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**Submission to the Ministry of Health on Public Health Legislation: Promoting public health, preventing ill health and managing communicable diseases**

The National Council of Women of New Zealand (NCWNZ) is an umbrella organisation representing 42 nationally organised societies. It has 34 branches throughout the country attended by representatives of those societies and some 150 other societies as well as individual members.

NCWNZ's interest in discussing health legislation and regulations has been a continuing feature of our activities for at least 100 years. We are therefore grateful for this opportunity to be able to make a submission on this discussion document. Responses have been received from members of the Health Standing and Nucleus Committees, from individual branch members and interested parties. Many of the respondents were experienced health professionals.

NCWNZ participated in the last major review of Public Health Legislation carried out in 1998. It is gratifying to note that points raised by our members about the layout of the discussion document have been adopted. Members have commented that the current document is well laid out and easy to follow.

For a document as complex as this there needs to be an appropriate period of time for adequate consultation to be completed. In this regard it was most unfortunate that the document was released just before the Christmas/New Year period. Comment was made about the number of questions posed. It appeared that some respondents ran out of time and/or steam as they approached the later questions.

**General Comment**
The Executive summary includes in the "General framework"**,** elements of the Bill that have already been agreed to by Cabinet. This discussion document covers aspects beyond those agreed on.

The document rightly points out that much has changed in New Zealand's legal and social structure since the Health Act became law in 1956. Work began on this Bill in the early 1990s, this being the second discussion document.

NCWNZ believes that legislation alone won't work. There needs to be Government, multisectoral, community and individual support and participation. A good example of such a model is the antismoking campaign that is still in progress.

**Inequalities**
NCWNZ acknowledge that there are many factors that impact on the health of individuals and that of the community. Poverty, housing and the market economy often have a substantial effect on health outcomes. The differences between rich and poor, and the wholeness of health need to be considered.

These inequalities can result in difficulties in accessing health services and the lack of availability of choice. Where possible, there should be choices available, and people have a right to accurate information to assist them in making choices appropriate for their situation. Respondents

suggested that the statement in section 3.4, para 1, *"The theme of reducing inequalities is most relevant to issues concerning Maori and Pacific peoples."* should also include "…and all people on a low income."

**Privacy *vs.* public good**
NCWNZ strongly supports the position that there are times when the greater good of the community is more important than the rights of the individual. Where individuals pose a risk to public health and safety, and refuse to cooperate or decline medical treatment, they must accept the consequences of their actions. However, it is vital that processes and procedures are simple and transparent and that individual rights and privacy are respected, wherever possible.

**Flexibility to cope with change**
NCWNZ believe it is essential that the Public Health Bill is flexible and able to accommodate for changing circumstances, new technologies and materials, re-emergence of 'old' conditions and new or emerging conditions that pose a threat to public health. An example of the latter is Severe Acute Respiratory Syndrome (SARS). People are dying as a result of SARS. It would appear that the medical profession and others here did not originally know what was causing the condition, where it had come from, or its mode of transmission. Currently there is no specific treatment for the condition and the only means of controlling an outbreak seems to be isolation of the patient.

**Promoting Public Health**
NCWNZ strongly supports the concept of developing programmes for healthy lifestyles. In the long run embracing this concept will save tax dollars through more effective and efficient use of health resources.

The Government and health providers should make a commitment to a right to health. This does not mean perfect health, but the best that is possible for each person.

The five components of the framework developed by the WHO to approach issues in their 1986 *Ottawa Charter for Health Promotion,* are set out, and make a foundation of ideals on which to build a policy. One ideal of this charter, *Health for all by 2000*, was the basis for forming Healthy Cities and its network in the 1990s. This was started enthusiastically in some New Zealand cities, e.g. Lower Hutt, until the later 1990s when Public Health withdrew its support. Health for all by 2000 has not happened, either in Lower Hutt or globally as stated in the Ottawa Charter. The five components are very good ideals but the concept needs wide-ranging, long term resources and a consistent and easily managed approach.

**Prevention**
NCWNZ believe that the underlying message from this review should be that not only is prevention better than cure it is also more cost effective. An example of this would be the prevention of childhood illness such as whooping cough, measles, etc. By working towards maintaining healthy children in society we are also establishing a sound basis for long-term health goals for society as the population ages.

**Specific Comments**
**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).*

Respondents generally agreed that the term 'condition' should be used instead of 'disease'. Comment was made that the term 'disease' was too narrow and should be replaced by the broader

term. It was noted that such a change would cover the incubation stage of a disease/illness, syndromes and the carrier state. It would also cover the situation where a definitive diagnosis had not yet been established.

There was some concern expressed that the change in terminology merely made the situation sound less threatening and negative. These respondents felt strongly that the term 'disease' should be retained but they were in the minority.

**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).*

NCWNZ supports the specific purposes of notification as outlined in 4.4.4 (p15) of the discussion document.

However, respondents identified several critical issues that need to be addressed, including:

- Speed of communication and data security issues.
- Privacy issues and the need for trust.
- The need for transparency of the process.
- Provision of information to the patient including reasons for decisions made.
- Respect for privacy is critical.

