



Health

Public Health Act 2010 Statutory Review Discussion Paper

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1. Introduction

1.1 Overview of the Public Health Act 2010

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 The Act followed on from an extensive review of the now repealed Public Health Act 1991.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
- 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.

1.2 Review of the Public Health Act

In accordance with s136 of the Public Health Act, a review of the Act must be held 5 years after assent of the Act to determine whether the policy objectives of the Act remain valid and whether the terms of the Act remain appropriate for securing those objectives. A report on the review is to be tabled in Parliament within 12 months from the commencement of the review.

On 1 October 2015, a letter was sent to key stakeholders seeking preliminary submissions on relevant matters relating to the Public Health Act to be considered as part of the NSW statutory review. The preliminary submissions received were considered in developing this Discussion Paper.

It is noted that a number of the submissions raised issues relating to the provisions of the Public Health Regulation 2012 rather than the Act. Issues relating to Public Health Regulation will be considered during the review of the Regulation as part of the staged repeal program.

1.3 Submissions

Comment is invited on issues raised in this Discussion Paper or on any other aspect of the Public Health Act. There is no special form for submissions. Submissions should be in writing and directed to:

Health Protection NSW
NSW Ministry of Health
Locked Bag No. 961
North Sydney NSW 2059
Email: publichealth@doh.health.nsw.gov.au

This Paper can be found at <http://www.health.nsw.gov.au/legislation/Pages/acts-under-review.aspx>. The closing date for comment is **3 June 2016**.

Individuals and organisations should be aware that generally submissions made on the Review may be made publically available under the Government Information (Public Access) Act 2009. The Ministry of Health, in formulating its Report on the Review, may also circulate submissions for further comment to other interested parties or to publish parts of submissions. If you wish your submission (or any part of it) to remain confidential (subject to the Government Information (Public Access) Act), this should be stated clearly and marked.

2. Objects of Public Health Act

Public health is a broad concept that aims to ensure the best possible health outcomes for individuals and the public as a whole. The Public Health Act is just one of a number of Acts that deal with matters relating to the health of the public. For example, the Fluoridation of Public Water Supplies Act 1957 relates to fluoridating public water supplies, the Public Health (Tobacco) Act 2008 and the Smoke-free Environment Act 2000 regulate the sale and supply of tobacco products and the areas in which smoking is prohibited, the Protection of the Environment Operations Act 1997 and the Protection of the Environment Administration Act 1991 regulate environmental issues that can pose a risk to public health and the Food Act 2003 aims to ensure the safety of the food we eat.

The Public Health Act is aimed at protecting public health primarily through the monitoring and control of diseases and conditions that can adversely affect public health. To that end, s3 of the Public Health Act sets out the objects of the Act 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.

Further, section 3 provides that 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 objectives are considered to remain valid. This is because they recognise the overall objective of protecting, promoting and improving public health and controlling risks to public health, particularly in relation to infectious diseases. Further, the objectives also recognise that local governments play an important role in protecting public health. This objective was included in the 2010 Act and followed on from the review of the 1991 Act. The Ministry considers that it remains important to continue to recognise the role of local government which plays an important role in regulating environment health premises.

While overall, the Ministry's preliminary view is that the objects of the Act are still valid, it is noted that the objectives do not include any reference to monitoring of diseases and conditions. 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 Ministry seeks submissions on whether this role should be included in the objectives.

Issues for consideration?

- 1) Are the objectives of the Public Health Act valid and appropriate?
- 2) Should s3 include a new objective relating to monitoring by NSW Health of diseases and conditions affecting the people of NSW?

3. Areas for 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 officers of NSW Health and local government. In particular, local government officers have a 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 the role local government plays, when the 2010 Public Health Act was drafted, a number of specific provisions were included to recognise this role. To that end:

- 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,
- a number of provisions were included in the Act to 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 offenses, 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, it 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.

There are considered to still be strong arguments for continuing to allow local governments such discretion in relation to their compliance activities. This is because there are gradients of risk associated with different environmental health premises and a mandated generic inspection regime is unlikely to be conducive to protecting public health. Requiring local governments to have annual inspections of all premises would not allow local governments a discretion to undertake a risk based approach to compliance. A risk based approach to compliance would allow local governments to direct resources to area of highest risk, which is considered appropriate.

Accordingly, the Ministry does not at this time consider any changes are required in the legislation in relation to the role and recognition of local governments. However, the Ministry would hear submissions on this issue.

Issues for consideration?

- 3) Do sections 3 and 4 adequately recognise the role of local government in the Public Health Act?

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. However, the Ministry will consider any issues raised in relation to Part 2.

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 apply to suppliers of drinking water. In general the provisions are aimed at responding to serious risks associated with the public drinking water supply. As such, there are provisions allowing the Minister to take action with respect to unsafe drinking and giving the Chief Health Officer a power to issue boil water alerts. In general, these provisions are reactive and allow for a public health response to issues that arise with the supply of drinking water.

However, s25 does allow for a proactive approach. Section 25 requires a supplier of drinking water to establish and adhere to a quality assurance program (QAP) that complies with the requirements in the Regulation. The 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.

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)¹. 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.

A supplier of drinking water under the Act means²:

- (a) *Sydney Water Corporation,*
- (b) *Hunter Water Corporation,*
- (c) *a water supply authority within the meaning of the Water Management Act 2000,*

¹ 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

² Section 5 Public Health Act 2010

- (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,*
- (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.*

This is a broad definition that captures large utility suppliers who are subject to extensive regulation, such as Sydney Water and Hunter Water, as well small scale operators who provide drinking water as an ancillary part of a commercial undertaking, for example a bed and breakfast where drinking water to customers is supplied through tank water (rather than water that is supplied from another drinking water supplier). As some suppliers of drinking water are subject to other extensive regulation, s25 allows the Chief Health Officer to exempt a class of suppliers from the requirements in s25. Sydney Water and Hunter Water have been exempted. Further, as this was a new requirement in the 2010 Act, s25 was given a delayed commencement, commencing on 1 September 2014 so as to allow suppliers time to comply.

To date, compliance with s25 is very dependent on the type of supplier of drinking water. While all public water utilities (the some 95 regional local council water suppliers and county council water supply authorities) have developed QAPs, as required by s25, compliance by “private water suppliers” and “water carters” has been low.

“Private water suppliers” are not defined in the current Act, however they fall within (h) of the definition above. Private water suppliers provide drinking water in the course of a commercial undertaking from an independent supply (rather than from another water supplier), such as rainwater, private bore or dam. Examples may include caravan parks, guest houses, conference centres, but not water utilities (i.e. town water) or individual household supplies. Water carters would fall within the “j” of definition above and are persons who supply water from a water carting vehicle. Up to November 2015, Public Health Units had identified 2282 private water suppliers and water carters, of which only 396 had submitted a QAP (a 17% response rate). Of the QAPs submitted, several require further work to address the requirements of the Regulation. Public Health Units are continuing to follow up with known suppliers that have not provided a QAP.

Section 25 is an important proactive provision that seeks to ensure the safe supply of drinking water that is particularly important to suppliers who are not subject to other regulatory oversight in relation to their supply of water. However, there are limited provisions to enforce compliance. 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 QAP³, 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.

The Ministry is therefore considering whether there should be mechanisms to establish an appropriate compliance regime in relation to s25. An appropriate compliance regime in relation to s25 could allow more proactive action to protect drinking water quality (e.g. implementation of an appropriate QAP) without waiting until an outbreak, contamination incident, or other risk to health is identified.

Action to protect and improve water supplies can lead to a reduced incidence rate of gastroenteritis, in turn reducing expenditure on healthcare, productivity loss with both work and household activities, and the reduced cost of mortality. The prevention of disease saves costs to the community and government. The NSW Government Trade and Investment *Cost-Benefit Analysis of Unfunded Backlog Projects for the Country Towns Water Supply and Sewerage Program* estimated the total cost avoided due to reduced cases of gastroenteritis was \$956.68 per case in 2013-14 prices.

A compliance regime for s25 could take different approaches. For example, a penalty provision could be included in the Act for breaches of s25. In addition, provisions could be included in the Act to allow improvement notices to be issued where a supplier has not complied with s25. The Act could also potentially include a power to issue prohibition orders preventing the supply of drinking water where there is a serious risk to public health. However, there are already provisions in the Act that allow the Minister and Chief Health Officer to take action where water is unsafe and therefore prohibitions orders may not be necessary in relation to drinking water. The Ministry would like to hear submissions on this issue.

