Report on the Statutory Review of the *NSW Public Health Act* 2010

Contents

1. Introduction

The *Public Health Act* passed Parliament in 2010, with most of the provisions of the *Act* commencing in 2012. The *Act* followed on from an extensive review of the now repealed *Public Health Act 1991*. The 2010 *Act* carried over many of the provisions of the 1991 *Act* but also included a range of new provisions designed to better protect public health.

The *Public Health Act* contains a range of legislative provisions relating to the protection of public health in NSW. Among other things, the *Act* contains provisions:

- Allowing the Minister or Health Secretary to respond to a public health emergency,
- Relating to the notification of certain diseases and conditions to the Secretary,
- Allowing public health orders, which require treatment and/or detention, to be made in respect of persons with certain infectious diseases,
- Relating to the control of sexually transmitted infections,
- Defining the responsibilities of child care and school principals in respect of vaccine preventable diseases,
- Relating to environmental health, such as public swimming pools, regulated systems, drinking water and skin penetration premises,
- Establishing the pap test register and other public health and disease registers,
- Allowing the Secretary to establish a public health inquiry, and
- Defining the appointment and functions of public health officers and authorised officers.

While the *Public Health Act* deals with a diverse range of matters, the overall aim is to protect public health.

1.1 Review of the *Public Health Act*

Section 136 of the *Public Health Act* requires that a review of the *Act* must be held 5 years after assent of the *Act* and a report on the review is to be tabled in Parliament within 12 months from the commencement of the review.

In accordance with s136, the NSW Ministry of Health commenced a review of the *Public Health Act* to determine whether the policy objects of the *Act* remain valid and whether the terms of the Act are appropriate for securing those objectives.

As part of the Statutory Review, the NSW Ministry of Health released the *Public Health Act 2010 Statutory Review Discussion Paper* (*Discussion Paper*) to canvass key issues that have arisen since the commencement of the *Act*, or were raised by stakeholders through a preliminary submission process.

Two hundred and sixty nine submissions were received in response to the *Discussion Paper*. These submissions were made by a range of stakeholders including members of the community, community based organisations, local government and health providers.

This Report has been prepared to detail the findings of the review. Submissions received in response to the *Discussion Paper* have been considered in developing this Report.

2. Objects of *Public Health Act*

The *Discussion Paper* noted that public health policy and law aims to ensure the best possible health outcomes for individuals and the public overall. The *Public Health Act* is one of several *Acts* that deals with public health matters. The objects of this *Act* are set out in s3 which provides:

> *(1) The objects of this Act are as follows:*
> *(a) to promote, protect and improve public health,*
> *(b) to control the risks to public health,*
> *(c) to promote the control of infectious diseases,*
> *(d) to prevent the spread of infectious diseases,*
> *(e) to recognise the role of local government in protecting public health.*
> *(2) The protection of the health and safety of the public is to be the paramount consideration in the exercise of functions under this Act.*

These are broad objects and overall recognise the importance of protecting and promoting public health and controlling risks to public health. In addition, the objects recognise the important role local government plays in public health. The *Discussion Paper* sought submission on whether the objects remain valid and appropriate.

In addition, the *Discussion Paper* noted that the objects do not include any specific reference to the monitoring of diseases and conditions that are notifiable to the Secretary. The *Public Health Act* requires a range of conditions and diseases to be notified to the Secretary, which allows NSW Health to monitor their impact on the people of NSW and take appropriate public health action if required. As monitoring of diseases and conditions forms a large part of the provisions of the *Act*, the *Discussion Paper* sought submissions on whether this should be specifically included in the objects.

In respect of the overall objects, most submissions considered that the objectives are valid and appropriate. However some submissions argued that additional objectives should be included, such as the promotion of healthy environments, the reduction in health inequalities or the need to protect privacy of persons with notifiable diseases.

With respect of the issue of including an objective relating to the monitoring of diseases and conditions that are notifiable to the Secretary, while some submissions argued that it was not necessary to have a specific objective, most submissions received on this issue supported including a specific objective to recognise this role.

After considering the submissions received, the Ministry agrees that the current objectives remain valid and appropriate. In respect of the submissions that argued that additional objectives relating to the promotion of healthy environments, the reduction in health inequalities and privacy protections should be included in the *Act*, this is not considered necessary or appropriate.

The *Public Health Act* is primarily an *Act* in relation to the protection of public health in relation to infectious diseases. While the promotion of healthy environments and the reduction in health inequalities are appropriate public health goals, they are not the focus of the *Public Health Act*. In relation to the issue of privacy, it is also not considered appropriate to include this as an objective. The privacy protections that apply under the *Public Health Act* are in line with the privacy protections that apply to health information more broadly (although there are stricter requirements in respect of certain matters, particularly HIV) and it is not necessary to include a specific objective in this regard.

However, in respect of the additional objective relating to monitoring of diseases and conditions affecting the people of NSW, which was raised in the *Discussion Paper*, this is considered to be a different matter.

The *Public Health Act* requires notifications of a large number of different diseases and conditions, including birth, sudden infant death syndrome, tuberculosis, measles and cancer. A broad range of provisions in the *Act* relate to receiving such notifications but there is no specific objective that recognises this role.

Notifications of conditions and diseases is an important function of the *Act* and allows NSW Health to understand the health of the whole community by allowing the gathering and monitoring of epidemiological data, including rates of, and risk factors for, diseases and conditions.

While it could be argued that this role is adequately reflected in the very broad objective of promoting public health and controlling and preventing the spread of infectious diseases, including a standalone objective of monitoring of diseases and conditions affecting the people of NSW is considered to better reflect the role and purpose of the *Public Health Act*. It is noted that including a new objective would not change the functions and activities carried out by NSW Health, including the privacy requirements that apply. Rather, it would ensure that the objectives of the *Act* are more appropriately reflective of the provisions of

the *Act*. To that end, the Ministry recommends that an additional objective relating to monitoring of diseases and conditions affecting the people of NSW be included in the *Act*.

Recommendations

1) The objects of the *Act* remain valid and appropriate.
2) However, in order to better reflect the provisions of the *Act*, a specific objective relating to the monitoring of diseases and conditions affecting the people of NSW should be included in s3.

3. Issues considered as part of the Statutory Review

3.1 The role of local government

Local government authorities play an important role in the regulation of public health under the *Act*. Authorised Officers, who carry out functions under the *Act*, are appointed both from NSW Health and local government.

Local government officers have a particular role to play in regulating "environment health premises" (premises containing regulated systems e.g. cooling towers, public swimming pools and spa pools, and premises carrying out skin penetration procedures). In recognition of this role, the *Discussion Paper* noted that when the *Act* was made in 2010, a number of specific provisions were included to recognise the role of local government, being:

- the objects provision in s3 specifically includes a provision that recognises the role of local government in protecting public health,
- s4 of the *Act* specifically sets out the responsibilities of local governments to take appropriate measures to ensure compliance with the requirements of the *Act* in relation to environmental health premises, including the responsibility of appointing authorised officers to exercise functions under the *Act*, and
- a number of provisions in the *Act* assist compliance and enforcement activities by local government authorities, such as improvement notices and prohibition orders and allowing penalty infringement notices to be issued in respect of particular offences, and allowing fees to be issued in relation to a number of activities.

While the *Act* sets out the responsibilities of local government in relation to environmental health premises, the *Discussion Paper* noted that the *Act* does not specify how that responsibility is to be exercised, for example it does not require annual inspections of environmental health premises. Rather, it was considered that local governments should have discretion as to how to exercise its functions in order to protect public health and allow different local government authorities to tailor activities to suit their local areas. The *Discussion Paper* noted that this approach allows for a risk based approach to compliance

and would allow local governments to direct resources to area of highest risk, which is considered appropriate. However, the *Discussion Paper* sought submissions on whether the current approach was still appropriate.

In respect of the issue of the *Act* not specifying how the local government's responsibility is to be exercised, some submissions argued that by not specifying the regulatory functions that local government authorities or NSW Health are expected to undertake, inconsistencies arise in approaches to regulation across the State. Some therefore argued that the *Act* should clearly and specifically define the roles and responsibilities of all appropriate regulatory authorities including NSW Health and local government. However, other submissions considered that local government should continue to use a risk based approach to compliance, based on consideration of local needs and advice from NSW Health.

Local governments play an important role in the regulation of public health and it is important that the *Act* both recognises this role and ensures that the legislative framework assists local government in undertaking their role.

After considering the submissions received, the Ministry considers that the *Act* does appropriately recognise the role of local government. The objects provision in s3 of the *Act* specifically recognises this role and s4 of the *Act* more specifically sets out the responsibilities of local government. Section 4 provides:

> *(1) A local government authority has, in relation to its area, the responsibility to take appropriate measures to ensure compliance with the requirements of this Act in relation to public swimming pools and spa pools, regulated systems and premises on which skin penetration procedures are carried out (as referred to in Part 3).*
>
> *(2) In particular, a local government authority has the responsibility of appointing authorised officers to enable it to exercise its functions under this Act and ensuring that its authorised officers duly exercise their functions under this Act.*

While the *Act* does not give specific details about how local governments are to undertake their role, this is considered appropriate. This approach allows local governments to undertake a risk based approach to regulation and focus their work on areas that pose the biggest public health risk, which may change over time and in respect of different areas of the State. Local governments are considered to be in good position to be aware of the local public health risks facing their community. In addition, NSW Health public health units work with local government to help assess the risk and support local government response to public health threats. Accordingly, it is not recommended that the *Act* more specifically set out how local governments are to undertake their functions.

That said, a number of the recommendations in this *Report* may result in additional functions and responsibilities being given to local governments and the Ministry recognises

the importance of local governments being able to recover their costs in undertaking their responsibilities under the *Act*. Accordingly, the *Act* should ensure that there are appropriate mechanisms to enable appropriate fees to be levied in respect of the activities regulated by the *Act* and the functions undertaken by local government officers, including inspections.

Recommendations

3) Sections 3 and 4 adequately recognise the role of local government in the *Public Health Act*
4) However, there should be appropriate mechanisms in the *Act* to ensure that appropriate fees can be levied in respect of the functions undertaken by local government, including inspection of premises.

3.2 Part 2 of the *Act*

Part 2 of the *Act* sets out a range of powers the Minister and Secretary have to respond to public health emergencies. As they are powers to respond to public health emergencies, including during a state of emergency, they are broad powers and include powers to issue orders and take actions to respond to the public health emergency. It is an offence not to comply with such orders given.

These powers are rarely used but are considered necessary and appropriate to protect and promote public health and control risks to public health. As such, no changes to Part 2 are considered necessary.

3.3 Safe supply of drinking water

3.3(a) Quality assurance programs

Division 1 of Part 3 of the *Act* relates to safety measures for drinking water and applies to suppliers of drinking water.

A supplier of drinking water under the *Act* means[1]:

(a) Sydney Water Corporation,
(b) Hunter Water Corporation,
(c) a water supply authority within the meaning of the Water Management Act 2000,
(d) a local council or a county council exercising water supply functions under Division 2 of Part 3 of Chapter 6 of the Local Government Act 1993,
(e) the Lord Howe Island Board,

[1] Section 5 Public Health Act 2010

(f) a licensed network operator or a licensed retail supplier within the meaning of the Water Industry Competition Act 2006,

(g) any person who treats or supplies water on behalf of a person referred to in any of the preceding paragraphs,

(h) any person who supplies drinking water in the course of a commercial undertaking (other than that of supplying bottled or packaged drinking water), being a person who has not received the water:

(i) from a person referred to in any of the preceding paragraphs, or

(ii) in the form of bottled or packaged water,

(i) any person who receives water from a person referred to in this definition and who supplies drinking water from a water carting vehicle in the course of a commercial undertaking.

While there are a number of different classes of suppliers of drinking water, they can be summarised into two categories:

- Public water utilities (being Sydney Water Corporation, Hunter Water Corporation, water supply authorities within the meaning of the *Water Management Act*, local council water suppliers, the Lord Howe Island Board and licensed operators or retail suppliers within the meaning of the *Water Industry Competition Act*) who generally supply to large sections of the community and are subject to other extensive regulation, and
- Private water suppliers (being persons who fall within the definition of (h) above and water carters, who fall within the definition of (j) above) who often supply water to smaller cohorts of the population as part of a commercial undertaking and are subject to less extensive regulation (often the supply of water may only be a small part of the commercial undertaking by a private water supplier, for example a bed and breakfast operator may be a private water supplier if they supply their guest with tank water).

The provisions relating to the supply of drinking water are aimed at responding to serious risks associated with the public drinking water supply. The *Discussion Paper* noted that, in general, these provisions are reactive and allow for a public health response only after issues have arisen with respect to the safe supply of drinking water. However, s25 allows for a more proactive approach.

Section 25, and the *Public Health Regulation* 2012, requires a supplier of drinking water (unless exempted by the Chief Health Officer) to establish and adhere to a quality assurance program (QAP) that complies with the requirements of the Regulation. The current Regulation requires the QAP to address the elements in the Framework for Management of Drinking Water Quality (as set out in the *Australian Drinking Water Guidelines* published by

the National Health and Medical Research Council) that are relevant to the operations of the supplier of drinking water concerned[2].

Section 25 is a new provision that was included in the *Act* when it was made in 2010. It followed on from the *Report of the Independent Inquiry into Secure and Sustainable Urban Water Supply and Sewerage Services for Non-Metropolitan NSW* (2008)[3]. The Inquiry noted that the previous "light-handed" regulatory approach had not always resulted in all non-metropolitan communities having access to safe drinking water at all times. The Inquiry recommended strengthening regulation of non-metropolitan local water utilities to ensure all relevant plans, guidelines and standards in relation to drinking water are implemented.

However, the *Discussion Paper* noted that there are limited provisions to enforce compliance with s25. For example, there is no offence if a supplier fails to establish a QAP. While the *Public Health Regulation* does allow the Secretary to arrange for a review of a QAP[4], there is no means to require a supplier to amend the QAP if it is found that the QAP does not adequately address the requirements in the *Act* or *Regulation*. Further, the *Discussion Paper* noted that while all public water utilities have developed QAPs, compliance has been very low among private water suppliers.

