



Victorian AIDS Council Gay Men's Health Centre

including the Positive Living Centre

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**6 Claremont Street
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Mr Carlo Carli MP
Chairperson
Scrutiny of Acts and Regulations Committee
Parliament House
MELBOURNE VIC 3000

Dear Mr Carli

Public Health and Wellbeing Bill 2008

Thank you for the opportunity to make a submission to the Committee on whether the provisions in the Public Health and Wellbeing Bill 2008 unduly trespass on rights and freedoms or are incompatible with the human rights set out in the *Charter of Human Rights and Responsibilities Act 2006*.

The Victorian AIDS Council was formed in 1983 as the central part of the Victorian gay community's response to HIV/AIDS. In 1986 the Gay Men's Health Centre was formed to address the broader health needs of the gay community. Together, the Victorian AIDS Council and the Gay Men's Health Centre work to confront the continuing challenges of the HIV/AIDS epidemic and, increasingly, the gay community's broader health concerns. Our core work aims to preserve the independence, dignity and health of people with HIV/AIDS and to reduce the transmission of HIV. We are committed to social justice and social change.

In making this submission, we acknowledge that drafting modern public health legislation was always going to be a complex process in striking a balance between public health (and broader notions of the public good) and individual rights like autonomy and privacy. Our view is that the current Bill gets the balance right in most areas. However, we believe that it gets the balance wrong in a few areas and these are the focus of this submission to the Committee. We also acknowledge that the Bill is drafted to encompass all of the current and prospective risks to public health. However, our expertise is in the area of HIV/AIDS and sexually transmitted infections and it is this experience we have drawn on to frame this submission.

Information handling and disclosure

Clauses 55-57 and Clause 227

We remain concerned about the breadth of the disclosure powers in the Bill, particularly in relation to personal or health information about an individual. We have noted the comment in the Charter Statement that the Secretary and councils will be required to comply with Information Privacy Principle 1.3 when information is

collected from individuals under or for the purposes of parts 6 or 7 of the Act. It is unclear how this will work in practice or whether it will involve full disclosure that will be comprehensible to members of the public who may be affected.

In particular, we are concerned about the exchange of information between the Secretary and the police under Clause 56, particularly where that information was gathered by the Secretary or departmental staff without advising the person that the information may be provided subsequently to the police or that they have the right, bolstered by the provisions of Clause 212, not to provide information that would tend to incriminate them.

One simple means of redressing the imbalance here would be a requirement that, where the Secretary or a council discloses information that would identify an individual, that person must be advised in writing that the disclosure has been made, the nature of the material disclosed and the individuals to whom that material has been disclosed. We believe that such a requirement would be consistent with the general principles of health privacy and information privacy that people know where their personal health information is being used and who has access to it.

Public health orders

s.117

We are concerned that the coercive powers given to the Chief Health Officer under s.117 seem to require a lesser standard than similar powers given to the Secretary under s.120 of the *Health Act 1958*. A similar distinction can be drawn between the old Act and this Act in other areas, for example in the clauses relating to compulsory testing. The old act required that the Secretary had a reasonable belief before invoking the powers where the Bill only requires the Chief Health Officer to have a belief.

The Charter statement identifies a number of areas in which rights protected by the Charter are engaged by this section of the Bill.

We note that the drafting in Clause 117(1)(a) enables the Chief Health Officer to make an order where a person has an infectious disease or has been exposed to an infectious disease in circumstances where a person is likely to contract the disease. In 2003, the National Public Health Partnership published *Principles to be Considered When Developing Best Practice Legislation for the Management of Infected Persons Who Knowingly Place Others at Risk*. That document at p.7 recommended that orders for examination or testing should be based on the formulation set out in Clause 117(1)(a) but the more restrictive orders set out in Clause 117(5) should normally be restricted to a person who is known to be infected with a particular disease. Given the restriction on Charter rights authorised by Clause 117, we submit that these orders should only be made if a person is known to be infected with a particular disease. Making such orders on the basis of a supposition unduly trespasses on peoples rights and is incompatible with the rights set out in the Charter, in particular the right not to be subjected to medical treatment without one's full, free and informed consent.

s.117(5)(i)

The November 2005 draft policy paper *Review of the Health Act 1958* in recommendation 120 (b) at pp.69-70 proposed a number of exceptions to the power to administer prophylaxis, including vaccination. As the Bill is drafted, none of these exceptions is included. It is our submission that the failure to include these exceptions, particularly the exception in relation to conscientious objection, unduly trespasses on peoples rights and is incompatible with the rights set out in the Charter, in particular the right not to be subjected to medical treatment without one's full, free and informed consent.

s.117(5)(j)

