



*Public Health Association
of New Zealand Inc.*

13 March 2008

Mr Graham Hill
Clerk of the Committee,
Health Select Committee
Parliament Buildings,
WELLINGTON

Dear Mr Hill

Firstly I thank you your agreement that the Public Health Association have an extension of time to complete our submission.

I enclose 2 copies of the submission from the Public Health Association of New Zealand on the Public Health Bill.

The Public Health Association would like to make an oral submission when the Committee is considering submissions.

Yours sincerely

GM Keating
National Executive Officer

31 March 2007

Revised removing proofing errors. Thank you once again

G. M. Keating



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of New Zealand Inc.*

**Submission on the Public Health Bill
to the Health Select Committee**

Public Health Association of New Zealand

31 March 2008

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Public Health Association of New Zealand

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Submission on the Public Health Bill

Public Health Association of New Zealand

Executive Summary and Recommendations

Executive summary

The Public Health Association of New Zealand is very pleased to see the Public Health Bill introduced to Parliament. We are very supportive of the changes that have been made from the Health Act 1956 to provide increased control of risks to public health and that increased provisions to protect human rights.

We are particularly pleased with four sets of changes. These four are:

- the purpose includes reducing inequalities for Maori and other populations
- improvements to notifications and contact tracing
- improvements to “regulated activities”
- explicit coverage of non-communicable diseases.

However we are particularly disappointed that there is no recognition of te Tiriti o Waitangi. This must be included.

Important areas that need change include retaining the number one regulation-making power of the Health Act (1956) – the power to make regulations to improve, promote and protect public health. There needs to be explicit powers to make regulations in relation to risk factors and sectors for reduction in the risk of non-communicable diseases.

Another area that the Bill proposes deleting from the current Act relates to screening for children; this must be retained.

The Bill is full of missed opportunities.

It should adopt a systematic, proactive (as well as responsive) approach to threats to public health. This needs to cover information, systems and flows, transparency, alignment of planning responsibilities, monitoring and workforce competence. The ability to make Health Impact Assessment mandatory is also missing.

There are many opportunities to align the public health responsibilities of Territorial Authorities and District Health Boards to the benefit of the people who are served by both these public bodies. (There may even be moderate economies of scale achievable.)

The Public Health Association congratulates the Minister of Health for introducing this Bill; we urge Parliament to make good use of it to improve the ways that we can improve, promote and protect the health of all of the people of New Zealand.

Recommendations

2 Fundamental principles and approaches

2.1 *Being proactive – or just responding?*

That the Bill contains powers for planning to protect public health in a co-ordinated manner, and that this is supported by the necessary information systems and workforce standards.

2.2 *Treaty of Waitangi*

Include a section concerning te Tiriti o Waitangi in *Part 1 Preliminary provisions* similar to the NZ Public Health and Disability Act (2000) and the Local Government Act (2002). That section should read:

“In order to recognise and respect the principles of the Treaty of Waitangi, and in order to help attain optimal and equitable health outcomes for Māori, this Act provides for mechanisms to enable Māori to contribute to decisionmaking on all activities to improve, promote and protect public health, to issue guidelines, to appoint designated officers, environmental health officers and other officers and to otherwise participate in the delivery of public health services.”

That a principle influencing all actions under this legislation is that decisions and actions that affect Māori should, wherever possible be made by Māori through Māori institutions.

That the Bill should make provisions to empower iwi rununga to hold statutory powers and employ officers with full powers (such as Inspectors of Health) under the Bill in relation to taonga Māori, if the rununga should choose.

Reiterate that, in relation to matters covered in this Bill, Territorial Authorities and DHBs have obligations concerning consultation with Māori as described in the Local Government Act (2002) and the NZ Public Health and Disability Act (2000).

Confirm that, in relation to matters covered in this Bill, DHBs have obligations to develop Māori capacity to participate in and provide for the needs of Māori under the NZ Public Health and Disability Act (2000).

That, in situations where Territorial Authorities or DHBs or the Ministry of Health take proactive action to improve, promote or protect health, priority is given to Māori and where possible the action is carried out by Māori institutions.

That the Ministry of Health, Territorial Authorities and DHBs, when developing and collecting information concerning hazards to health and/or health outcomes, include data from iwi on risks to health from a Māori point of view.

That all statutory health officers have training and are obliged to maintain continuing competency in Māori Public Health and before being employed locally are assessed by iwi as competent to work in partnership with iwi.

2.3 Equity

That there be greater detailed clarity in the way that the aim to reduce health inequalities will be achieved by specifying the relevant powers and duties further.

That there is consistency of policy intent under the NZ Public Health and Disability Act (2000) and this Bill concerning equity by aligning the language in both to be reducing inequalities, where inequalities are defined as “*unfair and avoidable or remediable differences in health among social groups*”

That there is consistency of policy intent under the NZ Public Health and Disability Act (2000) and this Bill concerning equity so that reductions are “with a view to eliminating” the inequalities.