To assist with compliance, and better protect public health, the *Discussion Paper* sought submissions on whether a compliance regime, involving an offence for a breach of s25 and/or allowing improvement notices to be issued, should be a introduced in respect of s25.

Submissions on this issue were received from local councils, local health districts, peak bodies, such as Local Government NSW, and government agencies, such as the Independent Pricing and Regulatory Tribunal (IPART) on this issue. Most submissions were supportive of the establishment of a compliance regime involving penalties and/or improvement notices. These submissions considered that a compliance regime would support a more proactive approach and could improve the establishment, quality and effectiveness of QAPs leading to reduced incidence of disease and healthcare expenditure.

However, other submissions opposed a compliance regime in respect of s25 and suggested that adequate reporting and auditing regimes already exist. IPART considered that, although ongoing compliance and auditing are significant for the protection of public health, the

[2] Clause 34 of the Public Health Regulation 2014

[3] Armstrong I. and Gellatly C. (2008) Report of the Independent Inquiry into Secure and Sustainable Urban Water Supply and Sewerage Services for Non-Metropolitan NSW: http://www.water.nsw.gov.au/__data/assets/pdf_file/0007/557278/utilities_local_sustainable_urban_water_and_sewerage_for_non_metropolitan_nsw_report.pdf

[4] Clause 34, Public Health Regulation 2012

compliance scheme as proposed would result in duplication of its regulatory functions with regard to Sydney Water, Hunter Water and *Water Industry Competition Act* (WICA) licensees. Other submissions argued that better compliance could be achieved if sufficient time and resources are allowed for proper education of drinking water suppliers regarding the requirements, and expressed concerns regarding the resources and expertise required to implement a compliance scheme, especially if the enforcement responsibility is shared with local government.

The provision of safe drinking water is an important element of public health and outbreaks of water borne disease can occur where there is not appropriate regulation in place. However, the *Public Health Act* is not the only *Act* that regulates the supply of drinking water and the Ministry recognises the importance of avoiding duplication in regulation.

The *Act* already recognises that other regulation does exist with respect to the regulation of public water suppliers. As such, the *Act* already allows the Chief Health Officer to exempt a water supplier from the operation of s25, which avoids regulatory duplication with IPART. Exemptions have been granted to Sydney Water, Hunter Water and the Sydney Desalination Plant (WICA licensee). All other public water utilities (regional local council water suppliers and county council water supply authorities) in NSW have developed QAPs.

In 2008 NSW Health launched the NSW Private Water Supply Guidelines and resources for water carters to assist compliance with the *Australian Drinking Water Guidelines*. The NSW Private Water Supply Guidelines and the NSW Water Carter Guidelines were developed to provide specific guidance to private water supplies and water carters in implementing the *Australian Drinking Water Guidelines* to assist in meeting the requirements of the *Act* and *Regulation*. The two year implementation period associated with s25 was used to develop resources including templates for QAPs and provide training and education to assist compliance with the *Public Health Act* requirements. These efforts, though, have only resulted (as of November 2015) in a response rate of 17% for QAPs submitted by private water suppliers and water carters. Many of the QAPs submitted require further work to address the requirements of the *Regulation*. Local Health District's public health units continue to follow up in writing and through repeated visits with known private water suppliers and water carters to improve submission rates and the quality of QAPs submitted. A compliance regime, with enforcement tools, would add further options to ensure the intentions of the section 25 requirements are realised and a QAP is made.

The lack of a compliance regime limits a public health unit's effectiveness and efficiency with achieving compliance and protecting public health. There is no recourse for wilful non-compliance or negligence. The Ministry therefore considers that there is benefit in having a compliance regime associated with s25 that creates an offence for failure to establish and

adhere to a QAP. This would assist in ensuring that action can be taken in relation to water supplies before the water supplies pose a risk to public health.

That said, it is recognised that the current requirements for a QAP, being that the QAP must address the elements in the Framework for Management of Drinking Water Quality (as set out in the *Australian Drinking Water Guidelines* published by the National Health and Medical Research Council), may not meet the needs of all classes of water suppliers, particularly private water suppliers and water carters. Therefore, the Ministry will review the existing Regulation to ensure that the requirements of the QAP meet the different needs of the different classes of water suppliers.

Recommendations

5) The *Act* should be amended to create an offence for a supplier of drinking water who fails to establish and adhere to a quality assurance program.
6) The Ministry will review the existing requirements relating to quality assurance programs to ensure the requirements are suitable for all classes of suppliers of drinking water.

3.3(b) The role of local government in relation to drinking water

The *Discussion Paper* considered the issue of whether the *Act* should recognise a role for local government authorities in relation to the regulation of private water suppliers and water carters. Local government often has a relationship with these entities as they may already be carrying out inspections under other legislative responsibilities, such as the *Food Act 2003* or the *Local Government Act 1993*. Where local government officers are already undertaking activities on these premises, the *Discussion Paper* noted it may be more practical for local government authorised officers to undertake compliance activities to ensure compliance with requirements in relation to QAPs and requirements on water carters (under the *Act*, water carters are required to keep certain records). This could avoid a duplication of effort by different levels of government in relation to the same premises. Accordingly, the *Discussion Paper* sought submissions on whether the *Act* should recognise a role of local government in relation to the regulation of private water suppliers.

Submissions received on this issue were from local governments, local health districts, peak bodies, such as Local Government NSW and government agencies, such as the IPART. The majority of submissions supported the amendment of the *Public Health Act* to recognise a role for local government authorities in the regulation of private water supplies and water carters. These submissions agreed that some duplication could be reduced and suggested that the role should be clearly defined and limited to private water suppliers and water carters. Some submissions identified that providing a role for local council may have resourcing implications for local government authorities, but that the issues could be

addressed with a cost recovery mechanism, a compliance regime and ongoing training from NSW Health.

Some submissions did not support the proposal and expressed concerns about the capacity and capability available in local government to adequately take on this role. IPART and several councils recommended that NSW Health collaborate with local government in the development of this regulatory proposal to assess the capacity and capability of local government and better clarify what the most appropriate role would be. Several submissions suggested that the role should not change unless accompanied with a cost recovery mechanism, a compliance regime, and adequate ongoing support and training from NSW Health.

Private water supplies are entities that supply drinking water in the course of a commercial undertaking. The primary business of these entities, which is often not actually the supply of water, is often regulated by local government through other legislation such as the *Food Act* 2003 and/or *Local Government Act* 1993. Water suppliers are required to keep a record of water carters who draw from their water supply. In rural and regional NSW the water supplier is often the local government authority. Regulatory activity under these pieces of legislation may involve consideration of the safety of the water supply. As such, the Ministry considers that having provision in the *Public Health Act* that will ensure that local government authorised officers can undertake compliance activities in respect of private water suppliers and water carters is both practical and will help avoid regulatory duplication.

Allowing local government authorised officers to take regulatory action in respect of private water suppliers including water carters is not intended to completely replace the role of NSW Health. NSW Health will continue to offer training, guidance and resources to local governments and private water suppliers and NSW Health authorised officers will continue to be able to undertake regulatory functions in respect of private water suppliers as required or appropriate. Rather, ensuring the *Act* allows local government authorised officers to also take regulatory action in respect of private water suppliers will help increase flexibility, reduce regulatory duplication and improve regulatory efficiency. That said, as noted earlier in the Paper, the Ministry supports measures to ensure that appropriate fees can be levied in respect of the functions undertaken by local government so as to assist in appropriate cost recovery for local governments.

Recommendation

7) That the *Public Health Act* is amended to recognise the role of local government authorities in relation to compliance and regulatory activities for private water suppliers and water carters (establishing and adhering to a QAP) and record keeping requirements of water carters

3.4 Environment health premises – regulated systems, public swimming pools and spa pools and skin penetration

Part 3 of the *Act* regulates certain environmental health premises that have the potential to cause significant public health issues, these are:

- premises containing regulated systems, including air-handling systems, hot water systems, humidifying systems, warm-water systems and water-cooling systems. Regulated systems have the potential to spread legionella bacteria which can cause legionnaire's disease, a serious, and potentially fatal, form of pneumonia,
- premises containing public swimming pools and spa pools where disinfection of pools is critical to prevent the survival or growth of disease causing micro-organisms such as *Cryptosporidium*, and
- premises carrying out skin penetration procedures. Such procedures have the potential to spread blood borne viruses such as HIV and hepatitis C or hepatitis B.

Due to the serious nature of the risks associated with these premises, they are regulated by the *Public Health Act* in order to mitigate and control the risk of the spread of diseases.

The provisions in the *Act* and *Regulation* require occupiers of such premises to notify the Local Council of their premises and require occupiers to comply with the requirements set out in the *Regulations* in relation to the premises. Failure to comply with these requirements can result in an improvement notice being issued. If there is a failure to comply with an improvement notice, a prohibition order can be issued if the order is necessary to prevent or mitigate a serious risk to public health[5]. A prohibition order is an order that prevents a regulated system from operating, requires a public swimming pool or spa to not open to the public or prevents skin penetration procedures from being carried out. A prohibition order operates until a clearance certificate is issued.

The *Discussion Paper* considered a number of issues in relation to the provisions relating to environmental health premises.

3.4(a) Premises undertaking skin penetration procedures

The *Public Health Act* regulates premises carrying out skin penetration procedures due to the potential risk of the spread of blood borne viruses, such as HIV, hepatitis B and hepatitis C, at such premises if proper infection control procedures are not carried out. Skin penetration procedures are defined in s5 of the *Act* to mean:

[5] A prohibition order can also be issued if an improvement notice is not first issued provided that there was a failure to comply with a prescribed requirement and the prohibition order is urgently necessary to mitigate or prevent a risk to public health.

any procedure (whether medical or not) that involves skin penetration (such as acupuncture, tattooing, ear piercing or hair removal), and includes any procedure declared by the regulations to be a skin penetration procedure, but does not include:

(a) any procedure carried out by a health practitioner registered under the Health Practitioner Regulation National Law, or by a person acting under the direction or supervision of a registered health practitioner, in the course of providing a health service, or

(b) any procedure declared by the regulations not to be a skin penetration procedure.

Importantly, the definition of a skin penetration procedure requires there to be a penetration of the skin. Where there is penetration of a mucous membrane, such as in eyeball tattooing or tongue piercing, there may be a similar risk of a transmission of blood borne viruses. While the *Public Health Regulation* was recently amended to include eyeball tattooing, tongue tattooing and tongue piercing in the definition, the *Discussion Paper* asked whether the definition of skin penetration should be amended to include all procedures that penetrate a mucous membrane.

In addition, the *Discussion Paper* noted that there are other skin penetration/body modification procedures that pose significant risks apart from blood borne virus infection. For example, eyeball tattooing appears to be a rare, although potentially emerging practice. While the medical literature contains a small number of reports of the procedure being done for medical purposes (to mask opacification after amniotic membrane grafting for stromal corneal ulcer and to treat debilitating glare in a child with traumatic iris loss), concerns arise when people who are not relevant registered health practitioners perform procedures such as eyeball tattooing that can result in significant adverse outcomes such as loss of sight. Accordingly, the *Discussion Paper* asked whether there should be additional regulation, or limitations, on people who perform high risk procedures such as eyeball tattooing.

In relation to the definition of skin penetration, most submissions that addressed this issue considered that the regulation of premises carrying out skin penetration should extend to premises that carry out procedures that penetrate a mucous membrane. However, some submissions argued that the definition of skin penetration should be more specific and list the actual procedures that are regulated as the concept of mucous membrane penetration may not be generally understood. Concerns were also raised that broadening the definition of skin penetration may result in an increased regulatory burden for local councils. Other submissions that considered the issue of skin penetration also suggested that the provisions should apply to a broader range of procedures, such as scarification, sub-dermal implants and skin divers, inserting contact lenses and applying fake eyelashes and makeup.

In respect of additional regulation for high risk procedures such as eyeball tattooing, most submissions received on the issue considered that there should be additional regulation of eyeball tattooing. Some submissions argued that only relevant registered health practitioners, such as medical practitioners, should be able to perform eyeball tattooing. The Royal Australian and New Zealand College of Ophthalmologists noted that potentially serious risks are associated with eyeball tattooing, including, perforation of the eye which can lead to blindness, retinal detachment (which can lead to blindness), bleeding and infection, risk of transmission of blood borne viruses and delayed diagnosis of medical conditions as the true colour of the sclera is changed. However, some submissions cautioned that further regulation may lead to 'backyard' or 'underground' eyeball tattooing. This may cause procedures to become even more hazardous and difficult to regulate. Alternatively, several submissions recommended a mandatory minimum qualification or accredited training for persons undertaking high risk skin penetration activities.

In respect of the definition of skin penetration, after considering the submissions received, the Ministry considers that the definition in the *Act* should be amended to reference procedures that penetrate the mucous membrane. The penetration of a mucous membrane carries similar risks to the penetration of skin, with such risks being able to be mitigated via appropriate infection control requirements. Ensuring that premises that carry out procedures that penetrate the skin are appropriately regulated under the *Act* will assist in protecting public health. NSW Health can provide further information, education and guidance in situations where there is potential for misunderstanding as to what is a mucous membrane.

In respect of the issue of eyeball tattooing, the Ministry acknowledges the serious risks that apply to eyeball tattooing and these risks are over and above the normal risks that arise in respect of skin penetration procedures. There are therefore good reasons to consider that additional regulation and/or a prohibition should be put in place with respect to eyeball tattooing. However, the Ministry also agrees with the argument that additional regulation and/or prohibition of eyeball tattooing runs the risk that the practice would be driven underground. This in turn would not prevent the practice from occurring but would make it extremely difficult to regulate as operators may continue to practice but not notify local governments as to their operation and therefore local governments would not be aware of the premises in order to undertaken inspections to ensure appropriate infection control requirements are being met. This in turn may result in public health risks as inappropriate infection standards would not be identified and addressed.

After weighing up these matters, and after considering that the practice of eyeball tattooing appears very rare in NSW, it is considered at this time that the better public health outcome would be to continue to regulate eyeball tattooing as a skin penetration procedure. This would assist in ensuring operators notify local governments of their premises, inspections

can be carried out and action taken to address infection control risks. However, the Ministry also recognises that should eyeball tattooing become more common in NSW, the appropriate regulation of eyeball tattooing will need to be further considered in order to best protect public health and the health of individuals undergoing eyeball tattooing. Accordingly, the Ministry will keep this matter under review to determine if further regulation in the future is required.

