

**SCRUTINY OF ACTS AND REGULATIONS COMMITTEE**

**Inquiry into Public Health and Wellbeing Bill**

Melbourne — 4 June 2008

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Witness

Mr M. Kennedy, executive director, Victorian AIDS Council, Gay Men's Health Centre (affirmed).

**The CHAIR** — The next witness will be Mr Mike Kennedy, the executive director of the Victorian AIDS Council. Mr Kennedy, thank you for attending these hearings. This is a hearing in regard to the Public Health and Wellbeing Bill. The committee is seeking written and oral evidence as to whether provisions in the proposed laws constitute undue trespass to rights and freedoms and whether the provisions are incompatible with the rights set out in the charter of human rights and responsibilities. Anything you say or publish before the committee today is protected by parliamentary privilege. However, once you leave the hearing anything you say or publish outside this room is not so protected. In the next day or two you will be provided with a draft copy of the transcript of your evidence. You will have the opportunity to correct anything that the Hansard reporters may not have correctly recorded. However, it is not an opportunity to put anything additional to what was actually said by you at these hearings.

I would like to invite you now to make a statement to the committee on the relevant issue that you see may be involved in this proposed legislation. Following your opening statement, members of the committee may have questions they wish to put to you. The committee has determined that it will take sworn evidence. Can you state the name of your organisation and your position?

**Mr KENNEDY** — I am the executive director at the Victorian AIDS Council / Gay Men's Health Centre. Thank you very much for the opportunity to give evidence to the committee. There is a written submission there. The point that I would make is that the basis for our concerns about the bill that we have set out in the submission is the issue of balance — the balance between the use of the power of the state and the rights of individuals — which goes directly to the issues that this committee is looking at.

What I did want to say that is not in the submission is that the underpinning consideration with the submission is that — and it is something that is not often talked about openly — the response to HIV in Australia has been built on what we would refer to as an informal compact with people living with HIV/AIDS; so preventing HIV transmission, we have said, should be a shared responsibility between two people. But the reality is that it is not an equal responsibility. The compact with PLWHA, People Living with HIV/AIDS, is that they will act in a way that prevents transmission to others, with, I suppose, the Crimes Act as the fallback position if they act in a way that puts other people at risk. We know from a good amount of social research in Australia that knowing your HIV status has an HIV-preventive effect — that is, that overwhelmingly most people living with HIV/AIDS will take the steps that are necessary to prevent transmission once they know that they are infected. In return they expect that they will not be stigmatised or discriminated against or have their rights unnecessarily intruded upon. For them, confidentiality and privacy are the key issues because there is still significant discrimination.

The difficulty, I think, that the drafters of the legislation and this committee face is that if people with HIV believe that that compact will break down — it does not necessarily need to break down, but if they believe it will break down — they are therefore less likely to be tested for HIV. They are also — and this would be our concern — less likely to seek assistance if they are experiencing difficulty in maintaining safe-sex practices. That belief is affected by three key factors: what is in the act, how the chief health officer or the secretary apply the provisions and the powers that are given in the act, and then the media treatment of particular cases. We have seen recently here and elsewhere a kind of moral panic around these cases that does not make people living with HIV feel secure and protected. The consequence of the breakdown of that informal compact, we think, could be a worse outcome for public health if people either do not test or do not seek help if they are having difficulty maintaining safe sex or for that matter safe injecting practices than would occur if there were one or two outliers in the PLWHA community who were acting in a way that was putting other people at risk. That is the underlying assumption that sits behind the four areas that we have referred to in the submission. I am happy to take questions in relation to any of those. There are two other issues that have arisen since we did the submission that I would not mind briefly touching on if we have time. I can link one of those at least back to a clause in the act. The other one I had difficulty with because it was something that is not in the act that we believed should be and it was raised in the policy paper that the department had circulated before the act was drafted.

**The CHAIR** — If they are within our terms of reference, I think it would be good to get you to just outline them.

**Mr KENNEDY** — The difficulty I had and why it was not in the submission is that I was having difficulty getting it within the terms of reference. I think in the couple of days since I have put it in I have managed to wrestle it in.

**Mrs PEULICH** — And Mr Burnside did not broaden it in his earlier comments?

**Mr KENNEDY** — I think the areas that it engages with are the charter right in relation to medical treatment, the charter right in relation to privacy or having your home interfered with, and the charter right in relation to freedom of movement. It relates to a section in the draft policy paper that the department produced in November 2005, and it refers to the partner notification officers, more commonly referred to as the contact tracers. Those officers in DHS are the primary point of contact between people living with HIV and the operations of this act. The November 2005 draft policy paper suggested bringing their powers and their actions in under the act, and that is set out in the discussion paper at pages 85 to 87.