Issues for consideration?

- 4) Should a compliance regime be established in the Act in relation to s25 (which requires suppliers of drinking water to establish and adhere to a quality assurance program)?
- 5) If so, should this compliance regime involve a penalty for non-compliance and/or the ability to issue improvement notices for non-compliance?

³ Clause 34, Public Health Regulation 2012

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

As noted earlier in the Discussion Paper, the Public Health Act gives local governments a role in relation to environment health premises, which are premises containing regulated premises, public swimming pools and spa pools, and premises carrying out skin penetration procedures. Currently, the regulation of drinking water under the Act often falls to NSW Health authorised officers.

However, in relation to private water suppliers and water carters, local government officers may inspect the premises of private water suppliers and water carting vehicles for other reasons, such as to undertake compliance activities under the Food Act 2003 or the Local Government Act 1993. Councils can provide inspections on a fee-for-service basis under the Local Government Act. NSW Health understands that many local councils visit premises with a private water supply in order to regulate food businesses and/or on-site sewage management facilities (e.g. septic tanks). Where local government officers are already undertaking activities on these premises, 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. This could avoid a duplication of effort by different levels of government in relation to the same premises. NSW Health will continue to support local government, including through training and expert advice. In recognition of this, the Ministry is seeking submissions on whether the Public Health Act should recognise a role of local government in relation to the regulation of private water suppliers and water carters.

Issues for consideration?

- 6) Should the Act be amended to recognise a role of local government authorities in relation to the regulation of private water suppliers and 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*.

- 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 health⁴. 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.

Issues in relation to these provisions are set out further below.

3.4(a) Premises undertaking skin penetration procedures

As noted above, the Public Health Act regulates premises carrying out skin penetration procedures due to the potential risk of the spread of blood borne viruses at such premises if proper infection control procedures are not carried out. Due to the serious nature of potential risks arising, these provisions are considered necessary to mitigate those risks to protect and promote public health.

Some of the preliminary submissions received suggested that the provisions relating to skin penetration procedures should be further extended to other premises that provide personal appearance or beauty services. Many of these premises (such as nail salons) undertake skin penetration procedures, and those activities are captured by the current provisions of the Act. However, unless such premises engage in skin penetration which carries a risk of blood borne virus transmission, they carry little public health risk that requires regulation from the Public Health Act. Accordingly, it is not considered necessary or appropriate to regulate all personal appearance or beauty services under the Public Health Act.

However, that said, the existing definition of skin penetration procedures may not be broad enough to capture all procedures that pose a risk relating to the spread of blood borne viruses.

⁴ 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.

Skin penetration procedures is defined in s5 to mean 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.

Relevantly the definition requires there to be a penetration of the skin. Where there is a 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 which can be mitigated by appropriate infection control practices. To that end, the Ministry recently amended the definition of skin penetration to include eyeball tattooing, tongue tattooing and tongue piercing, and preliminarily considers that the definition of skin penetration should be amended to include all procedures that penetrate a mucous membrane.

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. 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) however concerns have been raised as to whether people who are not relevant registered health practitioners should be permitted to perform high risk procedures such as eyeball tattooing, given the significant health risks that may be associated with the procedure.

Issues for consideration?

- 7) Should the definition of skin penetration include all procedures that penetrate a mucous membrane?
- 8) Should there be additional regulation to limit people who can perform high risk procedures such as eyeball tattooing to relevant registered health practitioners?

3.4(b) Legionella control

While a number of preliminary submissions raised issues in relation to the regulation of premises containing a regulated system, these primarily related to the operation of the Regulation. The Regulations will be reviewed as part of the staged repeal process and so are not being considered at this time.

However, one issue relates to whom the obligations under the Act apply.

Currently, the requirements to comply with the required standards in relation to regulated systems 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 a 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. However, this definition creates difficulties with respect to regulated systems in multi tenanted buildings. In large multi tenanted buildings, such as an office block, while there will generally be a range of different tenants who are responsible for the relevant areas of the building that are leased (such as one floor of the building), 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. Shared services are likely to include air-handling systems and water cooling systems and other regulated systems. In such a case, the Ministry considers that a more appropriate person to be responsible for the maintenance of the regulated system would be the owner or the management company responsible for the building.

To that end, the Ministry seeks 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.

Issues for consideration?

- 9) Should the Act be amended to ensure that 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?

3.4(c) Public swimming pools and spa pools

Issues have been raised in relation to the definition of public swimming pools and spa pools. Currently, the definition in s34 provides that:

public swimming pool or spa pool 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 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.

Concerns have been raised that the definition does not expressly cover pools situated in residential premises where those premises are also used for a 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 a bed and breakfast and residential premises.

The Ministry considers that the current definition would apply to such premises as they would not be private residential premises during the times they are being used for a commercial operation (and noting of course that an authorised officer's power of entry and inspection under s108 do not extend to any part of a premises that is used solely for residential purposes, such as the residential houses or units, except with consent or a warrant). However, due to the confusion that can arise, the Ministry seeks submissions on whether s34 should be clarified so that it is clear that the definition applies to a pool on a 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.

Issues for consideration?

- 10) Should the Act be amended to clarify that the definition of public swimming pool applies to a pool in a 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?

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
- 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.

A range of issues arise in respect of these provisions.

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

As noted above, the Public Health Act sets out the diseases and conditions that medical practitioners, pathology laboratories, hospitals, child care centre directors or primary school principals are required to notify to the Secretary. The Registrar of Births, Deaths and Marriages is also required to notify the Secretary of deaths where the apparent cause of

death is a scheduled medical condition. In addition, health practitioners and hospitals are required to report certain deaths involving the use of anaesthesia or sedation.

The diseases and conditions listed include a diverse range of different diseases and conditions, from birth to sudden infant death syndrome, to lead poisoning, and to a range of different infectious diseases, such as influenza, chlamydia and HIV. All notifications, except in respect of HIV and AIDS, include the full name and other identifying details of the affected person.

Notification of these conditions and diseases serve a range of different purposes that depends, 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;
- 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.

As seen above, notification serves a diverse range of purposes. 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 notifications. In addition, in some cases it may be more appropriate for other persons or bodies to manage the notifications, or some of the functions relating to notifications.

For example, Creutzfeld-Jacob disease (CJD) is a rare, fatal condition, with an incidence of around 1 per million people per annum. It is a scheduled medical condition and a notifiable disease under the Act. Most cases of CJD are sporadic or have a familial link, but rarely cases are associated with exposure to infected materials. In the past grafts of brain linings from deceased donors transmitted the infection to recipients. An outbreak of variant CJD was recognised in the United Kingdom in the 1990s associated with consuming contaminated beef. Incidents of CJD have both a state and national interest. As such, the Commonwealth has a National CJD Register. As there is a national register, it will often be more appropriate for experts at the national register to undertake the investigation of the case, including confirming the diagnosis through expert review of case details, determining whether the person underwent any neurosurgical procedures or other risk exposures, and determining any epidemiological links to other Australian cases.

The Public Health Act does not have not any express provisions relating to another person or body managing notifications received by the Secretary under the Act. However, as there will be cases where another person or body is the most appropriate entity to manage the notification of a particular diseases (such as the example above of CJD), or manage part of the functions relating to notifications, the Ministry's preliminary view is that there should be an express provision in the Act allowing the Secretary to arrange for another person or body to undertake public health actions in respect of the notification of a particular disease or condition.

Issues for consideration?

- 11) Should the Act be amended to give the Secretary an express power to arrange for another person or body to undertake specified public health actions in respect of notifications of a particular scheduled medical condition or notifiable disease?

3.5(b) Requirement to notify and obtaining further information

The requirements to notify diseases and conditions, or provide further information about a disease or condition that is required to be notified to the Secretary, are set out in various sections of the Act. There are a number of issues with some of these provisions which are set out below.

Notifications by pathology laboratories

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.

One Category 3 condition is lead poisoning. While a test result indicating lead poisoning may have originated from a request from a medical practitioner, other reasons for testing also arise. For example, testing may be carried out on employees as a result of requirements on employers under the Work, Health and Safety Regulation 2011 to conduct “health monitoring” of certain employees in high risk occupations.

