

## **Submission on the Review of the *Health Act 1958* VicHealth**

### **Introduction**

The Victorian Health Promotion Foundation (VicHealth) works with a range of partner organisations to deliver innovative responses to the complex social, economic and environmental forces that influence the health of all Victorians.

VicHealth seeks to contribute value to the wider public health system through building evidence and capacity for health promotion across a range of sectors. The Foundation's work still reflects the mandate articulated in the Tobacco Act 1987, in many ways one of the most visionary pieces of public health legislation in the past 50 years.

VicHealth's vision is for a community where health is a fundamental human right; everyone shares in the responsibility for promoting health; and everyone benefits from improved health outcomes. The Foundation's mission is to build the capabilities of organisations, communities and individuals in ways that change social, economic, cultural and physical environments to improve health for all Victorians and strengthen the understanding and the skills of individuals in ways that support their efforts to achieve and maintain health.

### **The name of the Act**

VicHealth supports the retention of the current name of the Act or its expansion to the Population Health Act. The *Health Act* succinctly and aptly describes the aim of the legislation – to promote and secure the health of the people of Victoria. Alternately "Population Health Act" describes the intended outcome of the application of the Act so might also be appropriate. "Public Health" may not be as pertinent as it describes a specific approach to population health and is associated with a field of practice, which, along with other professions in the health sector (eg environmental health, health promotion), seek to improve the health of Victorians. It may also be confused with the provision of health care through the public hospital system.

### **The scope of the Act**

The scope of the revised Act should reflect current health concepts, initiatives and challenges in Victoria. Understandings of health have expanded to encompass individual and collective wellbeing. Non-communicable disease is now the major cause of ill health and health promotion is arguably the key strategy for addressing it. Inequalities in the health of different social groups has emerged as the major issue confronting population health. Thus issues such as wellbeing, health promotion, health inequalities and non-communicable disease should be addressed in an Act purporting to address population health. Some suggestions for how this may be done follow in the sections below.

The proposed changes to the Act seek to address current and future health challenges predominantly through an expansion of the powers of the State. VicHealth contends that powers under the existing *Health Act* and other legislation are sufficient to meet whatever risks to health could foreseeably arise and that the

suggested amendments to these powers will not be effective in addressing the risk scenarios presented (such as incidences of corporate negligence) and may also be used against vulnerable members and groups in our community.

The focus of innovation in the review of the Act is thus arguably misplaced. The proposed changes detail a simple "risk management" approach to population health that is, when unpacked, really a repetition of older (though necessary) approaches to public health, and does not provide the more sophisticated tools required to address non-communicable disease. The review would benefit from a paradigm shift, from an attempt to fortify traditional responses to potential health threats (in a way that provides less guidance and reduced certainty to the public), to an endeavour to identify opportunities for the Act to function as, or be a foundation for, innovative legislative solutions to real and significant health challenges.

It is noted that the recommendations contained in *The Application of Risk Management Principles in Public Health Legislation, Final Report* (NPHP, 2000) have been set out only in part by the discussion paper. Recommendations dealing with standard setting, public participation and advisory committees are not detailed in the same fashion. We have attempted to remedy some of these gaps in this submission.

VicHealth concurs with the statement in the discussion paper that there is little to gain from consolidating population health legislation dealing with food, drugs or tobacco as these areas have separate administrative and enforcement frameworks.

### **Inequalities in health**

Health inequalities pose significant strategic challenges for governments, including working across sectors and influencing social determinants of health. This requires long term integrated research, planning and policy making capacity at a state level. Legislative reform has made and should continue to make a contribution to initiatives to reduce health inequalities. Revisions to the *Health Act* can begin, in a small way, to address inequalities in health and the wellbeing of disadvantaged Victorian communities.

Health inequality might be addressed through the following legislative mechanisms:

- A reference to health inequalities in the preamble, objects and functions of the Act;
- A statutory requirement for the collection and dissemination of information on the health status of population subgroups and on socio-economic determinants of health that are particularly directed toward locating health inequalities;
- A health inequalities impact assessment included in law providing for HIA ;
- The creation of specific mechanisms for consultation and partnerships with Indigenous peoples and community groups; and
- A committee on health inequalities.

The functions of a committee on health inequalities might include requirements for:

- Coordination of information collection, analysis and dissemination on health inequalities;
- Representation of and consultation with disadvantaged communities;
- Coordinated state and municipal health planning functions; and
- Biannual recommendations to the Minister on research, policy and programs.

## **Definitions**

Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity (WHO, 1946).

To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities (WHO, 1986).