Most of the submissions that were made in response to that draft policy paper supported that action being taken to provide some clarity. That has not been done. It is not in the bill. There is nothing in any of the material that is publicly available as to why that would be. It is not clear to us whether their actions are covered by clauses 189 and 190 of the bill, which refer to the powers of authorised officers. What the discussion paper proposed was that the powers that the contact tracers could exercise when they were dealing with a person with HIV could be counterbalanced by a set of limitations, I suppose, as to how that information could be used, and, in particular, that information that was gathered could not be accessed under any order of a court except to meet a purpose of the proposed Public Health and Wellbeing Act, and could not be used in any proceedings except ones that related to the proposed act. I think that goes to the first point that we have made in relation to the submission about our concern about the information handling and disclosure provisions that are in the current bill.

The second one specifically relates to clause 134 in division 5 of the act. It is an old provision. It is a provision that was introduced when the amendments were made in 2005, I think it was, to the old Health Act, and it relates to orders for tests. We made a submission to the department at the time that we thought that was a bad provision. We also suggested at the time that one of the counterbalances might be to require reporting on when the provision had been used. That was not taken up at the time. We are very pleased to see that the current bill does require that where these coercive powers are used, they will need to be reported.

What seems to me to be a very strange position is that if I went into hospital for surgery, for example, and there was some kind of medical misadventure and I was unconscious or in a coma, my partner — who has an enduring medical power of attorney for me — could on my behalf make a decision that a not-for-resuscitation order was to be put in place or that I was to be disconnected from a respirator, for example. It seems to me, though, that clause 134, and particularly clause 134(1)(b), would say that I could have an HIV test and it would override that enduring medical power of attorney. So my partner with the power of attorney could do quite extreme things in relation to my medical treatment but would not need to be consulted if either the chief health officer or a medical officer in the hospital decided that I needed to be tested for HIV. That seemed to us to be bizarre at the time. It still seems to us to be bizarre now. We have no information that would allow us to understand how many times it has been used, if at all, but on the face of it, it does seem to us to call into question the medical treatment provision that is in the charter.

**The CHAIR** — Thank you, Mr Kennedy. Again, I will open up to any questions or clarifications.

**Mr BROOKS** — Mr Kennedy, thank you for attending today. Just in relation to the submission you have made, one of your concerns — and I suppose you spoke broadly of the issues in your verbal presentation then — is in relation to provision of information to the police, for example. Proposed section 9 of the act essentially says that:

Decisions made and actions taken in the administration of this Act —

- (a) should be proportionate to the public health risks sought to be prevented, minimised or controlled; and
- (b) should not be made or taken in an arbitrary manner.

Section 38 of the charter of human rights talks about the need for a public authority to act compatibly with a human right unless another law makes it reasonable to act differently. I am wondering whether those clauses combined provide you with a level of comfort around those issues that you have raised in your submission.

**Mr KENNEDY** — They do not. In making that response, I looked not just at the Michael Neal case, which I do not particularly want to comment on because it is currently before the courts, but also at the Stuart McDonald case in South Australia and the Hector Scott case in the ACT. I would not do the chief health officer's job for any salary at all. I think they are in an impossible position. If they act too early, then people like me

castigate them for trampling on people's rights, and if they act too late, then everybody says they are not doing their job in protecting public health. I would not want to do that job. The reality is, though, that often these cases — and they are extreme cases — happen at a time when there is pressure on the minister, if the cases are public, and when there is often moral panic in the media, and I think that does influence decisions.

In the Stuart McDonald case in South Australia, Stuart McDonald found himself detained in a psychiatric hospital for a period of time, and when the matter finally got to the court, it ordered that he be released immediately and since then has significantly subsequently reduced the conditions that apply. I think if I were the chief health officer, I would probably use whatever the powers were that were in the act to a degree where I thought the minister was not going to sack me and the media was not going to attack me on the front page of the *Age*, and then allow the courts to deal with the consequences of that.

At a population level that is probably okay, but if I were the person sitting in a secure psychiatric facility waiting to be able to exercise my rights, then I would probably not feel that way. I think these powers are going to be used irregularly. They are mostly going to be used for HIV and TB. We have suggested that rather than giving people a right to ask for a statement of reasons, a statement of reasons ought to be provided. At that stage if I am locked in a secure psychiatric facility, then at least I might be able to understand how those sections of the act, that suite of things that you are saying would give me some satisfaction if I knew they had been properly considered, had been taken into account in arriving at that decision. Otherwise, I do not think if I were on the receiving end of it I would necessarily understand how all of those things had come into play. Again, given that the purpose of the act is enhancing public health, the argument we make in this submission is that that would reinforce the information that had already been given to the person about the seriousness of the situation they were in and how those considerations had been weighed up.

**The CHAIR** — Thank you, Mr Kennedy. Thanks for coming in, and thanks for the submission. We would always appreciate your input into the work of this committee.

**Mr KENNEDY** — Thank you.

**Committee adjourned.**