

# **Review of Health Act 1958**

**Discussion Paper**

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# Foreword

The *Health Act 1958* is a very important piece of Victorian legislation. In simple terms, it is part of a series of responses made by the Victorian Government to protect public health in Victoria in partnership with the community.

The Health Act was first passed last century, although it has been amended on many occasions since then. Most notably in 1988, there was a significant review of the Act which resulted in substantive amendments to it. As a result, it has been well regarded as a modern piece of public health legislation.

However, over the last ten years there have been significant scientific, social and policy changes and it is time to look again at our Health Act to ensure that it remains a modern Act that is sufficiently flexible to support current and future strategies for public health, is accessible and understandable and is consistent with modern legislative thinking. In addition, because the Act has been amended many times over the last few decades, it looks more like a patchwork of largely unrelated ideas than a coherent piece of legislation. Therefore, some consolidation and rationalisation of the provisions in the Act may now be appropriate.

In 1995 the Council of Australian Governments agreed to implement the National Competition Policy based on the recommendations of the National Competition Policy Review Committee chaired by Professor Fred Hilmer. In addition to the broad policy review described above, the Health Act is subject to review under the National Competition Policy. The National Competition Policy represents a commitment by all Australian Governments to a consistent national approach to fostering greater economic efficiency and improving the overall competitiveness of the Australian economy.

This discussion paper raises issues relevant to both the wide ranging policy review of the Health Act and the National Competition Policy review of the Act. Questions are raised for your consideration throughout the paper but you should not feel bound by these. You are quite welcome to give your views on any aspect of the Act and its operation. The discussion paper is intended to encourage robust debate; it does not represent the policy of the Victorian Government, the Department of Human Services, or any other organisation.

I commend the paper to you and encourage you to read it and make submissions, to grant those charged with the responsibility of carrying out these reviews the benefit of your views.



**ROB KNOWLES**  
Minister for Health



# Chapter 1 – Introduction

## 1.1 Background

The Public Health and Development Division of the Victorian Department of Human Services is currently undergoing a period of transition and reform. A new strategic direction is evolving to ensure the protection and promotion of public health and the prevention of disease, injury and disability into the 21st century. The strategic intent of the Public Health and Development Division now is:

With others, to take Victoria into the 21st century with a level of health and well-being on course to compare with the best in the world.<sup>1</sup>

The mission of the Division is:

To protect and promote the health of all Victorians, and strengthen the performance of the health system by providing leadership, support and services, in partnership with key stakeholders and communities.

In line with these changes, the Division wishes to ensure that the Health Act is a modern Act that is sufficiently flexible to support current and future strategies for public health, is accessible and understandable and is consistent with modern legislative thinking.

## 1.2 National Competition Policy

As a result of the agreement of all Australian jurisdictions to enter into the National Competition Policy (NCP), legislation review is firmly on the agenda in all jurisdictions. This includes the Health Act, which is required to be reviewed for restrictions on competition under NCP.<sup>2</sup> This NCP review is being carried out at the same time as the broader policy review described above. A full description of NCP and the way in which the Department of Human Services is meeting its obligation to review the Health Act under this policy can be found in chapter 4.

## 1.3 Previous Reviews of the Health Act

The Health Act has been reviewed on a number of occasions, most notably in 1988 when many necessary changes were made, especially those relating to infectious diseases and more particularly HIV/AIDS. As a result, it has been well regarded as a modern piece of public health legislation. In their publication *Public Health Law in Australia: Its current state and future directions* Bidmeade and Reynolds have stated:

Victoria has quite modern and upgraded public health law. In many ways it presents as a model of 'core' public health practice.<sup>3</sup>

Consequently, the review has been approached with the recognition that we are working with a sound piece of legislation. However, advances in scientific knowledge and shifts in government policy require up-to-date legislative infrastructure to support them. In addition, the Act has been amended many times over the last few decades, which has meant that it looks more like a patchwork of largely unrelated ideas than a coherent piece of legislation. Therefore, some consolidation and rationalisation of the provisions in the Act may now be appropriate. It may also be appropriate to consider, as part of the review process, whether other legislation administered by the Minister for Health should be included within the ambit of the Health Act.

## 1.4 The Purpose of the Discussion Paper

The difficult but very important considerations of what ought to be included in a modern Victorian Health Act must be the subject of considerable thought by the Government in consultation with the people of Victoria. This discussion paper is intended to describe the current operation of the Act, suggest some options and alternatives for the future and stimulate robust debate. **It does not constitute a government policy position.** In some areas broad comments are sought and no options are suggested. The Public Health and Development

1 See the Public Health and Development Division's website at <http://hna.ffh.vic.gov.au/phb>

2 The terms of reference for this review appear in Appendix II.

3 Ian Bidmeade and Chris Reynolds, *Public Health Law in Australia: Its current state and future directions*, Australian Government Publishing Services, Canberra, 1997, p. 37.

Division welcomes any comments which people or organisations may have about the matters raised in this discussion paper or any suggestions as to ways in which the efficiency and effectiveness of the Act might be enhanced. Questions are specifically asked in many sections of the paper but you need not feel constrained by these; all comments are welcome. The questions are designed simply to serve as a stimulus for discussion.

In summary, the purposes of this discussion paper are:

- To invite input on how the present Health Act works for those affected by its operations and other interested parties and any ways in which it may be improved, taking into account, where appropriate, the national context.
- To identify the restrictions on competition which appear in the Health Act 1958, the Health (Infectious Diseases) Regulations 1990, the Health (Prescribed Accommodation) Regulations 1990 and the Health (Pest Control Operators) Regulations 1992 and to seek public comment as to whether:
  - The benefits of those restrictions to the community as a whole outweigh the costs and
  - The objectives of the legislation/ regulations can only be achieved by restricting competition.

## 1.5 Structure of the Discussion Paper

The Health Act deals with a wide range of issues and affects a broad range of people. Where possible, an attempt has been made to group similar provisions together under broad subject headings. These groupings do not always follow the current structure of the Act itself. This has been done to facilitate discussion, and does not necessarily indicate an intention to restructure the Act along the same lines. Appendix I sets out each section of the current Act together with a cross reference to the part or parts of the discussion paper in which they are addressed.

## 1.6 Review Process

The Health Act review is overseen by a Steering Committee which comprises:

Professor John Catford	Director, Public Health and Development Division (Chair)
Ms Jan Norton	General Manager, Public Health and Development Division
Dr William Hart	Chief, Health Intelligence and Disease Control
Dr John Carnie	Deputy Chief, Health Intelligence and Disease Control
Mr Ray Judd	Assistant Director, Social and Environmental Health
Dr Graham Rouch	Chief Health Officer
Mr Ron Tiffen	Regional Director, Grampians Region
Ms Pauline Ireland	Manager, Competition Policy, Acute Health Division
Mr Andrew Stripp	Assistant Director, Mental Health, Aged Community and Mental Health Division

It is carried out by the Legislation Review Team, which reports to the Steering Committee. The Legislation Review Team comprises:

Ms Genevieve Howse	Manager
Mr Timothy Lunn	
Ms Carmel Benham	

Contact arrangements for the Legislation Review Team and further details regarding the consultation arrangements for this review are contained in chapter 12.

The Victorian Government's legislative program is determined by Cabinet in light of many competing priorities. At this stage it is planned that, subject to Cabinet endorsement, any proposals for amendments to the Health Act that occur as a result of this review will be put to Parliament in its spring 1999 sittings. The proposed timetable for this review is as follows:

- Discussion paper released in November 1998
- Responses to discussion paper received no later than **26 February 1999**
- Analysis of responses to discussion paper and consultation with key stakeholders from December 1998 to March 1999
- Report to the Minister for Health on the broad policy review of the Health Act in May 1999
- Report to the Minister for Health in respect of the restrictions on competition which have been identified in May 1999
- Response to that report by the Department of Human Services in May 1999
- Presentation of proposed amendments to Parliament in the spring 1999 sittings.

# Chapter 2 – Background and Policy Context

## 2.1 Introduction

Supporting public health strategies has the potential to reap enormous benefits for Victorians. People will be well aware that substantial government resources are directed into the hospital and acute care stage of the health system. Naturally most Victorians would prefer to prevent illness rather than obtain treatment to help them manage one. Professor Tony McMichael recently made the very obvious point that ‘prevention of disease, wherever achievable, is better (and usually cheaper) than cure’.<sup>4</sup>

This chapter describes how legislation is one of the important mechanisms used to support public health strategies. It also provides some history and explanation of the role of public health and the relationship between public health practice and the law.

## 2.2 What is Public Health?

This is a subject which has generated great discussion and debate, with views emerging that range from the cynical through to the thoughtful and constructive. Mark Twain stated that ‘the only way to keep your health is to eat what you don’t want, drink what you don’t like and do what you druther not’. However, a rather more positive and useful definition of ‘public health’ is that it is the organised response by society to protect and promote health, and to prevent illness, injury and disability.<sup>5</sup> For some people the focus of this response is limited to traditional subjects of regulation such as sanitation and controlling the spread of disease. Others take a broader view of public health. The World Health Organisation has defined health as a ‘state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’.<sup>6</sup> Public health has also been defined as the ‘combination of sciences, skills and beliefs that is directed to the maintenance and improvement of the health of all people’.<sup>7</sup>

Whatever the subject matter of public health regulation should be, it is clear that the focus of public health is the health of populations rather than the treatment of individuals. Public health practice considers the underlying causes of ill health and is committed to preventative strategies which are based on a strong scientific and analytical foundation.

## 2.3 Influences on Public Health

Many determinants influence people’s health, including the environment, social and economic factors and biological and physical factors. Some of these society has been able to influence or control through public health measures or interventions. Significant improvements to public health have occurred in the last 100 years through measures to control cleanliness of air and water and ensure appropriate disposal of waste. The development of immunisations for various diseases has seen the eradication of smallpox and the significant reduction of serious threats to health such as poliomyelitis, diphtheria and tetanus. Research into causes of injury and illness has identified numerous environmental, social and behavioural factors which affect health. These extend from more obvious health related matters such as diet, exercise, smoking, excessive consumption of alcohol and exposure to ultraviolet radiation, through to the benefits of wearing seatbelts and workplace safety arrangements.

## 2.4 What are Public Health Strategies?

Over time, the activities which are the focus of public health interventions change, but strategies which are used to achieve good public health outcomes have remained relatively constant. These strategies, broadly speaking, have been health protection, prevention of disease and health education and promotion. Underpinning these strategies is the use of epidemiological analysis to

4 Tony McMichael, Professor of Epidemiology, London School of Hygiene and Tropical Medicine, London, *Public Health Research, A Continuing Need*, Public Health Education and Research Program Network Newsletter, July 1998.

5 Definition of public health in the Memorandum of Understanding signed by all jurisdictions to establish a National Public Health Partnership for Australia. This memorandum can be seen at <http://hna.fh.vic.gov.au/nphp/mou.htm>

6 Declaration of Alma-Ata, International Conference of Primary Health Care, Alma-Ata, USSR, September 1978 (see the World Health Organisation’s website at <http://www.who.int/hpr/hep/conference>).

7 J Last (ed.), *Public Health and Preventive Medicine*, Appleton Century Crofts, Norwalk, 12th ed, 1986, p. 3.

understand disease and trends in health as well as research. This analysis and research is often multidisciplinary, since it is recognised that many factors influence our state of health and well-being.

### **Health Protection**

Health protection relates primarily to the regulation of particular activities to protect public health. Legislation aimed at protecting public health also provides for government intervention where it is necessary to limit or prevent the spread of disease. Examples include legislation to ensure clean air and water, regulation to control the spread of infectious diseases and regulation of potentially dangerous elements such as drugs and radiation.

### **Prevention of Disease**

Action aimed at prevention of illness acknowledges the fact that disease develops along a continuum, and that in many cases medical interventions can be made which prevent the onset of disease, halt the progress of disease or aid in recovery or rehabilitation from disease. Preventative measures are classified into three groups depending on the stage at which intervention occurs. Primary prevention aims to prevent the disease altogether and includes health measures such as immunisation programs. Secondary prevention involves early intervention before the development of the disease, and includes screening programs such as those for breast or cervical cancer. Tertiary prevention seeks to minimise the impact of a developed disease.

### **Health Education and Promotion**

Health education and promotion is a more recent strategy which focuses on providing information about disease, and attempts to influence people towards a healthier lifestyle. As more people understand the risk factors associated with disease, there is increased capacity for people to take control over their own health outcomes. For example, many Victorians will recall the health promotion messages about skin cancer from the Anti-Cancer Council, stopping smoking from Quit Victoria and dietary advice from the National Heart Foundation. Recent public health education messages have included safe food handling to prevent salmonella and increased folate intake for pregnant women.

## **2.5 Legislation as a Tool to Support Public Health Strategies**

Part of the organised response to public health concerns is the implementation of legislative mechanisms to support public health strategies. It is the view of the Public Health and Development Division that legislation can be a very powerful tool to facilitate public health strategies for the protection and promotion of public health and the prevention of illness, injury and disability.

Indeed, ever since the English *Public Health Act 1848*, which required adequate standards of sanitation in response to the high rates of death and illness in the rapidly expanding urban populations of that country, there has always been a very close relationship between public health and legislation. The first 'public health' Act (in the sense of it being an environmental health Act) in Australia was passed in Victoria in 1854. The many amendments to Australian public health laws since their inception suggest that there has been an ongoing recognition of the value of law in public health practice.

Health promotion and many health education and protection strategies can be undertaken in the absence of a supporting legislative framework. Legislation, however, is always necessary where individuals are required to behave in a certain manner for the benefit of the community at large. For example, if society decides that waste must be disposed of in a certain manner, that certain premises should be registered or that certain activities can only be undertaken with a licence, it needs to pass a law making this clear. More particularly, interventions which interfere with people's rights, such as those which allow for the detention or isolation of a person with an infectious disease who may present a risk to the community, can only be achieved through legislation.

Over the history of legislation in the public health area, innovations have often been challenged rather than welcomed. Dr Chris Reynolds wrote in a recent article that:

Public health laws are by their very structure controversial and will never be free of criticism. They engage and often challenge a range of other social values, particularly those that support the right to be left alone or call for less regulation.<sup>8</sup>

Rights and responsibilities in legislation must be thoughtfully balanced in this sensitive area. There is a legitimate public expectation that the Government will be vigilant in its care of public health and will take measures to protect it. The very difficult and vexed questions when legislating for public health are the point at which Government should intervene, how it should intervene, the extent to which it should intervene and the best balance between individual rights and community interests and expectations.

History has shown that interventions which interfere with people's rights have often been counter-productive to good public health outcomes. Increasingly it is apparent that people who suffer discrimination or who are economically, socially, or culturally disadvantaged have a lower quality of health. Statistical comparisons of health status between different groups illustrate this point. Interventions which override people's rights should be a last resort, with clear preference given to other public health measures. Where obligations are imposed or people's rights interfered with, the legislation also needs to include proper safeguards on the exercise of power and ensure rights of appeal where appropriate.

## 2.6 Scope, Objects and Name of the Health Act

There is a wide variety of legislation which governs public health. One of the primary pieces of Victorian legislation covering public health matters is the Health Act 1958. It is in many ways an overarching piece of legislation, in that it governs much of the administrative arrangements for how public health services are delivered, as well as regulating some specific public health issues. These administrative matters and specific public health issues are discussed in the following chapters, and some areas of possible amendment are explored.

## The Scope of the Act

It may be appropriate to consider as part of the review process whether there are any other legislative provisions administered by the Minister for Health which more properly fit within the Health Act. Examples include the *Tobacco Act 1987* which contains provisions which prohibit certain sales or promotion of tobacco products. It may be that these provisions fit better into the Health Act which serves to protect the public health of Victorians. Consideration could also be given to incorporating other Acts or parts of Acts into the Health Act such as the *Cancer Act 1958* which governs reporting of cancer and establishes the Anti-Cancer Council. In considering the matters raised in this discussion paper, you may have views on other legislative provisions which could be considered for inclusion as part of the Health Act.

*The review seeks your comments on the scope of the Health Act and whether there are matters which are currently dealt with by other legislation which may more properly be included within this Act.*

## The Objects of the Act

Before considering each of the areas which are currently regulated in the Health Act, perhaps some thought should also be given to whether there are any overarching principles which should govern the way in which matters affecting public health should be addressed, and whether they should be included in a separate provision of the Act.

Generally, a provision explaining the objects of an Act gives meaning to the rest of that Act. An objects provision provides a statement of principles or aspirations on which the legislation is based, thereby enabling Parliament proactively to state a philosophical position. It provides a clear signal to courts, administrators and the public about the interpretation which should be given to the rest of the Act.

Objects were inserted into the Health Act as a result of the 1988 review, but these have never been proclaimed. The objects that were inserted at that time as section 5A stated as follows:

<sup>8</sup> Dr Chris Reynolds, *Ideas and Arguments about Public Health Law*, a paper commissioned by the Legislation Reform Working Group of the National Public Health Partnership, to be published as part of that group's *Legislators' Toolkit* in March 1999.

The objects of this Act are—

- (a) to ensure equity in health; and
- (b) to help people live as full a life as possible no matter what their pre-existing level of health; and
- (c) to reduce the incidence of disease, disability, distress and symptoms of ill health; and
- (d) to reduce the incidence of untimely death.

In the 1978 Declaration of Alma-Ata,<sup>9</sup> the World Health Organisation reaffirmed that health is a fundamental human right and that people have the right and duty to participate individually and collectively in the planning and implementation of their health care. The conference stated that inequality in health status is politically, socially and economically unacceptable and that therefore Governments, along with other sectors, should work together to the attainment of the highest possible levels of health.

This was followed and developed in the 1986 Ottawa Charter,<sup>10</sup> which contains a commitment to health promotion and adopted the following strategies:

- Build healthy public policy which recognise that health promotion goes beyond health care and combines various measures to achieve healthier outcomes. Decisions of policy makers across all sectors may have health related consequences.
- Create supportive environments which recognise that health cannot be separated from other goals. The inextricable links between people and their environment constitute the basis for a socioecological approach to health. Health promotion focuses on achieving equity in health.
- Strengthen community action in the setting of priorities, making decisions, planning strategies and implementing them to achieve better health. Empowering communities requires access to information.
- Develop personal skills through the provision of information, education for health and enhancing life skills to enable people to exercise more control over their own health and environment

and to make choices conducive to health.

- Re-orient health services in recognition that the responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and Governments. They must work together towards a health care system which contributes to the pursuit of health.

The Jakarta Declaration<sup>11</sup> extended the principles of the Ottawa Charter and developed the following priorities:

- Promotion of social responsibility for health
- Increased investments for health development
- Consolidation and expansion of partnerships for health
- Increased community capacity and empowerment of the individual
- Securing of an infrastructure for health promotion.

Following consideration of the World Health Organisation's discussion of public health priorities as outlined above, the definitions of public health discussed earlier in this chapter and the subject matter of the rest of this discussion paper, what are your views regarding objects in the Health Act?

*The review seeks your comments on whether the Health Act should contain a provision specifying its objects and if so, what should be included in that provision.*

## The Name of the Act

The Health Act contains very wide ranging provisions which are each in their own area aimed at protecting or promoting public health. There have been many amendments made to the Act since it was first passed. Does the name 'Health Act' adequately reflect the role and purpose of the Act as it is now or is intended to be in the future? Would it be more appropriate to call it something such as 'Public Health Act', as it is in New South Wales, the Australian Capital Territory and Tasmania, or

9 International Conference of Primary Health Care, Alma-Ata, USSR, September 1978 (see the World Health Organisation's website at <http://www.who.int/hpr/hep/conference>).

10 See the World Health Organisation's website at <http://www.who.int/hpr/hep/conference>

11 *ibid.*

'Population Health Act', as proposed by  
Queensland?<sup>12</sup>

*The review seeks your comments on whether the  
Health Act should have a different name and if so,  
what that name should be.*

---

12 Queensland Health, *Draft Policy Paper on Review of the Health Act 1937*, February 1998.

# Chapter 3 – Intersectorial Relationships

## 3.1 Introduction

Using the definition of public health as the organised response by society to protect and promote health, and to prevent illness, injury and disability,<sup>13</sup> the question which immediately springs to mind is in what way is it organised? In addition to State Government departments such as the Department of Human Services, there are in fact many players involved in the delivery of such health outcomes, all using to some extent the three strategies discussed in chapter 2 of health promotion, disease prevention and health protection.

One vitally important provider of public health services is local government, which plays a crucial role at the 'coalface' in carrying out operational activities to protect and promote public health. The Health Act regulates the relationship between local and State governments and sets out the roles and responsibilities of each. It is very important that these are clearly defined and support good public health outcomes for all Victorians.

The Commonwealth Government and the other State Governments are facing the same kinds of issues as those raised in this paper. Public health concerns do not stop at State and Territory borders where the laws stop. It is recognised that there are opportunities to work cooperatively with our neighbours across those borders to advance public health.

There is also an increasing amount of legislation which deals with fundamental health issues but which is administered by departments other than traditional health departments. Examples include legislation dealing with environmental health, occupational health and safety and the meat and dairy industries.

Finally, there are a large number of community based organisations which have a very important

role to play in developing and implementing beneficial public health strategies. We need to ensure that the Health Act facilitates this valuable work as much as possible.

This chapter discusses the role of the Secretary to the Department of Human Services and others involved in the delivery of public health services and considers how intersectorial cooperation in public health matters might be improved.

## 3.2 Functions of the Secretary

As a starting point, consideration must be given to the functions of the Secretary.<sup>14</sup> The Secretary has the primary responsibility for administration of the Health Act and has numerous powers under the Act. A specific provision which outlines the Secretary's role was inserted into the Act at the same time as objects were inserted, but it has also never been proclaimed. That provision is as follows:

### 5B. Functions of the Chief General Manager

The functions of the Chief General Manager under this Act are as follows—

- (a) To promote independent research into—
  - (i) the nature, scale and causes of disease; and
  - (ii) the effectiveness of various interventions; and
  - (iii) the nature of the population most likely to benefit by the intervention—and to determine priorities accordingly;
- (b) to analyse the health impact of a broad range of current and proposed public policies, conveying this information in useful ways to policy makers, the public and the media to promote informed debate;
- (c) to plan for changing social conditions, explore the possible consequences for people's health and propose appropriate policy options;
- (d) to equip individuals and local communities to take responsibility for their own health;

13 Definition of public health in the Memorandum of Understanding signed by all jurisdictions to establish a National Public Health Partnership for Australia. This memorandum can be seen at <http://hna.fh.vic.gov.au/nphp/mou.htm>

14 There may be some confusion on reading the Act and seeing numerous references to the position of Chief General Manager. In fact, the most senior position in the Department of Human Services is now termed 'the Secretary'. This is reflected in the definition section of the Act which states that the term 'Chief General Manager' means the Secretary to the Department of Health and Community Services, unless acting as a body corporate. The Department of Health and Community Services became the Department of Human Services in 1996. That change of name came about via administrative arrangements. This discussion paper will refer to the 'Secretary' rather than to the 'Chief General Manager'.