The purpose of obtaining notifications of Category 3 conditions is to ensure the Secretary is aware of levels of diseases and conditions in the community so as to undertake appropriate public health surveillance and actions. As such, whether a positive test result arises from a request from a medical practitioner or otherwise is immaterial from a public health perspective. 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.

On the other hand, it can be argued that worker health is the remit of SafeWork NSW, and inclusion of these other laboratories is outside the remit of NSW Health and would lead to duplication of process.

The Ministry would like to hear submissions on 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.

Obtaining further information about scheduled medical conditions and notifiable conditions

Under s54, a medical practitioner must notify the Secretary if a patient has a scheduled medical condition. In addition, the Secretary has the power to require the practitioner to provide any additional information relating to the patient’s medical condition and transmission and risk factors. It is an offence to not comply with the section.

Under s53, the Registrar of Births Deaths and Marriages must notify the Secretary of deaths from scheduled medical conditions. Under s55, where a pathology laboratory notifies the Secretary of a scheduled medical condition, if the Secretary considers the report to be incomplete or incorrect, the Secretary may ask the medical practitioner involved in the

treatment of the person to provide information to complete the report or provide information concerning the person's medical condition and transmission and risk factors as is available to the medical practitioner. While the Act allows the practitioner to provide the information, it is not an offence for the practitioner to not comply.

There are inconsistencies in s53, s54 and s55 relating to the ability of the Secretary to obtain further information, in that it is an offence for a medical practitioner to not provide the further information in s54, but not under s55 or s53. In addition, and more problematically 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.

This means, for example, if the first notification of a scheduled medical condition, such as tuberculosis or cancer, occurred following a post-mortem (such as in circumstances where the person died in a car accident before being diagnosed), the person's treating practitioner may have relevant information about risk factors of the disease. However, unless the person's treating practitioner performed the post-mortem, which is highly unlikely, the treating practitioner is not required to provide information to the Secretary about the condition.

Also if a laboratory notifies that a person has legionellosis, that the treating doctor is permitted, but not required, to provide further information about the person's risk factors, clinical symptoms, and known exposure sources to the public health unit. Such information may be crucial to public health investigation and control.

In order to ensure that the Secretary can obtain relevant information about transmission and risk factors of diseases and conditions, the Ministry is seeking submissions on 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 and transmission and risk factors in all sections of the Act that require notifications of diseases or conditions to the Secretary.

Issues for consideration?

- 12) Should the requirement on pathology laboratories to notify results be extended to chemical testing facilities or other facilities carrying out biological testing?
- 13) Should s55 be amended to require laboratories to notify the Secretary 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?
- 14) Should 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 be extended 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

As noted earlier in the Paper, all scheduled medical conditions and notifiable diseases are notified to the Secretary in a format that gives the name and address of the person with the condition or disease. However, there is an exception. Section 56 provides that any notification for a category 5 condition is to be in a de-identified format. Category 5 conditions are HIV and AIDS.

Section 56 (**Protection of patient's identity**) provides

- 1) *A registered medical practitioner must not include a patient's name or address:*
 - (a) *in a certificate under section 54, if the condition to which the certificate relates is a Category 5 condition, or*
 - (b) *in a written or oral communication made by the medical practitioner for the purpose of arranging a test to determine whether the patient has a Category 5 condition.*
- (2) *Subsection (1) (b) does not apply if the patient concerned:*
 - (a) *is receiving hospital services or other health services, within the meaning of the Health Services Act 1997, provided by a hospital, or*
 - (b) *consents to the disclosure of his or her name and address in the relevant communication.*
- (3) *A person who, in the course of providing a service, including the conduct of a pathology test under section 55, acquires information that another person (the person concerned):*
 - (a) *has been, is to be or is required to be tested for a Category 5 condition, or*
 - (b) *is, or has had, a Category 5 condition,*

must take all reasonable steps to prevent that information from being disclosed to any other person.
- (4) *Subsection (3) does not apply to the disclosure of such information:*
 - (a) *with the consent of the person concerned, or*
 - (b) *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, or*
 - (c) *to the Secretary, if a person has reasonable grounds to suspect that failure to disclose the information would be likely to be a risk to public health, or*
 - (d) *in connection with the administration of this Act or the regulations, or*

(e) for the purposes of any legal proceedings arising out of this Act or the regulations, or of any report of any such proceedings, or
(f) in accordance with a requirement imposed under the Ombudsman Act 1974, or
(g) in the circumstances prescribed by the regulations.

(5) A registered medical practitioner or other person must not, without reasonable excuse, fail to comply with the requirements of this section.

Maximum penalty: 100 penalty units or imprisonment for 6 months, or both.

There are three parts to s56:

- 1) It requires notifications to the Secretary to be made in a de-identified format,
- 2) It prevents a person's identifying details being used for the purpose of arranging a diagnostic test for HIV (except in hospital situations or with consent), and
- 3) It includes strict confidentiality requirements that require a person who, in the course of providing a service, obtains information that a person has been tested for HIV or has HIV/AIDS to take reasonable steps to prevent that information from being disclosed (except in limited circumstances).

In 2010 a new Public Health Act was enacted to replace the 1991 Act. This new legislation continued to include a section (i.e. s56) requiring de-identified HIV and AIDS notification, similar to that required by the 1991 legislation.

This policy of requiring de-identified notification of HIV and AIDS was first formulated in the 1980s, at a time when the vast majority of HIV infections were in gay men and there was considerable societal stigma and discrimination against homosexuality (the so-called "sodomy laws" that criminalised homosexuality remained in force in some Australian states/territories and laws to protect against HIV related discrimination were not fully in place). There was concern that named notification would provide the government with the names of people with HIV and AIDS, which could be used to take some form of unwarranted action. A strong position against mandatory notification was taken by a number of activists, clinicians and community organisations.

Therefore, notification provisions like those originally contained in the 1991 Public Health Act were considered necessary protections if people with risk behaviours, including those potentially undertaken by people other than gay men such as people who inject drugs or female sex workers, were to be encouraged to access HIV testing and health care services without fear of recrimination.

At the time that de-identified notification of HIV infection was introduced, there was little individual health benefit for a person without symptoms to be tested for HIV as there were no effective treatments and an HIV diagnosis was regarded as a uniformly terminal condition. As mentioned above, there were also heightened concerns about privacy and HIV

related stigma and discrimination and the adequacy of laws and policies to address these important issues.

However, community attitudes to HIV have improved markedly over the past 30 years and this has been assisted by the introduction of evidence based laws, policies and programs to address privacy, stigma and discrimination concerns. Today, we also have highly effective combination anti-retroviral therapy (ART) available, with new evidence clearly demonstrating the individual health benefits of starting ART as early as possible after infection as well as the public health benefits of ART in helping prevent onward HIV transmission. The current focus of HIV prevention encompasses not only prevention strategies like condom use and safe injecting, but also biomedical strategies including using ART to prevent HIV transmission. This means it is essential to ensure that within the population of people living with HIV there are high levels of early treatment initiation and retention in care if HIV transmission is to be reduced.

Therefore, in many ways, the de-identification of HIV and AIDS notifications is now arguably anachronistic:

- People living with HIV have for some time been required to provide identifiable information in other areas of the health system, such as providing their Medicare number prior to being dispensed HIV antiretroviral medications.
- HIV is now a manageable chronic disease. Initiation of ART as soon as feasible after diagnosis has been shown to be beneficial for both the health of the person with HIV infection and to reduce the risk of transmission of HIV; that is, the public health management at the population level aligns with best clinical management of individuals. Being able to collect routine data that allows barriers to care to be better identified will assist the HIV affected community. Early linkage to care for people with diagnosed HIV, improved retention in care and ensuring people are not lost to follow up is vital to maximise the individual and public health benefits.
- Notification of all other scheduled conditions in NSW includes the name and address of people diagnosed with the condition. These details allow, where necessary, for efficient follow up of people who have these conditions to optimise health care and protect public health according to approved protocols. The information is held and managed securely to protect against unlawful use or disclosure.
- When the 1991 Public Health Act commenced there was no privacy law in NSW. Since that time, privacy of health information has been strengthened across the health system through the Health Records and Information Privacy Act 2002. Protections in this Act limit the use and disclosure of health information.
- There have been significant positive changes in the social environment and attitudes towards people with HIV, although it is recognised that people with HIV and affected communities such as gay and homosexually active men, injecting drug users and sex workers can continue to experience stigma and discrimination.