Recommendations:

8) The definition of skin penetration in the *Act* should be amended to include all procedures that penetrate a mucous membrane.
9) No additional regulation in respect of eyeball tattooing should be pursued at this time. However, NSW Health will continue to keep this matter under review to determine if further regulation in the future is required.

3.4(b) Legionella Control

Definition of occupier

The *Discussion Paper* considered the issue of who should be responsible for complying with the required standards in relation to regulated systems. Currently, the requirements sit with the occupier of the premises. The definition of occupier under the *Act* means:

> *(a) except as provided by paragraph (b), the owner of the premises or part, or*
> *(b) if any other person is entitled to occupy the premises or part to the exclusion of the owner, the person so entitled.*

In essence, this definition means that where an owner leases premises to a tenant, the tenant is the occupier for the purposes of the *Act*. Where there is no tenant, the owner is considered the occupier.

This definition can create difficulties with respect to regulated systems in multi-tenanted buildings. While there will generally be a range of tenants who are responsible for the relevant areas of the building that are leased, the owner of the building, or a management company contracted by the owner, will often be responsible for the overall maintenance of the building itself and any services that are shared by the multiple tenants; this often includes air-handling systems, water cooling systems and other regulated systems. As such the *Discussion Paper* sought submissions on whether the *Act* should be amended to ensure the owner of a tenanted building, or the person that the owner has arranged to manage the building, is considered the occupier for the purposes of the provisions relating to regulated systems.

Most submissions received on this issue supported amendment to the *Act* to ensure that the owner of a multi tenanted building, or the person that the owner has arranged to manage the building, is considered the occupier for the purposes of the provisions relating to regulated systems. However, some submissions recommend nominating the owner as the responsible party, regardless of contractual arrangements relating to the management of the regulated system, as the owner ultimately makes resource decisions.

After considering the submissions received, the Ministry considers that there is benefit in amending the *Act* to provide, in respect of legionella control, that the occupier of multi tenanted premises is the owner of the building where the regulated system serves the whole or substantial parts of the building (this is to ensure that where the tenant has responsibility for the regulated system, they are still considered the occupier). As the owner of a multi tenanted building is likely to be responsible for the maintenance of the regulated system, this is considered to better reflect existing arrangements. In respect of making the person that the owner has arranged to manage the building be seen as the occupier, this is not considered necessary. The *Act* already provides that where the occupier arranges for a duly qualified person to install, operate or maintain the regulated system, the duly qualified person can be held accountable[6]. Where an occupier arranges for a duly qualified person to maintain and operate the system, it is reasonable for that duly qualified person to ensure that the appropriate standards in respect of regulated systems are complied with.

Recommendation

10) The *Act* should be amended to provide that that the owner of a multi tenanted building, is the occupier for the purposes of the provisions relating to regulated systems where the regulated system serves the whole or substantial parts of the building.

Other matters relating to regulated systems

Subsequent to the release of the *Discussion Paper*, there were several outbreaks of Legionnaire's disease linked to contaminated cooling towers, which is a type of regulated system, in Sydney. NSW Health formed an Expert Advisory Panel to consider whether additional reforms are necessary to prevent the risk of Legionnaire's disease associated with contaminated cooling towers.

The current regulatory framework in NSW allows for varying levels of testing and inspection to be carried out by cooling tower operators or their agents without regard to the risks of contamination associated with the particular design of the cooling tower system. The Expert Panel considered that the model used in Victoria, which includes risk management plans for individual cooling tower systems and independent auditing, provided a rational approach

[6] See sections 28, 29 and 30 of the *Public Health Act*

for regulating cooling towers in NSW, particularly as it is already used by many national organisations that operate in Victoria and NSW. Notification by laboratories of high levels of bacteria in cooling towers and the provision of evidence of compliance with the risk management plan to local councils would provide a check that building owners were complying with these regulatory requirements.

The Expert Advisory Panel made several recommendations, including that:

- NSW develop a regulatory framework that requires minimum standards of testing and inspection for cooling towers,
- building owners have a risk management framework for the operation of cooling towers, ensure that cooling towers are uniquely labelled, demonstrate compliance risk management plan through annually independent audits, provide evidence of compliance to the local council, and perform disinfection when required by an authorised officer,
- require the risk management plan to be audited annually by an independent auditor,
- testing laboratories notify certain cooling tower test results to local councils, and
- personnel involved in controlling cooling towers risk are skilled.

These recommendations are expected to only require changes to the *Public Health Regulation*, relating to the prescribed requirements for regulated systems, and not the *Act*.

The Ministry in principle supports these recommendations as appropriate to help minimise the risk of outbreaks of Legionnaire's disease into the community. However, further public and industry consultation is necessary before implementing the recommendations. In this regard, it is also noted that some of the recommendations, particularly those that rely on appropriately skilled personnel (such as independent auditors), may require changes to training in NSW and may take time to develop. The Ministry can work to develop the necessary training, and policy to support the training and education. Further, the recommendation that independent auditors review cooling tower risk management plans will require a market to be developed, as this is not a current requirement in NSW. That said, it is a requirement in Victoria, and it is understood that many national companies already comply with Victorian requirements. Nonetheless, a transition period will be necessary to allow for the appropriately skilled people to become available and a market to develop.

It is also noted that some of the recommendations may create some additional regulatory burdens on local government. Further consultation with local government is required regarding the implementation of these recommendations. Also, as noted in section 3.1, the *Act* should ensure that there are appropriate mechanisms to enable fees to be levied in relation to these activities.

Recommendation

11) That the recommendations of the Expert Advisory Panel relating to legionella control should be supported in principle and be implemented subject to further consultation with industry and the public.

3.4(c) Public swimming pools

The definition of a public swimming pool or spa pool is outlined in the *Public Health Act 2010* and means:

A swimming pool or spa pool to which the public is admitted, whether free of charge, on payment of a fee or otherwise, including:

- *(a) A pool to which the public is admitted as an entitlement of a membership of a club, or*
- *(b) A pool provided at a workplace for the use of employees, or*
- *(c) A pool provided at a hotel, motel or guest house or at holiday units, or similar facility, for the use of guests, or*
- *(d) A pool provided at a school or hospital, but not including a pool situated at private residential premises.*

A swimming pool includes any structure that is used or intended to be used for human bathing, swimming or diving, and includes a water slide or other recreational aquatic structure.

The *Discussion Paper* noted that concerns have been raised that the definition does not expressly cover pools situated in residential premises where those premises are also used for commercial purposes, such as a backyard pool that is used on certain days as a commercial learn to swim pool or a pool in a house that is used both as bed and breakfast and residential premises. The *Discussion Paper* sought submissions on whether the *Act* should be amended to clarify this situation.

Most submissions on this issue supported clarification relating to the definition of a public swimming pool relating to pools in residential premises where the pool in question is used by members of the public as part of a commercial undertaking by the occupier of the premises. However, some submissions were concerned about the additional burden to councils or the need for adequate resource recovery, whilst others thought that pools within residential premises should not be defined as public swimming pools as they do meet the requirements.

After considering the submissions, the Ministry supports clarification of this issue. Pools in residential premises used for public swimming classes can be busy with multiple children who may not be toilet trained and therefore present a risk of pool contamination and outbreaks of gastroenteritis to the public. While the current definition is already likely to capture such pools, there would be benefit in clarifying the definition to reduce confusion and better protect public health.

There are other types of aquatic structures, such water splash parks and "interactive foundations" where similar issues arise.

Water splash parks and interactive fountains, which are similar in design and intent, have become increasingly popular in recent years. Although the user does not bathe in water in the same way that they would a swimming pool, a splash park can confer similar health risks. The splash park water can rinse contaminants of those who attend these facilities into the water holding tank. This may include faecal material and other microbial contaminants. The splash park may also be contaminated from animal sources. This is similar to someone who swims in a pool where the pool then rinses the contaminants into the pool. The potentially contaminated water in a splash park can then be expelled from the water holding tank and sprayed on to other users, potentially spreading disease through pathways such as inadvertently swallowing water. Appropriate treatment of this water, as with swimming pools, can help reduce the health risk associated with splash parks. Diarrhoeal outbreaks have been linked to splash parks internationally, emphasising the importance of appropriate microbial control of waters used. Clarifying that the definition of a public swimming pool includes water splash parks and interactive fountains would aid appropriate regulation.

Accordingly, the Ministry also recommends that the Act should be amended to make clear splash parks and interactive fountains are captured within the definition of public swimming pools. Further, in order to be able to adequately and promptly respond to new and emerging aquatic structures that pose a similar risk to public health, there should be a regulation making power in the Act to include other aquatic structures within the definition of a public swimming pool.

Recommendation:

12) The *Act* should be amended to clarify that the definition of a public swimming pool applies to a pool in residential premises used by members of the public for swimming lessons.
13) The *Act* should be amended to include Interactive Water Fountains, water splash parks, water slides or other recreational water areas under the definition of a 'swimming pool'.

14) A regulation making power should be included in the *Act* to capture new and emerging public aquatic structures that pose a similar risk to public health as public swimming pools.

3.5 Scheduled medical conditions and other disease control measures and notifications – Part 4 and 5 of the Act

Parts 4 and 5 of the *Act* relate to scheduled medical conditions and other diseases control measures and notifications. These parts contain provisions relating to notification of scheduled medical conditions and notifiable diseases, the making of public health orders, and provisions relating to control of vaccine preventable and sexually transmitted infections.

Under the *Act*, medical practitioners and pathology laboratories are required to give notice to the Health Secretary (in practice, notice often goes to the public health unit of the relevant local health district) of persons suffering from scheduled medical conditions. Scheduled medical conditions are the conditions set out in Schedule 1 of the *Act*. Schedule 1 is divided into 5 categories:

- Categories 1 and 2 are the diseases and conditions that must be notified by a medical practitioner,
- Category 3 lists the diseases and conditions that must be notified by pathology laboratories,
- Category 4 lists the diseases and conditions for which an authorised medical practitioner can make a public health order. A public health order in respect of a category 4 condition can, among other things, require a person to undergo treatment and to be detained while undergoing treatment. Category 4 conditions are serious infectious diseases as tuberculosis and viral haemorrhagic fevers, and
- Category 5 conditions are conditions for which a public health order can be made. However, unlike a category 4 public health order (which only allows detention while a person is undergoing treatment), a public health order in respect of a category 5 condition can require a person to be detained for the duration of the order. There are also special provisions in the *Act* that apply to category 5 conditions. In particular, s56 prevents a person's name and address from being included in any notification of a Category 5 condition to the Health Secretary and provides for strict confidentiality controls over information relating to a person who has, or is tested for, a Category 5 condition. Currently, only acquired immune deficiency syndrome (AIDS) and human immunodeficiency virus (HIV) infection are listed in Category 5.

Hospitals are required to notify the Secretary of notifiable diseases, which are set out in Schedule 2. Principals of primary schools and child care facilities are required to notify certain vaccine preventable diseases, which are set out in Schedule 3. There are also a range of other provisions relating to vaccine preventable diseases. Part 4 also has provisions relating to sexually transmitted infections, which sets out the responsibilities of treating medical practitioners and persons with a sexually transmitted infection.

The *Discussion Paper* considered a range of issues in respect of these provisions which are discussed further below.

3.5(a) Notification of scheduled medical conditions and notifiable diseases

Medical practitioners, laboratories, hospitals, child care centres and primary school principals are required to notify a range of diseases and conditions set out in the *Public Health Act*. The diseases and conditions listed in the *Act* are diverse from sudden infant death syndrome, to lead poisoning and a range of different infectious diseases such as influenza, chlamydia and HIV. All notifications, except HIV and AIDS, include the full name and other identifying details of the affected person.

As noted in the *Discussion Paper*, notification of conditions and diseases serve a range of different purposes that depend, in part, on the disease or condition being notified. However, in general notification:

- allows the gathering of epidemiological data on diseases and conditions. This allows information to be gathered on rates and risk factors of diseases and conditions. Such information allows for monitoring and surveillance of diseases and conditions and can assist in developing population health interventions,
- facilitates the measurement and monitoring of outcomes of specified population health interventions,
- allows NSW Health to identify unexpected outbreaks or clusters of diseases or conditions and determine an appropriate response to limit the public health consequences,
- facilitates the identification and monitoring of risk factors for diseases and conditions, including being able to identify any linkages between one scheduled medical condition or notifiable disease and another;
- facilitates the investigation and identification of sources of infections, which can allow for appropriate control measures in respect of outbreaks of diseases,
- facilitates the identification and monitoring of exposure to chemicals or other environmental factors that impact, or may impact, adversely on the health of individuals,
- allows NSW Health to contact the patient and undertake contact tracing to try and ensure contacts of a person with a scheduled medical condition or notifiable

condition are aware of the risks of transmission and actions to take to reduce the chance of transmission, and

- facilitates the care, treatment and the follow up of persons who have diseases or have been exposed to diseases and, where necessary, the management of individuals who have an infectious disease who pose a risk to others.

Under the *Act*, all notifications are made to the Secretary. However, in practice other areas in NSW Health, generally Health Protection NSW or public health units, manage notifications and undertake activities in respect of the infectious disease notifications. The *Discussion Paper* noted that in some cases it may be more appropriate for other persons or bodies outside NSW Health to manage some or all of the functions relating to notifications but recognised that the *Public Health Act* does not have any express provisions relating to another person or body managing notifications received by the Secretary.

Of the submissions received on this issue, many indicated in principle support for the Secretary to have express powers to arrange for another person or body to undertake public health actions in respect of notifications in limited circumstances. The Cancer Institute argued that such a provision would give registers such as the NSW Cancer Registry, which the Cancer Institute manages on behalf of the Secretary, a clear and transparent statutory foundation.

However multiple submissions raised serious privacy concerns regarding the dissemination of identifiable health records containing sensitive information outside NSW Health, potentially without adequate safeguards. The Office of the Privacy Commissioner NSW questioned the appropriateness of handing sensitive information about individuals that must be provided under the law to government to private sector entities that may not be subject to the same requirements in respect of that information. Others argued that sufficient justification should be provided for the delegation and suggested that a regulation would be required to specify the particular circumstances (including the condition and external body) under which this power should be exercised. There was also the view that appropriate review processes should be in place to ensure this power is not misused.