- (e) to develop and enforce up-to-date public health standards and intervene if the health of the community is threatened;
- (f) to monitor the activities of, and to assist, other agencies which have an impact on public health and, if necessary, advocate on behalf of the Victorian public for the adoption and enforcement by those agencies of appropriate standards.

The Secretary also has responsibility for all the other health legislation administered by the Department of Human Services, and to a great extent is responsible at the State level for liaison with other tiers of Government to facilitate effective health outcomes. The functions listed above would be relevant not only in respect of the Health Act but also the other public health legislation administered by the Secretary.

*The review seeks your comments on whether the functions of the Secretary should be included in the Health Act and if so what those functions should be. Are the functions as stated above still appropriate?*

Also at a State level, the issue arises of the need for coordination and cooperation across Government and portfolios. Many government agencies administer legislation which regulates activities which may impact on the health of the public. For example, the Department of Natural Resources and Environment has direct involvement with the meat and dairy industries, control of use of agricultural chemicals and regulation of matters such as pollution. Formal and informal links exist between the Department of Human Services and these other government agencies which minimise and alleviate problems where there is overlap or intersection of responsibility.

Do these mechanisms need to be enhanced in any way and, in particular, should the Health Act vest the Minister or the Secretary with any formal role with respect to activities which may have a negative impact on the public health? For example, if a provision specifying the functions of the Secretary is to be included in the Health Act, should those functions include a general function of protecting the public health?

*The review seeks your comments on whether any new statutory mechanisms are desirable to enhance public health outcomes by ensuring that public health issues are addressed proactively and in a timely fashion in relation to all decision making processes which have the potential to impact on health.*

*Your comments are also sought on how such mechanisms could be integrated with existing statutory processes.*

### 3.3 Local Councils

There is a longstanding partnership between State and local government in the administration of health legislation. Local government has always been the front line of operational activities in traditional public health matters, with the Department of Human Services having primarily a policy and advisory role involving superintendence of the legislative framework.

Section 29A of the Act states that it is the function of every council to seek to prevent diseases, prolong life and promote public health through organised programs including prevention and control of environmental health dangers, diseases and health problems of particularly vulnerable population groups. This is to be achieved by a range of measures specified in the Act. These are:

- Isolating the special factors affecting the health of people within the municipal district
- Developing and enforcing up-to-date public health standards and intervening if the health of people within the municipal district is affected
- Monitoring the activities of, and assisting other agencies whose work has an impact on public health and, if necessary, advocating on behalf of the people within the municipal district for adoption and enforcement by those agencies of appropriate standards
- Coordinating the immunisation of children living or being educated within the municipal district and
- Ensuring that the municipal district is maintained in a clean and sanitary condition.

Councils are subject to the special powers of the Secretary and are obliged to report to the Secretary in an annual report. There is a special power for the

Secretary in an emergency or sudden necessity to order the council to perform any duties or to carry out any of the functions of the council.

Councils are required to ensure that these things occur within their municipal district but are not necessarily required to perform these functions themselves. They are required under the Act to appoint a medical officer of health, who must be a registered medical practitioner, and one or more environmental health officers, who must be eligible to be members of the Australian Institute of Environmental Health. Medical officers and environmental health officers can be shared between councils. Medical officers of health provide advice and assistance to councils and the Secretary on health related matters. Environmental health officers perform many of the functions of authorised officers under the Act but an authorised officer does not have to be an environmental health officer.

Other parts of this discussion paper also deal with local government where its functions and powers specifically relate to the subject matter under discussion.

*The review seeks comments on whether these provisions adequately reflect the role of local councils now and into the 21st century. The review also seeks comment on the role of medical officers of health and environmental health officers.*

### 3.4 Municipal Health Plans

One of the functions of councils is the preparation of municipal health plans every three years in consultation with the Secretary. These plans must be reviewed annually and must:

- Identify and assess public health dangers affecting the municipal district and
- Outline the programs and strategies which the council intends to pursue to prevent or minimise those dangers and enable people living within the district to achieve maximum well-being.

The plan must provide for periodic evaluation of programs and strategies.

The requirement for municipal health plans was inserted into the Act as a result of the 1988

amendments and provides a mechanism for proactive public health practice. The Act does not at present require community participation in the development of municipal health plans. There is no provision for municipalities to create joint plans in areas of mutual concern. All of these matters may be sufficiently addressed by ordinary council processes, or you may consider that there is room to expand the provisions relating to municipal health plans.

*The review seeks your comments on the operation of municipal health plans.*

### 3.5 National Issues

There is a significant amount of work relating to public health which is done at the national level. The Department of Human Services has important links with other States and the Commonwealth. Regular meetings of Health Ministers (through the Australian Health Ministers Conference) and of the heads of their Departments provide mechanisms for consultation and coordination on a wide range of public health issues. Victoria is also a member of the Australian Health Ministers' Advisory Council and participates in a number of its sub-committees.

Victoria also participates in other national bodies and through those has the opportunity to influence national policies, programs and standards. One example is the National Public Health Partnership (NPHP), and in particular its Legislation Reform Working Group (LRWG) which concentrates on public health legislation and laws affecting public health. The NPHP was established in October 1996 by Australian Health Ministers from all jurisdictions. Its broad objectives, formalised in a joint Memorandum of Understanding, are to:

- Improve collaboration between stakeholders in the national public health effort
- Achieve better coordination and sustainability of public health strategies and
- Strengthen public health infrastructure and response capacity.

The LRWG was established by the NPHP in order to capitalise on the momentum for public health legislation reform established as the result of concurrent legislative reform initiatives being undertaken by the Council of Australian Governments, and in particular the National Competition Policy. It provides a forum for jurisdictions to share information regarding public health law and to identify and develop best practice legislative solutions, with a view to the modernisation and harmonisation of public health law across Australia.

Particular elements of the LRWG's work plan which may assist in the review of the Victorian Health Act include:

- Finalisation of a book being prepared for the LRWG which will discuss a range of issues relevant to public health legislation.<sup>15</sup>
- Development of model best practice legislative solutions in relation to:
  - The notification of disease and the response to infected persons
  - Cross border management of the risk of infectious diseases
  - Immunisation of children against vaccine preventable diseases.
- An analysis of the issue of confidentiality and privacy in respect of public health legislation which will include model best practice legislative provisions if appropriate.

Other national bodies with which Victoria is involved include the National Environmental Health Forum, the National Health Information Management Group, the Communicable Disease Network of Australia and New Zealand, the National Health and Medical Research Council and the Australian and New Zealand Food Authority Advisory Committee.

Legislation both generally and in the health portfolio provides opportunity for the adoption of various nationally and internationally recognised standards. Adoption of these standards in the Victorian Health Act would facilitate uniform

national approaches to public health regulation. The establishment of the LRWG is a recognition of the fact that in many health matters there is scope for greater consistency of legislation and regulation across Australia.

Where appropriate in this discussion paper, reference is made to work that is occurring at a national level and consideration given to its possible application in Victoria.

### 3.6 Community Sector

The chapter so far has dealt with the role of Government in the advancement and protection of public health. There are, however, also many non-government organisations which are involved in matters affecting public health and have a strong commitment to public health issues and policy.

Although the Act does not currently give any formal recognition to the role of these organisations, there are many avenues for liaison between the government and non-government sectors. The Victorian Government considers partnership with the community in the area of public health to be very important and values the high level of cooperation between government and non-government organisations in the delivery of public health services.

*The review seeks your comments on whether there is a way in which the role and responsibilities of community organisations involved in public health can be enhanced by legislation.*

*Is there any way in which the Health Act could be amended to enhance community consultation on matters affecting public health?*

<sup>15</sup> This publication will build on the survey of public health law in Australia performed by Bidmeade and Reynolds which is referred to in footnote 3. For further information contact the LRWG Secretariat, Mr. Scott Harlum, at Queensland Health, GPO Box 48, Brisbane QLD 4001 or via email at harlums@health.qld.gov.au

# Chapter 4 – National Competition Policy

## 4.1 Introduction

In 1995 the Council of Australian Governments (COAG) agreed to implement the National Competition Policy (NCP) based on the recommendations of the National Competition Policy Review Committee chaired by Professor Fred Hilmer.<sup>16</sup>

NCP represents a commitment by all Australian Governments to a consistent national approach to fostering greater economic efficiency and improving the overall competitiveness of the Australian economy.

## 4.2 How NCP is Given Effect

NCP is being given effect through the implementation of three intergovernmental agreements signed by COAG in April 1995, namely:

- The *Conduct Code Agreement*, which committed Governments to the application of uniform competition laws.
- The *Competition Principles Agreement*, which established consistent principles governing pro-competitive reform of government business enterprise and government regulation.
- The *Agreement to Implement National Competition Policy and Related Reforms*, which incorporated a timetable for reform and a commitment by the Commonwealth to make additional general purpose payments to the States conditional upon compliance with the agreed reform agenda and timetable.

## 4.3 Competition Principles Agreement

As part of the *Competition Principles Agreement*, all Governments agreed to adopt the following **guiding legislative principle**:

Legislation should not restrict competition unless it can be demonstrated that:

- The benefits of the restriction to the community as a whole outweigh the costs  
**and**
- The objectives of the legislation **can only** be achieved by restricting competition.

To give effect to this principle, Governments have agreed to:

- Review and, where appropriate, reform all existing legislative restrictions on competition against the guiding legislative principle  
**and**
- Ensure that all new legislative proposals are assessed against this principle.

The *Competition Principles Agreement* provides that in assessing the costs and benefits of a restriction on competition, the following matters, where relevant, are to be taken into account:

- Government legislation and policies relating to ecologically sustainable development
- Social welfare and equity considerations, including community service obligations
- Government legislation and policies relating to matters such as occupational health and safety, industrial relations and access and equity
- Economic and regional development, including employment and investment growth
- The interests of consumers generally or of a class of consumers
- The competitiveness of Australian business  
**and**
- The efficient allocation of resources.

The *Competition Principles Agreement* also requires that legislation reviews consider the following:

- The objectives of the legislation
- The nature of the restriction on competition
- The likely effect of the restriction on competition and on the economy generally
- The costs and benefits of the restriction and their balance  
**and**
- Alternative means for achieving the same result, including non-legislative approaches.

## 4.4 NCP Purpose and Philosophy

The purpose of the guiding legislative principle is to critically assess whether restrictions on competition are necessary to achieving the objectives of the legislation in which they appear. As is stated in the

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16 *National Competition Policy: Report by the Independent Committee of Inquiry*, Australian Government Publishing Service, Canberra, 1993.

Victorian Government's *Guidelines for the Review of Legislative Restrictions on Competition*.<sup>17</sup>

These [restrictions] typically evolved to serve wider public policy objectives, including protection of the consumer, the environment or the wider public from unscrupulous, unsafe or environmentally destructive practices, processes or products. The guiding legislative principle established under the *Competition Principles Agreement* does not imply that competition objectives should take precedence over these important policy objectives. However, the form which regulation takes often creates unwarranted barriers to entry to relevant markets, limiting consumer choice, stifling innovation and generating monopoly rents for existing producers which result in higher prices to consumers.

Application of the guiding legislative principle is intended to establish whether particular restrictions on competition remain necessary to the achievement of specific public policy objectives through a rigorous assessment of the benefits to the public of each restriction compared with the costs involved, and assessment of non-regulatory alternatives.

The general proposition underlying these reviews is that open and unrestricted competition in markets is generally the most efficient method of allocating the community's resources, and that the benefits of a restriction on competition will generally only outweigh the costs in situations of 'market failure'. Therefore, intervention in markets should generally be restricted to those situations.

## 4.5 Application of NCP to the Health Act<sup>18</sup>

Some public health legislation intervenes in the operation of markets or otherwise involves the imposition of costs on society in order to safeguard public health. It is a principal function of public health law to help ensure that society avoids the significant human and economic costs that would result from market failure in the delivery of the goods and services necessary to safeguard, maintain and improve public health. Therefore, there may be

times when legislation intervenes in the operation of markets or otherwise imposes costs on society in order to safeguard public health.

Most commonly, market failure arises in the presence of one or more of the following:

- **public goods** – where goods would not be provided if left to the free operation of the market
- **externalities** – where an activity or a transaction confers benefits or imposes costs on people who are not involved in it
- **natural monopolies** – where it is open to a firm to abuse its market power
- **information asymmetries** – where the seller of a good or service has more knowledge about it than the buyer, meaning that buyers are unable to adequately protect themselves during the transaction or incur unacceptably high costs in finding a suitable provider.

Most of the restrictions on competition in the Health Act and Regulations made under it involve some form of licensing or registration system. The perceived market failure which those systems are intended to address are the costs which the relevant activity or transaction may impose on third parties (negative externalities) and the knowledge disparity between sellers and buyers of the relevant service (information asymmetries). Examples of negative externalities which the Health Act aims to prevent include exposure of the general public to harmful amounts of pesticide and radiation and the spread throughout the community of infectious disease. Examples of information asymmetries which it aims to address are the differing levels of knowledge about pesticides and radiation use between the people who apply them and the general public.

Some of the costs of these licensing and registration systems may include:

- Restrictions on entry which reduce the number of potential providers and weaken competition to the detriment of consumers
- Requirements for licensed or registered providers to satisfy a minimum level of expertise which restricts the supply of services and raises their prices

<sup>17</sup> Victorian Department of Premier and Cabinet, 1996, p. 29 (available from Information Victoria, telephone 1300 366 356).

<sup>18</sup> The *Legislators' Toolkit*, which will be published by the Legislation Reform Working Group of the National Public Health Partnership in May 1999, will contain a chapter on the application of NCP to public health legislation.

- Administrative costs to Government in establishing and running the licensing or registration scheme which may result, if costs are recouped through licence or registration fees, in higher prices to consumers.

Some of the benefits of those systems may include:

- A generalised assurance of service quality
- Lower transaction costs
- Facilitation of mutually beneficial transactions
- Enhanced consumer confidence
- Reduction of opportunistic behaviour
- Reduction of costs to people not involved in the relevant activity or transaction.

All of the restrictions on competition which appear in the Health Act, the Health (Infectious Diseases) Regulations 1990, the Health (Prescribed Accommodation) Regulations 1990 and the Health (Pest Control Operators) Regulations 1992 and some alternative ways in which the objectives of those pieces of legislation might be achieved are identified in this discussion paper. Those restrictions and the chapters in which they are discussed are as follows:

- The licensing system for people (except medical radiation technologists) who deal with radiation apparatus and radioactive substances – **chapter 6**
- The registration system for medical radiation technologists – **chapter 6**
- The registration system for pest control businesses – **chapter 7**
- The licensing system for people who apply pesticides in the course of those businesses – **chapter 7**
- The registration system for hairdressers, beauty parlours or other similar businesses and premises where the business conducted involves skin penetration procedures such as tattooing, ear piercing or acupuncture – **chapter 8**
- The registration system for prescribed accommodation, which includes residential accommodation, hotels and motels, hostels, student dormitories and holiday camps – **chapter 8**
- The qualification requirements for a person providing information regarding a HIV positive test – **chapter 8**
- The limitation on the laboratories which can test for HIV to those which are prescribed – **chapter 8**.

Some less restrictive alternatives to the registration and licensing systems referred to above may include:

- Negative registration/licensing, in which there is no restriction on the right to provide a particular service, but people who can be shown to have done so unsafely have that right removed.
- A scheme in which there is no restriction on the right to provide a particular service, but only registered or licensed people can use a certain title.
- Co-regulation, in which people are required to be part of a relevant professional association to which the regulatory powers of Government have been delegated.
- A certification scheme which requires people to inform a central authority of their educational qualifications and previous experience in the relevant industry without a requirement for any minimum standards as a precondition of practice.
- Recognition of appropriate competencies as an industry credential under vocational education and training schemes.
- A requirement on people to give certain information to clients about the potential health consequences of the service they are providing.
- Self-regulation, perhaps assisted by an industry developed code of conduct.
- Reliance upon the existing law to enforce appropriate health standards.
- A public information campaign about the service that is being provided.

Note also that even if an occupational licensing or registration system is adopted, some criteria may be more restrictive than others. For instance, a scheme which requires that people hold a prescribed qualification before they can be licensed or registered is more restrictive than a scheme which only requires that they be able to demonstrate certain competencies.

The way in which these alternatives might operate in relation to some of the restrictions on competition which have been identified is discussed further in the chapters which analyse those restrictions.<sup>19</sup>

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19 See also *Regulatory Alternatives*, Office of Regulatory Reform, Victorian Department of State Development.

## 4.6 Methodology for the NCP Review of the Health Act and Regulations

The Terms of Reference for the NCP Review of the Health Act and the Regulations made under it appear in Appendix II. That review will be conducted in accordance with the Victorian Government's *Guidelines for the Review of Legislative Restrictions on Competition*. Those Guidelines suggest a four step approach to the review of legislation for NCP purposes. These are as follows:

**Step 1:** Describe the industry as it currently exists and the existing or proposed legislative framework.

**Step 2:** Identify the restrictions on competition in the existing or proposed legislation.

**Step 3:** Show that the restriction is necessary to achieve the objective which the legislation is attempting or will attempt to achieve. This involves:

- Stating the objectives of the legislation or proposed legislation
- Showing why the restriction on competition is necessary in order for that objective to be achieved and
- Demonstrating that there are no alternative means of achieving that objective which do not involve a restriction on competition, or at least which involve a lesser degree of restriction on competition.

**Step 4:** Assess the costs and benefits to the community of the restriction on competition. This involves:

- Identifying who is affected by the restriction on competition
- Identifying likely effects of the proposed restriction on the economy
- Assessing the costs of the restriction to the community as a whole
- Assessing the benefits of the restriction to the community as a whole and
- Analysing whether the benefits outweigh the costs to the community as a whole.

As stated in chapter 1, the report on this NCP review will be presented to the Minister for Health in May 1999. It is intended that any amendments to

the Health Act which are proposed as a result of that report will be presented to Parliament in the spring 1999 sittings together with any amendments which result from the broader policy review.

# Chapter 5 – Public and Environmental Health

## 5.1 Introduction

This chapter considers the relationship between public health and the environment and specifically looks at a number of provisions in the Act which deal with what might broadly be defined as environmental health. It also discusses ways in which the Act presently addresses public health risks in general and suggests some options for change in that area. Finally, the chapter discusses the regulation of some particular public health issues, namely drugs and meat supervision.

## 5.2 The Relationship Between the Environment and Public Health

There is a growing understanding that good health and well-being are linked with the state of the environment. People need protection from hazards in their environment that pose a risk to their health. There is a growing public appreciation of the impact of human lifestyles, consumption patterns and settlements on the state of the environment, and recognition that environmental degradation and overload may lead to new hazards and diseases. The concept of environmental health, with its focus on hazard identification, risk assessment and risk management is critical in public health efforts to prevent illness.<sup>20</sup>

Many other policy statements regarding both public health and the environment recognise the interrelationship between the two and the significant contribution of the environment to people's health. For example, the World Health Organisation has stated that:

Healthy environments and healthy populations are interdependent. Ensuring that public health will not be adversely affected by environmental degradation and urban development requires more than simply preventing or countering the problems of

environmental pollution (chemical, physical and biological); it also involves the promotion of health through improved housing, living, working and public environments.<sup>21</sup>

The Ottawa Charter made the point that '[t]he inextricable links between people and their environment constitute the basis for a socioecological approach to health'.<sup>22</sup> The Commonwealth Government's National Strategy on Environmentally Sustainable Development describes the need to 'establish an effective, cooperative and holistic approach to public health, which is based on a sound knowledge of environmental and health problems, their causes and the best means by which they can be resolved, and includes a focus on health and human and natural environments, and on the interrelationships and interactions which sustain or threaten them'.

It can be seen that public health and the environment are inextricably connected. Historically, that is how they were treated. In fact, the first public health legislation in Victoria was to a large extent a piece of environmental legislation, in that it related to matters such as management of drains, sanitation, abatement of nuisances and seizure of unwholesome food. However, in the last 30 or so years they have begun to be seen as quite distinct and different. The development and strengthening of specific environmental protection legislation has been an important development and remains so. The issue that this raises, however, is how the interface and overlap between these two areas should be managed.

In their report *Public Health Law in Australia: Its current state and future directions* Bidmeade and Reynolds explore the link between public health and environment protection and suggest that administrative and operational links between them should be explored and developed.<sup>23</sup>

20 National Environmental Health Forum and National Public Health Partnership, *Environmental Health in Australia: Towards a National Strategy*, Commonwealth Department of Health and Family Services, Canberra, September 1998, p. 1. This paper is available from the Commonwealth Department of Health and Family Services, telephone (02) 6289 5767, and can be seen on that Department's website at <http://www.health.gov.au/pubhlth/strateg/envhlth/drstrat/>

21 World Health Organisation, *Our Planet, Our Health* (Draft Document), Second Meeting of the WHO Commission on Health and Environment, Geneva, 1991.

22 See the WHO's website at <http://www.who.int/hpr/hep/conference/index.html>

23 Australian Government Publishing Service, Canberra, 1997, p. 82

There has been a great deal of work done which explores these issues in depth. Recently the National Public Health Partnership and the National Environmental Health Forum released a paper entitled *Environmental Health in Australia: Towards a National Strategy*,<sup>24</sup> which makes a number of recommendations aimed at providing a more unified and strategic approach to the management of environmental health issues.

Chapter 3 discussed the issue of intersectorial management of health issues across the various levels of Government and between different departments of the Victorian Government. One ongoing issue is the attention given to public health concerns in environmental impact assessments. A further issue is the capacity for public health agencies to take action with respect to environmental hazards which may pose a risk to public health. While human health is clearly an important consideration for those involved in environmental regulation, their responsibility is much broader than health issues. There may be occasions where there is little environmental impact from an activity which is within their area of responsibility but it has significant ramifications for public health. At such times a public health agency may wish to take action to protect the public health.