**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)?*

Members generally agreed with the proposed criteria for notification. Some suggested that broad outlines might be better than specific criteria as circumstances could change. Others also highlighted the need to cope with rapid change and urged that this might be met by the appropriate formulation of schedules/regulations that could be amended quickly, as and when necessary.

Considerable concern was expressed that issues relating to 'patient rights to privacy' should not result in diseases (e.g. HIV/AIDS, Tb, meningitis etc.) being removed from the notifiable list. These members believed that all communicable diseases should remain notifiable without exception.

NCWNZ members felt that all the criteria listed had merit, although No 4 ("the nature or extent of socioeconomic impact") was regarded, by some, as being the least important.

Some suggested that adverse reactions to immunisation should be notifiable. It was seen as highly desirable to have an accurate database of adverse reactions in order to counter the growing anti-immunisation lobbying, much of which is based on unproven data and supposition.

Comment was made about the importance of the respect for privacy, particularly for those seeking treatment for 'sensitive' diseases/conditions (e.g. HIV/AIDS, STDs etc).

**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.*

NCWNZ members agreed with the four categories suggested. It was suggested that general reports should be kept simple and general. It was also noted that privacy and permission to use data is important and that registers and databases should retain as much anonymity as possible.

Respondents agreed that an easily amenable schedule to the Bill would be sensible as 'conditions' that need to be notified could change with time.

Very few respondents made comment on this question possibly due to difficulty in understanding it i.e. the 4 categories listed in the question do not appear in 4.4.2.

**5.** *Reports from bodies (such as the National Mortality Review Committee) responsible for investigating issues relating to individual safety (para 4.1.2).*

NCWNZ supports provision for regulation-making powers following receipt of reports from specific bodies (e.g. National Mortality Review Committee). It was thought that this would provide for flexibility in an environment of change.

Some respondents raised concerns about the added costs of Special Reporting Bodies. Some members thought that liaison with other individuals/organisations was important (e.g. Coroners, ACC). Further, that use should be made of information derived from registers e.g. Cancer Register.

Several of our members stressed the importance of transparency and privacy issues when dealing with personal information and the sharing of that information. However, while the individual right to privacy is important, most felt that the safety of the community was paramount.

**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?*

Several respondents agreed that an extension to the definition of 'health information' by inclusion of the additional provision ((e) p13) was warranted. Most respondents did not comment on this issue but two expressed concerns about the proposed extension. One group felt the extension was too broad and both had concerns about gaining consent to include 'incidental' information or at least informing the individual that this information was being stored.

NCWNZ agrees that the Privacy Act must not be allowed to override the need for information disclosure. Some members suggested that it might be timely to review some aspects of the Privacy Act.

Members suggested that cooperation was unlikely to be forthcoming in the case of information of a sensitive nature (e.g. pregnancy, abortion, STDs, prostitution etc.) unless privacy issues were dealt with appropriately and informed consent obtained. Patients should at least have the right to know what 'health information' is being stored, why it is being stored, which agencies have access to the information and for what purpose.

Concern was expressed about consent in the case of an unconscious patient or someone mentally incapable of making a rational decision. Members believed it was still vital to gain consent and that this could be sought from another suitable, responsible adult e.g. next of kin, close relative, lawyer, or a person with power of attorney. In case of emergency, and the need to save life, the Hospital Medical Officer should be able to give consent.

Health information about an identifiable individual should be stored in a secure manner. Concern was expressed about methods of disclosure of personal health information. Some felt that such information should not be disclosed by Fax or e-mail to any person or authority. However, there are secure methods for transmitting such information and it was suggested by some that electronic signatures in specified contexts should be valid as hard copy.

**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).*

All respondents agreed that the Bill should include either an obligation or discretion to notify non-notifiable conditions. However, opinion was evenly split on whether there should be an obligation or whether discretion was preferred.

There was support for the ability to declare a condition 'temporarily notifiable' in specific circumstances and for a defined period of time.

Comment was made that, in the case of a non-notifiable condition, identifying details be permitted only when the Medical Officer of Health considers it warranted and preferably after informing the person involved.

Members supporting the option of an obligation to report were concerned that discretion would result in an uneven response. Some practitioners are unreliable and there would be 'different levels of discretion'. It was acknowledged that an obligation might be difficult to police. Health practitioners would need to be informed of the obligation to notify and the value of the data collected.

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

NCWNZ supports the concept of a condition being declared 'temporarily notifiable'. It allows more flexibility in dealing with seasonal conditions or a sudden outbreak of illness. Members stressed the importance of rapid notification to assist in the control of the spread of the condition.

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

Respondents generally agreed with the proposed list of those to be included in the Bill as having notification obligations. It was suggested that the obligation should be by as wide a group as possible.

Some members suggested the list be enlarged to include Coroners and Registrars of Births, Deaths and Marriages. Others were strongly opposed to non-registered health practitioners being included. They expressed concerns about accountability for this group. Some were also opposed to a CEO or Manager of a Hospital being included on the list.

