for that condition, taking into account the level of case information required to meet that need, the best source and recipient for the information, and the best way the information can be transmitted. Consultation with the sector will be essential in configuring the list appropriately. The following comments illustrate this recommendation further.
107. At present, the heading of the second column of the table listing the schedule of notifiable conditions in the draft Bill suggests that conditions may differ according to who is required to notify. However, conditions are not differentiated according to this dimension: for each condition, notification is required by both the medical practitioner and the "*specified person in charge of a laboratory*".
108. ARPHS recommends that the list of conditions with a requirement for medical practitioner notification is reduced from that presented in the current draft Bill. This was a decision made at the last Notifiable Disease Review Committee meeting held in May 2007, and was based on the assumption that it would enhance notification by medical practitioners of conditions for which clinical notification is vital. ARPHS supports this position on the following grounds:
109. Experience since the implementation of section 74AA of the Health Act has shown that laboratory notifications provide sufficient information to enable ARPHS staff to process and appropriately manage high-volume notifications such as campylobacteriosis, giardiasis and most salmonellosis. Diagnosis of these conditions is founded almost universally on laboratory confirmation of the pathogen in a clinical specimen: negligible numbers of cases are notified clinically in the absence of

laboratory confirmation. Therefore, ARPHS can see no value in retaining the requirement for clinical notification (i.e. from medical practitioners) in addition to the requirement for laboratory notification—to do so (as appears to be suggested in Schedule 1 to the current draft Bill) would create unnecessary work in collating and matching clinical with laboratory notifications. The advent of laboratory notifications has meant that ARPHS receives laboratory results at the same time as the ordering clinician, and can take action immediately.

110. Conversely, some conditions are only be diagnosed on a clinical basis. For these conditions (e.g. AIDS, rheumatic fever), notification by laboratory staff is redundant and the requirement for laboratory notification should be removed from the Schedule.
111. The draft Bill's requirement that all conditions are notifiable by medical practitioners may be predicated on primary care being able to generate automatically pre-populated electronic notifications. While ARPHS is very supportive of the concept of electronic notification from practice management systems in primary care, it is not sure that the priority for primary care and available resources are such that the requirement could be met in time for implementation once the Bill is enacted. Ideally, if this could be scoped out prior to putting the requirement into the legislation it would be very reassuring.
112. ARPHS recommends that the requirement to notify hepatitis B should be further specified. At present, ARPHS recommends that hepatitis B notifications should be restricted to acute hepatitis B, until guidelines have been developed and services are in place to standardise the response nationally for those identified with chronic Hepatitis B. This can be added by order of council once the programme is ready for implementation. An exception to this would be notification of maternal hepatitis B carriers (identified through antenatal screening). This is of high priority for implementation, and ARPHS would support its inclusion.
113. ARPHS has concerns about the current provisions for notifying sexually transmitted infections. Consultation on this Bill overlaps with another request for feedback on Draft Chlamydia Management Guidelines (closing date February 21). These draft Guidelines suggest that planned public health legislation will introduce direct reporting of unnamed positive results to the medical officer of health and ESR (p2). Conditions such as chlamydia are to be included on the notifiable disease schedule to direct policy-based initiatives. If notifications are to be unnamed and come directly from labs, then they should go to a separate central secure database for analysis; ARPHS recommends that this be hosted by ESR. Notification of unnamed cases to the medical officer of health would be of little practical value, and would be an unnecessary use of resources. The medical officer of health clearly cannot take action on unnamed cases, and the volume would be such that ARPHS would need to process approximately 10,000 additional notifications annually, doubling the current volume. ARPHS recommends that these conditions are made notifiable by laboratories to the national surveillance centre (ESR), not to the district medical officers of health. This may require provision in the legislation to either enable notification to the national surveillance centre or that these conditions are notifiable to the Director of Public Health who would then delegate receipt of notifications to ESR.
114. To summarise this area, ARPHS we would like to know that the changes to the notifiable conditions schedule have been thoroughly planned before they are added to the schedule.

#### **Other aspects that could be improved**

115. No comments.

## **Schedule 2**

### **Areas that require substantial improvement**

116. ARPHS suggests that a reference should simply be made the relevant standard, rather than selecting specific aspects of that standard as to what is notifiable.

## **Schedule 3**

### **Areas that require substantial improvement**

117. See comments under Part 6 about the need to update this Schedule.

## **Schedules 4 and 5**

118. No comments.

## **Conclusion**

119. Thank you for the opportunity to provide comments at this stage of the process. ARPHS is supportive of the need to update public health legislation, but has some concerns about the narrow scope of the current version of the Bill.

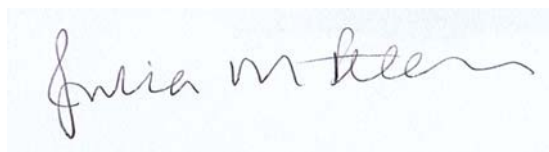
120. ARPHS has identified three key lost opportunities in the Bill as it presently stands: to provide a statutory basis for an independent public health voice; to provide robust public health tools for non-communicable disease control; and to more strongly assert the role of local government in improving public health.

121. As it currently exists, this is much more of a health protection bill than one aimed at dealing with the wider issues facing public health.

Yours sincerely



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