

<b>Chapter 3 Overarching framework</b>	
Section 3.1 Name of the New Act	<p>1. <i>Should the Act be renamed and, if so, what name would best reflect the role and purpose of the new Act?</i></p> <p>The AIEH believes that name of the Act should be consistent across Australia. As the majority of States have their Health Act named the 'Public Health Act', it is recommended that the Act be titled the "Public Health Act".</p>
Section 3.2 Scope of the new Act	<p>2. <i>Are there matters that are currently dealt with by other legislation that should be included in the new Act?</i></p> <p>The AIEH membership believes that there are a number of matters currently dealt with by other legislation that should be included in this Act, in particular those that relate to the control of infectious diseases and public health issues. An example is Parts 5A and 5B of the Building Act dealing with cooling towers (because of the link of preventing an infectious disease i.e. <i>Legionella</i>). Where some matters are currently dealt with by other legislation the EHO may not always be consulted with in resolving or addressing situations prior to becoming issues or as they evolve (such as in statutory planning issues / permits). It is appropriate that some specific health related issues are to be dealt with by other legislation such as the Tobacco Act and Food Act - these matters were originally included in the Health Act but were separated to make administration clearer.</p> <p>3. <i>Should the new Act recognise the importance of promoting public health, and, if so, how should the new Act aim to achieve this?</i></p> <p>The AIEH believes that the new Act should recognize the importance of promoting public health. This can be done by recognising health as a positive condition, not merely the absence of disease or infirmity, and inclusive of physical, social and mental well-being. It should also include major approaches in responding to public health needs such as health protection, health prevention, health education and promotion, and harm minimisation. Municipal Public Health Plans currently provide some forum for promoting public health.</p>

<b>Chapter 3 Overarching framework</b>	
Section 3.2 Scope of the new Act	<p>4. <i>Should the new Act recognise the need to address inequalities in the health and wellbeing of disadvantaged communities and, if so, how should the Act aim to achieve this?</i></p> <p>The AIEH membership believes that such inequalities can be addressed through enabling provisions that promote public health partnerships, create flexibility that enhances ability to respond to changing public health circumstances, and by the recognition that health includes physical, social and mental well-being. Some inequalities are already being addressed through the Municipal Public Health Planning process.</p>
Section 3.3 Objects	<p>5. <i>What objects provisions would represent the public health objectives, values and outcomes that the new Act should be aiming to achieve?</i></p> <p>The AIEH feels that the following objects would assist in defining the aims of the new Act:</p> <ul style="list-style-type: none"> <li>• a definition of <i>public health</i> that focuses on population based health and draws a distinction between public and environmental health;</li> <li>• the recognition of <i>health</i> as a positive condition, not merely the absence of disease or infirmity, and inclusive of physical, social and mental well-being;</li> <li>• a proclamation of the proposed objectives previously set out in Section 5A of the existing Act together with the inclusion of the major approaches used to improve health namely health protection, health prevention, health education and promotion; and harm minimisation;</li> <li>• a greater emphasis on the inclusion of <i>enabling</i> provisions to promote public health partnerships and respond to changing public health circumstances; and</li> <li>• a stronger focus on a risk management / systems based approach to achieve ongoing relevance and sustainability</li> </ul>
Section 3.4 Guiding principles	<p>6. <i>Should the new Act contain a provision specifying guiding principles, and, if so, what principles should be included?</i></p> <p>The AIEH supports the view that a provision specifying guiding principles be incorporated into the new Act.</p>

<b>Chapter 4 Intersectoral relationships</b>	
Section 4.1 Functions of the Secretary	<p>7. <i>Should the new Act include a statement that the function of the Secretary is to implement policies and programs to achieve the objects of the Act?</i></p> <p>The AIEH believes that the functions and general responsibilities should be identified and established within the new Act so that they are well defined and understood. This should include:</p> <ul style="list-style-type: none"> <li>• the roles and functions of the Secretary as spelt out in the unproclaimed and subsequently deleted Section 5B of the current Act;</li> <li>• the Secretary have a responsibility to consult with and develop partnership agreements with local government which are subject to regular review (three yearly basis with provisions for annual review);</li> <li>• provisions requiring DHS to prepare state and regional public health plans, inclusive of a requirement to consult with local government and the community sector as part of the process; and</li> <li>• coordinating and supporting annual reporting requirements for state, regional, and local public health authorities that provide a statement on current public health priorities; actions undertaken to address issues; reporting of health indicators; and proposed strategies to be implemented.</li> </ul> <p>8. <i>Should the new Act include a power for the Secretary to conduct inquiries into matters of public health concern and should have the power to direct that an inquiry be conducted?</i></p> <p>The AIEH supports the view that the Secretary or delegate should have a power to conduct such enquiries, but also when directed by State Government or the Coroner. It should also extend to provide the Secretary the ability to co-opt resources for these activities as required.</p>

<b>Chapter 4 Intersectoral relationships</b>	
Section 4.2 Functions of municipal councils	<p>9. <i>Should the new Act retain the functions for municipal councils as set out in the current Act?</i></p> <p>The AIEH believes that the functions of municipal councils be redefined in the new Act to include:</p> <ul style="list-style-type: none"> <li>• Initiating, supporting and managing public health planning processes at the local level of government</li> <li>• Facilitating and supporting the efforts of other local public health organisations to improve public health status</li> <li>• Ensuring that National, State and Regional priorities inform and influence Council’s service planning activities and the service planning activities of local health service providers;</li> <li>• Ensuring the development of healthy public policies through the integration of the public health planning processes with other strategic planning processes of council;</li> <li>• Within a competitive business environment, promoting the sharing of local health information between health services and planners;</li> <li>• Advocating on behalf of the local community for appropriate local, state and federal public health policy, increased public health resources, integrated and coordinated service delivery, and appropriate delivery of services;</li> <li>• Engaging with public health regional planning processes;</li> <li>• Regulating and controlling risks and potential risks to the health of the municipal community; and</li> <li>• Immunisation co-ordination.</li> </ul> <p>At present the functions of councils specified in the Act are vague. This is an opportunity to clearly specify and update what Council’s are expected to carry out under the Act. This will enable Councils to better plan and resource their activities and at the same time make them more accountable for delivering on these functions. There should be some scope for DHS to explore partnership arrangements and resource implications.</p>