Members generally supported the need to specify separately notification obligations with respect to a person who has died with a possible or confirmed notifiable condition. However, some suggested that it was not necessary to include providers of funeral services, as other health professionals should already have provided the necessary information.

**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).*

All but one of the respondents supported this proposal. It was seen as an appropriate mechanism to ensure rapid notification (some GPs are slow in returning reports) and it also provides a double check. It was suggested that Medical practitioners might not recognise a disease pattern as each may only see one or two cases. Laboratories were more likely to see an emerging trend in a particular population.

Members also suggested that notification should occur before confirmation of diagnosis. Perhaps 'early notification' (i.e. awaiting confirmation) could be specified to reduce paper work in the Ministry of Health. If the laboratory also provides notification of the final diagnosis this should eliminate the possibility of a patient slipping through the cracks because the GP failed to notify the Ministry. Thus, the laboratory should inform both the GP and the Ministry. However, the Health practitioner rather than laboratory should inform the patient.

The dissenting view preferred to see health practitioner taking sole responsibility for notification as "they have capability to view the patient as a whole".

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

Suggestions included:

- Influenza, chicken pox, measles, whooping cough, pediculosis (nits), scarlet fever, and possibly impetigo; and
- Various gastro-enteritis infections; and
- Conditions of a sensitive nature (e.g. HIV/AIDS) that require appropriate counselling, information and referrals for treatment; and
- Other conditions that laboratories don't routinely test for.

It was noted that schools and GPs are often the first to notice an outbreak and use should be made of this information. However, it was acknowledged that some people do not attend a GP and therefore would slip through the net.

**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).*

The majority of respondents supported the suggestion that the Medical Officer of Health be able to modify who is responsible for notification. It was suggested that the availability and reliability of local services needs to be considered and that the Medical Officer of Health was the most appropriate person able to do this.

One respondent did not agree with the obligation of the laboratory to notify the Ministry. The other dissenting view suggested that notification should be able to be made by either laboratories and/or health practitioners (i.e. that there is no need for the Medical Officer of Health to interfere with this obligation). However, it should be noted that the Ministry of Health has statutory obligations.

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

Members generally agreed that it should be the Medical Officer of Health who decides what other agencies should be notified. There should be clear guidelines concerning other agencies that might be notified and the circumstances in which this is required.

There was general agreement about the agencies listed. However, one respondent suggested that the list should include Immigration authorities, particularly if quarantine may be necessary, following identification of a new case of a communicable disease in the country from a new arrival. Another respondent queried the need for OSH, MAF, the Food Safety Authority and ERMA to be included on the list as they operate under their own legislation and regulations.

**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).*

While NCWNZ supports the need to protect personal privacy as far as is practicable, this must not prevent notification. Members were strongly of the view that privacy issues must not compromise personal and community safety.

It was agreed that data stored on computer must be secure. There must be appropriate protocols developed for the access to such information and for its release to other parties or agencies. Further, the information pathway must be clear and uncomplicated.

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

NCWNZ agrees that people who are the subject of notification should be informed accordingly. Provision of information will be vital to gaining community trust in the system. Every effort must be made to ensure that every subject of notification is traced and notified. It is acknowledged that there will be circumstances that will make the provision of information to the patient difficult (e.g. when the patient is a child; or comatose; or intellectually impaired; or suffering from psychoses or dementia; or cannot be traced). However, these circumstances should not in themselves remove the obligation to provide information. It may be appropriate to provide the information to a guardian, close relative or main caregiver.

It was suggested that the threat of notification might cause the patient to delay or avoid treatment. In these circumstances it is important that the GP or some other appropriate health practitioner/provider follow up on the patient. Support people should be encouraged to ensure treatment is completed. It was suggested that it should be obligatory for the patient to stay in contact with the health practitioner/provider and that they should be required to stay in the area. In the event of a patient being uncooperative, other mechanisms will need to be put in place to ensure the safety of other individuals and the community at large.

***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)?*

Members agreed with the proposal on the proviso that the wording given in the discussion paper (p27) is adhered to i.e. that it includes "…preventable ill health from communicable and non-communicable diseases and accidental injury…". These important aspects are omitted from question 15.

There was agreement that the Bill should not include direct provisions at this stage but should allow the use of regulations and specified conditions at a later stage. Issues that might require the use of regulations include: advertising 'high fat/sugar' snacks/foods to children, direct drug advertising to public, elimination of passive smoke in all public places.

Members suggested that provision of appropriate education was vital to the success of public health promotion. Areas of particular concern were underage drinking/drunkenness, drink driving, the effects of alcohol on the unborn child, the effects of abuse of illegal substances and obesity in Pacific peoples and the young. Educational programmes to tackle these issues need to be targeted. There should be full consultation with all appropriate agencies to ensure good information flow and to prevent duplication of educational efforts.

Concern was expressed about the apparent ease of access by teens to drinks laced with alcohol (pre-mixers). Members felt that this did not demonstrate real commitment to tackling the teenage drinking problem seriously. Present rules should be enforced, the age limits needs to be reviewed and more education is required. Comment was also made that more education was required on 'healthy eating'. School tuck shops and fast food outlets should be encouraged to provide healthier options to young people.

