Health Select Committee
Select Committee Services
Parliament Buildings
WELLINGTON 6160

Dear Sir/Madam

Submission on Health (Protection) Amendment Bill

Thank you for the opportunity for Regional Public Health (RPH) to provide a submission to the Health (Protection) Amendment Bill. RPH would like to be heard at any submissions hearing.

Please refer to Appendix 1 for more information on RPH.

RPH understands that all submissions will be available under the Official Information Act 1982, except if grounds set out under the Act apply.

The primary contact point for this submission is:

Dr Annette Nesdale
Medical Officer of Health
Medical Team
Regional Public Health
Private Bag 31907
Lower Hutt 5040
04 570 9002
RPH@huttvalleydhb.org.nz

EXECUTIVE SUMMARY AND KEY RECOMMENDATIONS

1. This submission from Regional Public Health (RPH) supports the provisions of the Health (Protection) Amendment Bill ("the Bill"). We strongly support that use of powers is proportionate to public health risk, subject to review and used within the context of the New Zealand framework to protect human rights.

2. RPH supports adding HIV infection, gonorrhoeal infection and syphilis to the proposed schedule C, infectious diseases notifiable to medical officers of health without personally identifiable information. RPH recommends that consideration be given to also including chlamydia within this schedule.

3. RPH also recommends that consideration be given to making specified antibiotic resistant bacterial infections notifiable.

4. Contact tracing is a cost-effective way to protect population health and prevent long term complications from infectious disease, and we welcome the prominence it has in the Bill. We consider that service changes will be necessary in order to make best use of the contact tracing provisions identified in the Bill, and we recommend that funds are allocated to support implementation.

5. RPH supports the proposed range of medical officers of health powers that provide a wider scope of options than are currently available to protect public health. RPH recommends that clinicians in sexual health, general practice and infectious disease medicine also be given the ability to issue community-level directions, with support from medical officers of health as necessary.

6. RPH supports repealing the existing tuberculosis legislation and consolidating it in the Bill.

7. RPH supports banning the provision of commercial artificial UV tanning services to people under 18 years of age, and recommends that provision is made for the issuance of infringement notices or compliance orders for non-compliance with this legislation.

Yours sincerely

Peter Gush
Service Manager
Regional Public Health

Dr Jill McKenzie
Clinical Head of Department
Regional Public Health

Introduction

8. New Zealand has a complex arrangement of legislation to protect public health. Communicable disease control provisions in existing legislation do not encompass the range of actions currently indicated as best practice, and offer little flexibility for tailoring responses to individual situations. Regional Public Health (RPH) supports the consolidation of legislation in this area as indicated by the Health (Protection) Amendment Bill ("the Bill"). Prevention and control of infectious disease and inspection of ultraviolet (UV) tanning sites to minimise harm from commercial UV exposure are important parts of the work of RPH.

9. During the preparation of this submission we consulted with the local staff at the Wellington Sexual Health Clinic, the Wellington Regional Plastics, Maxillofacial and Burns Unit at Hutt Hospital, and the Wellington Regional Infectious Disease service.

10. Below are comments and recommendations from RPH on specific elements of this Bill.

Inclusion of HIV, gonorrhoea and syphilis as notifiable conditions

11. Collection of data is central to infectious disease control. New Zealand has a reliable system to collect information on a number of specified infectious diseases that have public health impacts, through compulsory reporting by doctors and diagnostic laboratories. These data inform local-level actions to control disease spread and to detect outbreaks, as well as strategic actions to identify trends, determine risk groups, guide development of programmes and evaluate preventive actions.

12. Sexually-transmitted infections (STIs) are largely excluded from this system. AIDS is notifiable on an anonymous basis, and data on HIV infection collected by an anonymous passive surveillance system. Surveillance data on other STIs are collected from sexual health and family planning clinics, and from some diagnostic laboratories, but the dataset is patchy and incomplete. The ability to investigate and respond to threats such as re-emerging syphilis and gonorrhea and emergence of antibiotic resistant strains is therefore impeded.

13. RPH therefore supports making reporting of gonorrhea, syphilis and HIV compulsory. This change will improve the accuracy and completeness of data collection to help develop policy to prevent and control illness.