<b>Chapter 4 Intersectoral relationships</b>	
<p>Section 4.2 Functions of municipal councils</p>	<p>10. <i>Should the new Act recognise municipal councils' role in:</i>  <i>Planning, advocating and providing organised public health programs?</i> <i>Developing and implementing strategies to promote and improve public health and promote community health and wellbeing?</i></p> <p>The AIEH supports this question in accordance with the redefined role of councils specified in the response to Question 9. It is critical for local government's role to provide services meeting the needs of their communities across the full spectrum of health approaches, including preventative, promotion, community development, advocacy, and facilitation. It should also give Councils the ability to respond to emerging public health issues, particularly those that are not covered by other mechanisms</p>
<p>4.3 Partnerships in public health</p>	<p>11. <i>Should the concept of partnership between state and local government, and between government and non-government, be addressed in the new Act?</i></p> <p>The AIEH supports this notion. The Institute has in the past expressed its' concerns that the relationship between local government and other levels of government is not based on sound partnership agreements or with clearly defined roles and responsibilities. The new Act should acknowledge the importance of establishing linkages across governments, agencies and the community sector to improve public health outcomes and include mechanisms that require formal consultation and agreement on joint responsibilities. Acknowledgement of such relationships would improve collaboration in public health effort, provide better coordination and sustainability of strategies, clarify roles and responsibilities, rationalise funding and resource allocation, and assist in developing appropriate public health infrastructure. This partnership concept in the new Act should include</p> <ul style="list-style-type: none"> <li>• Policy development; strategic planning;</li> <li>• Effective consultation through planning processes;</li> <li>• Establish linkages between service agreements and funding arrangements and the outcomes of public health planning</li> <li>• Program design;</li> <li>• Service purchasing and service contract management;</li> <li>• Service delivery;</li> <li>• Health surveillance;</li> <li>• Resource allocation;</li> <li>• State, regional and local data collection and analysis; and</li> </ul>

	<ul style="list-style-type: none"> <li>Monitoring and evaluation.</li> </ul>
<b>Chapter 4</b> <b>Intersectoral relationships</b>	
Section 4.4 Municipal public health plans	<p>12. <i>Should the new Act place greater emphasis on implementing the MPHP and achieving its outcomes, rather than just developing a document, and if so, how could this be achieved?</i></p> <p>The AIEH supports this position in the discussion paper. A possible way of achieving outcomes is to incorporate the MPHP as part of the council Corporate Plan or equivalent, which would then link to the annual budget process, mandatory reporting requirements internally and externally; and ensuring connections to individual department service/activity plans through the annual planning process. Public health planning should become and be seen as a core local government responsibility.</p> <p>Current legislation requires MPHP development including strategies, however it does not enforce the implementation of MPHP actions and priorities identified. In addition there is no legislative requirement for non government agencies to implement the actions specified. Other current barriers to the implementation and achievement of outcomes include competing council interests and priorities, other corporate planning activities, the perceived status of MPHP within the individual council, and resourcing.</p> <p>13. <i>Should the new Act require that municipal councils set out how they intend to fulfil their statutory functions in their MPHPs?</i></p> <p>The AIEH provides qualified support for this view, however this should be in the context that the MPHP should be part of the corporate planning process, and as part of annual reporting many statutory function outcomes are already reported. By requiring councils to show their intent it provides councils with a further opportunity to prioritise services and outcomes / activities. Greater clarification is required regarding what the function and purpose of this proposed change to the Act would entail, and the respective benefits. Councils also undertake annual reviews of MPHPs outlining their progress in implementing their MPHPs.</p>

<p><b>Chapter 4</b> <b>Intersectoral relationships</b></p>	
<p>Section 4.4 Municipal public health plans</p>	<p>14. <i>Should the new Act retain the requirement to prepare MPHPs at set intervals and to review MPHPs annually in consultation with the Department of Human Services?</i></p> <p>The AIEH supports the view that MPHPs are to be prepared at set intervals and reviewed regularly, however it may not be practicable for the review to be carried out in consultation with the Department of Human Services. It may be more appropriate for the Department to provide information that will assist councils in the development and review processes, and also to have the capacity to request copies of the annual reviews as required for review by the Department if and when required. The AIEH membership believes that set intervals for preparing MPHPs should be in line with the corporate plan process (every four years). It may be more appropriate for the formal reviews to occur every two years, rather than annually.</p> <p>15. <i>What should be the local government reporting requirements, if any, under the new Act? For example, should the new Act retain the requirement to report annually, and at other times as directed by the Secretary? Should there be a requirement to submit MPHPs at set intervals? If so, what would be the expected value of such reporting requirements?</i></p> <p>The AIEH membership believes that reporting would be most beneficial as required by the Department. The value in reporting to the Department would come from a need by the Department to verify that some identified trends regarding public health have been considered and acted upon by the council or to work with councils to assist in plan development. It may not be appropriate to submit all MPHPs and reviews to the Department if the Department is acting as a repository only. The MPHPs and reviews would be available at the particular council for audit at any time by the Department. Any reporting requirements should be folded into requirements associated with the Council Plan (with a link to the MPHP as suggested) to avoid duplication and encourage integration in planning and monitoring. Statutory functions have previously been reported to the Department (but no longer).</p> <p>16. <i>Should the new Act link the requirement to prepare a MPHP to other planning processes within local government, such as the Council Plan? For example, should the requirement be to prepare MPHPs every four years?</i></p> <p>This position is supported by the AIEH, as discussed earlier.</p>

<b>Chapter 4 Intersectoral relationships</b>	
<p>Section 4.5 Medical officers of health</p>	<p>17. Should the new Act remove the requirement that every council appoint a MOH, and instead rely on non-legislative mechanisms for ensuring municipal councils have access to medical expertise?</p> <p>The MOH has previously been a high profile role, but mainly in relation to immunisation programs and the inspection of skin penetration premises. However, since the introduction of other professionals to perform immunisation activities and public health now incorporating significantly more non-medical related issues, the role of MOH has become less involved and more consultative. Local medical practitioners are becoming more popular in obtaining advice on a range of issues by councils. The AIEH supports the view that the requirement to appoint a MOH is removed from the Act. Councils may also wish to enter into a partnership arrangement to access a MOH according to their needs. Another option may be for Regional Medical Officers of Health be appointed by the Department as a point of liaison between local practitioners and councils.</p>
<p>Section 4.6 Environmental Health Officers</p>	<p>18. <i>Should an EHO who is appointed by a council automatically be an authorised officer for the purposes of the Act?</i></p> <p>The AIEH supports the view that an EHO who is appointed by a council should automatically be an authorised officer of the Act. EHOs are specialists in delivering public health programs. In particular, within the public health system and pursuant to the Health Act, EHOs have been fulfilling a number of key roles within the legislative framework for decades, including statutory monitoring and maintenance, program development and implementation, education and promotion of health awareness, community liaison and strategic planning.</p> <p>19. <i>Should the new Act require specific qualifications and/or experience for appointment as an EHO?</i></p> <p>The AIEH supports the view that the new Act should require specific qualifications and/or experience for appointment as an EHO. The qualifications should be determined by the peak body being the AIEH. The AIEH would determine the requirements and other criteria for a person to be certified as a practising EHO.</p> <p>The AIEH is an Australian wide organization. It has world-wide affiliation through the International Federation of Environmental Health. The Victorian Division of the AIEH is committed to the development of best environmental health practice and enhancement of public health standards.</p>

