Submission to the Health Select Committee

on the

Public Health Bill

A submission made jointly by

New Zealand Health Trust ("NZHT") and
New Health New Zealand Incorporated ("New Health").

- NZHT is a charitable trust focused on health education and New Health is an incorporated society representing the interests of the New Zealand Health Consumer.
- New Health currently has over 34,000 members.
- Both groups are non-profit organisations with no commercial interest in the matters under discussion.
- Information about both submitters and contact details for them are set out in Appendix I.
- Both the New Zealand Health Trust and New Health New Zealand wish to be heard in support of their submission.

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Introduction

1. We agree with the statement in the explanatory notes that "Reliable flows of accurate information are fundamental to health and disability policy and action."
2. We would caution that much information used to shape public health thinking is neither reliable nor accurate. For example, whilst much is known about diabetes and heart disease, the medical literature is littered with debate regarding aetiological factors such as diet and exercise, and preventative treatments such as cholesterol lowering drugs and blood thinners.
3. The proposed Bill gives significant powers to public health officials that will require policy and action based not on "reliable flows of accurate information" but on incomplete and often unreliable and inaccurate information.
4. This information is likely to be shaped by politically correct thinking and latest fashion ideology that opens the door for restriction of consumer choice by mandatory codes of practice and regulation which could affect many things including food, telecommunications, and potentially natural and traditional healthcare product choices.
5. The Submittors fully support efforts to reduce significant and unacceptable risks associated with the development of disease provided the balance between individual rights and public good are maintained.
6. The Submitters fully support appropriate regulation and reasonable and appropriate codes of practice that enable consumers to make informed choices but not when such actions prevent consumers from making any choice.
7. In other words, we believe that the proposed Act should not open the door to overly protective regulators and health officials being able to dictate what consumers and businesses can/can't consume or do.

Terminology and definitions.

8. We submit that terminology and definitions should be standardised and unambiguous and draw to the Select Committee's attention two specific examples that in our opinion require addressing.

9. **Epidemic diseases vs Quarantinable diseases:** It is proposed to amend the section 5(1) (and related sections) of the Epidemic Preparedness Act 2006 (2006 No 85) by substituting the term "quarantinable disease" [(within the meaning of the Health Act 1956)] with the term "epidemic disease" [within the meaning of the Public Health Act 2007].

10. The Submitters oppose this on two grounds.

11. Firstly, the term ‘epidemic disease’ is loosely defined in normal use as disease incidence that is higher than expected in a population.

12. It is increasingly being used in public health and medical vernacular as a descriptor of many disorders in society that are not intended to be considered in terms of the Epidemic Preparedness Act. Recent examples of disorders described as epidemic disease include the recent meningococcal outbreak, diabetes, and even depression. None of these would be likely candidates for consideration in relation to the Epidemic Preparedness Act.

13. The Epidemic Preparedness Act is an Act relating to extreme circumstances, and the definition used to relate to such circumstances should reflect the serious risk intended in the Act.

14. There is a need to ensure that diseases included in Prime Ministerial /emergency declarations are reserved for serious infectious diseases that have a very high probability of becoming serious epidemics.

15. The term “quarantinable disease” implies a much higher threshold than the increasingly ubiquitous use of the term, ‘epidemic disease.’ Obesity, diabetes, arterioschlerosis, meningococcaemia have/are all referred to as epidemic diseases but they are neither infectious nor are they quarrantinable. [Note: less than 2 percent of meningococcal disease cases are related. Neisseria meningitidis is a normal commensal organism that does not cause disease in the vast majority of circumstances.]

16. Quarantinable disease is a useful threshold and its meaning and implied use is beyond doubt within political, bureaucratic, medical and lay communities.

17. As such, it is proposed that the term “quarantinable disease” be retained and included in the definitions section of the proposed Public Health Act to maintain clarity, avoid confusion and to reduce the prospect of regulatory creep by public health officials.

18. **Vaccination vs Immunisation:** The terms ‘immunisation’ and ‘vaccination’ are used 16 and 8 times respectively in the Bill.

19. It is proposed that terminology be standardised with use of the term vaccination being an accurate description of use in the Bill.

20. Vaccination is the use of vaccines to attempt to prevent specific diseases by

inducing an immune response.