Perhaps there should be some explicit recognition of the importance of the environment to public health in a provision outlining the Act's objects or in a provision explaining the functions of the Secretary. There may be other mechanisms through which the interface between the two areas could be recognised. Furthermore, provisions which allow for management of public health risks, as discussed later in this chapter, may provide a mechanism for public health agencies to act when concerned about risks to public health, irrespective of how caused.

*The review seeks your comments on the importance of the link between public health and the environment and ways in which this link ought to be recognised in the Health Act.*

## 5.3 General Sanitary Provisions

### Introduction

These provisions appear in Part 4 of the Act. This Part was extensively amended as a result of the review which took place in 1988.<sup>25</sup> The provisions dealing with refuse, night-soil and sanitary conveniences, septic tank systems, plumbing and gas-fitting, sewers and drains, the use of waste water and the keeping of certain animals were repealed. Responsibility for many of those matters was transferred to the Environment Protection Authority. Others were deemed appropriate for repeal because they over regulated the activities of municipal councils.

Part 4 therefore now contains a relatively small number of provisions dealing with:

- Offensive waterways on municipal district boundaries, or running into two or more municipal districts
- The protection of water supplies
- Rats and mice.

### Offensive Waterways

Division 4 of Part 4 of the Act deals with offensive waterways. The purpose of these provisions is to ensure that there is someone who has responsibility for waterways which may otherwise be left in an offensive condition.

The provisions allow the Secretary to make orders for the clean up and improvement of waterways which are near to or on the boundaries of two or more municipal districts and which are foul, offensive or out of repair. They apply even though the waterway, ditch or channel in question may not be under the control of the relevant council or councils. However, the Act does allow those councils to recover the costs incurred by them in complying with the order from people who are responsible for the waterway, ditch or channel. Section 275 of the *Melbourne and Metropolitan Board of Works Act 1958* states that these provisions do not apply to rivers, creeks or watercourses which are under the management and control of the Melbourne and Metropolitan Board of Works.

<sup>24</sup> Commonwealth Department of Health and Family Services, Canberra, September 1998.

<sup>25</sup> See *Review of Health Legislation Discussion Paper Series: Sanitation Systems and Waste Management*, Health Department Victoria, May 1987.

It appears that these provisions have not been used for a considerable period of time.

*The review seeks your comments on the operation of Division 4 of Part 4 of the Health Act.*

## Protection of Water Supplies

Victorians are justifiably proud of the quality of their water supply and their drinking water in particular. A very important function of the Act is to grant the Secretary power to protect water supplies. This is covered in Division 6 of Part 4.

To facilitate the protection of water supplies, the Act empowers the Secretary to protect sources of water supply from contamination. It also gives the Secretary the power to close sources of water supply once they have become contaminated. Finally, the Act allows the Governor in Council to make regulations for protecting water supplies. Those regulations are the Health (Quality of Drinking Water) Regulations 1991. Currently these Regulations provide for inspections and sampling of water supplies, reporting of waterborne illness and purification of contaminated water supplies.

The Act does not provide any detail as to what the Secretary may do to protect sources of water supply from contamination. This is partly addressed by the provision giving the Governor in Council power to make regulations with respect to a range of matters including purification of water supplies, sampling and testing of water supply systems, health evaluations, reporting of waterborne illness and inspection of water supply systems and catchments. However, it may be appropriate if additional provisions were included to spell out more clearly the powers of the Secretary to prevent contamination of the sources of water supply.

Once a water supply has become contaminated, the Act gives the Secretary the power to close the source of that contaminated water supply. However, perhaps consideration should be given to the inclusion of other powers in the Act with respect to contaminated water supplies besides the power to simply close down their source. Closing the source of a water supply is a drastic measure. In some cases it may be more appropriate for an order to be made directing that a water supply or a receptacle in

which water is stored be cleaned, or that some other action be taken to protect the source of the water which stops short of ordering its closure.

Naturally people have particular concern about the quality of their drinking water. Perhaps consideration should also be given to specific arrangements relating to the supply of drinking water as opposed to the supply of water for other purposes. The 1996 *Australian Drinking Water Guidelines* produced by the National Health and Medical Research Council and the Agricultural and Resource Management Council of Australia and New Zealand provide best practice guidelines, but not mandatory standards, for acceptable drinking water quality.

Should there be specific standards for the supply of drinking water? What programs should be in place for the monitoring of the quality and characteristics of drinking water? Should it be possible to declare that some water supplies are not for human consumption? If water is supplied which is not fit for human consumption, what should be the legislative mechanism to deal with that? Should there be an offence of supplying water which is not fit for human consumption? Should there be power with the Secretary to make Orders with respect to such water?

The Act and the Health (Quality of Drinking Water) Regulations refer specifically to water supply authorities and do not cover others involved in the supply of drinking water. In particular, transportation of water which is intended for human consumption is currently not specifically regulated. Should the Act and the Regulations be extended to cover all those who provide water for human consumption?

*The review seeks your comments on the operation of Division 6 of Part 4. How should the Health Act best provide for the protection of sources of water supply from contamination? In particular, should the Act go into more detail as to what the Secretary may actually do to protect sources of water supply from contamination?*

*Should the Secretary have a broader range of powers when dealing with water supplies once they have become contaminated?*

*Should there be specific provisions relating to the supply of drinking water? If so, what should be included in such provisions?*

## Rats and Mice

Section 87 of the Act gives the Governor in Council power to make regulations regarding rats and mice. It is the only provision in the Division of the Act dealing with animals (Division 7A of Part 4) that was not repealed as a result of the review of the Act which occurred in 1988. This power to make regulations regarding rats and mice is exercised in regulation 36A of the Health (Infectious Diseases) Regulations 1990.

Currently these Regulations provide that the owner or occupier of premises can be given reasonable directions to destroy any rats or mice on those premises or take steps to remove or rectify any conditions on the premises which are conducive to the breeding of rats and mice.

*The review seeks your comments on the above provision.*

## 5.4 Nuisances

Part 3 of the Act which applies to nuisances was also extensively amended in 1988. The Act applies not only to nuisances which are, or are liable to be, dangerous to health, but also to those which are offensive. 'Offensive' is defined fairly broadly to mean noxious, annoying or injurious to personal comfort.

The Act requires municipal councils to remedy as far as possible all nuisances which occur within their municipal district and creates an offence of causing or allowing a nuisance to exist.

It also provides for a scheme by which nuisances can be dealt with. This scheme requires councils to investigate any notice of a nuisance occurring within their districts and to take action to abate the nuisance or provide advice as to methods for settling the matter privately.

The Act does not necessarily require councils to take action to provide relief from nuisances themselves.

They can serve a notice on a person who is causing the nuisance, or from whose land it emanates, requiring them to 'abate' or take action to lessen the impact of the nuisance. If there are problems with compliance with the notice, or recurrence of the nuisance, the council may take the matter to the Magistrates' Court. The court may order that the notice be complied with, that works be carried out to prevent a recurrence of the nuisance, that the person pay a fine or that a house not be used for human habitation.

If an abatement order has been made, the council may enter the land to which the order relates to abate the nuisance and recover the costs incurred in doing so from the person against whom the order was made. Failure to comply with an abatement order attracts a penalty of up to \$10,000.

The Act provides that if a council does not investigate the notification of a nuisance within a reasonable time, the person who made the notification may make a complaint to the Magistrates' Court. The court may then proceed as if the complaint had been made by a council and may make an order for costs against the council.

Section 421(2) of the Act provides that the provisions with regard to nuisance summarised above are in addition to any rights under the Health Act, any other Act or the common law.

As stated above, the Act applies to nuisances which are liable to be dangerous to public health, noxious, annoying or injurious to personal comfort. This broad definition would appear to be consistent with the definition of health used by the World Health Organisation quoted in chapter 2. However, public health legislation in some other jurisdictions has a narrower scope. For example, Queensland Health is proposing to narrow the scope of the nuisance provisions in its *Health Act 1937*, as it believes that currently they cover matters which pose no real risk to public health. It also proposes to replace the term 'nuisance' with the term 'public health risk' because of views expressed that 'nuisance' has connotations of matters which are relatively trivial. Its proposed definition of public health risk is 'any structure, activity, animal, substance, or thing which may contribute to disease in humans or have adverse effects on human health'. A number of matters will

be specified as constituting a public health risk for the purposes of the Act.<sup>26</sup>

The current nuisance provisions appear to have worked reasonably successfully. Many of the problems which existed prior to their amendment were overcome by the changes that were made in 1988. Thus they appear to provide a broad and flexible tool for dealing with problems which arise at a local level. You may, however, have views on their operation and how they could be improved.

*The review seeks your comments on the operation and effectiveness of the provisions of the Health Act relating to nuisance. What are your views on the use of the term nuisance and its current definition?*

## 5.5 Public Health Risk Management

The Health Act has a broad range of powers for dealing with public health problems which arise. These range from the nuisance provisions discussed above, which provide a mechanism for dealing with health issues at a local level, through to emergency powers (discussed in chapter 8). These, as the name suggests, are significant powers which can be invoked in public health emergencies.

There are, however, potential gaps in the Health Act in dealing with matters which are not confined to localities or which do not fall within the ambit of the nuisance provisions. Many of the powers in the Act are also of a reactive nature and there is therefore little scope to deal with public health issues in a proactive manner. Furthermore, when considering the scope of the subject matter covered by the Health Act, it becomes clear that health can be affected by many different factors. The Act has in the past generally developed specific legislative provisions to cover public health issues which arise. It may be appropriate now to consider whether there is scope for a general provision or provisions enabling action to be taken with respect to any matter that is a risk to public health. This may in turn replace some of the more specific powers in the Act.

Other jurisdictions have taken various approaches in dealing with public health risks. In the discussion of the nuisance provisions above there was brief reference to the proposal in Queensland for the replacement of the concept of nuisance with that of public health risk. New Zealand has also released a discussion paper for a review of its public health legislation, in which the possibility of a provision imposing a duty on people not to cause risks to public health is canvassed.<sup>27</sup> The public health Acts of many other Australian jurisdictions already make reference to public health risks and allow for the making of public health orders in respect of those risks.

These provisions are different from the nuisance provisions in the Victorian Health Act. As stated above, the nuisance provisions are an effective way for Victorian councils to deal with public health risks within their municipalities, irrespective of the number of people whose health may be adversely affected. However, it may be worth considering enacting broader provisions which give the Secretary who reasonably believes that something represents a public health risk the power to make an order or take action.

For example, in South Australia if an activity gives rise to a risk to health the Health Commission may, by notice in writing to the person responsible for the activity, require that they stop that activity or observe certain requirements in relation to it. If the person to whom the notice is addressed fails to comply with it, they are guilty of an offence.<sup>28</sup> In the Australian Capital Territory the Minister can declare an activity to be a public health risk activity and can require various things to be done in respect of it, including compliance with a particular code of practice or accreditation standard or the obtaining of a licence.<sup>29</sup> In Tasmania, a person who undertakes a specified public health risk activity can also be required to be licensed.<sup>30</sup> Public health risk activity is defined in the Tasmanian legislation as an activity which may result in the transmission of disease.

26 Queensland Health, *Draft Policy Paper on Review of the Health Act 1937*, February 1998, pp. 18-23.

27 New Zealand Ministry of Health, *Public Health Legislation Review Discussion Document*, July 1998, p. 31.

28 Section 17 *Public Health and Environment Act 1987* (S.A.).

29 Sections 29-66 *Public Health Act 1997* (A.C.T.).

30 Sections 104-112 *Public Health Act 1997* (Tas.).

The South Australian provision enables conditions to be put on an activity which is presently occurring. The Australian Capital Territory and Tasmanian models represent a more proactive approach in that they provide an opportunity to regulate matters which may be a public health risk in the future. Is there any scope for inclusion in the Health Act of a provision which enables the licensing of activities which may present a risk to public health in the future? This licensing regime would aim to ensure that the activity in question was conducted in a safe manner and would only apply where that activity was not already regulated. Such a provision would need to be justified under the National Competition Policy, that is, it would need to be shown that the benefits of this licensing system outweigh the costs and that there is no other way of achieving the objectives of the legislation.

If any provisions were to be included in the Act allowing for an activity to be declared to be a public health risk, questions arise as to what powers should flow from such a declaration, who should exercise those powers, who should have responsibility for enforcement of any orders which are made in respect of the risk and what appeal rights should exist.

A further question is how any provisions which provide for the management of public health risks would fit with the nuisance provisions which already exist in the Act. Presumably this power would reside in the Secretary and would be able to be exercised when the public health risk in question did not fall within the jurisdiction of a council under the nuisance provisions, or when for some other reason it was more appropriate that the power be exercised by the Secretary than by a council.

*The review seeks your comments on the possible inclusion into the Health Act of a general power to declare an activity to be a risk to public health. In particular your views are sought on the circumstances in which it may be appropriate to declare a matter to be a public health risk, the powers which should follow the making of such a declaration, who should exercise those powers and what limitations or appeal rights should exist on the exercise of those powers.*

*If such a power exists, what would be an appropriate definition of public health risk activity?*

## 5.6 Drugs, Substances and Articles

Part 14 of the Act relating to Drugs, Substances and Articles covers the mixing, sale, advertising and labelling of drugs. There are also some miscellaneous provisions which deal with other potentially harmful items such as lead in toys. Part 14 also deals with offences and legal proceedings relating to these matters.

These provisions appear to have been superseded by the introduction of specific legislation relating to therapeutic goods and more general fair trading and consumer protection legislation, and therefore may be suitable for repeal.

*The review seeks your comments on Part 14 of the Act, and in particular on what would be the effect of its repeal.*

## 5.7 Meat Supervision

The provisions relating to meat supervision have largely been superseded by specific food legislation and the *Meat Industry Act 1993* (particularly the amendments which were made to that Act by the *Food (Amendment) Act 1997*).

There are now only eight sections relating to meat remaining in the Health Act. These restrict slaughter and sale of certain meat and storage of certain meat from premises where food is sold or prepared for human consumption. The *Meat Industry Act 1993* and the *Food Act 1984* regulate food that is to be sold for human consumption. Some of these provisions in the Health Act are therefore now clearly redundant. However, two of the provisions in the Health Act are slightly broader, in that they prohibit the slaughter and preparation of certain animals for human consumption irrespective of whether the food will be sold. There may be occasions where meat is prepared and not sold and yet will be consumed by a reasonable number of people. Should there be any provisions which regulate preparation of meat even where the meat is not for sale?

*The review seeks your comments on whether there is a need for controls on the preparation of meat for human consumption in circumstances where the meat is not to be sold. Would this be more appropriately dealt with by the inclusion of a power into the Act to make orders which deal with specific risks to the public health as and when they arise?*

# Chapter 6 – Radiation Safety

## 6.1 Introduction

The use of radiation as a tool to benefit the health of Victorians is quite well known. Many people would have had the experience of receiving an x-ray to look at the position of their teeth, to search for the cause of back pain or to receive radiotherapy to treat cancer. Radiation is also of assistance in medical and scientific research and industry. However, radiation is a powerful agent and can be harmful if not used with great care. It is important to regulate the use of radiation to ensure that Victorians receiving diagnosis or treatment with radiation are confident that the person delivering the diagnosis or treatment is well qualified to do so and that the equipment used is safe. Appropriate legislative standards in this area are also important to protect the health of members of the public and people using radiation apparatus and radioactive substances, as well as to protect the environment.

There are a number of ways in which the Health Act attempts to protect medical patients, people who use radiation, members of the public and the environment from the dangers of radiation. These are:

- Requiring radiation apparatus and sealed radioactive sources to be registered
- Requiring people who deal with radiation apparatus and radioactive substances (other than registered medical radiation technologists) to be licensed
- Providing for the making of regulations in respect of radiation safety
- Establishing the Radiation Advisory Committee
- Establishing a system of registration for medical radiation technologists.

This chapter discusses each of these mechanisms in turn.

## 6.2 Registration of Radiation Apparatus and Radioactive Sources

The Act requires the registration of certain radiation apparatus (for example, a linear accelerator used in cancer treatment or an x-ray machine) and sealed radioactive sources (for example, a radioactive substance sealed in a metal capsule). It imposes a number of conditions on the person in whose name

the apparatus or source has been registered. It also states that the Secretary will not register any radiation apparatus or sealed radioactive source unless satisfied in respect of a number of safety issues.

This registration system is in addition to the systems of licensing people to deal with radiation apparatus and radioactive substances and registering medical radiation technologists which are described below.

The registration system, and in particular the conditions on registration imposed by section 108AE(3), does pose an additional compliance burden on people supplying services which involve the application of radiation. They would be expected to pass that burden on to the public through higher fees. However, this registration system allows the Secretary to prevent the inappropriate use of radiation apparatus or radioactive sources and the use of apparatus or sources which do not meet the necessary safety standards. It may be said that this additional level of safety protection is justified in view of the potentially harmful effects of radiation and the fact that the person who is licensed to deal with the registered apparatus or source is usually not its owner. Moreover, the registration system allows the Secretary to know where radiation apparatus and radioactive sources are being kept, and therefore quickly conduct an information campaign or safety audit of types of apparatus and substances which have been shown to represent a particular hazard.

*The review seeks your comments on whether, given that people who deal with radiation apparatus and radioactive sources are either licensed or registered under the Health Act, it is necessary for the equipment and substances which they deal with to also be registered.*

## 6.3 Licensing of People to Deal with Radiation Apparatus and Radioactive Substances

### Explanation of Licensing System

The Act sets up a licensing scheme for all people who deal with certain radiation apparatus or radioactive substances, unless a particular

individual is exempted from that requirement. It provides that the Secretary may impose conditions on a licence and restrict the range or type of procedures which may be performed under the licence according to the training, qualifications or experience of the applicant. It specifies the grounds on which the Secretary may refuse to grant a licence. These include that the Secretary:

- Considers it necessary to do so in the interests of public safety
- Considers that the proposed use of radiation is inappropriate or unnecessary
- Is not satisfied that the applicant
  - Is a fit and proper person to hold the licence
  - Has the appropriate training, qualifications and experience
  - Has appropriate safety equipment and shielding devices.

#### Regulation 11 of the Health (Radiation Safety)

Regulations 1994 lists a broad range of professions and occupations in respect of which an operator licence may be issued. It should be noted that members of the medical and veterinary professions on that list are already under the jurisdiction of a registration board which has power to inquire into their professional conduct. It should also be noted that due to amendments to the Regulations which were made in 1997, this list does not include medical imaging technologists, radiation therapy technologists or nuclear medicine technologists, who are now covered by a separate registration scheme. This separate registration scheme is discussed later in this chapter.

Regulation 12 allows for a licence to be issued to a company or institution which wishes to sell, service or transport radiation apparatus or radioactive substances, carry out research involving irradiation of human volunteers or employ a person to deal with unsealed radioactive sources.

The Act provides that both of these categories of licence shall, unless sooner cancelled or suspended, continue in force for a period not exceeding three years.

The Regulations provide that the fee for an operator licence is \$99, and that the fee for a company or institution licence is \$320.

## National Competition Policy

This occupational licensing system represents a restriction on competition because it is a barrier to entry into the market for the provision of services which involve the application of radiation. Moreover, because this system involves a restriction on the right to practice the licensed activity, it is more anti-competitive than the occupational registration systems applying to most health professions, which only restrict the right to use relevant titles. In order to assess this restriction on competition against the guiding legislative principle in the *Competition Principles Agreement* the review panel needs to answer the following questions:

- Do the costs of this occupational licensing system outweigh its benefits?  
and
- Is this system necessary to achieve the objective of the legislation?

In respect of the first question, the main cost of the licensing system is a restriction on the number of people who are able to provide health care, veterinary and industrial services involving the application of radiation, thereby allowing those people who do hold licences to charge higher fees for their services than they might be able to do in the absence of that restriction.

Some benefits of the occupational licensing system may be:

- Reduced possibility of uncontrolled use, or misuse, of radiation apparatus and radioactive substances, thereby benefiting patients who receive radiation as part of their medical treatment, people who use radiation apparatus and radioactive substances, the general public and the environment. The licensing system aims to achieve this objective by
  - Preventing inappropriate or unnecessary use of radiation
  - Ensuring that only individuals with appropriate training, qualifications and experience are able to apply radiation
  - Ensuring that radiation is only applied in conjunction with appropriate safety equipment and shielding devices
  - Ensuring that radioactive substances are handled and disposed of safely.

- Increased community confidence in the provision of health care which involves the application of radiation, which may encourage people to seek and agree to necessary medical examination and treatment.

*The review seeks your comments on the costs and benefits of the occupational licensing system imposed by the Health Act in respect of the use of radiation apparatus and radioactive substances and whether those costs outweigh those benefits.*

In respect of the second question in the guiding legislative principle, some alternative means of achieving the objective of protecting patients, operators, members of the public and the environment from the dangers of radiation may be:

- Negative licensing, in which there is no restriction on the right to deal with radiation apparatus or radioactive substances, but people who can be shown to have done so unsafely have that right removed.
- A registration scheme which involves only protection of title rather than restriction on right to practice.
- A certification scheme which requires people who administer radiation to inform a central authority of their educational qualifications and previous experience in the industry without a requirement for any minimum standards as a precondition of practice.
- Self-regulation, perhaps assisted by an industry developed code of conduct.
- Reliance upon the existing law to enforce appropriate standards of radiation safety, including the legislation regulating the professional activities of the health care providers listed in regulation 11, the *Health Services (Conciliation and Review) Act 1987* which establishes the Office of the Health Services Commissioner and the law of negligence.

*The review seeks your comments on whether these alternatives would provide sufficient protection to patients, members of the public, operators and the environment against the dangers of radiation. Are there any other ways of achieving that objective which do not involve a restriction on competition, or which at least involve a lesser degree of restriction?*

## Relationship between Licensing System and Professional Registration Acts

As stated earlier, the medical and veterinary professions listed in regulation 11 of the Health (Radiation Safety) Regulations 1994 are already under the jurisdiction of various registration boards which have power to inquire into the professional conduct of people whom they register. In determining whether to grant a licence to a member of one of these professions, the Secretary pays particular regard to whether that person is registered under the relevant professional registration Act. For example, the Secretary would be reluctant to issue an operator licence in respect of a person's profession as a chiropractor or medical practitioner unless that person was registered under the *Chiropractors Registration Act 1996* or the *Medical Practice Act 1994* respectively. This is because one of the main purposes of these professional registration systems is ensuring the provision of appropriate standards of health care, and therefore a health practitioner who is registered is more likely to apply radiation safely.