<b>Chapter 4</b> <b>Intersectoral relationships</b>	
Section 4.7 Authorised Officers	<p>20. <i>Should the new Act require that authorised officers have qualifications and/or experience prescribed by the Secretary?</i></p> <p>The AIEH does not support the view that the Secretary should prescribe qualifications for authorised officers. There needs to be a distinction between the role and functions an EHO as an authorised officer and “other authorised officers”. In the case of the latter, clear guidelines need to be drawn as to what this officer is authorised to carry out. The AIEH believes that the new Act should require specific qualifications as determined by the AIEH. As stated previously, the AIEH would determine the requirements and other criteria for a person to be an authorised officer under the Act.</p> <p>21. <i>Alternatively, should the Act provide that councils may only authorise persons appropriately competent?</i></p> <p>The AIEH believes that the determination of competency of authorised officers should not be the responsibility of councils. Qualifications should be determined as suggested above to enable councils to appoint suitably, rather than have to assess competency of individuals.</p>

<b>Chapter 6</b> <b>Health impact assessments</b>	
Section 6.2 Legislative models for health impact assessment	<p>27. <i>Should Victoria continue to rely on a legislative requirement for HIA in EIA legislation?</i></p> <p>The AIEH believes that Victoria should continue to rely on health impact assessments in EIA legislation, however the requirement for a HIA should be contained within the new Act.</p> <p>28. <i>Alternatively, should a separate requirement for HIA be introduced in the new Act and, if so, in what circumstances should HIA be conducted and what should be the threshold for triggering it??</i></p> <p>The AIEH believes that a HIA should be carried out when either the Secretary (or perhaps council) becomes aware of a proposed development that could constitute a public health risk (which would need to be defined), and that there would be some third party appeal system for appeals against a decision not to conduct a health impact assessment.</p>

<b>Chapter 7 Statutory duties, powers, offences and defences</b>	
Section 7.1 A risk management approach	<p>29. <i>Should the new Act support and enhance the practice of risk management?</i></p> <p>The AIEH believes that the new Act should support and enhance the practice of risk management. However applying such an approach to all issues in the Act may be difficult especially in relation to individuals and small business where such an approach may be well beyond their capabilities. As such clear general requirements and guidelines will be required.</p>
Section 7.2 A general statutory duty	<p>30. <i>Should the new Act include a general statutory duty of care?</i></p> <p>The Institute recognises that councils through their historical approach to dealing with a range of diverse complaints may be reluctant to support this concept against the perhaps more tried and legislatively supported nuisance concept. The AIEH supports in principal the introduction of a statutory duty of care in the new Act, however this raises some concerns about its' enforcement and administration as well as the scope of the statutory duty of care. The principle of public health is now a very broad issue which relates more to lifestyle, environment, community support and questions of how to deal with an ageing population. The new Act needs to concentrate on these contemporary issues and the application of the duty to public health and its creation in statute should be considered.</p> <p>31. <i>If so, what should be the scope of the duty?</i></p> <p>The scope of the statutory duty of care should consider a wider approach so it can apply to a range of scenarios, and include and even extend the scope of the existing nuisance provisions. In addition, a wider approach could also capture new and emerging public and environmental health issues. The difficulty with having a wider scope however is that it may be more difficult or problematic to enforce, similarly to the existing nuisance provisions currently found within the Health Act. The scope needs to be defined to provide some certainty in enforcement and administration.</p> <p>32. <i>If adopted, should the duty be positive or negative?</i></p> <p>The AIEH believes that the new Act should adopt a negative duty of care, i.e. conduct is not injurious to public health. Public Health is generally actively promoted in a number of programs by Environmental Health Practitioners and this is an important role, however, it does not need to be legislated.</p>

## Chapter 7

### Statutory duties, powers, offences and defences

#### Section 7.2

A general statutory duty

33. *What should follow from being in breach of the duty: criminal and/or civil liability or should the consequences of breach be limited to administrative powers?*

The AIEH believes that the consequences for breach of duty should be limited to administrative powers.

34. *Should failure to comply with the duty be the basis on which costs are recovered?*

The AIEH believes that there should be provision for cost recovery for failing to comply with the duty. This would coincide with other legislation such as the Environment Protection Act.

35. *Should compliance with the duty provide a defence against some offences under the Act?*

The AIEH believes that compliance with the duty should provide a defence against some offences under the Act.

36. *How might the duty of care work in practice?*

The AIEH believes that the duty of care should not only compliment other legislation where there has been a breach of duty but also act as a 'safety net' to respond to problems where there is no other obvious statutory remedy (eg. operation of solariums). Local authorities should have the discretion and decide how risks within their municipality should be managed.

<b>Chapter 7 Statutory duties, powers, offences and defences</b>	
Section 7.3 Duty to abate a nuisance	<p>37. <i>Should a general statutory duty of care, if adopted, replace the separate nuisance provisions and, if so, should municipal councils still retain responsibility for dealing with public health risks similar to nuisances in their municipalities?</i></p> <p>The AIEH is of the view that the current definition of nuisance is extremely broad. The nuisance provisions can be difficult to enforce and be quite unreasonable given that the definition of nuisance requires a nuisance to exist before it can be deemed to be dangerous to health or offensive. Therefore, a situation which exists which is not a nuisance but can be potentially dangerous to health or offensive cannot be adequately dealt with under these provisions. This highlights the need for another mechanism such as a ‘duty of care’ provision.</p> <p>We consider it would be appropriate to complement the ‘nuisance’ provision with a general duty of care and local authorities should still retain responsibility for dealing with public health risks similar to nuisances.</p> <p>38. <i>If separate nuisance provisions are retained, should nuisance be defined so as to focus on public health risks and, if so, does removing the term ‘annoying’ from the definition of ‘offensive’ achieve this?</i></p> <p>The AIEH believes that should separate nuisance provisions be retained, the definition should focus on matters involving public health risks, rather than annoying or irritating matters. The term ‘annoying’ from the definition of ‘offensive’ is useful in solving trivial matters under the Act, which aren’t necessarily a risk to public health. Should the term ‘annoying’ be removed, non-health related problems that are currently caught under the broad nuisance definition could be dealt with via local laws, which should be supported by infringement notices.</p> <p>39. <i>If the obligation on municipal councils to abate nuisance in their municipality is retained, should the abatement provisions be removed and municipal councils instead rely on general enforcement provisions under the new Act?</i></p> <p>The AIEH believes that removing abatement provisions and relying on general enforcement provisions under the new Act will simplify the enforcement process and remove the need for multiple types of improvement or compliance notices. The current abatement processes are not necessary in achieving the outcome as non-compliance with them only gives rise to additional penalties. In reality they do the same as an improvement notice or other direction to comply.</p>

