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PUBLIC HEALTH AMENDMENT (REVIEW) BILL 2017

Second Reading

The Hon. SCOTT FARLOW (17:21): On behalf of the Hon. Niall Blair: I move:

That this bill now be read a second time.

I am pleased to bring before the House the Public Health Amendment (Review) Bill 2017, which seeks to amend the Public Health Act 2010 following a statutory review of that Act and subsequent developments in public health since that review. The Public Health Act passed Parliament in 2010 and aims to protect and promote public health, and control the risks to public health. The Act deals with a range of public health matters such as powers during a public health emergency, notification of diseases and conditions to the health secretary, vaccination enrolment requirements in childcare facilities and primary schools, and the regulation of a number of areas that have the potential to affect public health, such as drinking water, skin penetration and public swimming pools. In 2016, a statutory review of the Public Health Act was undertaken by the Ministry of Health to determine whether the objectives of the Act remain valid and whether the provisions of the Act are appropriate for securing those objectives.

As part of the review, the ministry released a public discussion paper to seek submissions from stakeholders and members of the public. More than 200 submissions on the discussion paper were received from members of the public and from stakeholder organisations. I thank members of the public and those organisations for their thoughtful contributions to the review of the Public Health Act, which were considered in preparing the final report on the review. The report on the review was tabled in Parliament in November 2016. The report found that, overall, the objectives of the Act remain valid, but recommended a new objective be added relating to the monitoring of diseases and conditions. In addition, the report recommended a range of amendments to ensure that the Act can best protect public health. The bill follows on from the review of the Act and subsequent developments in relation to public health.

I turn first to the area of vaccination, which is one of the cornerstones of public health. It is a safe, cost-effective means of effectively preventing individuals from catching and suffering from the once common and fatal illnesses that wreaked havoc and misery on the community. Measles, tetanus, polio and diphtheria are just some of the diseases that once caused fear, pain, suffering and death but which are now, thankfully, largely controlled in Australia due to the success of vaccination. However, not everyone can be safely vaccinated, and vaccines are not always fully effective. Young babies cannot be fully protected by vaccination and some children and adults cannot be vaccinated for medical reasons. That is why it is the responsibility of all of us who do not have a medical contraindication to be vaccinated and to ensure our children are vaccinated. If people who can be safely vaccinated are, we provide a greater level of protection to those who cannot. The higher the rates of vaccination amongst those who can be vaccinated the lower the risk of infection to those who cannot be safely vaccinated.

Thankfully, most members of the community fully support vaccination, as evidenced by more than 93 per cent of New South Wales children registered as being fully vaccinated. However, the success of vaccination can result in some people becoming complacent about vaccination. More disturbingly, there are small pockets in the community that not only do not support vaccination but also peddle lies and misinformation about the safety and effectiveness of vaccination. We cannot allow the community to become complacent and we must fight back against the untruths about vaccination. To properly protect and promote public health we must maintain the highest level of immunisation possible within the community, and an important place to start is vaccination of children in childcare facilities. I note the Minister for Early Childhood Education is present in the Chamber. Childcare facilities can offer a breeding ground for the spread of disease due to the close proximity of children in a confined space. Herd immunity is especially important in that environment. Increasing the proportion of children in child care who are vaccinated will help to protect those who cannot be safely vaccinated or are not yet fully vaccinated.

As such, this bill will amend the Public Health Act to require a principal of a childcare facility to prevent a child who is not vaccinated solely due to the objections of their parents from being enrolled in child care. Under the changes contained in section 87, a childcare facility will be able to enrol a child only if the facility is provided with evidence that the child is age appropriately vaccinated, is on an approved catch-up schedule, or has a medical contraindication to vaccination. It will be an offence for a principal not to comply. The report on the statutory review of the Act recommended strengthening existing childcare vaccination requirements, although exclusion of unvaccinated children from child care was not included in the recommendations.

However, the New South Wales Government has considered the issues and has heard community calls, and indeed calls from the Prime Minister, to increase vaccination rates in child care. This Government supports the need to increase the rates of vaccination, and the need to protect and to promote public health is the basis for these changes. Some may argue this change is unfair because it disadvantages children as a result of the decisions of their parents. The Government does recognise the importance of early childhood education. However, what is unfair is parents choosing to place their own child, as well as other children and other members of the community, at risk of serious harm or even death by not vaccinating their children.

Parents who have chosen not to vaccinate their child or children will have a decision to make—to listen to all credible medical and public health experts and to protect their own child or children and others by vaccinating the child or children or ignoring the experts and science, leaving their child or children unvaccinated at the risk of life-threatening infections and not being able to enrol their child or children at child care. I urge parents not to make the latter choice. Vaccination is a success story of the modern era. We live in an age when some diseases can be prevented before they begin. All children should have the advantages of vaccination and those who can be vaccinated should be to protect themselves and others.