After considering the submissions received, the Ministry does not propose to make any changes to have a general power allowing the Secretary to arrange for a person or body outside of NSW Health to undertake specified public health actions in respect of notifications of a particular scheduled medical condition or notifiable disease. While there may be benefits to allow another person or body to manage certain notifications, the Ministry accepts the community concerns about amending the legislation to allow external bodies to handling public health notifications. However, it is important to retain current practice where certain NSW Health bodies in practice handle the notifications. For example, the Cancer Institute manages the cancer notifications on behalf of the Secretary and the

Clinical Excellence Commission manages the notifications of deaths under anaesthesia or sedation on behalf of the Secretary. This current practice will continue and ensure that the notifications are handled by the most appropriate NSW Health body.

Recommendation

15) No changes are made to the *Act* to provide for an express power to allow the Secretary to arrange for another person or body to handle notifications received under the *Act.*

3.5(b) Requirement to notify and obtain further information

The requirements to notify diseases and conditions, or provide further information about notifications are set out in various sections of the *Act*. However, issues have been identified with some of these provisions.

The *Discussion Paper* noted that under s55, pathology laboratories are only required to notify Category 3 conditions if a test is requested by a medical practitioner for the purpose of determining whether a person has a Category 3 condition. This means that if a test is carried out for another reason, but still indicates that a person has a Category 3 condition, then notification is not required by the pathology laboratory. In addition, the reference to "pathology laboratory" in s55 may be unduly narrow and not take account of other laboratories, such as chemical laboratories, which may undertake testing for Category 3 conditions. The *Discussion Paper* considered the example of the Category 3 condition of lead poisoning. Testing may be requested by medical practitioners or employers who are conducting health monitoring as required under the Work, Health and Safety Regulations 2011. The *Discussion Paper* noted that for the purposes of public health surveillance and actions, the origin of the test is immaterial but also recognised that inclusion of other laboratories could lead to duplication of processes.

The *Discussion Paper* asked whether s55 should be amended to require notification by laboratories whenever a pathology test is carried out for the purpose of indicating that a person has a Category 3 condition and indicates a positive result, regardless of who requested the test, and whether this requirement should apply to all laboratories, and not just pathology laboratories.

Of the submissions received on this issue, there was general support to amend s55 to require laboratory notification regardless of the origin of the request. Almost all of the submissions received on this issue, including from SafeWork NSW, were in support of extending the notification requirement to chemical testing facilities and other facilities carrying out biological testing. However, a number of submissions also highlighted the need

to ensure that individuals undergoing such testing at other laboratories are aware of any changes and the need to ensure that laboratories are subject to privacy requirements.

After considering the submissions received, the Ministry agrees that notification requirements should be extended to all laboratories who conduct testing for diseases and conditions. If a positive result is made, it does not matter which laboratory undertook the test. Similar issues arise in respect of who ordered the test to be undertaken, in that in principle if a positive result occurs notification to the Secretary should not be dependent on who ordered the test. In practice most test request are made by medical practitioners, however evolving clinical practices may mean that other registered health practitioners, such as nurse practitioners or dental practitioners, will more frequently order testing for diseases and conditions. Accordingly, there should be a mechanism in the *Act* to require reporting by other classes of persons other than medical practitioners. As such, the Ministry recommends that s55 should be amended to require laboratories to report positive test results if the request for the test is made by a medical practitioner or other class of persons prescribed by the regulations. A regulation making power will allow for appropriate flexibility to respond to changing clinical practices.

In respect of the submissions relating to ensuring patients are aware of the changes, the Ministry agrees that patients should be aware of how their information will be used and disclosed. However, the Ministry does not consider that there is a need to make any specific changes in legislation in this regard. Privacy legislation, such as the *Health Records and Information Privacy Act* 2002, requires organisations to inform patients how information that is collected will be used and disclosed. This obligation will remain and is supported. Such information can be given by way of a privacy leaflet to patients, such as the *NSW Health Privacy Leaflet for Patients*[7].

Recommendations

16) That the *Act* be amended to extend the requirement on pathology laboratories to notify results to all laboratories or facilities carrying out biological testing.
17) That an amendment is made to s55 to require laboratories to notify the Secretary whenever a pathology test is carried out, to determine whether a person has a Category 3 condition and indicates a positive result, when the request is made by a medical practitioner or other person of a class prescribed by the *Regulations*.

Another issue that was considered in the *Discussion Paper* relates to the issue of obtaining further information in relation to notifications.

[7] The NSW Health Privacy Leaflet informs patients that information may be disclosed for statutory reporting requirements, such as to report notifiable diseases, for example, cancer and infectious diseases: http://www.health.nsw.gov.au/patients/privacy/Pages/privacy-leaflet-for-patients.aspx

A medical practitioner, under s54, and a pathology laboratory, under s55, must notify the Secretary if a patient has a scheduled medical condition. Under s53, the Registrar of Births Deaths and Marriages must notify the Secretary of deaths from scheduled medical conditions. There are inconsistencies in s53, s54 and s55 relating to the ability of the Secretary to obtain additional information relating to the patient's medical condition, transmission and risk factors essential to the public health investigation and response.

Under s54 the Secretary has the power to require a medical practitioner to provide any additional information relating to the patient's medical condition, transmission and risk factors. It is an offence for the medical practitioner not to provide such information. However, while the Secretary may request additional information from the treating doctor under s55, the treating doctor is not required to provide this. In addition, the current ability for a medical practitioner involved in the treatment of the patient to provide additional information about notifications is limited to the narrow circumstances in s54 and s55.

The *Discussion Paper* considered the example where an initial notification of tuberculosis or cancer occurred following a post-mortem. The person's treating practitioner may have relevant information about risk factors of the disease but is not currently required to provide this to the Secretary. Another example provided in the *Discussion Paper* was a case of legionellosis. If the notification is made by the laboratory, the treating doctor is permitted, but not required, to provide information such as known exposure sources which is crucial to the public health investigation.

The *Discussion Paper* asked whether the *Act* should be amended to give the Secretary a power to require a medical practitioner involved in the patient's care to provide information concerning the person's medical condition, transmission and risk factors in all sections of the *Act* that require notifications of diseases or conditions to the Secretary.

Of the submissions received on this issue, overall there was broad support for the proposal. The Cancer Institute argued that the ability to seek further information from a medical practitioner in all circumstances where a Category 3 condition or notifiable disease is notified to the Secretary is necessary in order to maximize the quality of the data held in respect of notifiable conditions.

However, despite supporting the amendment several submissions raised the importance of patient privacy, particularly around the provision of sensitive information such as homosexual activity and drug use without patient consent. One submission highlighted that careful consideration was required to ensure such changes did not jeopardise the relationship between the patient and medical practitioner and impact on patient care. One local health district strongly argued that the requirement for a medical practitioner to provide additional information should remain optional for conditions such as STIs and

HIV/AIDS as an expansion of public health powers may deter testing and retention in care for specific population groups such as sex workers, people who inject drugs and men who have sex with men. Another submission advised that further consideration should be given to how sensitive information is protected, especially where it relates to activities that are stigmatised and/or criminalised.

Where a medical practitioner notifies a category 1 or 2 scheduled medical conditions, such as AIDS, HIV, syphilis and tuberculosis, the existing provisions in s54 require the medical practitioner to provide information on transmission and risk factors to the Secretary. Medical practitioners can also, but are not required, to provide information on transmission and risk factors when a notification is made by a pathology laboratory under s55. When a pathology laboratory notifies a condition, the pathology laboratory is highly unlikely to be able to provide information about a patient's risk factors relating to transmission. The patient's treating medical practitioner is more likely to be in a better position to provide such information. Similar issue can arise when the first notification of a disease is made to the Secretary via a notification of a death of a scheduled medical condition by the Registrar of Births, Deaths and Marriages. In such cases, information about risk factors relating to transmission of disease is essential public health information as it enables NSW Health to proper assess the notification and the past and future risk to the public.

Accordingly, the Ministry considers that there are public health benefits in requiring such information to be provided which would justify including a specific requirement in the *Act* requiring medical practitioners to provide information on risk factors when a notification is received about a scheduled medical condition or notifiable disease. The Ministry acknowledges the concerns about testing and retention in care for vulnerable groups such as sex workers, people who inject drugs and men who have sex with men. However, in many cases, where such individuals were diagnosed with a scheduled medical condition, the report on the condition will be made by the medical practitioner under s54. As noted earlier, s54 already has requirements on the medical practitioner to provide the additional information on risk factors to the Secretary. In addition, general privacy principles apply and there are strict limits on the use and disclosure of any information obtained by the Ministry. That said, the Ministry acknowledges the general concerns about the disclosures of information obtained under the Public Health Act and is proposing additional protections in respect of such information. While there are already strict privacy controls in place, the issue of additional protections, via protections from subpoena, is discussed further at 3.5(c).

Recommendation

18) That the *Act* is amended to extend the existing provisions in s54, which require a medical practitioner involved in the treatment of the person to provide the Secretary with further information in order to complete the notification report or provide information concerning the person's medical condition and transmission and risk

factors as is available to the medical practitioner, to all provisions of the *Act* where a disease or condition is notified by the Secretary.

3.5(c) Section 56 and notification of HIV and AIDS

De-identified notifications of HIV and AIDS to the Secretary and protection of information

All scheduled medical conditions and notifiable diseases are notified to the Secretary in a form that gives the name and address of the person with the condition or disease, with the exception of HIV and AIDS. Section 56 provides that any notification for a category 5 condition is to be in a de-identified format; currently category 5 conditions are HIV and AIDS. The *Discussion Paper* asked whether HIV and AIDS notifications should continue to occur in a de-identified format.

The *Discussion Paper* noted that the confidentiality provisions specific to HIV and AIDS within s56 of the *Act* were enacted at the time when HIV infection was a fatal disease for which there was no effective treatment and when there was considerable discrimination faced by the main affected population group, namely homosexual men, and by people with HIV infection. The current laws that protect against HIV discrimination and protect privacy of health information were not yet in place. The *Discussion Paper* noted that community attitudes to HIV have improved markedly and the advent of antiretroviral therapy means that HIV infection is now a chronic manageable disease like many other conditions. The *Discussion Paper* notes that s56 could contribute to "HIV exceptionalism" where HIV is considered differently to other conditions, and this may perpetuate HIV stigma and discrimination.

With respect to the possible inclusion of a person's name and address in HIV notifications (named notification) the *Discussion Paper* noted that there are individual and public health benefits of named notification including: improved accuracy of HIV epidemiological information that is critical for monitoring the impact of HIV prevention efforts; better capacity to offer support to people living with HIV (PLHIV); more effective and efficient methods to monitor HIV co-infections to inform prevention and treatment services; improved estimates of HIV mortality and morbidity; and improved information on the outcomes of HIV infection. However, the *Discussion Paper* also noted that these benefits must be balanced against potential harms including that named notification may deter people at risk of HIV infection from testing, and may deter PLHIV and clinicians from reporting risk factors for infection such as injecting drug use.

The *Discussion Paper* asked whether the *Act* should be amended to require named notification of HIV and AIDS. In addition, the *Discussion Paper* asked, if named notification occurred, whether additional protections should be included in the *Act* to protect the

information received by the Secretary, such as protection from subpoena, should be included in the *Act*.

Fifty-three submissions were received that addressed issue of named notification.

Many medical peak groups and local health districts supported the introduction of named notification citing the benefits articulated in the *Discussion Paper*. The Kirby Institute also supported named notification and suggested also considering named HIV viral load notification, but noted that prior to the introduction of such measures that discussion with the affected communities and monitoring of HIV testing before and after the introduction should be done. The national and NSW peer based organisations of PLHIV (NAPWHA and Positive Life NSW) were both in favour of named notification combined with community discussion about privacy provisions and the use of notification data, indicating that there is no evidence that named notification will decrease HIV testing uptake and that the benefits outweigh the harms. Support from both these organisations was contingent on protection of notification data from subpoena.

However, the other HIV community based organisations (national and NSW based) including ACON, AFAO, ASHM, SWOP, HALC and others, various other organisations including Pozhet (Heterosexual HIV Service NSW), and private individuals who made a submission were opposed to named notification. By far the greatest concern was that because there is still a high level of stigma and discrimination against PLHIV, named notification would deter people at risk of HIV from having an HIV test. Many submissions noted that that there were still high levels of stigma and discrimination against PLHIV that remain, particularly in culturally and linguistically diverse (CALD) and rural communities, and even within the health care setting. Some argued that any change would impact most on people from CALD backgrounds, many of whom come from communities where HIV stigma is strong and there is a high level of mistrust of government. Concerns were expressed about the potential for misuse of identified HIV information in the future (e.g. by the Police and for the purposes of "criminalisation of HIV" within the criminal code and public health orders) and that public health follow-up of PLHIV who choose not to be on treatment could become coercive. Some submissions acknowledged that a fear of testing because of named notification was not justified, but it nevertheless exists, and therefore is sufficient reason not to introduce named notification at this time. Some submissions made suggestions for alternative methods other than named notification to better engage and retain PLHIV in care.

After considering the submissions received, the Ministry in principle remains supportive of named notification of HIV and AIDS. However the Ministry acknowledges and recognises the high level of concern express in the community and therefore is not proposing any change at this time. Named notification would represent a major shift in HIV policy and legislation and it is important that there is community support for any such change.

A large proportion of submissions indicated that considerable engagement with affected communities should occur to build trust and confidence in privacy provisions before the introduction of named notification. There has been considerable progress that has been made in NSW in implementation of successive NSW HIV Strategies towards the goal of virtual elimination of HIV by 2020, particularly in increasing HIV testing, and in monitoring strategy outcomes and supporting doctors who diagnose HIV despite HIV notification data that is de-identified. This work can and will continue and in addition the Ministry can continue community discussion about the issue of named notification in order to attempt to build understanding and support among the whole HIV community.

In respect of the issue of additional safeguards and protections of notifications received by the Secretary, most, but not all, submissions that supported named notification supported the introduction of protection from subpoena of notification records, and several, including community based organisations, made their support for named notification contingent on the protection from subpoena. Additionally, some submissions that did not support named notification were strongly in support of additional protections for information to be included in the *Act* should named notification be introduced.