<b>Chapter 7 Statutory duties, powers, offences and defences</b>	
<p>Section 7.4 Standards of Practice and guidelines</p>	<p>40 <i>Should best practice standards continue to have a role in the regulation of public health risks?</i></p> <p>Best practice standards have a role to play in the regulation of public health risks, but are not required to be prescribed in legislation. The Infectious Disease regulations need to ensure that they address higher risk activities and their critical control points, so that they are enforceable under the new Act. This will ensure that the public's safety is not adversely compromised.</p> <p>Guidelines in particular, the current Guidelines for Personal Care and Body Art industries create an expectation from the industry that they will be enforced. The practice of DHS developing guidelines and codes of practice as minimum standards should be continued and is supported by the AIEH. The AIEH will assist the monitoring process / surveillance practices by developing appropriate audit tools to promote consistency across councils and the membership.</p>
<p>Section 7.5 Risk Management Plans</p>	<p>41 <i>Should RMPs have a role in the regulation of public health risks under the new Act?</i></p> <p>Risk Management Plans similar to those used in the systems developed for the Food Act 1984, the Building Act 1993 and the Safe Drinking Water Act 2003 could be seen as a method of ensuring that proprietors of registered premises and/or licensed activities are complying with the Act. There is currently insufficient evidence / data to validate that these processes are effective (i.e. in terms of food safety programs for the general food industry) and success is very reliant on the implementation process. A Cost benefit analysis must be undertaken before the requirement for RMPs is prescribed.</p> <p>In any instance where this type of management system is implemented the onus must be on the operator to ensure that they are complying with the guidelines and their Risk Management Plans. The AIEH is of the view that in administrating these requirements it would be the role of councils to verify that actions are being taken to demonstrate that RMPs are effective.</p> <p>The Act would also have to include a system of auditing and enforcement of risk management systems, including the auditing function, certificates of audits and avoiding conflicts of interests.</p>

## Chapter 7

### Statutory duties, powers, offences and defences

Section 7.5  
Risk Management  
Plans

42 *Who should be required to prepare RMPs:*

- *persons undertaking a registrable or licensable activity by way of a condition of registration/licence?*
- *persons required to do so by an improvement notice?*

There are varying public health risks in registrable premises, and the AIEH believes that it would not be appropriate to regulate all registered premises to have a Risk Management Plan. There would be definite benefits in requiring an RMP for premises that have a history of poor performance, high-risk registered premises (skin penetration) and for non-registrable premises with similar risks (colonic irrigation).

Model Risk Management plans like those developed by the department for Food premises in the Food Act 1984 could be created for the implementation of the Health Act.

The new Act should set out the broad criteria that must be addressed by a risk management plan, including:

- Identifying the risks
- Determining the likelihood of the risks
- Setting out steps to manage the risks
- Ensuring compliance with the requirements by auditing, verification or monitoring.

The onus for the RMPs must be on the owner occupier or business, not the municipality.

Improvement notices issued to persons creating a nuisance or public health risk could require that person to develop a Risk Management Plan.

The AIEH believes that for individuals who are required to develop risk management plans there may be economic impacts, and should not be automatically required to have independent audits. Councils should have discretion on the auditing requirements of an RMP.

## Chapter 7

### Statutory duties, powers, offences and defences

Section 7.6  
Registration and  
licensing

43 *What criteria should be used in deciding which activities should be subject to the requirement of registration or licensing?*

The AIEH supports the rationale for registration being 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. This rationale applies for individuals conducting a public health risk activity and should be continued for certain specified purposes such as pest control operators.

44. *What regulatory parameters for registration/licensing would provide a more up-to-date, flexible, graduated and responsive approach to the level of public health risk?*

Registration and licensing of any activity where there is a potential for a risk to public health that isn't subject to other legislation by more appropriate authorities should be registered or licensed under the new Act. This process should be based on potential for risk and be flexible enough to include other premises that are found needing to be monitored (reflecting community needs).

Classification of premises in regards to the risk involved would provide a graduated and more responsive approach. A definition of the risk classification involving types of businesses / activities must be included.

General provisions applying to all registered or licensed premises should be set out in the new Act, including

- a. Grant, renew, vary suspending of registrations
- b. Determination of whether the registration/ licence applicant is a fit and proper person
- c. Setting of registration/licensing periods

## Chapter 7

### Statutory duties, powers, offences and defences

Section 7.6  
Registration and  
licensing

45. *Are there any other public health risk activities that should be regulated under the new Act through the system of registration or licensing and, if so, what specific requirements should be imposed on those activities?*

The Secretary should have the power to declare specific or classes of activities as registrable based on emerging and potential public health. The AIEH supports the view that other establishments that may provide a risk to health are regulated, for example colonic irrigations, solariums and child play centres.

There should be specific minimal requirements imposed on these premises that should be prescribed and not simply included in codes / guidelines. These include firstly the registration of premises, the possible development of risk management plans, and notification of defined incidents.

Swimming Pools and Spas are currently regulated under the Infectious Diseases Regulations, which reflects the risk they pose to the public due the number of people that use them and the potential for illness. The registration of public pools and spas should be included in the regulations. This could include an inspection or water sampling to be undertaken at least once per year to ensure compliance.

Solariums have the potential to cause skin cancer if not properly regulated. Currently solariums operate under a code of practice and it is felt that it is important to register and regulate solariums to ensure that the customer's health is not put at risk. These premises should have RMPs that reflect industry best practice. Colonic Irrigation is an emerging area of concern with the possibility of infections and the spread of blood borne viruses. For this reason it is felt justified having these premises registered similar to the skin penetration premises and have RMPs in place to ensure standards are maintained.

