Public Health Legislation Review

A new public health legislative framework

Discussion document

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Contents

Preface

This document presents information, raises issues for consideration and seeks answers to questions in relation to options for a new public health legislative framework.

While a number of statutes are identified as 'public health' legislation, the focus of this initial review is on the Health Act 1956. The authors of the document are also mindful of the need to maintain consistency and co-ordination with other related reviews in progress.

The document is being widely distributed for consultation. Submissions expressing comment and opinion are invited from interested people, whether representing organisations or as individuals. When sent on behalf of an organisation, the submission should include the position within the organisation of the person making or signing the submission and an indication of the extent of consultation, discussion and support within the organisation for the options, opinions and advice expressed in the submission.

To assist with the analysis of submissions, explicitly worded brief dot points with question, page and paragraph references are helpful in formatting responses. Should text changes be suggested, please word appropriately for inclusion.

Please send submissions to:

Public Health Legislation Review
Consultation Officer
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Ministry of Health
PO Box 5013
Wellington

or fax to (04) 496 2340.

The *firm* closing date for submissions is Wednesday, 30 September 1998.

All submissions received will be considered and analysed before the development of policy advice to the Minister of Health.

Please note that submissions may be the subject of a request under the Official Information Act 1982. If there is any part of your submission that you consider could *properly* be withheld under that Act, please include comment to that effect in your submission.

1 Summary Guide to the Document

1.1 Key proposal and background to the review

1.1.1 This discussion document forms a central part of the consultation process that will help to inform the preparation of policy advice on the scope and shape of public health legislation for the future. The key proposal is to develop a new public health act which provides for a flexible, risk-management and outcome-focused legislative framework with clear responsibilities and accountabilities. Proposals arise from previous consultation, related reviews and the analysis of other significant problems and risks associated with the existing public health legislative framework (see discussion in *Introduction* and in *Fundamental Questions*). Comment is invited on a range of related issues.

1.1.2 As an initial part of the overall review, this consultation does not seek comment on future decisions that will need to be made about enforcement arrangements or on non-regulatory matters (eg, health promotion). However, it is intended to provide for robust transitional arrangements, over a reasonable period of time, to enable such decisions to be properly made. This should ensure service continuity and maintenance of the confidence of both the public and the health sector. The value of non-regulatory public health activities and the relationship to regulatory activities is also acknowledged.

1.2 Fundamental questions and principles

1.2.1 The discussion in *Fundamental Questions* is intended to encourage comment on the nature of public health, the role of the Government, why the Government is involved with the provision of public health services, when it is necessary to legislate for public health purposes and what the purpose and content of a core public health statute should be. The economic concept of a 'public good' and problems and risks associated with today's public health legislation are also raised for consideration.

1.2.2 Problems and risks that have been identified are listed below with an indication of the section of the document in which they are discussed.

- *Volume and complexity of public health legislation leading to difficulties with understanding and application of the legislation.* This issue is largely addressed in the section *Public Health Risk Management*. In particular there is a proposal to provide for a 'menu of interventions' within an enabling, outcome-focused regulatory framework.
- *Inflexibility of the legislation, compromising the ability to respond quickly or appropriately to some emerging public health risks.* This issue is addressed in the section *Public Health Risk Management*. Emergency provisions,

communicable disease prevention and control and other relevant issues are addressed in the same section.

- *Role confusion arising from the interface with legislation administered by other sectors which impact on public health.* This issue is addressed in the section *Co-ordination with Other Laws*.

- *Inconsistency with recent legislation.* This issue is addressed throughout the document, particularly in the sections *Public Health Risk Management* and *Affirmation of Human Rights*.

- *Inconsistency with altered and developing health sector roles and accountabilities.* This issue is addressed in the section *Legislative Frameworks and Functions.*

- *Barriers to the development of innovative solutions to public health problems and inability to recover costs where it may be appropriate.* This issue is addressed in *Public Health Risk Management*. However, the detail of possible cost-recovery regimes is not considered.

- *Compliance and active enforcement are discouraged by relatively small penalties.* This issue is not explicitly addressed in this document. However, the promulgation of a new statute will afford an opportunity to correct anomalies.

1.2.3 Key principles that underpin the proposals are outlined in *Co-ordination with Other Laws, Affirmation of Human Rights, New Zealand's International Obligations and Commitments, Enhancing the Capacity of Mäori and Other Communities to Improve, Promote and Protect Public Health and Surveillance, Monitoring and Reporting*. To encourage comment on the value and relevance of the principles and how they may carry over into legislation, some practical examples are given along with the discussion on the importance of each principle.

1.2.4 Attention is particularly drawn to issues associated with:

- determining a need to report regularly on the state of public health and surveillance or monitoring systems that may be required to inform such reports

- the relationship of the new public health act with other legislation which impacts on public health, including clarification of interfaces and reduction or elimination of duplication of legislative coverage

- balancing individual human rights with the exercise of public health powers intended to protect the population at large

- providing appropriate opportunities and mechanisms for Mäori and other communities or people to participate in public health processes

- the importance of the impact of globalisation (eg, trade, travel and telecommunication) and the influence this has in the domestic sphere.

1.3 Public health risk management

1.3.1 The discussion in *Public Health Risk Management* continues and expands upon that in *Fundamental Questions* in relation to when it is necessary to provide for public health regulatory interventions.

1.3.2 It also seeks comment on proposals to provide for:

- a general duty on authorities to consider alternatives and to assess the benefits and costs of these before determining whether or not a policy, rule or other regulatory intervention is necessary
- a very flexible regulatory environment by way of a 'menu' of possible interventions and descriptive (enabling) regulation
- a general duty not to cause risks to public health
- the ability to make requisitions to ensure communities have access to safe and sufficient services of particular public health significance (eg, drinking-water supplies)
- mechanisms to assist with the prevention and control of communicable diseases, including processes for promulgating requirements for diseases or syndromes to be notifiable
- a precautionary approach to managing potential public health risks where research into health effects is not well developed
- public health emergency management principles and powers.

1.4 Legislative framework and a preferred configuration of functional components

1.4.1 The discussion in *Legislative Framework and Functions* identifies the functional components and desirable features of a legislative framework. Functional components include the public and regulated matters as well as audit, enforcement, funding/ contracting regulatory authority, Department of State and Ministerial functions.

1.4.2 For reasons outlined in the discussion, analysis of possible configurations of the functional components centres on options for Department of State and regulatory authority functions. Comment is sought on a preferred option to help to identify opportunities for enhancement that may have been overlooked in the analysis to date. Comment is also invited on any alternative preferred configuration, along with a statement of the advantages and costs/risks associated with that alternative.

1.5 Appendices

1.5.1 Several appendices support some of the discussion. The headings of each appendix are set out below with an indication of the section of the document in which they are referenced.

1. Appendix One: Related Reviews in Progress — *Introduction.*
2. Appendix Two: Current Roles and Responsibilities — *Introduction*.
3. Appendix Three: An Example of the Need for Statutory Co-ordination — *Co-ordination with Other Laws*.
4. Appendix Four: Examples of Regulatory Processes ¾ *Public Health Risk Management*.
5. Appendix Five: Future Enforcement Decisions — *Legislative Frameworks and Functions.*
6. Appendix Six: Consultation Questions — consolidated list of questions from all sections of the document.

2 Introduction

2.1 Scope of consultation

2.1.1 This discussion document forms a key part of the consultation process that will help to inform the preparation of policy advice on options for the scope and shape of public health legislation for the future. The intention is to develop a flexible, risk-management and outcome-focused legislative framework which provides for clear responsibilities and accountabilities as well as being durable and widely accepted.

2.1.2 *While a number of statutes are identified as 'public health' legislation, the focus of this initial review is on the Health Act 1956. Comment is invited on a preferred configuration for the functional components of a new regulatory framework to help to identify options for enhancement that may have been overlooked in the analysis to date.*

2.1.3 *This consultation does not seek comment on future decisions on enforcement arrangements. If, as intended, significant changes are to be made to the public health legislative framework, robust transitional arrangements, over a reasonable period of time, will be provided for in the new public health act. This will be essential to maintain service continuity and the confidence of both the public and the sector.*

2.1.4 *This consultation focuses on the regulatory aspects of public health activities. The value of non-regulatory public health activities (eg, health promotion) and the relationship to regulatory activities is acknowledged. However, this consultation does not seek comment on non-regulatory matters.*

2.2 Legislative environment

2.2.1 The legislative environment consists of a hierarchy of statutes (Acts of Parliament), and subordinate or delegated legislation (eg, Regulations and bylaws). The principal public health statute is the Health Act 1956. The Act establishes public health management arrangements for communicable disease, some environmental health risks (particularly those associated with water and waste disposal) and other miscellaneous issues. Other 'public health' Acts administered by the Ministry of Health include:

- Food Act 1981
- Misuse of Drugs Act 1975
- Plumbers, Gasfitters and Drainlayers Act 1976
- Radiation Protection Act 1965
- Smoke-free Environments Act 1990

- Toxic Substances Act 1979
- Tuberculosis Act 1948.

2.2.2 Some other Acts administered by the Ministry of Health, such as the Burial and Cremation Act 1964, also have some public health application.

2.2.3 Legislation in other sectors such as local government, housing, environment, agriculture and social welfare also impacts on public health. The legislation is too extensive to list, but examples are the Immigration Act 1977, Resource Management Act 1991, Sale of Liquor Act 1989, Building Act 1991, Meat Act 1981, Dairy Industry Act 1952 and the Health and Safety in Employment Act 1992.

2.3 Imperatives for reform

2.3.1 The review has an explicit relationship with the Government's Strategic Result Area concerned with health and disability services, in particular, 'Improving the regulatory and administrative frameworks for public … health and safety … so as to minimise the risks, incidence and impacts of illness and injury' (Department of Prime Minister and Cabinet 1997).

2.3.2 Recent reviews have confirmed the need for reforms and developments since those reviews mean that it is opportune to proceed with a comprehensive public health legislation review. Those developments include:

- completion of consultation on the *Public Health Role of Local Government* (Ministry of Health 1996b)
- previous consultation and earlier related reviews of public health legislation (see below)
- completion of the review of *A Strategic Direction to Improve and Protect Public Health* (Public Health Commission 1994). The analyses of submissions indicated clearly that most stakeholders preferred comprehensive public health legislative reforms to *ad hoc* reviews and amendments. This review (Ministry of Health 1997a, 1997b) also indicated that a strong public health infrastructure is essential for successful public health policy. One of the principal components of this infrastructure is the legislative framework for public health action
- substantial changes to the structure and nature of the health sector, creating new and altered accountabilities.

2.4 Previous consultation and earlier related reviews

2.4.1 A number of reviews of public health legislation have been undertaken during the last decade. The reviews have taken into consideration other contemporary legislation. (eg,

Resource Management Act 1991, Building Act 1991, Health and Safety in Employment Act 1992).

2.4.2 The significant findings from these reviews have been that:

- the public health legislation is out of date
- a health act in some form is needed to allow fast action in response to public health risks and emergencies such as a communicable disease epidemic
- the Health Act 1956 and subordinate legislation are prescriptive and do not recognise the range of effective interventions now available to prevent and control risks to public health
- protection of individual human rights is weak under the Health Act 1956, compared with other recent legislation
- the roles and responsibilities of public health service staff designated under the Act are not always clearly differentiated from those of staff employed by local authorities.

2.4.3 An extensive consultation programme on the public health role of local government was undertaken by the Ministry in 1996/97. This consultation confirmed confusion over roles and priorities. There was clear frustration at the perceived lack of progress with legislative reform. Other concerns included funding issues, leadership and the need for more recognition of local autonomy.

2.4.4 Submissions on *Strengthening Public Health Action: The strategic direction to improve, promote and protect public health* (Ministry of Health 1997b) supported the need to review the Health Act 1956 and identified the following issues as needing consideration:

- the overlap and confusion between health sector legislation and other legislation impacting on public health (eg, the Resource Management Act 1991, the Building Act 1991, and the Hazardous Substances and New Organisms Act 1996)
- the unclear relationship between designated officers and territorial authorities
- the weak protection of individual human rights under the Act compared to more modern legislation
- a backlog of administrative mechanisms that need updating
- the lack of a clearly stated purpose related to the importance and breadth of public health.

2.4.5 The analysis of subordinate legislation during 1997 contributed to the decision to proceed with the current review in preference to consultation on a number of individual sets of regulations.

2.5 Other reviews in progress and roles and responsibilities

2.5.1 Please refer to Appendix One for information on other related reviews in progress and to Appendix Two for information on the *current* roles and responsibilities of agencies and statutory officers.

3 Fundamental Questions

3.1 What is 'public health'?

3.1.1 The Health and Disability Services Act 1993 (section 2) refers to 'public health' as the health of all of the people of New Zealand; or a community or section of such people. However, the term 'public health' is also used to refer to the discipline of public health and may be defined as 'the science and art of promoting health, preventing disease, and prolonging life through organised efforts of society' (Acheson 1988).

3.1.2 The common feature of both these definitions is the focus on the health and well-being of an entire population or community, rather than of an individual. Public health services are services provided for the primary purpose of improving, promoting or protecting public health. This contrasts with personal health services, provided to an individual for the primary purpose of improving or protecting the health of that individual. Although there is not always a clear demarcation between public health services and personal health services in practice, the conceptual distinction is clear. Public health is founded on the notion that the Government has an interest and role in the health of the population that is different from the sum of the outcome of individuals' interactions with health services.

3.1.3 The 'public' nature of public health points to another important characteristic. Public health is what economists sometimes refer to as a 'public good'. Two particular features characterise such public goods:

1. There is little or no extra cost for persons additional to the target group to enjoy the benefits of the good. For example, the cost of developing a standard for drinking-water quality and making it available for use by 100 drinking-water suppliers is probably little different from the same standard being available (eg, on the Internet) for use by 1000 or more suppliers.