Some submissions indicated that protection from subpoena is important for all information held under the *Act*, as such information should be used only for the purposes for which it was collected (i.e. for protection of health). Identified records of people notified with a blood borne virus other than HIV were highlighted.

On the other hand, some submissions indicated that additional protections were not needed as the current system is robust and the data is secure.

While the Ministry is not recommending changes in relation to named notification at this time, the issue in relation to the appropriate safeguards of notifications received by the Secretary is an important consideration. The public and NSW Health gets the greatest benefit where public health notifications are accurate and complete and individuals are confident that their information will be securely held. The Ministry considers that there are strong public interest grounds to justify safeguarding notifications received by the Secretary from subpoena. While it is also acknowledged that there is a public interest in ensuring that Courts have access to relevant information required in legal proceedings, protecting notifications to the Secretary would not unduly interfere with the Court processes. This is because information held by the Secretary would also be held by another person or body who could be subpoenaed, for example a GP or a hospital. However, it is considered that amending the legislation to provide that the information held by the Secretary is not subject to subpoena would address a number of the concerns raised in this review relating to the importance of protecting information collected and held by the Secretary for public health

purposes. Therefore, the Ministry recommends that the *Act* be amended to provide that public health notifications obtained by the Ministry are not subject to subpoena.

Recommendation

19) While in principle the Ministry supports HIV and AIDS notifications to the Secretary including the person's name and address, changes to introduce named notification are not recommended at this time.
20) The *Act* be amended to provide that notifications received by the Secretary under the *Act* are not subject to subpoena.

Prohibition of a person's identifying details being used for the purpose of arranging a diagnostic test for HIV (except in hospital situations or with consent)

Section 56 of the *Act* prevents a person's identifying details being used for the purpose of arranging a test for determining whether a patient has HIV (except in hospital settings) except with consent. The *Discussion Paper* noted that this provision can have impacts on good clinical care. For example, antenatal screening for HIV is critical in reducing the vertical (mother to child) transmission of HIV, and should ideally be included as a part of routine antenatal serological screening for a range of different infections, such as syphilis, hepatitis B, and rubella. However, application of current legislation means that if the clinician orders an "antenatal screen" on a pathology request form containing the pregnant woman's name, the pathology laboratory may not be assured that consent has been given for HIV testing using the patient's identifying information. That is, HIV tests have a different consent process to other tests. Therefore when testing for HIV is combined with testing for other diseases, such as an antenatal screen, the different requirements for an HIV test form may mean that the HIV test is not carried out.

The *Discussion Paper* also argued that this provision is out-dated as there is no similar provision for HIV viral load or drug resistance testing, as the provision only applies when a person is being tested to determine whether they have HIV. This means that there is no additional identity protection by requiring consent when these tests (which also demonstrate that the person has HIV infection) are ordered. To that end, the *Discussion Paper* sought submissions on whether the prohibition on including a person's identifying details being providing in arranging a test for determining whether a patient has HIV except with consent should be removed from the *Act*.

The majority of submissions that addressed this issue supported the removal of the need for consent for identifying information to be included on a pathology request form for HIV testing. Some submissions stated that the current provision is a barrier to testing and some added that it confuses clinicians. An example was given where de-identified information on the test request form resulted in someone being given another person's HIV test result.

Several submissions in support of the removal of the need for consent added that individuals should however still be able to choose de-identified or anonymous testing.

On the other hand, some submissions did not support any amendments. Some argued that individuals should have a choice regarding whether their names are included on a pathology test form and raised privacy concerns in relation to removing the provision from the *Act*. Some also argued that it is important to ensure that the person expressly consents to any HIV test.

HIV is unique among conditions in requiring specific patient consent to have their name on a test request. This has the potential to create confusion and other problems as if a person's name is not included on the form, there is a risk that a patient will be given someone else's test results, with possible harm occurring as a result. Further, the Ministry considers that amendment to this section of the *Act* will help remove a potential barrier to testing, contributing to the goal of eliminating HIV transmission through earlier diagnosis and treatment of people living with HIV. Amending this section may also contribute to reducing the stigma associated with HIV by removing another area where HIV differs to other infectious conditions. In relation to concerns about anonymous testing, the proposal would not affect any existing ability to be tested anonymously. In respect of the issue of the need to ensure consent for testing, the proposed change would also not remove the existing requirement to obtain appropriate consent for testing for HIV.

Recommendation

21) The prohibition on including a person's identifying details in a pathology request form for HIV testing without specific consent of the person be removed from the *Act.*

Additional confidentiality of information that a person has HIV or AIDS

Section 56(3) of the *Act* sets out strict confidentiality requirements in respect of category 5 conditions (HIV and AIDS) which provides that a person who, in the course of providing a service, acquires information that another person has HIV or AIDS or has been tested for HIV must take reasonable steps to prevent the information being disclosed. However, there are exceptions to this requirement set out in s56(4)(b) which permit disclosure "*to a person who is 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*".

The *Discussion Paper* noted issues with this provision in that it can be interpreted narrowly by clinicians and health services to mean that the exemption applies only where the disclosure is to a person who is directly involved in the care or treatment of the person's HIV infection. This has created difficulties within health service settings because it means that

HIV information may only be shared after it has been established that the other clinician involved in the treatment of care of the person will be managing the impacts of the HIV infection. However, with the evolution of HIV infection from an almost universally fatal condition to a chronic manageable disease with a life expectancy close to that of non-infected people, and the fact that HIV infection and the drugs used to treat it affect virtually all body systems, HIV status information is increasingly important for all medical care. The "lockdown" of HIV test results within health service patient records risks the provision of poor clinical care. The *Discussion Paper* therefore asked whether s56 should be amended to allow HIV information to be disclosed for the purpose of health care (noting that general privacy principles would continue to apply and therefore the same limits to disclosure would be in place for HIV information as for all other health information).

Around half of the submissions received on this issue agreed that the *Act* should be amended to allow for information about a person's HIV status to be disclosed for the purpose of providing medical or health care. In most, the rationale for this position was that HIV status information is necessary for the provision of good clinical care and existing privacy provisions for health information will protect the HIV status information. Positive Life NSW supported such an amendment arguing that the current system can lead to mistakes and the information on HIV status is needed for proper health care. Another rationale included in some submissions was that s56(4)(b) is ambiguous and places doctors in a position of unresolvable conflict between trying to avoid medical negligence by not omitting important health information in health communications and adhering to the *Act*. Further, the current legislation can result in multiple HIV tests for the same person when new clinicians are not aware of prior results, increasing costs and unnecessary test result waiting times and doesn't allow for documentation of informed consent for HIV testing within a patient's medical record.

On the other hand, just under half of the submissions, including from most community based organisations, including ACON, HALC and others, and from individual members of the public and some health services, did not support amending this section of the *Act*. The predominant argument was that PLHIV should be able to control who has access to their HIV information as stigma and discrimination against HIV persists in health settings, particularly in non-urban areas. Fear of disclosure and of stigma may result in PLHIV not accessing care. It was argued that reporting and prosecution for instances of discrimination and/or privacy breach are avenues that can be taken only after harm has been done. Some submissions indicated that should such an amendment be made, it should be a clear delineation as to what types of health professionals would have access to the HIV status; PLHIV should be able to opt-out of having their HIV status disclosed to other medical professionals; and PLHIV would need to be advised when their status had been shared with other practitioners.

The Ministry acknowledges the submissions that indicate that HIV stigma and discrimination still occur in some health care settings (and in other areas of life) and that this can and does cause harm. As such, there are good reasons to limit access to information about a person's HIV status. However, on the other hand, limiting a clinician's access to a person's HIV status also has the potential to cause serious harm. HIV remains a serious medical condition with a broad set of potentially life-threatening comorbidities. There is a risk of harm to a person with HIV if there is a lack of appropriate communication between health practitioners about a person's HIV status. A lack of knowledge about a patient's HIV status can compromise good clinical care. Accordingly, it is necessary to balance these two, sometimes competing, issues.

In doing so, the Ministry notes that there are other measures in place to protect HIV information and provide readdress for instances of discrimination. The *Health Records and Information Privacy Act* places strict limits on the use and disclosure of health information. In addition, it is both unethical and unlawful (on the basis of disability discrimination) for health care providers to engage in HIV related discrimination. Mechanisms are in place in local health districts to respond to complaints, including in relation to privacy and discrimination. Additionally the Health Care Complaints Commission can hear and respond to complaints about unethical behaviour of health practitioners and the Anti-Discrimination Board can hear complaints regarding unlawful discrimination.

On the other hand, the current limitations in s56(3) and (4)(b) have the potential to cause real harm to patients with HIV that cannot be reasonably managed without allowing clinicians appropriate access to relevant health information. Whether a patient has HIV may impact on the question of diagnosis and treatment of a patient for illness and conditions that are both related and unrelated to HIV. In order to provide the best possible care to patients, clinicians should not be unduly constrained in accessing information about a patient's HIV status.

After considering these issues, the Ministry's view is that the *Act* should be amended to make clear that it is not an offence for information about a person's HIV status to be disclosed for the purpose of providing medical or health care. This will assist in providing appropriate care and treatment to patients and will assist in ensuring clinicians are not unduly limited in having access to relevant information. However, it is important to note that such a change does not mean that all health professionals will be able to access a patient's HIV information. HIV information, as with all health information, will be subject to the *Health Records and Information Privacy Act*, which places strict limits on the use and disclosure of health information.

Recommendation

22) Section 56(4)(b) be amended to make clear that it is not an offence for information about a person's HIV status to be disclosed for the purpose of providing medical or health care.

3.5(d) Disclosure of STI status – s79

Section 79 of the *Act* makes it an offence for a person with a sexually transmitted infection (STI) to have sex with another person unless the person informs their partner of the risk of transmission of the STI prior to sexual intercourse and the partner voluntarily accepts the risk. However, if reasonable precautions are taken to prevent transmission of the STI, then this is a defence under the *Act*. While s79 applies to any STI, it is usually considered in the context of HIV infection.

The *Discussion Paper* noted that that there is no evidence that s79 is effective in preventing the spread of STIs. In fact, it may have overall negative impacts on HIV and STI control because: many STIs, including HIV infection may be asymptomatic, so a person may be infected but not diagnosed and therefore non-disclosure of an STI by a prospective sexual partner does not mean there is no risk of acquiring an STI; s79 may discourage HIV or STI testing because if a person is not aware of their HIV status they are not required to disclose; and s79 may result in stigma and discrimination and even coercion against the person who has disclosed, as once they have disclosed their HIV status to a prospective sexual partner that person may tell other people or use the information against the person with HIV. Moreover, s79 does not align with public health messages which focus on safe sex.

On the other hand, there is an argument that knowledge of the HIV or STI status of a potential sexual partner is needed to enable individuals to make an informed choice on whether to engage in sexual activity. However, reliance on a sexual partner's notification about their STI status may provide a false sense of security because a person may not know they are infected. Even a person recently tested for HIV can be unknowingly infectious if tested during the 'window period' between acquiring the infection and the test becoming positive.

The *Discussion Paper* sought submission on whether s79 should be removed from the *Act*. In addition, the *Discussion Paper* sought submissions on whether a provision setting out responsibilities of both people with an infectious disease, and people at risk of acquiring an infectious disease, should be included in the *Public Health Act*. The example of the principles set out in the Victorian *Public Health and Wellbeing Act* 2008[8] was provided in the *Discussion Paper*. These principles, as well as stating that someone with an infectious

[8] See s111 of the Public Health and Wellbeing Act 2008 (Vic)

disease should take all reasonable steps to eliminate or reduce the risk of transmitting the disease to another person, also state that a person who is at risk of contracting an infectious disease should take all reasonable steps to avoid contracting the infectious disease.

Of the submissions received on this issue, there was almost universal support for the removal of s79 from the *Act*, with many submissions, including those from health services and community based organisations, indicating that s79 is ineffective in preventing STI transmission. Many added that s79 undermines sexual health promotion messages focusing on safe sex and/or undermines the concept of mutual responsibility of both sexual partners for the prevention of HIV and other STIs.

One sexual health service felt that there is a difference between situations where sex is occurring in a context where everyone is aware of the need to take responsibility for their own sexual health (such as a sex on premises venue) and a situation in which someone is in a relationship believing that the relationship is monogamous and therefore it is safe to have unprotected sex. Disclosure becomes important in the latter situation. Two submissions did not support the removal of s79, arguing that s79 complements safe sex messages and works as an additional health protection measure.

After considering the submissions received, the Ministry supports the removal of s79 from the *Act*. While the importance of disclosure of STI status to sexual partners is recognised, s79 is considered to be a blunt and ineffective tool for protecting public health. In respect of the protection from STIs, public health is best protected by focusing on the need to protect a person's health, and the health of their partner, though safe sex and undergoing screening for STIs.

It is noted that removal of s79 would not affect the provisions of the *Crimes Act 1900* which make it an offence to intentionally or recklessly causing grievous bodily harm through the transmission of a grievous bodily disease[9].

In respect of the issue of the *Act* including a provision setting out the responsibilities of both people with an infectious disease, and people at risk of acquiring an infectious disease, while a small number of submissions did not support this approach, most submissions supported such a provision. Only two submissions on this issue did not support the proposal.

After considering the submissions received, the Ministry considers that there should be a provision in the *Act* setting out the responsibilities of all persons with respect to the prevention of infectious diseases. The protection of public health is an important

[9] See sections 4, 33 and 35 of the Crimes Act 1900

responsibility of all members and sections of the community. Having an express provision in the *Act* relating to the responsibilities of individuals to reduce the risk of transmission of an infectious disease of both those with an infectious disease and those at risk of contracting an infectious disease is considered to appropriately reflect general community expectations about measures that should be taken to minimise the transmission and spread of infectious diseases.

Recommendation

23) Section 79 be removed from the *Act*.
24) The *Act* includes a new section setting out general principles that apply to persons relating to the prevention and management of infectious diseases.

3.5(e) Public Health Order

Under the *Act*, an authorised medical practitioner can make a public health order requiring a person with a Category 4 or 5 condition who poses a risk to public health be detained and/or treated. Category 4 conditions are listed in Schedule 1 and include serious and often life-threatening infectious conditions which have the potential to cause outbreaks with major implications for the community. These are avian influenza in humans, tuberculosis, viral haemorrhagic fevers (such as Ebola), typhoid, SARS coronavirus and Middle East respiratory syndrome coronavirus (MERS). Category 5 conditions are HIV and AIDS.

