

SOUTH GIPPSLAND SHIRE COUNCIL

Review of the Health Act 1958

A commentary on issues presented for discussion

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List of issues for comment

	<i>Issue</i>	<i>Section reference</i>
1	Should the Act be renamed and, if so, what name would best reflect the role and purpose of the new Act?	3.1
	<p>Comment: Health Protection Act 2005 OR Public Health Act 2005</p> <p>Conversely, it may be better to leave it unchanged if individual health is to be further emphasized in the new amendments (e.g. Health Act 2005).</p>	
2	Are there matters that are currently dealt with by other legislation that should be included in the new Act?	3.2
	<p>Comment: See answers to questions 71, 78, 118 & 120.</p>	
3	Should the new Act recognise the importance of promoting public health, and, if so, how should the new Act aim to achieve this?	3.2
	<p>Comment: Yes, some recognition and empowerment of public health promotion initiatives should be considered to reduce the burden upon our acute health services.</p>	
6	Should the new Act contain a provision specifying guiding principles, and, if so, what principles should be included?	3.4
	<p>Comment: Yes - this could help with interpretation of various sections and provisions contained within the Health Act. (As per the Review Guide)</p>	
9	Should the new Act retain the functions for municipal councils as set out in the current Act?	4.2
	<p>Comment: Yes, the functions of Council as laid out under section 29A provide a broad enough scope and workable overarching framework. However, the provisions for implementation of LGA statutory responsibilities should be thought through very carefully and in close consultation with Local Government to ensure that there is enough flexibility where appropriate.</p>	

	<i>Issue</i>	<i>Section reference</i>
10	<p>Should the new Act recognise municipal councils' role in:</p> <ul style="list-style-type: none"> ➤ Planning, advocating and providing organised public health programs? ➤ Developing and implementing strategies to promote and improve public health and promote community health and wellbeing? 	4.2

Comment:

Yes. There should be a shared interest between council, the community and other NGOs in public health protection, promotion and advocacy. Councils play an important if not central role in community public health issues.

Councils role in public health:

- planning;
- advocacy;
- promotion; and
- strategy

should be recognized. Once again, any further statutory responsibility proposed for introduction should only be considered through close consultation with councils (MAV, etc.) and after careful consideration of the current representative capacity and resources available to LGAs.

The Municipal Public Health Plan is currently the major vehicle for implementation of the above and consideration of how this living document can be enhanced and supported as the driver for these activities is recommended.

11	Should the concept of partnership between state and local government, and between government and non-government, be addressed in the new Act?	4.3
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Comment:

Yes, most definitely. The significant issues of:

- resourcing;
- integration of stakeholder effort;
- centralising of current initiatives; and
- community acceptance and involvement

could potentially be addressed in a far more effective manner than other less integrated, disjointed and under-resourced approaches (i.e. Everybody just doing their own little thing!)

	<i>Issue</i>	<i>Section reference</i>
12	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?	4.4
	<p>Comment: Yes. Currently, many LGA MPHPs can sit on the shelf just collecting dust - the initiatives are not implemented because the objectives and desired output of the document often are not aligned or incorporated into the Council's corporate objectives/plan.</p> <p>To address this the MPHP could be more closely integrated into the council's Corporate Plan (i.e. be written into the Corporate Plan as a legislative requirement) and have the flexibility to address/focus upon the 'givens' in terms of Public Health Programs (egg. Immunisation, Food, Body-piercing, Waste Management, Environmental Health, etc.) and Health Promotion Programs to address community health and well-being (e.g. through planning for supportive environments for physical activity and crime prevention through environmental design) but also to address the local issues, which vary from council to council. This would allow councils to formulate programs that produce the most relevant and beneficial outcomes for their municipality and align closely with corporate objectives as well. A Risk-based approach (RA & Risk Matrix) could be used to determine the public health priorities for each council's plan. This should then drive Program structure and delivery. It should be emphasized at this point that this should never be misapplied as a mechanism to rationalize core services.</p> <p>Additionally, consideration should be given to how any other public health partnership NGOs (e.g. Primary Care Partnerships) relate into the MPHP and their contributions to the whole process.</p>	
13	Should the new Act require that municipal councils set out how they intend to fulfill their statutory functions in their MPHPs?	4.4
	<p>Comment: Not sure. Possibly - it would depend on how this proposed requirement was implemented. It could not be a requirement that placed an unfair burden upon LGA in terms of planning and reporting to State Government. State Government would have to put in place the reporting mechanism (to centralize the data) and the requirements would have to be stated very explicitly.</p>	

	<i>Issue</i>	<i>Section reference</i>
14	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?	4.4

Comment:

The review process should be formalized as part of the normal planning process. The issue is - how would the consultation with DHS work in practice (what mechanism would work?) and how many layers would the document have to pass through within DHS before sign-off? The responsibility or onus for review implementation should possibly still rest with councils. Could DHS manage the review of 80 MPHPs on an annual basis that would fit within the timeframes involved in council planning cycles?

Currently, Health Promotion Plans (for Community & Women's Health Funding) are dealt with by regional DHS offices (through the Regional Health Promotion Officer). This sort of regionally-based system may work well for the annual assessment of the 80 MPHPs.

15	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?	4.4
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Comment:

Annual reporting at a set time would allow councils to plan more effectively - however, would either party deliver their output within the set timeframes? The submission of 80 MPHPs at the same time to DHS has the potential of creating the same situation as the recent attempt at auditing all the Victorian Health Services Cooling Tower Risk Management Plans (i.e. a glut of programs too big to process within the short timeframe required). Perhaps stagger the process dependant upon a RA of regions.