46 *Should there be a positive obligation on persons conducting activities subject to registration/licensing to notify authorities in event of certain types of incidents occurring?*

Persons conducting activities subject to registration/licensing should be required to notify authorities in the event of defined incidents occurring. These notifications must be part of the Risk Management Plan.

47 *Should there be an obligation placed on proprietors of non-registered premises (for example, swimming pools and brothels) to notify authorities where there has been an incident that might present a risk to public health?*

Proprietors of non-registered premises (for example, swimming pools and brothels) should also be required to notify authorities where there has been an incident that might present a risk to public health.

## Chapter 7

### Statutory duties, powers, offences and defences

#### Section 7.7 Enforcement Powers

48. *Should all enforcement powers be brought together in one part of the Act?*

The AIEH supports all enforcement powers being brought together in one part of the Act.

49. *Should the enforcement provisions of the Health (Infectious Diseases) Regulations 2001 be broadened to cover other public health threats not involving infectious diseases?*

Yes, The AIEH supports broadening the enforcement provisions of the Health (Infectious Diseases) Regulations 2001, and this may require a change name of regulations to reflect as such i.e. anthrax – public health risks.

The changes need to also consider the interrelationship with current other emergency provisions.

The changes need also to consider providing for emerging issues which may not currently be identified as a threat but which may arise in the future and require the ability to control.

50. *Are the enforcement powers in the Health Act appropriate to allow authorised officers and EHOs to carry out their duties?*

The AIEH supports maintaining and strengthening these powers, and strongly feels they should not be eroded in any way. The ability to issue “on the spot fines” would enhance an officer’s ability to resolve issues expediently by adding this step without necessarily taking court action. This would need to be supported by some guidance or framework by the Department to ensure consistency in approach in the issuing of “on the spot” fines, as they would may not be as clearly defined as for parking or local law offences.

The range of duties undertaken by authorised officers often raises the need to consider OHS issues in an uncontrolled environment. There is a need for ongoing further training in this area.

The Department should also consider establishing a “Memorandum of Understanding” with Victoria Police for when an officer needs assistance.

The AIEH also has identified a need to increase penalties for assault or obstruction of an officer. The “Proof of identity” should be the same as in the Food Act.

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### Statutory duties, powers, offences and defences

#### Section 7.7 Enforcement Powers

51. *In addition to the power to take samples and make copies of seized documents, are there any other additional powers that should be included in the new Act?*

The AIEH membership has identified some deficiencies in the power to act in an emergency situation e.g. turn off alarms / noise equipment (would need to confirm that detention powers exist).

The AIEH membership has identified a need for further powers in line with ongoing changes in technology and acceptable forms of evidence.

The AIEH membership has identified a need and supports the option to widen the powers relating to search and inspect.

52. *Should the power to search for and seize goods without a warrant be widened to allow the Secretary to search for and seize things other than goods, such as records, biological agents or other items?*

Yes. The AIEH supports the option to widen the powers relating to search, inspection, & seizure to include “any other relevant item or thing”

53. *Should the new Act contain a procedure for the issuing of improvement and prohibition notices by authorised officers?*

Yes, the AIEH supports the Act containing a procedure for the issuing of improvement notices.

There would also be a requirement for the development of appropriate standard documents and protocols.

54. *Should notices cover:*

- *nuisance?*
- *licensable or registrable public health risk activities?*
- *where the activity may otherwise contravene the Act?*

The AIEH supports the Act enabling notices to be issued in relation to all 3 of the above scenarios. In the case of Nuisances, there should be further clarification on offences within the Act.

## Chapter 7

### Statutory duties, powers, offences and defences

#### Section 7.7 Enforcement Powers

55. *Should the new Act establish general criteria for issuing notices?*

The AIEH supports the new Act establishing general criteria for issuing notices with more specific information being provided in guidelines, which will help to achieve uniformity and provide guidance.

56. *Should the new Act set out an inclusive list of the types of work a person subject to an improvement notice could be required to perform?*

The AIEH is of the view that the Act should contain an inclusive list of the types of work a person subject to an improvement notice could be required to perform, however the Act needs to be clear that other actions may also be required by a notice to allow for differing situations and solutions.

57. *What method of review should apply to improvement and prohibition notices?*

The AIEH is of the view that the review method would need to be somewhere that has an ability of a quick turnaround and that it is a forum that is independent or seen to be independent. There have been identified time deficiencies in the current VCAT system with backlogs of several months, which is totally inappropriate for health related issues.

One possibility is that the review/appeal position be similar to that in the Food Act where the review is retained by the Magistrates Court. Other options could be the local government ombudsman or VCAT.

An alternative would be the establishment of a separate tribunal to address public health issues.

The Act should prescribe the specific timeframes for appeal. In addition the issue of the status of an improvement or prohibition notice pending an appeal should be considered and defined in the review of the Health Act, as these would have been implemented due to some immediate public health risk. If the notice still stood, this would be different to other legislation generally where decisions are set aside or not formalised pending appeal outcomes.

## Chapter 7

### Statutory duties, powers, offences and defences

Given that the world has changed dramatically since September 11, the need to be able to act quickly and with flexibility should now be imperative, as no-one can be sure what may happen next.

The mood and feeling within the community is that there is an expectation that the government will look after whatever goes wrong (eg Longford) and that the timing for "radical" changes with the powers of governments is now.

The proposed change in the Health Act to broaden the emergency provisions to include other public health emergencies will support this.

#### Section 7.8 Emergency Powers

58. *Should emergency powers be general for 'public health emergencies' or be specific to infectious disease?*

At present the Governor in Council is empowered to proclaim an emergency to stop prevent or limit the spread of infectious disease. In our current environment the AIEH supports the broadening of this to proclaim a clearly defined public health emergency. The definition should be based on existing models or framework.

In order to enable an effective response for the emergency to be contained or controlled without delay, the emergency powers of the Secretary should be as general as possible. If these powers are restrictive then the ability to act effectively is lost.

59. *Should the proclamation of an emergency be extended to four weeks, with renewal periods not exceeding two weeks, to a maximum of six months?*

The proclamation time once again needs to be flexible in order to adequately address the situation. Imposing a maximum time could have some limitations to any proposed corrective action or Order from the Secretary and may not allow enough time to implement such action.

60. *Should there be a fast track mechanism for notifying a disease associated with public health emergency?*

The AIEH strongly supports a fast track mechanism for disease notification associated with a public health emergency.