While it will no longer be acceptable for parents who choose not to vaccinate to enrol their child in child care and to place others at risk, the Government does recognise that there may be some groups in the community that have difficulties producing vaccination records at enrolment. These groups include children in emergency out-of-home care or a child who has been evacuated during a state of emergency. The changes are not intended to affect these classes of children. However, the bill amends the public health regulation to exempt two additional groups from the initial vaccination enrolment requirements. Those groups are Aboriginal and Torres Strait Islander children, and children in out-of-home care.

The groups in the public health regulation that will be exempted from the vaccination enrolment requirements are not groups the ministry expects to be unvaccinated. In fact, some, such as Aboriginal and Torres Strait Islander children, have higher rates of vaccination than non-Aboriginal and Torres Strait Islander children. However, parents and guardians of these children may find it more difficult to produce records on enrolment and therefore their children may be disproportionately negatively affected by the changes.

The regulation will require the vaccination records for these groups of children to be provided within 12 weeks of enrolment.

This important change will be supported by additional amendments to the provisions of the Public Health Act relating to vaccinations as recommended by the report on the statutory review. Currently under the Act, principals of primary schools and childcare facilities must collect information about a child's vaccination status. When a child at primary school or child care has a vaccine-preventable disease, a public health officer can issue an exclusion order. An exclusion order excludes a child with a disease or any unvaccinated child from attending a primary school or childcare centre during the outbreak period.

The bill extends these provisions to high schools and allows an exclusion order to be issued when an unvaccinated child has come into contact with a person with a vaccine-preventable disease anywhere, regardless of whether there is an outbreak at the particular school or childcare facility that the child attends. Despite the success of vaccinations, outbreaks of vaccine-preventable disease occur from time to time. However, the changes in the bill will assist in the better management of such outbreaks by preventing unvaccinated children who have no medical contraindication to vaccinations from being enrolled in child care, which will assist in protecting and promoting public health.

I turn now to the other changes in the bill, which mostly follow on from the recommendations contained in the "Report on the Statutory Review of the Public Health Act". The bill amends section 3 of the Act, which is the objects clause of the legislation. The objects recognise the importance of protecting and promoting public health, controlling the risks to public health, and the important role that local government plays in public health. As found by the report, these objectives are appropriate but there is no express objective relating to the monitoring of diseases and conditions. This is despite the fact that the Public Health Act requires a range of conditions and diseases to be notified to the Secretary of Health by medical practitioners, hospitals and laboratories.

Notification allows NSW Health to monitor the incidence and impact of diseases and conditions and to take appropriate public health action, if required. Accordingly, and in line with the report's recommendations, the bill amends section 3 to include monitoring the diseases and conditions affecting public health as an objective of the Act. In respect of notification of diseases and conditions, the bill amends section 54, section 55 and section 83 to allow the Secretary of Health to obtain further information about a person with a scheduled medical condition or notifiable disease from the patient's treating medical practitioner. These changes will ensure that when the treating medical practitioner is not the person who made the notification, relevant information about the patient's medical condition and risk factors can be obtained by the Secretary of Health.

The Public Health Amendment (Review) Bill includes a new section 130A. The new section will ensure that information about notifications of diseases and conditions received by the Secretary of Health cannot be disclosed under subpoena or given in evidence except in relation to proceedings under the Public Health Act. The new provision is intended to ensure that the public can trust that the sensitive information obtained and held by the Secretary of Health will not be unduly disclosed. The change will help to facilitate the public and clinicians in providing accurate and complete information to the Secretary of Health.

I turn now to the amendments in section 62, section 63, section 64 and section 68 relating to public health orders. Currently under the Act, if a person with a high-risk disease such as Ebola, Middle East respiratory syndrome [MERS], severe acute respiratory syndrome [SARS], avian influenza in humans, or typhoid, is acting in a way that places the public at risk, a public health order can be made. A public health order can require a person to refrain from certain conduct, be detained and/or treated. However, a public health order cannot be made in respect of a person who has come into contact with a person with a high-risk disease but has not yet developed the disease. A contact may be infected and then can be infectious prior to developing symptoms of the disease. This means that if a contact who may not be displaying any symptoms refuses to undertake appropriate risk mitigation measures, such as not entering public places, they may place other members of the public at risk of infection.