- Successful implementation of the NSW HIV Strategy 2016-2020 with the goal of virtual elimination of HIV transmission in NSW by 2020, can be assisted by more accurate measurement of the impact of HIV on the community.

As such, the review presents an opportunity to consider whether s56 is still appropriate or whether changes are required.

Requirement for notifications to the Secretary to be made in a de-identified format

The prohibition in the Public Health Act on including a person's name and address in any HIV notification to the Secretary, means that the Secretary is notified in a de-identified manner, usually by 2x2 name code i.e. the first two letters of the surname, first name and date of birth of the person newly diagnosed with HIV.

Within Australia, there is not a consistent provision in relation to whether notification of HIV should be in an identified or de-identified format. Victoria,⁵ Western Australia,⁶ Tasmania⁷ and the Australian Capital Territory⁸ require de-identified notifications of HIV (a 2x2 format is used). Queensland allows for notifications to be done in an anonymous format⁹ (although there is power to require a person's name to be provided¹⁰). South Australia and Northern Territory require identified notification but such notifications are recorded in a database by a name code¹¹.

Communicable disease surveillance, prevention and control often involves balancing action for the public good and restriction of the rights of individuals. Considering named notification for persons with HIV therefore involves a balance between the benefits for public health at the population level and potential harm to HIV infected individuals. As noted earlier, notification of all other scheduled conditions in NSW includes the name and address of people diagnosed with the condition. For conditions where enhanced surveillance is undertaken, further details about risk factors and clinical information pertinent to the particular condition are sought via the diagnosing clinician. With some diseases and conditions, including HIV, quite sensitive and personal information is collected

⁵ Schedule 6 Public Health and Wellbeing Regulation 2009

⁶ Section 276A Health Act 1911

⁷ Section 46 of the Public Health Act (Tas) and the Guidelines for Notification of Notifiable Diseases, Human Pathogenic Organisms and Contaminants, published by the Tasmania Department of Health and Human Services, accessed at http://www.dhhs.tas.gov.au/_data/assets/pdf_file/0003/53319/Notifiable_Diseases_Guideline_FINAL_Feb_2010.pdf.

⁸ Section 105 of the Public Health Act 1997 (ACT) and the ACT Reporting of Notifiable Conditions Code of Practice 2006, accessed at http://health.act.gov.au/sites/default/files/Reporting_of_notifiable_conditions_code_of_practice_and_form_0.pdf

⁹ Section 74 of the Public Health Act 2005 (Qld)

¹⁰ Section 75(4) of the Public Health Act 2005 (Qld)

¹¹ *ASHM. Guide to Australian HIV Laws and Policies for Health Care Professionals*. Available at <http://www.ashm.org.au/HIVLegal>

to inform disease control policies and procedures. HIV surveillance includes collection of information for each notification about the gender of sexual partners, injecting drug use, clinical indicators of stage of infection, and CD4 count and viral load around the time of treatment initiation¹². However, similar information is collected on notifications of a number of other conditions. Syphilis notifications include information on the gender of sexual partners and any history of recent sex work, and shigellosis notifications include information on the gender of sexual partners. Hepatitis B and hepatitis C notifications include information about injecting drug use (and sexual history is also collected for hepatitis B). Tuberculosis notifications include information on treatment initiation and completion and outcome details.

Named notification for HIV would provide a range of benefits to the current efforts to eliminate HIV in NSW.

- Notification data is used to target services for the prevention, diagnosis and treatment of people with HIV and monitor the impact of these services. Named notification would reduce errors in notification data and result in more accurate estimates for monitoring the HIV epidemic in NSW. Reporting errors, such as coding and transcribing errors (including putting the first two letters of the first name first or incorrect dates of birth resulting in duplicate notifications for the same person), or under-notification if two people with the same date of birth and same name code (e.g. James Wilson and Jason Williams) are counted as one, would be avoided.
- Named notification would help understand and manage HIV co-infections (such as hepatitis C), by enabling better linking of HIV notifications with notification of other conditions. This is important for preventing such infections, and also for better understanding the role that STIs, such as syphilis, play in the transmission of HIV in NSW. It would also greatly improve data linkage of HIV notifications with the death register improving estimates of the number of people living with diagnosed HIV infection and of death rates in people with HIV infection.
- The NSW HIV Strategy 2016-2020 has a focus on improving the health and wellbeing of people living with HIV by strengthening retention in care. Named notification would enable the confidential follow up of individuals diagnosed with HIV to determine whether or not they are retained in care or have effectively linked to services after being referred. These efforts conducted in a non-coercive way would be for the purpose of supporting retention in care and effective health care management.
- Named notification would enable responsibility for follow up to be initiated by a health officer other than the diagnosing clinician, particularly where the person with HIV has not returned to the diagnosing doctor for clinical care.

¹² <http://www.health.nsw.gov.au/Infectious/Pages/notification.aspx>

- Named notification would better enable NSW Health officers to liaise with clinicians to ensure patients with complex needs are effectively managed. This would lead to improved outcomes for individuals with such needs.
- Named notification would not change the current ability of an HIV positive person to choose whether and when to engage with care and to initiate treatment.
- Named notification would not change the current situation relating to anonymous testing.

The benefits of named notification must be balanced against adverse consequences at the population and individual level, including:

- People may be deterred from testing for HIV knowing that a positive test will be reported to NSW Health. This may arise from a general discomfort with the role of government or concerns that such information may adversely affect other government processes such as visa/residency/citizenship applications. However, HIV information, as with other health information, is subject to strict privacy laws relating to the use and disclosure of information. The Health Records and Information Privacy Act places strict limits on the use and disclosure of such information.
- Reluctance to be tested for HIV infection should named notification for HIV be introduced may disproportionately affect population groups such as people from culturally and linguistically diverse backgrounds or people who inject drugs, but may be able to be mitigated via communication with the relevant communities.
- People diagnosed with HIV may be less willing to report illegal risk factors for infection (e.g. injecting drug use) for fear of their information being used for law enforcement purposes.
- Clinicians may be less likely to report illegal risk factors when notifying HIV infection, leading to poorer data about the HIV epidemic in NSW. However, clinicians readily report injecting drug use as a risk factor for newly acquired hepatitis C infection.

While these issues are recognised and a reduction in testing would have clear adverse impacts on individuals' health and the transmission of HIV, the Ministry is not aware of any evidence suggesting that named notification leads to decreases in HIV testing. There is in fact evidence that named notification does not reduce HIV testing^{13,14}.

The Ministry is however concerned about the potential for any adverse impacts on the health of individuals and on HIV transmission risks in NSW and would therefore initiate a

¹³ Nakashima, et al. Effect of HIV Reporting by Name on Use of HIV Testing in Publicly Funded Counseling and Testing Programs, *Journal of American Medical Association*, [October 28, 1998, Vol 280, No. 16](http://jama.jamanetwork.com/article.aspx?articleid=188100&resultclick=1), <http://jama.jamanetwork.com/article.aspx?articleid=188100&resultclick=1>

¹⁴ Tesoriero JM et al. The Effect of Name-Based Reporting and Partner Notification on HIV Testing in New York State. *American Journal of Public Health* 2008 April;98(4):728-35

range of effective communication strategies targeting relevant communities should named notification be introduced.

Also of note is the concern raised in early consultation that named notification may unnecessarily increase the information NSW Health has about people with HIV, as this could be used by NSW Health to undertake additional investigations concerning people with HIV allegedly placing others at risk of infection. The Ministry argues that this concern is unfounded as it already has powers to obtain identifying details about a person with HIV if that person is placing others at risk and, if necessary, place the person on a public health order. These powers have rarely been used in NSW and only in specific circumstances. This is because NSW Health has a clear policy, based on national guidelines on the management of people with HIV who place others at risk, which defines a series of escalating levels of management focused on counselling with the principle that the lowest level of management that prevents transmission risk must be used¹⁵. The process is managed by an expert panel with membership that includes representatives from the HIV community sector, an HIV specialist, HIV support services, public health unit directors and an ethicist. The majority of cases referred to the panel involve people living with HIV who also have other complex needs such as mental health and/or drug and alcohol issues. The focus in NSW is on education and counseling, effective case management, treatment uptake and support for long term engagement in care. Nevertheless, in the context of named notification, fear of this policy may deter some people from being tested or engaging with services.