The criteria for refusal of a licence in section 108AF(7) of the Act would appear to be wide enough to justify this approach. However, given that registration of health practitioners is central to the protection of public health in Victoria, it may be appropriate to provide expressly for the link between the grant of a licence to administer radiation and registration under the relevant health practitioner legislation.

*The review seeks your comments on whether the grounds on which the Secretary may refuse to issue a licence to deal with radiation apparatus or radioactive substances in section 108AF(7) of the Health Act should include failure to be registered under the health practitioner legislation which regulates the applicant's profession.*

## Variation, Suspension or Cancellation of Licence or Registration

The Act specifies a number of grounds on which the Secretary may vary, suspend or cancel registration of a radiation apparatus or sealed radioactive source or a licence to deal with radiation apparatus and radioactive substances, and details the procedures

which the Secretary must follow when intending to do so.

Section 108AG, which lists these grounds, does not specifically include the fact that the licensee has ceased to be registered under the legislation that governs their profession. Given the importance of the registration of health practitioners to the initial decision to grant a licence, and also to the Victorian public health system in general, it may be desirable for the grounds on which the Secretary may vary, suspend or cancel a licence to deal with radiation apparatus or a radioactive substance to include specifically the fact that the licensee has ceased to be registered under the Act governing their profession.

*The review seeks your comments on whether the grounds on which the Secretary may vary, cancel or suspend a licence to deal with radiation apparatus or radioactive substances in section 108AG(1) of the Health Act should include the fact that licensees have ceased to be registered under the health practitioner legislation which regulates their profession.*

### **Appeal Rights in Respect of Licensing and Registration Decisions**

Section 108AH provides that a person who feels aggrieved by a decision of the Secretary to vary, suspend, cancel or impose conditions on a licence or registration may appeal to the County Court, and that the decision of the County Court is final and without appeal.

This appeal provision is in addition to the general appeal provision in section 387 of the Act, which confers a right of appeal in respect of a decision of the Secretary to refuse an application for, or for renewal of, a licence or registration. Section 387 applies in respect of the original decision to refuse a licence or registration application or renewal, whereas section 108AH applies in respect of the decision to vary, suspend, cancel or impose conditions on that licence or registration once it has been granted.

It is potentially confusing for appeals from decisions of the Secretary regarding radiation safety to be dealt with in two separate provisions of the Act.

*The review seeks your comments on whether section 108AH of the Health Act, which deals with appeals from decisions of the Secretary to vary, suspend, cancel or impose conditions on the registration of radiation apparatus or radioactive sources and on a licence to deal with radiation apparatus or radioactive substances, should be incorporated into a general appeals provision such as that which appears in section 387.*

The discussion of section 387 in chapter 10 raises the issue of whether appeals against administrative decisions of the Secretary ought more properly be made to the Victorian Civil and Administrative Tribunal than to the County Court. This question is also relevant to the specific appeal provision in respect of decisions varying, cancelling, suspending or imposing conditions on a person's licence or registration.

*The review seeks your comments on whether appeals against a decision of the Secretary varying, cancelling, suspending or imposing conditions on a person's licence to deal with radiation apparatus or radioactive substances or on the registration of a radiation apparatus or radioactive source should be heard in the Victorian Civil and Administrative Tribunal rather than the County Court.*

### **6.4 Penalty for Radiation Safety Offences**

The Act provides that any person who contravenes or fails to comply with any provision of the Division which deals with radiation safety or with any condition, restriction or limitation of any licence, registration or exemption under the Division shall be guilty of an offence and liable to a penalty of not more than \$10,000.

*The review seeks your comments on whether this maximum penalty is adequate, given the potential hazards of radiation.*

### **6.5 Regulations**

The Act allows for the making of regulations in respect of radiation safety, which are the Health (Radiation Safety) Regulations 1994. Those Regulations do the following:

- Define radioactive substances for the purposes of the Act
- Describe the type of licences which may be given under the Act, set licence fees and describe the licence requirements for the sale of ionisation chamber smoke detectors and ionising radiation apparatus
- Describe the notification requirements in respect of registered radiation apparatus and sealed radioactive sources, and set registration fees
- Specify radiation safety testing requirements
- Allow for exemptions from the licensing and registration systems imposed by the Act and from the requirement to undergo a medical examination imposed by the Regulations
- Specify a range of general safety precautions and reporting obligations which must be taken by licensees and people in whose name an apparatus or source has been registered
- Specify measures aimed at controlling the radiation dose received during medical diagnosis or treatment
- Provide for the personal monitoring of persons who may be exposed to radiation
- Provide for the medical examination of persons who may be exposed to radiation
- Specify safety requirements in respect of the transport of radioactive materials
- Specify safety requirements in respect of the disposal of radioactive waste
- Allow for the inspection of premises, records and radiographs and the seizure of radiation apparatus and radioactive substances
- Specify dose limits for members of the public and people who have exposure to radiation in the course of their employment.

## 6.6 Radiation Advisory Committee

The Act provides for a Radiation Advisory Committee appointed by the Minister which is required to advise the Minister or the Secretary on any matters relating to the administration of the provisions of the Act relating to radiation safety.

## 6.7 Registration of Medical Radiation Technologists

### Explanation of the Registration System

The Act establishes the Medical Radiation Technologists Board of Victoria and gives that Board power to register persons to practice in radiography or nuclear medicine technology as medical imaging technologists, radiation therapy technologists or nuclear medicine technologists. These three groups are known collectively as medical radiation technologists. The Act also allows the making of regulations with respect to:

- The functions of the Board
- The registration of medical radiation technologists
- Inquiries into the conduct and capacity of persons registered by the Board
- Prohibiting a person not registered by the Board from practicing as a medical radiation technologist or using a title which implies that the person is registered or qualified to practice in radiography or nuclear medicine technology
- The practice of persons in connection with radiography or nuclear medicine technology.

As stated earlier, medical radiation technologists who are registered under this system are exempt from the requirement that people be licensed before they can deal with radiation apparatus and radioactive substances.

While the Act allows for the making of regulations which both restrict the right of an unregistered medical radiation technologist from practicing as such and from using certain titles, the Health (Medical Radiation Technologists) Regulations 1997 only allow for protection of title. This means that the Regulations do not prevent unregistered people from practicing radiography or nuclear medicine technology. However, they would be prevented from doing so in practice. This is because the provision in the Act exempting registered medical radiation technologists from dealing with radiation apparatus or radioactive substances without a licence (section 108AF(1A)) would not apply to them, and there is no provision in the Act or the Health (Radiation Safety) Regulations 1994 for the licensing of unregistered medical radiation technologists.

## National Competition Policy

This occupational registration system is a restriction on competition because it is a barrier to entry into the market for the provision of services which involve the application of radiation. Moreover, because this system effectively involves a restriction on the right to practice radiography and nuclear medicine technology, it is more anti-competitive than the occupational registration systems applying to most health professions, which only restrict the right to use relevant titles.

The registration system for medical radiation technologists was assessed against the guiding legislative principle in the Competition Principles Agreement as part of the regulatory impact statement which was performed in respect of the Health (Medical Radiation Technologists) Regulations 1997. That analysis stated that the costs of the registration system are:

- A reduction in the supply of medical radiation technologists, thereby increasing their cost
- The reduced income earning potential of a medical radiation technology graduate which may result from being required to complete one year of practical training before being eligible for registration.

On the other hand, the benefits of this registration system were said to be:

- A reduction in the possibility of uncontrolled use, or misuse, of radiation equipment and subsequent over-exposure of patients to radiation
- Increased community confidence that the detrimental effects of exposure to radiation through medical applications will be minimised
- Encouragement of the responsible handling and disposal of radioactive materials.

The analysis demonstrated that the benefits of the occupational registration system which would be established by the Health (Medical Radiation Technologists) Regulations 1997 did outweigh the costs.

With respect to the second limb of the guiding legislative principle, namely that the objectives of the legislation could only be achieved by restricting

competition, the regulatory impact statement examined the possibility of attempting to protect against the dangers of radiography and nuclear medicine technology through industry developed codes of practice. It found that although strong incentives do exist for self enforcement of best practice among medical radiation technologists, this alternative would not be sufficient to deal with the dangers of their work because membership of the two relevant professional organisations remains voluntary and only covers approximately 85 per cent of practitioners.

The National Competition Policy assessment of the proposed regulations concluded that the safeguards imposed by them, namely the levels of training and competency required as a condition of registration and the fact that the Board was able to scrutinise conduct and impose penalties or cancel registration for breaches of professional standards, were the most appropriate tools to minimise the exposure of Victorians to radiation via the activities of medical radiation technologists.

*The review seeks your comments on whether the costs of the occupational registration system established by section 108AL of the Health Act and the Health (Medical Radiation Technologists) Regulations 1997 outweigh the benefits of that system. Are there any other ways of protecting people against the dangers of radiography and nuclear medicine technology which do not involve a restriction on competition, or which at least involve a lesser degree of restriction?*

## Separate Act for Medical Radiation Technologists?

All other health practitioner registration systems are established under a discrete Act, whereas the registration system in respect of medical radiation technologists is established by a combination of section 108AL of the Health Act and the Health (Medical Radiation Technologists) Regulations 1997. It should be noted that if the registration system was recreated under a separate Act, that new legislation would probably be expected to accord more closely with the model which has been used in respect of other health practitioner legislation.<sup>31</sup> The main differences between that model and the system

<sup>31</sup> See for example the *Chiropractors Registration Act 1996* and the *Podiatrists Registration Act 1997*

established by section 108AL and the Health (Medical Radiation Technologists) Regulations are as follows:

- Registration boards must be incorporated as legal entities
- All boards must include legal and community representation
- Boards have a broad range of disciplinary options, including informal hearings in appropriate cases
- A standard definition of 'unprofessional conduct' is adopted
- Legislation includes standard powers of boards to deal with false and misleading advertising
- There is a formal system of referral of complaints from boards to the Health Services Commissioner in appropriate cases
- Disciplinary hearings are open rather than closed
- People making complaints against a health practitioner have the right to be present at a hearing
- Appeals from a decision are directed to the Victorian Civil and Administrative Tribunal.

*If the system of registration for medical radiation technologists established by section 108AL of the Health Act and the Health (Medical Radiation Technologists) Regulations 1997 is to be continued, the review seeks your comments on whether it should be recreated under a separate Act, and if so, whether that Act should be in accordance with the model for Victorian health practitioner registration Acts.*

### **Incorporation of Elements of Model Health Practitioner Legislation?**

If there is no new Act separately regulating medical radiation technologists, it may be desirable to have some elements of the model provisions for health practitioner legislation incorporated into the relevant provisions of the Health Act and/or the Health (Medical Radiation Technologists) Regulations 1997. In particular, consideration could be given to including the provision incorporating professional registration boards as separate legal entities which are capable of suing and being sued, dealing with property and generally doing all things which a body corporate may, by law, do or suffer.

In the absence of such a provision, the Medical Radiation Technologists Board will continue to be part of the Crown and its actions will in law be those of the Crown. This might be an appropriate status for other statutory authorities established by the Health Act which have a purely research and advisory role, such as the Radiation Advisory Committee and the Consultative Council on Obstetric and Paediatric Mortality and Morbidity. However, it may not be appropriate for a body such as the Board, which itself makes important decisions affecting people's livelihood and radiation safety.

At present the Crown is responsible for decisions of the Medical Radiation Technologists Board over which it has no direct control. If the Board was incorporated in the same way as other registration boards, it would be better able to establish itself outside of the Public Health and Development Division of the Department of Human Services, and would be responsible for its own actions. In this regard it should be noted that the model provisions for health practitioner legislation provide for members of registration boards to be immune from civil or criminal liability for anything done by them in good faith.

*The review seeks your comments on whether any of the provisions in the Victorian Government's model for health practitioner legislation which are not already included in the registration system for medical radiation technologists established by section 108AL of the Health Act and the Health (Medical Radiation Technologists) Regulations 1997 should be added to that registration system.*

# Chapter 7 – Pest Control

## 7.1 Introduction

Victorians are sometimes subject to invasions that they would prefer to ward off. Termites, mites, spiders and rodents are some of the unwelcome invaders against which pest control measures may be taken. Also, land can be overtaken by weeds or other pest plants, and owners may wish to use pest control measures to deal with the problem.

This kind of work often entails the application of potentially harmful chemicals, particularly where fumigation is involved. It is important that people who work in the pest management industry have a proper understanding of the chemicals with which they work, and adopt proper methods and processes to ensure the health and safety of themselves, their employees, members of the public and the environment.

There are a number of means by which the Health Act attempts to control the use of pesticides. These include:

- Establishing a registration system for businesses which use or intend to use pesticides
- Establishing a licensing system for people who apply pesticides in the course of those businesses
- Prohibiting the use of certain pesticides except as permitted in the Regulations
- Requiring pest control operators to provide certain information to the Secretary
- Requiring licensees to submit to regular medical examinations.

This chapter discusses each of these mechanisms in turn.

## 7.2 Registration of Pest Control Operators

### Explanation of the Registration System

The Health Act provides that pest control operators using or intending to use pesticides in the course of their business cannot operate unless a registration fee of \$230 has been paid and their names are currently entered on a register of pest control operators kept by the Secretary.

Certificates of registration of pest control businesses are endorsed as allowing them to conduct any or all of the following activities:

- Control of arthropods (that is, insects including termites, mites, spiders, et cetera) and rodents in commercial and industrial areas
- Control of weeds, horticultural pests and diseases on urban, industrial, municipal and public lands
- Control of weeds and pest plants on urban, industrial, municipal and public lands
- Control of vermin and pest animals
- Control of pests by fumigation: structural – phosphine
- Control of pests by fumigation: structural – methyl bromide
- Control of pests by fumigation: soil – methyl bromide and chloropicrin
- Control of pests by fumigation: grain – phosphine
- Control of pests by fumigation: methyl bromide
- Other specified activities.

The Department of Human Services' *Guidelines for Pest Control Business Registration* require that the business in question have a person who is licensed at the technical manager level, and whose licence is endorsed so as to permit the type of pest control activity which the business intends to perform. Therefore, for example, if the pest control operator seeking registration intends to perform control of weeds, the operator must employ a person who is licensed at the technical manager level and whose licence is endorsed so as to permit the control of weeds. They also require that there be at least one person licensed at the technician level for every four people licensed at the trainee level. Finally, they state that for a pest control operator to be registered the technical manager must demonstrate the required knowledge and skills and that the operator's equipment and storage facilities are adequate.

The Act provides that the Secretary may deregister a pest control operator for such period as the Secretary determines if that pest control operator is convicted of an offence relating to pest control under the Act or the Health (Pest Control Operators) Regulations 1992.

Under section 368(1) of the Act, registration lasts for 12 months or until 31 December next after the date of registration. Under section 370 it can be transferred to any other person with the approval of the Secretary.

If the Secretary refuses or neglects to grant an application for, or for the renewal of, registration as a pest control operator, section 387 gives the applicant a right of appeal to the County Court. The question of rights of appeal under the Health Act, and in particular whether those appeals ought more properly be considered by the Victorian Civil and Administrative Tribunal, is discussed further in chapter 11.

This registration system is in addition to the system of licensing people to use pesticides in the course of the business of a pest control operator described in the next section.

### **National Competition Policy**

This business registration system, and in particular the staffing, equipment and storage requirements imposed by the Secretary as a condition of registration, represents a restriction on competition because it constitutes a barrier to entry into the market for the provision of pest control services. In order to assess this restriction on competition against the guiding legislative principle in the Competition Principles Agreement the review panel needs to answer the following questions:

- Do the costs of this business registration system outweigh its benefits?  
and
- Is this system the only way of achieving the objective of the legislation?

In respect of the first question, the main cost of the registration system is a restriction on the number of businesses which are able to provide pest control services, thereby allowing those businesses which are registered to charge higher fees for their services than they might be able to do in the absence of that restriction. There are also costs to businesses of complying with the conditions of registration, which they would be expected to pass on to the public in higher fees.

On the other hand, this registration system enables the Secretary to impose certain minimum standards on pest control operators. Some of the benefits which may result from this include:

- A decrease in the occupational, public health and environmental risks associated with the use of pesticides

- The institution of a 'level playing field' for pest control operators who are prepared to incur the costs involved in complying with appropriate safety standards
- More effective pest control which in turn would lead to a decrease in the disease and economic loss caused by pests
- Enhanced public confidence in the pest control industry
- Improved efficiency and productivity for pest management businesses.

The system of registering pest control operators also enables the Secretary to know where those operators are located, and therefore quickly conduct an information campaign or safety audit in respect of pesticides or pest management practices which have been shown to represent a particular hazard.

*The review seeks your comments on the costs and benefits of the system for registering pest control operators imposed by the Health Act, and whether those costs outweigh those benefits.*

In respect of the second question in the guiding legislative principle, the question needs to be asked as to whether it is necessary for the business of a pest control operator to be registered, given that people who apply pesticides in the course of such a business are required to be licensed. Some alternative means of achieving the objective of protecting pest management technicians, members of the public and the environment from the dangers of pesticides may be:

- Removing this registration system altogether and relying upon the system whereby the employees of pest control businesses are required to be licensed.
- Negative registration, in which there is no restriction on the right to apply pesticides but businesses which can be shown to have done so unsafely have that right removed.
- A scheme in which there is no restriction on the right to provide pest control services, but only registered businesses can use a certain title.
- Co-regulation, in which pest control businesses are required to be part of a relevant professional association to which the regulatory powers of Government might have been delegated.
- A certification scheme which requires businesses

which apply pesticides to inform a central authority of their previous experience in the industry, without a requirement for any minimum standards as a precondition of practice.

- A requirement on pest control businesses to provide information to clients about the pesticides they have used.
- Self-regulation, perhaps assisted by an industry developed code of conduct.
- Reliance upon the existing law to enforce appropriate standards of safety, including occupational health and safety, hazardous chemicals and consumer protection legislation, other provisions in the Health Act and the law of negligence.
- A public information campaign about the proper application of pesticides.

*The review seeks your comments on whether these alternatives would provide sufficient protection to pest management technicians, members of the public and the environment against the dangers of pesticides. Are there any other ways of achieving that objective which do not involve a restriction on competition, or which at least involve a lesser degree of restriction?*

### Operation of this Registration System

If a system of registration for pest control operators is to remain in force, then the review seeks your views on the operation of that system.

*The review is particularly interested in your views on the following questions:*

- *What should the criteria for registration be?*
- *Should the Secretary have power to impose conditions, limitations or restrictions on that registration?*
- *Should the Secretary be given power to suspend registration as well as cancel it?*
- *What should be the grounds on which the Secretary may suspend or cancel registration?*
- *Is it necessary that registration be renewed every 12 months and, if not, what longer period of registration would be appropriate?*
- *Should the Secretary have the power to exempt pest control operators from these registration requirements?*

- *Should appeals against registration decisions of the Secretary continue to be made to the County Court, or would it be more appropriate for them to be made to the Victorian Civil and Administrative Tribunal?*

## 7.3 Licensing of People Who Apply Pesticides

### Explanation of the Licensing System

The Act prohibits the use of a pesticide in the course of the business of a pest control operator unless the person doing so is licensed. In order to become licensed a person must pay the prescribed fee (\$115) and satisfy a number of criteria. The prescribed criteria are set out in regulation 9 of the Health (Pest Control Operators) Regulations 1992 and include:

- Completing one of the pest control courses nominated in those Regulations
- Passing the relevant examination conducted by the Department of Human Services
- Being at least 18 years of age and
- Demonstrating the necessary practical skills.

The Secretary may also refuse to grant a licence to use pesticides if the applicant has previously breached a provision of the Act or the Regulations regarding pest control.

The Department of Human Services' *Guidelines for Pest Control Licensing* state that applicants for a licence may apply for endorsements to their licences for the types of pest control they wish to do, and for which they qualify. The types of endorsements which may be requested are the same as those which apply to certificates of registration of pest control businesses described earlier. These licences are granted at one of three levels, namely technical manager, technician and trainee.

It should be noted that Victoria, along with other States and Territories, is considering adopting the *Draft National Occupational Health and Safety and Public Health Certification Standard for Pest Management Technicians*, whereby people are licensed to apply pesticides on the basis of assessed competencies rather than on the basis of educational qualifications. Under this system there would be

common criteria for the licensing of pest management technicians in all Australian jurisdictions based on units 5, 6 and 18 of the *National Pest Management Competency Standards* which have been developed by the National Occupational Health and Safety Commission. People would also be authorised to conduct fumigation by completing units 6 and 11 of those standards.

In order to satisfy units 5, 6 and 18 of the standards, the applicant for a licence would need to demonstrate competency in the modification of the environment to manage pests, the application of pesticides to manage pests and the proper maintenance and storage of equipment and pesticides. Under this system people would be granted a pest management licence on the basis of their ability to manage environments and apply pesticides safely rather than on the basis of their ability to deal with particular types of pests, as is the case with the present licensing system. It therefore focuses more appropriately on the public health concerns raised by the commercial application of pesticides, and also allows the one licence to apply to a broader range of pest control activities.

The proposed national licensing standard also differs from the present licensing system in that licensees would no longer be classified into technical manager, technician and trainee.

Another important difference between the present licensing system and that which would be in place if Victoria adopted the draft national standard referred to above is that the Act presently provides for licences to remain current for one year, whereas the draft national standard only requires that licences be renewed every five years.

Unlike the situation that exists with respect to the licensing of people to deal with radiation apparatus and radioactive substances, the licensing system currently in the Act does not allow the Secretary to impose conditions on a licence such as, for example, with regard to the safety precautions which must be followed or the way in which pesticide receptacles are to be cleaned. Nor does it allow the Secretary to restrict the range or type of procedures which may be performed under the licence according to the training, qualifications or experience of the applicant.