Comment was made that the Hillary Commission started encouraging exercise but that this has not been followed up. Local authorities and schools should be encouraged to provide more swimming pools with a full range of pool activities being made available to encourage exercise.

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

Most respondents agreed that the Bill should include regulation-making powers for promoting public health. Some urged that clear and substantive provisions must be made or they will be ignored or misrepresented (e.g. the Privacy Act) by some sectors of the community. It was agreed that some public health strategies may require regulations as part of the strategy and the Bill should include/allow this at some stage.

However, some respondents were vigorously opposed to this proposal. They suggested that in many instances there were adequate controls already in place, e.g. supply of alcohol to minors, drinking and driving, underage drivers, speed limits etc. There was a strong feeling that these controls should be enforced rather than add yet more controls. There clearly are problems in enforcing the current controls. These respondents suggested that people should have freedom to make choices irrespective of the outcome. They believed that improved educational programmes were the preferred way to go.

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

The majority of members supported the Bill including a reference to health impact assessments.
It was generally agreed that health impact assessments should be carried out when formulating policies or prior to the introduction of new legislation. Considerable concern was expressed over the increase in consumption of alcohol by teenagers as a result in a change in the law and the increase in gambling resulting from an increase in licences for casinos and gambling machines.

Members acknowledge the determinants of health and their importance to population health and stressed that the issues need to be addressed in a proactive manner by requiring policy development in housing, education and social services to be predicated on 'healthy outcomes". Health impact assessments are essential and should be obligatory.

The dissenting view was that there was not enough evidence at this stage to be so specific.

**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)?*

The majority of members agreed that legislation was an appropriate vehicle for health impact assessments (see response to Question 17) and hence did not comment here.

There was considerable support for more/better education programmes and better access to appropriate information.

Some members urged that there should be an increase in services to reduce health, education, employment, and income and accommodation inequities – using current evidence based outcomes.

Some commented that belief in a change of behaviour because it is 'good for you' and has 'pleasing results' is more likely to be followed than implementing legislative or regulatory instruments.

***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).*

NCWNZ supports the proposal that the Bill specify as one of its purposes the importance of child health. Members agreed that child health should be paramount. Members also agreed that there should be reference to UNCROC.

There was minority disquiet about the inclusion of "prevention of vaccine preventable disease and disability" (p30).

**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?*

The majority of respondents did not comment on this question.

Some members suggested the Bill be more specific about: physical, mental or sexual abuse; poor nutrition; and the physical or mental neglect of children. Others suggested that the Bill should go further and promote regular health surveillance of all children to ensure that abuse or neglect was identified as early as possible.

Concern was expressed about the increase in neonatal, paediatric and adolescent deaths in NZ. It was noted that in Hamilton, 25% of children do not have a regular GP. Many of these children come from underprivileged families. Often cost and/or accessibility are major factors inhibiting attendance at a regular practice. When the need for medical attention arises they often attend after hours health service providers. It was also noted that there are increasing reports of children being taken to their GP and/or hospital too late. Comment was also made about reports of alarming numbers of adolescents being depressed and suicidal. The reasons for these increases need to continue to be investigated and the issues addressed.

***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).*

NCWNZ supports the proposal to allow the establishment by regulation of specialised registers following consultation.

Members agree that there should be a National Immunisation Register. Currently immunisation registers are operated by a number of different groups. Many families either don't have a regular health provider or are mobile and keep changing their health provider. The lack of a National Immunisation Register hampers efforts to identify children at risk and ensure that such families are provided with information and ongoing care/treatment. However, reference was made to the need to accommodate the rights of people to have a choice not to immunise and this needs to be recorded on National Immunisation Register. This should prevent these parents from being hassled in an opportunistic setting. Most importantly, a National Immunisation Register would allow these children to be traced and the parents given the option of keeping their children away from school in the event of an epidemic e.g. measles epidemic that has about a five year cycle. Consideration also needs to be given to 'at risk' children.

It was noted that registers are already being trialled and assessed in hospitals. Encouragement should be given to these, interest taken in any difficulties encountered, and assessments done with a view to soon making them obligatory.

It was agreed that there must be full consultation with all appropriate agencies regarding the need for a specific register and the regulation of the register. It is also important that there is coordination and improvement of current registers and that duplication is avoided.

**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).*

NCWNZ supports the proposals for privacy and disclosure provisions for registers. Members stressed the importance of patient trust in the security and privacy of the system.

Opinion was divided about whether registers should be "comprehensive", "opt-off" or "opt-on". What was clear was that the "opt-on" option was not favoured.

Members strongly urge that before the requirements for a specific register are changed there must be consultation with patients. Several references were made to the Cervical Screening Programme. Some patients were so angry over confidentiality issues and the lack of consultation before the "opt-on" option was discontinued that they stopped participating in the programme. Members regarded this as a bad outcome. It is clear that the requirements have to be considered very carefully and involve wide consultation to minimise the need to change requirements at a later date.

Members support the right of individuals to be informed of what information is being stored about them and to be able to correct errors.