Some of the concerns about named notification in relation to HIV may relate to a lack of knowledge about how information on notifiable conditions is used by NSW Health. As noted earlier in the Paper, notifications serve a range of important public health purposes, from facilitating better health outcomes for individuals, the gathering of epidemiological data, and identifying risk factors which help inform preventative health programs. Notifications of diseases and conditions help serve the public, persons with the disease, and persons at risk of contracting a disease. While persons with HIV (or certain other diseases) can be placed on a public health order, which can provide for compulsory treatment and/or detention, public health orders are rarely used and would only ever be used as a last resort – this approach would continue to be the case regardless of whether HIV notification is named or not

It is important to consider any feasible alternatives by which the benefits of named notification could be gained without changing the *Public Health Act* to require identified HIV notifications. These are outlined in Table 1 below.

¹⁵ http://www0.health.nsw.gov.au/policies/pd/2009/pdf/PD2009_023.pdf

Table 1: Benefits of named HIV notification and alternative methods to achieve these benefits

What benefit would named notification bring?	How else could this benefit be gained?	What are the relative issues?
Improved accuracy of HIV notification information	No other feasible method	
Offers of advice and direct referral to support services for PLHIV provided by public health staff, community based services and other relevant health services	By offers of support for PLHIV only in circumstances where specific consent has been provided by the person themselves via the managing doctor to public health staff	<p>For all other notifiable conditions where advice is provided directly to the person notified with the condition, public health staff seek consent from diagnosing doctors before contacting the diagnosed person so that the doctor is aware that their patient may be contacted and provided with advice. The need to obtain specific consent from the patient is an additional and potentially burdensome step for the treating doctor, particularly when the patient has missed appointments, which is when public health support may be of greatest benefit</p> <p>Currently, public health staff do not routinely make direct contact with people notified with HIV but doctors who are inexperienced with HIV in NSW often expect public health follow-up. This leads to mistaken understandings of roles and missed opportunities to reduce transmission</p>
Real time on-going surveillance of HIV coinfections (where someone with HIV infection is co-infected with another STI or blood borne virus)	Regular “snapshot” data linkages of HIV notifications (deidentified) with STI/hepatitis C notifications	Reduced accuracy of data linkage resulting in greater (and unknown) uncertainty about the level of co-infections

infection; the presence of a co-infection is a risk factor for HIV transmission)	Analysis of data from the ACCESS research project	Data available only on PLHIV who attend clinics participating in ACCESS for all their sexual health and HIV care
Improved estimates of HIV mortality (to estimate the number of PLHIV) and morbidity (hospitalisations)	Regular “snapshot” data linkages of HIV notifications (deidentified) with the death register and with hospital admitted patient data	Linkage of de-identified data on HIV notifications with large datasets will result in a higher level of mismatches and match failures than the use of identified data. An analysis of data linkage of the national HIV database to the National Death Index and compared to known deaths of PLHIV and known non-deaths found that the optimal matching strategy failed to detect 18% of known deaths and 8% of the detected deaths were false positives ¹⁶
Improved information from clinicians to determine the outcomes of a person notified with HIV infection (e.g. in care, referred to another practitioner, moved out of NSW, died, lost to follow up)	Request information from clinicians based on 2x2 code and date of birth	Some clinicians, particularly in the private sector, do not have the ability to search their files by 2x2 name code (or date of birth) so cannot locate the relevant patient file (the file for a person recently diagnosed with HIV is usually easily obtainable, but this is not the case for older diagnoses)

Overall, the Ministry’s preliminary view is that there are more benefits than harms in moving to named notifications of HIV and AIDS, with the key benefits being:

- Improved accuracy of epidemiological data, including improved identification of risk factors which may assist in improving prevention strategies and improving patient management, and improved estimates of HIV mortality
- Improved surveillance of HIV and STI/BBV co-infections

¹⁶ Nakhaee F, McDonald A, Black D et al. A feasible method for linkage studies avoiding clerical review: linkage of the national HIV/AIDS surveillance databases with the National Death Index in Australia. *Aust NZ J Public Health* 2007;31:308-12

- Improved retention of patients in care, and therefore increasing those who are on ART with suppressed viral load providing both individual and population health benefits
- Improved patient follow up and linkage to care and services
- Reduced “exceptionalism”, where HIV is considered differently to other conditions, which may perpetuate stigma and discrimination.

However, the question of whether notification of HIV and AIDS should be done in an identified format is a sensitive issue which must take into account both the individual and public health benefits as well as any harmful consequences. Accordingly, the Ministry seeks submissions on this and related issues.

Further, if the Act is amended to require named notification of HIV, the Ministry would also like to hear submissions on whether there should be any additional safeguards in the Act relating to information held by the Secretary. This could include, for example, not allowing notifications received under the Act to be subject to subpoena. Not allowing notification information to be subpoenaed may assist in persons with HIV, or other conditions, being assured that information collected under the Act will be used for public health purposes and not for other external purposes while not unduly affecting Court processes (as pertinent information would still be able to be subpoenaed directly from a medical practitioner).

Issues for consideration

- 15) Should HIV notifications to the Secretary include the person’s name and address?
- 16) Should any additional protections be included in the *Public Health Act* relating to information held by the Secretary, and if so what are they?

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 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 or with consent). There are a number of issues that suggest this requirement is out dated, inconsistent and impacting on patient care.

- The prohibition only applies if the test is to determine whether a patient has HIV. This means, that where testing is done for a non-diagnostic purpose, such as HIV viral load testing or HIV drug resistance testing, the patient’s name can be included on the pathology request form. This difference and inconsistency in legal requirements can result in confusion for clinicians and pathology laboratories but importantly negates any protection afforded by s56 in requiring consent for a laboratory to have identifying details about someone with HIV infection.
- The de-identification requirement can present a barrier to testing for HIV in certain situations. 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 cannot 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. This current legislative requirement for not including a person’s name on an HIV test request without consent has been raised by pathology service providers as a barrier to testing for HIV in antenatal screening, which then presents a risk that HIV testing is missed altogether resulting in a risk to both the mother and unborn child.

The removal of barriers to HIV testing is critical if NSW is to drive down HIV infection rates. Testing for HIV is now relatively commonplace and is indicated in a very large number of clinical situations not based on HIV risk and therefore in itself the fact that a person is tested for HIV is unlikely to result in discrimination. Privacy protections on requests for HIV diagnostic tests are therefore considered unnecessary and could in fact be further contributing to stigma.

As such, the Ministry’s preliminary view is that s56 should be amended to remove any restrictions on including a person’s identifying details in a pathology request testing for HIV and seeks submissions on this issue.

Issues for consideration

- 17) Should the prohibition on including a person’s identifying details in a pathology request form for HIV with specific consent of the person be removed from the Act?

Additional confidentiality of information that a person has HIV or AIDS

Section 56(3) 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 (with penalties for non-compliance). However, there are exceptions to this requirement which are set out in s56(4), which include:

- *with consent of the person,*
- *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 (s56(4)(b)), or*

- *to the Secretary where the person has reasonable grounds to suspect that failure to disclose the information would be likely to be a risk to public health,*
- *for certain legal proceedings*
- *in connection with the administration of the Public Health Act*

Section 56(3) and (4) was designed to ensure that a person's HIV status is not disclosed for inappropriate or unreasonable purposes and was included in the 1991 Public Health Act due to ongoing concerns about discrimination and stigma faced by persons with HIV.

The Ministry understands that there is still stigma and discrimination faced by people living with HIV and is not proposing to remove s56(3) and (4) from the Act. However, in the modern health care setting, sections 56(3) and (4) have been reported to create real barriers to patient care and, with moves towards electronic health records, can result in confusion and an inconsistent approach to different parts of a patient's health record. As noted above, there are specific circumstances where HIV information can be disclosed, relevantly including at s56(4)(b) if the disclosure is to another 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."*

As currently drafted, s56(4)(b) can be read as meaning that HIV information can only be disclosed to another person who is directly involved in the care or treatment of the person's HIV infection. This means that HIV information can only be shared once it is established that the other clinician involved in the treatment or care of the person with HIV has a specific clinical need to know about the person's HIV status.