2. It is difficult, if not impossible, to prevent people from enjoying the benefits of public goods (ie, they tend to be non-excludable). The 'herd effect' of large-scale immunisation programmes is an example. Where many members of a population are immunised against a communicable disease, the reservoir of susceptible persons reduces, making it harder for the disease to survive and spread. This benefits both those who are immunised and also those of their associates who are not. It is difficult to exclude people who are not immunised from the benefits of this herd effect.

3.1.4 As a consequence of these two features, public goods share a third property. Left to themselves, markets either will not provide, or will provide inadequately, public goods. It is this predisposition to market failure which provides the rationale for the Government's role in the provision of public goods.

3.2 What is the Government's interest in public health?

3.2.1 The Government has an interest in public health in order to:

- protect health and to reduce illness and injury due to avoidable harm
- invest appropriately in the future health and wellbeing of the population
- ensure a healthy workforce able to maintain a strong economy
- protect vulnerable populations from undue risks
- reduce the fiscal risk from the cost of avoidable illness, disease and injury
- support the acceptance of responsible health behaviour throughout the community
- determine rights, responsibilities, and procedures that are fair to all parties
- establish the circumstances in which coercive powers may be exercised by the state, and ensure that there are safeguards against excessive or arbitrary use
- define appropriate health outcomes on behalf of Mäori and other communities or people where it is accepted that public health interventions are required
- honour New Zealand's international commitments.

3.2.2 The Government's interest in public health is reflected in its Strategic Result Area for 1997/2000 of improving the overall health status of New Zealanders through health, disability services and injury prevention regimes that, among other matters, maximise health gains in a cost-effective way (Department of Prime Minister and Cabinet 1997). Particular emphasis is placed on improving regulatory and administrative frameworks to minimise the risks, incidence and impacts of illness and injury.

3.3 When is it necessary to legislate for public health?

3.3.1 Many of the Government's objectives for public health may be achieved without the need for legislation. Significant activities to protect health and prevent illness, injury and disability may be carried out by individuals, organisations, or communities without regulatory intervention. Government interventions through regulation and central specified safety requirements are increasingly seen as appropriate only where objectives cannot be better achieved by using other strategies such as contracting, economic instruments, and other non-regulatory instruments.

3.3.2 However, it may be necessary to legislate for public health when the exercise of statutory powers is more effective and efficient than the voluntary response of society in improving, promoting and protecting public health. The protection of the health of

the population may, as a last resort, require the exercise of coercive powers to remedy or mitigate an established harm or avert a potential harm to public health.

3.3.3 Health promotion activities may be more effectively supported by facilitative measures, such as the provision of information, than by directive or controlling mechanisms (see the discussion in *Surveillance, Monitoring and Reporting*).

3.3.4 It may also be necessary to legislate to protect the quality of health and disability services. Statutes such as the Medicines Act 1981, the Health and Disability Commissioner Act 1994, and the Medical Practitioners Act 1995, although they indirectly protect the wellbeing of the public, are primarily aimed at protecting the health of individuals rather than the population as a whole.

Question 1: Under what circumstances do you consider it is necessary to legislate for public health? Please provide information (explanation or references) to support your answer.

3.4 What should be the purpose and content of a core public health statute?

3.4.1 A stated purpose is a useful aid to interpreting or applying an Act. A number of possible purposes have been considered, for example:

- to provide for the effective management of risks associated with public health
- to promote the sustainable management of public health risks
- to protect the public, and the health and safety of people and communities, by preventing or managing the adverse effects of public health risk activities, goods and situations.

3.4.2 While worthy, such purposes do not reflect the full range of public health protection and promotion practices. Also, they do not fully acknowledge that statutory controls complement the range of non-statutory initiatives also undertaken to improve health status. The preferred purpose is:

- to improve, promote and protect public health.

3.4.3 The concepts of improving, promoting and protecting are each different, but collectively cover the range of public health. Key words (see the *Oxford Dictionary* 1991) are:

- *improve*: make or become better
- *promote*: advance or raise, help forward, encourage, support actively
- *protect*: keep safe, defend, guard, shield, prevent injury.

3.4.4 The proposed purpose formalises the goal of enhancing collective health status. The key words already appear in the Health and Disability Services Act 1993 as an objective for regional health authorities (ie, the Health Funding Authority) and in the Health Act 1956 (as a function of the Ministry of Health and a duty of territorial authorities). The same key words were supported during public consultation on the preparation of *Strengthening Public Health Action: The strategic direction to improve, promote and protect public health* (Ministry of Health 1997b).

Question 2: Do you agree with the proposed purpose? If not, please explain why and suggest amendments or an alternative purpose.

3.4.5 Assuming that public health legislation is enacted only where the exercise of statutory powers is more effective and efficient than the voluntary response of society in improving, promoting and protecting the public health, the following topics are proposed for inclusion in a core public health statute:

- public health regulatory infrastructure
- public health risk management
- clarification of interface with other public health legislation
- monitoring and reporting on the state of the population's health.

Question 3: Do you agree with the statements of what should be included in a core public health statute? Please suggest additions, deletions or amendments to what is discussed and explain your answer.

3.5 What is wrong with public health legislation today?

3.5.1 From analyses to date, it seems that there are several significant problems and risks associated with the existing public health legislative framework that cannot be easily resolved by administrative means. These problems are outlined below.

Volume and complexity of public health legislation leading to difficulties with understanding and application of the legislation

3.5.2 The Health Act 1956 and some 25 pieces of subordinate legislation prescribe a host of different, and many similar, roles and responsibilities for the Ministry of Health, the Director-General of Health, Designated Officers, the Health Funding Authority, territorial authorities (city and district councils), environmental health officers and many

others. Many of the roles and responsibilities are interrelated; some are not. Others are simply ambiguous.

3.5.3 The Health Act 1956 and subordinate legislation are generally not outcome-focused. Most public health legislation does not include clear or detailed statements as to objectives, functional requirements or performance measures that must be met. Consequently, interpretation, understanding and implementation of provisions may vary considerably. A significant risk is that, because of such misunderstanding, important public health interventions do not occur as and when they are needed to avoid, remedy or mitigate substantial threats to public health. On the other hand, a great deal of time and resources may be extended on matters that are of minimal risk.

Inflexibility of the legislation, compromising the ability to respond quickly or appropriately to some emerging public health risks

3.5.4 The prescriptive nature of the legislation and the cumbersome processes that must be followed to make changes compromise responses to emergent issues. It may take years to have important and serious 'new' diseases added to the schedule of notifiable diseases. This has resulted in Medical Officers of Health following up cases and contacts without statutory authority. Common-sense improvements, like laboratory notifications of diseases, have also been thwarted.

Role confusion arising from the interface with legislation administered by other sectors which impact on public health

3.5.5 There is a great deal of legislation administered by departments other than the Ministry of Health which impacts directly on public health. For example, issues arise particularly in relation to the interface with local government, transport, environment (resource management), health and safety in employment, hazardous substances, the built environment (housing) and social services.

Inconsistency with recent legislation

3.5.6 The provisions of some public health legislation sit uncomfortably with other recent legislation. For example, the nuisance provisions of the Health Act 1956 (which apply to the Crown) may be invoked to prevent any person from doing anything which is likely to be offensive or injurious to health. Legal advice has been received that these provisions could possibly be used to thwart a pest eradication or control programme undertaken in support of a Crown objective in terms of the Biosecurity Act 1993.

Inconsistency with altered and developing health sector roles and accountabilities

3.5.7 Public health legislation has not kept pace with recent changes within the health sector. The legislation gives rise to confused accountabilities and potential conflicts of interest. For example, the designated officer function involves contractual and statutory obligations to employers, the Health Funding Authority and to the Director-General of Health. Because the powers involved are significant and are fundamental to almost all existing public health legislation, the Ministry of Health considers that risks associated with addressing this issue in an *ad hoc* fashion would be unacceptable.

Barriers to the development of innovative solutions to public health problems and inability to recover costs where it may be appropriate

3.5.8 Much public health legislation is prescriptive in terms of what is required and how the requirement is to be met. It often relies on a 'command and control' approach to regulating activities. Also, there are limited opportunities for cost-recovery or user-pays regimes. Consequently, in many instances the cost of monitoring and enforcement is met, by default, from public funds (taxes or local authority rates).

Compliance and active enforcement are discouraged by relatively small penalties

3.5.9 The Health Act 1956 prescribes a maximum fine of $500 plus $50 for every day, in the case of a continuing nuisance (a condition likely to be offensive or injurious to health). If it were possible to prosecute the same offence under the Resource Management Act 1991 or the Building Act 1991, the maximum fines that could be imposed, would be $200,000 plus $10,000 and $200,000 plus $20,000 for every day, respectively. Because penalties under the Health Act 1956 (fines in particular) are so small, they do not appear to serve as an incentive for compliance. As the cost of litigation is likely to greatly exceed any penalty imposed, there is little encouragement for enforcement. Consequently, public health risks may remain unchecked.

4 Co-ordination with Other Laws

4.1 How will a core statute relate to other public health legislation?

4.1.1 Initially, the new public health act will replace only the Health Act 1956 and the Tuberculosis Act 1948. It will complement, but not replace, other public health statutes administered by the Ministry of Health. However, it will provide a framework that is sufficiently flexible to enable future amendments to encompass such laws.

4.1.2 The repeal of the Health Act 1956 and enactment of a coherent public health act is in itself an ambitious goal. It is expedient to accept that, for the meantime, laws related to tobacco regulation (the Smoke-free Environments Act 1990) and radiation protection (the Radiation Protection Act 1965) should remain outside a core public health statute but some appropriate consequential amendments may be considered.

4.1.3 The new legislative framework will provide generic arrangements for the appointment, roles and accountabilities of enforcement officers. Specific powers, functions and duties are still likely to be contained in other legislation, but consequential amendments may include making those other legislative requirements subordinate to the new public health act.

4.1.4 Co-ordination with the legislative and organisational arrangements implemented as a result of the concurrent food administration review is also important. This is because of the overlapping roles of MAF, the health sector and local government agencies, and the interface between communicable disease control and food-borne illness investigation and countermeasures. The Ministry of Health and the Ministry of Agriculture and Forestry are currently working closely on progressing the food administration review and will be assessing the implications of the wider review of public health legislation for the food review, and vice versa.

4.1.5 There is a great deal of legislation, administered by departments other than the Ministry of Health, which impacts directly on public health. Issues particularly arise in relation to the interface with local government, transport, environment (resource management), biosecurity (pest management), meat and dairy (agriculture), Mäori, health and safety in employment, hazardous substances, the built environment (housing), consumer protection and social services. A few statutes actually include explicit provisions for interventions or input by public health services, for example, the Education Act 1989, Hazardous Substances and New Organisms Act 1996, Litter Act 1979, Sale of Liquor Act 1989 and the Local Government Act 1974.

4.2 Clarification of interfaces with legislation not administered by the Ministry of Health

4.2.1 The pervasive nature of public health means that there will always be legitimate overlap and interplay between public health legislation and that of other sectors. This is distinct from the issue (discussed below) of duplication. A great deal of clarity may be achieved through active and open communication. How best to manage the communication process will depend on the issue, the legislation involved and the range of interested parties.

4.2.2 In communicating with other sectors, it is necessary for the health sector to recognise and to accept the legitimacy and value of the provisions of legislation administered by those other sectors. This recognition and acceptance is important, particularly where there may have previously been more direct or authoritative health sector involvement in processes such as policy development, decision-making or enforcement in relation to the issues covered by that legislation. This in no way diminishes the role of the health sector in advocating the best possible public health outcomes. Rather, it increases the importance of that role and demands active and positive health sector participation in the public processes of other sectors.

4.2.3 Adequate resourcing, the establishment of strategic alliances, open communication and the presentation of robust arguments in support of public health interests should help to ensure that appropriate weighting is given by other sectors to public health concerns. Monitoring and reporting on the state of public health (see discussion in *Surveillance, Monitoring and Reporting*) will also assist the health sector advocacy role.

> ***Question 4: Please explain what, if any, legislative provisions you consider are needed to support public health advocacy in relation to the statutory functions of other sectors and why they are needed.***

4.3 Reduction or elimination of duplication

4.3.1 At the least, to ensure clear roles and economy of effort, it seems essential to reduce or eliminate any duplication of statutory functions and powers. Duplication would include provisions in two or more statutes which may be used to address the same issue and where there is no statutory guidance on which provision should be used in preference to the other. A few examples of duplication between public health legislation and legislation administered by other sectors are listed below.

Examples of duplication

Public Health Legislation	Other Legislation
Section 39 of the Health Act 1956 requires, in respect of dwellinghouses, water supply, refuse water disposal and sanitary conveniences	Similar references to water supply and sanitary facilities in section 64(4) of the Building Act 1991
Section 42(1) of the Health Act 1956 uses the term 'insanitary' and referring to the situation of a building and the likelihood of injury to health	Section 64(4) of the Building Act 1991 uses the same term and references
Section 64 of the Health Act 1956 prescribing subject matter for local authority bylaws relating to public health	Section 684 of the Local Government Act 1974 also prescribes subject matter for local authority bylaws relating to public health
The meaning of the term 'nuisance' in section 29 of the Health Act 1956	Section 17 of the Resource Management Act 1991 in relation to adverse effects on the environment, bearing in mind that 'environment' includes ecosystems and their constituent parts, including people and communities Workplace hazards and activities covered by the Health and Safety in Employment Act 1992
Part IV of the Health Act 1956 relating to quarantine (and Regulations relating to anthrax prevention and quarantine)	Provisions of the Biosecurity Act 1993 with respect to unwanted organisms, risk goods and pest management
Regulations made pursuant to the Health Act 1956 in relation to particular workplaces (eg, electroplating, lead processing and spray coating)	Workplace hazards and activities covered by the Health and Safety in Employment Act 1992

Question 5: Please supply details of statutory duplication you consider ought to be eliminated or retained. Where you wish it to be retained, please give reasons and details of the circumstances you consider one statute should be applied in preference to the other.