21. If 100 people are vaccinated with a vaccine which is, say, 80 percent effective at inducing an appropriate immune response, then only 80 percent of those vaccinated will be immunised.

22. Thus, as used in the Public Health Bill, we request that the term vaccination be acknowledged and used as the technically correct term and it should replace the incorrect term immunisation.

Health Impact Assessments

23. The explanatory notes state that the Bill includes provisions "that encourage, but that do not require, health impact assessments for new proposals, for example, in relation to policy development and decision making by central and local government."

24. The Submitters request that Health Impact Assessments be mandatory, especially with regards to policy development and decision making by central and local government.

25. Without such assessments lack of transparency and subjective/emotive decisions are more likely to be made.

Extreme Emergency Circumstances

26. The explanatory notes state that "In extreme emergency circumstances (such as the threat of a pandemic with serious health impacts), mandatory vaccination might be in the best interest of public health. But there is no framework to determine what such circumstances might be, what individual obligations or rights would be, and what enforcement powers would be available."

27. We agree that treatment should not be physically forced on citizens by the State. If universal vaccination were to be implemented, then experience with the MeNZB vaccination programme suggests that more than enough people will voluntarily queue up to accept any vaccination or other treatments to keep available vaccinators busy for many weeks.

28. Citizens who choose not to accept the State's offer of vaccination should be allowed to go to the back of the queue to enable further consideration of their decision.

29. As noted in the MeNZB campaign, people often are not saying ‘no’ to treatment options, but are simply saying, ‘not yet.’

30. As an epidemic takes hold or abates the risk/benefit equation changes and decisions can change and citizens should be allowed to take advantage of that, especially that any vaccine for an emerging epidemic/pandemic is likely to be of unknown effectiveness and risks will also be unknown.

31. There needs to be a framework to determine what such circumstances requiring mandatory vaccination might be, what individual obligations or rights would be, and what enforcement powers would be available.

Consultation

32. In the explanatory notes section it says, Clause 82 requires the Director-General, before issuing a code of practice or guidelines, to consult with representatives of affected groups.

33. However, Clause 82 actually says, “Before the Director-General issues a code of practice or guidelines or amends or revokes a code or guidelines, the Director-General must consult with any person or organisation that the Director-General considers to be representative of the sector affected by the proposed code or guidelines, amendment, or revocation.”

34. This is a very dangerous and disconcerning clause. The submitters experience with the failed Australia New Zealand Therapeutic Products Agency Bill was such that the regulators excluded certain people or groups from their ‘consultation’ who disagreed with their philosophy but included certain people or groups who agreed with their philosophy. This is an example of unexpected use of power.

35. It must not be left to the Director General to decide who represents an industry or industry sector or people affected by deemed regulation. This is undemocratic and not acceptable to the submitters.

Overarching principles

36. We agree with the principles set out in sections 91 to 93 to be taken into account by every person and every court performing a function under this Part with one addition.

37. The individual citizen must be able to make an **informed decision** regarding

compliance of any directive or order. As such, the alternatives must be provided to the citizen concerned and where possible a consensus outcome sought. Acceptance and compliance is much more likely in such circumstances.

Urgent health risk orders

38. Clause "106: Medical officer of health may make urgent health risk order" is problematic and cause for concern.

39. It is proposed that if a Judge of the Court is not available then the Medical officer of health **MUST** get approval from the Director of Public Health, the Director General of Health or two JPs sitting jointly to establish reasonable grounds.

40. **ALL** health risk orders, whether issued under clause 106 or by the Court should be required to be reviewed by an appropriate independent commissioner such as the Health & Disability Commissioner within 3 months of the order being issued to establish that the order was fair and reasonable and did not involve abuse of power.

Clause 196: Taking of all practicable steps to prevent risks to public health

41. Prevention of risk strategies must balance consideration of the risk being managed with the known/potential risks of any proven/unproven treatments.

42. Subsection (2) needs to give more weight to the uncertainties surrounding the two issues in (2)(d)… " the current state of knowledge about the means available to achieve the result, and about the likely efficacy of each;"

43. It is requested that this be separated to three sub-points…

    i. (d) the current state of knowledge about the means available to achieve the result,

    ii. (e) the current state of knowledge about the likely efficacy or effectiveness of each;

    iii. (f) the current state of knowledge about adverse events and/or harm associated with each;

44. There should also be a requirement for consumers to be fully informed of these factors so that they can make an truly informed choice.