This limitation can create real difficulties as NSW Health, along with other health services, move towards electronic records. Generally speaking in an electronic record system, all health information on the individual is included and the content of that record is protected by general privacy principles under the *Health Records and Information Privacy Act* which limits the uses and disclosures that can be made. In NSW Health, electronic health information is further protected by audit trails where the information system records which health care worker accessed which health record at which time/date and for how long. Across the NSW Health public health system, regular random audits are conducted to ensure that health care workers only access records relevant to their clinical practice. However, due to the limitations in section 56, HIV test results are often "locked down" so that they are not readily accessible or omitted from the electronic health record entirely. This can result clinicians delivering care to individuals with HIV not having access to their HIV information even though relevant.

With the advent of modern ART, HIV is now a chronic manageable disease and people with HIV infection are ageing and developing the same chronic diseases as non-infected people.

Also, long-term living with HIV and ART use has impact across a wide range of body systems (brain, bone, kidneys, liver), and some of these can become more troublesome over time. An individual's HIV status has now become important for almost all medical consultations and a failure to take this into account can lead to poorer health outcomes, or lead to unnecessary repeating of diagnostic testing.

Due to these issues with s56(4)(b), the Ministry preliminarily considers that this section should be broadened to allow disclosure for the purposes of all medical or health care, (with no caveat that the HIV status must be relevant specifically to the nature of the medical care being provided). Such an amendment will assist in ensuring that clinicians have access to relevant information about a person's HIV status, which will assist in providing appropriate care to patients. If such an amendment were to be made, HIV information in clinical settings would still be protected by the Health Records and Information Privacy Act, which places limits on the use and disclosure of health information.

Some stakeholders have raised concerns about broadening the scope of s56(4) and argue that some people with HIV still face discrimination, including by health care providers and have raised concerns that any changes may result in confidential information being inappropriately disclosed and discrimination occurring. It is unethical and unlawful (on the basis of disability discrimination) for health care providers to engage in HIV related discrimination. Mechanisms are in place in all Local Health Districts for the management of inappropriate health provider related discriminatory behaviour. 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.

Issues for consideration

18) Should s56(4)(b) be amended to allow for information about a person's HIV status to be disclosed for the purpose of providing medical or health care (with such information being subject to the *Health Records and Information Privacy Act*) ?

3.5(d) Disclosure of STI status – s79

Section 79 of the Public Health 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. A similar provision was included in the 1991 Act. However, the 2010 Act significantly includes as a defence if reasonable precautions are taken to prevent transmission of the STI. The defence of reasonable precautions has not been tested in Court

but it is noted that, in respect of HIV, using a condom or having an HIV viral load less than 400 copies per ml¹⁷ can significantly decrease the risk of transmission of HIV.

The inclusion of s79 was, and continues to be controversial in view of the argument that s79, although applying to all STIs, unfairly targets people living with HIV and that the disclosure requirement:

- discourages HIV or STI testing (because if a person is not aware of their HIV status, they are not required to disclose);
- encourages anonymous sexual encounters (because if a person knows they are infected but do not provide their real identity, they can't easily be traced in order to be prosecuted); and
- results in discrimination and stigma of persons with HIV and potentially leaves persons with HIV open to coercion or even blackmail (because if a person tells someone else they are infected, that person may pass on that information or use it against the person).

Sexual health promotion messages communicated across NSW strongly emphasise the need for safe sex in order to protect one's own health. Some stakeholders argue that s79 dilutes this message and detracts from the notion of shared responsibility.

Further, s79 may result in the creation of a false sense of security by leading a person to assume that if a sexual partner does not inform them that they have HIV infection or an STI, then the person does not need to use a condom to help prevent transmission.

On the other hand, some argue 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, relying on disclosure by sexual partners to prevent HIV or STI acquisition provides a false sense of security, as people who have not been tested recently may not know they are infected, or may not tell the truth. Even persons regularly tested for HIV can be unknowingly infectious if tested during the 'window period' between acquiring the infection and developing a detectable immune response, and in fact it is thought that this may be a high risk period for transmission.

There is no evidence that the disclosure provision is effective in reducing HIV or STIs in populations at risk of infection, and in fact may have negative impacts on HIV and STI control. The use of condoms and other safe sex practices have formed the basis of STI prevention education in NSW for over 20 years. With many STIs (including HIV) being asymptomatic and remaining undiagnosed in individuals, a public health response of relying on disclosure by sexual partners is ineffective. Condom use and other evidence based

¹⁷ NSW HIV Strategy 2016-2020. Available at:
http://www0.health.nsw.gov.au/policies/ib/2015/pdf/IB2015_062.pdf

measures, including ART as prevention for HIV, are effective public health interventions that should be promoted in NSW as reasonable precautions.

Based on the above points, the Ministry in principle supports the removal of s79 from the Act. It is noted that the removal of s79 would not affect the criminal code provision of intentionally or recklessly causing grievous bodily harm, through the transmission of a grievous bodily disease¹⁸.

If s79 of the Act is removed, it may be appropriate to include a provision setting out the expected responsibilities of a person with an infectious disease, including an STI, as well as those of a person who is at risk of contracting an infectious disease. It is noted that the Victorian [Public Health and Wellbeing Act 2008](#) has a provision setting out the principles relating to the management and control of infectious disease¹⁹, which states:

The following principles apply to the management and control of infectious diseases—

(a) the spread of an infectious disease should be prevented or minimised with the minimum restriction on the rights of any person;

(b) a person at risk of contracting an infectious disease should take all reasonable precautions to avoid contracting the infectious disease;

(c) a person who has, or suspects that they may have, an infectious disease should—

(i) ascertain whether he or she has an infectious disease and what precautions he or she should take to prevent any other person from contracting the infectious disease; and

(ii) take all reasonable steps to eliminate or reduce the risk of any other person contracting the infectious disease;

(d) a person who is at risk of contracting, has or suspects he or she may have, an infectious disease is entitled—

(i) to receive information about the infectious disease and any appropriate available treatment;

(ii) to have access to any appropriate available treatment.

An emphasis on personal responsibilities 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, may be better suited to protecting public health as it recognises the role of all members of the public in taking preventive action to help minimise the spread of disease within the community.

¹⁸ Crimes Act 1900, sections 33, 35 and 4

¹⁹ Section 111, *Public Health and Wellbeing Act 2008* (Vic)

Issues for consideration

- 19) Should s79 be removed from the Act?
- 20) Should the Act contain a new section setting out the principles that should apply to the management and control of infectious diseases?

3.5(e) Public Health Orders

Under the Act, an authorised medical practitioner (being the Chief Health Officer or other medical practitioner authorised by the Secretary) can make a public health order in respect of a person if satisfied on reasonable ground that:

- the person is suffering from a Category 4 or 5 condition; and
- because the way the person is behaving, or as a consequence of the condition, the person is a risk to public health.

A public health order, among other things, can require a person to 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-CoV). Category 5 conditions, as noted earlier in the Paper, are HIV and AIDS.

In respect of Category 4 conditions, a public health order may require the person to refrain from certain conduct, submit to supervision, undergo treatment or counselling, or be detained while undergoing treatment. Such orders are initially limited in duration to 28 days (although they can be reviewed by the NSW Civil and Administrative Tribunal (NCAT) earlier) unless a further order is made by NCAT.

Public health orders are used sparingly, and only when the person presents a risk to public health (generally as a result of a failure to follow medical/public health advice). For HIV (category 5) there have only ever been two individuals who were subject to public health orders. Over the past 10 years only two orders for TB were identified. However, the review presents an opportunity to ensure that the provisions in the Act are adequate to protect public health.

It is noted that while the provisions in the Act would enable a public health order to be made in respect of a person with a Category 4 condition, the public health order provisions

do not apply to contacts of a person suffering from a Category 4 condition who may have been infected and are in the incubation period before the symptoms of the illness present.

It is rarely, if ever, possible to confidently exclude a contact as having been infected on the basis of a screening medical test; contacts generally need to pass the maximum incubation period for the infection before being excluded as being infected. Avian influenza in humans is an example of an infection which can be contagious before a person shows signs or symptoms of the disease. People with this disease are potentially infectious for at least 24 hours before symptoms begin.