## **Preamble, objects, functions and guiding principles of the Act**

The discussion paper notes that the objects of an Act give meaning to the rest of the Act. It further indicates that they are an “opportunity to state the core public health objectives, values and outcomes that the legislation aims to achieve”.

The objects proposed in the discussion paper appear more like functions of a Department than objects of an Act. They are not aspirational (in that they appear to be readily achievable) and do not convey a philosophical position on the importance in promoting and protecting health as a human right and a social good. The objects of the Act should be expressed as outcomes or goals rather than strategies. These objects and functions also attempt to address disability though it is recognised that this is dealt with in part through other legislation.

The following is an example of alternate objects and functions:

### *Whereas*

*The State of Victoria has a significant role in promoting and protecting the health of all Victorians; and*

*It is accepted that health is a state of individual and collective wellbeing, not merely the absence of disease; and*

*It is accepted that health is a fundamental human right amongst other human rights; and*

*It is accepted that some Victorians have a poorer chance of achieving their full health potential as a result of socioeconomic disadvantage; and*

*It is possible to improve the population’s health status and reduce health inequalities between sub groups of the Victorian population through population health interventions;*

### **Objects**

*The objects of the Act are:*

*To ensure all Victorians are enabled to achieve the best possible state of health and wellbeing regardless of social inequity or pre-existing level of health;*

*To prevent and reduce disease, illness, injury, disability and premature death; and*

*To assure the conditions in which the people of Victoria can be healthy.*

### **Functions**

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

*To implement policies and programs to achieve the objects of the Act;*

*To protect population health and prevent disease, illness, injury, disability and premature death;*

*To promote population health and wellbeing through built, social, economic and natural environments;*

*To monitor population health status and provide soundly based information to the public about population health;*

*To develop equity-related health targets, policies and programs and assist in reducing health inequalities;*

*To address economic, social and cultural barriers to the attainment of good health;*

*To support, equip and empower communities to develop and implement policies and programs that address their health needs; and*

*To develop and enforce laws and standards which protect population health and intervene if the health of populations is threatened.*

### **Principles to Guide the Implementation of the Health Act**

As alluded to in the discussion paper, a human rights framework for health has gained significant popularity and influence. VicHealth is keen to support such a framework and we believe that health and human rights principles should guide the implementation of the new Act. A section outlining these guiding principles might state the following:

*While health programs must consider the need of the population of Victoria as a whole, special attention should be given to those population groups considered most vulnerable, marginalized, disadvantaged or stigmatized and the individual characteristics of such groups recognised and addressed.*

*Health programs and systems should be designed, implemented and be made accessible to all without discrimination on any prohibited grounds.*

*A gender perspective should be adopted which recognizes that both biological and sociocultural factors play a significant role in influencing the health of men and women and that policies and programmes must consciously set out to address these differences.*

*Any health data collected should be disaggregated to detect underlying discrimination.*

*Beneficiaries of health policies or programs should be ensured free, meaningful and effective participation in decision-making processes that affect them.*

*Beneficiaries of health policies or programs should have the right to seek, receive and impart information and ideas concerning health issues. However, this should not impair the right to privacy.*

*Personal freedom should be limited by a health policy or program only as a last resort and should only be considered as legitimate if: the restriction is provided for and carried out in accordance with law; the restriction is in the interest of a legitimate objective of general interest; the restriction is strictly necessary to achieve the objective; there are no less intrusive means available to achieve the objective; and the restriction is not imposed arbitrarily, unreasonably or in a discriminatory fashion.*

*Identifying benchmarks and indicators should be identified to ensure meaningful monitoring of the progressive realization of rights in the field of health.*

*A key consideration at all stages of programme development should be transparency in, and accountability for, administrative decision-making.*

These principles are based upon *25 Questions and Answers on Health and Human Rights* (WHO, 2002) and the *Declaration of Alma-Ata* (WHO, 1978).

## **The Health of Indigenous Victorians**

The extent of disparity in health between Indigenous and other Australians is a key concern of government. Debate on legislative mechanisms to improve Indigenous health has focused on constitutional law, land rights, laws that regulate behaviour and environmental health (Reynolds, 2004; NPHP, 2002). However the *Health Act* should also function to improve the health of Indigenous Victorians.

Some suggested revisions to the Act to promote the health of vulnerable groups, including Indigenous Victorians, are included in this submission under sections on participation and partnership, health inequalities, health impact assessment and municipal health planning.