There was a minority view that informed consent should be required at all times even for data stored regarding patients who have died. In this circumstance consent from the family should be obligatory. Informed consent should also be mandatory before using existing databases or 'backloading' of data.

***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).*

The majority of respondents agreed with the proposal that there should be empowering provisions for making regulations on immunisation.

There was support for the proposal that the certificate of immunisation status should state reasons for non-compliance. Some supported a stronger stance and urged that parental objection should be recorded as a statutory declaration. As well as parents still having choices, preschools can choose to exclude children but schools should not demand compliance by law. It was suggested that any adverse reactions to immunisation should be recorded on the certificate, where appropriate. There was support for a requirement for regular updating of certificates.

Some respondents were concerned that schools could be empowered to refuse a child's enrolment without certification. There was also concern that schools might insist on compliance before allowing enrolment.

Concern was expressed that there is a growing group who are opposed to immunisation, including some health professionals. There are now 2 generations of people who have not seen the ravages caused by these diseases and just how extremely ill they can make people. Training videos showing cases of these diseases e.g. diphtheria might change some attitudes, particularly of the health professionals.

There was a minority view that did not support the proposal. These respondents felt that setting up a national register would require huge resources and may not result in the desired outcome. They suggested that immunisation coverage might be improved by increasing resources to current immunisation registers held locally e.g. by IPAs, PHOs, Primary Health Providers. They considered that better coordination and provision of more resources to existing services would provide a better result. Of course this minority view contradicts the view expressed in question 21 that supported the establishment of a National Immunisation Register. Opinion among members was divided on this issue.

**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).*

The majority of respondents agreed with the proposal that all children should be immunised unless there was a conscientious objection stated or there was a reasonable possibility of an adverse reaction.

It was noted that many parents are now influenced by a powerful lobby who are opposed to immunisation. Some parents are bombarded with literature, may feel confused and opt-out, rather than 'risk' immunisation. It is vital that the importance and safety of immunisation be widely advertised and emphasised.

It was agreed that it was important that there be appropriate mechanisms for consultation and that quality educational programmes addressing immunisation issues were required.

Members generally agreed that the regulations should take into account a parent's "conscientious objection" to immunisation and "reasonable possibility" of an adverse reaction. Some suggested that a conscientious objection should take the form of a statutory declaration.

Concern was again expressed that children should not be excluded from school if they do not have an immunisation certificate. Schools should not have to 'police' immunisation.

The dissenting view was that the parent is responsible for the wellbeing of the child. Some parents simply don't trust health officials rather they have more faith in their GP.

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

Although opinions were fairly evenly divided, the majority supported that references to immunisation should be mainly focussed on child health. The opponents suggested that immunisation should be general across population groups. They stated that the elderly are another 'high risk' group.

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

The majority of respondents agreed that references to immunisation should extend to adults where appropriate. References were made to open cases of Tb (exposure of health practitioners) and tetanus (risk to elderly gardeners) as examples where immunisation of adults was appropriate.

The dissenting view was that adults should take responsibility for their own health.

**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).*

The majority of respondents agreed with this proposal. The member expressing dissent did not provide any reason for their view.

Those supporting the proposal suggested that it was vital to assess the results of any immunisation campaign. They indicated that antibody level cannot be tested in all children and that batches of vaccine vary in efficacy. It was also suggested that establishing the 'efficacy' of the vaccinator was important. They agreed that it was important to monitor the conditions that are relevant to the general immunisation schedule.

**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)?*

The majority of respondents agreed with the proposal that there should be emergency powers for vaccinating people without their consent. It was suggested that a natural disaster e.g. earthquake, volcanic eruption etc. could result in sewage lines being broken and water supplies compromised leading to risk of diseases like typhoid fever. Members suggested the whole community should be vaccinated or revaccinated under these conditions except those who refused vaccination on the grounds of "reasonable possibility" of an adverse reaction. There is an expectation that the large numbers of people vaccinated would reduce the risk of infection to those not able to be vaccinated.

It was acknowledged that it was better that consent was obtained wherever possible. However, the safety of the community, and in particular children, was paramount.

There was a minority view that children should be vaccinated in such circumstances but compulsion should not extend to adults. There was a further view that there should be no

compulsion for adults or children. Rather, there should be more information provided and more steps taken to encourage voluntary vaccination.

***Screening***

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

Most respondents agreed to the need to make regulations to specify circumstances in which screening would be appropriate. It was suggested that such provisions needed to be in place in case required urgently.

Members suggested that it might be appropriate to introduce screening of all blood and organ donors. It might also be appropriate for screening for hepatitis antibodies in health professionals, particularly operating theatre staff, laboratory technicians, and dialysis unit staff. Consideration should be given to ensure people have a choice in certain areas e.g. in relation to ethnic issues.

It was suggested that other screening should be encouraged e.g. vision, hearing, development and recorded on a Health Register of all children.

The dissenting view was that written consent should be required for all screening procedures. While current evidence would support screening programmes in primary care services, national programmes are not justified and therefore legislation is not required until further evidence becomes available to support the need for a national programme. In the event of primary care screening being undertaken adequate resources must be provided.