14. Consideration will need to be given to point of care and on-site testing provided by organisations such as the NZ AIDS Foundation. Currently these tests are mostly screening tests that require laboratory confirmation. However testing technology is dynamic with advances in test accuracy, specificity and sensitivity. Any legislative changes need to consider these future advances and whether notification needs to be wider than laboratories and doctors.

15. Data on HIV and AIDS are currently compiled by the AIDS Epidemiology Group (AEG), based at the University of Otago. RPH recommends that the implementation of the Bill recognises and incorporates the AEG's systems and experience and does not result in less detailed information.

16. RPH recommends that the Bill also considers making chlamydia a notifiable disease. Research indicates that chlamydia is New Zealand's most common sexually-transmitted infection, and carries considerable risk of harm such as pelvic inflammatory disease and potential loss of fertility.

17. RPH has consulted with the Wellington Sexual Health clinic, where staff identify benefits in making chlamydia notifiable. These include better surveillance data, more involvement of public health services and staff, and more options for managing contact tracing and difficult cases requiring behavioural change. Chlamydia as a notifiable disease would support a broader approach on youth-focused prevention due to the burden of disease falling on young persons. Potentially, there would be a very large number of notifications, and consideration would need to be given to how best to implement this.

18. Making reporting of sexually transmitted infections (STIs) mandatory has caused concern that some patients may be deterred from seeking treatment. RPH supports the provision for anonymised reporting, which along with the ability for clinical staff to be appointed as contact tracers and strict patient confidentiality should allay such fears.

19. Consideration will need to be given to implementation of the proposed anonymous reporting by both community and hospital laboratories. For aggregate data to be useful demographic data such as age, geographical location ethnicity and gender will be needed to identify trends, outbreaks and population groups at higher risk. In addition, automated laboratory reporting is currently based on NHI, and any deviation from this may require manual coding of every notification which would be extremely time consuming and potentially error prone.

20. RPH and the Regional Infectious Disease Service at Wellington Hospital support consideration of specified antibiotic resistant bacterial infections also being notifiable for surveillance purposes (i.e. not for the purposes of contact tracing). Antibiotic resistant organisms such as carbapenem resistant enterobacteriaceae, MRSA (among others) pose significant global and national concerns.

Ability of medical officers of health to issue graduated directions

21. The Bill provides medical officers of health with a wider range of options for public health action to control communicable disease. Existing legislation provides few options other than the most punitive, such as detaining or quarantining persons at risk of spreading communicable disease. As described in the Bill's explanatory statement, a weakness of current legislation is the lack of legislated support for possible actions that could be used to control low-to-moderate risks of disease spread, particularly among persons who could present a risk over a long period.

22. For many communicable diseases, preventing spread of infection requires action by the patient with the infectious illness. This might mean accepting treatment, or changing their behaviour so that others are not placed at risk. Punitive measures, such as detention, are unhelpful in all but the most extreme situations because they are likely to engender a sense of grievance and reduce trust and cooperation with public health authorities.

23. In contrast, measures such as participation in counselling, regular contact with health professionals and support workers, and pharmaceutical treatment form the basis of more workable, sustainable solutions. RPH supports that the Bill provides legislative measures for these options, and by enabling them to be issued as statutory orders the Bill substantiates their importance and will give them greater effect.

24. The Ministry of Health's regulatory impact statement succinctly sums up the current situation as 'detention or nothing.' RPH supports introducing a more graduated range of powers, and agrees that higher-level interventions should require District Court oversight, be time limited and be subject to appeal.

25. This approach is in line with the legal situation in Australia. In 2007, concerned by a lack of a unified national strategy, the Australian Health Ministers' Advisory Council commissioned a national report into the management of people with HIV behaving in a manner likely to harm others. The report recommended that a variety of strategies may be required to manage those who are placing others at risk. The overarching principle was that the least restrictive, community-based strategies should be prioritised, before there is up-scaling of the legal response.[1] These recommendations have been adopted in various forms by Australian state and territory governments.

26. RPH anticipates that higher level orders, such as the provision for 72-hour detention in exceptional cases, will be required extremely infrequently. Community-level directions, such as to undertake counseling, are likely to prevent situations from deteriorating to the point where court action is required, and are likely to result in a better outcome for all involved. It is appropriate that higher level orders are subject to judicial oversight, and are able to be appealed.