The only ground on which the Secretary may suspend or cancel a licence is breach of the provisions in the Act or the Regulations regarding pest control. This again compares with the licensing system which exists in respect of radiation apparatus and radioactive substances, where there are a number of grounds specified in the Act on which the Secretary may suspend or cancel a licence. The draft national standard provides additional grounds for cancellation or suspension of a licence besides contravention of the Act or the Regulations regarding pest control, including that:

- The licence was issued in error or because of a misrepresentation
- The licensee has not complied with a condition of the licence
- The licensee has incompetently performed the occupation for which the licence was granted.

If the Secretary refuses or neglects to grant an application for or the renewal of a licence to apply pesticides in the course of the business of a pest control operator, section 387 of the Act gives the applicant a right of appeal to the County Court. The question of rights of appeal under the Health Act, and in particular whether those appeals ought more properly to be considered by the Victorian Civil and Administrative Tribunal, is discussed further in chapter 11.

## **National Competition Policy**

Any occupational licensing system for pest control operators represents a restriction on competition because it is a barrier to entry into the market for the provision of pest control services. In order to assess this restriction on competition against the guiding legislative principle in the *Competition Principles Agreement* the review panel needs to answer the following questions:

- Do the costs of this occupational licensing system outweigh its benefits?  
and
- Is this system the only way of achieving the objective of the legislation?

In respect of the first question, the main cost of the licensing system is that it imposes a restriction on the number of people who are able to provide pest control services, and thereby allows those people

who do hold licences to charge higher fees for their services than they might be able to do in the absence of that restriction. Pest management technicians would also incur costs in meeting the licensing standards, which would be expected to result in higher fees for their services.

On the other hand, this licensing system enables the Secretary to impose certain minimum standards on pest management technicians. This would be expected to have similar benefits to those which follow from the registration of pest control operators, which may include:

- A decrease in the occupational, public health and environmental risks associated with the use of pesticides
- The institution of a 'level playing field' for pest management technicians who are prepared to incur the costs involved in complying with appropriate safety standards
- More effective pest control, which in turn would lead to a decrease in the disease and economic loss caused by pests
- Enhanced public confidence in the pest control industry
- Improved efficiency and productivity for pest management businesses.

*The review seeks your comments on what you consider to be the costs and benefits of a system for licensing people who apply pesticides for gain, reward or as part of their employment. Do those costs outweigh those benefits?*

In respect of the second question in the guiding legislative principle, some alternative means of achieving the objective of protecting pest management technicians, members of the public and the environment from the dangers of pesticides may be:

- Negative licensing, in which there is no restriction on the right to apply pesticides but people who can be shown to have done so unsafely have that right removed.
- A scheme in which there is no restriction on the right to provide pest control services, but only licensed pest management technicians can use a certain title.
- Co-regulation, in which pest management technicians are required to be part of a relevant

professional association to which the regulatory powers of Government might have been delegated.

- A certification scheme which requires people who apply pesticides to inform a central authority of their educational qualifications and previous experience in the industry, without a requirement for any minimum standards as a precondition of practice.
- Recognition of appropriate competencies as an industry credential under a vocational education and training scheme.
- A requirement on pest management technicians to provide information to clients about the pesticides they have used.
- Self-regulation, perhaps assisted by an industry developed code of conduct.
- Reliance upon the existing law to enforce appropriate standards of safety, including occupational health and safety, hazardous chemicals and consumer protection legislation, other provisions of the Health Act and the law of negligence.
- A public information campaign about the proper application of pesticides.

*The review seeks your comments on whether these alternatives provide sufficient protection to pest management technicians, members of the public and the environment against the dangers of pesticides. Are there any other ways of achieving that objective which do not involve a restriction on competition, or which at least involve a lesser degree of restriction?*

## Operation of the Licensing System

If a system of licensing for pest management technicians is to remain in force, then the review seeks your views on the operation of that system, and in particular on the operation of the proposed draft national licensing standard.

*The review is particularly interested in your views on the following questions:*

- *What should the licensing criteria be?*
- *Should the Secretary have power to impose conditions, limitations or restrictions on a licence?*
- *What should be the grounds on which the Secretary may suspend or cancel a licence?*

- *For what period of time should licences be granted?*
- *Should the Secretary have power to exempt pest management technicians from these licensing requirements?*
- *Should appeals against licensing decisions of the Secretary continue to be made to the County Court, or would it be more appropriate for them to be made to the Victorian Civil and Administrative Tribunal?*

#### **7.4 Prohibiting the Use of a Prescribed Pesticide Except as Permitted in the Regulations**

Section 108D(b) of the Health Act states that when pesticides are used in the course of the business of a pest control operator, the person so using the pesticides shall not use any pesticide prescribed as a regulated pesticide except as permitted in the Regulations. No pesticide has been prescribed as a regulated pesticide and therefore this provision is currently not being used.

*The review seeks your comments on whether the capacity in section 108D(b) to include a provision in the Regulations to make a pesticide the subject of special safety requirements should be exercised, and if so, what those safety requirements should be.*

#### **7.5 Requiring Pest Control Operators to Advise the Secretary Regarding Use of Pesticides**

The Act requires pest control operators to advise the Secretary as to what pesticides have been used in the course of their business and the purpose for which and places where they have been used. The Regulations also require that pest control operators keep these records for at least three years and give the Secretary the power to inspect them at any time their premises are open for business.

*The review seeks your comments on these requirements in the Act and the Regulations.*

#### **7.6 Requiring Licensees to Submit to Regular Medical Examinations**

The Act provides that every licensee who uses any pesticide in the course of the business of a pest control operator shall submit to a medical examination as prescribed in the Regulations. The Regulations require that any person who holds a valid licence as an authorised user of aldrin, chlordane, ethylene dibromide (EDB), heptachlor or methyl bromide shall submit to this medical examination in March each year. The Act provides that after considering a report relating to this medical examination the Secretary may suspend or cancel the authorisation of the licensee to use a particular pesticide or class of pesticides, or the licence as a whole.

In fact the only one of these chemicals which is still in use in Victoria is methyl bromide, and production and use of that chemical is being phased out.

*The review seeks your comments on these requirements in the Act and the Regulations.*

# Chapter 8 – The Control of Infectious Diseases

## 8.1 Background

One of the vital roles of public health agencies is the management and control of infectious diseases. Over time this role has changed and evolved as improvements in living standards and a greater understanding of disease have led to a decrease in the morbidity and mortality associated with some diseases. Traditional approaches to prevent the spread of infectious disease, such as quarantine and isolation, have now been supplemented by a wide range of strategies including health education and promotion, immunisation and the use of epidemiology to monitor and track the incidence of disease, thereby enabling a wide range of targeted responses and strategies to respond appropriately in managing disease.

Despite these changes in public health practice, infectious diseases remain a significant public health concern, and the role of Government in monitoring, tracking, investigating and responding to possible and actual outbreaks of disease remains as important as ever. Effective legislative provisions are important to enable investigation and intervention by public health authorities to prevent the spread of disease.

The Health Act has a large number of provisions that are primarily concerned with controlling and preventing the spread of infectious diseases. Many of these provisions were extensively reviewed and modernised in the 1988 amendments to the Act. The provisions that are there now are therefore considered to be a good model for legislation relating to the control of infectious diseases. As with any legislation, however, consideration must be given to whether there are ways in which it can be improved.

One of the most important means of controlling the spread of infectious diseases is through a mandatory notification and surveillance system which provides for monitoring and tracking of diseases. Because of its links with other aspects of information gathering, this monitoring and surveillance system is discussed in chapter 10, which deals with health information. This chapter will address the following matters relating to infection control:

- Requirements for the registration of premises where there is considered to be a risk of transmission of infectious disease
- How potential and actual outbreaks of infectious diseases are investigated
- The power to examine and restrict or isolate people with infectious diseases
- Emergency powers to limit or prevent the spread of infectious diseases and
- Special provisions relating to HIV.

## 8.2 Registration of Premises

One of the ways in which the Health Act minimises the risk of the spread of infectious disease is by requiring the registration of premises from which certain businesses operate. The rationale for registration is that the nature of the business being conducted from the premises is such that without certain standards of hygiene and cleanliness being observed, there is an increased risk of transmission of disease. Currently premises that must be registered are:

- Hairdressers
- Beauty parlours or other similar businesses
- Premises where the business conducted involves skin penetration procedures such as tattooing, ear piercing or acupuncture and
- Prescribed accommodation.<sup>32</sup>

Part 19 of the Act deals with the registration of premises. Provisions relating to prescribed accommodation are also found in Part 12. Because there are some particular issues relating to prescribed accommodation, it is dealt with separately in the next section of this chapter.

Part 19 requires that the premises to which it applies be registered with the local council, provides for the form and fee for registration of premises, and gives power to grant or refuse to grant registration. The Secretary has the power to inspect premises which are seeking registration or renewal of registration, and to require any alterations or improvements to premises in order to ensure that they comply with the requirements of the Act. There are a number of

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32 As defined in Part 12 of the Act and the Health (Prescribed Accommodation) Regulations 1990.

regulation making powers which include all the procedural aspects of registration and also other matters relating to the cleanliness of the premises and matters necessary to safeguard the health of persons likely to be using the premises. The Health (Infectious Diseases) Regulations 1990 provide for things such as sterilisation of equipment and standards of hygiene for persons performing skin penetration procedures.

The Act also provides for certain premises to be exempted from the registration requirements. Currently these are the practices of registered medical practitioners, registered dentists, registered chiropodists and accredited pathology services. Also exempted are mobile hairdressers and beauty therapists where the mobile premises are not the principal place of business.

The requirement that certain premises be registered and the requirement to observe certain standards on those premises are barriers to entry to the market for hairdressing, beauty therapy, tattooing, ear piercing and acupuncture services. As such they are a restriction on competition which must be reviewed under the requirements of the National Competition Policy as explained in chapter 4.

The test that must be applied is that legislation should not restrict competition unless it can be demonstrated that:

- The benefits of the restriction to the community as a whole outweigh the costs and
- The objectives of the legislation can only be achieved by restricting competition.

As stated above, the objective of the legislation in including provisions requiring registration of certain premises is to minimise the spread of infectious disease. The rationale for the provisions is that where the activities undertaken on premises involve an inherently higher than normal risk of transmission of disease, the requirement for the premises to be registered is necessary to minimise that risk. To be registered, premises are required to maintain certain levels of cleanliness and hygiene. Once premises are registered, controls also apply to the activities undertaken on those premises. People performing procedures which involve skin

penetration et cetera are required to do so in accordance with the Health (Infectious Diseases) Regulations. Registration facilitates targeted education which helps ensure that proprietors observe procedures which minimise the risk of transmission of disease. Registered premises can be inspected to ensure that the requirements of the Act and the Regulations are being complied with and offences can be prosecuted. In severe cases, premises can be deregistered.

In considering the objectives of the legislation, the question arises as to whether the type of premises required to be registered should be amended to reflect current risk activities that occur. There are procedures which have recently grown in popularity such as branding, beading and scarification which are arguably outside the scope of the existing provisions.

With respect to hairdressers, where the primary concern is razors, and the risk of transmission from other activities is less than with other groups which are regulated, the question as to whether there is a method other than registration of premises that would be appropriate to meet the objectives of the legislation is particularly relevant.

Some alternatives to the requirement that all premises from which hairdressing, beauty therapy or skin penetrating services be registered might include:

- A requirement that only those premises which have been shown to have breached appropriate hygiene standards be registered
- More vigorous enforcement of public health standards contained in the Health Act, the Health (Infectious Diseases) Regulations and the Health (Prescribed Accommodation) Regulations with respect to those premises.

*The review seeks your comments on whether it is in the public interest to have a scheme for the registration of the premises of:*

- *Hairdressers*
- *Beauty therapists*
- or*
- *Businesses where skin penetration occurs.*

*Do the benefits in each particular case outweigh the costs, and are there other less restrictive methods of protecting the public from the spread of infectious disease?*

*Are there other activities to which the requirements for registration of premises should apply? If so, what are these activities?*

*Are there other premises which should be exempted from these provisions? If so, what are they? Should the Act specify criteria for exemption of businesses from the operation of these provisions?*

### 8.3 Prescribed Accommodation

Prescribed accommodation is defined in Part 12 as:

- Any area which people are permitted to use for camping, on a frequent or intermittent basis, where payment is made to the proprietor of the land
- Any vessel, vehicle, house, tent, caravan, building or other structure which is used as a dwelling, where a person can live on payment to the proprietor and which is prescribed to be subject to the Act.

Currently, the following classes of accommodation are prescribed in the Health (Prescribed Accommodation) Regulations 1990:

- Residential accommodation
- Hotels and motels
- Hostels
- Student dormitories
- Holiday camps.

Specifically exempted from those Regulations are:

- Houses or flats under the exclusive occupation of the occupier
- Public hospitals or health service establishments registered under the *Health Services Act 1988*
- Houses, buildings or retirement villages under the *Retirement Villages Act 1986*
- Houses, buildings or structures to which the *Caravan Parks and Movable Dwellings Act 1988* applies
- Any vessel, vehicle, tent or caravan
- Premises in which, other than the family of the proprietor, not more than five persons are accommodated.

Prescribed accommodation must be registered with

the local council and there are a significant number of regulation making powers which apply. These include the power to make regulations for standards of hygiene and cleanliness, safety, ensuring suitable facilities for cooking, washing and bathing, and other matters such as maintenance and advertising. The Regulations themselves specify things such as the minimum size of rooms and standards for maintenance, cleanliness, waste and refuse disposal and toilet and bathing facilities.

The object of the Act in requiring premises of this nature to be registered is to minimise the risk of transmitting infection given the high number of people using the premises. The objectives of the Regulations are stated in the Regulations themselves as being to:

- Prevent overcrowding
- Ensure reasonable standards of hygiene, sanitation and safety and
- Minimise the risk of airborne and other communicable diseases among people living in prescribed accommodation.

As with hairdressers and skin penetration premises discussed above, the requirement for registration of prescribed premises and the minimum standards specified in the Regulations are barriers to entry into the market for these services. As such, they are a restriction on competition and therefore must be reviewed under the National Competition Policy against the guiding legislative principle outlined above.

Some of the matters to which the Regulations apply have now potentially been dealt with by other legislation such as the *Building Act 1993* and the *Building Regulations 1994*, and therefore consideration must be given to whether they remain necessary.

Some alternatives to the requirement that all prescribed premises be registered are similar to the alternatives for registration of other premises described above. That is:

- A requirement that only those premises which have been shown to have breached appropriate hygiene standards be registered
- More vigorous enforcement of public health

standards contained in the Health Act, the Health (Infectious Diseases) Regulations and the Health (Prescribed Accommodation) Regulations with respect to those premises.

*The review seeks your comments on whether it is in the public interest to have a scheme for the registration of prescribed accommodation, whether the benefits outweigh the costs, and whether there are other, less restrictive methods of protecting the public health.*

*The review also seeks comment on the nature of premises, if any, which should be prescribed as requiring registration, given the objective of limiting the spread of infectious disease. In achieving this objective, what controls should apply to premises which are prescribed under these provisions?*

## 8.4 Powers for Investigation and Control of Infectious Diseases

There are a number of powers in the Health Act and the Health (Infectious Diseases) Regulations that facilitate the investigation and control of infectious diseases. Some of these functions may need to be performed by people with special expertise.

Regulation 14 of the Health (Infectious Diseases) Regulations gives power to the Secretary to investigate the potential or actual outbreak of an infectious disease. For the purpose of investigating the outbreak the Secretary may:

- Enter premises and search or seize goods without a warrant
- Require information from people who have or may have been in contact with an infected person to give information about the contact for the purpose of tracing the source of the infection or preventing the spread of the infectious disease
- In respect of premises where the disease may be spread, take action necessary to stop, limit or prevent the spread of the disease from the premises
- Close a school or children's services centre and
- Direct any person to take any action he or she considers necessary to prevent the spread of the infectious disease.

Currently, information regarding a possible outbreak may come from a number of sources, including via the notification system outlined in chapter 10. The wide range of powers is necessary given the varying nature of potential infectious disease outbreaks and therefore the differing responses required. For example, in the case of meningococcal infection, it is important to obtain information from those who have been in contact with the person. The information obtained about contacts is important to enable treatment of close contacts of the person with antibiotics and to enable information to be given to other contacts regarding symptoms of the disease and action to undertake if any of the symptoms are experienced. Legionella is an example of a disease where action may need to be taken in respect of premises, to ensure cooling towers are properly treated.

There are some diseases which are so highly infectious that an immediate response is necessary to limit the number of people that may be affected by an outbreak or particular unhygienic practices.

Also for the purposes of investigating an infectious disease, there is power in the Act to require a registered medical practitioner with appropriate qualifications to conduct an autopsy where the Secretary reasonably believes that an infectious disease caused or contributed to a person's death and the Coroner does not have jurisdiction over the body.

There is also power in the Act to order tests where an incident occurs that could result in the transmission of an infectious disease. The incident must involve a care-giver or custodian acting in that capacity. The term 'care-giver or custodian' relates to certain health professionals and people in charge of others who have been taken into legal or protective custody. Before such an order can be made the Secretary must believe that:

- The incident could result in the transmission of a disease, if any of the persons involved were infected with one
- Any of the persons to whom the disease could have been transmitted has been counselled regarding the medical and social consequences of being infected and has consented to be tested for the disease

- Any of the persons who could have transmitted the disease has been offered counselling and has refused to be tested for the disease and
- The making of an order is necessary for the rapid diagnosis and treatment of those involved.

The order enables a test to be undertaken against the wishes of the person being tested. However, the procedure outlined in the Act (section 120A) provides that an attempt must be made to obtain consent from the person to be tested and that that person must be offered counselling about the disease.

New treatments for diseases which have been developed since these provisions were included in the Act raise the question of whether it is always appropriate to attempt to obtain the consent of the person to be tested. For example, there are now new treatments for HIV which significantly reduce the likelihood of a person developing the disease if the treatment is given within 24 hours of the injury which may result in the infection. These treatments have significant side effects and would therefore not be administered unless there is a real likelihood of the disease being transmitted. Cases where it may not always be possible to obtain consent within the timeframe necessary to administer the treatment include where the person suspected of having an infectious disease is unconscious or is legally unable to give consent due to a psychiatric or intellectual disability.

The Act also provides for the making of orders for the examination, testing, counselling, restriction and isolation of people with infectious diseases where the Secretary believes that a person is likely to transmit an infectious disease and there is a serious risk to public health.

These provisions represent a staged approach to the management of people who have an infectious disease who may transmit the disease to others. Section 121 provides for examination and testing to determine whether a person does have an infectious disease. If the results of the test are positive, an order for counselling about the disease can be made, if that is appropriate. If counselling is not

appropriate or has been unsuccessful, an order restricting a person's behaviour or movements can be made. Finally, an order can be made that a person be isolated or detained. The Act clearly envisages that the least restrictive option must be considered first and must have been inappropriate or attempted and been unsuccessful before a more restrictive order is made.

While these provisions apply to all infectious diseases, the Department of Human Services has issued guidelines for the management in Victoria of HIV infected people who knowingly or recklessly risk infecting others. These guidelines support and facilitate the staged management of people in this position. This is consistent with national strategies and recommendations which relate to the management of infectious diseases, particularly HIV/AIDS.<sup>33</sup>

The power to isolate someone who presents a risk has been used where that has been necessary to protect public health, although very rarely.

There are specific appeal provisions in relation to restriction and isolation orders. There is firstly provision to apply to the Secretary for review of the order and then a right of appeal to the Supreme Court. The Supreme Court may substitute its decision for that of the Secretary upon considering the matters outlined in the Act. There is limited opportunity to appeal a decision for an order for testing. Note that chapter 11 discusses whether the Supreme Court is the most appropriate forum to hear appeals of this nature.

Where a person is on an isolation order there is a power for the police to arrest the person if he or she has absconded from the place stated in the order. No such power exists with respect to someone who is the subject of an order imposing restrictions on his or her behaviour or movements. The structure of the Act is such that where a person fails to comply with an order imposing restrictions, the more restrictive isolation order can be imposed. This however may not necessarily always be the most appropriate option. As an example, a person under an order of this nature may be restricted to a particular place of residence. The aim of the order is

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33 See *National HIV/AIDS Strategy: A Policy Information Paper*, Australian Government Publishing Service, Canberra, 1989.

to keep people in a home type environment while still protecting the public from the risk presented by their behaviour. If they are not cooperative with respect to the restrictions placed upon them, there is little that can be done to enforce those restrictions. If they continually abscond, there is no power to find them and have them returned. Despite the lack of cooperation, however, it may still be preferable for a person to remain on a restriction order rather than to be placed on an isolation order. Therefore, the question arises as to whether the Act should provide for a power to arrest a person who is the subject of a restriction order.

*The review seeks comment on the powers to investigate and control infectious diseases. In particular the review seeks comment on the adequacy of the powers, the appropriateness of the review mechanisms and whether the powers in the Regulations should be included in the Act. Note that other matters relating to statutory powers are raised in chapter 11 of this paper.*

*The review also seeks your views on when it is appropriate to make an order that a person be tested for an infectious disease against their wishes or without their consent and what safeguards should exist on the making of such an order.*

*Comment is also sought on the inclusion of a power to arrest a person who is the subject of an order imposing restrictions.*

## 8.5 Interstate Transfer of Orders

One of the reasons for the establishment of bodies such as the National Public Health Partnership and its Legislation Reform Working Group is the fact that Australia is a Commonwealth and in many areas all jurisdictions need to come together to look at mutual problems, possibilities for harmonisation and difficulties that arise from the fact that public health issues do not stop at State and Territory borders.

One of the issues that has arisen for discussion is the management of people whose behaviour may place others at risk of being infected with a disease. Society is increasingly mobile and transient. When people who are the subject of orders or restrictions move to a new jurisdiction, the order ceases to have effect.

The legislation in most jurisdictions makes provision for orders similar to those discussed above to assist with the management of unsafe behaviours of some people with infectious diseases. They are generally similar to those in Victoria, although there is variation as to who can make them, their duration, appeal mechanisms, et cetera.

In other areas of the law, legislative schemes have been put in place to enable interstate recognition of orders. Examples exist in mental health legislation, legislation dealing with family violence and legislation governing guardianship of children. Such schemes usually provide for interstate recognition of court orders rather than orders of a government authority as would be the case here. While not always the case, generally provision is made for the lodgement of the order with a court in the jurisdiction to which the relevant person has moved to enable its recognition and enforcement in that jurisdiction.