An annual reporting cycle could serve beneficial purposes to both parties if an effective and timely submission and processing procedure was followed. Timelines would have to be adhered to by both parties for the system to work. The benefits could include -

For Councils:

- Feedback and direction from DHS
- A framework and incentive to continuously review, develop and improve their MPHP

For DHS:

- Keeping in touch with MPHP progression across the state
- Centralising MPHP data

	<i>Issue</i>	<i>Section reference</i>
16	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?	4.4

Comment:

Yes - see answers to previous questions 12, 13 & 14. However, the statutory requirement should be made under the Local Government Act 1989 (perhaps linking it to the MPHP content requirements of the Health Act 1958).

Yes, additionally the linkage to the Council Plan should be direct with some uniform core objectives (public health 'constants') prescribed by DHS for all councils to address. These public health 'constants' would have to be generic enough to be relevant and achievable for all 80 Victorian councils.

Generally speaking, all strategic and operational plans produced by council should seek to be as integrated as possible into the overarching (corporate) plan and objectives to ensure their implementation.

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?	4.5
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Comment:

Possibly. Although MOHs do not currently play a significant part in day to day operations of councils they are meant to be there as a 'backstop'/backup to provide expert medical opinion on different health issues of concern or as an expert advisor in medical or public health emergencies. To remove this requirement could potentially allow the downgrading or removal of the utilization of medical expertise by some Councils in the above circumstances.

However, there is also an argument for the removal of the MOH requirement. In practice, MOHs do not currently play a significant role in Councils. Either the requirement to have an MOH should be removed and DHS provide access to expert medical opinion or the MOH requirement remains but undergoes a major overhaul. If this requirement was to remain the improvements could include MOHs being required to undertake specified duties (i.e. be a formal part of Council Committees and attend immunization updates/meetings).

	<i>Issue</i>	<i>Section reference</i>
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18

Should an EHO who is appointed by a council automatically be an authorised officer for the purposes of the Act?

4.6

Comment:

Yes. Automatic authorization of EHOs ensures efficiency of appointment (through delegation to LGAs) and removes any legal complexities surrounding their appointment and authorization. Will reduce delegation workload on Council.

Removing this ability (for Councils to appoint their own EHOs) reduces Councils ability to choose the functions of their staff.

	<i>Issue</i>	<i>Section reference</i>
19	Should the new Act require specific qualifications and/or experience for appointment as an EHO?	4.6

Comment:

It is worth raising the point that cementing specific qualifications into the legislation may serve to undermine the current ability to recognize a broad range of prior public health related learning in the accredited tertiary education and final attainment of the EHO qualification (sometimes students with enough prior learning from previous qualifications are only required to complete 1 to 2 years - at the most - of the 4 year Swinburne course). The current arrangements allow EHOs from broad practical and educational backgrounds to be appointed (people who have had some involvement in Public Health related education, programs or enforcement). Tightly defining the qualification could cement the parameters too narrowly and further erode the current supply of EHOs who come from many different backgrounds related to Public Health practice.

The most important point here is that for an EHO to become qualified, whatever system is place must ensure that the individual comes out of that process with a broad understanding of public health and the necessary skills to practice in the broad range of different disciplines required.

If specific qualifications were to be defined in the Act the limitation of having to amend these every time new qualifications were developed or variations of the qualifications were approved could create a significant administrative burden.

Reference must be made to AIEH membership to ensure the flexibility of the system. It just depends whether the development and setting of these competency standards is best left with the AIEH or moved across to DHS. It is in the interests of EHOs to be represented by the AIEH in the setting of these competency standards and to have this association integrally involved in the development and continuous improvement cycle/responsibility.

	<i>Issue</i>	<i>Section reference</i>
20	Should the new Act require that authorised officers have qualifications and/or experience prescribed by the Secretary?	4.7
Comment:	<p>Not sure.</p> <p>The qualification could be prescribed by the Secretary. State Government could provide a clear and flexible framework for Councils to assess the competency of EHOs. The Secretary should gazette officers using the framework above.</p>	
21	Alternatively, should the Act provide that councils may only authorise persons appropriately competent?	4.7
Comment:	<p>Yes - the system should be such that it creates a common base level of public and environmental health skill, which fulfills the "appropriately competent" requirement.</p>	
23	Should the new Act make more explicit the forms, which such collection of comprehensive data may take? For example, should the new Act provide for the Secretary to establish registers, databases and other collections of public health information and to state some of the uses of that information?	5.1
Comment:	<p>Yes. The above would be a valuable resource of centralized information. However, it would obviously have to be decided on a needs basis.</p>	
	<p>If DHS is to require comprehensive data collection from Councils then it should collate and report on the data broken down into LGAs and Regional Areas in a timely manner and on a regular basis.</p>	

	<i>Issue</i>	<i>Section reference</i>
27	Should Victoria continue to rely on a legislative requirement for HIA in EIA legislation?	6.2
Comment:	<p>HIA could be beneficial as a specific requirement under the Health Act in a tightly defined set of conditions or circumstances. Additionally, a specific HIA process should be prescribed and referenced across to all other Acts requiring it, so that the process is centralized under the Health Act and only appropriately competent/certified persons may undertake a HIA. However, this would not be effective if in any way it interfered with the Executive powers of the Secretary to initiate public health interventions.</p> <p><u>Essentially, HIA should continue to function in the EIA legislation (with possible improvement) but through the authority and direction of the new Health Act. HIA should be a whole of Government approach and should recognize that other sectors influence health.</u></p>	
28	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?	6.2
Comment: See Above.		
29	Should the new Act support and enhance the practice of risk management?	7.1
Comment:	<p>Yes - it has already been proven as an effective method of public health risk mitigation through its application to the regulation of Cooling Towers (See the Department of Human Services publication "Guide to developing Risk Management Plans for Cooling Tower Systems, November 2001"). Additionally, there is a distinct lack of RM practice in many other areas as well.</p>	