**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)?*

Members generally agreed that the Bill should contain general provisions and regulation-making powers to authorise the establishment of new screening programmes.

It was suggested that the system must be amenable to change to deal with the emergence of new conditions and adjust for the implications of new research findings. It is vital that any provisions encompass quality assurance, evaluation and research. There is also a need to provide for recall or reassessment to ensure follow up.

Some members reiterated that all programmes should provide for an “opt-off” option.

Concern was expressed at the current lack of emphasis on men’s health. It was suggest that health screening at age 50 would be a good move for all.

The dissenting respondent commented “screening would be regarded as good practice in primary health service”.

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

Responses were mixed to this proposal, however, the majority supported the use of registers for purposes other than screening programmes. Some thought that any proposal to improve general health in the community should be considered.

However, others saw the costs of implementation as a problem. Members urged that the Ministry should do one thing at a time properly, ensure that it is established and working successfully before adding another function/requirement. In this way the money will be well spent. More than one under funded programme being enforced is likely to lead to poor results and undermines confidence in such health schemes.

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

The majority of respondents agreed that the Bill should include a reference to privacy impact assessments. It was generally agreed that impact assessments should be carried out early in the development of health programmes. Further, it is vital to encourage and retain public trust in the system. Ensuring that the process was transparent would assist this.

***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.*

Although there was minority support for options 1 and 2, the majority of respondents supported option 3. Option 3 was generally thought to be the broadest and most reasonable option. Respondents supporting option 3 urge that the lists of communicable conditions need to be reviewed and updated regularly to meet changing circumstances and the emergence of new conditions. It was suggested that the lists should be readily available to all.

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

NCWNZ supports the proposal that the Bill set out the rights and duties of people with communicable conditions.

It was stressed that the aim should be to gain co-operation rather than resorting to coercion. However, it was acknowledged that there were people who would be uncooperative and coercion might be necessary. It was suggested that many patients were unaware of their rights and oblivious of duties to partners, friends and community. There was no clear support for criminalising behaviour that results in the risk of transmission of a communicable disease.

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

The majority of respondents supported the proposal that the Public Health Bill include offences for behaviour that involves infecting other people. Some felt strongly that if this issue is not already covered by current criminal law then it must be covered in the proposed Bill.

It was generally agreed that criminalisation might not be desirable, however, the greater good of the community must be considered. The concept of public health orders was supported. It is important that the process be simple to follow, transparent and able to be applied speedily.
Members who disagreed with this proposal suggested that offences under the Public Health Bill would be difficult to police.

*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)?*

There was a mixed response to these options. The majority of respondents supported option (c), followed closely by option (a). A few respondents supported option (b) or a combination of options.

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

NCWNZ supports the inclusion in the Bill of the suggested duties of health practitioners in relation to persons with communicable conditions.

Members suggested that there should be provision for the inclusion of a guardian, carer or family member if the patient were a child, or a person with intellectual impairment or a significant psychiatric condition. It was also suggested that continuing surveillance should also be included.

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

NCWNZ supports the proposed range of powers applicable to a person with a relevant condition.

Members urged that all possible measures to minimise the risk to others must be taken. Members agreed that the Medical Officer of Health, who should have the relevant information, would be the most appropriate person to determine what action should be taken. In life threatening conditions there should be powers of enforcement.

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

Option 3 gained the most support from members. There was also some support for option 1 with the proviso that the Medical Officer of Health be able to call an advisory committee together.

Comment was made that the current powers assume cooperation. This is not always the case and the legislation and regulations must take this into account.

Members believed the lists included all relevant criteria, according to the severity of the communicable disease. The criteria should be based on:

- The health and safety of others.
- WHO regulations. However, it was pointed out that the International Health Regulations (1969) are being revised.

- The severity of the condition in terms of disability, illness, mortality.
- The ability of the exposed people to protect themselves from a high-risk condition e.g. intellectually impaired resident in a home for people with intellectual impairment.

The role and responsibilities of the Medical Officer of Health must be clearly defined.

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

The majority of members supported the proposal that some powers should be exercised only by a court. While it was accepted that court might be necessary in extreme cases, this was seen as a last resort. It was accepted that court action was appropriate where more coercive powers were required which could lead to detention for a non-finite term.

Some members suggested that use of the court should parallel the current situation with regard to mental health and care providers.

The dissenting view the Medical Officer of Health should have the power to make all decisions. However, the development of appropriate guidelines and directions would be paramount.

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

The majority of respondents favoured the use of the Family Court. Supporters of this option felt that this forum was less threatening, that the court had more experience on ethical issues, that privacy issues were better catered for, and that there was more opportunity for advocacy. It was acknowledged that there might be problems with regard to access to a Family Court.

There was considerable support for the use of the District Court. Supporters of this option felt there was better access and that this option was preferred when speed was paramount. Some members also believed that this forum was more appropriate because whole communities may/could be at risk not just an individual patient or family. It was suggested by some that the Press should be excluded during such hearings.

