PUBLIC HEALTH BILL 2014

Introduction and First Reading

Bill introduced, on motion by **Dr K.D. Hames (Minister for Health)**, and read a first time.

Explanatory memorandum presented by the minister.

Second Reading

DR K.D. HAMES (Dawesville — Minister for Health) [12.31 pm]: I move —

> That the bill be now read a second time.

The Public Health Bill 2014 is one of two bills being introduced to facilitate the comprehensive reform of public health regulation in Western Australia. The second bill is the Public Health (Consequential Provisions) Bill 2014. The introduction of these bills is a major step towards preventing illness and protecting and promoting the health of all Western Australians. The need to reform public health regulation in Western Australia has been widely acknowledged for many years. The Health Act 1911 was passed more than a century ago and it has been extensively amended in an ad hoc fashion on more than 100 occasions. The framework and content of the Health Act 1911 was itself substantially drawn from the Health Act 1898 and The Public Health Act 1886, the latter of which was the first stand-alone public health legislation in Western Australia.

Although the passage of the Health Act 1911 was an important milestone for public health in Western Australia, the act addresses the public health concerns that prevailed at the beginning of the last century. It was developed in the context of limited knowledge and understanding of the causes of various illnesses and disease, and before modern treatments and means of prevention had been discovered or developed. A substantial focus of the Health Act 1911 is on sanitation. Amongst other things, the Health Act 1911 includes many antiquated provisions, such as for the removal of nightsoil and for pans to be "removed in a suitable cart" at least once a week and cleansed by "superheated steam"; to prohibit the erection of buildings on ground "impregnated with faecal, animal or vegetable matter"; and to require any house, furniture or goods to be "cleansed". The Health Act 1911 also contains extensive provisions for the notification and management of infectious diseases, including provisions for the treatment and custody of lepers; to require the master of any ship to report "any illness of a suspicious kind, or any infectious or contagious disease, or any complaint attended with eruption or eruptive symptoms"; to prohibit "any person who is in a verminous condition" from entering any public vehicle; to require the examination of prisoners for signs of venereal disease; and to prohibit children from attending school for three months after suffering any dangerous infectious or contagious disease, and only when a "legally qualified medical practitioner" has certified that the child is free from disease and infection and that all the child's clothes have been properly disinfected. There are also provisions to regulate offensive trades such as bone mills, knackeries, gut scraping and blood drying establishments; to require the keeper of lodging houses to report deaths to the nearest coroner; and to protect water holes from trespassing pigs, dogs, ducks and geese. In the second reading speech for the Health Bill 1910, which became the Health Act 1911, the colonial secretary wisely noted that —

> The main principle contained in the Bill is for the better protection of public health, and in saying that, members will readily recognise that a Bill which is twelve years old—for the principal Act was passed in 1898—naturally requires amendment, for I venture to say nothing has made such progress as the science of public health. What might have been considered an efficient and satisfactory Act twelve years ago, in no sense of the term can be held to be sufficient to guard our public health at the present time, hence the necessity for introducing this measure.

The colonial secretary would perhaps have considered it quite remarkable that the Health Act 1911 would remain in effect for over a century. I think that all members would agree that legislation passed in the early twentieth century, and based on a model developed in the late nineteenth century, cannot be capable of providing an adequate framework for the regulation of public health in 2014 and beyond. For this reason, the Department of Health has been working over many years to develop the bills that I today have the great pleasure of presenting to the house. The bills are the culmination of almost 10 years of work, including extensive public consultation, and I am confident that they achieve the lofty goal of implementing the modern, flexible and proactive risk-based framework that has been long anticipated by so many people.

Amongst other things, part 1 of the bill provides for the binding of the Crown. The bill thereby gives effect to the principle that all persons are entitled to the same public health standards irrespective of whether the land or buildings that affect them are owned, managed or controlled by the Crown. In failing to bind the Crown, the Health Act 1911 has, at least in part, contributed to the variation in public health standards that exist across Western Australia. The bill does not, however, authorise enforcement action to be taken in respect of the Crown. This means that the Crown cannot be prosecuted or issued with an enforcement order under part 13 of the bill.