	<i>Issue</i>	<i>Section reference</i>
30	Should the new Act include a general statutory duty of care?	7.2
	<p>Comment: The concern here is that this could create a massive increase in EHO workload that LGA is not currently equipped to deal with. If the scope of the duty of care was widened to make it a more general one, realistically it may extend the duty of care to issues affecting community or individual health that are outside of council’s influence and scope of control.</p> <p>Further, if in any way a general statutory duty of care resulted in Councils becoming responsible for intervention or resolution of health issues that individuals or companies would previously engage private professionals or specialists to address then the economic impact to Victorian businesses could potentially be quite significant.</p> <p>Additionally, this could in turn introduce a need for EHOs to increase their technical skill-base across the fields of public and environmental health practice, medicine & science, engineering & construction (knowledge to interact with these respective industries and the built public environment), civil, trade practice & public health law. Currently, this skill-base varies amongst EHOs depending upon vocational experience and academic qualifications. To achieve the perceived level of competency required to operate at this broader level, additional training and experience for most EHOs would be necessary.</p> <p>If any general statutory duty was to be introduced, then the parameters of this would have to be tightly defined to ensure no ambiguity and to ensure that the scope is not too broad.</p> <p>A Public Health Protection Policy creating a duty to enforce these policies would be good. This would enable flexibility in a rapidly changing environment.</p>	
31	If so, what should be the scope of the duty?	7.2
	<p>Comment: See above. Additionally, the scope should be limited to public health nuisances and disease prevention.</p> <p>A Public Health Protection Policy creating a duty to enforce these policies would be good. This would enable flexibility in a rapidly changing environment.</p>	
32	If adopted, should the duty be positive or only negative?	7.2
	<p>Comment: Both are necessary. The preference (and emphasis) should be upon pro-active approaches to public health protection where appropriate. However, negative duty is also required (particularly with enforcement).</p>	

	<i>Issue</i>	<i>Section reference</i>
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?	7.2
	<p>Comment: Both. The administrative powers should be embraced with a duty of care (Council should be responsible, and not the individual officer, where there has been a definite failure to protect public health - within reason and jurisdiction). Continue with orders (notices) to administer authority. However, the definitions of nuisance and public health risk should be tightly defined.</p>	
34	Should failure to comply with the duty be the basis on which costs are recovered?	7.2
	<p>Comment: Yes.</p>	
35	Should compliance with the duty provide a defense against some offences under the Act?	7.2
	<p>Comment: Yes.</p>	
36	How might the duty of care work in practice?	7.2
	<p>Comment: Evidence-based judgement of whether DOC met by council. Benchmark level set at foreseeable risk to health by a reasonable person and must fit within public health matters that fall within council's responsibility (this must be clearly defined by the State Government).</p>	
37	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?	7.3
	<p>See O.P.</p>	

Comment:

Yes, councils should still retain the responsibility for dealing with public health risks. Any introduction of further flexibility to resolve public health issues in concert with the introduction of the general statutory duty of care is welcomed.

However, a general statutory duty of care to deal with public health risks replacing the nuisance provisions raises the question of what will be the level of expansion? That is, what would the scope be in terms of the broadening of the public health issues council will be expected to address (e.g. will there be an increase in non-food related premises requiring registration/inspection and infectious diseases requiring investigation)?

This also raises the issue of liability. Who will be responsible for defining what constitutes a risk to health? Will a 'risk to health' be adequately and explicitly defined by DHS under the Health Act legislation (with narrow and unambiguous wording) to capture only the risks that councils could be reasonably expected to deal with? Or will there be room for subjective judgement/quantitative assessment on the part of councils? This could present serious liability issues for both Local and State Government.

Additionally, there is the resourcing and capability issue raised previously of whether current EHO qualifications and experience is adequate to cover these broader areas and in some cases the specialist technical skills required to make an informed assessment of whether or not a particular issue is in fact a risk to public health. A greater understanding of the technical issues involved in more complex public health issues may well be required. The broadening of involvement in areas of public health could perceivably extend under the new structure to elements of:

- Pest control
- Building standards
- Engineering design & conformance with Industry/Australian Standards.
- Health & Safety issues (occupational & public)
- Risk/Environmental Management & Quality Assurance Systems
- Noise measurement & assessment (background & source measurement, attenuation and control methods).
- Agricultural fertilizer & pesticide application standards (and chemical knowledge) and acceptable farming practices.
- Public Health & Trade Practice Law

The fact that councils currently have the delegated power to appoint EHOs enables them to select the most appropriate candidates for the position or train existing health staff to the appropriate level. For the effective implementation and administration of the above Local Government still needs the discretionary powers related to appointing officers and assessing competency. If this flexibility and discretionary power was removed or reduced, the process of appointment could become too cumbersome for both State and Local Government. Additionally, it would not give councils the ability to respond themselves to changes in practice, legislation and their own communities.

	<i>Issue</i>	<i>Section reference</i>
38	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?	7.3

Comment:

Yes - the nuisance provisions should be retained and they should be defined with a public health focus. The term "annoying" could be removed, however retaining the term "injurious to personal comfort" effectively addresses the same area. It should be noted that the inclusion of the terms "annoying" and "injurious to personal comfort" have been useful in their own right in solving trivial problems that are not necessarily a risk to public health. Removing the ability for council officers to make a subjective decision as to whether or not an issue is "annoying" (i.e. qualifies as a nuisance) may reduce council's capacity to resolve these types of issues (as some nuisances can not be measured quantitatively). The current definition allows for consideration to be given to an individual's comfort zone being affected by an activity. Consideration should be given to the value of retaining this provision because of the protection it offers against the possible long-term/chronic effects that some "annoying" or "injurious (to personal comfort)" activities/stimuli can have upon different people (we are all different).