We have other recommendations that are more specific to Indigenous people. General concerns have been raised in a consultation with Indigenous health organisations about the scope of the Act. In particular, the Act is seen to continue the dominance of traditional western understandings of health, with an individualistic

and curative focus and a bias toward traditional public health approaches. Broadening the scope of the Act to include collective and individual wellbeing, health as a human right and the social determinants of health may help to ensure the concept of health, as embodied in the Act, is more compatible with Indigenous understandings of wellbeing.

There are also specific clauses in the Act, for example in relation to nuisance and accommodation, which have been problematic to Indigenous communities. Indigenous Victorians may have different cultural understandings of a range of issues, for example of the importance of public gathering or the need to make accommodation for visiting relatives. In particular, there is concern in Indigenous communities over provisions relating to orders for restriction, isolation and detention of individuals in the case of suspected infectious disease, which presents a serious risk to population health (Section 121(3)). The health risks that detention and isolation pose to Indigenous individuals are documented in reports of the Royal Commission on Aboriginal Deaths in Custody (1991). In view of these risks, the Department may wish to enter into a dialogue with VACCHO and other Indigenous organisations about the relevance of recommendations from the Royal Commission to the review of the *Health Act*, in particular chapters 21-25. It is suggested that when drafting the legislation the Department consult with Indigenous communities to identify these areas of potential concern and possible legislative mechanisms to prevent unintended harms to individuals or communities.

Opportunities for consultation with Indigenous communities need to be seen as both a process and product of the *Health Act* review. Strategies to address Indigenous health may be very different from mainstream population health strategies and may require greater community participation in planning. The Act needs to include specific mechanisms for continuing involvement of the Indigenous community in health planning. Examples include:

- An Indigenous health commissioner;
- Indigenous involvement in health policy and program development at a state level, for example the representation of Indigenous groups in a population health advisory or health inequalities committee created by the Act;
- Enacting guidelines on consultation to be developed in association with Indigenous health organisations;
- A reference to partnerships with Indigenous health organisations in any provisions dealing with partnership;
- A requirement that municipal health planning and health impact assessment include consultation with vulnerable groups, including Indigenous communities; and
- A mechanism that accounts for small discrete communities and offers alternative means for consultation outside formalised meetings.

### **A state population health plan**

The discussion paper recognises the potential of the Act to support municipal health planning to promote health, but does not really explore how legislation could ideally function as a structural framework for the population health role of State government (NPHP, 2002, p.27). The functions, powers and duties of the state are outlined in respect to specific issues such as health information and infectious disease control. Above and beyond this the state functions under the Act in “a policy and advisory role

involving superintendence of the legislative framework” (DHS, 1998, p.10). However a broader, more positive and active role for the State in protecting and promoting the health of Victorians could be prescribed by the Act.

Template public health legislation from the USA includes a provision requiring the development of a comprehensive state wide public health plan to set priorities, develop strategies and outline a work plan for essential public health services and functions (Public Health Statute Modernization National Excellence Collaborative, 2003, section 3-106). This is overseen by a Public Health Advisory Council, with representatives from the public health sector, tribal public health agencies and the community, that serves as an advisory body to the state public health agency (Ibid., s 3-107).

A National Public Health Partnership document has stated that a Public Health Advisory Committee should be formed to ensure that there is public input into policy questions concerning the administration of health legislation (NPHP, 2000, p.79). It is noted that it is:

“critical that genuine community voices are heard and taken account of in this process. The Advisory Committee should be an independent process whose decisions can be publicly reported and which can actively encourage community participation in decision-making.”

A Victorian Population Health Advisory Committee is therefore recommended.

There is no doubt that state level population health planning would be beneficial. A state plan is a proactive tool for promoting good health and a mechanism for community input into program and policy development. It would help to realise and operationalise the Act through the functions of the department, enhance central and local government communication and articulate and coordinate state and local government roles (eg provide a framework for the development and support of MPHPs). Special consideration should be given to how a state population health plan would correspond with other plans (eg the DHS strategic plan).

### **Functions of municipal councils**

VicHealth supports the proposal that the new Act should recognise municipal councils’ role in promoting health. The Act should create “a structural framework for the public health role of State and local government” (NPHP, 2002, 27). It is questionable whether the current wording of the Act reflects local government’s dedicated role in promoting health and wellbeing or its broader activity in influencing social determinants of health, or provides an adequate framework to support them.

The functions of municipal councils in the new Act could be reframed to reflect the functions of the Act such as those suggested on page 4 above. This would assist in aligning state and municipal population health planning and program activity and ensure that local government health functions realise the objects of the Act.