27. RPH also supports the formalised process by which medical officers of health may require an educational institution to temporarily close (partially or fully) due to risk of transmission of infectious disease.

28. While welcomed, the ability granted to medical officers of health to give community-level directions is likely to increase the legal and procedural workload for DHBs. In addition, medical officers of health are not routinely part of the clinical teams working with clients that may require community-level direction.

[1] Guide to Australian HIV laws and policies for health professions: management of people with HIV who place others at risk. Australian Society for HIV Medicine. Available at: http://www.ashm.org.au/HIVLegal/Default.asp?PublicationID=2&ParentSectionID=P2&SectionID=341

29. RPH recommends other health professionals, such as general practitioners, sexual health physicians or clinical nurse specialists, should also have the ability to issue community-level directions, in parallel with the scope provided in the legislation for other health professionals to be appointed as contact tracers. These groups may receive this ability directly from the legislation, or through authorisation by a medical officer of health.

30. Enabling clinical health professionals to give community-level directions would create a more seamless process that supports and recognises the expertise of the clinical teams working with patients. Medical officers of health would remain engaged with the work of their clinical colleagues, supporting and assisting with the use of community-level directions in an interdisciplinary manner.

31. We have consulted with Wellington Sexual Health service, where staff are open to their service having the ability to issue community-level directions around behavioural change, as long as clear protocols were in place.

Compulsory co-operation with contact tracers

32. Contact tracing is a key tool for public health in preventing and controlling outbreaks of infectious disease. It is appropriate that it is a prominent feature of this Bill. RPH supports making cooperation with contact tracers compulsory.

33. Respect for privacy is an integral feature of healthcare, and can only be breached in rare circumstances. With regard to contact tracing, a balance needs to be struck between protecting the index case's privacy, and the need to identify other people potentially at risk of an infectious disease. The nature of such illnesses means that there is often time pressure to identify such at-risk people rapidly to prevent disease deterioration and reduce the risk of any subsequent long-term complications and further disease spread.

34. Another key principle of health ethics is respect for patient autonomy. The stigma around infectious disease, especially sexually transmitted infections (STIs), is such that patients may be ashamed and reluctant to inform close contacts. However, this too needs to be balanced against the rights of people who may have been exposed to an infectious disease, and need prophylactic or active treatment.

35. There are two main approaches to contact tracing currently in practice. For diseases notified to medical officers of health, such as tuberculosis, meningococcal disease and measles, public health officials collect information on the contacts of the notified patient. These officials then undertake to locate these contacts, and manage them accordingly. Other health professionals, such as general practitioners, may also support the management of identified contacts.

36. The approach differs for patients identified with a STI. Diagnoses of STIs are usually made by sexual health clinics or general practitioners. The majority of people with a STI are counselled on the need to make contact with their recent sexual partners in order to

inform them of their risk, and patients are provided with advice on how to do this. This process is called partner notification. Health services providing this counseling have little information on the extent to which patients follow these recommendations. The health service may undertake partner notification themselves, on behalf of the patient, if the patient has given consent.

37. In New Zealand, the identity of the patient is never disclosed by contact tracers to potential contacts without permission of the patient. It is important to also recognise the skilled and sensitive way in which contact tracing is carried out, by experienced staff in various disciplines including public health, sexual health and general practice. It should be emphasised that a very small minority of people do not engage voluntarily with contact tracing, which itself is testament to the professional way in which this important process is carried out. This is confirmed with Wellington Sexual Health Services from a STI point of view.

38. Making cooperation with contact tracing mandatory is an innovative step forward. Australia does not have federal or state law that requires cooperation with contact tracers. State health systems in that country leave responsibility for investigating contacts with clinicians making the diagnosis. Assistance can be requested from public health units if required, but to overcome non-cooperation with contact tracers requires the same legal and procedural pathway as for someone with an infectious disease behaving in a reckless or unsafe manner.[2]

39. It makes sense to have a separation of responses when it comes to limiting the spread of infectious disease. There is a clear difference between people displaying high-risk or reckless behavior, and simple good practice in identifying close contacts, and this should be reflected in legislation. Mandating cooperation normalises the process as part of a best practice approach to someone diagnosed with a STI - or any other infectious disease. Providing experienced contact tracers with this legislative backing will further support the identification of contacts at risk.