Additionally, if the affect of a nuisance is not limited to the number of people affected then in some instances (e.g. one person affected by an odour arising from a neighbour's property where its qualification as a nuisance is purely a subjective assessment) it would be difficult to argue that a particular issue was a "public health nuisance".

Perhaps, there could be a separate risk from the nuisance-related provisions with linkages to mental health promotion activities?

	<i>Issue</i>	<i>Section reference</i>
39	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?	7.3
	<p>Comment: Currently, councils can issue a Nuisance Abatement Notice without having to go to court. This is an essential provision for council's having the ability to respond in a timely and effective fashion to nuisances within their municipality.</p> <p>The abatement notice should be retained as an option that compliments a general enforcement package that also allows the Risk Management Plan approach, prohibition notices, on the spot fines, and improvement notices to be utilized where necessary.</p>	
40	Should best practice standards continue to have a role in the regulation of public health risks?	7.4
	<p>Comment: Best practice standards have a role in providing some guidance, however they are not strictly enforceable. So far the only real method of introduction into an operator's processes is through their integration into any mandatory risk management processes and/or risk management plan/s required by law.</p> <p>A better system would be the introduction of Public Health Protection Policies into the new Health Act to facilitate flexibility and enforcement.</p>	
41	Should RMPs have a role in the regulation of public health risks under the new Act?	7.5
	<p>Comment: Yes, but how they are applied to either individuals or sections of industry (i.e. conducting certain processes or operating certain equipment that poses a risk to public health) is an important issue. It could be argued that the ability for council's to impose the RMP requirement on particular individuals or operations (commercial or otherwise) could be invaluable in addressing public health risks emanating from these types of sources. Additionally, it is certain that councils have an integral role to play in providing advice to State Government on industry groups that would merit the RMP approach being imposed upon them via legislation (contribution to the assessment and selection process). But like Food Safety Programs, they would require templates for individuals and/or minor issues.</p>	

	<i>Issue</i>	<i>Section reference</i>
42	<p>Who should be required to prepare RMPs:</p> <ul style="list-style-type: none"> ➤ persons undertaking a registerable or licensable activity by way of a condition of registration/license? ➤ persons required to do so by an improvement notice? 	7.5
	<p>Comment: Most importantly, a RMP should be prepared by a competent person - whether on behalf of an owner/operator or by the owner/operator themselves. There needs to be some requirement that ensures that a person that is suitably qualified/knowledgeable of the RMP subject matter prepares the plan (if this is possible to achieve!). Short of this, a template RMP structure provided by State Government with the ability to register/incorporate other Industry-specific RMPs would be fantastic (similar to the Governments implementation of the Legionella reforms and the Cooling Tower RMP requirement). For public health risks at the significant end of the scale, such as Cooling Tower Systems (CTS), a requirement to produce a RMP as a part of the registration process (similar to the current CTS registration process) would prove very beneficial.</p> <p>Additionally, a RMP to be developed through an improvement notice would also be an very effective means of ensuring individual cases of activities posing a high risk to public health would be adequately addressed.</p>	
43	<p>What criteria should be used in deciding which activities should be subject to the requirement of registration or licensing?</p>	7.6
	<p>Comment: Any business whose main activity has the potential to create a risk to public health that is currently not under any form of regulation or requires registration or licensing.</p>	
44	<p>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?</p> <p>See O.P.</p>	7.6

Comment:

A system based upon a risk management approach. That is, the regulatory process of identifying (and then serving or imposing the regulatory requirement), monitoring, controlling and reviewing the risks involved. Obviously, this approach would only be implemented where elimination of the risk is not a viable option (always apply the risk management hierarchy).

Potentially, a system that houses registration responsibility with the most appropriate authority. So that the different common sources of public health risk are registered, monitored and regulated by the authority best equipped to handle with that group through a combination of enforcement, education and policy measures. There are potentially other sources that would require specialist regulation outside the resources of Local Government and this could potentially be best achieved by centralizing the regulation of these sources through DHS (similar to the current arrangements for Cooling Towers).

The detail of respective RMPs for the different public health risk could be scaled up or down depending upon the perceived need and the type of risk involved. Some risks may need to be micro-managed by a more comprehensive set of procedures/processes, others may only require the implementation of a basic set of measures to address the risk.

The most important indicator of what type of approach will be the most appropriate is if the answer to the question "Will the risk be adequately addressed?" is "Yes". It cannot be emphasized how important the inclusion of the word "adequately" is to the success of risk management process implementation. If left out, there is no assessment made (either on an initial or continuous basis) as to the effectiveness of the risk management/control measures being applied. Equally important to this point is the provision of a clear-cut definition of what is deemed adequate.

This has been the only shortfall of the Cooling Tower risk management process, where RMP auditors are not required to make an assessment as to the adequacy of the RM measures outlined in the owner/responsible persons RMP. They are only required to confirm that the RMP addresses the specified risks prescribed under the regulations. Subsequently, the writer of an RMP can detail RM measures in the RMP that whilst meeting legislative RMP content requirements (specified under the Building [Cooling Tower Risk Management] Regulations 2001) operate at a level that does not adequately address the actual site-specific public health risks. This is compounded by the fact that most of these audits are conducted as a Desktop exercise only, and the auditor hardly ever actually visually inspects the source of the risk itself to make an informed assessment (in this case the cooling tower system and its immediate surrounds). There is far too much reliance upon the accuracy of the RMP document content. Hence, the value of the audit process in this example is significantly reduced by the fact that it is not a true audit process, which assesses the adequacy of the RM measures in place.

There should be a streamlined process of accreditation/authorisation for EHOs to undertake the above and other proposed auditing activities.

Auditors should only be accredited by DHS if they are competent enough to assess not only conformance of the RMP content with the legislative requirements but the adequacy of the RM measures themselves in relation to the actual site and source-specific risks (to which DHS could provide guidelines).