The *Discussion Paper* acknowledged that in practice, such orders are very rarely used as most people agree to follow public health advice. However, the review provided an opportunity to ensure that the provisions in the *Act* are adequate to protect public health.

Existing public health order provisions do not apply to contacts of a person with a Category 4 condition who may have been infected and have yet to develop symptoms. The *Discussion Paper* considered whether current powers for public health orders should be extended to contacts. It argued that it is almost always impossible to exclude a contact as being infected until a defined time period (the maximum incubation period) has passed. The *Discussion Paper* referred to the recent Ebola virus disease outbreak in west Africa and the MERS outbreak in South Korea as examples where the effective management of high-risk contacts was critical to prevent transmission in the wider community. However, the *Discussion Paper* also acknowledged that contacts generally follow medical advice which may negate the need for any coercive action and recognised that extending public health orders to contacts could place restrictions on the rights and liberties of persons who do not currently have a Category 4 condition and in whom such a condition may never eventuate.

The *Discussion Paper* also noted that s60 of the new Commonwealth *Biosecurity Act* 2015 gives powers to Human Biosecurity Officers to impose a human biosecurity control order (which is akin to a public health order) on an individual who has been exposed to a listed human disease. However, the listed diseases do not include all Category 4 conditions.

A related issue in the *Discussion Paper* was that public health orders in respect of Category 4 conditions only allow a person with a Category 4 condition to be detained in order to receive treatment. However, detention may be required to prevent disease transmission from a person with the infection regardless of whether treatment can also be given.

Another issue canvassed in the *Discussion Paper* is whether greater transparency of public health orders made under the *Act* is required such as mandatory reporting of the number of orders made and the disease or condition, in the Annual Report of the Ministry.

There were mixed views in the submissions received on these issues. Some submissions supported the proposal to extend the provisions for public health orders to include high risk contacts of a person with a Category 4 condition with additional measures to appropriately protect the rights of contacts, such as an efficient appeal mechanism and appropriate measures for independent review.

However, other submissions did not support the proposal to extend Category 4 public health orders to high risk contacts. One submission argued that existing provisions in the Commonwealth *Biosecurity Act* 2015 are sufficient and it was also argued that additional powers for Category 4 conditions in NSW could potentially undermine the rights to liberty and freedom of movement for individuals at risk of such infectious diseases. Concern was also raised that legislative change could undermine the willingness of individuals to declare information on entry into the country (specifically international ports in NSW) and seek testing or treatment if unwell or otherwise engage with NSW Health regarding their movements and self-monitoring. Another submission opposed public health orders for high risk contacts of cases with diseases that have an effective treatment. In such situations they felt the benefits of restricting a "potentially incubating" individual may not outweigh the deprivation of liberty an order would apply.

The issue of detaining people for public health purposes is a contentious and serious issue. It involves balancing the right of individual liberty against the need to protect the public from serious public health threats. The Ministry acknowledges and accepts that the right to liberty should not be affected without proper justification and oversight.

Some Category 4 conditions (avian influenza in humans, SARS, MERS, and viral haemorrhagic fevers (e.g. Ebola)) have the potential to cause widespread and/or serious illness and death. In addition, people may be infectious, and spread the disease to others

before they exhibit definitive symptoms and/or are diagnosed with the disease. If a person who is a contact of such a disease or illness refuses to quarantine themselves, or take other appropriate action to mitigate the risk of the spread of the disease, the contact is potentially placing other members of the public at risk of serious harm. It is considered that this risk would justify having a power to make a public health order, in the same way that a person with the disease who is acting in a way that places others at risk of serious harm can be placed on a public health order.

The Ministry agrees that for all cases, obtaining voluntary compliance with public health measures is most desirable, and required by NSW Health policy[10]. Use of a public health order to detain a person suffering from a Category 4 condition would only be undertaken if no other means was available to protect public health. As several Category 4 conditions (MERS, SARS, viral haemorrhagic fevers) do not have treatments available, the Ministry considers it is a necessary additional power to allow detention of cases of Category 4 conditions while infectious, irrespective of whether they are receiving treatment.

In relation to the argument that the Commonwealth *Biosecurity Act* 2015 contains sufficient powers to protect the public, the Ministry is of the view that it is preferable for NSW officers to rely on the *Public Health Act* to manage public health risks in NSW rather than relying upon a Commonwealth *Act*. This is because NSW officers are more familiar with the *Public Health Act* and, in the event of the need to use such powers, additional powers in the *Public Health Act* may be required. Accordingly, it would seem to be more appropriate to have NSW officers only needing to rely on one piece of legislation.

Accordingly, and after considering the submissions received, the Ministry is of the view that, in order to protect public health, there should be a mechanism in the *Act* to place restrictions and/or detain contacts of a person who is suffering from certain diseases and who is posing a risk to public health. However, the Ministry also recognises the need to ensure that appropriate safeguards are in place when placing such restrictions on the person. While the existing provisions contain a number of safeguards relating to public health orders, it is considered that additional safeguards should be included in the *Act* in relation to extending public health orders to contacts of persons with a Category 4 conditions.

Currently, under the *Act* where a public health order is made in respect of a person with a Category 4 condition, while the NSW Civil and Administrative Tribunal (NCAT) can, on application, review the order at any time,[11] NCAT's involvement is only *required* if an application is made to extend the order beyond 28 days. This can be contrasted with a

[10] See for example, the NSW Health Policy Tuberculosis Management of People Knowingly Placing Others at Risk of Infection, http://www0.health.nsw.gov.au/policies/pd/2015/pdf/PD2015_012.pdf
[11] Section 66 *Public Health Act*

public health order in respect of Category 5 (HIV and AIDS). In such cases, NCAT must review and confirm the order in 3 working days[12]. An earlier review date by NCAT for a public health order in respect of a contact of a person with a Category 4 condition is considered appropriate. An early review date would provide an independent review of whether the person who is the subject of the order is in fact a contact of a person with a Category 4 condition and their level of risk to the public. In addition, the maximum period for which an order could operate should be limited by the maximum incubation period for the disease in question, for example the maximum incubation period for avian influenza, MERS and SARS is ten days, while the incubation period for viral haemorrhagic fever (such as Ebola) is longer, up to 21 days. Contacts should not be able to be detained longer than the incubation period.

Further, it is acknowledged that there would not be a need to apply the new provision to all Category 4 conditions. For example, with tuberculosis most contacts of a person with tuberculosis will not develop the disease and treatment, including preventative treatment, is available and therefore a public health order for a contact would not be considered appropriate. However, other category 4 conditions are different. Ebola (or other viral haemorrhagic fever), SARS and MERS may be highly infectious, with people being infectious prior to diagnosis. Treatment for these diseases is not generally effective and/or currently available. With respect to typhoid, people can be infectious prior to diagnosis but generally the public health risk arises when the person with typhoid, or the contact, is involved in food handling or has close personal care of others. Accordingly, it is only proposed to apply the new provisions to viral haemorrhagic fevers, SARS and MERS and typhoid. However, diseases can change in their nature and/or new strains of diseases can emerge. Therefore, there should be a mechanism to apply the public health order contact provisions to other diseases if necessary to protect public health.

In relation to the issue of allowing a public health order for a Category 4 condition to order that a person be detained, regardless of whether treatment was available, while some submissions did not support this proposal, there was broad support for amending the *Act* to allow detention regardless of whether treatment was available.

There was universal support for greater transparency requirements relating to public health orders that have been made.

After considering the submissions, the Ministry considers that the *Act* should be amended to allow a Category 4 public health order to be made allowing a person with a Category 4 condition to be detained, regardless of whether treatment can be given to the patient. There may not necessarily be effective treatment available for a patient. However, if a patient refuses to take appropriate public health measures, the patient may be placing

[12] Section 64 *Public Health Act*

others at risk of serious harm. An order allowing a person to be detained while infectious, regardless of whether treatment is available, is considered an appropriate mechanism to protect public health in those rare cases where people do not follow appropriate public heath advice. The Ministry also considers that improving transparency around the making of public health orders is appropriate. Public health orders, while necessary in limited cases to protect public health, represent an infringement of liberty and the Ministry should be transparent in relation to the numbers of such orders made. This could be done by way of requiring the Ministry to include in its annual report the number of public health orders made.

Recommendation

25) The *Act* should be amended to allow a public heath order to be made in respect of a person who is contact of a person with a viral haemorrhagic fevers, SARS and MERS and typhoid (with a power to add additional diseases as appropriate) if the person is posing a risk to the public. However, appropriate safeguards should be in place with respect to public health orders regarding contacts.
26) That the provisions in the *Act* relating to Category 4 public health orders be amended to allow an order to be made requiring a person to be detained, regardless of whether or not the person can receive treatment for the disease.
27) That the *Act* be amended to require the Ministry to report, in its Annual Report, the number of public health orders made.

3.6 Vaccine preventable diseases

3.6(a) Extension of existing provisions relating to vaccine preventable diseases to high schools

Division 4 of Part 5 of the *Act* addresses vaccine preventable diseases and the responsibilities of principals of schools and child care facilities with respect to immunisation. The provisions in the Act are threefold:

1. Firstly, they require principals of primary schools to request information about a child's immunisation status at enrolment.
2. Secondly, in respect of child care facilities, the *Act* provides that principals must not enrol a child unless they first obtain a vaccination certificate in an approved form indicating that the child is age appropriately vaccinated, on a catch up schedule, has a medical contraindication to vaccination, or has parents who have a conscientious objection to vaccination.
3. Thirdly, principals of child care facilities and primary schools are required to notify cases of vaccine preventable diseases to the public health officer. During an outbreak of a vaccine preventable disease, a public health officer can take action to exclude a child who is at risk of contracting the disease through not being vaccinated for that condition.

The *Discussion Paper* noted that while rates of different vaccine preventable diseases vary from year to year, in recent years the incidence of some vaccine preventable diseases, such as measles, has been higher in high school aged children than younger children.[13] In addition, the *Paper* noted that following the establishment of the Commonwealth Australian Childhood Immunisation Register (ACIR), parents have an easier mechanism to obtain their child's immunisation history. Accordingly, the *Discussion Paper* asked whether these provisions should be extended to high schools.

Most of the submissions received on this issue, including those from educational and social welfare peak bodies, were supportive of the extension of the existing provisions to high schools, arguing that there should be a consistent approach to protecting public health across the education sector. Many cited the extension of the ACIR in 2016 to all persons up to the age of 19 years in making this possible and mitigating any additional administrative burden on schools or parents. While the impact of loss of educational attendance was recognised as more significant on a high school student than on a primary school child, a number of submissions noted that technological strategies could be used to ensure that excluded children were still able to access school materials and teachers.

Some submissions gave qualified support, on the basis that there needs to be careful epidemiological consideration and adequate operational support so that the bureaucratic burden on school staff is minimised and there is consultation between the Public Health Officer and the Principal to ensure that no further harm results from such a decision, e.g. ensuring that there is adequate supervision at home for excluded children. While generally supportive of the extension of these provisions, the Department of Family and Community Services also raised the concern that there might be a disproportionate impact on children in out-of-home (e.g. foster) care.

Other submissions did not support the proposal. Some argued that extension of these provisions to high schools was unnecessary, as secondary school students have a greater ability to follow public health advice and infection control measures and that the impact on high school students could have a greater impact on learning, particularly at critical times of the year. The Royal Australasian College of Physicians suggested that school based vaccination clinics be offered in outbreak settings, which could also improve immunisation coverage in the longer term.

High schools are a higher risk setting for measles outbreaks as there is a higher risk of older children having missed routine childhood vaccines either due to lower overall coverage when they were infants, or because they have moved to Australia after infancy and missed

[13] The NSW Vaccine Preventable Diseases Report for 2009-2013 can be accessed at: http://www.health.nsw.gov.au/Infectious/reports/Pages/vpd-reports.aspx

the opportunity to be vaccinated. During all recent measles outbreaks in NSW, cases in primary aged children have been very uncommon compared to high school aged children.

The *Discussion Paper* considered whether the disease control objectives of excluding potentially infectious unvaccinated high school students from school could be subverted by the students attending non-school settings such as shopping centres or parties. However, these activities may occur, regardless of whether the child is excluded from school or not.

New powers for exclusion from high school could be utilised to complement existing public health interventions such as mass vaccination clinics in cases of measles, and having a record of unvaccinated students held by the school would facilitate identification of children requiring vaccination. Further, it should be noted that if an outbreak occurred, an unvaccinated child who received the vaccine within three days exposure is unlikely to require exclusion from school.

While exclusion from school could potentially have a more significant impact on senior high school students than on primary or even junior high school students, the relative ease of electronic communication, such as email, would generally make it easier for any excluded student to keep in contact with their teacher/class. Further, the purpose of exclusion is to contain an outbreak of a vaccine preventable disease, most likely measles. If the public health officer does not have the power to contain an outbreak by exclusion, it is likely that more children will miss schooling due to illness.

Since the requirement for early childhood centres and primary schools to request a vaccination record was introduced to the *Public Health Act* in 1993 the ability for parents to obtain vaccination records of older children has been made considerably easier, most particularly with the extension of the Australian Immunisation Register to a whole of life register in 2016. Additionally, in the public school sector at least, children's records, including vaccination records, can transfer from primary to high school utilising a statewide data system. Thus the previous barrier to requiring a vaccination certificate on enrolment to high school has been greatly reduced.

The incidence of some vaccine preventable diseases, such as measles, has been higher in high school aged children than younger children in recent years. Exclusion of unvaccinated high school children during an outbreak could assist in controlling such outbreaks. This requires a reliable and easy access to vaccination records for these students. With the maturing of the ACIR, which commenced in 1996, and its extension from 1 January 2016 to accept vaccinations given up to 19 years of age, parents will have easier access to vaccination records for high school children. Vaccination records from public primary schools can automatically transfer to public high schools along with the child's other records, further reducing the administrative burden of this change. Accordingly, the Ministry

supports amendments to the *Act* to extend existing provisions relating to vaccine preventable diseases to high schools.