The issue for discussion therefore is whether there is any need to make provision in the Act for a scheme which enables the interstate recognition of orders which seek to control the behaviour of a person who may transmit an infectious disease. If a person is subject to an order imposing restrictions of behaviour or movement or isolation and seeks to move to a different jurisdiction, should the legislation make provision for this? If such a scheme is to be implemented, consideration would need to be given to determining the most effective mechanism to allow this to occur. This issue is presently being considered by the Legislation Reform Working Group.

*The review seeks your comments on whether the Act should make provision for the recognition and transfer of orders relating to infected persons between jurisdictions. If so, what are your views on how such a scheme should operate?*

## 8.6 Knowingly or Recklessly Infecting Another Person

As a further mechanism for protecting the public health, section 120 of the Health Act provides that it is an offence to knowingly or recklessly infect another person with an infectious disease. It is a defence in any prosecution to prove that the person infected with the infectious disease knew of and voluntarily accepted the risk of being infected. The maximum penalty for the offence is \$20,000. This is separate to similar offences which exist in the *Crimes Act 1958* and have been the basis of recent prosecutions. The relevant provisions in the Crimes Act are section 19A and section 22, which are as follows:

### section 19A

- (1) A person who, without lawful excuse, intentionally causes another person to be infected with a very serious disease is guilty of an indictable offence.

Penalty: Level 2 imprisonment (25 years maximum).

- (2) In sub-section (1) "**very serious disease**" means HIV within the meaning of the **Health Act 1958**.

### section 22

A person who, without lawful excuse, recklessly engages in conduct that places or may place another person in danger of death is guilty of an indictable offence.

Penalty: Level 5 imprisonment (10 years maximum).

These provisions of the Crimes Act have been included because of their relevance but they are not the subject of this discussion paper.

There has not been a prosecution under section 120 of the Health Act. Good public health practice relies primarily on health education and promotion and encouraging behavioural change. It assumes that the majority of people that are well informed will take control of their own health outcomes and take steps which protect their own health.

In a recent speech to the United Nations,<sup>34</sup> Justice Michael Kirby of the High Court of Australia stated that the 'most effective strategies that we have so far found to help promote reduction of the spread of HIV involve the adoption of laws and policies which protect the rights of people most at risk of infection.' He also stated that

Experience teaches that responses [which criminalise particular target groups] have little impact on the containment of an epidemic of this nature. They actually tend to have a negative impact on behaviour modification because they place targeted groups beyond the reach of the requisite information. They undermine the creation of the supportive social and economic environment in which effective strategies can be prosecuted.

The offence provision as it is framed in the Health Act is relatively narrow in its scope. It is limited to circumstances where the victim of the offence is infected with an infectious disease and, as stated above, it is a defence to the prosecution to prove that the person infected with the infectious disease knew of and voluntarily accepted the risk of being infected. The penalty is also quite different to the offences in the Crimes Act in that it provides for a fine rather than imprisonment. It is arguable that because of the existence of the offence provisions in the Crimes Act, the offence provision in the Health Act is even less likely to be prosecuted, given its narrower scope and the lesser penalty. Against this, it must be noted that the Health Act offence applies to infectious diseases generally whereas section 19A of the Crimes Act is limited to HIV.

The above discussion indicates that public health practitioners tend to view mechanisms for controlling infectious diseases as a range of tools, the choice of which will vary according to the circumstances. The aim is always to promote the best public health outcome and this generally occurs when people who may be the subject of intervention participate in the process without fear of recrimination or prejudice. It should be noted, however, that under section 120 as it is presently drafted the offence can be prosecuted at any time that a person knowingly or recklessly infects another with an infectious disease, and there is no

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<sup>34</sup> *Human Rights and the HIV Paradox*, Lancet, 1996, 348: 1217-18.

requirement that other public health measures have been taken or attempted.

*The review seeks your comments on the above offence provision.*

## 8.7 Emergency Powers

The Act currently provides power for the Governor in Council to proclaim an emergency for the purpose of stopping, limiting or preventing the spread of an infectious disease. The Act provides that the proclamation:

- Must state the area to which it applies
- Lasts for the period, not exceeding two weeks, that is stated in the proclamation and
- May be renewed for a period not exceeding two weeks.

The proclamation may be revoked by the Governor in Council or by resolution of either House of Parliament.

Once a proclamation is made, the Secretary can make orders which restrict the entry and exit of people from the specified area and the seizure of land, buildings or things. There is a provision conferring a right to compensation for people who are innocently affected by a seizure of any land, building or thing.

These powers date back a long time, originating in the need to prevent the spread of plague. While the use of these provisions would be extremely rare, there are infectious disease risks such as the ebola virus or germ or biological warfare that may require the sort of response for which these emergency powers allow.

*The review seeks your views on the need for emergency powers in the Health Act and whether the powers as currently expressed remain appropriate for potential future emergencies.*

## 8.8 HIV

The HIV pandemic has been the subject of a significant amount of national and international

research and work and continues to be so. Australia has a very good record in its management and control of the spread of this virus as a result of strategies developed and adopted in the late 1980s and early 1990s. As a result of amendments made in 1988 Victoria produced very progressive legislation which helped support good public health practice with respect to HIV.

Division 6 of the Act contains special provisions relating to HIV. The provisions are varied and deal with the following matters:

- The requirement that certain information regarding the medical and social consequences of being tested be given to a person before being tested for HIV.
- Where the result of such a test is positive, the requirement that that information can only be given to the person by certain people.
- The requirement that the person be given information about the medical and social consequences of being infected and guidelines on ways to prevent the transmission of the disease to others.
- A special provision requiring people who, in the course of providing a service, acquire information regarding a person being tested for HIV or being infected with HIV, to take reasonable steps to develop and implement systems to protect the person's privacy.
- The power to close a court or tribunal where evidence is proposed to be given of any matter relating to HIV and it is necessary to do so because of social or economic consequences to a person if the information is disclosed.
- The requirement for the Secretary and those in charge of places where blood testing for HIV occurs to keep certain records regarding the incidence of HIV.

There are a number of other infectious diseases for which these same provisions may be relevant. For example, there are other diseases where it may be appropriate for counselling to occur regarding transmission and ways to prevent transmission to others. In other areas of this Part of the Act, HIV is not specifically referred to, that is, it is treated in the same way as all other infectious diseases. Recent

35 Information was obtained by visiting the United Nations website at <http://www.unhchr.ch/>

reports of the United Nations indicate that there is still a need for specific measures to be taken to help deal with the issues of HIV transmission.<sup>35</sup> Does this mean that there is still a need for specific **legislative** provisions such as those described above with respect to HIV or are these principles relevant more broadly? Are there any other medical conditions or infectious diseases for which these same principles could be relevant?

*The review seeks your view on whether these provisions remain necessary in relation to HIV and whether it remains necessary and appropriate to deal with HIV separately from other infectious diseases. Should these provisions be broadened to refer to infectious diseases generally or specific diseases prescribed by regulation? If they are to be expanded beyond HIV, what should be the criteria applied for including an infectious disease within the above provisions?*

## 8.9 Restrictions on Competition with Respect to the Provisions Relating to HIV

### 1) Qualification Requirements for a Person Providing Information Regarding a HIV Positive Test

Section 127(2)(a) of the Act specifies that a person must not be advised of the results of a positive HIV test except by and in the presence of a registered medical practitioner or a person of a prescribed class. Regulation 18 of the Health (Infectious Diseases) Regulations 1990 states that a person of a prescribed class is:

- (a) A person who has at least one year pre test or post test counselling experience about the HIV antibody test at the time the person is informed of the test result
- or
- (b) A person who has successfully completed a course approved by the Secretary in pre test and post test counselling in relation to the HIV antibody test.

The requirement that a person providing this information must have a certain level of experience or qualification is a restriction on competition which must be justified under the National Competition

Policy's guiding legislative principle. That principle is that legislation should not restrict competition unless it can be demonstrated that:

- The benefits of the restriction to the community as a whole outweigh the costs and
- The objectives of the legislation can only be achieved by restricting competition.

The objective of the legislation is that individuals who are tested for HIV infection receive informed support and advice regarding transmission of that disease, thereby reducing the risk of it spreading.

*The review seeks your comments on the costs and benefits of this restriction, whether those costs outweigh those benefits and whether there are any less restrictive means of achieving this objective.*

### 2) Limitation on Laboratories Which Can Test for HIV

Section 130 of the Act provides particulars that must be kept by laboratories with respect to HIV tests. The section also requires that testing of the blood of humans for HIV must occur in prescribed places. The laboratories that can undertake these tests are prescribed in regulation 19 of the Health (Infectious Diseases) Regulations.

The limitation as to who can test for HIV is a restriction on competition which must be justified under the guiding legislative principle set out above.

The objective of the legislation is to ensure that particular standards apply to centres which conduct this test. It is arguable that due to the potentially enormous social and other consequences which may follow from a false positive or false negative test there is a need for the Governor in Council to be able to determine who can provide these tests.

*The review seeks your comments on the costs and benefits of this restriction, whether those costs outweigh those benefits and whether there are any less restrictive means of achieving this objective.*

# Chapter 9 – Vaccine Preventable Diseases

## 9.1 Background

Immunisation has prevented more suffering and saved more lives than any other medical intervention this century. It is one of the safest and most cost-effective procedures in modern medicine. It is also the most cost-efficient.<sup>36</sup>

The Victorian Government is committed to increasing immunisation coverage at all ages, to reduce morbidity and mortality associated with vaccine preventable diseases. As part of its policy, Victoria has adopted the targets of the National Immunisation Strategy, which proposes that by the year 2001 there be:

- Greater than 90 per cent coverage of children at two years of age for all scheduled vaccines
- Near universal coverage of children at school entry for all scheduled vaccines, and near universal coverage for girls and boys under 17 years of age for measles, mumps and rubella.<sup>37</sup>

It is not the policy of either the current State or Federal Governments to make immunisation compulsory, as it is believed that high immunisation coverage can be achieved through other measures.

One tool in achieving high immunisation coverage is the legislation which allows for a child's immunisation status to be recorded upon entry into child care centres and schools. To minimise the spread of infectious disease, the legislation also provides for the exclusion of unimmunised children during outbreaks of certain diseases. The legislative provisions are currently found in Part 7 of the Health Act, the Health (Immunisation) Regulations 1990 and the Children's Services Regulations 1998.

The importance of the school entry certificate was recognised by the Commonwealth Government in its program entitled 'Immunise Australia'. This was a seven point plan for increasing immunisation coverage released by the Commonwealth Department of Health and Family Services in 1997. One point of that plan was the inclusion of legislative requirements for school entry certificates specifying children's immunisation status.

## 9.2 Immunisations Status Certificates

Part 7 of the Health Act provides for immunisation status certificates to be produced upon enrolment at primary school. The immunisation status certificate is provided by the parent of the child to the person in charge of the school at the time of enrolment. The certificate is issued by a person authorised by the local council based on information provided by the parents of the child in relation to certain specified diseases. The parent must provide one of the following:

- Evidence that the child has been immunised
- Evidence that the child has not been immunised against the disease/s due to the reasonable belief of a medical practitioner that the child may suffer an adverse reaction to the vaccination
- A statutory declaration that the parent or guardian believes that the child has been vaccinated
- A statutory declaration that the parent or guardian has a conscientious objection to vaccination  
or
- A written undertaking to immunise the child within six months.

The provisions allow for conscientious objection to immunisation, but this does not preclude the requirement to obtain an immunisation status certificate. The requirement to provide an immunisation status certificate even when the child is not vaccinated facilitates the control of infectious diseases during any outbreak that may occur.

Currently the certificate must be obtained for measles, diphtheria, poliomyelitis, tetanus and mumps as these are the diseases prescribed by the Health (Immunisation) Regulations. However, the list of diseases in the Regulations no longer reflects the diseases for which children are in fact immunised. Immunisation in practice occurs in accordance with the National Health and Medical Research Council (NHMRC) immunisation schedule. This discrepancy between the list of diseases in the Regulations and the NHMRC immunisation schedule means that the

36 National Health and Medical Research Council, *Immunisation Procedures*, 4th ed, Canberra, 1991.

37 For full details of Victoria's immunisation policy see *Victoria's Immunisation Policy 2001 and Beyond*, available on the Department's website at <http://www.dhs.vic.gov.au/>

diseases to which the immunisation status certificate applies do not reflect the current NHMRC guidelines regarding immunisation. The schedule for vaccinations in the Regulations has not been able to keep pace with changing practices in immunisation resulting from new and developing vaccines that have emerged and are emerging.

Because immunisation is a priority for all Australian Governments, Victoria is keen to remain consistent with other jurisdictions, in particular in respect of adherence to the NHMRC guidelines on immunisation. This applies to both the schedule of recommended immunisations and doses and the recommended exclusion periods.

Before an immunisation is added to the NHMRC recommended schedule, a significant amount of work occurs to ensure its safety and a cost benefit analysis is undertaken regarding the possible inclusion. The question therefore arises as to whether the Health Act should be amended to reflect the fact that immunisation occurs in accordance with the NHMRC guidelines. Some possible options for achieving this would be:

- To continue to prescribe the diseases by regulation but clarify Victoria's participation in a national scheme to facilitate quicker amendment of the Regulations
- Amend the Health Act to provide that the immunisations required for school entry certificates be in accordance with current NHMRC guidelines
- Amend the Health Act to provide that the immunisations required for school entry certificates be specified by Order of the Governor in Council, Minister or Secretary.

*The review seeks your comments on amendment of the Health Act to facilitate consistency with the NHMRC schedule for immunisation.*

As stated previously, the immunisation status certificate is currently issued by a person authorised by the local council to do so. This reflects the fact that in the past immunisation has primarily been provided as a service by local councils. Increasingly there are other providers of immunisation, some of which are contracted by local government, but also including registered medical practitioners who are

undertaking a higher number of immunisations.

*The review seeks your comments on whether the range of people who can issue an immunisation certificate should be broadened to reflect the changes which have occurred in the way immunisation services are delivered.*

The Act also provides that while an immunisation status certificate is compulsory, failure to produce one is not a grounds for refusing a child admission to the school. Section 144(2) states that:

A person in charge of a primary school must not refuse a child admission to the school only because an immunisation status certificate has not been produced in respect of that child.

While there is a penalty for failing to produce a certificate (\$500), the compulsory nature of the certificate may be weakened by continued admission to school despite the failure to produce an immunisation status certificate.

*The review seeks your comments on section 144(2) of the Act.*

### 9.3 Exclusion of Children During Outbreaks of Infectious Diseases

Section 145 of the Health Act and the Health (Immunisation) Regulations provide for the exclusion of children from schools during outbreaks of specified infectious diseases where the child:

- Has the disease
- Has been in contact with the disease
- Is not immunised against the disease
- or
- Has an immunisation status which is unknown.

Exclusion is done by the person in charge of the primary school if he or she reasonably believes that there has been an outbreak of an infectious disease at the school or if the council's medical officer of health reasonably believes that there has been an outbreak.

Exclusion of children from child care centres is done under regulation 39 of the Children's Services Regulations which requires that arrangements be made for an ill child to be removed as soon as

practicable if it is necessary in the interests of the health, safety or well-being of the child or other children attending the centre. There is no power to exclude unimmunised children.

The provision regarding exclusion from schools does not reflect changing practices with respect to immunisation procedures. Notifications of infectious diseases all come to the Secretary who undertakes investigations of outbreaks. Exclusion of children is also generally done in consultation with officers of the Department of Human Services under delegation from the Secretary. Consideration is being given at the national level as to whether exclusion from a school should only occur upon consultation with the public health authority whose role it is to confirm outbreaks of infectious diseases and take measures to prevent the spread of the infectious disease.

In keeping with that general legislative function regarding infectious disease, should these legislative provisions state that exclusion from a school should only be on the advice of the Secretary or Chief Health Officer? Should child care centres also be required to consult the Secretary regarding exclusion of children on the grounds that those children have not been immunised against a specified infectious disease, given that children can be excluded for a lengthy period? To further facilitate this, should persons in charge of schools and child care centres be required to notify the Secretary of a suspected or actual outbreak of an infectious disease in the centre or school of which they are in charge?

*The review seeks your comments on whether exclusion of children from schools and child care centres during outbreaks of infectious diseases should only occur upon advice from the Secretary or Chief Health Officer. Should schools and child care centres be required to notify the Secretary of suspected outbreaks of infectious diseases for which there is a power to exclude children from the school or centre?*

## 9.4 Immunisation Status Certificates and Child Care

Information regarding the immunisation status of children attending child care centres or preschools is governed by regulation 16 of the Children's Services

Regulations. That regulation requires that information regarding the immunisation of a child be provided to the centre at the time of enrolment of the child. There is no requirement for an immunisation status certificate. Immunisations for very young children occur frequently, with immunisations being required at approximately 2 months, 4 months, 6 months, 12 months and then 18 months. Further immunisations do not then occur until around school age. The requirement for an immunisation status certificate for all children attending child care would mean frequent updating of that certificate. It may be appropriate, however, to require an immunisation status certificate at 18 months when all the scheduled immunisations should have occurred. Part of the maternity payment is now given when a child is 18 months upon proof of up-to-date immunisation. The requirement for an immunisation status certificate at this age would ensure that a child care centre has accurate information regarding a child's current immunisation status. This would also facilitate exclusion of unimmunised children from child care centres during an outbreak of infectious disease which would protect the health and safety of the children attending that centre.

*The review seeks your comments on whether immunisation status certificates should be required for child care and preschool settings as well as at school age. If so, what are your views on how frequently this should occur, given the number of immunisations very young children receive?*

All the provisions relating to immunisation of children in child care centres are contained in separate Regulations. While this makes the requirements accessible for preschool and child care centre operators, there is a question as to whether all provisions regarding immunisation status should be contained within the same piece of legislation. This is particularly relevant if those provisions are in any way expanded as a result of this review.

*The review seeks your comments on whether provisions relating to immunisation should all be contained in a single piece of legislation irrespective of the venue to which they apply.*

# Chapter 10 – Health Information

## 10.1 Introduction

If we describe 'public health' as the organised response by society to protect and promote health, and to prevent illness, injury and disability,<sup>38</sup> we must recognise that to organise its response society needs to have access to health information. This allows epidemiological and other analytical work to be done so that public health interventions can be best directed to the promotion of health and the prevention of illness, injury and disability.

Reliable information on the determinants of health, the causes of ill health, and the patterns and trends of health and illness in populations is fundamental to developing effective health policies and programs. In the area of public health, information is required to:

- Monitor trends in the health and well-being of the community
- Help determine priorities for public health initiatives
- Identify issues that require action
- Contribute to the design (or redesign) and the management of public health activities and
- Monitor the effects of those activities.<sup>39</sup>

The Health Act has numerous provisions which relate to the collection and use of information. This chapter will describe the issues relating to health information including:

- How it is gathered
- The purposes for which it is used and
- The privacy protections applying to the use of that information.

## 10.2 Gathering Health Information

There is a need for accurate, timely and comprehensive information for the ongoing work of government, non-government and private organisations to benefit public health. There are many sources of data collected throughout the health care system. These include hospital records, cancer registries, notification regarding cases of

infectious diseases made under the Health Act and perinatal statistics which are also collected under the Health Act. Sources outside the health care system include the registry of Births, Deaths and Marriages, the Coroner and the Australian Bureau of Statistics. Analysis of death certificates and coronial inquests provide an important source of information about medical factors which contribute to death as well as providing information about death through accidents or suicide. Some of this information will be of an identifying nature and some of it will not.

This information may be collected for purposes other than public health, but can be very useful for identifying specific public health issues. For example, information on hospital admissions may be used to identify a higher prevalence of asthma in certain regions which may reflect different management practices or the presence of different risk factors. Where information is collected for a different primary purpose than advancement of public health, there may be occasions where this affects the usefulness of the data.

Types of data that are collected include:

- Mortality data, including that of specific sub-population groups such as neonates and infants
- Demographic data, such as the size and age structure of a given population and including sub-population data on Kooris and other ethno-specific groups
- Morbidity data, usually based on treatment service utilisation patterns or special surveillance systems (for example, notifiable diseases)
- Self reported data on perceptions of ill health or the reasons for use of treatment services
- Special data, such as indices of socioeconomic disadvantage, nutrition, cigarette and alcohol use, injury and suicide rates
- Environmental data, incorporating known population exposure to environmental pathogens such as food and water contamination, air pollution and radiation exposure.

Some of this information is collected by virtue of requirements for mandatory notification under the

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38 Definition of public health in the Memorandum of Understanding signed by all jurisdictions to establish a National Public Health Partnership for Australia. This memorandum can be seen at <http://hna.ffh.vic.gov.au/nphp/mou.htm>

39 Australian Institute of Health and Welfare, *Australia's Health 1998*, Canberra, p. 4.

Health Act and other legislation. For others, it is dependent on voluntary provision through cooperative arrangements with health care professionals and/or the individuals using health services.

### Notification of Infectious Diseases

One of the main sources for the collection of health information under the Health Act is mandatory notification of certain diseases and conditions. The Act provides for the making of regulations which can specify the diseases which must be notified and other necessary matters. Notification of disease is one of the topics addressed in this chapter. However, the public health interventions which may flow once a condition is notified to the Secretary are covered in Chapter 8, The Control of Infectious Diseases.

Currently, infectious diseases form the vast majority of conditions that are notifiable. The Health (Infectious Diseases) Regulations 1990 provide for a system of notification to the Secretary and it is generally registered medical practitioners or pathology laboratories that are required to make the notification. Under the Regulations, diseases are classified into four groups and the form of notification is dependent upon which group the disease falls into. This ranges from immediate notification by telephone or facsimile, irrespective of whether the diagnosis has been confirmed, for particularly serious diseases, through to written notification within seven days of confirmation of diagnosis.

Notification of disease is one of the matters that has been considered by the Legislation Reform Working Group of the National Public Health Partnership. Some of the matters that have been raised as issues are the varying lists of notifiable conditions across the country and the different case definitions that can apply to a particular disease. Consideration is being given to whether there should be a core list of diseases which are notifiable in every jurisdiction and if so how that might be achieved.