### **Municipal Health Planning**

Statutory requirements for the development of municipal public health plans (MPHP) are one of a limited suite of mechanisms in health legislation (as opposed to

legislation in other sectors) that can be effective in addressing social determinants of health and non-communicable disease.

VicHealth therefore supports in principle the proposals that the Act:

- Places a greater emphasis on implementing the MPHP and achieving its outcomes;
- Requires that municipal councils set out how they intend to fulfil their statutory functions in their MPHP; and
- Requires that MPHP be aligned with the municipal four year planning cycle and linked to municipal corporate and strategic plans, and that this be done in a coordinated fashion with the development of a State strategy (see above).

These suggestions are complementary and may help in making planning a more meaningful and straightforward exercise by pulling health considerations into broader council priority setting and planning. This would, in theory, considerably strengthen the impact of MPHP.

However there are practical challenges for local governments in municipal health planning which need to be addressed if this legislative mechanism is to be effective in addressing health determinants. These include:

- Integrating and simplifying planning requirements under three legislative mechanisms;
- Resourcing statutory requirements for municipal health planning; and
- Ensuring legislative changes continue to support democratic processes for health at a community level (see Appendix 1).

Consulting local government to obtain further information on these challenges and how they may be overcome would be helpful prior to expanding any requirements for municipal public health planning.

### ***Reporting requirements***

Changes under the Act to reporting requirements for MPHP require further consultation with local government. VicHealth supports the premise that a careful analysis of the expected value of reporting requirements be undertaken, in consultation with local government, including an exploration of issues outlined in Appendix 1.

### **Partnership and participation**

The discussion paper addresses the question of whether partnerships between state and local government, and between government and non-government agencies should be addressed in the new Act. It also identifies community interest in population health and the importance of collaboration in its principles. However there is little discussion of specific mechanisms to increase partnerships with community groups or community participation in planning and decision-making in the Act.

VicHealth contends that it is important that the Act contain specific provision for consultation with community groups – especially disadvantaged groups. A range of consultative mechanisms to engage community input into planning could be made explicit in the Act such as:

- An Indigenous health commissioner (see above);

- Community representation on a Population Health Advisory Council (see above);
- Community representation on a committee on health inequalities (see above);
- Regular (eg quarterly or biannually) regional or issues based round table consultations with interested population health and community groups to exchange information, views, suggestions and ideas;
- Guidelines for community consultation in municipal planning and health impact assessment processes which are contained in the Act; and
- Guidelines for consultation with Indigenous communities which are detailed in the Act.

Consideration should also be given to interdepartmental mechanisms. All these mechanisms need to be underpinned by requirements for transparency and accountability.

### **Health Impact Assessment (HIA)**

Banken (2001, p.4) argues that “two different conceptual streams marked the evolution of HIA: the assessment and mitigation of unintended environmental consequences of development projects, and the public health concepts of the importance of the social and environmental determinants of health” (Ibid., p.4). These two different conceptual streams underpin two different approaches to health impact assessment (environmental health impact assessment and policy related health impact assessment). It can be argued that both these approaches are unique and make a legitimate contribution to population health in their own right. It could also be argued that they are more appropriately led and/or undertaken by different sectors and, as such, more appropriately underpinned by different legislative frameworks.

As such VicHealth supports the propositions that:

- Victoria should continue to rely on a legislative requirement for environment focused HIA in environmental legislation;
- A separate requirement for policy related HIA should also be introduced in the new Act; and
- These two separate legislative frameworks be underpinned by some common administrative elements, for example common procedural guidelines and access to health sector expertise located in the department.

Issues in the inclusion of HIA in the Act include:

- The adoption of a minimalist framework for policy related HIA in the Act;
- The strengthening of existing environmental HIA processes under environmental legislation; and
- The development of administrative frameworks supporting these legislative frameworks (see Appendix 2).

VicHealth recommends the Department consult other governments which have introduced, or are attempting to introduce, policy related HIA through legislative frameworks (see Appendix 2).

## **Inquiries into matters of population health concern**

Section 384 of the *Health Act* should be revisited. Governments must have the option of conducting thoroughgoing investigations into matters of concern in the area of population health. When doing so it is appropriate that there be wide-ranging powers that can be called upon. The powers contained in ss20 – 26 of the Tasmanian *Public Health Act 1997* are more comprehensive than those found in the current Victorian Act.