Recommendations:

28) The provisions in the *Act* relating to vaccine preventable diseases should be extended to include high schools

3.6(b) Actions undertaken during an outbreak of a vaccine preventable disease

The *Public Health Act* currently requires principals of primary schools and child care facilities to inform the Public Health Officer if there is an outbreak of a vaccine preventable disease at the school or child care facility. Under section 88, the Public Health Officer may then direct the principal to exclude a child with a vaccine preventable disease and/or an unvaccinated child from a primary school or child care facility where there is an outbreak of a vaccine preventable disease.

However, if a Public Health Officer becomes aware that an unvaccinated child has been in contact with someone with a vaccine preventable disease but attends a school at which there is not an outbreak, there is no legal power to exclude that child from school/child care. Many vaccine preventable diseases are infectious before any definitive symptoms show, which means that contacts of a person with a vaccine preventable disease may risk passing the disease onto other persons before they themselves become ill.

The *Discussion Paper* considered whether the provisions of the *Act* should be extended to enable an unvaccinated child who is a contact of someone with a vaccine preventable disease to be excluded from primary school or child care, regardless of whether or not there is an outbreak at the facility. It further considered whether, subject to feedback on the previous issue, this provision should also be extended to high schools.

Many submissions were supportive of extending this provision to unvaccinated contacts of a person with a vaccine preventable disease, arguing that it would reduce the potential for transmission to other unvaccinated or partially vaccinated children. One submission was supportive, but argued that the burden of evidence should be quite high. The Royal Australasian College of Physicians did not support the extension of this provision, arguing that these circumstances are rare and that examples of children who are excluded yet later do not develop illness could be used to argue that such policies and actions are both discriminatory and needless. Such examples could reduce the constructive engagement of parents with educational and childcare settings.
Where submissions supported the extension of the provision to unvaccinated contacts in primary schools and childcare facilities, they were also generally supportive of the extension of the provision to high schools.

However, a number of submissions strongly opposed this proposal and the proposal to extend this to high schools. Some argued that only those with the disease should be excluded as an unvaccinated child is no more likely to transmit disease than a vaccinated child; that the definition of a "contact" was very broad making this a heavy handed approach; and that this measure may have a detrimental effect on the parents' employment as they would be required to stay home to care for their child.

The Ministry recognises that the exclusion of a child from early childhood education or school is a significant step, and is only done in accordance with the requirements of the *Act* and relevant guidelines. In recent years, due to current disease patterns in NSW, exclusion has only been used for measles outbreaks, and rarely for whooping cough outbreaks in early childhood centres with highly vulnerable infants. Exclusion is one part of a suite of measures available to NSW Health to control outbreaks that have the potential to cause significant public health impacts.

While such a measure is rarely employed, the Ministry considers that it is important that Public Health Officers do have a full suite of measures available to control outbreaks, as uncontained outbreaks lead to further illness, with potentially severe outcomes. If an unvaccinated child who was definitely in the same house as another child with confirmed measles was to attend childcare or school, any other unvaccinated children and children for whom vaccination had been unsuccessful, would be potentially exposed to measles if the contact were to attend childcare or school in the early days of developing measles while infectious before developing the rash.

The Ministry is of the view that the provisions in section 88 of the *Act* should be extended to permit the exclusion of unvaccinated children who have been in contact with someone with a vaccine preventable disease. Further, in line with recommendation 28, this amendment should also apply to high school. While the circumstances whereby this provision would come into use are relatively rare, the Ministry sees the provision as a logical extension of the current powers to exclude unvaccinated students in an outbreak.

Recommendations:

29) Section 88 of the *Public Health Act* (NSW) should be amended to allow a public health officer to direct an unvaccinated child whom the officer reasonably believes has been in contact with a case of a vaccine preventable disease be excluded from child care or school, regardless of whether there is an outbreak at the school or child care the child attends.
30) That this amendment also apply to students of high schools

3.6(c) Childcare enrolment requirements

The *Act* provides that principals of child care facilities must not enrol a child unless they first obtain a vaccination certificate in an approved form indicating that the child is age appropriately vaccinated, on a catch up schedule, has a medical contra indication to vaccination, or has parents who have a conscientious objection to vaccination.

When this amendment was made in 2013 the approved forms were the Australian Childhood Immunisation Register (ACIR) history statement and exemption forms. The provisions in the *Act* allowing a principal to enrol an unvaccinated child in child care whose parents were conscientious objectors, if their parents provided the relevant forms, was at the time in line with Commonwealth requirements relating to certain social security payments, such as the Child Care Benefit.

However, in 2015 the Commonwealth passed the *Social Services Legislation Amendment (No Jab, No Pay) Act* 2015[14] which removes the ability of parents who are conscientious objectors to vaccination to receive the Child Care Benefit, Child Care Rebate and the Family Tax Benefit Part A end of year Supplement. These changes commenced on 1 January 2016. The Commonwealth amendment required NSW to approve a new form in NSW to record details about conscientious objectors, being the "*Interim vaccination objection form for enrolment in NSW child care centres* (valid 1 January 2016 to 31 December 2016)".

Changes to vaccination and child care enrolment were also made in other jurisdictions. Victoria recently passed legislation requiring a child to be vaccinated (or have a medical contraindication to vaccination) before being enrolled in child care[15]. While this legislation contains a number of exemptions, there is no conscientious objector exemption. Queensland has also amended its legislation to allow a child care facility to refuse to enrol a child who is unvaccinated[16].

The *Discussion Paper* accordingly asked whether the *Act* should be amended to remove the current exemption allowing children of vaccination objectors to be enrolled in child care, so as to align with the Commonwealth provisions and recent changes to legislation in Victoria and Queensland or whether the requirements to obtain a conscientious objection exemption for enrolment in child care in NSW should be strengthened.

The majority of submissions received on this issue, in particular those from educational peak bodies, did not support removal of the vaccination objection exemption, citing the potential

[14] See http://www.aph.gov.au/Parliamentary_Business/Bills_LEGislation/Bills_Search_Results/Result?bId=r5540
[15] The *Public Health and Wellbeing Amendment (No Jab, No Play) Act* 2015 (Vic)
[16] *Public Health (Childcare Vaccination) and Other Legislation Amendment Act* 2015 (Qld)

educational and social disadvantage to children of vaccination objectors. The National Centre for Immunisation Research and Surveillance also raised concern over the potential for unregistered child care facilities to be established to cater for unvaccinated children, with an increased risk of transmission of vaccine preventable diseases. A number of submissions raised the concern that other people involved in childcare spread disease, quoting that less than 30% of child care facility staff are fully vaccinated. Other submissions argued that removing the vaccination objection exemption would deny children early education and socialisation; impact on family finances (and thereby the child's wellbeing) where a parent could no longer work in the absence of alternative childcare options; be discriminatory, coercive and trespass on the rights of parents to make decisions around medication; and was unreasonable and disproportionate to the problem.

Whereas most submissions did not support the removal of the exemption, many did support strengthening the requirements to obtain such an exemption.

Some of the submissions that supported removal of the exemption from the *Act* felt that vaccination should be a prerequisite for entry into childcare unless medically contraindicated. Other submissions cited consistency with Victorian, Queensland and Commonwealth provisions.

It should be noted, however, that there is only nominal consistency between these State and Commonwealth provisions. The Commonwealth *No Jab, No Pay* provisions relate to family assistance payments for children from 0 to 19 years of age. In Queensland, a childcare centre may refuse or cancel enrolment if a child's immunisation status is not up to date, and in Victoria, early childhood services must not enrol a child without evidence that the child is fully immunised for their age or on a catch up program or has a medical contraindication to vaccination, subject to a number of exemptions.

The Ministry has considered the submissions on this issue and is of the view that the *Act* should not be amended to remove the conscientious objector exemption to enrolment in a childcare facility. The Commonwealth's removal of the conscientious objection exemption in respect of family assistance payments already acts as a factor limiting access of these children to paid childcare. Prior to the cessation of the Commonwealth collecting conscientious objector status in December 2015, the percentage of children under 7 years of age with a registered conscientious objection had decreased from a peak in NSW of 1.54% to 1.15%. Childhood vaccination at key milestones as recorded on the ACIR continues to improve with 93.3% of non-Aboriginal and 95.7% of Aboriginal children in NSW fully vaccinated by 5 years of age for the year ending June 2016. Coverage at 1 year of age increased by 2% from 2014-15 to 2015-16. Thus the Commonwealth No Jab No Pay measures, in concert with NSW initiatives such as the "Save the Date to Vaccinate"

campaign and the Aboriginal Immunisation Health Worker Program are progressively increasing the percentage of children protected by vaccination.

Further, exclusion of children whose parents have a vaccination objection could disadvantage these children socially and educationally. Given the high vaccination coverage of the vast majority of children, the small risk posed by unvaccinated children in childcare can be managed by other public health control measures as happens elsewhere in the community, rather than totally excluding unvaccinated children from the benefits of early childhood education.

However, the Ministry is of the view that the requirements for a parent to obtain a vaccine objection exemption should be strengthened. This could include, for example, requiring parents to make more than one visit to an immunisation provider in order to have the vaccination objection form certified and/or renew the exemption each year. This would ensure that parents are appropriately counselled and warned of the risks of not vaccinating their child at appropriate times.

Recommendations:

31) The *Public Health Act* should not be amended to remove the conscientious objector exemption to enrolment in a childcare facility.
32) However, other options should be pursued to strengthen the requirements to obtain a conscientious objection exemption for enrolment in child care in NSW.

3.7 Public Health Registers

3.7 (a) Public Health and Disease Registers

Part 6 set out provisions establishing the Pap Test Register and other public health and disease registers.

The provisions relating to other public health and disease registers are found in sections 97 and 98 and were new provisions included in the 2010 *Public Health Act* for the first time. The provisions allow a public health or disease register to be established for certain purposes, being:

> *(a) to facilitate the care, treatment and the follow up of persons who have diseases or have been exposed to diseases,*
> *(b) to facilitate the identification of sources of infection and the control of outbreaks of diseases,*
> *(c) to facilitate the identification and monitoring of risk factors for diseases or conditions that have a substantial adverse impact on the population,*

(d) to facilitate the measurement and monitoring of outcomes of specified population health interventions,
(e) to facilitate the identification and monitoring of exposure to chemicals or other environmental factors that impact, or may impact, adversely on the health of individuals.

Under the *Act*, the Secretary can enter into arrangements with other organisations or persons regarding the inclusion of information on a register and a public health organisaton must, if directed to do so, provide information to the Secretary for the purpose of a register. Identifying information can only be included with consent. However, personal information can be provided to a health records and linkage organisation for the purpose of establishing and providing a unique identifier number to be used for the register. Consent is not required to provide personal information to a health records and linkage organisation. A health records and linkage organisation is a body approved by the Secretary. Currently, the Centre for Health Record Linkage (CHeReL) has been approved.

The *Discussion Paper* noted that the main purpose of these provisions is to enable personal information from different data sources to be provided to the CHeReL to create a unique person number that can be used to link records for the same person across the different data sources in a de-identified format. The use of CHeReL ensures that data from different sources can be linked and then used in a de-identified manner and is an important mechanism to preserve privacy.

Before the commencement of the *Public Health Act*, to use CHeReL generally required an ethics approval process to comply with the requirements of the *Health Records and Information Privacy Act.* Requiring ethics approval to undertake routine public health work was considered unnecessary, resource intensive and unduly burdensome.

Accordingly, s97 and s98 were included in the *Public Health Act*. However, these provisions are intended to operate in addition to existing provisions in the *Act* and not attach any additional limitations on the creation of registers that are otherwise already created, or may be created, under the *Act*. For example, where the Secretary obtains notifications of scheduled medical conditions or notifiable diseases, such as cancer for example, the information is often collated into a database or register to be used for a range of public health purposes, such as surveillance, monitoring or follow up where there is a public health risk. These databases or registers, by their very nature, contain personal information and are not intended to be subject to the provisions of s97 and s98.

The scheduled medical conditions or notifiable conditions registers rely on information collected under the *Public Health Act*. The section 97 and 98 registers, on the other hand,

are designed and intended to link health information across a range of sources for the specific purposes in s97.

The *Discussion Paper* noted that there was some concern that the new register provisions in s97 and s98 may be seen as placing limits on the scheduled medical conditions or notifiable conditions registers by limiting the ability to include identifying information on such registers. Accordingly, the *Paper* sought submissions on whether s97 and s98 should be amended to clarify that other registers relating to scheduled medical conditions and notifiable diseases can be created under the *Act* and that such registers are not subject to the requirements of s97 and s98.

A small number of submissions were received on this issue. Concerns were raised that the provisions in s97 and 98 may be seen as confusing and limited and that amendments should clarify the purpose and intent of these provisions.

Sections 97 and 98 are important provisions that enable public health information to be used for a range of important public health purposes while ensuring that the use of the information occurs in a privacy preserving way. The limitation on including identified information on a public health register except with consent, but allowing identified information to be disclosed to CHeReL to obtain a unique identifier to be used in the register, ensures that registers contain only de-identified information, unless people have consented otherwise, but still allows information to be linked and used for public health purposes. It is considered that the intent and purposes of s97 and s98 are appropriate. However, these provisions are not intended to limit the other uses that may be made of information obtained under the *Public Health Act*. As noted above, when the Secretary receives notifications about a scheduled medical condition, such as cancer, a database or register or the notifications may be created. As these notifications are identified, the database or register created will necessarily include identified information. Sections 97 and 98 are not intended to prevent this from occurring. Accordingly, the Ministry recommends that the *Act* be amended to clarify that the register provisions in s97 and s98 do not limit the creation of other registers or databases relating to scheduled medical conditions or notifiable diseases.

Recommendations:

33) The *Public Health Act* should be amended to clarify that sections 97 and 98 do not limit the creation of other registers or databases relating to scheduled medical conditions or notifiable diseases.

3.7(b) The Pap Test Register

Division 2 and 3 of Part 6 of the *Act* relate to the Pap Test Register. These provisions require the Secretary to establish, or arrange for the management of, the Pap Test Register for the purpose of reducing the incidence of, and mortality from, preventable cervical cancer. The Pap Test Register is currently managed by the Cancer Institute on behalf of the Secretary. The *Act* requires medical practitioners and laboratories to provide information about pap test results to the Register. The Register then uses the information to remind women to undergo a pap test (unless the woman has opted out of notification) and to monitor rates of cervical cancer to assist in planning and management of testing programs for research into the prevention and treatment of cervical cancer. Other jurisdictions operate similar pap test registers.

