RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Submission to the Statutory Review of the Public Health Act 2010 (NSW)

June 2016

Responses to the issues for consideration

3.1 The Role of Local Government

1) Are the objectives of the Public Health Act valid and appropriate?

The RACP agrees the objectives are valid and appropriate.

2) Should s3 (Objects of this Act) include a new objective relating to monitoring by NSW Health of diseases and conditions affecting the people of NSW?

In our opinion, the inclusion of monitoring of infectious diseases is a moot point, as this is really a means to the stated objectives, rather than an end or objective in and of itself.

3) Do sections 3 and 4 (Objects of this Act and Responsibilities of local government relating to environment health) adequately recognise the role of local government in the Public Health Act?

No comment.

3.3 Safe supply of drinking water

3.3(a) Quality assurance programs

4) Should a comprehensive 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)?

The RACP agrees with this recommendation.

Given that failure to develop quality assurance programs by some smaller water suppliers is a significant issue, the precautionary principle should apply here.

Waiting for an outbreak to be identified would mean that there are likely to be cases orders of magnitude greater than those reported. It is of much greater public health utility to provide for more robust preventive mechanisms in ensuring water quality, rather than simply outbreak response.

5) If so, should this compliance regime involve a penalty for non-compliance and/or the ability to issue improvement notices for non-compliance?

Although constructive engagement between water providers and Public Health Units should remain the cornerstone of improving compliance, we agree that an enforcement mechanism with penalties is would be appropriate and proportionate given the potential population-level health effects of contaminated water.

As with many penalty provisions, this would serve first as an incentive to comply, but also as a mechanism of last resort for wilfully non-compliant providers. Improvement notices with penalty for non-compliance by a specified date seems appropriate.

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

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?

The RACP agrees with the proposed amendment to recognise a role of local government authorities relating to the regulation of private water suppliers and water carters.

The amendment is an appropriate addition to the Act because it aligns with the local government's responsibility for buildings and their use, and for supplying drinking water.

The implementation and enforcement of state regulatory standards for drinking water supplies should be carried out by local authorities.

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

3.4(a) Premises undertaking skin penetration procedures

7) Should the definition of skin penetration include all procedures that penetrate a mucous membrane?

The RACP supports this change in definition as it makes intuitive and scientific sense. These are high risk procedures and a clear, well-defined explanation would be beneficial.

8) Should there be additional regulation to limit people who can perform high risk procedures such as eyeball tattooing to relevant registered health practitioners?

This is a difficult question, as the few individuals who seek this type of tattooing for aesthetic/ cosmetic (rather than medical) purposes are unlikely to seek out a registered health practitioner for the procedure.

The option should be made more widely known and tattooists should be made aware of their liability and the risks of conducting the procedure. Consumers should, of course, be appropriately informed.

Therefore, the RACP does not agree with this amendment as it may lead to “backyard” procedures on eyeballs and other high risk procedures.

3.4(b) Legionella control

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 provision relating to regulated systems?

We support this amendment. Compliance with the Act is practically difficult for tenants or unclear as to who is responsible, especially in multi-tenanted premises. Amendments should allow that the owner can still nominate a specific building manager, to whom the Act applies.

3.4(c) Public swimming pools and spa pools

10) Should the Act be amended to clarify that the definition of public swimming pool applied to a pool in a residential premises where the pool in question us used by members of the public as part of a commercial undertaking by the occupier of the premises?

Our view is that care should be taken to avoid a situation whereby the commercial undertaking is only loosely associated with use of the pool, such as a residential barbeque fund-raiser, with access to a residential pool.

Thus, the RACP recommends the Act specify that it only applies when the pool in question is used primarily or inherently as part of a commercial undertaking.

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

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?

The RACP supports this amendment, as this would avoid any perception that said body is undertaking follow-up of notifications without the express authorisation of the Secretary.

3.5(b) Requirement to notify and obtaining further information

12) Should the requirement on pathology laboratories to notify results be extended to chemical testing facilities or other facilities carrying out biological testing?

The RACP agrees with this recommendation, although the remit for disease follow-up and management may lie with SafeWork NSW, such as in the case of "health monitoring" of employees in high risk occupations.

A case can be made that knowledge of all diseases should be consolidated within NSW Health, for Public Health epidemiological and management purposes. It does not imply that action by NSW Health is required in workplaces - only that disease epidemiology is a public health issue which informs population-level interventions, including education and awareness and occasionally changes to workplace exposure standards (as occurred with asbestos previously).