	<i>Issue</i>	<i>Section reference</i>
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?	7.6

Comment:

Yes. These include:

- Solariums,
- Colonic irrigation services,
- Public Pools/Spas
- Sanitary Provisions for Mass Gathering Events (such as Agricultural Shows & Expos)
- Child Play Centres
- Gym Equipment
- Sex on premise venues (SOPVs) - commercial premises
- Needle syringe services

Specific minimal requirements should be mandated in the legislation (and not just referred to or included in guidelines or codes of practice). These should be based upon the evidence-based risks. The minimal requirements could then be supported by the development of specific codes of practice or guidelines that may or may not be called up by the legislation. Not all of these would necessarily be registered by LGA.

Where DHS currently has officers assigned to inspect some of the above premises (e.g. Partner Notification Officers for SOPVs and Brothels) there may be no requirement to impose a formal licensing/registration and inspection program, particularly on special cases such as SOPVs.

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?	7.6
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Comment:

Yes - these notifiable events should be defined in the legislation.

	<i>Issue</i>	<i>Section reference</i>
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?	7.6
	<p>Comment:</p> <p>Yes - these should be incidents that present a serious present or potential risk. (Question: Aren't Brothels already registered with State Government). Who do they notify DHS or LGA?</p>	
48	Should all enforcement powers be brought together in one part of the Act?	7.7
	<p>Comment:</p> <p>Yes- where possible.</p>	
49	Should the enforcement provisions of the Health (Infectious Diseases) Regulations 2001 be broadened to cover other public health threats not involving infectious diseases?	7.7
	<p>Comment:</p> <p>Yes - to cover any emerging public health threats and new diseases not addressed in this or any other legislation. These provisions should be careful not to duplicate or address any of the provisions of the Emergency Management legislation.</p>	
50	Are the enforcement powers in the Health Act appropriate to allow authorised officers and EHOs to carry out their duties?	7.7
	<p>Comment:</p> <p>In the main, yes. The provisions currently in place should not be diminished in any way. However, the following is a list of suggested additions:</p> <ul style="list-style-type: none"> • On-the-spot fines • Increase the penalty associated with obstruction of an officer • Provision for formalized Memorandum of Understandings between appropriate authorities detailing assistance to be provided in certain circumstances (e.g. Police). • Proof of identity to be the same as the Food Act 1984 	
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?	7.7
	<p>Comment:</p> <p>Yes - the power/authority to take certain actions in a public health emergency situation (turn off equipment). Additionally, the power to seize/remove/deactivate items presenting a risk to public health should be considered (the occupational health & safety implications of this would have to be taken into account).</p>	

	<i>Issue</i>	<i>Section reference</i>
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?	7.7
	Comment: Yes - including computers and/or other relevant data storage items.	
53	Should the new Act contain a procedure for the issuing of improvement and prohibition notices by authorised officers?	7.7
	Comment: Yes - with procedures, documents (form templates) and protocols.	
54	Should notices cover: <ul style="list-style-type: none"> ➤ nuisance? ➤ licensable or registerable public health risk activities? ➤ where the activity may otherwise contravene the Act? 	7.7
	Comment: Yes, with specific offences attributed to these (clearly outlined).	
55	Should the new Act establish general criteria for issuing notices?	7.7
	Comment: Yes and the guidelines should be more specific to ensure uniformity in their application.	
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?	7.7
	Comment: Yes - as long as its application is flexible and still at the discretion of council.	

	<i>Issue</i>	<i>Section reference</i>
57	What method of review should apply to improvement and prohibition notices?	7.7
	<p>Comment: Creation of a separate Public Health Tribunal (VCAT/Magistrates Court not appropriate). This must have a quick turnaround with short timeframes for appeal and processing.</p>	
58	Should emergency powers be general for 'public health emergencies' or be specific to infectious diseases?	7.8
	<p>Comment: Keep the emergency powers general but tightly defining the nature of an incident that would qualify as a public health emergency.</p>	
60	Should there be a fast-track mechanism for notifying a disease associated with a public health emergency?	7.8
	<p>Comment: Yes - as the situation is obviously more critical than a routine investigation.</p>	
61	Should the Secretary be given powers in a public health emergency to compel examination, testing, vaccination, treatment (including preventative treatment), isolation and quarantine?	7.8
	<p>Comment: Yes.</p>	
62	Should the Secretary be given a 'catch all' power in a public health emergency such as 'any other order deemed necessary'?	7.8
	<p>Comment: Yes.</p>	
63	Should compliance with demands from the Secretary during an emergency or outbreak of an infectious disease be specifically exempted from confidentiality?	7.8
	<p>See O.P.</p>	
	<p>Comment: Possibly - where required and as long as it is not in breach of fundamental constitutional rights. How do you address such a sensitive area? Victorian Guidelines for the Management of HIV positive people who risk infecting others?</p> <p>This is a difficult question to answer because the Secretary may have to breach individual rights to protect the public's health.</p>	

	<i>Issue</i>	<i>Section reference</i>
64	Should the Secretary's power to act when local government is in default be limited in any way?	7.8
Comment:	Perhaps limited in some circumstances, but definitely not hindered in terms of being able to respond appropriately where required.	
65	Should the new Act include a provision for cost recovery where a person: <ul style="list-style-type: none"> ➤ has been convicted of an offence? ➤ has contravened the Act, but there has been no conviction? ➤ has caused a risk to public health? 	7.9
Comment:	Yes - where warranted.	
66	Should the new Act include a new offence of 'risk to health'?	7.10
Comment:	This depends. Will there be a clear distinction between a risk to the public as opposed to a risk to an individual, or will both be covered? Potentially this is far too broad and in some cases - specialized for Local Government to deal with alone.	
There needs to be a specific definition of "risk to health" that provides enough clarity to direct the necessary actions required to measure/quantify the risk to health.		
67	If so, what should amount to a 'risk to health'?	7.10
Comment:	<p>It is agreed that a risk to health should comprise the factors listed in section 7.10.1. That is:</p> <ul style="list-style-type: none"> • Actual injury not required - just reasonable risk that person's health may have been adversely affected. • A risk to health does not cease because only a small number of people are affected • Activities that are hazardous by nature should not be considered a risk to health, if properly managed. • The seriousness of the risk must be considered, so as to not capture trivial risks • A policy element, such as a Public Health Protection Policy, in the way risks are enforced must be included to allow the exercise of discretion in the decision of whether or not to prosecute. The issues of public interest and appropriateness must be considered. 	