Some respondents thought that both options should be available and that the choice would depend on what was most appropriate for the circumstances.

There was a dissenting view (i.e. did not believe the courts should be used at all: see response to Question 39).

**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)?*

NCWNZ supports the proposal that a Medical Officer of Health should be able to issue an emergency public health order to have effect for a short period. Further, that the period may be extended after application to the Court.

Members agreed that the system should be simple and that speed was essential. The process should be used as only a last resort after all other steps have failed. It was agreed that there should be a right of appeal.

***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.*

All respondents agreed with this proposal. It was suggested that there is currently a gap in the legislation and that this measure would prevent people falling between two pieces of legislation.

Comment was made that some people gradually slip into a state of not caring which they are reluctant to admit to and either do not recognise that they need help or refuse to seek help. Some aged/infirm will not accept care and being stubbornly independent dig their heels in. They may be oblivious of the dangers to themselves and community. If they are not physically safe then action needs to be taken. It was stated that unsanitary conditions could attract vermin etc.

**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)?*

There was a wide range of opinions on the proposal to replace the term 'aged and infirm' with 'public health welfare'. The majority, who supported the proposal, stated that it was not just the aged and infirm who were unable to care for themselves. Reference was made to 'street kids' and young alcoholics and drug addicts. It was believed that the phrase 'public health welfare' was a 'friendlier' term and it recognised that there was a community health problem. It was also suggested that there was a tendency to remove reference to age in legislation.

Opponents of the proposal claimed that the term 'public health welfare' was too general/nondescript and not specific enough. The term 'aged and infirm' is 'old hat' but specific. However, they suggested alternative terms such as 'elderly and/or infirm' or 'infirm and neglected people'. The Nucleus Group preferred the term 'elderly and/or infirm'.

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

NCWNZ supports the proposed conditions, powers and procedures for using these powers as outlined in para 7.3.2 (p47).

Members urged that the powers be as broad as possible to prevent people unable to care for themselves being ineligible for care. Concern was expressed about the need for supervision of "street kids".

Some respondents gave qualified support for the proposal. They stated that these powers should only be used if the individual concerned presented a health risk to others. They suggested that everything should be done to avoid the use of coercive powers. They stated that some people prefer to live on the street. Their freedom to do so should not be interfered with lightly.

***Chapter 8***

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

NCWNZ supports the need for legislative provision for contact tracing.

Legislative protection is needed in the event of non-compliance that could endanger all contacts and associates of the original infectious person. Some people appear to have no conscience. Where there is reluctance to notify contacts, the professional needs legislative backing or they could be sued for breach of privacy.

Some conditions present particular problems because of sensitivity. In cases involving STDs and HIV/AIDS, for example, the patient may be reluctant to inform contacts. However, members are adamant that a partner has the right to know the danger of contracting STDs or HIV/AIDS. The patient should be given the opportunity to inform others and strongly urged to do so. If they fail to provide proof of having informed contacts, the health professional should carry out this task. There was strong feeling that informing contacts should be compulsory. The only issues being by whom and how.

**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.*

There was a mixed response to this question. The majority of respondents favoured a single option and the vast majority of these favoured option 4. Some members supported a mix of options. There was little enthusiasm for option 3.

Those supporting option 4 commented that it is important to minimise public health risk as far as possible. This option was clear and uncomplicated and encapsulates all conditions. It would provide the greatest measure of protection for the community.

**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)?*

NCWNZ supports the proposal that the Bill should provide for contact tracing where the condition is associated with an offence under the Crimes Act.

Members agreed that this was an appropriate provision, as the public health risk must be minimised as much as possible.

It was acknowledged that a person subject to this provision is a person acting irresponsibly who could be placing the community at risk. In such circumstances the safety of other individuals and the community are paramount.

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

The majority of respondents did not comment on this question.

Comments were made about open case Tb, meningitis, HIV/AIDS and Salmonella. Concern was expressed about the increasing problem of drug-resistant Tb. In such a case all family, particularly children, and contacts should be traced. Contact tracing should occur where any serious condition is spread by exposure to droplets.

**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)?*

NCWNZ supports the proposal that the Bill specifies the duties of people with risk conditions to provide information and assistance.

Members agreed that patients with risk conditions and patient contacts had a duty to cooperate. However, legislation needs to be available for use with patients and/or contacts who are uncooperative. It is important that all practicable steps are taken to control the spread of infection. Failure to do so could result in important health sequelae.

**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)?*

The majority of respondents agreed that the Bill should make specific provision for partner notification. This measure would also protect the health practitioner from breach of confidentiality.

Members were strongly of the view that partners had the right to be informed about risks to which they might be exposed so they could take appropriate steps to protect their own health and that of others. If a partner were not informed of the risks they might unwittingly spread the infection.

Members agreed that the infected person should be given the option of telling their partner first, but the partner must be made aware of the risks. It was acknowledged that some partners avoid the responsibility of informing partners of sexual diseases and HIV/AIDS. For this reason there must be a mechanism to ensure that contacts are notified if the infected person is unable or unwilling to do so.