Non-communicable disease risk factors

45. The Bill includes principles and provisions for the making of codes or guidelines to address non-communicable disease risk factors. The Director General will be able to make nonbinding codes and guidelines to promote public health, for example, in relation to—

- exposure to, or access or use by, the public generally or specific groups in respect of products and services relevant to non-communicable disease risk factors:
- matters relevant to the advertising, sponsorship, or marketing (direct or indirect) of products and services with an impact on non-communicable disease risk factors:

46. Clause 374 gives the Governor General the power to make regulations by Order in Council. This clause concerns us.

47. Clause 374(c) the vaccination of persons for the prevention of quarantinable conditions and other conditions, and the adoption of any other measures for the prevention and mitigation of significant risks to public health:

i. The term 'quarantinable condition' is not defined. Any inclusion of such a term should align with the Epidemic Preparedness Act and any Prime Ministerial declaration related to that Act.

ii. We are concerned that this clause is sufficiently loose that regulatory creep could use it to mandate vaccines for less serious diseases in the future.

48. Clause 374(r) The prohibition or regulation of importing, packaging or selling anything likely to introduce or increase a health risk.

i. This clause is sufficiently broad that it could be used to prohibit or regulate the importation of any goods such as natural and traditional health products, or, for that matter, any food item that became the subject of public health concern based on fact or fiction.

49. Clause 374(x) Reducing, or assisting in reducing, risk factors (within the meaning of section 79) associated with, or related to, non-communicable diseases.

i. This could be used to implement any broad politically correct regulation of risk factors associated with non-communicable diseases. Such powers are open to a lack of transparency and require extensive consultation, public debate, and oversight of Parliament.

ii. This clause opens the door to the undermining of the democratic process

and transferring power from the consumer to public health officials.

50. A model for prioritising risk management policy and resources is attached that we believe should be used when establishing degrees of risk, prioritisation and appropriate responses. It is becoming all to common for low risk activities being regulated out of proportion to the determined risks while at the same time allowing high risk activities to go unregulated.

51. We believe that the proposed Public Health Act should include reference to Good Regulatory Practice guidelines and require proportional risk management responses.

Summary

52. This is a comprehensive and very important piece of proposed legislation that raises many issues related to freedoms, consumer choice, informed decision-making, free markets, social responsibility and the like.

53. As noted, this submission is made jointly by the New Zealand Health Trust ("NZHT") and New Health New Zealand Incorporated ("New Health").

54. We reserve the right to raise other significant issues and concerns as they come to light and when we appear before the Health Select Committee during the hearing process.

Appendix I: Details And Contact Information Of Submitters

NEW ZEALAND HEALTH TRUST

Objects of the New Zealand Health Trust.

The Trust is established for educational and charitable objects and purposes within New Zealand only. In particular the Trust is established:

(a) To commission research into health issues and, in particular, health care products, devices, practices and services within New Zealand by all such means as may be thought advisable;

(b) To acquire information in relation to health conditions, afflictions and diseases to enable a better understanding of the health needs of the community and any treatment or prevention recommended as a result thereof;

(c) To procure from and to communicate to any other organisation or body whether incorporated or not whose objects are similar to those of the Trust such information as may be likely to assist or forward any of the objects of the Trust;

(d) To stimulate, co-ordinate and support research within New Zealand, into the cause, prevention, alleviation and cures of health disorders and to obtain and disseminate information on any aspects of the foregoing;

(e) To encourage and provide opportunities for persons and corporate bodies within New Zealand to take an active interest in the funding of complimentary health care products, devices, practices and services and general health research for prevention, diagnosis and treatment;

(f) To inform and educate persons and publicise progress on the research of the Trust;

(g) To work in co-operation with the New Zealand health services and the health care providers in New Zealand;

(h) To provide registering, monitoring and reporting programmes and processes on health care products, devices, practices and services;

(i) To raise and employ funds for any educational or charitable purposes within New Zealand authorised by these objects;

(j) To promote the recognition and support of the Trust's objects by Government, local authorities, other statutory bodes, the New Zealand business community and all persons living in New Zealand generally;

(k) To assist with the provision of equipment, venues, information sources and material necessary for the conduct of training programmes, research and the promotion of these objects;

(l) To hold seminars, tutorials and lectures and to demonstrate the research to promote the aims and objects of the Trust to the community generally.