It is clear that there are scenarios where the effective management of high-risk contacts is critical to prevent transmission of serious infectious diseases in the wider community. Some examples of these scenarios include:

- The multi-country outbreak of Ebola virus disease (EVD) in west Africa has highlighted the need for the strict quarantine of close contacts of cases of viral haemorrhagic fevers, such as EVD, during the 21 day incubation period of the condition in order to minimise the risk of the disease spreading and so protect public health.
- The enforced quarantine of contacts was also crucial in the control of the international outbreak of SARS coronavirus in 2003. Failures in contact control during the recent outbreak of the related MERS coronavirus in South Korea led to many additional cases and deaths²⁰, and allowed an infected contact to travel to China, exposing many more individuals²¹. Contacts of a case of tuberculosis are routinely followed-up and screened. However, with the increasing emergence of tuberculosis strains which are extremely resistant to antibiotics there may be a need for stronger powers to require contact testing or treatment in the future.

Generally, effective management of contacts happens on a voluntary basis and any proposed management action is based on the degree of risk that a contact poses. Some contacts of a person with a category 4 condition will be of low risk to developing the condition and no management is required other than for the person to notify the relevant health service if symptoms develop and in some cases prophylaxis medication can be taken to reduce the risk of developing the condition. However, some contacts may be deemed at high risk of contracting a category 4 condition and a health service would ask the contact to restrict their interaction with other people. Most high risk contacts will agree to follow the advice of the health service (as most people with a Category 4 condition do which makes the use of public health orders rarely required). However, in rare cases where a high risk contact refuses to take action to prevent the possible spread of the condition, there is currently no specific power in the Act to take action to protect the public.

²⁰ <http://www.wpro.who.int/mediacentre/releases/2015/20150613/en/>

²¹ http://www.who.int/csr/disease/coronavirus_infections/risk-assessment-3june2015/en/

It is noted that s60 of the new Commonwealth Biosecurity Act 2015 (to commence in June 2016) does give powers to Human Biosecurity Officers to impose a human biosecurity control order (which is akin to a public health order) on individuals if the officer is satisfied that the individual has a listed human disease or if the individual has been exposed to a listed human disease or another individual who has signs or symptoms of a listed human disease. The listed diseases are: human influenza with pandemic potential, MERS, plague, SARS, smallpox, viral haemorrhagic fevers and yellow fever. These necessarily differ from the Category 4 conditions in the NSW Public Health Act as the Commonwealth Biosecurity Act relates principally to quarantine at international borders.

While the Commonwealth legislation will allow restrictions to be placed on a contact of a person with a listed disease, the Ministry would like to hear submissions on whether the Public Health Act should be amended to extend the existing provisions in relation to public health orders to high risk contacts of a person suffering from a Category 4 condition. The benefit of including the provisions in the Public Health Act is that NSW officers are arguably more familiar with the NSW Public Health Act rather than the Commonwealth Act. It also ensures that the ability to impose a public health order on contacts extends to all diseases listed in Category 4.

However, it is recognised that such an extension of public health orders 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. As such, should public health orders be extended to contacts of persons suffering from Category 4 conditions, it may be that additional protections are required in the Public Health Act to better balance the need to protect public health with the rights of persons who may have been infected with a serious infectious disease. This could include, for example, an earlier review by NCAT or a higher threshold before an order is made.

A related issue with public health orders in respect of Category 4 conditions is that an order for detention can currently only be made if the person is receiving treatment. This means that if no treatment is available in respect of the Category 4 condition, then detention is not possible under the Public Health Act. Where a person has a Category 4 condition and is behaving in a way that places the public at risk, detention may be required in order to prevent the onward transmission of an infection regardless of whether treatment can also be given to the person with the Category 4 condition. As such, the Ministry would also like to hear submissions on whether the Act should be amended to allow a public health order, in respect of a Category 4 condition, to require a person to be detained while the person is infectious and/or to be detained for the purpose of treatment.

Another issue in respect of public health orders is whether greater transparency of public health orders made under the Act would be beneficial. Public Health orders are serious

measures that can result in compulsory treatment and/or detention and appropriate transparency in the making of such orders is appropriate. Such transparency could include for example, requiring reporting of the number of orders made, and in respect of what disease or condition, in the Annual Report of the Ministry. Submissions on this issue are sought.

Issues for consideration:

- 21) Should the current powers for public health orders be extended to include high risk contacts of a person with a Category 4 condition?
- 22) If so, should additional protection be included in the Act to appropriately protect the rights of persons who have been in contact with a person suffering from a Category 4 condition?
- 23) Should the Act be amended to allow a public health order to be made requiring a person with a Category 4 condition to be detained while infectious and/or in order to receive treatment?
- 24) Should there be greater transparency requirements in the Act relating to public health orders that have been 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 current provisions do not apply to high schools. When these provisions were first introduced to the 1991 Act in 1993²² there was not a reliable mechanism to obtain immunisation histories for older children as the Australian Childhood Immunisation Register (ACIR) had not commenced and it was considered too burdensome for parents of high school children to provide a vaccination record. However, with the maturing of the ACIR and its extension to include people up to 19 years of age from 1 January 2016, parents will have easier access to vaccination records for high school children which could be provided to high school principals. Further, 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 children²³.

Accordingly, the Ministry would like to hear submissions on whether the current requirements on principals to request and hold vaccination records and the ability of public health officers to exclude unvaccinated children during an outbreak should be extended to high schools. It is considered that extending the Act in this way would assist in controlling outbreaks. The information provided to high schools could also be used to help schools direct parents to resources or services to update under-immunised children. Due to the extension of the ACIR to all persons up to the age of 19 years, any additional administrative burden on schools or parents is considered to be minimal.

The impacts on families and students of excluding unvaccinated children during an outbreak of an infectious disease may differ in high schools compared to impacts in child care or primary school. While any loss of educational attendance may impact a child's learning, it is arguably more critical for high school students if they are required to be absent from school, particularly senior students preparing for final exams. Further, consideration needs to be given as to whether disease control objectives will be achieved by excluding potentially infectious students from high school, as similar controls cannot be placed on them attending non-school settings (such as shopping centres or parties), which may pose equal or greater risks of exposing susceptible individuals.

Issues for consideration:

- 25) Should the current provisions in the Act relating to vaccine preventable diseases be extended to apply to high schools?

²² The Public Health (Amendment) Act 1992, which commenced in 1993

²³ 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>

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 exclude a child with a vaccine preventable disease and/or an unvaccinated child from a primary school or child care facility when directed to do so by a public health officer. This ability to exclude a child with the disease and unvaccinated children assists in controlling an outbreak of a vaccine preventable disease where parents are unable or unwilling to voluntarily exclude their child from school or child care. However, the current powers are limited in that they only apply to unvaccinated children at a primary school or child care facility where there is an outbreak of a vaccine preventable disease.

If there is an unvaccinated child who has been in contact with someone with a vaccine preventable disease but who attends a school at which there is not an outbreak, there is currently 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.

NSW Health may become aware of an unvaccinated child coming into contact with a person with a vaccine preventable disease through contact tracing after a case of a vaccine preventable disease has been notified to the Secretary. While the parents could be asked to voluntarily exclude their child from school or child care, and most parents will, if the parents refused and there is no outbreak at the school or child care that the child attends, then there is no power in the Public Health Act to exclude the child from child care or school. If the child then attends school or child care, there is a risk of an outbreak developing at their school, which has the potential to harm other children who are too young to be vaccinated, or who can't be vaccinated due to medical reasons.

In order to better protect public health, the Ministry would like to hear submissions on whether the Act should be amended to allow an unvaccinated child whom a public health officer reasonably believes to have come into contact with a vaccine preventable disease to be excluded from school or child care during the incubation period of the disease, regardless of whether there is an outbreak at the school or child care facility that the child attends. Subject to the feedback on the preceding section, this ability to exclude an unvaccinated potentially infectious child could be extended to include children attending high school.

Issues for consideration:

- 26) Should the Act 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?

27) Subject to feedback on issue 25, should this amendment also apply to students of high schools?

3.6(c) Childcare enrolment requirements

As noted above, 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. 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 in line with Commonwealth requirements relating to certain social security payments, such as the Child Care Benefit.

However, the Commonwealth recently passed the Social Services Legislation Amendment (No Jab, No Pay) Act 2015²⁴ that 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. It is noted that Victoria recently passed legislation requiring a child to be vaccinated (or have a medical contraindication to vaccination) before being enrolled in child care²⁵. 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 unvaccinated²⁶.