In Victoria, the list of diseases which are notifiable are specified by regulation. The majority of other jurisdictions provide a different method which enables easier amendment of the list, except for

New South Wales where the list is in a schedule to the Act. Options other than regulation for determining what should be notifiable conditions include:

- Order of the Minister or Secretary
- Order of the Governor in Council
- Order of the Director of the Public Health and Development Division
- Order of the Chief Health Officer.

Emerging infectious diseases can present a real threat to public health. The process for amending regulations can be slow and does not lend itself to a rapid response to emerging infectious disease threats. For a notification system to work, it must be both practical and current. This of course must be weighed against the fact that obligations which people have under the legislation must be clear and therefore any list would need to be published in an accessible manner. Also, there are many powers to intervene which may flow once a condition is notified to the Secretary.

*The review seeks your comments on whether the list of conditions which are notifiable should be specified by regulation or whether there is a more appropriate method of determining what diseases are notifiable. If it is not done by regulation what restrictions, if any, should be placed on the power to determine a list of notifiable conditions?*

*The review also seeks comment on whether there should be power in the Health Act to enable guidelines to be issued with respect to case definitions of notifiable diseases or conditions.*

### Notification of Other Conditions

As discussed above, under the Health Act the main source of information is the mandatory notification of conditions. These notifiable conditions are predominantly infectious diseases, although the Act also contemplates notification of abnormal bodily conditions (which is not defined). The focus, however, has clearly been on infectious diseases because the provision allowing for mandatory notification of conditions is in that Part of the Act which covers the control of infectious diseases.

Other information provided under a mandatory requirement in the Health Act is certain information

regarding births and still births. This requirement is more limited than is the case in certain other jurisdictions. In New South Wales, the *Public Health Act 1991* provides for mandatory notification of scheduled medical conditions. This enables information to be obtained and analysed about conditions which do not readily fit into a disease category. For example, in that State Sudden Infant Death Syndrome is a scheduled medical condition. New South Wales also collects information with respect to congenital abnormalities and adverse reactions to vaccines.

The question therefore arises as to whether the Victorian Health Act ought to be amended to allow for the mandatory notification of medical conditions such as these which do not necessarily fit within the categories of infectious disease or abnormal bodily condition.

Furthermore, where the information is collected primarily for purposes other than public health, should there be some provision in the Health Act which enables the Secretary to obtain additional information necessary for the performance of the Secretary's functions? For example, information regarding death is currently provided to the Registry of Births, Deaths and Marriages for basic vital statistics. This is useful for public health purposes, as causes of death are notified on death certificates. However, there is insufficient detail to identify preventable contributing factors to death.

It may also be appropriate to consider amending the Act to have all information which is collected listed together so that it is clear what information comes to the Secretary. A number of issues flow from this. Firstly, some information that is received results in potential intervention at a personal level, whereas other information is used for more generic purposes. If all notifiable conditions and information are listed together they would need to be categorised in a way which makes clear the use to which information about those conditions will be put.

Secondly, as discussed earlier, there is some difficulty with the list of notifiable infectious diseases being specified by regulation. This can be a lengthy process which does not facilitate a quick response when new infectious diseases emerge.

If the determination of what conditions should be notified were not done by regulation, what criteria, if any, should be included in the Act for determining what is notifiable and what safeguards would need to be in place in respect of the use to which that information is put?

*The review seeks your comments on whether the Health Act should be amended to allow for the mandatory notification of events such as congenital abnormalities in children or adverse vaccine reactions.*

*The review also seeks your comments on the obtaining of information necessary for identifying preventable causes of death and disease.*

*The review also seeks your comments on whether the provisions relating to health information should be all together in a Part of the Act which relates solely to health information, so that it is clear what information is obtained, how it is gathered and the purposes for which it is used.*

*What might be some appropriate ways of categorising that information, or ensuring appropriate safeguards exist with respect to its use?*

### 10.3 Use of Health Information

Chapter 2 described the strategies of public health as being health protection, prevention of disease and health education and promotion. These are sweeping terms which cover extensive public health activities. These activities can be said to include:

- Public health intelligence, including surveillance and monitoring information and epidemiological information identifying determinants of health and causes of ill health, and describing patterns and trends of health and ill health in populations
- Public health programs, including developing policy and planning strategies and activities aimed at disease prevention, and protection and promotion of the health of the community and
- Public health infrastructure including administrative, legislative, information, research and program delivery systems, and the workforce required to implement them.<sup>40</sup>

40 Australian Institute of Health and Welfare, *Australia's Health 1988*, Canberra, p. 115.

These activities cannot be effectively undertaken without access to reliable and accurate data. This section will address how health information supports these public health activities.

## 10.4 Public Health Intelligence

One of the important uses of health information is surveillance and monitoring of infectious diseases, disease trends and other important indicators of population health. Effective surveillance systems are recognised world wide as the key to communicable disease control. A number of countries and international agencies have recently reviewed their surveillance arrangements in recognition of the continuing threats posed to public health by communicable diseases and the need for a strategic capacity to assess and manage these threats, both in the short and long term.<sup>41</sup>

Notification of disease has long been accepted as vital to protection of the public health, with provisions relating to compulsory notification of infectious disease being included in legislation in Victoria as early as 1888. Without a surveillance system, prevention strategies for infectious diseases will be significantly hampered and interventions will be far less effective and often too late.

The collection of accurate information is also important in the areas of environmental and occupational health where monitoring of things such as exposure to lead, arsenic or other environmental hazards is important to prevent the risk of health problems developing.

Another important use of health information is the development of reports on health status, health outcomes, the determination of factors which contribute to death and disease and health service utilisation mapping. In many ways the beginning point for the use of any health information which is received is an analysis and interpretation of it. Development of public health programs and policy, targeted education programs, effective surveillance and appropriate interventions all rely on proper analysis of good data.

In recognition of this, section 9 of the Health Act places an obligation on the Secretary to:

- (a) establish a comprehensive information system which includes information on—
  - (i) the causes, effects and nature of illness among Victorians and groups of Victorians; and
  - (ii) the determinants of good health and ill health; and
  - (iii) the utilisations of health services in Victoria; and
- (b) analyse and disseminate this information widely to the public.

A strong program of epidemiology is vital to the proper care of the health of the population of Victoria. Many important breakthroughs in the identification of health risk factors and in the treatment of existing disease have come about as the result of painstaking epidemiology. It is important that the need to support this necessary function be kept in mind when considering the Health Act.

*The review seeks your comments on whether the Health Act should specifically refer to the importance of epidemiology in establishing a comprehensive information system as currently required under section 9 of the Act.*

*The review also seeks comments on whether the Act should contain a requirement that the Department provide a comprehensive report, based on epidemiology, on the health status of the Victorian population at regular intervals. If so, what should that interval be?*

## 10.5 Public Health Programs

### Planning and Policy

As stated above, one of the primary benefits of the collection and analysis of information is the production of reports such as health status reports or health service utilisation mapping. This in turn leads to a better understanding of health needs and therefore better targeting of services and interventions which can most effectively improve health outcomes.

Do the people of rural Victoria have access to sufficient advice on health promotion? What is the

<sup>41</sup> National Communicable Diseases Surveillance Strategy 1996.

likely need for limited care dialysis services in Victoria? Can the higher costs of 'Hospital A' be explained by its treatment of more seriously ill patients? Are the outcomes of the new adjunctive chemotherapy regime in terminal cancer worth the investment? Does the apparent cluster of new cancer cases in a central urban region indicate cause for investment in a major study of environmental toxins in the region?

These and many other questions regarding the efficiency of resource allocation are at the hub of the concerns of public health. They enable informed decisions to be made as to which of a range of interventions for different diseases will be offered given limited resources. Priorities in public health are often based on a combination of factors, including the severity of the condition, the frequency with which it occurs, the ease with which it can be prevented, the cost to the individual and the cost to the community. Provision of services is driven by concern for equity in health and a desire to provide services in areas of highest need.

The central role of epidemiology within the Public Health and Development Division is to provide valid, reliable and appropriately interpreted data upon which these kinds of decisions can be based.

### **Activities Aimed at Disease Prevention, Health Protection and Health Promotion**

Public health activities are very broad and diverse. Mechanisms for dealing with public health issues include legislation and regulation, development of design or environment changes, education and provision of information to the public about how to prevent disease or injury, promotion of healthier lifestyles, the tracing of infectious diseases and the taking of emergency action to address or prevent public health emergencies.

Determination of public health priorities as a result of policy and planning may result in any number of the interventions mentioned above. The appropriate intervention will depend on a variety of factors. For example, there may be public health awareness campaigns directed at identified areas. A major public health campaign directed towards prevention of burns and scalds in children has seen a significant decrease in the number of children being injured in

this manner. Other major public health awareness campaigns have been directed towards immunisation, food and nutrition, skin cancer, smoking, drugs and alcohol, to name a few.

Where necessary, the legislation also provides for public health interventions at an individual level. Contact tracing is the important task of tracing the contacts of people who have contracted communicable diseases such as tuberculosis, typhoid fever, poliomyelitis, hepatitis A, B or C or HIV. Contacts of people with such diseases may be traced to discover the source of the disease. Those people can be provided with the necessary information and education to help to prevent the further spread of disease. This may include checking food handling practices and advising about hygiene arrangements or changed sexual practices. If the provision of education and guidance fails to effect behaviour change in a person with an infectious disease who is likely to transmit that disease, then the Act enables a range of possible actions for the Secretary from relatively non-restrictive through to quite restrictive. These are described in Chapter 8, The Control of Infectious Diseases.

## **10.6 Public Health Infrastructure**

Quite a sophisticated system exists for the development, implementation and delivery of public health services. Chapter 3 discusses the various roles and responsibilities of those players involved in the delivery of these services. This chapter deals only with consultative councils as they are established under the Health Act and have special functions which rely on the obtaining of information in accordance with the Act.

### **Consultative Councils**

The Health Act provides for the establishment of consultative councils in section 24 and Part 9B. They are bodies with specialist knowledge and expertise. The powers to set them up are quite broad in scope. Generally speaking, currently established consultative councils play a role in health service evaluation. They collect data on mortality and morbidity in their particular area of expertise such as anaesthetics and paediatrics, and make suggested changes to practice to ensure better health outcomes.

They report to the Minister and the Secretary.

There are two mechanisms by which these councils are established under the Act.

Firstly, Part 9B establishes the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, which has a number of functions. Broadly speaking, these are to conduct inquiries and investigations into maternal and perinatal deaths and deaths in children from 28 days to 14 years, and to establish a perinatal data collection unit which has a responsibility to collect data for various purposes specified in the Act. Details that are to be reported to the Council are specified in the Act and the Health (Consultative Council on Obstetric and Paediatric Mortality and Morbidity) Regulations 1992. This council has been operating for more than 30 years and the information collected is reviewed by a variety of specialist committees. The analysis of this information is then fed back to the profession in order to improve quality of care.

Secondly, section 24 provides a general power to set up consultative councils. They can be established by an Order of the Minister for the purposes of any Act which imposes powers or functions on the Secretary. Currently established consultative councils are:

- The Consultative Council on Anaesthetic Mortality and Morbidity
- The Medicines Evaluation Committee.

The Minister is presently considering the formulation of a Surgical Consultative Council which will examine avoidable deaths associated with surgery.

The Governor in Council has powers to make regulations with respect to prescribing the powers and duties of consultative councils.

There is no mandatory requirement for the provision of information to consultative councils created under section 24. However, section 162G does mandate the reporting of every live birth or still-birth of a child in Victoria together with some details of the location of the birth and the health professional attending the mother to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity.

All consultative councils established under the Act are subject to very strong protections safeguarding the confidentiality of the information provided to them. Anyone who is or has been an officer, member or employee of the council is prohibited from disclosing any information obtained in the course of or in connection with their employment. Nor is such a person able to give evidence in any legal proceedings, whether it be through the answering of questions or the provision of documents. However, section 24 provides a power for the Minister to approve the disclosure of information held by a consultative council. There is no such provision applying to information held by the Consultative Council on Obstetric and Paediatric Mortality and Morbidity.

Given the significant functions of consultative councils, an important question arises as to whether they need the mandatory provision of information to carry out their functions. This is currently available to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity, but not to the other consultative councils. Is the role of a consultative council more effective when it is undertaken cooperatively with the relevant profession rather than compulsorily? If information is provided on a voluntary basis, what mechanism should there be for ensuring that all relevant information is received by the council?

If a requirement for the mandatory provision of information is considered necessary for a consultative council to perform its functions, how should this be achieved? What safeguards should be placed on the provision and use of that information? In weighing up these issues, there needs to be a proper balance between the interests of individuals in having information about their health status remain private and the interests of the wider community in having consultative councils examine incidents and draw conclusions from them that will ultimately benefit the health of all Victorians.

Another question which arises in respect of consultative councils is whether they should have an additional duty to report to the Minister on matters where health care could be improved.

If there were changes to the provisions relating to consultative councils, it may be appropriate to consider including the Consultative Council on Obstetric and Paediatric Mortality and Morbidity in the provisions generally applying to consultative councils, rather than address it separately in a different Part of the Act. For example, it may be possible for the Act to give general powers to establish councils and for each council to be established under separate regulations which specify the functions et cetera of the individual council in question.

Another matter which would need to be considered if there were changes to the provisions relating to consultative councils, particularly with respect to reporting of information, is the type of regulation making powers which would be needed to support such legislative provisions. There is currently a provision allowing for the making of regulations with respect to the powers and duties of consultative councils.<sup>42</sup> However, this may need to be strengthened to grant power to do certain things, such as prescribing forms seeking the information required by each consultative council.

*The review seeks your comments on whether all consultative councils should be dealt with together in the Health Act in a more consistent approach.*

*What should be the roles and responsibilities of consultative councils?*

*The review also seeks your comments on whether, given that there are requirements for the mandatory provision of information to the Consultative Council on Obstetric and Paediatric Mortality and Morbidity but not the other councils, all councils should have such a power.*

*Alternatively, is there a need for any council to have such a power?*

## 10.7 Privacy Protection for Health Information

Where information of an identifying nature is gathered for the purposes of public health, it must be handled with care. Personal information can be very sensitive and Victorians have a right to understand how information gathered about them will be handled and what mechanisms are in place to protect their privacy. This section will cover confidentiality and privacy issues in relation to public health information.

Dr Chris Reynolds in a recent paper entitled *Confidentiality and Privacy Provisions in Public Health: The transfer of information between Australian jurisdictions*<sup>43</sup> defined the terms 'confidentiality' and 'privacy' as follows:

- The term **privacy** is used to relate to the interest that persons are said to have in the integrity of information relating to them.
- The term **confidentiality** is the general obligation to keep that information confidential; not to release it to others. Under Australian law this obligation arises from a relationship the person has with a range of advisers or service providers (typically the doctor–patient relationship) or as specified by specific statutory requirements.

These definitions have been adopted for use in this chapter.

### Current Law

The current law in regard to confidentiality and privacy is a mixture of legislation and the common law. The Department of Human Services has also recently completed the development of a detailed privacy policy.<sup>44</sup>

The existing legal and policy position relating to confidentiality and privacy of public health information will be summarised and questions raised about possible reforms.

### Provisions in the Health Act

There are a number of specific provisions in the Health Act dealing with confidentiality and privacy.

<sup>42</sup> Section 24(4)(a).

<sup>43</sup> This paper was commissioned by the Legislation Reform Working Group and is to be published later in 1998.

<sup>44</sup> *An Information Privacy Policy for the Department of Human Services*, June 1998.

Section 119 sets out principles for the application of Part 6 of the Act dealing with the management and control of infectious diseases generally. Section 119(a) states that the spread of infectious diseases should be prevented or limited without imposing unnecessary restrictions on personal liberty and privacy. Section 119(e)(ii) states that people with an infectious disease or at risk of contracting an infectious disease have a right to have their privacy respected, so long as these rights do not infringe on the well-being of others.

Section 120D provides that when advising a caregiver or custodian who may have been infected with a specified infectious disease of the test results of the person who may have transmitted the disease, the Secretary may not reveal the identity of the person who was tested.

Section 128 requires persons who, in the course of providing a service, acquire information that a person has been or is required to be tested for HIV or is infected with HIV, to take 'all reasonable steps to develop and implement systems to protect the privacy of that person'.

Section 129 provides for courts or tribunals that hear matters where evidence of HIV status is being given to order that the evidence be given in closed session if, in the court's or tribunal's opinion, that is necessary 'because of the social or economic consequences to a person if the information is disclosed'.

Section 141 of the *Health Services Act 1988* covers confidentiality and privacy requirements for information obtained by health services such as public and private hospitals, community health centres and supported residential services. This Act is being separately reviewed and its provisions will not be addressed in this paper.

## The Common Law

The common law has also addressed the issue of privacy from time to time, and is therefore relevant

to this discussion. There is no right to privacy as such recognised by Australian law.<sup>45</sup> However, courts will remedy breaches of privacy rights where the information was obtained through a relationship recognised by the courts as confidential, such as the doctor-patient relationship.<sup>46</sup>

The common law position is that such privacy interests are not absolute and they can be overridden if there is a compelling public interest. In the absence of any statutory provisions which address this question, the common law would apply. Current common law cases<sup>47</sup> suggest that a court would be inclined to approve a transfer of information that entailed a breach of privacy, provided that it is reasonable under the circumstances and made in good faith. In the case of the risk of knowing or reckless infection with an infectious disease such as HIV, this conclusion is strengthened by the fact that the harm that is being prevented attracts serious penalties.<sup>48</sup>

## Information Privacy Principles

The Commonwealth passed the *Privacy Act 1988* in accordance with its obligations under the International Covenant on Civil and Political Rights. In particular, article 17 sets out the right of persons 'not to be subjected to arbitrary or unlawful interference with their privacy, family, home or correspondence'. The Commonwealth Act establishes 11 privacy principles which provide rights to persons to be informed about the purpose to which personal information about them will be put, safeguards regarding the security and accuracy of record keeping and rights of access to records.

The Department of Human Services has recently completed the development of a privacy policy. This is entitled *Information Privacy Principles*<sup>49</sup> and contains 11 principles relating to the following issues:

- Collecting information (principles 1–4)
- Storing and security issues (principle 5)

45 *Victoria Park Racing and Recreation Grounds v Taylor* (1937) 58 CLR 479.

46 *Furness v Fitchett* [1976] NZLR 396.

47 *Furness v Fitchett* [1958] NZLR 396; *W v Edgell* [1990] All ER 385; *Duncan v Medical Practitioners Disciplinary Committee* [1986] 1 NZLR 513.

48 See section 19A of the *Crimes Act 1958* and section 120 of the *Health Act 1958*.

49 *Information Privacy Principles*, Department of Human Services, June 1998.

- Openness, access and correction issues (principles 6–8)
- Retention and disposal of person information (principle 9)
- Use and disclosure of personal information (principle 10)
- Unique identifiers (principle 11)
- Conducting audits (principle 12)

The 11 privacy principles in the Department’s policy were based on those in the Commonwealth Act. They are not enshrined in legislation, although this is a possibility and will be addressed below. The Policy states that:

The onus is on individual staff members to ensure that the privacy principles are adhered to. It is their responsibility to demonstrate that, for the purposes of audits and complaints investigations, personal information has been handled in accordance with the relevant Principles. It is noted however, that information is usually handled within a supervisory context, in which case there is a corresponding responsibility on the supervisor to ensure information about these Principles is readily available to staff and that training has been conducted where necessary.<sup>50</sup>

Principle 10 is of particular interest in relation to limits on the use and disclosure of personal information. It reads:

The Department or a funded service provider holding personal information shall only use or disclose the information where:

- The use or disclosure is for a purpose for which the information was originally collected or a directly related purpose
- The use or disclosure is authorised by the individual concerned or the individual’s authorised representative where the individual is deceased, or the individual is unable to give his or her authority under this rule due to age, intellectual disability, mental illness, medical condition or some other recognised condition
- The use or disclosure is necessary for:
  - The maintenance of the law by any public sector agency including the prevention, detection, investigation,

- prosecution and punishment of offences
- The protection of the public revenue
- The conduct of proceedings before any court or tribunal (being proceedings that have been commenced or are reasonably in contemplation)
- or
- improving the health, wealth or safety of the community where the use or disclosure is authorised by an appropriate ethics committee
- or
- The use of the disclosure is required or authorised by law.

Principle 11 covers the use of unique identifiers. It provides as follows:

- The Department or a funded service provider shall only assign a unique identifier to an individual if the assignment of that identifier is necessary to enable the Department to carry out any one or more of its functions efficiently and to ensure the health, safety or welfare of its clients.
- The Department or a funded service provider assigning unique identifiers to an individual must take steps to ensure that unique identifiers are assigned only to those individuals whose identity is clearly established through the collection of other relevant pieces of information.
- Unique identifiers should not be used by multiple organisations or for multiple purposes in a manner which fails to meet the privacy protection standards established in these principles.
- When seeking a service from the Department or a funded service provider, it should not be compulsory for an individual to provide a unique identifier unless it is required or authorised by law, or unless it is in connection with a purpose (or a directly related purpose) for which the identifier was assigned.

## Data Protection Bill

The Victorian Department of State Development has also released a discussion paper entitled *Information Privacy in Victoria: Data Protection Bill*.<sup>51</sup>

<sup>50</sup> *ibid*, p 6

<sup>51</sup> *Information Privacy in Victoria: Data Protection Bill*, Department of State Development, July 1998.

That discussion paper describes the regime for privacy protection in Victoria which the Data Protection Bill would introduce. The regime will have two elements: support for voluntary schemes and codes; and a default legislative scheme. This regime will cover health information. The discussion paper refers to the *Health Records (Privacy and Access) Act 1997*, recently passed by the ACT Government. It states that the Victorian data protection regime will provide a similar level of certainty and will complement developments in the ACT and other jurisdictions. The paper also says that the Federal Privacy Commissioner's *National Principles for the Fair Handling of Personal Information* will be at the heart of the Victorian data protection regime.

The regime will give priority to approved voluntary codes. These will oust the default legislative scheme from the date of gazettal.

It is possible that the Department's *Information Privacy Principles* will be approved under the new privacy legislation as a voluntary code and gazetted to make them legally binding. They would then bind all officers working for the Department of Human Services, including those collecting information for the purposes of public health.

## Current Issues

One area of doubt about the scope of public interest exceptions to confidentiality and privacy requirements is when it is permissible to share information between jurisdictions about people with infectious diseases who are suspected of knowingly placing others at risk of infection. Australian jurisdictions have varying restrictions on the use of identifying information relating to the health status of such people.