## **Risk Management**

Generally speaking, the greater the certainty in legislation the better. This is particularly so for legislation that creates duties or offences. Even the 2000 NPHP paper promoting risk management principles in public health law notes:

“It is not clear that a statutory framework that guides the use of these powers and establishes the criteria, particularly those relating to risk is crucial. However, if not in statute, there is certainly a case for administrative guidelines to ensure that issues of risk are properly and thoughtfully addressed at this point in the application of public health legislation and also to ensure that a systematic approach is taken by the many authorities responsible across Australia for the application of abatement orders.” (NPHP, 2000, p.88)

In addition, what might be gained on the swings in the sense of ostensible flexibility might be lost in the roundabouts. The ACT *Public Health Act 1997* is a case in point. It has adopted quite a general approach in the Act. However regulations deal with immunization and exclusion from school, cervical cytology, drug preparation and supply, and general sanitation (including animals and birds, water supply and toilets). There are other regulations dealing with public baths, poisons and drugs, confidentiality in epidemiological studies, gene technology, and radiation.

Risk management plans have some superficial appeal. However those charged with the responsibility of developing such plans would need to know what was required of them and probably need guidance to draft and complete them. Such plans would need to be monitored by those with the skills to ascertain whether they were sufficient and able to be implemented. Without these supports being in place the introduction of this requirement would be nothing more than a meaningless burden.

## **Offence of risk to health**

There are a number of reasons why VicHealth opposes the introduction of an offence of this nature. It has already been noted that a “risk management” approach has much in common with the traditional biomedical approach to health. There is nothing wrong with this as long as standards can be set in a fair and accountable fashion. However an offence of causing a risk to health has many drawbacks from a statutory perspective. These will be dealt with in turn.

Generally speaking, an offence of this nature would not be useful in dealing with non-communicable or chronic diseases. This would require a dedicated legal framework and campaign such as that adopted for tobacco. For example, it is difficult to conceive of the offence of risk to health being used to prosecute a fast food chain for having giant servings or putting too much sugar in their rolls.

On the other hand the danger is that the vulnerable and marginalised would yet again be the targets of prosecution. Even with the best intention to do otherwise, it tends to be these groups who are most socially visible and thus most open to legal action.

The offence would be of uncertain scope. As such it would most likely be read down by the courts and interpreted in favour of defendants. Again, the ostensible argument in favour of such offences is their flexibility. However given the potential breadth of the offence, it might also be fairly described as an affront to civil liberties.

In addition, as demonstrated by the criminal offence of reckless endangerment, courts struggle to make sense of offences when the intent is unclear. In the case of reckless endangerment when used to prosecute individuals accused of placing others at risk of being infected with HIV, the courts ended up relying upon statistical probabilities of infection as they related to one or more acts of sexual intercourse and asked that the government provide further specific guidance.

The problem that is being addressed by the “risk to health” offence is unclear. The diving shop and eclipse glasses examples provided might be dealt with under fair trading legislation. Section 10 of the *Fair Trading Act 1999* deals with misleading conduct in relation to goods. It states:

“A person must not, in trade or commerce, engage in conduct that is liable to mislead the public as to the nature, the manufacturing process, the characteristics, the suitability for their purpose or the quantity of any goods.”

The penalty is 600 penalty units in the case of a natural person and 1200 penalty units in the case of a body corporate.

Nuisance legislation is well understood by environmental health officers and the courts. There is also an expectation by the public that municipal councils will attend to their complaints about neighbours making a racket at 3am or something rotting in the gutter. Though it forms part of the armoury of the “old public health” approach, a great deal would be lost by doing away with nuisance provisions.

The *Emergency Management Act 1986* might also be relied upon in the case of significant risks to health caused by disasters or even the next influenza pandemic as its powers extend to health.

### **Powers for investigation and control of infectious diseases**

There are a number of matters deserving of specific comment in this part of the discussion paper.

Contact tracers have worked in a “twilight zone” and the recommendation that their work be properly authorised and that accountability for their functions be included is supported by VicHealth.

The sort of person that is usually the focus of coercive infectious disease powers tends to be poor, perhaps intellectually disabled and or mentally ill. Such a person is likely to be unable to organise their own legal representation for the purposes of an appeal to VCAT. It is suggested that a separate fund be set aside for legal representation in the odd case where restrictions are intended. It is noted the NPHP

recommend that legislative mechanisms should ensure ... processes involve minimal costs to the appellant (NPHP, 2003, p.15).

At present the opportunity for external review of decisions to impose restrictions occurs at the initiation of the person concerned after the restriction has been imposed. A fairer process would require external review as soon as practicable to determine whether the restriction was warranted. This is the model that applies in New South Wales. This can be done expeditiously.