5 Affirmation of Human Rights

5.1.1 Since the enactment of the Health Act 1956, recognition of human rights has increased. New Zealand is a signatory to a number of international human rights conventions. In domestic law, human rights are affirmed in the New Zealand Bill of Rights Act 1990, the Human Rights Act 1993, and the Privacy Act 1993. The importance of patients' rights is reflected in statutory rights relating to the giving of informed consent, the ability to refuse treatment, and a duty of confidentiality in relation to health information.

5.1.2 Increasingly, the underlying complementarity between public health and human rights has been emphasised. The HIV/AIDS epidemic, which in western countries has predominantly affected marginalised sub-populations (men who have sex with men and intravenous drug users) has highlighted the need for effective anti-discrimination and privacy laws to support public health policy.

5.1.3 Some provisions of existing public health legislation sit very uncomfortably with other more recent legislation. For example, section 16 of the Tuberculosis Act 1948 and regulation 25 of the Health (Quarantine) Regulations 1983 enable certain persons to be required to submit to medical treatment. Section 11 of the New Zealand Bill of Rights Act 1990 provides everyone the right to refuse to undergo any medical treatment. Section 22 of the New Zealand Bill of Rights Act 1990 is also relevant, as it provides that everyone has the right not to be arbitrarily arrested or detained. To resolve these issues it is proposed that the new public health act will:

- refrain from arbitrarily requiring compulsory medical treatment
- prescribe criteria to enable an appropriate authority to determine the circumstances under which a person may be detained for the purposes of managing public health risks.

5.1.4 A range of other measures may be employed as an alternative to compulsory medical treatment. For example, the Australian Capital Territory Public Health Act 1997 provides for public health directions. The directions relate to matters such as:

- refraining from behaviours or activities that contribute significantly to a hazard
- ceasing work, work at a particular place or the use of particular equipment
- submitting to medical examination
- attending counselling
- confinement in, or exclusion from, a particular place.

Question 6: Do you accept that the exercise of public health powers may sometimes override individual human rights, such as the right to refuse medical treatment? Please explain your answer.

Question 7: If public health powers can override individual rights, what checks should be included in the new public health act to ensure the powers are not exercised arbitrarily?

Question 8: Who or what do you consider is the appropriate authority (eg, District Court Judge) to review the case for detaining a person for the purposes of managing a public health risk, to ensure that detention is not arbitrary?

6 New Zealand's International Obligations and Commitments

6.1.1 Through a number of international forums, New Zealand has made commitments in line with its position as a responsible member of the international community. The new public health act should reflect New Zealand's intention to honour its international commitments to improve, promote and protect public health.

6.1.2 New Zealand is a party to a number of important international instruments which it considers it is bound to fulfil. An example is the Agreement Establishing the World Trade Organisation (WTO) 1994. Other instruments (eg, the 1948 Universal Declaration of Human Rights) impose moral and political obligations on New Zealand to fulfil their terms. The New Zealand Government takes these obligations seriously.

6.1.3 In the public health arena, an example is the World Health Organization's (WHO's) International Health Regulations 1969 relating to human quarantine (which are largely reflected in the provisions of the Health Act 1956 and the Health (Quarantine) Regulations 1983). Additionally, every law of New Zealand must, unless expressly otherwise provided, be read subject to the Trans-Tasman Mutual Recognition Act 1997.

6.1.4 In addition to such agreements, the Government must take account of the undertakings it has made under instruments such as the Ottawa Charter for Health Promotion 1986, the New Zealand Australia Joint Food Standards Agreement 1995, the WHO International Code of Marketing of Breast-milk Substitutes 1981 and the Rio Declaration on Environment and Development (*Agenda 21*) 1992.

6.1.5 Recognition of the international instruments to which New Zealand is party is a common feature of modern legislation. Much statute law is affected by international obligations, and the Courts are increasingly willing to examine them when interpreting New Zealand law. Often internal processes must be developed or altered to harmonise with international obligations and domestic legislation is sometimes required to achieve this.

6.1.6 International obligations are thus of considerable importance in the domestic sphere because of the impact of globalisation (eg, trade, travel and telecommunication) on the state of public health in New Zealand.

Question 9: Do you consider the new public health act should impose a duty on all persons exercising powers, functions and duties under the Act to take into account New Zealand's international public health obligations? Please explain your answer.

7 Public Health Risk Management

7.1 Scope of public health risk management

7.1.1 Active protection and promotion of health can be gained through improvements in environmental quality, reduction of health risks, and a supportive social environment (Public Health Commission 1995a, Ministry of Health 1997b, Queensland Government 1998). People's lives may be affected by a number of health hazards. These include:

- structures, activities, animals, organisms, substances or products which may contribute to disease in humans or have adverse effects on human health
- environmental factors, such as the quality of drinking-water, which are essential to maintain life and can also act as media for the transmission of diseases
- social factors, such as inadequate social amenities or inadequate social support for vulnerable groups, and the general quality of living environments.

7.1.2 In assessing and prioritising the impact of hazards on health and considering appropriate measures to remove or control those effects, it is important first to estimate the likelihood and magnitude of the adverse health effects associated with a hazard — that is, the *risk*. It is then necessary to ensure the level of control is appropriate to the nature, scale and significance of the actual or potential effects of the controlled activity, situation or substance on health (Public Health Commission 1995a).

7.1.3 Identification, assessment and management of risks to public health may be undertaken locally and, where necessary, nationally. Various criteria for risk management and a menu of interventions are discussed below.

7.2 Duties to consider alternatives, assess benefits and costs

7.2.1 Persons with the ability to exercise powers in relation to the adoption of policies, rules, or other methods in relation to significant functions under the new public health act will be required to have regard to matters such as the following before exercising such powers.

7.2.2 (i) The extent (if any) to which the policy, rule, or other method is necessary in achieving the purpose of the Act. In doing so, consideration would be given to such matters as:

- the level of risk to public health associated with the hazard
- the existing level of risk to public health in the absence of the hazard
- the nature of the hazard/risk

- any relevant international obligations
- the extent to which the hazard/risk is managed by other legislation
- affirmation of human rights
- such other matters that appear relevant.

(ii) Alternative or additional means which may be used to manage the hazard/risk. For example, the provision of information, services, incentives, or the levying of charges.

(iii) Reasons for and against adopting the proposed policy, rule, or other method and a comparison with reasons for and against the principal alternative means available (including taking no action). For proper consideration it would also be necessary for there to be an evaluation of the likely benefits and costs, including:

- the extent to which the proposal (and the principal alternative) is likely to be effective in achieving the intended outcome
- monetary and non-monetary benefits and costs including the likely implementation and compliance costs.

7.2.3 In this way, decision-makers will be required to demonstrate that the intervention is appropriate, having regard to its efficiency and effectiveness relative to other means. This general duty, at least, would also apply to all significant local functions. For example, subject to the general duty, local enforcement services may be afforded discretionary powers to adopt more restrictive local policies, rules or other methods than those adopted nationally. This is enabling but would probably need to be limited by a requirement that local conditions or circumstances must be demonstrably 'different' in order to warrant a departure from the national approach.

Question 10: Do you agree with the general duty, as expressed, to consider alternatives and assess benefits and costs prior to the exercise of powers relating to significant risk management functions? If not, please explain why and suggest changes.

7.3 A menu of interventions

7.3.1 The new public health act could provide a 'menu' of interventions, such as the ability to:

- make rules (eg, regulations, standards or bylaws)
- enforce rules (eg, infringement notices, compliance orders or prosecutions)
- provide information (eg, public pronouncements)
- take action (ie, directly)

- monitoring (refer to Glossary)
- advise the Government (ie, on the most appropriate action to take, if any)
- co-ordinate other activities (eg, non-regulatory interventions or services provided by other sectors)
- audit (refer to Glossary).

7.3.2 The level of choice with the menu approach is further enhanced by options in terms of:

- prescriptive versus descriptive (enabling) regulation
- different methods being applied to manage activities, issues or settings (such methods being selected in accordance with the criteria outlined above).

7.3.3 In accordance with modern regulatory practice, it may be appropriate to provide for cost recovery in association with an intervention. Whether cost recovery (full, partial or otherwise) is appropriate will depend, for example, on factors such as:

- the degree to which it is possible to identify persons whose actions or inactions contribute to the need to manage a risk
- whether it is efficient to establish and maintain a targeted cost-recovery regime
- the proportion of public and private good and what incentives (positive and negative) will be created for the parties concerned.

Prescriptive versus descriptive (enabling) regulation

7.3.4 Prescriptive rules are used in the control regime established by the Health Act 1956 and its subordinate legislation. The advantages of this option are that known risks are identified and detailed control regimes are developed for them. Operators and the public, as well as public health practitioners, may more easily recognise what is required to meet legislative requirements. On the other hand, they may be prevented from developing and implementing innovative solutions to a public health problem.

7.3.5 Prescriptive approaches provide certainty but are less flexible (both for the regulators and the regulated party). Over time, prescriptive legislation can be seen to retain provisions that are redundant, outdated and which continue unnecessary restrictions. There is a need for regular revisions. An example from the Health Act 1956 is the requirement for a person to inform the driver or conductor of a public conveyance if he or she is suffering from a communicable disease.

7.3.6 Prescriptive legislation may also fail to control public health risks which were not envisaged at the time the legislation was drafted. The latter results in piecemeal and *ad hoc* amendments to the parent legislation as issues arise and prevents an appropriate and timely response to public health risks. Activities not explicitly addressed by the Health Act 1956, but which may be considered to pose a risk to public health, include skin piercing (tattooing, body piercing), large public gatherings on unserviced or inadequately serviced sites, and the protection of private water supplies.

7.3.7 The preferred option is to have descriptive (enabling) rules which focus on effects on public health. These rules would, subject to sensible exceptions or provisos, capture any risk activities, structures, substances, goods or settings of public health significance. The underlying principles of risk management would be the central theme of the new Act.

7.3.8 A process for specifying and gazetting regulated matters will be established, and then specified matters will be controlled by Regulations, standards, guidelines or codes of practice depending on the degree of risk (and so required degree of control). Mandatory objectives, functional requirements and performance standards could be defined in Regulations. Acceptable solutions could then be developed and approved by the regulatory authority. Applicants (or industries) could make use of the solutions provided, or develop and submit their own for approval.

7.3.9 Provision could be made for the Minister to 'call in' proposals to adopt interventions of national significance, perhaps because they form a precedent (such as the first consent application for the use of new technology) or because there are significant levels of concern among Mäori, other communities or people.

7.3.10 The key advantages of this option are that it would:

- provide a flexible framework capable of adapting to risks that may not be contemplated at present
- provide for controls to be reduced if a hazard disappears or becomes a less significant public health risk
- ensure hazards are managed in a manner that is appropriate to the level of risk
- provide for proactive responses to public health risks as well as reactive controls of hazards
- establish well-understood criteria for determining whether a hazard may be a public health risk.

7.3.11 The key disadvantages include:

- a hazard currently not considered a risk may have controls applied at a later date as a level of risk is identified, creating compliance costs an operator may not have foreseen
- involves costs on the party subject to regulation and uncertainty for parties dealing with the regulated party
- creates a risk of excessive precaution
- issues of interpretation create barriers to implementation.

7.3.12 It is considered that, in most instances, the advantages of descriptive (enabling) regulation outweigh the disadvantages. Controls will be imposed only where a significant risk to public health exists. Having assessed the risk, options to determine

the best solution need to be considered in accordance with the criteria outlined previously. Refer to Appendix Four for examples of processes that might be developed for activities, issues or settings of public health significance.

7.3.13 It is anticipated that proposals for a regulatory intervention for a particular risk would be the subject of appropriate consultation (see also the discussion in *Emergency provisions*, *Consultation* and *Local public health plans*).

> ***Question 11: Please indicate any additions, deletions or alterations you consider should be made to the 'menu of interventions'. Please explain your answer(s).***

7.4 General issues for consideration

7.4.1 In developing new legislation there will be a large amount of detail to support the approach outlined above. Particularly important issues are whether to provide for:

- a general duty not to cause risks to public health
- directions to provide infrastructural services of public health significance
- a precautionary approach to managing uncertain risks.

> ***Question 12: Do you consider there are other important issues to be addressed in the context of a risk-management framework? If so, please identify them and provide text to assist their consideration.***

General duty not to cause risks to public health

7.4.2 It would be possible to include a provision in the new public health act imposing a general duty on people (including companies, organisations, etc) not to cause risks to public health. Framed in the context of public health risk management, this duty would be expressed in a manner similar to the duty imposed by section 17 of the Resource Management Act 1991. As with the latter Act, the general duty would not be enforceable in itself. However it would be informative and provide a basis for associated provisions establishing enforcement options and procedures. The general duty and associated enforcement provisions would replace the nuisance provisions (section 29 etc) of the Health Act 1956. It may be possible to improve upon the resource management model.

7.4.3 The advantages of this proposal include:

- recognition of the importance of lifestyle factors and behaviours in public health risk management
- a framework for the control of risk-causing behaviour, where it is appropriate.

7.4.4 The disadvantages of the proposal include:

- it is not specific about the behaviours which may be included
- it may be seen as placing too much onus on individuals to avoid risk situations.

Infrastructural services of public health significance

7.4.5 It would be possible to continue to provide for requisitions to ensure communities have access to safe and sufficient services of particular public health significance. Examples of services this may apply to are those already covered in the Health Act 1956, such as reticulated water supplies and waste management.