40. The Bill will strengthen the effectiveness and completeness of STI contact tracing and offers legislative support and recognition of this important and labour-intensive process.

41. RPH wants to clearly state that more resources and financial support are required to carry out contact tracing. Wellington Sexual Health has a health advisor who is 0.6FTE, and part of their position is contact tracing – for the entire Wellington region. In contrast Bristol, a similar sized city to Wellington has four full time contact tracers working in sexual health.

42. Early identification of contacts of infectious disease is cost-effective in preventing the development of active disease and subsequent complications in the wider community such as pelvic inflammatory disease and infertility. It would be a missed opportunity if the authority to contact trace was provided without the means to support the process. This

[2] Guide to Australian HIV laws and policies for health professionals: contact tracing. Australian Society for HIV Medicine. Available at: http://www.ashm.org.au/HIVLegal/Default.asp?publicationID=2&SectionID=338

requires greater investments in employing and training skilled personnel, as well as establishing compatible information technology systems for managing disease surveillance and contact tracing.

Repealing the Tuberculosis Act 1948 and Tuberculosis Regulations 1951

43. One of the Bill's stated purposes is to make 'a number of administrative changes that will streamline legislation.' It is stated that tuberculosis is to be included in the schedule of notifiable diseases, and the Tuberculosis Act 1948 and Tuberculosis Regulations 1951 will be repealed. As mentioned earlier, it is sensible to consolidate health legislation, as there are multiple acts and amendments informing health policy in New Zealand. However, it is important to consider the current tuberculosis legislation in total, to ensure that none of its useful functions are omitted from the legislation that will replace it.

44. The Tuberculosis Act 1948 and Tuberculosis Regulations 1951 give medical officers of health the ability to issue directions, enter properties and, when needed, to isolate infectious persons to prevent community spread. The new powers in the current bill replace these, and are applicable to all infectious diseases.

45. It is important that the provisions under the Eligibility Directions 2011 (clause B23) that provides for the access to funded services for non-residents who have or are suspected to have an infectious or quarantinable disease are retained. New migrants are significantly over-represented in tuberculosis statistics.[3] It is important that treatment cost never becomes a barrier to treatment. For example, some treatment courses may last for up to nine months, and involve multiple medications and prescriptions. Partial or incomplete treatment can create drug resistant tuberculosis – a major issue of global concern.[4] There are similar concerns regarding drug-resistant strains of gonorrhea.[5] We have a national and international responsibility to ensure that tuberculosis and other infectious diseases are treated fully and appropriately.

46. Now that legislation regarding infectious disease is being consolidated, it is worth considering whether primary care visits for other infectious diseases should also be free of charge – especially in cases where patients or their contacts are facing significant financial hardship. This would be likely to increase attendance for examination in general practice, as the utility of contact tracing is severely limited if contacts do not present for examination or treatment.

Prohibiting the use of UV tanning beds for those under 18 years of age

[3] Ministry of Health. 2010. *Guidelines for Tuberculosis Control in New Zealand 2010*. Wellington: Ministry of Health.
[4] World Health Organisation 2014. *Drug Resistant Tuberculosis: Surveillance and Response (Supplement to Global Tuberculosis Report 2014).* Geneva: World Health Organisation.
[5] New Zealand Sexual Health Society 2014. *New Zealand Guideline for the Management of Gonorrhea 2014, and Response to the Threat of Antimicrobial Resistance.* Wellington: NZSHS

47. Prohibiting the provision of commercial artificial UV tanning services to people under 18 years of age is important in reducing the burden of skin cancer in New Zealand. The plastic surgical community and melanoma clinicians have long advocated for restrictions on the use of UV devices, and RPH is in agreement with their call to prohibit UV tanning devices for people of all ages, as has already happened in Australia and Brazil.