It is noted that equivalent public health legislation in the Australian Capital Territory, New South Wales, Queensland and South Australia also excludes the Crown from prosecution.

Part 2 of the bill provides for the continuation of longstanding arrangements whereby responsibility for public health is shared between state and local governments. On behalf of the state, the Minister for Health and the Chief Health Officer—a position equivalent to the existing executive director, public health—will perform a range of key functions under the bill. The retention of a statutory officer for public health underscores the importance of public health within government and within the community, and ensures that high-level leadership and advocacy is available to protect and promote public health in Western Australia. Consistent with the approach adopted in modern public health–related legislation, the bill provides for a range of functions to be performed by authorised officers. Unlike the Health Act 1911, the bill provides local governments with the autonomy to designate as authorised officers persons with a range of qualifications and experience to perform relevant functions under the bill. The bill does, however, recognise the particular role of environmental health officers within local government. The Chief Health Officer will also designate as authorised officers persons with medical, nursing and other appropriate qualifications to perform various functions under the bill, including those functions relating to notifiable infectious diseases.

Part 3 of the bill establishes the general public health duty. It is the key element of the risk-based approach that has been successfully utilised in the context of occupational health and safety and environmental protection legislation. Unlike the prescriptive and reactive nature of the Health Act 1911, the general public health duty is broad and flexible, ensuring that it is capable of capturing both known and emerging risks to public health. It is also consistent with a broad notion of public health that includes the promotion of health and wellbeing. Although breach of the general public health duty does not of itself constitute an offence, it may provide grounds for a range of actions to be taken under the bill. The regulations will play an important role in clarifying the application of the general public health duty and providing guidance as to the measures that will constitute compliance and noncompliance with the general duty in a range of specific contexts.

Part 4 of the bill provides a broad and flexible offence framework that is capable of capturing both known and emerging risks to public health. It creates the tiered approach that has been successfully utilised in environmental protection and public health legislation, and a modern and appropriate penalty framework that will deter unlawful conduct and thereby prevent or minimise harm to public health. The penalties provided by the Health Act 1911 are inadequate and this has been a source of concern for some time.

Part 5 of the bill requires both state and local governments to prepare public health plans. A longstanding criticism of existing public health legislation is that it tends to be reactive. A problem is identified and a remedy is then sought to rectify the problem. Public health planning requires government to provide a strategic and forward-thinking approach that ensures that public health can be effectively promoted and protected. In order to minimise the number of separate planning processes required of local government, local public health plans will be integrated with existing planning processes under the Local Government Act 1995.

Another important innovation for the long-term promotion and protection of public health is public health assessments, which are provided by part 6 of the bill. The implementation of public health assessments achieves a range of commitments made by the state, including those flowing from the hazardous waste fire at Bellevue and lead pollution in Esperance. Public health assessments will ensure that public health risks are identified and considered in conjunction with existing approval processes in a streamlined and efficient manner.

Part 7 of the bill provides a general framework for registration and licensing that can be applied to activities that are declared by the regulations to be public health risk activities. This part is likely to be utilised to regulate activities relating to asbestos, pesticides, skin penetration procedures and public events.