Issues of confidentiality and privacy are also relevant to the important task of tracing the contacts of people who have contracted communicable diseases such as tuberculosis, typhoid fever, poliomyelitis, hepatitis A, B or C, HIV or AIDS as discussed earlier in this chapter. The question is whether under the current law the threat which the identified public health risk might pose to others is sufficient to justify the breach of confidentiality which this contact tracing involves. In Victoria it is believed that such information sharing is quite legal

under a combination of the requirements of the Health Act and the common law.

## What Should Be Included in the Health Act?

As described above, the whole area of confidentiality and privacy is currently undergoing review. At the time of writing this discussion paper, details of provisions to be included in the Data Protection Bill were not available and therefore it is not possible to comment on its effect on matters touching the practice and administration of public health. However, this paper will raise for consideration a number of matters concerning confidentiality and privacy which are of particular concern in the context of a review of the Health Act.

In order to avoid any possible confusion in this sensitive area, and to make the law more accessible to all Victorians, it may be appropriate to enact a specific provision which states that the disclosure of information in certain circumstances involving a threat to the public health will be an exception to the confidentiality and privacy requirements of the common law.

It is believed that such an exception would be consistent with the current common law and provide clarity to Victorians about the circumstances in which confidential information collected about them could be disclosed in order to protect the public health. Officers charged with the responsibility of carrying out duties under the Act would have the protection of clear rights and responsibilities in their handling of personal information.

Another possible amendment to the Health Act could be the insertion of a provision allowing exemptions from the legislative and common law requirements for confidentiality and privacy in certain defined circumstances. These may include, for example, where the disclosure is made:

- To a person to whom, in the opinion of the Minister, it is in the public interest that the disclosure be made
- To the extent that is reasonably required in connection with the performance of a duty or the exercise of a power or function under the Health Act or any other Act

- To the Secretary  
or
- To the Minister.

Persons covered by such a provision could include officers of the Department of Human Services and people who otherwise provide services under the Act; for example, contracted service providers.

A similar provision is currently available in section 16 of the *Intellectually Disabled Persons Services Act 1986*.

*The review seeks your comments on whether the Health Act should contain additional privacy protections to those currently provided in order to adequately protect the privacy of Victorians.*

*The review also seeks your comments on whether there are issues specific to public health which ought to be considered in a review of policy about confidentiality and privacy.*

*If there are such issues, do they need to be dealt with in the Health Act?*

# Chapter 11 – Statutory Powers and Enforcement

## 11.1 Introduction

The greater part of any legislation naturally deals with the subject matter it seeks to regulate. For example, if you were considering what might be in a Health Act, you might think of infectious disease control, provisions about the collection of data, sanitation, immunisation regulations and controls over activities like ear piercing and tattooing. You would be less likely to think of provisions such as enforcement powers, power to grant delegations or regulation making powers.

However, such powers are very important machinery provisions which allow the objects of the Act to be met. Great care must be taken in considering such provisions to ensure a proper balance between the rights of the individual and a legitimate public expectation that the Health Act will give the Government the necessary tools to respond swiftly and effectively to threats to the public health.

The current provisions relating to powers are spread widely throughout the Act and some have been discussed specifically in other areas of this paper.

This chapter discusses:

- Enforcement powers
- Penalties
- Appeal rights
- Immunity provisions and statutory defences
- Delegations  
and
- Regulation making powers.

## 11.2 Enforcement Powers of Officers

The Health Act provides for a range of powers for officers to enable them to enforce its requirements. The Secretary has the power under the Act to delegate any of the functions or powers of the position (except the power of delegation itself), and there is also a power for local councils to authorise officers for the purposes of the Act. The officers are known as ‘authorised officers’ and must carry an identity card signed by the Secretary or person designated by the council at all times while exercising their powers under the Act.

The enforcement powers in the Act are used by authorised officers working in the area of pest control, infectious diseases and radiation safety and by environmental health officers in local councils. Examples of the use of such powers would be authorised officers or environmental health officers responding to a complaint about unsafe or unhygienic skin penetration procedures with tattooing needles or earpiercing guns or unsafe sexual practices in a brothel.

The powers in the Act enable officers to gather information about possible offences. There are powers to enter premises, make inspections, and search and seize items. To properly protect the public health, the powers must allow for a swift response to a threat to the public health. For example, a delay in the seizure of unsafe skin penetration equipment could mean the unnecessary infection of a number of people. Naturally, the powers must also be clearly set out and have clear limits to ensure the best balance between the rights of those people who are subjected to the use of the powers, and the rights of the rest of the community whose health Parliament has sought to protect by granting the powers.

The Act does not give specific power to make copies of documents that have been seized. Consideration will be given to including such a power in the Act.

Enforcement provisions are also contained in the Health (Radiation Safety) Regulations 1994, the Health (Pest Control Operators) Regulations 1992 and the Health (Infectious Diseases) Regulations 1990.

Prosecutions under the Act are conducted by an authorised officer of the Department of Human Services or of any council, or an authorised member of the police force. Offences under the Act are triable summarily in the Magistrates’ Court, unless the Secretary or a council is of the opinion that summary proceedings would afford an inadequate remedy. In such circumstances proceedings may be taken in the Supreme Court.

The Act also gives power to an aggrieved defendant to appeal to the County Court against any conviction or order made by the Magistrates’ Court.

An inspector of a council has power to take proceedings against any person offending against any by-laws made by the council.

*The review seeks your comments on whether the enforcement powers given in the Health Act are appropriate to allow authorised officers and environmental health officers to carry out their duties, and in particular whether there should be a power to make copies of seized documents.*

*The review also seeks general comments on whether there are any other powers that should be included in the Act. If so, what should be their extent, what limitations should exist on their use and what redress or appeal mechanisms should exist in respect of them?*

*Ought all enforcement powers be brought together under the Act rather than spread throughout the Act as they are presently?*

### 11.3 Penalties

Public health is best protected when people observe standards of practice which minimise risks in a particular field of activity. For example, when people understand procedures to follow to minimise the risk of the spread of infectious disease in a premises where skin penetration procedures are undertaken, better public health outcomes are achieved. Health promotion, education and training are the best tools to achieve these outcomes. However, prosecution is another useful tool when other methods have failed or are unlikely to be successful. This raises the question of whether it may be appropriate to include in the Health Act a provision for on the spot fines with respect to certain offences such as are provided for in respect of certain offences against the *Environment Protection Act 1970*. Would on the spot fines provide a useful middle ground between administration of a warning and formal prosecution, and would they provide a more immediate deterrent to unsafe practices than formal prosecution?

'On the spot fine' is a colloquial term for Penalty Notice by Registration of Infringement Notice (PERIN). Infringement notices can be issued for various offences, the most familiar example being parking or speeding offences. Usually the offences

are quite minor and require payment of a fine within a specified period. The offender retains the right to have the matter dealt with by a court, although this may result in a higher penalty if found guilty of the offence. If the fine is paid, the matter is finalised and no conviction is recorded. Failure to pay may result in court proceedings or direct enforcement of the penalty.

The advantage of this system is that it provides a speedy mechanism for dealing with offenders by diverting them from the formal court process. For the system to be effective it can only really be applied to highly specific offences such as, for example, failure by a pest control operator to provide information to the Secretary about the use of pesticides as required by section 108E of the Act, or failure of a person who deals with radiation to wear a personal monitoring device as required by regulation 53 of the Health (Radiation Safety) Regulations 1994 .

If a prosecution under the Health Act is successfully undertaken, at present the penalties are relatively low if you compare them with penalties in environmental health legislation, occupational health and safety legislation and trade practices legislation. For example, breaches of the Environment Protection Act will attract penalties of up to \$250,000 or two years imprisonment. Should penalties for causing a risk to the public health be greater than they are, to reflect community views of the seriousness of such behaviour?

The Environment Protection Act and the *Occupational Health and Safety Act 1985* also have penalties which reflect the fact that the aim of the legislation is to change behaviour which presents a risk to health. For a number of offences, the Environment Protection Act allows for a daily fine where the offence is continuing. The Occupational Health and Safety Act provides for a greater penalty to be imposed where the offence is not a first offence. It also allows for greater penalties to be imposed on corporate bodies than those imposed on individuals.

*The review seeks your comments on whether consideration should be given to different penalties for some offences in the Health Act, including on the spot fines, continuing penalties or greater penalties for subsequent offences. If so, in what circumstances or for which offences do you think this would be appropriate? Where prosecutions occur, should penalties be increased to reflect the seriousness of offences which pose a threat to the public health, and in particular should there be provision for higher penalties where the offender is a body corporate?*

## 11.4 Immunity Provisions

Officers who exercise powers and make decisions under the Health Act to protect the public health often do so in complex circumstances and in emergency situations. This is a difficult role and officers should be given all the support necessary to carry out their responsibilities in such circumstances. It is important that such officers are not troubled in making these decisions by concerns about the possibility of personal legal liability, as long as their decisions are made in good faith. An immunity provision may be one way of providing the necessary protection in this regard.

For example, in section 122 of the *Mental Health Act 1986* an immunity is given as follows:

No civil or criminal proceedings lies against any person for anything done in good faith and with reasonable care in reliance on any authority or document apparently given or made in accordance with the requirements of this Act.

*The review seeks your comments on whether the Health Act should contain an immunity provision and if so, who should be granted immunity and in what circumstances.*

The Act also currently provides an immunity for pathologists who give information to the Secretary about an infectious disease. Pathologists are required by the Health (Infectious Diseases) Regulations 1990 to notify the Secretary of the presence of a number of infectious diseases.

Other people are also required to notify the Secretary regarding various matters. For example, registered medical practitioners are required to notify of the presence of certain infectious diseases in their patients. Where a requirement exists to make a notification to the Secretary regarding another person in circumstances where that notification could be a breach of confidentiality, should there be a statutory immunity or some provision which makes it clear that complying with obligations under the Act does not amount to a breach of confidentiality?

*The review seeks comment on the protections which should be afforded to people who are required to provide the Secretary with information under the Health Act.*

## 11.5 Blood Donations

For the purposes of protecting the blood supply, a statutory defence also exists for the Australian Red Cross Society, hospitals and doctors, in certain circumstances where a person claims to have been infected by Hepatitis C or HIV from contaminated blood products supplied by them. This statutory defence is currently under consideration by the Australian Health Ministers' Advisory Council (AHMAC).

Late in 1997, AHMAC called on its Blood and Blood Products Committee to investigate and report back to it on options for achieving a nationally uniform statutory defence related to the threat of blood transmittable disease in the blood supply.

The project brief was limited to a consideration of the options to achieve a nationally uniform statutory defence. It did not extend to a consideration of the regulation of blood and blood products generally, or to a consideration of the provision of compensation to those infected by blood or blood products. Financial indemnity arrangements were to be considered by a separate consultancy.

It became apparent during consultations with State, Territory and Commonwealth nominated representatives that there was support for this inquiry into a national uniform statutory defence in respect of the administration of blood and blood products to be broadened.

At its meeting in March 1998, AHMAC recognised that matters other than the statutory defence described above require consideration. It agreed that the Blood and Blood Products Committee should consider the following additional issues:

- The legislative recognition of a national regulatory body which is at arm's length from the Australian Red Cross Blood Service, which can be entrusted and held responsible to ensure blood safety and quality, and to set uniform best practice standards for the blood supply system and
- Options and recommendations for a national uniform scheme designed to deal with issues of patients who otherwise lose their common law rights (including, but not limited to, health and compensation).

AHMAC also asked its Blood and Blood Products Committee to have close regard to the recommendations made by Justice Krever in the Canadian inquiry into blood<sup>52</sup> and to ensure that relevant officers in their jurisdictions are kept informed of progress on matters relating to a national regulation and compensation scheme.

A working party has also been commissioned to report to AHMAC on a number of funding and management issues.

As AHMAC is currently considering these matters in considerable depth, and Victoria will have the opportunity to participate in that process, these sections of the Health Act will not be considered as part of the current review. Interested people could contact the Blood and Blood Products Committee about further information on the projects it is undertaking.<sup>53</sup>

## 11.6 Appeal Rights from Administrative Decisions

There are powers to make a number of administrative decisions in the Act. These powers are conferred on the Secretary, the Minister or local councils and are often delegated to another officer

or officers within the Department of Human Services or within local councils. One example of this is the power to refuse or revoke registration of a pest control operator. (Note that where an offence occurs, the matter is heard in the Magistrates' Court with a right of appeal to the County Court.)

Currently, where there is a right of appeal against an administrative decision under the Health Act that appeal is to the County or Supreme Court. Statutory rights of appeal under the Health Act are quite limited and consideration needs to be given to whether there are other administrative decisions made under the Act for which a right of appeal should be included.

Under section 387, if the Secretary or any council refuses or neglects to give approval or consent to any application made under the Act, or to grant any application for renewal of any registration under the Act, there is a right of appeal to the County Court.

Section 108AH confers a right of appeal to the County Court in respect of decisions to vary, suspend, cancel or impose conditions on a licence or registration granted under that Part of the Act dealing with radiation safety. The question has already been raised as to whether it is desirable for appeals from licensing and registration decisions to be dealt with together in one section of the Act.

Section 122(3) of the Act gives a right of appeal to the Supreme Court to persons against whom a restriction order, isolation order or interim isolation order has been made under section 121. The choice of the Supreme Court as the appeal jurisdiction gives proper recognition to the seriousness of an order which may deprive an individual of liberty. However, it is also important that people affected by such orders have the opportunity to use an appeal mechanism which is as accessible and affordable as possible.

The Victorian Civil and Administrative Tribunal (VCAT) (Administrative Division) has jurisdiction to hear administrative decisions. The President of VCAT is a Supreme Court judge and the

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52 On November 26, 1997, Health Minister Allan Rock, on behalf of the Canadian Government, released the final report of the Commission of Inquiry on the Blood System in Canada (Krever Commission).

53 Enquiries should be directed to the Executive Officer of the Blood and Blood Products Committee, Ms. Jane Evans, Acute Health Division, Department of Human Services, Level 17, 555 Collins St, Melbourne, 3000.

Administrative Division is led by a Vice President drawn from the ranks of sitting County Court judges. Administrative decisions such as those made under the Health Act are generally appealable to tribunals rather than courts. Even decisions such as those made under section 121 are frequently heard by tribunals. For example, reviews from decisions of the Mental Health Review Board under the Mental Health Act are currently heard by VCAT. Issues raised in such cases have some similarities to issues raised in appeals from an isolation or restriction order.

*The review seeks comments on what decisions made under the Health Act should be subject to appeal. Where there is provision for an appeal from an administrative decision, what do you regard as the most appropriate venue to hear the appeal? Should all appeals go to the same forum or are there particular cases, such as where isolation orders have been made, which justify a specific appeal provision to a different forum?*

- Immunisation
- Birth notifications
- Prescribed accommodation
- Drugs and other substances
- Meat supervision and
- Registration of premises.

*The review seeks your comment on whether the regulation making powers in the Health Act should appear with the subject matter to which they relate, or whether it is more appropriate to have all regulation making powers together in the Act.*

*The review also seeks your comment on whether there are any other areas for which there should be a regulation making power and if so, why.*

## 11.7 Delegations

Presently all the powers in the Health Act are given to either the Minister or the Secretary. They have the power to delegate any of their functions and powers under the Act except that power of delegation itself. The Secretary also has power to authorise officers to carry out certain functions. The functions of the Secretary with respect to public health are primarily delegated to senior staff within the Public Health and Development Division, such as the Director or the Chief Health Officer.

## 11.8 Regulation Making Powers

As well as a general regulation making power, the Act presently has many specific provisions granting regulation making powers. Most of these are placed together in the Act with the subject matter on which regulations can be made. Currently there are specific powers to make regulations for:

- Nuisance
- The protection of water supplies
- Radiation safety
- Pest control
- Destruction of rats and mice
- Disease notification

# Chapter 12 – Consultation Arrangements

## 12.1 Information

Further information on this review is available from:

Ms Genevieve Howse  
Manager  
Legislation Review Team  
Department of Human Services  
Tel: (03) 9637 5508  
Fax: (03) 9637 5510  
Email: genevieve.howse@dhs.vic.gov.au

Members of the Legislation Review Team are available to meet with groups and individuals to discuss this review. Arrangements for meetings can be made by contacting Ms Howse on the above number.

## 12.2 Copies of Discussion Paper

Further copies of this discussion paper can be obtained by contacting:

Legislation Review Team  
Public Health and Development Division  
Department of Human Services  
GPO Box 1670N  
MELBOURNE VIC 3001  
Tel: 9637 5506  
Fax: 9637 5510  
Email: tim.lunn@dhs.vic.gov.au

The discussion paper is also located on the Internet at the following address:  
<http://www.dhs.vic.gov.au/phd/9810098/index.htm>

## 12.3 Submissions

Parties interested in commenting on this review may put in a written or taped submission. Submissions should be forwarded to:

Ms Genevieve Howse  
Manager  
Legislation Review Team  
Public Health and Development Division  
Department of Human Services  
GPO Box 1670N  
MELBOURNE VIC 3001

Submissions should be received no later than **26 February 1999**.



# Appendix I

## Health Act Provisions

The following table lists the provisions in the Health Act and indicates the chapter of the discussion paper in which they are covered. Clearly, the nature of the discussion paper is such that only very few provisions are discussed specifically.

PART 1—INTRODUCTORY		
Sections 3–5	Preliminary	Chapter 3
PART 1A — OBJECTS AND FUNCTIONS		
Section 5A	Objects	Chapter 2
Section 5B	Functions of the Chief General Manager	Chapter 3
PART 2 — ADMINISTRATION		
Sections 6–25 (except as listed below)	General	Chapter 3
Section 8A	Delegation by Chief General Manager	Chapter 11
Section 8B	Delegation by Minister	Chapter 11
Section 9	Data collection	Chapter 10
Sections 24–24A	Consultative councils	Chapter 10
Section 25	Further powers and duties of certain officers	Chapter 11
Sections 29A–37 (Division 3)	Local Administration	Chapter 3
PART 3—NUISANCES		
Sections 39A–47D	Nuisance	Chapter 5
PART 4—GENERAL SANITARY PROVISIONS		
Sections 68–72 (Division 4)	Offensive Waterways	Chapter 5
Sections 79–81 (Division 6)	Protection of Water Supplies	Chapter 5
Section 87 (Division 7A)	Animals	Chapter 6
PART 5—RADIATION SAFETY		
Sections 108AA–108AL (Division 2AA)	Radiation Safety	Chapter 6
Sections 108A–108H (Division 2A)	Pest Control Operators	Chapter 7
PART 6—MANAGEMENT AND CONTROL OF INFECTIOUS DISEASES		
Sections 118–119 (Division 1)	Preliminary	Chapter 8
Section 120 (Division 2)	Offences	Chapter 8
Sections 120A–122	Orders	Chapter 8
Sections 123–125 (Division 4)	Emergency Powers	Chapter 8
Section 126 (Division 5)	Autopsies	Chapter 8
Sections 127–130 (Division 6)	Special Provisions relating to HIV	Chapter 8
- Sections 131–136 (Division 7)	Blood and Tissue Donations	Chapter 11
- Section 137. Division 8	Immunity for giving information	Chapter 11
Section 138 Division 9	Disease Notification	Chapter 10
PART 7—IMMUNISATION		
Sections 143–145		Chapter 9
PART 8—REGULATIONS		
Section 146		Chapter 11

PART 9—BIRTHS NOTIFICATION		
Sections 158–162		Chapter 10
PART 9B—CONSULTATIVE COUNCIL ON OBSTETRIC AND PAEDIATRIC MORTALITY AND MORBIDITY		
Sections 162B–162I		Chapter 10
PART 12—ACCOMMODATION		
Sections 209–213	Prescribed Accommodation	Chapter 8
PART 13—PRECAUTIONS AGAINST FIRE		
Section 228	Not discussed as are administered by the Minister for Planning	
PART 14—DRUGS, SUBSTANCES AND ARTICLES		
Sections 230–304		Chapter 5
PART 15—MEAT SUPERVISION		
Sections 305–314		Chapter 5
PART 19—REGISTRATION OF PREMISES		
Sections 366B–376		Chapter 8
PART 20—GENERAL AND SUPPLEMENTARY		
Sections 377–387	General	Chapter 11
Sections 389–391	Proclamations, Regulations, By-laws, Orders	Chapter 11
Sections 399A–420	Enforcement of Act	Chapter 11
Sections 421–450	Offences & Legal Proceedings	Chapter 11

# Appendix II

## Terms of Reference for the National Competition Policy Review of the Health Act 1958

### Government of Victoria

### National Competition Policy Review of Legislative Restrictions on Competition

## Review of the Health Act

### Terms of Reference

The review of the *Health Act 1958* has been commissioned by the Minister for Health in accordance with the Victorian Government Timetable for the *Review and Reform of Legislation that Restricts Competition*, determined in accordance with National Competition Policy.

### Legislation to be Reviewed

The review will examine the case for reform of legislative restrictions on competition contained in the Health Act and Health (Infectious Diseases) Regulations, Health (Prescribed Accommodation) Regulations and Health (Pest Control) Operators Regulations, in accordance with the Victorian Government's Guidelines for the Review of Legislative Restrictions on Competition.

In particular the review panel will

- Clarify the objectives of the legislation
- Consider the general efficiency and effectiveness of the legislation
- Identify the nature of the restrictions on competition
- Analyse the likely effect of the restriction on competition and on the economy in general
- Assess and balance the costs and benefits of the restriction and
- Consider alternative means of achieving the same result including non-legislative means.

### Reform Options

Without limiting the scope of the review, the review should specifically address the appropriateness of regulating premises where certain activities are conducted, and regulating miscellaneous matters pertaining to public health while continuing to ensure a high standard of public health is maintained. The review should also consider the harmonisation of public health controls to maximise efficiency where regulation is considered necessary.

### Review Arrangements

This review is to be established and conducted in accordance with the In-House Review model contained in the Guidelines.

### Key Dates

The review will report its findings and recommendations to the Minister by **May 1999**.

### Secretariat

The Review Secretariat will be located in the Department of Human Services. The Secretariat can be contacted on:

Phone (03) 9637 5509  
Facsimile (03) 9637 5510  
Postal NCP Legislative Review  
Public Health and Development Division  
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GPO Box 1670N  
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