48. A clear link has been established between UV exposure and melanoma - including the use of sunbeds in early life. The Wellington Regional Plastics, Maxillofacial and Burns Unit at Hutt Hospital unequivocally states that the combination of cumulative UV exposure and high dose intermittent UV exposure under the age of 18 is considered the principle aetiological factor for melanoma. There is a regional incidence of approximately 300 new cases per year. At a national level, there are approximately 3000 new cases per year, of whom 300 will die. Melanoma is often the highest profile skin cancer, but UV radiation is also implicated in non-melanoma skin cancers. This group of cancers is an increasing health burden with up to 7000 new regional cases per year (50-75000 nationally) and also responsible for approximately 300 annual deaths at a national level.[6]

49. There are currently standards for operators of UV devices in New Zealand - ***AS/NZS 2635:2008 Solaria for Cosmetic Purposes.*** This standard was developed to aid voluntary compliance with practices that would protect public health. Between 2012 and 2014 the Ministry of Health commissioned a series of six monthly visits to premises offering artificial UV tanning services by public health units across New Zealand. It was noted that there has been an increase in the use of warning notices, consent forms and training, but, there has been a decrease in compliance with exclusion of people under 18 years of age, and those with skin Type 1 (skin that burns readily, is often freckled, and never tans – a skin type that is recommended to be excluded from use of UV tanning services).[7]

50. The experience of RPH in the Wellington region reflects this. During RPH visits to premises in July 2014, it was concerning to find that a prominent operator of UV tanning beds was ignoring the recommendations in ***AS/NZS 2635:2008*** and clearly placing clients at risk. This operator had no warning signs at reception or in cubicles, no client consent form, no exclusion of Type 1 clients, no enforcement of the minimum 48 hour interval between sessions, and staff were unaware of how to perform a skin type assessment.[8]

51. The Australian Government prohibited the commercial use of UV tanning devices on 1 January 2015. Concern is raised by the findings of a survey by Consumer NZ. 'Mystery shoppers' visited 60 operators of UV devices in NZ. No operators calibrated their devices

[6] Personal communication January 2015 from Mr Christopher Adams, FRACS. Plastic and Reconstructive Surgeon, Clinical Head of Department, Director. Wellington Regional Plastic, Maxillo-facial and Burns Unit. Hutt Hospital, Lower Hutt, Wellington.
[7] New Zealand Ministry of Health. 2014. *Visits to commercial solaria by DHB Public Health Units between 1 February and 31 July 2014: summary of findings.* Wellington: Ministry of Health.
[8] Mccall T. 2014. *Solaria Report: Regional Public Health – Reporting period ending June 2014.* Wellington: Ministry of Health

and therefore could not be sure of how much UV was being delivered to each client.[9] RPH is concerned that second hand UV devices from Australia may be installed and used without first checking the UV dose rate.

52. From a practical point of view, RPH recommends that the Bill provides for infringement notices or compliance orders as enforcement tools. Relying solely on prosecution is less effective as it is a costly and time consuming process. If premises are not complying with the Act, action should be swift and decisive so as to protect public health and send a message that this issue is taken seriously. The Food Act 2014 and Smokefree Environments Act 1990 have included these provisions, and offer a suitable model framework.

Conclusion

53. This is an important Bill for New Zealand health. It will significantly assist health professionals in limiting the spread of infectious disease, and prevent cases of skin cancer.

54. In conclusion, RPH supports this bill, but recommends that:
    a. consideration be given to also including chlamydia within this schedule;
    b. consideration be given to making specified antibiotic resistant bacterial infections notifiable;
    c. funds are allocated to support implementation of contact tracing;
    d. clinicians in sexual health, general practice and infectious disease medicine also be given the ability to issue community-level directions, with support from medical officers of health as necessary;
    e. the treatment of tuberculosis remains free of charge;
    f. the treatment of infectious disease in non-residents under the Eligibility Directions 2011 (Clause B23) is retained;
    g. consideration be given to free treatment of infectious diseases at primary care level in cases of significant hardship;
    h. provision is made for the issuance of infringement notices or compliance orders for non-compliance with this legislation to ban the provision of commercial UV tanning services to people under 18 years of age.

[9] Consumer New Zealand 2014. Sunbed Compliance Survey 2014. Accessed January 2015 at https://www.consumer.org.nz/articles/sunbeds

APPENDIX ONE

Regional Public Health serves the greater Wellington region, through its three district health boards (DHBs): Capital and Coast, Hutt Valley and Wairarapa and as a service is part of the Hutt Valley District Health Board.

We work with our community to make it a healthier safer place to live. We promote good health, prevent disease, and improve the quality of life for our population, with a particular focus on children, Māori and working with primary care organisations. Our staff includes a range of occupations such as: medical officers of health, public health advisors, health protection officers, public health nurses, and public health analysts.