With the removal of the conscientious vaccination objector exemption in relation to certain social security payments, and recent changes to legislation in Victoria and Queensland, it is timely to consider whether NSW should also remove the current exemption allowing children of vaccination objectors to be enrolled in child care from the Act.

The number of registered conscientious objectors is relatively small and has fallen since the Commonwealth's announcement of changes to the Social Security Legislation in May 2015 from 9,732 or 1.4% of children under 7 years of age to 8,642 or 1.2% of that cohort in September 2015. However, in certain areas of the State the proportion of children attending child care who are unvaccinated is higher, particularly on the North Coast and Mid North Coast. If children who were unvaccinated due to their parents' conscientious objection

²⁴ See

http://www.aph.gov.au/Parliamentary_Business/Bills_LEGislation/Bills_Search_Results/Result?bld=r5540

²⁵ The Public Health and Wellbeing Amendment (No Jab, No Play) Act 2015 (Vic)

²⁶ Public Health (Childcare Vaccination) and Other Legislation Amendment Act 2015 (Qld)

were excluded from child care facilities, it would likely support public health efforts to reduce the transmission of vaccine preventable diseases in child care settings, in particular in areas where there are high rates of unvaccinated children. Removal of the conscientious objection exemption from the NSW legislation is consistent with other strategies to encourage timely vaccination and reduce the likelihood of disease transmission in child care facilities, particularly for vulnerable children including immunocompromised children, children on a catch up schedule, and those too young to be fully vaccinated. Parents who choose not to vaccinate their children place these other children at risk of significant health consequences.

Following the passage of the Commonwealth legislation, NSW has introduced an Interim Vaccination Objection Form for Enrolment in NSW Child Care Centres during 2016. In order for a parent who holds an objection to vaccination to qualify for the exemption to enrol their child in care they must visit a GP or authorised nurse immuniser who must explain to them: the benefits and risks of immunisation; disease signs and symptoms and when to seek medical advice; the wider consequences of not complying with the NSW Immunisation Schedule (such as exclusion during disease outbreaks); the option of a referral to the Adverse Events Following Immunisation Clinic; and offer a follow-up appointment to review the decision. Both the provider and the parent must sign the form to acknowledge these matters have been discussed, then the form is to be lodged with the child care provider.

There are some short-comings to having a NSW-only immunisation form: potential confusion for GPs, parents and child care centres that are accustomed to using Commonwealth forms; and there will be no central repository for such a form and thus no method to centrally monitor objection rates or verify the validity of the certification.

Therefore, if NSW were to remove the conscientious objection exemption and align itself with the Commonwealth and Victoria it could reduce a potential source of confusion for the child care sector and parents. In addition, removal of the conscientious objection exemption would send a clear message to the community about the NSW Government's commitment to vaccination.

However, it has been suggested that where state legislation prevents child care centres from enrolling unvaccinated children, informal unregulated centres might be established to cater for children whose parents have a conscientious objection to vaccination. Paradoxically, this could increase the risk of disease acquisition and transmission in the community due to the concentration of unvaccinated children. While with limited or no access to financial assistance, such centres are unlikely to be financially viable (and depending on how they are established may be illegal), this remains a potential unintended consequence of not providing for legal enrolment of children of conscientious objectors in regulated child care centres.

The potential benefits of not allowing unvaccinated children to enrol in child care must be considered against the risks and costs. There is an increasing recognition of the importance of good early childhood education to later educational achievement and wellbeing. Prohibiting the enrolment of a child to child care on the basis of the decisions made by their parents risks the educational opportunities of that child, may exacerbate disadvantage for socially and economically vulnerable groups, and may affect attainment of early childhood education participation targets set at both NSW and Commonwealth levels. The interaction with the Commonwealth Disability Discrimination Act also needs to be considered.

In recognition of the educational benefits of child care, another option may be to further strengthen the requirements to obtain a conscientious objection exemption in NSW. This could be done by continuing the requirement for parents to make an explicit declaration as to their conscientious objection and/or requiring a second visit to a medical practitioner to reinforce the benefits and safety of childhood vaccination after further reflection by the parent.

Issues for consideration:

- 28) Should the Public Health Act be amended to remove the conscientious objector exemption to enrolment in a childcare facility from the Act, such that children who are not vaccinated due to their parents' conscientious objection cannot enrol in child care?
- 29) If the exemption is not removed from the Act, should other options be pursued to strengthen the requirements to obtain a conscientious objection exemption for enrolment in child care in NSW?

3.7 Public Health Registers

Part 6 of the Public Health Act 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.

The Secretary can enter into arrangements with other organisations or persons regarding the inclusion of information on a register and a public health organisation 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 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. There is 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 but limiting the ability to include identifying information on such registers.

In order to clarify the intent of these provisions, the Ministry is interested in 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.

More broadly, as s97 and s98 are new provisions, the Ministry would like to hear submissions on how the provisions are operating and whether any changes are required.

Issues for consideration:

- 30) Should the Act be amended to clarify that s97 and s98 does not limit the creation of other registers or databases relating to scheduled medical conditions or notifiable conditions under the Act?
- 31) Are any other changes to s97 and s98 required?

3.8 Public Health Inquiries

Under s106 the Secretary may inquire into any matter relating to public health, or any certain other matters relating to the Act. The Secretary can also 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.

Once an inquiry has been completed, there is no specific power for the Secretary to direct that a person take action to mitigate risks to public health, even if that person's actions have led to the risk to public health. For example, if a public health inquiry identifies poor infection control practices at a health facility that increases the risk of infection of blood borne viruses, the Secretary has no specific power to direct that the facility notify patients of the increased risk of infection and the actions to take to mitigate those risks. Rather, the Secretary, through NSW Health, must undertake the actions if the facility refuses to do so. While in some cases, notifications of persons at risk will be best done through NSW Health, in other cases, the facility may in fact be best placed to notify persons at risk.

In order to ensure that the Secretary has relevant powers to protect the public following a public health inquiry, the Ministry is seeking submissions on whether s106 should be amended to give the Secretary a power, following a public health inquiry, to direct a person or organisation to undertake action to mitigate risks to the public. If such a power is included, the Ministry would also like to hear submissions on what limits should be placed on the power, for example should the power only be exercisable if the Secretary considers that the person or organisation has caused the risks to the public?

Issues for consideration:

- 32) Should s106 the Act be amended to give the Secretary a power, following a public health inquiry, to direct a person or organisation take action to mitigate the risk to the public?
- 33) If so, what limits, and in what circumstances should such a power be exercised, should there be such a power?

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). There are a number of issues with this provision, relating to the definition of nursing home and the requirement for a registered nurse to be on duty at all times. The Legislative Council's General Purpose Standing Committee recently released a Report *Registered nurses in New South Wales nursing homes* and made recommended some changes to s104²⁷. Section 104 will be considered further as part of the Government response to the Legislative Council's Report.

3.10 Regulation of the disposal of bodies

The Public Health Act 2010 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,
- 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,

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<http://www.parliament.nsw.gov.au/prod/parlment/committee.nsf/0/5617FD421429545BCA257EEC008029E4>

- 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,
- 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 the public 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 infections 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 regulation making power in respect of the disposal of bodies is very broad and extends beyond matters relating to public health. 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.

Further, 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. With the passage of the Cemeteries and Crematoria Act 2013, cemeteries and crematoria are now subject to the regulatory oversight of Cemeteries and Crematoria NSW.

The Ministry is seeking submissions on the need for the Public Health Act 2010 to regulate the work, health and safety aspects of the disposal of bodies and the regulation of cremations, interment and exhumation preparation rooms, equipment and apparatus in mortuaries, crematories and cemeteries (where these are unconnected to public health) , given the provisions in the Work Health and Safety Act 2011 and the Cemeteries and Crematoria Act 2013.

Issues for consideration:

- 34) Is it still appropriate for the Public Health Act 2010 to continue to regulate the work, health and safety aspects of the disposal of bodies and the regulation of cremations, interment and exhumation, preparation rooms, equipment and apparatus in

mortuaries, crematories and cemeteries (where these are unconnected to public health)?

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.

Overall, the objectives of the Act appear to be appropriate and the provisions of the Act are appropriate for securing the objectives. However, this Paper considers whether there should be a number of changes to the Act to ensure that the Act continues to work effectively and that NSW Health has the right tools to control public health risks in order to better protect the public.