It is difficult to understand what justification there is for the suggestion that there be compulsory treatment. The existing or potential problem that might be addressed by such a draconian remedy is not made out. Despite the existence of such a requirement in earlier legislation (such as venereal diseases law) the majority of health care practitioners have long been opposed to treating people compulsorily.

### **Immunisation**

It is suggested that streamlining the collection of information concerning immunisation would be of assistance to parents. However it is noted that the Privacy Commissioner has expressed concerns about the ACIR in that it is a compulsory database that was created for one purpose and now is being used for several others. It can be used:

“to discriminate against (people) in the workplace, refuse them commercial services, deny them social benefits, or turn them down for mortgages or political office ... Thus the use of data collected for the purpose of promoting immunisation for social security purposes has been the cause of considerable criticism from organisations such as the Public Health Association, consumer groups and others.” (Health Issues Centre, Monash University and Corrs, Chambers, Westgarth, 2002).

Careful consideration should be given to any extension of the use of this database.

VicHealth regards the proposal that immunisation records be collected for tertiary students as impracticable. The exclusion of unimmunised students during outbreaks would be impossible to achieve.

### **Emergency powers**

No justification has been given for the extension of the emergency powers currently available under the Act in scope or duration. Some examples provided in the discussion paper of instances in which the Chief General Manager might be called upon to respond, such as a large scale terrorist attack, call for a whole of government response. In such cases as already noted, the Victorian government should rely upon powers contained in the *Emergency Management Act 1986*. The Chief General Manager has certainly carried out responsibilities under the State Disaster Plan in the past. Commonwealth quarantine powers might also be suitable for other purposes. The inter-relationships in this web of powers should be clarified to enable greater understanding of the gaps to be filled by any new Act. In this context, unless it can be shown to be necessary, it is preferable that powers under new legislation be confined to infectious diseases. It is suggested that the *Siracusa Principles* (Commission on Human Rights, 1985) guide the application of emergency powers.

## **Enforcement powers**

The discussion paper made reference to the report entitled *The Powers of Entry, Search, Seizure and Questioning by Authorised Persons* (Victorian Parliament Law Reform Committee, 2003) and the government response. The introduction to the report indicated that it was specifically dealing with “inspectors appointed to carry out duties related to public health matters”. The report appears to be a thorough evaluation of issues around enforcement and its recommendations generally seem sound.

However, particular note is made of the following principles cited in the Report:

- The State should exercise extreme restraint when giving itself powers to interfere with the privacy and liberty of its citizens;
- People have a fundamental right to their dignity, to their privacy, to the integrity of their person, to their reputation, to the security of their residence and any other premises, and to respect as a member of a civil society;
- No person, group or body should intrude on these rights without good cause; and
- Such intrusion is warranted only in specific circumstances where the public interest is objectively served and, even where warranted, no intrusion should take place without due process.

These principles are of interest because of their use of the language of rights, their consistency with the Siracusa Principles and their insistence that no intrusion should take place without due process. It is arguable that the current *Health Act* does not comply with this requirement.

The Report notes an interesting anomaly. This is that the *Health Act 1958* and the *Community Services Act 1970* allow the detention of a person but not their arrest.

Finally it is urged that, as noted above, the exercise of enforcement powers be sensitive to Indigenous culture.

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## **Appendix 1 Municipal Public Health Planning**

### **Challenges for Local Government in Strengthening and Integrating Municipal Health Planning**

There are many practical challenges for local governments in municipal health planning (MPHP) which need to be addressed if a legislative requirement for MPHP is to be effective in addressing health determinants.

The first challenge is that local government's population health roles are founded in both local government and public health legislation. Reform to the Health Act needs to be considered in light of local government's legislative mandate under the *Local Government Act 1989*, the *Local Government (Democratic Reform) Act 2003* and *Planning and Environment Act 1987*. Potential synergies between these planning mechanisms can be strengthened and duplications between them reduced so that MPHP planning is simplified and integrated.

It is important that the MPHP retain its strategic focus (rather than become overly operational). Changes should not have detrimental impacts on management and decision making processes in councils. It is essential that MPHP planning frameworks and support materials (eg DHS, 2001; VicHealth, 2002) be updated to help support municipalities. Obtaining further information from local government on the experience of undertaking MPHP and barriers to integrated planning will assist this process. It is noted that Local Government Victoria (Department of Victorian Communities) are undertaking a Joint State-Local Planning Project to review local government planning requirements and identify opportunities for consolidation and the facilitation of whole of government planning.