	<i>Issue</i>	<i>Section reference</i>
68	If adopted, what should be the defenses, if any, to the offence of 'risk to health'	7.10
	<p>Comment: Defenses would be:</p> <ul style="list-style-type: none"> • Person was complying with accepted "best practice" • Practical, reasonable RM measures were employed • Control measures were not possible/beyond person's control (this should allow the Leap Frog effect to the responsible person, e.g. Transfer of the offence) <p>All the above listed defenses would have to pass the reasonable test.</p>	
69	What should be the scope of the offence?	7.10
	<p>Comment: Should rely upon the expected knowledge of possible impacts of actions/activity (as tested by the "reasonable person"). Should also consider the presence of Standards of Practice, Codes of Practice & Guidelines available for each issue.</p>	
70	Should the 'risk to health' offence subsume the offence for knowingly and recklessly infecting another person with an infectious disease?	7.10
	<p>Comment: It could as long as it has the ability to apply the same penalty level to the elements of "knowing & reckless behaviour" and "confirmed infection". Obviously, in the rare scenario that somebody (the affected party) was not infected, there should still be the ability to address the action (as is currently the case) under the "risk to health" provisions.</p>	
71	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)?	7.10
	<p>Comment: Yes - if the above (see 70) can be achieved.</p> <p>No - if this section will not allow the range of tools and the strengths of the Health Act provisions to function properly.</p>	
72	Should the new Act introduce PERIN for suitable offences?	7.11
	<p>Comment: Yes - but would have to be absolutely clear in its application. PERIN is a useful tool for compliance in conjunction with Improvement Notices.</p>	

	<i>Issue</i>	<i>Section reference</i>
73	Should public health offences attract similar penalties to those attracted by offences under environment protection legislation?	7.12
	<p>Comment: Yes - the penalty must be commensurate to the offence. Is human life and wellbeing any less important than that of the environment? The penalties need to be at the least equivalent with the Environment Protection Act 1970 or possibly higher.</p>	
74	Should the new Act allow for greater penalties where the offender is a body corporate?	7.12
	<p>Comment: Yes - compared to the individual.</p>	
75	Should the new Act include a statutory defense of due diligence?	7.13
	<p>Comment: Yes, but the onus must be on the defense to prove due diligence</p>	
77	Do the current provisions appropriately address the public health risk associated with hairdressing, beauty therapy and skin penetration?	8.1
	<p>Comment: Yes.</p>	
78	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?	8.1
	<p>Comment: Possibly not. This is a sensitive and specialized area that would be better dealt with by DHS officers in terms of the health-related issues (rather than the police, Department of Justice or the Business Licensing Authority addressing the health-related issues).</p>	
79	Do the current provisions appropriately address the public health risk associated with prescribed accommodation (for example, hotels, motels, hostels and holiday camps)?	8.2
	<p>Comment: No. The current regulations are outdated and need reviewing. The definitions do not reflect accommodation facilities, the cleanliness requirements need more detail and the number of occupants should be changed to the maximum - set at either 4 or 6</p>	

	<i>Issue</i>	<i>Section reference</i>
86	Should public health orders under the new Act apply to any infectious disease or condition where there is a serious risk to public health?	8.5
	Comment: Yes.	
87	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?	8.5
	Comment: Yes - in certain extreme situations where it is the only option.	
	Force/restraint component should probably always be administered by the police. However, taking of the sample should always be performed by qualified medical practitioners.	
89	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?	8.5
	Comment: This power could only extend to a situation where the person is posing a real or potentially serious risk to public health and the risk is imminent, if not almost certain to translate into a serious incident affecting another non-complicit person, non-complicit persons or the public.	
	There should be a strict evidentiary process that the Secretary must satisfy (perhaps decided by the Governor) before such an order could be given. Democratic rights and civil liberties would outweigh any other situation that could not satisfy the significant burden of proof required to be shown by State Government to justify the action being taken.	
	If the above is not possible, then perhaps the Knowing & Reckless Working Party could have an involvement with a "Public Health Tribunal" and decisions/actions taken could be rubber-stamped by the Secretary within a 72 hour time-frame!	
92	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?	8.5
	Comment: Yes & Yes.	
93	Should the new Act continue to provide that it is an offence for a person to fail to comply with an order?	8.5
	Comment: Yes.	

	<i>Issue</i>	<i>Section reference</i>
97	Should the term 'notifiable disease' be replaced with the term 'notifiable condition'?	8.6
	<p>Comment: Possibly incorporate both.</p>	
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'?	8.8
	<p>Comment: Definitely - yes. This ensures that councils are still involved. Further cost-shifting from the Commonwealth to Councils would not be appreciated. However additional remuneration for councils would be appreciated.</p>	
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)?	8.8
	<p>Comment: Yes - due to the fact that ACIR is providing immunization status as of August 2004. As a result this requirement is not required to be stipulated under the Health Act 1958 as the duplication is not required.</p>	
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?	8.8
	<p>Comment: The new Act should jointly share the immunization status certificate (and/or ACIR immunization status certificate) responsibility between the Principal and Parents.</p> <p>The Immunisation Status Certificate (ISC) should be issued for new enrolments but not for re-enrolment at the same school. The Schools should be encouraged/required to transfer information to the new School. Not only does this assist councils in their School immunization involvement, but this will also help to satisfy DE&T concerns (highlighted from Audits) over Schools student record management and knowledge of students health and immunization status.</p>	

	<i>Issue</i>	<i>Section reference</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?	8.8

Comment:

Immunisation status should be made a compulsory requirement for Secondary Schools. The ISC form itself should be an extension of the same form provided for Primary School to avoid any confusion or duplication.