7.4.6 For example, the Minister of Health may currently require a local authority to provide 'sanitary works' such as a water supply or sewage reticulation and treatment. It is noted that local authorities are not the sole providers of drinking-water, sewerage or waste disposal. However, given a local authority's general responsibilities, its abilities to formulate plans controlling development and to levy rates, it seems likely that where an essential service of public health significance is not adequately provided, the local authority will still be required to ensure the provision of this service (either directly or indirectly).

7.4.7 The advantages of this proposal include:

- the provision of services of particular public health significance will be assured
- risks attendant with the absence of such services will be managed
- providers other than local authorities would not be prevented from providing such services
- the new public health act will focus on public health risks and be complementary to existing legislation
- direct public health action may be taken if public health is placed at significant risk through the inadequate or unsafe provision of services.

7.4.8 The disadvantages of this proposal include:

- detailed provisions relating to which services must be provided, at what level, and by whom are unlikely to be included
- the need for consistency with a range of legislation that will apply to the provision of these services
- no provision relating to resources for requisitions made.

Question 13: Do you agree with including a provision in the new public health act enabling requisitions to be made to ensure safe and sufficient infrastructural services of particular public health significance? If so, please explain which services and why. If not, please explain why.

Precautionary approach to public health risks

7.4.9 For some public health issues, research into health effects is not well developed. Studies may provide important clues to the origins of disease but be unable to provide strong evidence of cause and effect. However, even considering the limitations of current epidemiological and other evidence, this is not sufficient reason to reject such evidence. Biological plausibility is a weak criterion for assessing new exposures and flaws in research must be weighed against some consistency in outcomes.

7.4.10 Epidemiological and other evidence may be construed as either incomplete evidence of cause *or* incomplete evidence of safety. In these cases and in the face of scientific uncertainty, it is sensible to apply 'no cost' interventions to avoid or reduce exposures to potential public health risks, especially for populations that might be sensitive (eg, children). The application of 'low cost' interventions may also be considered, depending on the strength of evidence and level of absolute risk.

7.4.11 Section 7 of the Hazardous Substances and New Organisms Act 1996 provides for a precautionary approach when there is scientific uncertainty and a potentially high relative or absolute risk. It states, 'All persons exercising functions, powers, and duties under this Act … shall take into account the need for caution in managing adverse effects where there is scientific and technical uncertainty about those effects'.

Question 14: Do you consider the new public health act should provide for a precautionary approach to managing potential public health risks? Please explain your answer.

7.5 Emergency provisions

7.5.1 Public health services contribute substantially to a community's ability to cope with a major emergency or epidemic. Emergency powers are required to deal with a specific serious risk to public health. Consideration needs to be given to what sort of public health emergency might require legislative interventions. Examples could be:

- an epidemic of a serious communicable disease
- a large drinking-water supply suddenly rendered unfit for consumption by microbiological or chemical contamination requiring alternative supplies for a long period of time
- chemical contamination of a residential suburb leading to evacuation of homes
- natural hazards such as extensive ash fall-out from a volcanic eruption, causing significant respiratory distress.

7.5.2 Public health emergencies can be localised to very specific areas. For example, broken waste-water or sewage pipe causing flooding through shops and homes may require special powers. Even relatively major events such as the recent Mount Ruapehu volcanic eruptions may require additional powers but not be such that they warrant civil defence emergency status.

7.5.3 Public health problems, for example, with contaminated food and drinking-water following flooding, may exist some days or weeks after the initial crisis. So while a declared state of emergency may be lifted, contamination problems may exist for some time afterwards until the community infrastructure is repaired.

Emergency management principles and powers

7.5.4 An Emergency Management Unit has been established within the Department of Internal Affairs to establish a new Ministry of Civil Defence, to commence initial policy work on a new overarching emergency management framework and to develop new emergency management legislation. The principles for the emergency management framework are relevant to public health:

- Risk management
  - acceptance of individual responsibility and self-reliance
  - acceptance of Mäori and other communities' or peoples' responsibility and self-reliance
  - acceptance that routine events and emergencies are best handled at first level (local level) wherever possible

- Comprehensive emergency management
  - recognition of risk reduction, readiness for, and response to emergencies, and post-impact recovery as a continuum of activities
  - adoption of integrated emergency management systems between agencies and between levels of government
  - recognition and involvement of volunteer organisations
  - identification of risks through the all hazards approach
- Accountability
  - declarations of emergencies to be made at the most appropriate level of government by elected representatives
- Professional expertise
  - emergency management structures to be underpinned with appropriate technical information and expertise.

7.5.5 Given the background of the emergency sector reforms, features of emergency provisions for a public health act could include:

- an overall risk management strategy
- the means to activate additional powers in a public health emergency
- details of emergency powers
- the ability to make regulations
- immunities from prosecutions
- compensation provisions
- waiver of ordinary duties (eg, consultation requirements)
- the ability to give directions to another sector where that sector's performance is of critical importance to managing a public health risk.

7.5.6 Emergency powers could apply in their own right where no regional or national emergency is declared, or in tandem with emergency management legislation in a regional or national emergency. Powers for public health emergencies would be activated by an appropriate authority after prescribed criteria had been met. Authorisation may be followed by public declaration.

7.5.7 A public health emergency declaration would need to specify:

- the purpose of the declaration
- the nature of the emergency
- a geographic area (eg, health districts or territorial authority districts) to which it relates
- the period during which the declaration is to remain in force.

7.5.8 The advantages of a declaring a public health emergency would include:

- alerting the public and other agencies to a serious public health threat
- triggering extraordinary powers
- clearly identifying who is in charge of the situation
- allowing co-ordination of resources with other local agencies and health service providers.

7.5.9 Currently such declarations are not necessary. There is provision in the Health Act 1956 for Medical Officers of Health to be granted additional powers during a declared regional or national civil defence emergency or by the Minister in order to prevent the outbreak of infectious disease or on the outbreak of such a disease. Authorisation of activation is delegated to the Director-General of Health. Continuing this system in the new public health act would involve an appropriate authority activating additional powers upon being satisfied that prescribed criteria have been met.

Question 15: Do you consider declaration of public health emergencies (which are not civil defence emergencies) is necessary? Please explain your answer.

Details of emergency powers

7.5.10 For the duration of the local public health emergency, powers would be needed similar to those in sections 70–71 of the Health Act 1956. These could be carried over into new legislation, or more general provisions included, to be exercised under the circumstances the appropriate authority considers necessary or desirable. Special powers may need to be authorised:

- when there is a local public health emergency which has not been declared a civil defence emergency but which requires additional powers to protect the public health
- in the recovery phase following the lifting of a declared civil defence emergency
- in the event of another agency defaulting on its responsibilities, with a resulting serious and imminent threat to public health.

Question 16: Do you consider special powers are required for a public health emergency? If so, what situations do you consider should be added to, or deleted from, the list of situations in which special powers are needed? If not, please explain your answer.

Intervention upon default by another sector

7.5.11 A range of legislation administered by other sectors includes provisions which address public health risks. An example of how different legislation covers different aspects of the public health risks associated with drinking-water is set out in Appendix Three.

7.5.12 Upon default, agencies responsible for the administration and implementation of legislation are accountable (and possibly subject to penalty) to a higher authority. Accordingly, it seems reasonable to conclude that, ordinarily, public health legislation should not provide for direct public health action upon default by another sector. One possible exception would be a default that creates a serious and imminent threat to public health, to the extent that it might be considered a public health emergency (see discussion in *Emergency provisions*).

> ***Question 17: Do you consider there are risks covered by other legislation which may require direct public health action upon default by another sector? If so, please explain which risks and under what circumstances you consider such action is warranted. If not, please also explain your answer.***

7.6 Prevention and control of communicable diseases

7.6.1 The prevention and control of communicable diseases is a core public health function. Steps in communicable disease risk management may be supported by legislation and may include:

- clearly identifying the cause for concern
- identifying the hazard (the causative organism, an event, or combination of circumstances that could have potentially harmful consequences)
- defining the potential harm (outcome)
- deciding on and implementing action to eliminate or minimise the risks
- communicating to the public information on a risk and the decisions taken to combat the risk
- assessing the effectiveness of the control measures.

7.6.2 A ‘communicable disease’ is currently defined by the Health Act 1956 as including any infectious disease, tuberculosis, venereal disease, and any other disease declared by the Governor-General by Order in Council to be a communicable disease for the purpose of the Act.

7.6.3 Broad aspects of communicable disease control that are currently covered by separate pieces of legislation that could be included in a new public health act would be:

- infectious diseases, including quarantinable diseases
- tuberculosis
- venereal diseases
- immunisation requirements
- zoonoses (diseases communicated to humans by animals).

> ***Question 18: Are there any steps in communicable disease risk management or aspects of communicable disease control that you believe should be added to or deleted from those identified in this document? Please explain your answer.***

7.6.4 Two key advantages of consolidating public health regulation on communicable diseases into the new public health act are:

- the ability to readily identify relevant statutory provisions
- clear and consistent criteria for enforcement actions or other public health interventions.

7.6.5 The current *ad hoc* approach to communicable disease legislation has created difficulties (eg, inconsistent provisions in relation to the exclusion of people with communicable diseases from work, school or early childhood facilities).

Notifiable diseases and syndromes

7.6.6 Specific provisions may be required for the notification of diseases or syndromes as part of the risk management strategy. Notification would support prompt and appropriate public health action and provide surveillance information. The early detection of common source outbreaks, leading to the elimination of the source, and contact tracing for treatment of the index case and contacts of infection are important objectives for notification. Surveillance allows ongoing programmes to be evaluated and may indicate the need for new programmes.

7.6.7 At present, the list of notifiable diseases includes most serious communicable diseases, vaccine-preventable diseases, and certain disease outbreaks, such as gastroenteritis, where a common source of infection is suspected. Legislation needs to be flexible enough to allow for the ready amendment of the list and for the control of new and emerging risks.

7.6.8 The present system of amendment involves the Governor-General signing an Order in Council, and is administratively cumbersome. However, it does allow for scrutiny by the Executive. Alternatives such as gazetting of amendments may be less cumbersome, but may mean the reasons for making a disease notifiable are less transparent to the public.

7.6.9 Criteria would need to be developed to determine which diseases and syndromes ought to be notifiable. Such criteria could include:

- the number of deaths (mortality)
- ratio of deaths to cases
- illness (morbidity)
- incidence and prevalence
- outbreak potential
- route of transmission
- communicability (infectivity)
- socioeconomic impact (local, regional or national)
- public perception of risk
- the effective response time for public health action
- prevention strategies (eg, immunisation)
- international surveillance obligations
- other priorities for surveillance (eg, agricultural practices).

Question 19: Please indicate any additions, deletions or changes you consider should be made to the list of criteria to be used to determine which diseases and syndromes ought to be notifiable? Please explain your answer(s).

Question 20: What do you consider is the most efficient process for requiring diseases or syndromes to be notified? Please explain your answer.

7.7 Privacy

7.7.1 Privacy issues are of particular importance in the development of systems of public health surveillance, as such systems may require identification of individuals. However, most surveillance, evaluation, and monitoring of public health strategies use aggregated data. Much of the information provided by health professionals that contribute to these

epidemiology databases is anonymised, and in the case of the National Medical Data System *all* information is encrypted. Therefore such data are not restricted by the provisions of health information under the Privacy Act 1993 and the Health Information Privacy Code 1994.

7.7.2 Personal information may be required in instances of notification of some communicable diseases where contact tracing is necessary. In such cases, the requirement for information to protect the wider public health would need to outweigh considerations of individual privacy. It is likely that provision will be made in the new public health act for there to be a mandatory duty for medical laboratories, doctors and other health professionals to provide such information in specified instances. The Privacy Act 1993 provides for protection of such information when such a duty is imposed under other legislation. An example of a model for laboratory-based surveillance is the Cancer Registry Act 1993.

7.7.3 The new public health act will not prescribe the form, manner or timing of such reports, nor specifically outline the types of notifiable diseases that will require mandatory reporting. To enable greater flexibility and adaptability, such requirements will be outlined in guidelines or regulatory schedules.

8 Legislative Frameworks and Functions

8.1 Functional components of a legislative framework

8.1.1 Statutes create a matrix of powers, functions and duties to give effect to the Government policy. The components of the statute and their inter-relationships create a legislative framework.

8.1.2 In preparing for this review, several legislative frameworks were analysed and compared to the existing public health legislative framework to identify their principal components. The frameworks analysed were those established by the following statutes:

- Biosecurity Act 1993
- Building Act 1991
- Food Act 1981
- Hazardous Substances and New Organisms Act 1996 (HSNO)
- Health and Safety in Employment Act 1992
- Resource Management Act 1991
- Transport Act 1962.

8.1.3 The functional components identified as potential building blocks for a public health legislative framework are listed below, along with *current* examples:

> **The public**: all persons, including individuals and bodies corporate. May also include communities and in some cases the Crown. Expected to comply with all lawful requirements.

> **Regulated matters:** particular services, activities, goods or things which give rise to significant risks to public health and which warrant controls to avoid, remedy or mitigate any adverse effects (eg, camping grounds, plastic wrapping, imported animal-hair brushes).

Audit function: competent, independent persons approved by the regulatory authority. May be engaged by the person responsible for a regulated matter to carry out inspections/audits and to certify that legislative requirements are being met (eg, test certifiers under HSNO, auditors under the Food Act 1981, approved certifiers under the Building Act 1991).

Enforcement function: authorised persons or agencies which undertake compliance monitoring, risk assessment, contingency planning for emergencies, and allocated enforcement activities (eg, investigating complaints, issuing directions, interviewing witnesses and collecting evidence). Accountable to the regulatory authority (eg, Designated Officers and Environmental Health Officers).

Funding and contracting function: funds and contracts the delivery of services by service providers (eg, the Health Funding Authority and Transfund NZ).