13) Should s55 (Pathology laboratories to notify Secretary of Category 3 conditions) be amended to require laboratories to notify the Secretary whenever a pathologist 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?

We agree with this amendment. This is intuitively logical and again provides for a complete understanding of disease pathology as discussed above.

14) Should the existing provisions in s54, which requires 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?

The RACP supports this. It appears to be a genuine gap that in the example provided, a treating medical practitioner would not be required to provide information of public health importance simply because they did not carry out the post-mortem.

3.5(c) Section 65 and notification of HIV and AIDS

15) Should HIV notifications to the Secretary include the person's name and address?

We support the proposed amendments and agree with the justifications stated in the discussion paper.

We understand that Communicable Disease Network Australia (CDNA) has also investigated this issue and reached the same preliminary conclusion – that benefits would outweigh harms. Two by two coded notification of names for HIV notifications remains an anomaly and is potentially an element which sustains rather than reduces stigma, by continuing a special notification status for this disease alone. Other jurisdictions have always had, or have introduced, fully named notification without any reported negative issues.[1] The naming of some HIV positive individuals has occurred despite this coded mechanism of notification, and is a separate issue in and of itself.

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?

In our view, this is not necessary as this discussion paper outlines the existing provisions which are appropriate, robust and protect privacy and identity.

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?

We support the removal of this prohibition from the Act.

We also agree with the justification outlined in the discussion paper. However, the RACP suggests that request forms be designed to better preserve and protect patient privacy in general.

[1] Tesoriero, J.M., Battles, H.B., Heavner, K., Leung, S-Y J., Nemeth, C., Pulver, W and Birkhead, G.S (2008) The Effect of Name-based Reporting and Partner Notification on HIV Testing in New York State. American Journal of Public Health; 98 (4): 728-735.

18) Should s56(4)(b) [Subsection (3) does not apply to the disclosure of such information 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] 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)?

The RACP agrees with this proposed amendment for the reasons provided in the discussion paper. Advantages are again likely to outweigh harms and there is unintended but de facto sustaining of stigma by upholding the status quo.

3.5(d) Disclosure of STI status – section79

19) Should s79 (A person who knows that he or she suffers from sexually transmitted infection is guilty of an offence of he or she has sexual intercourse with another person unless, before the intercourse takes place, the other person voluntary accepts the risk) be removed from the Act?

We support the removal of s79 from the Act for the reasons stated in discussion paper. In our view, s79 is out of accord with public health principles of STI management and communicable disease risk. The de facto criminalisation of HIV positive individuals is a likely contributor to reduced testing, increased stigma and reduced engagement with primary carers in the health sector and beyond.

These are all essential elements needed to progress the elimination of HIV as a public health problem. As stated, a significant proportion of transmission occurs without the individual being aware of their status, at a time of high viral load. Barriers to early and frequent testing must be overcome through multiple measures, including the removal of s79.

There should be a shift in focus towards education on STI and HIV prevention and management.

20) Should the Act contain a new section setting out the principles that should apply to the management and control of infectious diseases?

The RACP agrees with this proposed amendment as this could present an opportunity to reinforce NSW Health's view of STI prevention and management as a shared responsibility.

3.5(e) Public Health orders

21) Should the current powers for public health orders be extended to include high risk contacts of a person with a Category 4 condition?

The RACP disagrees with this proposed amendment.

In our view, the current provisions in the *Commonwealth Biosecurity Act 2015* provide sufficient powers. The listed diseases are likely to include all diseases posing a substantial risk to the NSW community and would be amended should a serious emerging infectious disease arise. Although this Act is intended to apply at international borders, the powers of Human Biosecurity Officers extend to persons identified after passing through ports of entry.

Recent experience with the Ebola virus has highlighted that the high level of media and political concern can place enormous pressures on public health practitioners, including Chief Health Officers and Chief Human Biosecurity Officers, to apply overly-restrictive quarantine measures on individuals which are not required for public health purposes.

Additional powers for Category 4 conditions in NSW could potentially undermine the rights to liberty and freedom of movement for individuals at risk of such infectious diseases. Legislative change could undermine the willingness of individuals to:

- declare information on entry into the country (specifically international ports in NSW) and
- seek testing or treatment if unwell or otherwise engage with NSW Health regarding their movements and self-monitoring.

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?

We do not agree that this would be required for the reasons outlined in our response to the previous question.

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?