However, the obligation should not rest entirely with parents and Principals without any involvement from ACIR. The concern here is with the potential affects upon immunization objectives and schools not being aware of the requirements. There needs to be links to ACIR, which would include the responsibility to supply a duplicate certificate if required.

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?	8.8
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Comment:

No -with the exception of overseas students (to some level). In practice this would be harder to implement. Additionally, how does this balance with the relative duty of care required by Tertiary Institutions and the concept that many university students are basically independent adults?

However, the requirement for educational programs supplied by the universities and immunization service providers could be very beneficial for University students (many of whom who are beginning or continuing to engage in high risk activities and are also part of higher risk groups with respect to some of the diseases listed below).

Some of the relevant diseases to focus educational approaches upon include:

- Whooping Cough
- Diphtheria
- Meningococcal
- Measles/Mumps/Rubella
- Hepatitis B

	<i>Issue</i>	<i>Section reference</i>
108	Should the new Act provide for different forms of evidence of immunisation? If so, what should they be?	8.8
	<p>Comment: Yes - at present the ACIR and CIP evidence is utilized. Further forms of evidence supplied from Doctors and other Health Care providers could be provided for. However, this should not open the door for Homeopathic options.</p> <p>The forms of evidence stipulated under section 8.8.7 would be sufficient, except for a written undertaking to immunize the child against a specified disease within 6 months.</p>	
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?	8.8
	<p>Comment: Yes, agree.</p>	
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?	8.8
	<p>Comment: Yes, definitely agree on all points.</p>	
111	Should the new Act facilitate consistency with the NHMRC schedule for immunisation?	8.8
	<p>Comment: Yes, definitely agree (for funded vaccines).</p>	
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?	8.9
	<p>Comment: Yes, professional advice is required under these circumstances.</p>	

	<i>Issue</i>	<i>Section reference</i>
118	Should Parts 5A and 5B of the Building Act 1993 be transferred to the new public health Act?	
<p>Comment:</p> <p>Not if councils are to administer the statutory regulatory responsibility. Consistency of application would not occur and the level of responsiveness to disease/Outbreak investigation would not be rapid enough. The current centralized system whereby DHS is the administering authority for enforcement of maintenance/testing requirements and the investigation of cases/Outbreaks of Legionnaires' disease is the only system that would work.</p> <p>If the registration, risk management plan production, and auditing components of the Building Act 1993 were to be formally moved across into the Health Act 1958 and become the complete administrative responsibility of the Department of Human Services then the Department would have to be confident of its ability to capture and process the registration, RMP and Auditing data effectively and efficiently. As it currently stands the Department carries out many of the above-mentioned functions in a de-facto sense already and shares most of the same data housed in linked systems between themselves and the Building Commission. Hence, there may be value in moving all of the responsibility and functionality across to DHS (in terms of complete control and ownership over a registration and licensing system that is primarily health-focused).</p>		
119	<p>Are there other amendments that should be made to provisions currently in Parts 5A and 5B of the Building Act that would improve the effectiveness of the legislative scheme?</p> <p>See O.P.</p>	

Comment:

Yes. To ensure that a true audit process is performed upon Cooling Tower RMPs and that the specified risks (which translate into actual and different risks from CTS site to CTS site):

- Section 75E (2)(a) should be amended to include the word "adequately" immediately before the current first word "address".
- This should also be reflected in the whole of section 75F and clauses (3) (a)&(b) should be removed/repealed.

Further, to provide CTS owners with some feedback as to their progression in mitigating the risks associated with their CTS, under the section 75FB provisions the audit certificate should formalize a requirement that auditors record any non-conformances on the audit certificate and assign basic remedies and specific timelines for these non-conformances to be addressed (guidance/prescription to be provided by DHS). This is the basic process that is followed under any true auditing framework.

Finally, there should be no possible loopholes or room for confusion surrounding RMP content and adequacy and the RMPs interrelationship with the minimum maintenance requirements mandated by the Health (Legionella) Regulations 2001.

Currently, section 75E of the Building Act 1993 refers to and mandates compliance with any cooling tower maintenance/testing/risk/auditing requirements specified under the Building Act 1993 and the Health Act 1958. The cooling tower system requirements of the Health Act 1958 pertain to:

- Maintenance
- Testing
- Action-loop requirements in response to adverse test results
- Record-keeping & documentation
- Inspectorial & investigative powers

The cooling tower system requirements of the Building Act 1993 pertain to:

- Registration
- RMP production and review
- RMP Auditing
- Inspectorial & investigative powers

However, the Building (Legionella Risk Management) Regulations 2001 being the subordinate legislation of the Act which specify the required content of a RMP (the specified risks to be addressed) under regulation 4 talk only about the specified risks having to be addressed in a RMP. In no place are the minimum requirements of the Health (Legionella) Regulations 2001 stipulated or referred to. Hence, this allows the situation where RMPs can be written without addressing and adequately meeting the minimum maintenance requirements of the Health (Legionella) Regulations 2001 as long as they address the 5 specified risks under regulation 4 of the Building (Legionella Risk Management) Regulations 2001 (which do not ensure by default that the minimum maintenance requirements are covered). The fact that the DHS "Guide to developing Risk Management Plans for Cooling Tower Systems" publication is purely that - a guide - means that even though this document has been structured and written in such a way as to adequately address the minimum maintenance requirements of the Health (Legionella) Regulations 2001 and allow for the progression of the operator towards best practice the owner can choose to write their RMP completely differently and set the operating standard below that of the minimum requirements of the Health (Legionella) Regulations 2001. This is resulting in a significant number of inadequate RMPs being produced across the state and non-compliance with the Health (Legionella) Regulations 2001. The recommendation is that regulation 4 should also specify that the minimum maintenance requirements of the Health (Legionella) Regulations 2001 be met.