Regulatory authority function: overall responsibility for the implementation of legislation, including, determining consents, taking prosecutions, setting standards, maintaining registers, approving auditors, co-ordinating enforcement, preparing guidelines, planning for emergencies, undertaking enforcement on default of others (if appropriate), monitoring and reporting on the impact of regulatory activities on public health and advising the Department of State on public health regulatory matters (eg, to varying degrees, the Environmental Risk Management Authority, the Occupational Safety and Health Service of the Department of Labour and the Building Industry Authority).

Department of State function: policy development, advice to the Minister, administration (as distinct from implementation) of legislation, leadership to the sector, monitoring coherence of entire policy and legislative framework, international linkages and performance of the relevant subsectors.

Ministerial function: overarching priority setting and oversight role. Pinnacle of the accountability hierarchy. Reports to Parliament on all issues relating to improving, promoting and protecting public health. Likely to rely on the Department of State for advice if any Ministerial powers are to be exercised and also to report on the performance of the regulatory authority, funding/contracting and enforcement roles.

8.2 Desirable features of a public health legislative framework

8.2.1 Assessment of the functional components (described above) against the objectives for this review suggests a number of features which the proposed legislative framework must possess:

- clear and consistent objectives for all functional components, particularly the differentiation of and clear responsibilities for the audit, enforcement, regulatory oversight and Department of State functions
- maximum accountability for officers and functions at all levels
- operational autonomy for management practices, regulatory decision-making and enforcement functions
- transparency: to enhance public understanding and promote scrutiny of decisions and processes
- contestability: the introduction, where appropriate, of commercial disciplines and objective performance measures
- exposure of conflict: the removal or management of any conflicts of interest and the provision of free and frank advice to Ministers
- reducing opportunities for capture of advice: institutional design should limit the scope for agencies engaged in service delivery to be directly responsible for the provision of policy advice to the Government on those services
- complementarity: linking or integration of processes that use common information, processes or skills
- minimisation of duplication
- rational use of resources to maximise effectiveness, efficiency and equity
- clear and effective co-ordination processes
- clear information and communication flows.

8.3 Configurations considered

8.3.1 Several options for configuring functional components in a public health context, to achieve the desired features, have been assessed. These are outlined below. With some exceptions, there was only limited scope to review the responsibilities and behaviour of the public or the constitutional role of Ministers of the Crown. It will also be necessary to determine the nature and scope of the regulatory framework before considering options for the future provision of enforcement services. For these reasons, analysis centred on options for Department of State and regulatory authority functions (also see discussion in *Structure and organisational form*).

Configuration option outlines

Separate Department of State and Crown Regulatory Authority Functions

Public health regulatory and decision-making functions would be the responsibility of either a new Crown entity or grafted onto an existing Crown entity. For example, the roles mandated for ERMA and the BIA are relevant to the current review and could lead to an analogous body being established for public health. The entity would be monitored by the Department of State.

Separate Department of State and Independent Regulatory Authorities

Regulatory oversight functions could be devolved to multiple regional, district or area-based authorities, which would in turn be subject to monitoring and possible direction by the Department of State.

Status Quo

Regulatory authority functions spread across multiple agencies and individuals (territorial authorities, environmental health officers, designated officers, Director-General and the Minister of Health). If the existing legislative framework were to be retained, the Ministry would employ a mixed strategy of improved co-ordination between stakeholders and a systematic programme of amendments to, and revocations of, existing legislation. This approach would address some, but not all, of the problems associated with the current legislation.

Combined Department of State and Regulatory Authority Functions (The Preferred Configuration)

Following analysis of the desirable features, the basic principles of public health risk management, the functional components, their inter-relationships and options for configuring them, a preferred shape for the legislative framework emerged. Regulatory oversight and decision-making functions would be the responsibility of the Department of State. A detailed discussion of this configuration follows.

8.4 The preferred configuration

8.4.1 This preferred configuration arises from the framework analysis described above, accumulated experience and the results of several previous rounds of consultation. The proposed new public health act will clearly identify the powers, functions and duties of each of the functional components.

The public

8.4.2 The public will be required to comply with all lawful directions. Additionally, all persons will be subject to a general duty of care not to put public health at risk. While failure to comply with this general duty would not itself be an offence, it could serve as a trigger for a compliance order or other direction which would carry sanctions if ignored.

8.4.3 In summary, the public are:

- individuals or organisations who have responsibilities not to act (or to refrain from action) so as to cause a significant public health risk.

Persons responsible for regulated matters

8.4.4 Persons responsible for regulated matters (ie, risk activities, services, goods or things) would also be required to comply with all lawful directions. They will be expected to identify and manage risks to public health arising from the matter in question, obtain required consents, comply with all legislative requirements and be able to demonstrate this when appropriate. They may choose to implement an approved risk management programme or standard, or they may develop and submit for approval an acceptable solution of their own. They may choose, or be required to engage approved auditors to assist with demonstrating compliance.

8.4.5 In summary, persons responsible for regulated matters:

- must comply with all relevant legislative requirements *and* be able to demonstrate this when appropriate
- may develop risk-management programmes/acceptable solutions to meet rules that have been made in relation to regulated matters
- may engage approved auditors to audit and certify compliance.

Approved auditors

8.4.6 Approved auditors are competent, independent persons approved by the regulatory authority. They may be engaged by the person responsible for a regulated activity, service, good or thing to carry out inspections/audits and to certify that legislative requirements are being met. Their services are paid for by the person responsible for the regulated matter. Such auditors usually provide technical audits of commercial or other matters which are the subject of legislative requirements, and issue certificates of compliance to this effect. Such certificates are used to demonstrate compliance to enforcement agencies and to the public. Any instances of non-compliance which come to the attention of an auditor must be reported to an enforcement agency. While

engaged by the person responsible for the regulated matter, they are accountable to the regulatory authority for the veracity of their audits and subsequent certifications.

8.4.7 In summary, approved auditors:

- audit and certify regulated matters' compliance with legislative requirements
- report non-compliance to the enforcement agency.

Enforcement agencies

8.4.8 Enforcement agencies use the legitimate authority of the State to carry out their tasks. For this reason, command and control provisions and accountability requirements must be explicit. Multiple accountabilities and competing priorities must be avoided. The transaction and communication costs of attempting to co-ordinate the existing diversity of public health enforcement services consumes both time and resources, with questionable success. The preferred configuration will provide an opportunity to rationalise enforcement arrangements and to clarify the roles of the various sub-sectors.

8.4.9 In summary, enforcement agencies:

- are responsible for appointment of enforcement officers
- identify and manage risks to public health at a local or regional level
- monitor and report on compliance by the public, regulated matters and others with respect to legislative requirements
- take enforcement action as appropriate (surveillance/inspections, investigation, issue abatement notices/directions, requisitions, evidence-gathering and prosecutions in relation to local or regional rules)
- promote awareness of and compliance with legislative requirements
- carry out functions delegated by the regulatory authority
- report to and comply with directions from the regulatory authority.

Department of State/regulatory authority

8.4.10 The Department of State, most probably the Ministry of Health, would advise the Minister, Parliament and central government agencies on public health issues. This role includes advice on the adequacy and need for amendment to legislation, and to the Minister when exercising Ministerial powers.

8.411 To fulfil its role as the regulatory authority, the Department of State would be afforded significant powers and responsibilities. Adequate safeguards and accountability for these powers and responsibilities, most would need to be provided for. There would be some scope for delegation of functions, but not responsibility for those functions.

8.4.12 The Department of State/regulatory authority would develop technical standards, guidelines and codes (ie, risk management programmes) for implementation by those responsible for regulated matters. It would also have the power to approve risk-management programmes developed by other persons. The Department of State/ regulatory authority would approve and monitor the performance of independent auditors, employed by those persons responsible for regulated matters to demonstrate compliance with legislative requirements.

8.4.13 Regulatory authority functions also call for reporting to the Government on the cohesion, quality and quantity of enforcement activities, even if these are undertaken by other agencies. This would most likely occur as part of proposed reporting on the state of public health (see discussion in *Surveillance Monitoring and Reporting*). Regulatory oversight functions could be the core business of the Department of State or could be undertaken by a semi-independent business unit of such a department. The component functions of the regulatory oversight role would be clearly delineated and would complement the department's involvement in Cabinet processes, leadership of the sector and administration of legislation functions. This approach would also help maintain linkages with equivalent bodies overseas and with multilateral organisations like WHO (or bilaterals like ANZFA).

8.4.14 Combining regulatory authority and Department of State functions supports, and is itself supported by, the mutual interdependence of policy, technical and regulatory roles and expertise. This approach would also provide a viable environment for the delivery of non-regulatory public health services (eg, health promotion), which in many instances complement the legislative functions. Care would need to be taken to ensure that demand-driven regulatory and operational work did not occur at the expense of associated strategic policy functions or ministerial servicing.

8.4.15 The combination of Department of State and regulatory authority functions allows regulatory personnel to inform and to contribute directly to departmental advice to the Minister and to participate in central government processes, such as Cabinet Committees. However, with the present statutory position of the Director of Public Health, there may also be explicit provision for independent advice to the Minister on public health matters. This allows for advice on public health to be provided without risk of interference or filtering. Conversely, this may be seen as giving public health an unnecessary or inappropriate special status in the health sector.

8.4.16 While compliance monitoring, investigations and evidence gathering functions are likely to remain the responsibility of locally based enforcement services (according to performance standards developed by the Department of State/regulatory authority), experience to date suggests it may be more appropriate for prosecutions in relation to national rules to be undertaken and supported by a central agency. For example, under the existing health sector arrangements, there are few incentives for public health services to take prosecutions. Centrally co-ordinated management of prosecutions can make better provision for the required legal, technical and financial resources. Making the Crown responsible for decisions to prosecute (at least in relation to national rules) and for subsequent follow-through should also help to ensure consistency and due consideration of all relevant factors.

8.4.17 In summary, the combined Department of State/regulatory authority functions will include:

Department of State functions

- provides the Government with robust, free and frank policy advice on public health, including public health legislation
- administers legislation (ie, the development and amendment of legislation)
- manages/co-ordinates action on identified risks of national significance
- reports on the state of public health to the Minister (who in turn tables the report in Parliament)
- otherwise reports to and is subject to appropriate direction from, the Minister
- maintains linkages to international bodies, including reference to international obligations and emerging trends in best practice
- recognises 'whole of government' considerations
- undertakes Ministerial and Parliamentary servicing

Regulatory authority functions

- identifies and manages risks to public health of major or national significance
- determines activity consents and approves risk-management programmes and acceptable solutions developed by third parties
- develops/approves technical standards, guidelines and codes (ie, risk-management programmes with 'acceptable solution' status)
- may exercise enforcement powers on default of enforcement agencies or other sectors *in extremis* (eg, emergency powers)
- is responsible for co-ordinated and consistent implementation of legislation by enforcement agencies (eg, promulgation of performance standards)
- monitors performance of enforcement officers
- approves and monitors the performance of approved auditors
- has overall responsibility for prosecutions, particularly in relation to national rules
- ensures legislative requirements are being monitored and enforced by enforcement agencies/auditors
- monitors the performance of other sectors in relation to their impact on public health
- monitors and reports on the impact of the health sector's activities on public health
- provides technical and other evidence-based input to laws and regulations

- maintains registers as required
- delegates functions where it is appropriate to do so.

Minister

8.4.18 The Minister sets overall priorities and policy goals for public health and is accountable to Parliament for all aspects of public health, including the tabling of an annual report on the state of public health. He or she may exercise significant powers when judged necessary (eg, calling in activity consents of major public health significance or other powers with national or strategic importance).

8.4.19 In summary, the Minister:

- decides on policy direction for legislation
- can 'call in' consents, where appropriate
- has reserve powers to direct the regulatory authority, where appropriate
- tables reports in Parliament on the state of public health
- is ultimately accountable to Parliament for public health.

8.5 Summary assessment of the preferred configuration

Advantages of the configuration

8.5.1 To operate efficiently and effectively, the Department of State/regulatory authority role calls for close linkages with both the administration and implementation (enforcement) of legislation functions. Consolidation of overall responsibility for these functions and technical expertise reduces scope for boundary confusion and transaction costs. It also enhances the likelihood of consistent implementation and helps to ensure a coherent and authoritative voice for public health in central government processes. Other advantages include:

- a clear organisational focus and mandate
- independence of decision-making is achieved, but not at the expense of accountability or capacity to direct when required
- seamless decision-making, policy development and implementation
- removal of conflicts of interest and multiple accountabilities
- consistency, communication and co-ordination difficulties minimised

- maximum accountability of enforcement agencies and officers
- ability to rapidly re-prioritise and respond to emerging issues
- affords independence for routine operation with provision for political control when necessary
- explicit linkages between regulatory oversight role, sector leadership and administration of legislation functions
- explicit recognition of the important and mutual benefits of combining regulatory and non-regulatory (eg, health promotion) public health functions
- supports the synergistic relationship between technical, policy and regulatory frameworks
- clear public and industry understanding of who does what.