## Chapter 7

### Statutory duties, powers, offences and defences

#### Section 7.8

#### Emergency Powers

61. *Should the Secretary be given powers in a public health emergency to compel examination, testing vaccination, treatment (including preventative treatment), isolation and quarantine?*

Powers that compel examination, vaccination, isolation and quarantine should be given to the Secretary; however consideration must be given to civil liberties. These powers if not abused, should be in the best interests of the community and reducing or preventing the spread of infectious diseases.

62. *Should the secretary be given a “catch all” power in a public health emergency such as ‘any other order deemed necessary’?*

To adequately address any new or emerging situations, a ‘catch all’ power should be included. It is vital to public health that this flexibility be available.

63. *Should compliance with demands from the Secretary during an emergency or outbreak of an infectious disease be specifically exempted from confidentiality?*

The AIEH endorses the overseement of civil liabilities and the need for confidentiality of personal information. During an emergency, the demanding nature may deem confidentiality a lower priority in the best interests of the community, however even in such circumstances the AIEH believes that confidentiality still needs to be retained.

64. *Should the Secretary’s power to act when local government is in default be limited in any way?*

The exercise of the power of the Secretary to perform the functions of a municipal council in an emergency should be limited to emergency situations where there is a serious risk to public health. A “serious risk to public health” should be defined and included within the legislative framework.

## Chapter 7

### Statutory duties, powers, offences and defences

#### Section 7.10

A new offence of “risk to health”

66. *Should the new Act include a new offence of ‘risk to health’? Should the new Act include a new offence of ‘risk to health’?*

The AIEH supports the view that a new offence of “risk to health” should be introduced for more serious offences, but this needs to have a more specific definition. It should have the scope to somehow measure / quantify the risk to health.

67. *If so, what should amount to a ‘risk to health’?*

The AIEH believes that a “risk to health” should be sufficiently broad to encompass present or likely future change to a person’s health and well being. This needs to be explored and developed. What is a risk to health – environmental? Physical? Mental? Social? Is there a degree of health, or health impact? How should “health” be defined in this context? Social, emotional/mental, physical, environment (wide interpretation)? What should be the level of risk? If it is to include infectious disease, this could be defined / expanded in the regulations (Infectious Disease Regulations). “Risk to health” should support the broader definition of health, and may also be complementary to any definition related to a health impact assessment.

68. *If adopted, what should be the defences, if any, to the offence of ‘risk to health’?*

The AIEH believes that there should be two possible defences to the offence of ‘risk to health’. One would be that the alleged offender is complying with known “best practice” at the time; in the absence of other knowledge or standard(s). The other possible defence would encompass the reasonable test – is it practical, reasonable, knowingly/intentional, not feasible, beyond control.

69. *What should be the scope of the offence?*

The AIEH believes that the scope of the offence should be similar to that stated in the response to question 67, i.e. anything that is dangerous to health. Dangerous to health may require further qualification or test such as a “reasonable person” who should have knowledge of the impact or reasonably have enquired about the activity. The scope may also need to include knowledge etc from professional people employed in industries registered under the Act in relation to practice standards, competencies that ought to be known, and in this way apply to Health Act registered premises. It may be appropriate for the Department to develop a risk matrix with levels of risk.

<b>Chapter 7 Statutory duties, powers, offences and defences</b>	
Section 7.10 A new offence of “risk to health”	<p>70. <i>Should the ‘risk to health’ offence subsume the offence for knowingly and recklessly infecting another person with an infectious disease?</i></p> <p>The AIEH supports this view providing that there is an ability to respond to “reckless behaviour”, in addition to “confirmed infection”. Such changes should not be seen as undermining police enforcement roles, but consolidating the management of infectious disease issues. It may also be of benefit to develop a risk matrix for defining the risks.</p> <p>71. <i>Should the offence for knowingly or recklessly infecting another person with an infectious disease not be re-enacted due to the existence of the knowing and reckless offences in the Crimes Act 1958 (that is, sections 22 and 23)?</i></p> <p>A similar offence is already contained in Crimes Act and may create an issue of duplicity. Any changes should not be seen as undermining police enforcement roles. The AIEH believes that matters relating to public health should be consolidated into the Health Act. DHS is in a position to use / develop tools to address issues.</p>
7.11 ‘On the spot fines’	<p>72. <i>Should the new Act introduce PERIN for suitable offences?</i></p> <p>The AIEH supports this proposal, but it must clearly define breaches / offences. It is viewed as a useful tool to assist with compliance and continuous improvement, however it may be considered by some councils as a revenue raiser.</p>
7.12 Greater penalties to reflect the seriousness of offences	<p>73. <i>Should public health offences attract similar penalties to those attracted by offences under environment protection legislation?</i></p> <p>The AIEH supports this proposal, however the penalty must be relative to the offence and consistent with other Acts e.g. Environment Protection Act 1970.</p> <p>74. <i>Should the new Act allow for greater penalties where the offender is a body corporate?</i></p> <p>This is in keeping with other Victorian and national legislation, in comparison to the individual, and the AIEH supports this proposal.</p>
Section 7.13 Defence of due diligence in relation to alleged offences	<p>75. <i>Should the new Act include a statutory defence of due diligence?</i></p> <p>The AIEH believes that the opportunity to avail the defence of due diligence should become a statutory defence, however the onus should be on the defence to prove due diligence, similarly to other legislation such as the Food Act 1984.</p>

**Chapter 7**

**Statutory duties, powers, offences and defences**

Section 7.15  
Appeal rights from  
administrative  
decisions

76. *What method of review should apply to administrative decisions made under the Act?*

There have been identified time deficiencies in the current VCAT system with backlogs of several months, which is totally inappropriate for health related issues. One possibility is that the review/appeal position be similar to that in the Food Act where the review is retained by the Magistrates Court. Other options could be the local government ombudsman or VCAT.

An alternative would be the establishment of a separate tribunal to address public health issues.

The Act should prescribe the specific timeframes for appeal. In addition the issue of the status of an improvement or prohibition notice pending an appeal should be considered and defined in the review of the Health Act, as these would have been implemented due to some immediate public health risk. If the notice still stood, this would be different to other legislation generally where decisions are set aside or not formalised pending appeal outcomes.