Part 8 of the bill provides a modern regime for the management of infectious diseases and related conditions. The provisions of the Health Act 1911 that regulate infectious diseases are much the same as when they were first introduced over a century ago. Many of these provisions are no longer useful or appropriate, as they reflect earlier perspectives and out-of-date models of disease control, being written at a time when many of the organisms that cause infectious diseases had not yet been identified, and before modern treatments and means of prevention had been discovered or developed. The Health Act 1911 also fails to provide an appropriate balance between the use of coercive powers and the rights of individuals. The framework provided by part 8 of the bill is broad and flexible and is thereby capable of responding to both known and emerging risks to public health. It does this by providing a generic framework that utilises four common public health tools to aid the prevention and control of the spread of infectious diseases and related conditions: obligations for medical practitioners, nurse practitioners and pathologists to make notifications to the Chief Health Officer; orders for compulsory testing—test orders; orders to require or prohibit specified matters—public health orders; and measures to identify and inform persons who have or may be affected by or exposed to a notifiable infectious disease. Importantly, the bill strikes a balance between the powers necessary to prevent the spread of infection and the

rights of individuals. In addition to providing principles to be considered in the application, operation and interpretation of part 8, the bill provides a range of tangible rights and safeguards, including the right to receive specified information, to seek legal advice and to seek a review of a test or public health order.

Part 9 of the bill provides a framework for the Chief Health Officer to be notified of prescribed conditions of health. This part replaces part IXA of the Health Act 1911 and amongst other things facilitates the continuation of important public health programs and initiatives with respect to a range of non-infectious conditions such as cancer, developmental anomalies and lead poisoning.

The Health Act 1911 does not have the capacity to adequately deal with emerging public health risks such as bioterrorism or rapidly spreading epidemics of serious infectious diseases such as SARS or severe acute respiratory syndrome, pandemic influenza or Ebola virus. Parts 10 and 11 of the bill provide a framework for the exercise of widescale and sweeping powers when there is an overwhelming need to take action to protect public health. Part 10 of the bill empowers the Chief Health Officer to authorise the exercise of serious public health incident powers by authorised officers in order to prevent, control or abate a serious public health risk. Part 11 of the bill empowers the Chief Health Officer to authorise the exercise of emergency powers by emergency officers during a public health emergency declared by the minister. Although similar powers already exist under the Emergency Management Act 2005 with respect to some specified public health risks, parts 10 and 11 of the bill reflect the unique nature of health emergencies, which can typically be managed without the necessity to involve other agencies. However, when a coordinated interagency response is required, the exercise of powers under the Emergency Management Act 2005 may be appropriate.

Part 12 of the bill provides arrangements to address losses incurred by persons as a result of the exercise of parts 10 and 11 powers. This part substantially replicates the content of part 7 of the Emergency Management Act 2005.

Part 13 of the bill establishes improvement notices and enforcement orders as tools that are available to authorised officers and enforcement agencies to proactively manage public health risks. These tools support the general public health duty and ensure that appropriate action can be taken to protect, promote and improve public health.

Part 14 of the bill provides a framework for the conduct of inquiries into matters related to public health, with the findings of all inquiries to be laid before each house of Parliament.

Part 15 of the bill, which is modelled on part 5 of the Food Act 2008, provides authorised officers with robust powers including powers of entry, inspection, search and seizure.

Part 16 of the bill provides a mechanism by which the Minister for Health may issue the Crown and crown authorities with exemptions from compliance with the bill or the regulations. This part recognises that the Crown and crown authorities may not be capable of achieving immediate compliance with the bill. This is because many of the required improvements to infrastructure and service delivery can be achieved only in the medium to long term. The bill recognises that incremental measures may be required, and in appropriate circumstances the Minister for Health may issue an exemption to the Crown and to crown authorities from compliance with the bill or the regulations.

Part 17 of the bill contains liability, evidentiary and procedural provisions necessary to support the bill.

Parts 18 and 19 of the bill contain miscellaneous, transitional and savings provisions.

The bill will be implemented in conjunction with the Public Health (Consequential Provisions) Bill 2014 and with new regulations to replace the 47 regulations and by-laws that currently exist under the Health Act 1911. Implementation will occur in three broad stages over the course of a three to five-year period following royal assent. The Department of Health will liaise closely with stakeholders at each stage of the implementation process.

I commend the bill to the house.

Debate adjourned, on motion by **Mr R.H. Cook (Deputy Leader of the Opposition)**.