Costs and risks associated with the configuration

8.5.2 There are some costs and risks associated with the preferred configuration. These include:

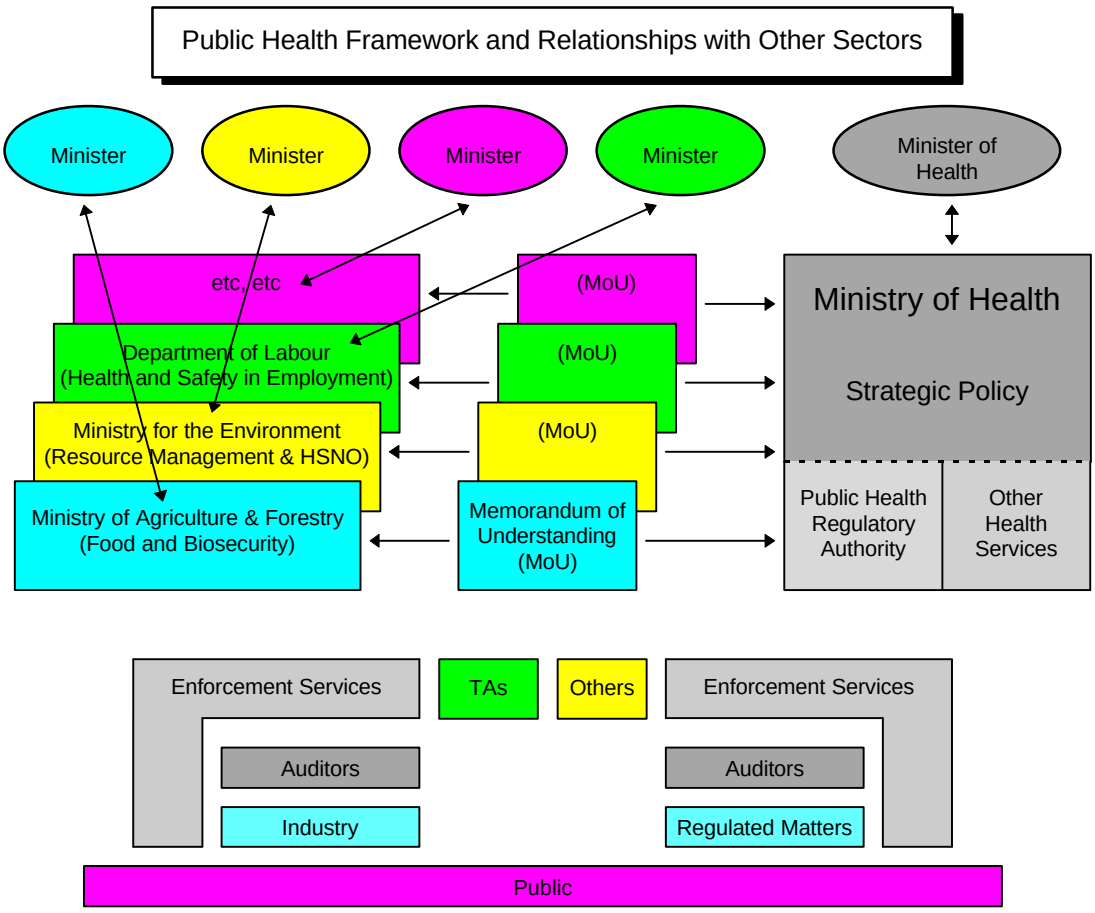
- possible structural change, or different allocations, of responsibilities leading to staffing disruption and implementation costs (subject to future consultation and decisions on enforcement arrangements)
- potential for a duplicated funding/contracting role if the Department of State/regulatory authority funds and contracts enforcement services directly (again, subject to future decisions)
- the risk that demand-driven regulatory and operational work occurs at the expense of policy or Ministerial servicing functions (or vice versa)
- possible difficulties with co-ordination, or direction of enforcement agencies.

Structure and organisational form

8.5.3 With all the components, functions and their necessary inter-relationships explicitly defined, it will not be necessary for the legislation to prescribe the structural and organisational forms to be adhered to. The functional components could be assembled according to the wider, and constantly evolving, political preferences for structural and organisational arrangements. This approach provides both certainty and flexibility. Certainty with regard to the functions and their associated accountabilities, and flexibility in that the structural and organisational form to give effect to the functions is not set in statute.

8.5.4 A number of different organisational configurations would therefore be possible under the proposed framework. However, some decisions on structures and organisational delivery of services are the prerogative of other legislation (eg, the Health and

Disability Services Act 1993) and of key decision-makers (eg, Cabinet Ministers and Chief Executive Officers).



When answering the following two questions, please note that this consultation does not seek comment on future decisions on enforcement arrangements (outlined in Appendix Five). If, as intended, significant changes are to be made to the public health legislative framework, robust transitional arrangements, over a reasonable period of time, will be provided for in the new public health act. This will be essential to maintain service continuity and the confidence of both the public and the health sector.

Question 21: Please comment on the preferred configuration for functional components to help to identify options for enhancement that may have been overlooked in the analysis to date.

Question 22: If you wish, please provide advice on your preferred alternative configuration of functional components and state the advantages and costs/risks associated with that alternative in a format similar to that used above (to aid comparison).

9 Enhancing the Capacity of Mäori and Other Communities to Improve, Promote and Protect Public Health

9.1 Context

9.1.1 It is contemplated that the community development and participatory dimensions of public health will be recognised in the public health regulatory framework. Strengthening community action is identified as a key public health strategy in the Ottawa Charter (see Glossary) and is consistent with the legitimate expectations of communities for involvement in matters affecting the health and safety of the public.

9.1.2 The Treaty of Waitangi (Te Tiriti o Waitangi) is acknowledged as New Zealand's founding document. The Government recognises that any discussion of enhancing the capacity of Mäori to improve, promote and protect public health should begin by acknowledging the special relationship between Mäori and the Crown under the Treaty of Waitangi (Te Tiriti o Waitangi).

9.1.3 Recognising the special needs of Mäori with a view to equity in health outcomes also requires an appreciation of the diverse nature and interaction between various structures including whänau, hapü, iwi and Mäori groups, organisations and communities. The determinants of health which promote and improve Mäori health include Mäori culture and traditions. Influencing the determinants of health to improve outcomes requires active participation by Mäori communities.

9.1.4 Public health action which strengthens Mäori community development is needed to reduce health outcome disparities. Disparities between Mäori and non-Mäori health outcomes have been a priority in the past and are predicted to be an ongoing Government priority in the future (Pool 1998). Currently, Mäori policy development is guided by the Mäori strategic result area and the Government's general policy direction for Mäori health identified in *Whäia Te Ora M*ö *Te Iwi* (Department of Health 1992).

9.1.5 Various legislation which impacts on public health has signalled the need to recognise the special needs of Mäori. Individually and collectively this legislation directs and influences activities which contribute to optimal health outcomes. The new public health act will need to reflect a legislative focus that addresses the special needs of Mäori in reducing the current and projected future disparities. Wording to consider for the new statute could be 'all persons exercising functions, powers and duties under this Act shall, to achieve the purpose of the Act, take account of the special needs of Mäori and other communities or people, including recognition of the relationship of Mäori and other communities or people with their culture, traditions and health'. This wording is consistent with that of the Health and Disability Services Act 1993 and the Health and Disability Commissioner Act 1994. There are similar requirements in a number of other

statutes, for example, the Children, Young Persons, and Their Families Act 1989, and the Education Act 1989.

9.2 Consultation

9.2.1 Consultation and public planning processes as two key mechanisms by which Mäori and other communities or people may participate to improve, promote, and protect public health. Consultation enables the views of Mäori and other communities or people to be considered in the formulation of robust policy advice, which shapes decisions that impact on population health outcomes.

9.2.2 A legislative requirement for consultation is one means of ensuring informed public health policy development. Current examples in health legislation are section 3F of the Health Act 1956 and sections 8(e) and 34 of the Health and Disability Services Act 1993. Similar requirements may be found in the Children, Young Persons, and Their Families Act 1989, the Education Act 1989, the Biosecurity Act 1993 (section 73), and the Resource Management Act 1991 (First Schedule, Part I, clause 3).

Question 23: Do you consider that the new public health act should include a requirement for consultation as part of the public health policy process? If so, please explain why and indicate how this requirement should be framed. If not, please explain why and identify alternative means of enabling wide participation in policy processes.

9.3 Local public health plans

9.3.1 Public planning processes are another way of enabling Mäori and other communities or people to participate in the development of public health policy. This is consistent with worldwide recognition that local services are well placed to design and implement innovative solutions to local public health problems. Provision for local public health plans are found in some Australian state laws, for example the Victorian Health Act 1958 and the South Australian Public and Environmental Health Act 1987. Section 29B of the Victorian Health Act 1958 states that Councils must prepare a 'Municipal Public Health Plan' every three years.

9.3.2 This approach is also compatible with principles which underpin the operation of the New Zealand health sector, including:

- services organised around patients and communities, not health professionals
- local solutions to local problems
- ensuring better relationships between those who provide public health services
- decisions about resources being made as close to the need as possible.

9.3.3 The advantages of local public health plans might include:

- better orientation of local services and programmes to meet the needs of Mäori and other communities or people
- better co-ordination between different local services (including Mäori and other communities' or people's groups), with services in other districts and with national services
- increased awareness of particular local public health issues
- increased access to, participation in and influence of local policy processes by Mäori and other communities or people
- local development and ownership of innovative solutions to local problems
- a sharper focus on specific issues and the desired outcomes.

9.3.4 However, local public health plans may have a number of disadvantages, including:

- difficulty in sustaining participation in the planning process
- the cost of developing and maintaining the plans
- addressing too many issues
- addressing issues that might best be addressed at a national or regional level
- duplication of effort with national programmes or with other districts
- inadequate or poor quality information used in developing the plan
- the risk of special-interest groups unduly influencing or capturing the planning process.

9.3.5 Such planning and co-ordination can occur on a voluntary basis when a specific need arises (eg, the Palmerston North City Council's Health Policy, November 1997). The motivation behind such voluntary planning may also help to overcome some of the key disadvantages (eg, finding adequate resources to support the process).

9.3.6 Also, the annual planning process set out in the Local Government Act 1974 already provides an opportunity for the development and maintenance of policies and programmes in relation to the public health responsibilities of local authorities.

Question 24: Do you consider that the new public health act should include a requirement for the development of local public health plans? Please explain your answer.

10 Surveillance, Monitoring and Reporting

10.1 Surveillance

10.1.1 The following are examples of some of the existing public health surveillance systems, currently operating in New Zealand (not all arise from legislation):

- *Surveillance of health conditions*
  - specified communicable diseases
  - cancers
  - birth defects
  - specified occupational diseases and injuries
  - Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome and Creutzfeld-Jakob Disease (HIV/AIDS and CJD)
- *Health hazard surveillance*
  - marine biotoxins in shellfish
  - drinking-water
  - food safety

10.1.2 There are many other hazard-related databases maintained by a wide variety of agencies, such as air quality monitoring by regional councils or data (based on applications to import or to manufacture) on hazardous substances and new organisms kept by the Environmental Risk Management Authority (ERMA). Other extensive databases on social and environmental conditions of relevance to health are maintained by agencies such as Statistics New Zealand.

10.1.3 Some of the current health registers provide valuable information on the health status of population groups and the success of particular health programmes, such as the cervical cancer screening programme provided for in the current Health Act 1956. Whether such registers require separate regulation or codes of practice will be addressed on an individual basis.

10.2 Monitoring of enforcement activities and public health risks

10.2.1 Consideration will be given to including provisions in the new public health act to enable information to be obtained from persons responsible for regulated matters and other specified agencies or sectors (such as local government, consumer affairs, transport, agriculture and forestry) on services, activities, goods and things which

relate to public health risk. Specification of reporting agencies and the information required is likely to be provided by way of regulation or standard. However, the collection and provision of such information is not a costless exercise, and any requirements in this regard will take into account the benefits and costs of information gathering and reporting.

10.3 Reporting

10.3.1 The Director-General of Health is currently required, under the Health Act 1956 (section 3C), to provide the Minister with an annual report on the state of the public health. This report in its current form, *Progress on Health Outcome Targets* (cf Ministry of Health 1997c), focuses on monitoring progress towards specified public health targets. The Minister is required to table this report in Parliament. In addition to an annual report, a five-yearly comprehensive report on population health status and on the major determinants of health outcomes forms part of this 'state of the public health' monitoring cycle. There are also in-depth reviews of individual topics which contribute to the provision of public health information.

10.3.2 If provisions for such reports are continued, it is anticipated that they will need to support the risk management framework proposed (see discussion in *Public Health Risk Management*) for public health legislation.

Question 25: Please indicate whether or not you consider reports on the state of public health (which focus on risk analysis) in New Zealand should be a statutory requirement? Please explain your answer.

Appendix One – Related Reviews in Progress

The public health legislation review will also influence and be informed by separate complementary reviews in progress. Some of the key reviews are identified below.

Health sector

- Water Supply Protection Regulations 1961: This review was commenced in 1997 by the Ministry of Health to address the fragmented, outdated and inadequate public protection provided by the existing Regulations.
- Food administration review: This review was commenced in 1997 and seeks to harmonise the food regulatory functions of the Ministry of Agriculture and Forestry and the Ministry of Health.
- Reform of health sector occupational registration: This review will reform the health-related occupational regulation statutes in a manner similar to the Medical Practitioners Act 1995.
- Consumer Safety Project: The Ministry has completed a review of the legislation that relates to rest-home and hospital licensing and to registration of homes for people with disabilities. A new Act to eliminate unnecessary duplication and to place responsibility for service safety will come into effect from 1 July 1999.
- Therapeutic Products Bill: Drafting instructions were prepared in 1994, but as there was no legislative priority the Bill did not proceed. The Minister is seeking revalidation of the 1994 decisions. The Bill aims to regulate products intended for therapeutic benefit under three broad categories: medicines, medical devices, and dietary supplements. The Bill will remove unnecessary requirements by focusing regulatory interventions on risk assessment, improve information for consumers, and enable closer co-operation with overseas jurisdictions.
- Radiation Protection: The Ministry is currently considering future structural arrangements for the delivery of radiation protection functions.

Other sectors

- An Emergency Management Unit has been established within the Department of Internal Affairs to establish a new Ministry and to commence initial policy work, including a substantial reform of relevant emergency management legislation (primarily the Civil Defence Act 1983).