<b>Chapter 8 Control of infectious diseases</b>	
<p>Section 8.1 Registration of premises</p>	<p>77 <i>Do the current provisions appropriately address the public health risk associated with hairdressing, beauty therapy and skin penetration?</i></p> <p>The Health Guidelines for personal care and body art industries have just been introduced and are seen as best practice for these industries. Used in conjunction with the Infectious Diseases Regulations, they provide an important tool for Environmental Health Officers to use to ensure that public safety is not compromised, but as the guidelines are voluntary the current provisions do not appropriately address these public health risks.</p> <p>78 <i>Should the brothels provisions be transferred to the Prostitution Control Regulations 1995, and Department of Human Services officers exercise their inspectorial powers in relation to infection control issues under the Prostitution Control Act 1994?</i></p> <p>The AIEH is of the view that all infectious diseases requirements should be included in the new Health Act or Regulations made there under including the brothels provisions. DHS should consider as part of this review whether brothels or premises covered by the Prostitution Control Regulations 1995, should be a local government responsibility.</p>
<p>Section 8.2 Prescribed Accommodation</p>	<p>79 <i>Do the current provisions appropriately address the public health risk associated with prescribed accommodation (for example, hotels, motels, hostels and holiday camps)?</i></p> <p>The regulations for prescribed accommodation are based on a historical risk. As the risks for most prescribed accommodation now is low, and mainly self regulated, the current provisions appropriately address the public health risk associated with prescribed accommodation (for example, hotels, motels, hostels and holiday camps) with the exception of the omission of caravan parks. The shared ablution facilities and other facilities that may create a risk to public health of caravan parks are not appropriately addressed in the Residential Tenancies Act.</p> <p>The AIEH believes that ablution and other facilities in these accommodation premises can pose a risk to health. Caravan parks are also broadening their services to include dormitory style rooms, permanent tents and cabin accommodation, with a high turnover of backpacker accommodation. The inclusion of caravan parks as a prescribed accommodation in the regulations should be addressed in particular as they fall into the rationale of registration in that without certain standards of hygiene and cleanliness being observed there is an increased risk of disease transmission.</p>

<b>Chapter 8 Control of infectious diseases</b>	
<p>Section 8.4 Incident involving care giver</p>	<p>83. <i>Should the new Act continue to outline the procedures for non-consensual testing orders where consent for testing has been refused?</i></p> <p>The AIEH supports this, however where testing has been refused the Institute also believes that exclusion should also be a possibility.</p> <p>84. <i>Should the new Act introduce a system for the authorisation of non-consensual testing where consent cannot be given to testing?</i></p> <p>The AIEH supports this position.</p> <p>85. <i>Should the provisions in the new Act be extended to beyond the care giver or custodian situation and, if so, to what situations?</i></p> <p>The AIEH supports this however the criteria should be defined within the Act, and established as a “risk to health”.</p>
<p>Section 8.5 Public health orders and management of infected persons</p>	<p>86. <i>Should public health orders under the new Act apply to any infectious disease or condition where there is a serious risk to public health?</i></p> <p>The AIEH supports this position.</p> <p>87. <i>Should the new Act provide a power for involuntary testing with reasonable use of force? If so, should it be exercised by ‘an authorised officer’, a delegate of the Secretary and/or the police?</i></p> <p>The AIEH supports this position, including who is able to exercise the powers.</p>

<b>Chapter 8 Control of infectious diseases</b>	
<p>Section 8.5 Public health orders and management of infected persons</p>	<p>88. <i>Should the Act contain a list of the types of restrictions that may be imposed by an order of the Secretary?</i></p> <p>The AIEH supports this position.</p> <p>89. <i>Should the new Act introduce a power to order that a person undergo treatment where treatment is refused? If so, what limits should be placed on the use of the power?</i></p> <p>The AIEH supports this position.</p> <p>91. <i>Should any or all public health orders require court/tribunal confirmation?</i></p> <p>The AIEH membership believes that public health orders should not require third party confirmation as this may cause delays in the making of such an order when dealing with public health risks.</p> <p>92. <i>Should there be a power for the police to apprehend a person who fails to comply with a public health order, rather than merely the ability to provide ‘assistance’ to the medical officer? If so, should there be a requirement to obtain a warrant to apprehend the person?</i></p> <p>The AIEH supports this position.</p> <p>93. <i>Should the new Act continue to provide that it is an offence for a person to fail to comply with an order?</i></p> <p>The AIEH supports this position.</p>

<b>Chapter 8 Control of infectious diseases</b>	
<p>Section 8.5 Public health orders and management of infected persons</p>	<p><i>94. What appeal and external review processes should be made available under the new Act?</i></p> <p>The AIEH is of the view that the review method would need to be somewhere that has an ability of a quick turnaround and that it is a forum that is independent or seen to be independent. There have been identified time deficiencies in the current VCAT system with backlogs of several months, which is totally inappropriate for health related issues.</p> <p>One possibility is that the review/appeal position be similar to that in the Food Act where the review is retained by the Magistrates Court. Other options could be the local government ombudsman or VCAT.</p> <p>An alternative would be the establishment of a separate tribunal to address public health issues.</p> <p>The Act should prescribe the specific timeframes for appeal. In addition the issue of the status of an improvement or prohibition notice pending an appeal should be considered and defined in the review of the Health Act, as these would have been implemented due to some immediate public health risk. If the notice still stood, this would be different to other legislation generally where decisions are set aside or not formalised pending appeal outcomes.</p>
<p>Section 8.8.1 Role of municipal councils in providing immunisation</p>	<p><i>103 Should the new Act state the role of municipal councils in relation to immunisation as ‘co-ordinating and providing immunisation services to children living or being educated within the municipal district’?</i></p> <p>The AIEH strongly supports the role of municipal councils in relation to immunisation service delivery and to be reflected in the Act as ‘co-ordinating and providing immunisation services’.</p> <p>The institute believes that formal partnership agreements with DHS would strengthen this role, provide for greater accountability and address funding inequities.</p>
<p>Section 8.8.2 Immunisation records and children’s services</p>	<p><i>104 Should provisions regarding recording the immunisation status of children at children’s services be retained in the Children’s Services Regulations 1998 (rather than included in the new Act)?</i></p> <p>As a result of ACIR now providing a Child History Statement this information is readily available and more accurate. The AIEH believes that this requirement creates unnecessary duplication and would not improve compliance. Therefore to allow for consistency regarding the provision of immunisation services this requirement should be included in the Health Act and deleted within the Children’s Services Regulations 1998. The recording of the immunisation status by operators of children services can be referenced within the Children’s Services Regulations 1998 so operators are aware of this requirement under the Health Act.</p>