	<i>Issue</i>	<i>Section reference</i>
120	Should the new Act re-enact provisions relating to meat supervision?	9.3
	<p>Comment: Possibly just the ability to legitimately inspect and require food safety-related issues to be addressed by the proprietor. Not necessarily transfer administrative and registration responsibility back to Local Government.</p> <p>A decision needs to be made as to the adequacy of the current arrangements and whether further assistance is required (and available).</p>	
121	Should the offence under the Food Act 1984 in relation to the sale of 'unsafe food' be broadened to include food that cannot be sold for human consumption under section 34(1) of the Meat Industry Act 1993?	9.3
	<p>Comment: Possibly, yes.</p>	

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Attachment A

1. There are is clear reliance being placed on the nuisance provisions of the Health Act to enforce wastewater infrastructure upgrade on individual properties (although it is a tenuous and risky process for Councils.)
2. There are also clear links between Municipal Public Health Plans and Municipal Wastewater Management Plans in that MWMP have to try and address a specific public health issue.
3. Risk Management with regard to wastewater is already being undertaken in Land Capability Assessments and Land Stability Assessments - there are clear links to Public Health if they fail. Wastewater must be addressed in the Health Act until local laws and other legislation can adequately manage these risks.

In a Council with 28 Unsewered Towns, Wastewater Management Planning is one of the most serious and obvious public and environmental health risk issues. There is currently no clear legal, technical and financial remedy to resolve this massive problem.

For example there are approximately 4000 households that have old permits to discharge all their household wastewater except toilet water directly into the street whether it is an open drain or not.

The changing policies with regard to reuse of greywater has the potential to create further environmental and public health problems even in sewerred towns and cities. We need to encourage more greywater reuse (to conserve drinking water) but we need to make sure we have clear powers to regulate any systems that become a problem.

Attached are the proposed amendments to the Environment Protection Act that were rejected by the previous State government. This was understandable because there were no checks and balances proposed to stop the blanket chaos and lack of proper technical solutions.

Things have now changed and with the right checks and balances in place, these reforms could help plug a major flaw in public health and environmental policy.

It is proposed that the attached amendments to the Environment Protection Act be incorporated within the Health Act under special Wastewater Nuisance Provisions until they can be moved across to the Environment Protection Act.

A clear constraint on the use of these provisions needs to be that the Minister agree to the designation of "scheduled districts or circumstances" limiting their application. Some need to cover existing sewer districts (to control greywater reuse where it might pose a nuisance). The other situation is a where a Municipal Wastewater Management Plan with Ministerial Approval designates a "Mass Upgrade District" for upgrade of septic tank systems in the interim until town sewer can be provided or to a higher standard where systems have to be made sustainable in the long term.

Council needs the protection and support of State legislation to be able to amend wastewater permits. Council's also require the protection to not apply these requirements in some circumstances because it might exceed the ability of authorities to keep up with the workload and proper planning associated with this challenging work.

Background

Many Environmental Health Officers feel uncomfortable using the Health Act as grounds for retrospectively requiring mass upgrade of septic tank permits already issued by Councils. There is a danger Council could be liable for the cost of the upgrade works as well as ongoing running costs and compensation for the loss of sometimes the whole front and back yard to the purpose of wastewater disposal.

There have been accelerated changes to public expectations regarding wastewater system performance and it should not be Council's role alone that bare the full cost. The polluting resident should take most of the responsibility for their environmental impact but some of the cost should be shared by the owners of downstream vacant properties that all benefit from the improved environment. Where there are surface discharges in some locations cleaning this up can double the value of the vacant land.

The State government, just as it does with subsidising town sewer installation, should be prepared to subsidise some of the upgrade costs because the old titles and out dated wastewater methods were installed in accordance with the State requirements of the time. It is also important to make sure that support for residents facing financial hardship also be provided by the State as it does for those facing difficulty paying for town sewer.

These are simple fundamental textbook issues that will fill a local unsewered town hall at the drop of a hat. We are talking direct pipe connections of every fixture in the house except the toilet into the open stormwater drain out the front, back or side of the property. The proposal to complicate the definition of nuisance by getting consultants involved to do a "risk assessment" is total overkill when applied to these situations compared to more complicated nuisances such as noise.

Just provide some clear wastewater management guidelines, technical solutions and funding.

The "risk assessment" component if required is better applied to the solution to make sure the nuisance is resolved. There are clear "risk assessment" options available to Councils when assessing all septic tank permits to install or alter in the form of Land Capability Assessments. These can include anything from tree stability to nutrient modelling.

All that Councils require with regard to wastewater is the power to safely apply the communities expectations of the day to ensure at least certain minimum standards of household wastewater management are in place.

If the objective of the Health Act Review is to remove public health wastewater nuisances then the risk of claims for costs and damages against Council (the rest of the community), also needs to be removed or at least minimised as well. This can be done by clarifying when and where Council's can insist on retrospective upgrades of wastewater systems.

Whether it is done in the Health Act or the Environmental Protection Act does not matter - the point is that greywater and wastewater issues are becoming particularly important and high profile and Councils need appropriate support to implement community expectations.

Regards,

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