- Ministry for the Environment: The Hazardous Substances and New Organisms Act 1996 is being implemented during 1998 to 'protect the environment, and the health and safety of people and communities, by preventing or managing the adverse effects of hazardous substances and new organisms'.
- The Ministry for the Environment is reviewing the Resource Management Act 1991 regarding national standards and guidelines.
- The Building Industry Authority and the Department of Internal Affairs are reviewing their respective roles in relation to drinking-water.
- The Building Industry Authority is reviewing the sections of the Building Act 1991 as they relate to dangerous and insanitary buildings.

Appendix Two – Current Roles and Responsibilities

This appendix provides a brief summary of the agencies and officers with current statutory roles and responsibilities relating to public health. It also identifies examples of other agencies and organisations which contribute to achieving public health goals, objectives and targets relating to improving, promoting and protecting public health.

Ministry of Health

The Ministry of Health's roles are strategic policy advice, monitoring the funder, Ministerial servicing and administering legislation. The latter role includes administration of public health legislation (section 3B Health Act 1956). The Ministry of Health has the function of improving, promoting and protecting public health. The Ministry's Public Health Group must institute a programme of regular consultation with such members of the public, persons involved in the provision of public health services, and other persons the Director-General of Health (after consultation with the Minister) considers appropriate (section 3F Health Act 1956).

The Director-General of Health and the Director of Public Health are employed in the Ministry of Health with specific statutory functions. For example, the Director-General has to report annually on the current state of public health and designates statutory officers (eg, Medical Officers of Health and Health Protection Officers). The Director of Public Health is required to advise the Director-General of Health on public health matters and may also advise the Minister of Health and provide reports on public health matters.

Health Funding Authority

The Health Funding Authority is required to improve, promote and protect the public health. It is responsible for monitoring the need for, and purchasing Crown-funded public health services (including some public health regulatory services).

Public health services

Currently, public health services are provided predominantly by Hospital and Health Services, with some private companies in a contracted or subcontracted capacity as well. The focus is on achieving health outcomes and improving the health status of the populations the providers serve.

Designated officers (eg, approximately 20 Medical Officers of Health and 120 Health Protection Officers) are employed by Crown-funded public health services to carry out a range of statutory and non-statutory activities to improve, promote and protect public health.

Designated officers have a statutory accountability to the Director-General. They receive information from, and work co-operatively with, local government and other agencies. Designated officers largely carry out functions under legislation administered by the Ministry of Health, such as the Health Act 1956, the Food Act 1981, the Toxic Substances Act 1979 (to be replaced with responsibilities under the Hazardous Substances and New Organisms Act 1996 when the relevant parts of that Act come into force), and the Smoke-free Environments Act 1991.

Territorial authorities (city and district councils)

Territorial authorities have a duty to improve, promote and protect the public health in their district (section 23 Health Act 1956). Environmental health officers and other officers with public health responsibilities are employed by territorial authorities. There are approximately 220 environmental health officers employed in New Zealand. They receive information from, and work co-operatively with, public health services and other agencies. Some territorial authorities do not employ officers directly but instead contract these services from other territorial authorities, public health services or private providers.

Functions undertaken can be divided into three broad categories:

- registration of premises or issuance of licences to trade
- complaints investigation and enforcement
- education, monitoring and advisory services.

Often, territorial authority staff will also carry out functions under legislation administered by agencies other than the Ministry of Health. Some examples are licensing inspectors under the Sale of Liquor Act 1989, building officials under the Building Act 1991, and enforcement officers under the Resource Management Act 1991.

Other agencies

A number of other agencies and organisations contribute to achieving public health goals, objectives and targets relating to improving, promoting and protecting public health. Examples are shown below to demonstrate the breadth of involvement by other agencies and organisations.

- Ministry of Transport and the Police have activities aimed at reducing road traffic crashes and including promotion of safe driving, use of seatbelts and motorcycle/bicycle helmets, prevention of drunk driving and excessive speeding.

- Department of Social Welfare is involved via its policy on income support, accommodation supplements and other support for low-income families and individuals.
- Ministry of Agriculture and Forestry plays a significant role in areas such as food safety, biosecurity, and food security, which complements that of the Ministry of Health.
- Te Puni Kökiri includes Mäori health in its work on Mäori development. Te Puni Kökiri has a statutory responsibility to monitor the adequacy of government agencies' service provision for Mäori (Te Puni Kökiri 1997).
- Ministry for the Environment and regional councils' work to encourage sustainable use of natural resources and to avoid, remedy or mitigate adverse effects on the environment will also benefit public health.
- A number of statutory and/or advisory boards and committees are established to advise the Minister of Health and/or the Director-General of Health on public health issues. These include the Radiation Protection Advisory Council, the Infectious Diseases Advisory Committee, and the Food and Nutrition Advisory Committee.
- Non-government organisations undertake non-regulatory activities which improve, promote and protect public health, not only through contracts with the Health Funding Authority, but also through their own initiatives. Examples of such organisations are the AIDS Foundation, Heart Foundation of New Zealand, Cancer Society, Plunket Society and the Mäori Women's Welfare League.

Appendix Three – An Example of the Need for Statutory Co-ordination

The following extracts and comments illustrate the point that there are currently a number of statutes and regulations that regulate the provision of safe and adequate drinking-water supplies. This arises from the need to regulate drinking-water supplies in different settings or situations (eg, buildings and workplaces) and the limited scope of the various legislation.

Drinking-water Supply for Buildings – Building Act 1991 and the New Zealand Building Code

Section 7 of the Building Act 1991 states:

> ALL BUILDING WORK TO COMPLY WITH BUILDING CODE –
> (1) All building work shall comply with the building code to the extent required by this Act, whether or not a building consent is required in respect of that building work.
> (2) Except as specifically provided to the contrary in any Act, no person, in undertaking any building work, shall be required to achieve performance criteria additional to or more restrictive in relation to that building work than the performance criteria specified in the building code.

The New Zealand Building Code is the First Schedule to the Building Regulations 1992. Clause G12 of the Code (also under review) provides the objectives, functional requirements and performance criteria for water supplies. *In relation to buildings*, the Code and further provisions of the Act (particularly those relating to dangerous or insanitary buildings) enable prompt and effective enforcement action to be taken for the purposes of safeguarding people from injury, illness or loss of amenity.

Drinking-water Supply for Employees in Workplaces – Health and Safety in Employment Act 1992

Section 6 of the Health and Safety in Employment Act 1992 states:

> 'EMPLOYERS TO ENSURE SAFETY OF EMPLOYEES –
> Every employer shall take all practicable steps to ensure the safety of employees while at work; and in particular shall take all practicable steps to –
> (a) Provide and maintain for employees a safe working environment; and
> (b) Provide and maintain for employees while they are at work facilities for their safety and health; and …'

Section 8 of the Health and Safety in Employment Act 1992 states:

> 'SIGNIFICANT HAZARDS TO EMPLOYEES TO BE ELIMINATED IF PRACTICABLE –
> Where there is a significant hazard to employees at work, the employer shall take all practicable steps to eliminate it.'

Regulation 8 of the Health and Safety in Employment Regulations 1995 states:

> DUTY IN RESPECT OF DRINKING WATER –
> Every employer shall take all practicable steps to ensure –
> (a) That drinking water is provided for employees at every place of work under the control of that employer; and
> (b) That any such drinking water is wholesome; and
> (c) That the amount of any such drinking water is sufficient, having regard to the number of employees in the place of work and the nature of the place of work; and
> (d) That all employees have access to any such drinking water in a way that is convenient to them.

Therefore, in workplaces, these and other provisions of health and safety in employment legislation enable prompt and effective enforcement action to be taken for the purposes of ensuring the health and safety of employees. Arguably there are elements of duplication between the building and health and safety legislation. However, for the purposes of this example, consider the protection afforded employees at a workplace that does not involve a building.

Drinking-water Supply Other than for Buildings or for Employees in Workplaces – Public Health Legislation

It follows that, if a drinking-water supply is assessed as a risk to public health, and the supply is not associated with a building or employees in a workplace, it would then be appropriate for this risk to be captured by the risk-management provisions of public health legislation.

Appendix Four – Examples of Regulatory Processes

An example of how provisions of new public health legislation may work for some regulated matters can be seen in existing legislative models such the Building Act 1991 and the New Zealand Building Code.

Simplified example of how new public health legislation might apply to a public health risk associated with hairdressing

Statutory Provisions and the Regulatory Authority Function

Act makes provision for regulations which may include a risk management code. A regulatory authority has the power to make determinations and to approve 'verification methods' and 'acceptable solutions'. The regulatory authority, or its delegate(s), determines consents in relation to regulated matters.

Risk Management Code Clause

Code clause provision in relation to preventing the spread of communicable diseases*:*

***Objective*:** to prevent the transmission of disease.
***Functional requirement*:** sterilise equipment before use on clients.
***Performance measure*:** equipment free from pathogens.

Acceptable Solution

Sterilise equipment by thoroughly cleaning and then soaking in a 70% alcohol solution for 10 minutes.

Public health risk criteria

To avoid capturing trivial matters, a process for determining which matters require consents would be necessary. This might include the development of threshold criteria for the nature or level of risks that would be subject to coverage by such a process. Furthermore, where adequate legislative protection is already in place (eg, occupational regulation or the Consumer Guarantees Act 1993), controls on matters would not be duplicated.

Independent auditors could then be engaged by the consent holder to verify ongoing compliance with the relevant requirements. The use of such auditors and consents would help to minimise unnecessary compliance costs and provide incentives for the appropriate and adequate management of risks to public health.

Incentives to comply

Incentives to comply would be relative to the degree of public health risk and include mechanisms to quantify the risk. Incentives may include avoiding penalties, reduced audit costs, an ability to innovate, ownership of the process, liability for damages, claims, consumer confidence and so on. The onus to prove compliance would rest with the consent holder in the first instance rather than an onus to prove non-compliance resting with the enforcement services.

It is proposed that there will be an ability to require the abatement or alteration of products, conditions, situations, activities or things which may be a risk to public health and not covered by other legislation. (See also the discussion in *Co-ordination with Other Laws*.)

Advantages and disadvantages

The advantages of this model were well explored during the development of other legislation which uses this approach. The key advantages for adopting this model in a public health act include:

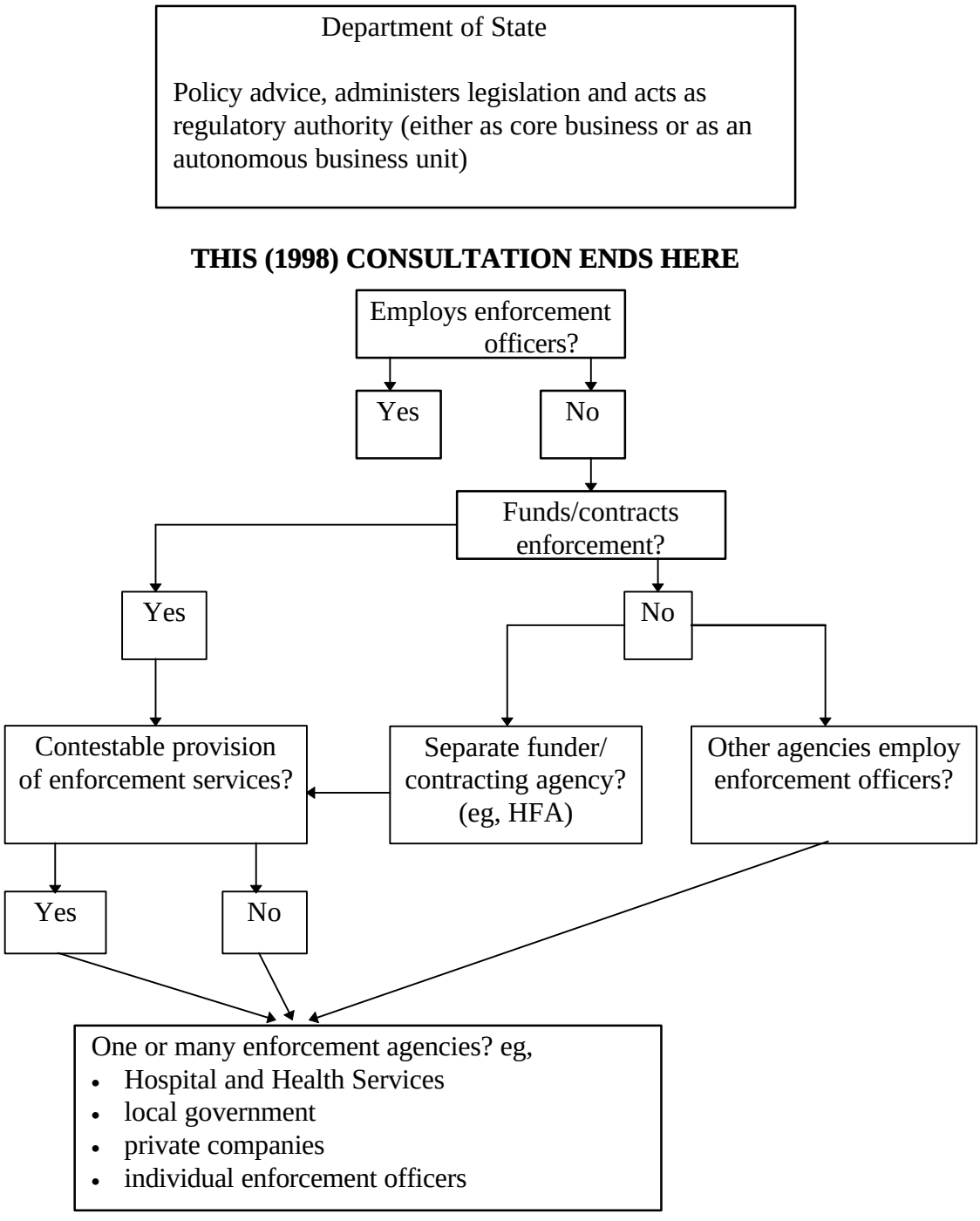
- flexible controls which should be based on actual hazards and be appropriate to the level of risk
- national consistency through the development of outcome-focused legislation
- provision for innovative solutions to be developed and implemented by the consent holder
- successful operation within other sectors
- built-in risk-management philosophy
- consent holder responsibility for compliance
- requirement for ongoing compliance to be demonstrated
- reduced enforcement costs.