The *Local Government (Democratic Reform) Act 2003* has arguably strengthened the policy context for integrated planning by setting councils the objective of promoting "social, economic and environmental viability and sustainability" and improving "quality of life". In reviewing the requirements for MPHP under the Health Act it would be worth exploring the impact of these changes on municipal planning, and whether this has promoted the integration of municipal health planning with other municipal strategic and community planning. If councils are interpreting this legislative framework broadly as a requirement for developing community wellbeing indicators as part of broader triple bottom line community planning and reporting, it may be appropriate for MPHP to be fully integrated into this process and legislative requirements for MPHP to be incorporated into the *Local Government (Democratic Reform) Act*.

The second challenge is that statutory requirements need to be properly resourced. Crucial issues and challenges facing local governments in undertaking their population health regulatory activities include their resourcing implications, balancing competing priorities, managing an increased proportion of contracted services and attracting and maintaining appropriately skilled workforces (NPHP, 2002). The potential advantages of increasing local government's population health regulatory planning and reporting requirements need to be assessed in view of local government's capacity to carry them out effectively.

The third challenge is how MPHPs can continue to support democratic processes for health at a community level. Municipal public health plans are intended to "enhance local responsibility and accountability for the performance of municipal public health

functions”, “provide a means by which public health planning and service delivery may be better co-ordinated” and “assist in the development and adoption of innovative local government programs” (DHS, 2004). Community input and ownership is important as they increase innovative problem solving, responsiveness to local issues and awareness of the needs of vulnerable groups (DHS, 2000). Legislative amendments should be framed to enable rather than impair councils’ capacity to generate community ownership of municipal health plans. The challenge for the Act is how to strengthen integrated and outcome focused health planning by local governments while retaining facility for innovative community input. The following issues should be addressed:

- How innovative community inspired solutions to health challenges might coexist with councils’ strategic plans for their provision of essential public health services;
- The articulation of municipal health planning with community generated indicators of wellbeing;
- The articulation of municipal health responsibilities and community health planning; and
- How effectively communities have been engaged in municipal health and other planning.

### **Reporting requirements**

Changes under the Act to reporting requirements for MPHPs require further consultation with local government. VicHealth recommends that an analysis of the expected value of reporting requirements be undertaken, including an exploration of questions such as:

- What is the role of the State in municipal public health planning? Is it one of facilitation and support and/or one of review?
- Who is responsible for ensuring the plan has been undertaken and accordingly to which parties should the MPHP be reported and how? It should be borne in mind that there are number of stakeholders (local community, LGA and state government) with a range of interests.
- How are reporting requirements to be resourced? Are reporting requirements too onerous for councils and a drain on municipal resources? Is this reflected in the current lack of compliance with the annual reporting requirement?
- If health planning is integrated with corporate and strategic planning should reporting follow the same time frame?
- What is the time span for expected program outputs and health behaviour and health status outcomes? How does this influence reporting requirements and time frames?
- Is there value in requiring information on local government spending on health and health determinants? Will this be useful for local government, state government and their constituencies in clarifying the significant investment municipalities make in health promotion and the reduction of non-communicable disease?

## **Appendix 2 Health Impact Assessment**

### **Legislative frameworks**

#### ***Environment***

VicHealth supports the proposal that the legislative frameworks for environmental HIA guidelines be strengthened by the incorporation of HIA guidelines into existing environmental and planning impact assessment. There are compelling reasons for continuing to integrate environmental health impact assessment in environmental and planning legislation including relative administrative simplicity and the potential for integrated social, health and environmental assessment.

#### ***Health***

VicHealth also supports including a requirement in population health legislation that HIA be conducted under certain circumstances, for example:

- For specific activities, policies or developments;
- Where an EIA process is inappropriate or unable to be triggered;
- Where there are high levels of community or political concern over health impacts requiring greater health sector involvement; or
- Where the Secretary determines it is appropriate.

Separate HIA provisions need to be included in the new Act because of the inherent limitations of HIA within the EIA process. The trigger for an assessment is a crucial difference between EIA and HIA and a key reason why a separate HIA process may be required. Although policies or projects across a range of sectors may have significant impacts on population health, if there is no expected impact on the physical environment, there will be no EIA process triggered, as in the case of the increased/ decreased provision of public housing, the extension of gambling machine quotas or the extension of the operating hours of a class of liquor licences.

The ability of the environment sector to lead and undertake these policy related investigations is also questionable as many of these issues are outside of their field of expertise. It can be convincingly argued that they require health sector expertise and leadership. In non-health sector policy proposals HIA represents a crucial check on the integration of health considerations in the planning process. In health sector policy proposals HIA represents an opportunity to assess the unintended impacts of these policies and the distribution of impacts (positive and negative) amongst the community (Simpson et al, 2004).