We do not support a power to *compel* people to take HIV treatments. We would also draw a distinction between treatment that is curative (e.g. treatment for Chlamydia) and treatment that is non curative (e.g. treatment for HIV). There are no circumstances in which we would support compulsory treatment for HIV given that it is non-curative and comes with significant metabolic side-effects. In our view, any legislative approach to mandated treatment should contain a conscientious opt-out clause and should specifically *not* include HIV treatments. We are particularly concerned that the Charter statement states that the purpose of requiring a person to undergo treatment "is to reduce the risk the person would otherwise pose to public health" (page 12 in our print). In our submission, any legislative provision that does not give primacy to the question of whether the treatment will benefit the individual concerned and whether the treatment is clinically indicated for the person concerned unduly trespasses on peoples rights and is incompatible with the rights set out in the Charter, in particular the right not to be subjected to medical treatment without one's full, free and informed consent.

For example, in February 2008, the Swiss National AIDS Commission published an article about safer-sex practices. Specifically, the Commission stated that HIV-positive people are not at risk for transmitting HIV to their partners if they meet all of the following requirements:

- * they are adherent to highly active antiretroviral therapy (HAART)
- * their viral load in the blood is consistently below the lower level of detection (usually 40 copies in Australia)
- * they are in a "stable relationship"
- * they do not have any sexually transmitted infections (STIs).

If this statement is accepted (and it is the subject currently of vigorous debate in the HIV community), it could be argued that compelling people living with HIV (who meet the other criteria) to take antiretroviral drugs would reduce the risk those people would otherwise pose to public health, even though taking treatment at that point might not otherwise be clinically indicated for them.

In making these comments, we note that force cannot be used to compel people to take treatments. However, failure to comply with an order would leave a person open to convictions, to rolling fines, and to an escalation of the orders.

In our view, it is possible to go some way to addressing the imbalances here. It is likely that these orders will be used irregularly. We believe that orders in relation to HIV under the previous Act were made on average twice a year for the past decade or so. Even adding in TB orders, it is unlikely that the total number of orders would be more than one per month. In those circumstances, we submit that the Chief Health Officer should be required to provide a person with a statement of reasons for the order when the order is made, rather than providing a right to a statement of reasons on request (Clause 122). The Act already provides at Clause 117(3) for information to be included in the written notice of an order. A comprehensive statement of reasons would enable the person to understand why the order had been made, what factors had been considered in deciding to make the order, what weight had been given to each of the factors set out in Clause 117(2), and how the decision complied with the Principles set out in Part 2 of the Act. Such a statement would also reinforce the seriousness of the order and add further weight to the discussions that had occurred to comply with Clause 117(1)(d).

Pre and post test information

ss.131, 132

Part 8 Division 2 provides for compulsory testing orders and would apply to HIV tests. Clauses 131 and 132 only require the provision of pre and post test counselling for a person who has requested an HIV test. Pre-test counselling is much more comprehensive than the information specified in Clause 113(e) and post test counselling is much more comprehensive than the information specified in Clause 115. It is our submission that people who will be subjected to an involuntary test will need as much information as a person requesting a test and failing to provide them with this information unduly trespasses on their rights and is incompatible with the rights set out in the Charter, in particular the right not to be subjected to medical treatment without one's full, free and informed consent.

We submit that this anomaly could be corrected by deleting "who has requested the test" in Clause 131 and substituting "who has been tested for HIV" for "who requested a test for HIV" in Clause 132.

Compulsory provision of information

s.188

In our submission the broad drafting of this Clause makes it inevitable that it unduly trespasses on peoples rights and is incompatible with the rights set out in the Charter, in particular the right to have one's privacy interfered with. Our particular concern is that it may enable a Chief Health Officer to require a medical practitioner or other health service provider to provide medical records or counseling notes that could then, under the powers granted to the Chief Health Officer under Clause 56, be handed over to the police. At present, police would need to provide the competent authority with the necessary basis to obtain a search warrant before they could get access to such information. Clause 188 as drafted provides none of the protections that would apply in the case of a search warrant; there is no requirement

to explain why the information/documents are required; there is no process for sealing the records and challenging the order; there are no designated review/appeal mechanisms.

In our view, having this provision drafted as broadly as it is, works against the purpose of the Act as well as being a breach of Charter rights. If people living with HIV/AIDS believe that this Act will enable the Chief Health Officer to obtain their medical or counseling records and make them available to the police, there will be a strong disincentive to testing for HIV and for seeking assistance if the person is having difficulties maintaining safe sex practices. Many more cases of inconsistent safe sex practices are “managed” effectively by support and ongoing assistance from general practitioners, counsellors and community services than are managed by the application of the provisions in the Health Act. In our submission the breadth of Clause 188 has a serious potential to keep people away from those services.

Public hearings

If your committee believed it was useful, I would be available to give oral evidence to the Committee.

Yours sincerely

Mike Kennedy
Executive Director