The RACP supports this recommendation. In our view, the existing gap with respect to treatment being available is a significant one. Totally drug-resistant Tuberculosis and other potentially pan-resistant bacteria may both require isolation in very rare and limited scenarios.

24) Should there be greater transparency requirements in the Act relating to public health orders that have been made?

We agree there should be greater transparency in the Act as this would build public confidence and accountability.

The issue of potentially identifying information for very rare diseases should be considered in this. That is, sometimes even the notifiable disease category can be enough to identify an individual. No information should be provided where such information can be linked to someone in enforced isolation.

3.6 Vaccine preventable diseases

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

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

The RACP does not agree with this amendment.

Extending exclusion powers to high school settings could have a greater negative impact on learning, especially at critical times of the year. Outbreak control is most effectively addressed by excluding infectious children and providing vulnerable contacts with post-exposure prophylaxis.

With the extension of the Australian Childhood Immunisation Register (ACIR) to individuals up to 19 years of age, identifying potentially susceptible children should be timely and efficient. School-based vaccination clinics can also be offered in outbreak settings. This is more constructive than exclusions as it actually improves immunisation coverage in the longer term.[2] Exclusion in itself provides no guarantee that a child would get immunised.

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

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 childcare or school, regardless of whether there is an outbreak at the school or childcare the child attends?

We disagree with this amendment.

These circumstances are rare. Constructive engagement is much more likely to be beneficial in terms of the relationship between educational services and the community. Examples of children who are excluded yet later do ***not*** develop illness could be used to argue that such policies and actions are both discriminatory and

[2] Ward, K., Quin, H., Bachelor, M., Byrant, V., Campbell-Lloyd, S., Newbound, A., Skully, M., Webby, R & McIntyre, P.B (2013) Adolescent school-based vaccination in Australia. Communicable Disease Intelligence. Volume 37 (2) E156-167

needless. Such examples could reduce the constructive engagement of parents with educational and childcare settings.

On the contrary, most community members understand the need for exclusion where the outbreak affects the setting in question. The "No Jab, No Pay" legislation is also likely to make such circumstances even more uncommon in the next few years. This makes such proposed changes to the Act appear unnecessarily draconian.

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

The RACP disagrees with this proposal for similar reasons outlined in Q25.

3.6(c) Childcare enrolment requirements

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 childcare?

The RACP does not agree with this proposed amendment.

Preventing children who are unvaccinated due to their parents' conscientious objection from enrolling in childcare would unfairly penalise children and potentially entrench their disadvantage.

In October 2015, the RACP's Paediatrics & Child Health Division (PCHD) issued a submission[3] to the Senate Inquiry into 'No Jab, No Pay' which stated that we do not support routinely denying children or their family's access to social benefits since denying access to these payments has the potential to entrench a child's disadvantage.

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 childcare in NSW?

No comment.

3.7 Public Health Registers

30) Should the Act be amended to clarify that s97 and s98 (Both provisions allow a public health or disease register to be established for certain purposes) does not limit the creation of other registers or databases relating to scheduled medical conditions or notifiable conditions under the Act?

The RACP supports this proposed amendment to s97 and s98.

31) Are any other changes to s97 and s98 required?

No comment.

3.8 Public Health Inquiries

32) Should s106 of the Act (Inquiries into any matter related to public health, or any certain other matters relating to the Act, by the Secretary) 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?

We agree with this amendment. Such powers are in keeping with the powers of Chief Health Officers in other jurisdictions, such as Victoria. These have been used rarely in circumstances where the risk to the public is considered serious, immediate and where more limited actions are considered to be insufficient to control the risk.

---

[3] RACP Paediatrics & Child Health Submission to the Senate Inquiry into 'No Jab, No Pay', *Submission 344*. Available online: http://www.aph.gov.au/DocumentStore.ashx?id=006ce194-7966-43c6-9a0b-8e8debed1b18&subId=405114 [last accessed 12/05/16]

33) If so, what limits, and in what circumstances should such a power be exercised, should there be such a power?

In our opinion, the power should be exercised when:

- the risk is considered serious,
- the impact would be significant (either because a large population is at risk or the consequences could result in death or serious illness); and
- where other actions have failed or been refused or existing interventions are insufficient to control the risk.

3.10 Regulation of the disposal of bodies

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, internment and exhumation, preparation rooms, equipment and apparatus in mortuaries, crematories and cemeteries (where these are unconnected to public health)?

The RACP considers the regulation of the disposal of bodies inappropriate for the Public Health Act 2010. It is our view that these are historical anomalies which have little connection to public health matters.