The key disadvantage of this option is:

- increased compliance costs for operators, owing to the need to improve risk management and to employ approved auditors.

Appendix Five – Future Enforcement Decisions

The following decision tree is presented to indicate that the proposed regulatory framework can be implemented, and to identify some of the decisions to be made in relation to funding/contracting and enforcement service arrangements. It does not indicate that these decisions have been made.



Appendix Six – Consultation Questions

Question 1: Under what circumstances do you consider it is necessary to legislate for public health? Please provide information (explanation or references) to support your answer.

Question 2: Do you agree with the proposed purpose? If not, please explain why and suggest amendments or an alternative purpose.

Question 3: Do you agree with the statements of what should be included in a core public health statute? Please suggest additions, deletions or amendments to what is discussed and explain your answer.

Question 4: Please explain what, if any, legislative provisions you consider are needed to support public health advocacy in relation to the statutory functions of other sectors and why they are needed.

Question 5: Please supply details of statutory duplication you consider ought to be eliminated or retained. Where you wish it to be retained, please give reasons and details of the circumstances you consider one statute should be applied in preference to the other.

Question 6: Do you accept that the exercise of public health powers may sometimes override individual human rights, such as the right to refuse medical treatment? Please explain your answer.

Question 7: If public health powers can override individual rights, what checks should be included in the new public health act to ensure the powers are not exercised arbitrarily?

Question 8: Who or what do you consider is the appropriate authority (eg, District Court Judge) to review the case for detaining a person for the purposes of managing a public health risk, to ensure that detention is not arbitrary?

Question 9: Do you consider the new public health act should impose a duty on all persons exercising powers, functions and duties under the Act to take into account New Zealand's international public health obligations? Please explain your answer.

Question 10: Do you agree with the general duty, as expressed, to consider alternatives and assess benefits and costs prior to the exercise of powers relating to significant risk management functions? If not, please explain why and suggest changes.

Question 11: Please indicate any additions, deletions or alterations you consider should be made to the 'menu of interventions'. Please explain your answer(s).

Question 12: Do you consider there are other important issues to be addressed in the context of a risk-management framework? If so, please identify them and provide text to assist their consideration.

Question 13: Do you agree with including a provision in the new public health act enabling requisitions to be made to ensure safe and sufficient infrastructural services of particular public health significance? If so, please explain which services and why. If not, please explain why.

Question 14: Do you consider the new public health act should provide for a precautionary approach to managing potential public health risks? Please explain your answer.

Question 15: Do you consider declaration of public health emergencies (which are not civil defence emergencies) is necessary? Please explain your answer.

Question 16: Do you consider special powers are required for a public health emergency? If so, what situations do you consider should be added to, or deleted from, the list of situations in which special powers are needed? If not, please explain your answer.

Question 17: Do you consider there are risks covered by other legislation which may require direct public health action upon default by another sector? If so, please explain which risks and under what circumstances you consider such action is warranted. If not, please also explain your answer.

Question 18: Are there any steps in communicable disease risk management or aspects of communicable disease control that you believe should be added to or deleted from those identified in this document? Please explain your answer.

Question 19: Please indicate any additions, deletions or changes you consider should be made to the list of criteria to be used to determine which diseases and syndromes ought to be notifiable? Please explain your answer(s).

Question 20: What do you consider is the most efficient process for requiring diseases or syndromes to be notified? Please explain your answer.

Question 21: Please comment on the preferred configuration for functional components to help to identify options for enhancement that may have been overlooked in the analysis to date.

Question 22: If you wish, please provide advice on your preferred alternative configuration of functional components and state the advantages and costs/risks associated with that alternative in a format similar to that used above (to aid comparison).

Question 23: Do you consider that the new public health act should include a requirement for consultation as part of the public health policy process? If so, please explain why and indicate how this requirement should be framed. If not, please explain why and identify alternative means of enabling wide participation in policy processes.

Question 24: Do you consider that the new public health act should include a requirement for the development of local public health plans? Please explain your answer.

Question 25: Please indicate whether or not you consider reports on the state of public health (which focus on risk analysis) in New Zealand should be a statutory requirement? Please explain your answer.

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Glossary

ANZFA: Australia New Zealand Food Authority.

Approved auditors: independent individuals approved by the regulatory authority and employed, by persons responsible for a regulated matter, to carry out audits and to certify that legislative requirements have been met.

Audit: a formal examination of the services performed, the performance of systems, management, and the accountabilities of the personnel providing the service.

Communicable diseases: diseases capable of being passed from one person to another.

Contact tracing: identifying and seeking out those people who have been in contact with a person with a communicable disease, with a view to controlling spread of the disease by either diagnosing and treating further cases, or providing protection such as preventive treatment or immunisation.

Contaminant: includes any substance (including gases, liquids, solids and micro-organisms) or energy (excluding noise) or heat, that either by itself or in combination with the same, similar or other substances, energy or heat may adversely affect health either directly because of its hazardous properties, or indirectly through contamination of the air, water, soil or food.

Designated officer/s: A Medical Officer of Health, Health Protection Officer, Smoke-free Officer or other officer designated or appointed by the Director-General of Health under the Health Act 1956 or other legislation for the purposes of enforcing legislation.

Director of Public Health: a statutory position established by the Health Act 1956 providing for a number of functions including independent provision of advice to the Minister on public health matters. The Director is employed within the Public Health Group of the Ministry of Health.

Director-General of Health: the chief executive officer of the Ministry of Health, charged with a number of statutory powers, functions and duties under public health (and other) legislation.

Dose-response assessment: a determination of the degree of health effects at different doses of a hazard.

Effects: include:

- any positive or adverse effect
- any temporary or permanent effect
- any past, present or future effect
- any cumulative effect which arises over time or in combination with other effects, regardless of the scale, intensity, duration, or frequency of the effect, including:

- any potential effect of high probability
- any potential effect of low probability which has a high potential impact.

Enforcement: the means of giving effect to and achieving compliance with the law.

Enforcement officer: competent individual appointed by the regulatory authority to enforce the legislation.

Environmental health: a subcategory of public health which focuses on environmental conditions and hazards which affect, or have the potential to affect, human health, either by direct or indirect means. It is the art and science of the protection of good health, the promotion of aesthetic, social, economic, cultural, and amenity values, and the prevention of illness and injury through the fostering of positive environmental factors and the reduction of potential hazards – physical, biological and chemical.

Epidemiology: the study of the distribution and determinants of health-related states or events in specified populations

ERMA: Environmental Risk Management Authority. A regulatory authority established under the Hazardous Substances and New Organisms Act 1996. ERMA's primary function is to assess and attach controls to hazardous substances and new organisms.

Exposure assessment: an estimation of the magnitude, duration and frequency of exposure to hazards, and the numbers of people exposed via different pathways.

Goal: a general aim to which to strive.

Hazard: a source or situation of potential harm.

Hazard identification: an assessment of the available evidence on the presence and hazards of matters likely to cause adverse effects.

Health district: a part of New Zealand established by the Director-General of Health for the administration of public health regulatory services.

Health Funding Authority (HFA): (formerly the Transitional Health Authority and prior to that, four separate regional health authorities) established under the Health and Disability Services Act 1993 to fund and contract for the provision of public health and personal health and disability services on behalf of the Crown.

Health protection officer (HPO): an officer designated by the Director-General of Health to undertake statutory functions and the exercise of statutory powers and responsibilities attached to that position.

Health status: a set of measurements which reflect the health of populations. The measurements may include physical function, emotional wellbeing, activities of daily living etc.

Hospital and Health Service: previously a Crown health enterprise (CHE): a company formed and registered by the share-holding ministries in accordance with section 37 of the Health and Disability Services Act 1993.

HSE: Health and Safety in Employment Act 1992. This Act is administered by the Department of Labour and enforced by the Occupational Safety and Health Service (OSH).

HSNO: Hazardous Substances and New Organisms Act 1996. This Act is a risk management statute focusing on assessing and managing hazardous (ie, toxic, eco-toxic, corrosive, flammable, explosive and oxidising) substances and new organisms. It is administered by the Ministry for the Environment and enforced by ERMA and a number of separate Departments of State and territorial authorities.

Intervention: a specific measure or activity designed to meet a programme, policy or legislative objective.

Kaitiaki: caregivers and guardians.

Legal proceedings: enforcement action taken against individuals or businesses for non-compliance with statutory requirements under public health legislation. The enforcement process involves evidence gathering, briefing of counsel, preparation for and/or attendance at formal statutory hearings or court proceeding, and prosecutions. The term also includes applications for committal of persons to obtain necessary medical care.

Legislation: Acts of Parliament (ie, statutes), Regulations, bylaws and in some cases formally recognised codes of practice, rules, standards or guidelines with legal status.

Local authorities / local government: district city and regional councils, or unitary authorities (see also territorial authorities).

Medical Officer of Health (MOH): an officer designated by the Director-General of Health to undertake statutory functions and to exercise the statutory powers and responsibilities attached to that position and who holds the requisite professional qualifications recognised under the Health Act 1956.

Monitoring: the performance and analysis of routine measurements, aimed at detecting changes in the environment, provision of services, delivery of outputs, or health status of populations.

Morbidity: illness.

Mortality: death.

Needle and Syringe Exchange Programme: a public health programme established by the Health (Needle and Syringes) Regulations 1987, pursuant to the Misuse of Drugs Act 1975 and the Health Act 1956, in which fresh disposable needle and syringe units are made available to injecting drug users at cost.

Notifiable disease: a communicable disease, sexually transmitted disease, or other medical condition of public health significance, notification of which is required by statute and the outbreak of which may be prevented, controlled or treated using the authority and powers particularly available under legislation.

OECD: Organisation for Economic Co-operation and Development. The OECD countries are Australia, Austria, Belgium, Canada, Czech Republic, Denmark, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Spain, Sweden, Switzerland, Turkey, United Kingdom, and the United States.

Ottawa Charter: the Charter developed and adopted by the first International Conference on Health Promotion held in Ottawa, Canada, in November 1986 under the auspices of WHO, Health and Welfare Canada and the Canadian Public Health Association. This Charter defines health promotion as the process of enabling people to increase control over, and to improve, their health. Health promotion actions means: building healthy public policy: creating supportive environments: strengthening Mäori and other communities' or people's action; developing personal skills and reorienting health services.

Personal health services: goods, services or facilities provided to an individual for the purpose of improving or protecting the health of that individual, whether or not they are also provided for another purpose.

Public health: depending on the context, either (a) the health status of populations (or sections thereof) or, (b) the science and art of preventing disease, prolonging life, and promoting health through organised efforts of society.

Public health services: depending on the context, either (a) services provided for the purpose of improving, promoting and protecting public health, or (b) goods, services or facilities provided for the purpose of improving or protecting the public health.

Regulated matter: services, activities, goods or things likely to give rise to significant risks to public health and which warrant controls.

Regulatory authority function: decision-making function with responsibility for the oversight and co-ordination of regulatory activities, including enforcement activities (may be a stand-alone agency or a component of another organisation).

Risk: the probability and magnitude of harmful consequences arising from a hazard. The likelihood of a specified undesired event occurring within a specified period or in specified circumstances. The probability of harmful consequences arising from a hazard. In quantitative terms, risk can be expressed in values from zero (no possible harm) to one (certainty that harm will occur). In relation to human health effects, risk is usually expressed as the probability (or likelihood) or dying or developing a disease or injury as a result of exposure to a hazard. For example, an acceptable health risk may be regarded as a one in a million lifetime risk of developing cancer.

Risk activity / risk good: see Regulated matter

Risk assessment: a widely used model to evaluate health hazards and conditions of human exposure to it in order to both ascertain the likelihood that exposed humans will be adversely affected, and to characterise the nature of the effects they may experience.

Risk characterisation: a combination of information obtained from the hazard identification, dose-response assessment, and exposure assessment to estimate the risk associated with each exposure scenario considered, and to present information on uncertainties in the analysis for risk management to proceed.

Risk communication: the process of establishing two-way communication, recognising that people's feelings and emotions are legitimate, involving people in making decisions that directly affect them, informing and advising Mäori and other communities or people about risks and their impact, and involving them in plans for managing the risk.

Risk factor: an aspect of personal behaviour or lifestyle, an environmental exposure or an inborn inherited characteristic that is associated with an increased risk of a person developing a disease.

Risk management: a process of setting priorities based on risk assessment, establishing efficient and consistent risk reduction policies (taking into account public perception of risk), evaluating the range of risk reduction alternatives (including the social, economic and cultural implication of options), identifying cost-effective risk reduction measures, and identifying risk mitigation and contingency measures.

RMA: Resource Management Act 1991: an effects-based statute focusing on sustainable environmental management. It is administered by the Ministry for the Environment and largely implemented by local authorities.

Sampling: the process of talking microbiological, chemical, or other specimens as part of a public health programme in order to test or monitor quality or public health risk.

Sexually transmitted diseases: infections spread by the transfer of organisms from person to person during sexual contact.

Statutory reporting: the reporting to authorities of statistical and other information about events and incidents significant to public health and which is required by law.

Surveillance: ongoing scrutiny, generally using methods distinguished by their practicability, uniformity, and frequently their rapidity, rather than complete accuracy. Its main purpose is to detect changes in trends or distribution in order to initiated investigative or control measures.

Target: an intermediate result towards the objective that a programme seeks to achieve.

Territorial authorities: city and district councils (see also Local authorities).

WHO: World Health Organization of the United Nations.