The greater promise of HIA is its potential to:

- Increase cross-government decision making;
- Enhance recognition of the social determinants of health and positive and negative impacts of policy and programs in other sectors on health;
- Enhance recognition of inter sectoral responsibility for health;
- Identify and strengthen the ways in which policy and proposals can promote health;
- Engage health professionals, policy makers and analysts in structured discussion and strategic planning with affected communities; and
- Encourage inter sectoral and interdisciplinary decision making and creation of advocate-academic-policy initiatives (Krieger et al, 2003).

Outside of its potential for supporting population health gain, a compelling reason to include some provision for HIA in the Act is the potential of HIA to strengthen the architecture of the Act. HIA may help to consolidate other proposed changes in the new Population Health Act, as it represents an opportunity to embody in the provisions:

- A legislative mechanism to address determinants of health inequalities
- A legislative mechanism to address determinants of chronic disease
- The proposed risk management framework
- The proposed evidence based management principle

### ***A Minimalist Framework***

A minimalist approach to legislative frameworks for HIA is advocated by some commentators (Banken, 2001; Kreiger et al, 2003; NPHP, 2004) who argue that legislative frameworks should:

- be clear and unambiguous
- provide the overall obligation for carrying out HIAs without fixing the exact procedures.
- contain the principles and values of HIA,
- define accountability and control mechanisms.
- ensure health sector participation in scoping, documentation and review stages
- be supported by well-documented administrative procedures and good liaison mechanisms (NPHP, 2004, p.72; Banken, 2001, p.30).

The inclusion of a clause for HIA in the new Quebec *Public Health Act 2004* is an example of a minimalist framework that is being developed through application in practice and research. The Act provides that the Minister of Health may inform other ministries about the effect their legislation may have on health.

Other countries attempting to institutionalise HIA through legislative frameworks include Hong Kong, Lithuania and France. The relative strengths and weakness of the legislative models these countries are using require further investigation.

A minimalist approach to legislation would also be useful in setting the foundation for any future integration of impact assessment (for example integrated environment, health and social impact assessment undertaken by the Department of Premier and Cabinet) by:

- Creating a mutual legislative obligation for:
  - The Secretary of Human Services to undertake, resource or support health impact assessment and to advise other Departments of health impacts and effective solutions to eliminate or reduce health risks; and
  - Other departments to consult DHS and to include health impacts in their own assessment of Acts, regulations and possibly major policies;
- Developing health sector and cross- government HIA capacity; and
- Institutionalising cross departmental HIA procedural and administrative frameworks.

This minimalist approach to legislation needs to be underpinned by strong administrative processes.

## **Administrative frameworks**

Banken (2001, p. 20) cautions that although legal frameworks are the strongest and most durable mechanism for health impact assessment (HIA) translating them into practice is dependent on the existence of administrative frameworks with tools, methods and procedures (Ibid. p.20).

Administrative frameworks that underpin the legislative frameworks deserve careful consideration. Protocols and guidelines for HIA need to include consideration of:

- Ensuring that the HIA process complements rather than duplicates the EIA process without causing fragmentation or omissions;
- How an HIA is initiated and who are its initiators and proponents;
- How screening criteria and assessment processes can effectively identify appropriate proposals for impact assessment and filter inappropriate proposals (criteria for HIA and decision making processes in screening);
- Different types of HIA that can be employed for different levels of potential risk;
- How an equity focus can be applied to determine differentials in the health impacts for population subgroups;
- Who defines who constitutes “affected populations” and who represents them;
- Who has the authority to determine if the HIA has been adequately and ethically conducted;
- How HIA relates to different types of social impact assessment; and
- The challenge of “coherence” in HIA (integrating perspectives on biophysical and social determinants of health) (Krieger et al, 2003; Banken, 2001)

Screening criteria and processes and HIA guidelines need to be developed to avoid potential complexities and adverse consequences, including:

- The emphasis on policies that enact changes rather than facilitate neglect (commission verses omission);
- The difficulties of determining potential impacts and measuring health outcomes on multiple levels and pathways over extended time frames;
- The potential for mandated HIA to become “mired in bureaucracy” and a barrier to effective decision making rather than a catalyst to improve decision-making processes and outcomes; and
- The costs of HIA and the decision as to who will bear them, in particular the potential for costs to be borne by disadvantaged communities or by services for those communities, consuming resources that could otherwise be used to promote their health (Kreiger et al, 2003).

These considerations need not necessarily be obstacles to the inclusion of HIA into legal frameworks.