<b>Chapter 8 Control of infectious diseases</b>	
<p>Section 8.8.3 Immunisation status certificates and primary schools</p>	<p><i>105 Should the new Act require school principals of primary schools to make reasonable efforts to seek an ISC in respect of every child enrolled in the school, and an immunisation update on re-enrolment?</i></p> <p>The AIEH supports the view that the new Act require principals of primary schools to seek an ISC as part of school enrolment and an immunisation update on re-enrolment. Furthermore the Institute agrees that this should be in addition to the obligation on parents to provide an ISC. All children who have their immunisations recorded on ACIR will receive a history statement once they have completed their 4 year old immunisation. In cases where immunisation status has not been recorded on ACIR parents can then obtain ISC through Council.</p> <p>The Institute believes that ISC should only be issued for new enrolments but not for re-enrolment and supports the position that when a child re-enrols that the principal must request a statement as to any change in immunisation status.</p>
<p>Section 8.8.4 Immunisation records and secondary schools</p>	<p><i>106 Should the new Act introduce an obligation on parents to supply evidence of immunisation on enrolment of their child into secondary school and an obligation on school principals to make reasonable efforts to seek immunisation records in respect of every child enrolled in the school?</i></p> <p>The AIEH supports the introduction to obligate parents to supply evidence of immunisation and an obligation on school principals to seek records. Furthermore immunisation records should be transferred from primary school to secondary school. Any parents who have not obtained an ISC in primary school should be directed to their local council or other service provider authorised by ACIR. As ACIR records all immunisation for children up to 7 years of age, all necessary information should be easily accessible.</p>
<p>Section 8.8.5 Immunisation records and tertiary facilities</p>	<p><i>107 Should the new Act introduce an obligation on tertiary students to supply evidence of immunisation on enrolment and an obligation on tertiary facilities to make reasonable efforts to seek immunisation records in respect of every student enrolled in the facility? If so, for which diseases should immunisation records be required?</i></p> <p>The AIEH does not support the introduction to obligate tertiary students to supply evidence of immunisation and an obligation on tertiary facilities to seek records. This would be too difficult to implement, particularly for international, interstate and country students who may not have ready access to their records. This would also be difficult for tertiary educational institutions to administer and to maintain.</p>

<b>Chapter 8 Control of infectious diseases</b>	
<p>Section 8.8.6 Issuing of immunisation status certificates</p> <p>Section 8.8.7 Forms of evidence of immunisation</p>	<p><i>108 Should the new Act provide for different forms of evidence of immunisation? If so, what should they be?</i></p> <p>The AIEH believes that the ACIR history statement or the ISC is easily understood by school staff, which clearly states whether that child is “complete” or “not complete”, and are currently recognised as approved forms of evidence. Other forms of evidence may create confusion and would require school staff to be adequately competent to make a determination on the status of immunisation.</p> <p>The institute supports the allowance of various forms of evidence of immunisation, however the determination and issuing of ISC should only be provided by an authorised officer of a municipal council or other service providers authorised by ACIR.</p>
<p>Section 8.8.8 Offences</p> <p>Section 8.8.9 Immunisation status certificates and school entry</p>	<p><i>109 Should the new Act introduce a penalty for failure on behalf of a parent or guardian to produce immunisation records on secondary school entry?</i></p> <p>The AIEH does not support the introduction of penalties for failure to produce records. In these cases where the parent/guardian cannot demonstrate completion of the immunisation schedule the child would be deemed to be “incomplete” and as such would be excluded in cases where a vaccine preventable disease outbreak occurs in a school setting. The institute believes that creating an offence would not facilitate compliance, as most parents would provide this information readily.</p>
<p>Section 8.8.10 Record keeping</p>	<p><i>110 Should the new Act require the principal teacher or person in charge of the school to take reasonable steps to ensure that immunisation records are maintained, and to allow inter-school transfer of ISCs?</i></p> <p>The AIEH does support the requirement for the principal teacher to ensure that immunisation records are maintained and to allow inter-school transfer of ISCs. It is current practice of primary schools to record the child’s immunisation status on their school history. The transfer of immunisation records makes practical sense for parents who have already obtained an ISC or ACIR history statement. This would eliminate the need for parents to provide records, however in cases where these are not maintained they would have the option of obtaining records directly through Council or ACIR.</p> <p>Privacy Laws may need to be considered with these arrangements.</p>

<b>Chapter 8 Control of infectious diseases</b>	
Section 8.8.11 Diseases covered by immunisation status certificates	<p><i>111 Should the new Act facilitate consistency with the NHMRC schedule for immunisation?</i></p> <p>The AIEH believes that the new Act should facilitate consistency with the NHMRC schedule for immunisation and reflect the on-going changes to the schedule. This should only apply to scheduled vaccinations and allow for flexibility in respect to new and emerging vaccines.</p>
Section 8.9 Outbreaks of infectious diseases at schools and children's services	<p><i>112 Should school principals and persons in charge of children's services be required to seek advice from the Department of Human Services before excluding children during an actual or suspected outbreak of an infectious disease?</i></p> <p>The AIEH membership believes that this would not be necessary, however the principal/person in charge should be able to discuss this issue with the Department and reverse the decision.</p> <p><i>113 Should there be a power in the new Act for the Secretary to waive or alter the prescribed periods in individual cases?</i></p> <p>The AIEH supports this power in the new Act.</p> <p><i>114 Should the requirement for a parent to inform the principal or a person in charge of a school or children's services centre be limited to where their child has a vaccine preventable or excludable disease?</i></p> <p>The AIEH believes that this requirement should be extended to where the child has also been in contact with a person that has a vaccine preventable or excludable disease. All such diseases should be defined in legislation. The AIEH also endorses the overseement of civil liabilities and the need for confidentiality of personal information.</p> <p><i>115 Should the new Act facilitate consistency with the NHMRC Guidelines on the Recommended Minimum Periods of Exclusion from School, Preschool and Child Care Centres of Infectious Disease Cases and Contacts?</i></p> <p>The AIEH supports this issue to be consistent with the national approach.</p>

<b>Chapter 9 Environmental health</b>	
Section 9.1 General sanitary provisions	<p><i>116 Should provisions dealing with offensive waterways not be included in the new Act?</i></p> <p>The AIEH believes that these provisions should be retained within the new Act.</p> <p><i>117 Should public health risks related to rats, mice, vermin, pests or other animals suspected of having a disease capable of transmission to humans be dealt with by the issue of an improvement notice?</i></p> <p>The AIEH supports this position.</p>