Management of contacts of persons with high-risk diseases can be central to the effective management of an outbreak of a disease and prevent ongoing transmission, as demonstrated in the 2003 SARS outbreak overseas. Generally, a contact would agree to risk mitigation measures. However, the report found that the public health order provisions should be extended to contacts with high-risk diseases who are potentially placing the public at risk. The recommendation was accepted by the Government and the bill amends division 4 of part 4 of the Act to allow a public health order to be made with respect to the contact of a person with a relevant condition, being viral haemorrhagic fever, MERS, SARS, avian influenza in humans, or typhoid. An order can only be made if the authorised medical practitioner is satisfied that the person has been exposed to the relevant condition and is at risk of developing the condition and that the person is behaving in a way that may be a risk to public health.

While public health orders for contacts are a necessary tool to protect public health in rare cases, they pose restrictions on a person's liberty. Therefore, a number of safeguards have been built into the bill. A public health order in respect of a contact with a person with a relevant disease must be revoked, at the latest, at the end of the incubation period for the relevant disease. For example, a public health order relating to a contact of a person with SARS can last a maximum period of 10 days, while the maximum duration of an order relating to a contact of a person with a viral haemorrhagic fever such as Ebola is 21 days. Further, if the authorised medical practitioner makes an order, the order will have to be reviewed and confirmed by the NSW Civil and Administrative Tribunal. Public health often involves balancing the rights of the individual and the public health needs of the community.

The provisions in the bill strike an appropriate balance between a person who has been exposed to a serious infectious disease and the safety of the public. Further, following amendments in the other place, the amendments to section 62 relating to the new public health orders will be reviewed 24 months after the commencement of the section. The bill amends section 106, which relates to public health inquiries conducted by the Health secretary. The bill will allow the secretary, following a public health inquiry, to order the person that has caused or contributed to a risk to public health to notify persons placed at risk. This amendment will assist in ensuring members of the public are aware of a public health risk and the measures to take to mitigate the risk. The bill also amends section 106 to ensure that a search warrant can be applied for the purpose of a public health inquiry.

I turn now to the changes in the bill relating to section 56. Section 56 provides for additional privacy protections for a person with a category 5 condition. There are only two category 5 conditions—human immunodeficiency virus [HIV] and acquired immune deficiency syndrome [AIDS]. Section 56 requires HIV notifications by medical practitioners or pathology laboratories to be given to the secretary in a de-identified format. This is different from all other diseases where notifications are given in an identified format. This prohibits a person's name from being included on an HIV pathology test request form outside of a hospital except with consent and it creates an offence for disclosing a person's HIV status, except in limited circumstances, including when the disclosure is made to a person involved in the provision of care, treatment or counselling to the person concerned so long as the information is relevant to the provision of such care, treatment or counselling.

Section 56 is based on section 17 of the old Public Health Act 1991 and reflects the historic circumstances of HIV. Historically, there was considerable and regrettable discrimination against homosexual men and people with HIV, which was a death sentence. As a result, additional confidentiality protections were included in the former Public Health Act 1991 and these were carried over to the 2010 Act. Thankfully, times have changed. HIV is now a manageable condition. However, section 56 can create a barrier to testing a person for HIV and the management of patients with HIV. Therefore, the bill seeks to update and modernise section 56. The bill removes the requirement that a patient consents to their name being included in a test request form. This will reduce a barrier to testing and bring HIV testing in line with testing for other conditions.

In addition, the bill amends section 56 to make clear that an exemption to the non-disclosure requirement is when HIV information is disclosed for the purpose of care, treatment or counselling, regardless of whether the care is being provided specifically for HIV. As HIV is a chronic illness, clinicians must be aware of a person's HIV status when treating a patient for a condition even if it appears completely unrelated to their HIV infection. However, the use and disclosure of a person's HIV status, as with any other health information, will be limited by the privacy principles set out in the Health Records and Information Privacy Act.

No changes are being made to the requirement that HIV notifications are to be in a de-identified format. The report noted that the ministry supported, in principle, named notifications as it would likely lead to improved epidemiological information and better capacity to support people with HIV. However, many stakeholders were not yet comfortable with moving to named notifications due to the unfortunate stigma that persons with HIV can still experience and concerns that named notifications may deter people from being tested for HIV.

The report did not recommend any changes in respect of HIV notifications but noted that the Ministry of Health would continue to work with stakeholders on this issue.

The bill also updates and modernises section 79. The bill removes the current requirement on persons with a sexually transmitted infection [STI] to notify their sexual partners of their STI status and replaces it with a requirement for persons with an STI to take reasonable precautions against the spread of the STI. The report found that there is no evidence that section 79 is effective at preventing the spread of STIs. It also found that section 79 is inconsistent with public health messages, which focus on safe sex and the need for persons with STIs such as HIV to be on treatment and can discourage people from getting tested for STIs.