Comment was made that the infected person might not be concerned about a casual partner and might deny knowledge of the source of infection or possible recipients of infection.

The minority view was that there was no need for this provision provided the individual took responsibility for disease management and agreed to inform partners. It is essential that those affected seek treatment. It was suggested that a draconian measure could mean an infected person avoids treatment.

**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)?*

NCWNZ supports the proposed procedures for contact tracing.

Members agreed that it was vital for all contacts to be advised so treatment and preventative measures could be undertaken. It was also agreed that authorisation of all concerned was ideal. However, it is imperative that there is a time limit on this. If person does not do it then someone else must. If permission was not obtained and the risk was deemed to be high, then the Medical

Officer of Health must have the necessary powers to obtain the information. It was suggested that the threat of notification to the Medical Officer of Health might induce cooperation.

***Chapter 9***

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

NCWNZ agrees in general terms with the outlined objectives for border health protection.

Members agreed that every effort must be made to protect New Zealand citizens and our primary industries. Some members thought that border controls should be stepped up.

**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.*

The vast majority of respondents supported option 2. Members supporting this option felt that the powers for control should be as wide as possible. Comment was also made that there may be instances where there was high risk with communicable disease and surveillance of people with preclinical symptoms could be desirable. Legislation needs to cover this possibility.

One respondent favoured option 1 and referred to other legislation in relation to the additional vectors mentioned in option 2.

**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).*

The majority of respondents supported this proposal. It was seen as vital to act quickly if returning New Zealanders or incoming travellers were suspected of being infected with a communicable disease. Some thought that in such circumstances incoming travellers should be denied entry. However, such a response could in some circumstances breach a 'duty of care' or be in contravention of an international obligation e.g. in the event of the person claiming political asylum.

The dissenting view raised the issue of the speed of air travel. They also commented that most entrants carrying communicable diseases are not identified at the border. It would be preferable for a health professional to be given discretion to contact the Medical Officer of Health.

**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)?*

Some respondents did not comment on this issue. Those who did comment supported the proposal that the concepts of quarantine and pratique should be retained and applied much as at present.

Members agreed that every effort must be made to prevent the entry into New Zealand of disease vectors of all types. It is vital for our agricultural based economy to prevent, as far as practicable, the entry of any disease or disease vectors.

It was suggested that there is a need for coastal surveillance for boat people.

**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)?*

The majority of respondents agreed with the proposal.

Members generally agreed that the emphasis should be on as wide a range of diseases and conditions as possible. New communicable diseases could emerge and the Bill must be flexible to allow for changes as they occur. It was suggested that the recommendations made in the Human Quarantine Review 2000 (Commonwealth Dept of Health and Aged Care) should be taken into account. It was noted that WHO is reviewing International Health Regulations 1969.

The dissenting view urged that visitors with significant health issues should be dealt with before leaving their country not at border control if they are not carrying a communicable disease.

**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)?*

The majority of respondents agreed with the provision for border health protection to apply to non-communicable conditions.

Members felt that any condition that could have public health significance needs to be able to be controlled to prevent the spread of infection.

Comment was also made that outbreaks of severe food poisoning or influenza in unfit patients could warrant detention in hospital. Visitors without New Zealand citizenship should be required to pay for any treatment (i.e. Travel Health Insurance should be mandatory). However, this would be in contrast to adventure tourists liable to sustain injuries. In this instance treatment is currently paid for by ACC.

The dissenting view felt that travellers without New Zealand citizenship should be required to pay for their own treatment.

**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)?*

NCWNZ supports the proposal that the Bill should allow for more restrictive powers to be available in the event of a border health emergency. Members agreed that this was necessary to ensure that action in response to a border health emergency could be swift. The proposal should also allow for flexibility in the event of the emergence of new infectious conditions.

Particular concern was expressed about 'boat people' who may be sick or disease carriers. It was also noted that departing travellers might be incubating communicable disease about to break out in New Zealand.

**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)?*

The majority of respondents agreed that the Bill should make more explicit recognition of the duty to prevent the export of pathogens.

Members agreed that New Zealand needed to be seen to be a responsible member of the international community. New Zealand authorities are currently responsible for standards of food and water leaving the country and this should continue. They should also be responsible for the cleanliness of craft departing for overseas. Other countries have an expectation that New Zealand authorities will cooperate with them in protecting their own public health status.

The dissenting view was that the Food and Hygiene Regulations cover the responsibility for this issue. It should not be an issue for border control.

**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)?*

Although some respondents declined to comment, the majority agreed with the proposal.

Members agreed that there needed to be wide powers for inspections for use if and when necessary. It was suggested that authorities needed to be eternally vigilant in this age of terrorism.

**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)?*

NCWNZ supports the proposal that border health protection should apply to items sent through the post.

Members suggested that with increasing importation of goods the risk of entry of pathogens was also increasing. It was agreed that substances must be included as well as pathogens. Members commented that threatening articles and substances are already being sent through the post.

NCWNZ thanks the Ministry of Health for this opportunity to comment on what is a complex field. We support the approach that is being taken and look forward to seeing the summary of submissions.

Beryl Anderson
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