Contact details

P O Box 34-057
CHRISTCHURCH Contact Person: David Sloan

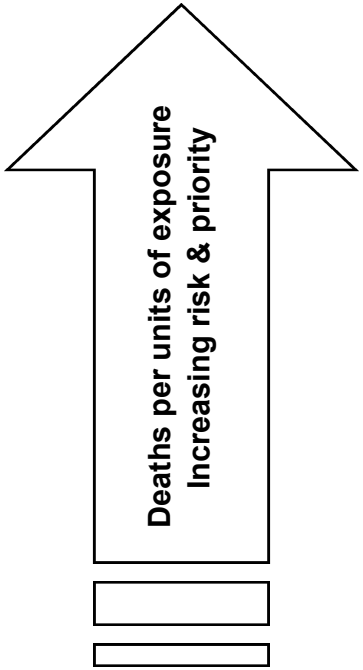
PH 03-351 9807 FAX: 03 351 7993

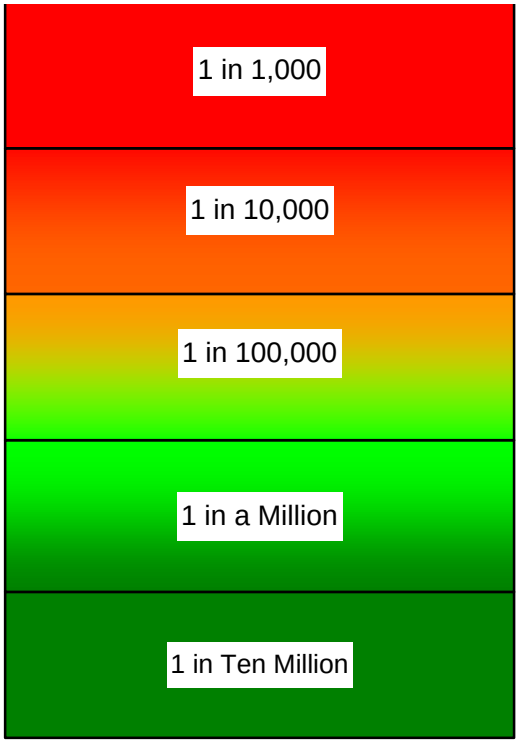
NEW HEALTH NEW ZEALAND INCORPORATED

New Health New Zealand is an incorporated society formed in 2005 as a consumer group. New Health currently has in excess of 34,000 members and is committed to;

- Creating a system focusing on best health outcomes for consumers
- Demanding accountability from the health system and health providers
- Promoting health not selling sickness
- Providing a single coordinated approach to health regulation
- Supporting businesses that put consumers first
- Change the focus from symptom control to addressing underlying causes
- Encouraging health innovation

A Model for Prioritising Risk Management Policy and Resources





Description of Risk

Dangerous
-prohibition, constraints required, major re-engineering of culture

Intolerable
-unacceptable; rule making on process, introduce mandatory best practice standards

Tolerable
-acceptable; rule making on product, risk reduction utilising ALARP/ALARA, safety culture and COBP

De minimis risk
-negligible risk, less regulation, more reliance on code of best practice, safety culture

Ultra Safe
-don't become complacent

Sources: Health Canada, Renshaw, Amalberti, Leape, NZFSA [⁂]

[⁂] http://www.hc-sc.gc.ca/pmra-arla/english/pdf/spn/spn2000-01-e.pdf; Renshaw, F. M. (1990). “A Major Accident Prevention Program.” Plant/Operations Progress 9, no. 3 (July), 194-197; Amalberti, R. (2001) Revisiting safety and human factors paradigms to meet the safety challenges of ultra complex and safe systems, In B. Willpert, & B. Falhbruch, Leape cited in Norton et al....Challenges and pitfalls of safety interventions, Elseiver; Leape, L., (2002) Safe Health Care: Are we up to it? http://www.vipcs.org/conf2002/leape.pdf; NZFSA (2000) A Risk Management Framework for Food Safety, http://www.nzfsa.govt.nz/policy-law/harmonisation/rmgmtpr.pdf