Section 79 is also out of alignment with other States and Territories, which do not have a requirement that a person with an STI notify their sexual partner. The bill therefore removes the notice requirement in section 79 and replaces it with a provision requiring a person with an STI to take reasonable precautions against the spread of the infection. Reasonable precautions would generally include the use of a condom. In addition, in respect of HIV, recent evidence shows that having an undetectable viral load as a result of being on treatment can prevent the risk of transmission of HIV. The new section 79 will better align the public health messages about safe sex and the importance of people being tested and treated for STIs. Following amendments in the other place, the new section 79 will be reviewed two years after commencement, with a report tabled in Parliament 12 months after that.

I turn now to the provisions of the bill relating to environmental health premises. Environmental health premises contain a public swimming pool or spa pool, or premises containing a "regulated system", which is a system such as a water-cooling system that is at risk of spreading Legionella bacteria, or premises where skin penetration is conducted. Environmental health premises all carry a risk of spreading serious infectious diseases. Therefore, the Act requires occupiers to comply with appropriate standards to reduce the risks of infection. These standards are set out in the Public Health Regulation.

The bill makes a number of minor amendments to these provisions. It clarifies that public swimming pools include pools on private residential premises that are used for a commercial purpose such as commercial backyard learn-to-swim pools, splash parks, and interactive fountains; it clarifies that where certain regulated systems are installed in a multi-tenanted building the owners' corporation is the occupier; and it brings procedures that penetrate a mucous membrane, such as a tongue, within the definition of a skin penetration procedure.

The bill also includes a new section 39A, which will make it an offence for a person other than a medical practitioner, or other person prescribed by the regulations, to perform eyeball tattooing. While the report on the review did not recommend prohibiting eyeball tattooing, it is an extreme form of skin penetration that carries risks over and above those of infection control. Eyeball tattooing can lead to serious damage of the eye and even blindness. Thankfully, eyeball tattooing has not become common in New South Wales. I cannot understand why anybody in their right mind would want their eyeball tattooed. While I have been advised of a small number of legitimate medical reasons that such tattooing may be carried out, the Government is preventing unqualified persons from performing eyeball tattooing.

The bill also makes changes in relation to suppliers of drinking water. Currently, section 25 of the Act requires suppliers of drinking water to establish and adhere to a quality assurance program. However, there is no penalty for non-compliance. The report found that a lack of penalty can impede compliance with suppliers establishing a quality assurance program. As such, the bill amends section 25 to include a penalty for non-compliance. In addition, and in line with the recommendations of the review, the bill also amends section 4 to recognise that local governments have a responsibility to regulate private water suppliers in line with their role in regulating environmental health premises.

I turn to the amendments in the bill relating to registers under the Act. Minor changes are also made to sections 97 and 98 in respect of public health and disease registers. The bill clarifies that the requirements in these sections apply only to a public health and disease register established under sections 97 and 98 and not to any other registers that may be created under the Act. In addition, regulations will be able to be made setting out additional purposes for which a public health and disease register can be created.

The bill also removes the provisions in the Act relating to the Pap test register. The Pap test register has been an important register maintained by the Cancer Institute on behalf of the Health secretary and has assisted thousands of women in remembering to undergo a Pap test, which can detect early signs of cervical cancer. Each State and Territory runs a similar register. However, the Commonwealth has moved to establish a national cancer screening register, which will replace the State and Territory Pap test registers. A national register has benefits as it will apply to cancers other than cervical cancer and can assist in ensuring that women who move interstate are not lost to follow-up appointments. Therefore, and in line with the recommendations in the report, the bill removes the provisions in the Act relating to the Pap test register.

I am pleased that many stakeholder groups and members of the public contributed to the review of the Public Health Act. Many of the submissions received related to nursing homes. Under the Act, certain nursing homes must have a registered nurse on duty at all times. However, the definition of "nursing homes" is problematic as it refers to facilities that provide care under the Commonwealth Aged Care Act in relation to an allocated place that requires a high level of residential care within the meaning of the Commonwealth Act. The Commonwealth has since removed the distinction between high levels and low levels of care.

Regulations are in place to grandparent existing nursing homes in New South Wales that previously had a requirement to have a registered nurse on site at all times. The issue of aged care is the responsibility of the Commonwealth. However, the New South Wales Government referred the issue of staffing in nursing homes to the Council of Australian Governments Health Council. I am pleased that the Commonwealth has subsequently undertaken public consultation on a proposed new set of quality standards for all aged care services. The draft standards include a requirement that facilities provide a sufficient skilled and qualified workforce to provide safe and quality care and services. I look forward to the development of these standards. The Public Health Act is the primary health legislation in New South Wales. The amendments in the bill will ensure that the Act remains effective and up to date in protecting public health and controlling the risks to public health. I commend the bill to the House.