In 2015, the Commonwealth announced that there would be a change to the cervical cancer screening program. A new test would be used (HPV-DNA) and testing will move to a 5-year interval (from the current 2-year interval) for many women. The "pap test" as a screening test for cervical cancer will become redundant – instead the HPV test (and ancillary cytology tests) would be used as the screening test for cervical cancer. The implementation of this new program is scheduled for May 2017.

In May 2016 the Commonwealth Government introduced a Bill to establish a national cancer screening register.[17] While the legislation lapsed prior to the federal election, it is expected that the Commonwealth will reintroduce the Bill. The Commonwealth Bill required medical practitioners to notify test results to the national register and provided for a notification service for patients in a similar manner to the Pap Test Register.

There are benefits to a national cancer screening register. It will ensure nationally consistent collection of data sets and better ensure a notification service for women who move between jurisdictions. Instead of each jurisdiction redeveloping their current registers, one national register will capture the data required to support the program. The national register will also focus on bowel screening, in addition to cervical cancer screening, which will enable better data to assess bowel cancer screening programs.

Assuming the Commonwealth reintroduces its Bill and it passes, the retention of the NSW Pap Test Register would create duplicatory processes in that medical practitioners and laboratories would be required to report both to the NSW Pap Test Register and the national register. In addition, notifications to women reminding them of the need to test for cervical cancer would occur at both the State and Commonwealth level, which may lead to confusion and would be an unnecessary duplication of resources.

[17] http://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r5662

Accordingly, in principle the Ministry considers that should the national register be established, the provision in the *Public Health Act* relating to the Pap Test Register should be removed from the *Act*. It is noted that this issue was not raised in the *Discussion Paper* as the Commonwealth Bill had not been introduced when the *Paper* was being prepared. However, if the national register is established, it would not generally be considered appropriate to maintain a State based Pap Test Register. That said, before any action is taken to remove the provisions in the *Act* relating to the Pap Test Register, the Commonwealth reintroduced legislation will have to be reviewed to ensure that it meets the needs of the people of NSW.

Recommendations:

34) In principle, if the Commonwealth establishes a national cancer screening register, the provisions in the *Act* relating to the Pap Test Register should be removed from the *Act*.

3.8 Public Health Inquiries

Under s106 the Secretary may inquire into any matter relating to public health and can authorise a person to exercise functions and powers, such as inspecting records or entering premises, for the purpose of an inquiry.

Section 106 is a broad power that allows the Secretary to review and inquire into public health matters. It is often used in circumstances where a risk of serious infectious diseases has been identified, in order to determine the level of risk and what actions are necessary to mitigate the risk of transmission of the disease. For example, a public health inquiry may be initiated to respond to concerns about inadequate infection control practices at a hospital or health facility. The inquiry may identify poor infection control practices that create an increased risk of the transmission of blood borne viruses, such as HIV or hepatitis C. As part of the inquiry, it may be recommended that patients of the facility are notified of the risk of infection.

The *Discussion Paper* noted that there is no specific power for the Secretary to direct a person to take action to mitigate risks to public health, even if that person's actions have led to the risk to public health. Rather, the Secretary, through NSW Health, must undertake the actions if the facility refuses to do so. The *Discussion Paper* asked whether s106 should be amended to give the Secretary a power, following a public health inquiry, to direct a person or organisation to mitigate the risk to the public and if so, in what circumstances such a power should be exercised.

Of the submissions that considered this issue, there was general agreement that the *Act* should be amended but many different views as to the limits and circumstances that such

powers should be exercised. Some argued that such powers should only apply where the person or organisation has caused the risks to the public whereas others did not consider this relevant. There was the view that powers should apply both to a person and/or the organisation or business which has caused the risk and the person and/or the organisation or business which had responsibility for the care of person(s) exposed to the risk. Others preferred an educational rather than a directive approach and indicated that powers should only be used in extreme situations.

Suggested limitations of scope included only for serious infectious diseases or where there is significant ongoing risk of disease transmission. One Local Health District suggested powers should only be used in situations where a large number of people need to be informed of a small risk and directed to appropriate services whereas another suggested only if an actual risk has been demonstrated by an inquiry and more than one member of the public is affected as a result of the same incident. One submission suggested limiting powers to a list of prescribed actions that the Secretary is empowered to direct.

Concerns were raised about the quality of the response once directed. A number of submissions held the view that a review mechanism or independent appeal process would be required if the *Act* was amended.

Inquiries under the *Public Health Act* are relatively rare – in recent years only a handful of public health inquiries would be established each year. Where an inquiry finds that there has been a significant risk to public health remedial measures to protect health will often be taken. Who is best placed to undertake the remedial measures will ultimately depend on the circumstances. In some cases, it will be the person or body responsible for the risk and there are strong grounds to consider that the Secretary should be able to direct that person or body to undertake action.

However, after considering the submissions the Ministry also agrees that it is appropriate that rather than a broad power to direct action to be taken, the power should be narrowly confined to the issue of notification to persons at risk. Where a public health risk is identified in an inquiry, the main area of concern is often ensuring people exposed to the risk, or potentially exposed, are notified of the risk and any preventative action, including testing for diseases, they can take to mitigate the risk. In some cases, it would be appropriate for the Secretary to undertake such notification (particularly if a public notice was required). However, it may be more appropriate, in other cases, for the person concerned to notify people at risk.

For example, if a public health inquiry identifies poor infection control practices at a health facility, notification of patients of the risk and the need to undertake appropriate testing may be best done by the health practitioner concerned as the practitioner is likely to have

the records of the patients and a relationship with the patients. In these circumstances, it is considered appropriate for the Secretary to have a power to direct the person to notify persons at risk and of measures that should be taken to mitigate their risk.

Subsequent to the release of the *Discussion Paper*, another issue in relation to public health inquiries has come to the Ministry's attention. As part of a public health inquiry, an authorised officer is often given the power to enter and inspect premises. However, should the occupier of the premises be non-contactable or un-cooperative, on a practical level the authorised officer cannot enter the premises. While there are provisions in the *Act* allowing a search warrant to be obtained, these provisions only allow a search warrant to be applied for where the authorised officer suspects that a provision of the *Act* has been contravened[18]. Where a public health inquiry has been undertaken, there may not necessarily be an offence committed under the *Act* (even if the inquiry is investigating a risk to public health). However, to properly inquire into the risk, premises, and records on the premises, may need to be inspected and force, via the use of a search warrant, may need to be used. Accordingly, the Ministry considers that the *Act* should be amended to allow a search warrant to be issued where an authorised officer needs to inspect premises as part of a public health inquiry.

Recommendation

35) Section s106 of the *Act* should be amended to give the Secretary a power, following a public health inquiry, to direct a person or organisation or business to notify persons at risk of harm of the risk and measures to mitigate the risk, including testing for diseases.
36) The *Act* should be amended to allow a search warrant to be issued where an authorised officer needs to inspect premises as part of a public health inquiry.

3.9 Nursing homes

Section 104 of the *Public Health Act* requires an operator of a nursing home to ensure that there is a registered nurse on duty at all times and that a registered nurse is appointed as a director or nursing (with any vacancy in the position filled within 7 days).

The NSW Legislative Council's General Purpose Standing Committee undertook an inquiry into registered nurses in New South Wales nursing homes. The Standing Committee released its Report on the inquiry in October 2015, recommending some changes to s104[19]. The *Discussion Paper* noted that s104 would be considered further as part of the Government response to the Legislative Council's Report.

[18] Section 109 *Public Health Act*

[19] https://www.parliament.nsw.gov.au/committees/inquiries/Pages/inquiry-details.aspx?pk=2275

Although s104 was not an issue for consideration in the *Public Health Act* review *Discussion Paper*, it generated the highest number of single issue submissions. These submissions were predominantly from individuals who argued that a registered nurse should be on duty at all times to assess the condition of patients, administer pain relief where required and prevent unnecessary transfers to hospital.

The NSW Government response to the Standing Committee report supported the availability of registered nurses where appropriate for the level of care required by residents. However, it also noted that nursing homes are a Commonwealth responsibility and retention and extension of NSW legislation would duplicate regulatory processes and therefore noted that the issue of appropriate staffing would be pursued through the COAG Health Council[20].

In accordance with the response provided to the Legislative Council, issues relating to staffing in nursing homes will be pursued through the COAG Health Council and therefore no changes are recommended to s104.

Recommendation

37) In accordance with the Government response provided to the Legislative Council General Purpose Standing Committee, issues relating to staffing in nursing homes will be pursued through the COAG Health Council.

3.10 Disposal of Bodies

The *Public Health Act* allows regulations to be made in respect of a number of matters, including relating to the disposal of bodies, being:

- the cases in which, the manner in which, and the conditions under which, cremations of human remains may take place,
- matters preliminary to, and consequential on, cremations of human remains,
- other public health matters relating to the disposal and handling of human remains,
- the registration of cremations and burials and (with any necessary modifications) the application to the registration of cremations of the provisions of any other *Act*, or of any law, in force in relation to the registration of a burial of the body of a deceased person,

20 https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/GovernmentResponse/5821/Government%20Response%20-%20Registered%20nurses%20in%20NSW%20nursing%20homes%20-%20received%2029%20April.pdf

- the embalming, interment, disposal and exhumation of the bodies of deceased persons,
- the preparation rooms, equipment and apparatus in mortuaries, crematories and cemeteries, and any other matter relating to mortuaries, crematories and cemeteries that is for the protection of the health of the public,
- the inspection of mortuaries, crematories and cemeteries and of premises that may reasonably be suspected of being mortuaries, crematories or cemeteries,
- the records to be kept in relation to mortuaries, crematories and cemeteries, and the inspection of records (including the making of copies or extracts from such records by or for authorised officers and the public), equipment and apparatus in mortuaries, crematories and cemeteries or premises that may reasonably be suspected of being mortuaries, crematories or cemeteries, and
- the fees that may be charged for the cremation of human remains, for the preservation or disposal of the ashes and for related services.

There is generally negligible risk to public health from a deceased body. Where a risk does exist, it is in the circumstances of a person being exposed to the contaminated blood, fluids or tissues of the body, should the deceased have been infected with certain infectious diseases while alive. Such exposures are generally confined to people in occupations who work directly with bodies, either in pathology services, medical research or in the funeral industry. However, should a worker be infected, there may be a risk of transmission from that worker to others in contact with the worker. The public health risks relating to infection can be mitigated by appropriate infection control requirements, as is contained in the *Public Health Regulation*. However, these matters can also be properly considered to be Work, Health and Safety issues and inclusion of such matters may lead to confusion and inconsistency in relation to requirements under the *Work, Health and Safety Act* 2011.

The *Discussion Paper* also noted that the regulation making power goes further than public health matters affecting workers and extends to other matters, such as the conditions under which cremations may take place, embalming, interment and exhumation of the bodies, preparation rooms, equipment and apparatus in mortuaries, crematories and cemeteries, and records keeping in relation to these matters. Following the passage of the *Cemeteries and Crematoria Act* 2013, cemeteries and crematoria are now subject to the regulatory oversight of Cemeteries and Crematoria NSW. Accordingly, the *Discussion Paper* asked whether there is still a need for the *Public Health Act* to contain a regulation making power in respect of the non-public health matters relating to the disposal of bodies.

Many submissions considered it inappropriate for the *Public Health Act* 2010 to continue to regulate the WHS aspects of the disposal of bodies and the regulation of crematoriums, internment and exhumation, preparation rooms, equipment and apparatus in mortuaries, crematoriums and cemeteries (where these are unconnected to public health). Given the

low public health impacts from a deceased body, provisions in the *Work Health and Safety Act* 2011 and the *Cemeteries and Crematoria Act* 2013, and the largely administrative activities of the funeral industry, several submissions feel that the relevant work health and safety organisations should monitor and manage funeral industry standards, as per other industries, and exclude aspects already covered in other legislation.

However, concern was also raised that the *Work, Health and Safety Act* is a broad document without inclusions of industry specific risks and therefore it may not be appropriate to remove the regulation making power from the *Public Health Act* unless and until specific requirements are included elsewhere. Cemeteries and Crematoria NSW supported the general retention of the regulation making power *at this time*, as most are not explicitly covered in the *Cemeteries and Crematoria Act*.

Some other submissions supported the retention of the current provisions in the *Act* and NSW Health's to regulatory oversight of the handling of human remains, burial and cremation. They considered that NSW Health is traditionally viewed as the appropriate body to regulate these activities, and their oversight will support stronger and more transparent public administration.

After considering the submissions, the Ministry is not recommending any changes to the regulation of the disposal of bodies at this time. While not all matters in the regulation making power for the disposal of bodies relate to public health matters, there is no comprehensive regulatory alternative for all aspects of the disposal of bodies that are currently covered by the *Act*. In these circumstances, it is considered reasonable and practical for NSW Health to continue to regulate disposal of bodies to ensure that appropriate and sufficient regulatory control is maintained. However, if other regulatory regimes, such as SafeWork NSW or Cemeteries and Crematoria NSW, introduce additional regulation in this area, in order to avoid regulatory duplication it may not be necessary to continue to make regulations in respect of all of the current regulation making power.

Recommendation:

38) While the Ministry considers that the *Public Health Act* is not the most appropriate *Act* for regulating all aspects of the disposal of bodies, no changes to the *Act* are proposed relating to the regulation making power at this time. However, the Ministry will keep the matter under advisement to ensure that there is regulatory efficiency and regulatory duplication is avoided.

4. Summary

The *Public Health Act* is an important *Act* that has the objectives of protecting public health, by promoting, and improving public health and controlling the risks to public health, particularly in relation to the spread of infectious diseases. It is important that the provisions of the *Act* support these objectives in order to protect the health of individuals and the community as a whole.

The review of the *Act* has found that generally the objectives of the *Act* remain valid and appropriate and that the provisions of the *Act* support the objects. However, a number of changes could be made to the *Act* to better reflect the objectives of the Act and to ensure that the *Act* continues to operate in a way to best protect public health.