This Bill does (and should) pose additional duties on agencies. Any attempt to resist the additional duties on the grounds of costs should be strenuously opposed.

The additional cost of these duties needs to be noted and a range of ways to meet these costs should be investigated.

In carrying out proactive public health functions such as developing plans, collecting, analysing or reporting information, developing regulations or bylaws, agencies should specifically place a priority on actions that contribute to improving, promoting or protecting the health of Māori and poor New Zealanders.

In carrying out public health *or other* functions related to housing, agencies should specifically place a priority on actions that contribute to improving, promoting or protecting health, particularly for families that include children.

In carrying out proactive public health functions agencies should specifically place a priority on actions that contribute to improving, promoting or protecting the health of Māori infants and their families, including the health of women prior to conception.

The Bill should provide sufficient powers and obligations on agencies to ensure the collection and analysis of information on public health hazards, health events, determinants of health and public health interventions. (see below re information systems) in a way that enables understanding of the equity implications for the health of all of the people of New Zealand, or in communities or in sections of the general population or communities.

The Bill should explicitly provide mechanisms that specify the professional competency (and ongoing competency) requirements for all statutory officers, and should also provide mechanisms that specify the organisational competency requirements of agencies that employ public health statutory officers (see below re training requirements).

This Bill does (and should) pose additional duties on agencies in relation to environmental health. Any attempt to resist the additional duties on the grounds of costs should be strenuously opposed

The additional cost of these duties needs to be noted and a range of ways to meet these costs should be investigated.

That empowerment of individuals and communities is a principle for the entire Bill and should guide the ways in which agencies and officers should carry out public health functions.

Confirm that, in relation to matters covered in this Bill that Territorial Authorities and DHBs have obligations concerning consultation in the Local Government Act (2002) and the NZ Public Health and Disability Act (2000).

Confirm that, in relation to matters covered in this Bill that DHBs have obligations to develop Māori capacity to participate in and provide for the needs of Māori under the NZ Public Health and Disability Act (2000).

That the Bill should make provisions to empower iwi rununga to hold statutory powers and employ officers with full powers (such as Inspectors of Health) under the Bill in relation to taonga Māori, if the rununga should choose

That additional intensive effort in contact tracing is applied and resourced to help achieve health equity for populations already at greater risk

That when agencies and officers are carrying out proactive functions of public health (such as planning, information systems, and development of regulations, bylaws and codes) they must specifically consider impacts and act in a way that not only improves health but also reduces health inequalities.

In carrying out proactive public health functions (such as developing plans, collecting, analysing or reporting information, developing regulations or bylaws) agencies and officers should specifically place a priority on actions that contribute to improving, promoting or protecting the health of vulnerable groups including but not restricted to :

- children and young people
- pregnant women
- people in poverty
- people with disabilities, particularly mental illness
- refugees and asylum seekers with high and complex needs
- isolated people
- people in institutions
- those experiencing discrimination.

The Bill should require agencies to adopt a quality-improvement cycle including planning, processes, action monitoring and review including collecting, analysing or reporting information, developing regulations or bylaws, to contribute to achieving optimal health and equitable health outcomes.

That the Bill specifies that Health Impact Assessment carried out under the Public Health Bill should be equity-based.

2.4 Definitions

Use the following as definition of Public Health (s4)

Health of all of the people of New Zealand, or in communities or in sections of the general population or communities.

Use the following definition of Health Impact Assessment (s4)

..assess...health of all of the people of New Zealand or in communities or in sections of the general population or communities and the distribution...

Make appropriate use of “hazard” and “risk”.

Consistently use “risk to public health” or “public health risk”.

Define “risk to public health” or “public health risk” perhaps as *a risk of harm to public health*.

Consistently use “serious risk to public health”.

Define “serious risk to public health” as a public health risk involving potential harm to public health that is irreversible, of a high impact or on a wide scale.

Define “serious communicable condition” as communicable condition involving potential harm to public health that is irreversible, of a high impact or on a wide scale.

Define “risk factor” in a generic way and specify narrower uses (eg for only non-communicable diseases) where necessary.

2.5 Public Health approaches

That the public health functions and objectives of DHBs should be the same in both the NZ Public Health and Disability Act (2000) and the Public Health Bill; these functions should be based on the Essential Functions of Public Health

That the Local Government Act (2002) *Part 2 Purpose of local government, and role and powers of local authorities* be amended to explicitly include the purpose to improve, promote and protect public health, with reference to the Public Health Bill.

That the public health functions of Territorial Authorities should be described in a similar way to the public health functions of other agencies in the Bill. In particular they should be described in a way that reflects the role of Territorial Authorities in carrying out the Essential Functions of Public Health

For avoidance of doubt there should be consequential amendments to various other Acts to be clear that the actions of Territorial Authorities under those Acts are part of the public health functions of Territorial Authorities.

That the Bill uses the WHO Essential Functions of Public Health as an organising framework to describe the roles and responsibilities of relevant agencies and individuals in the Bill

That the functions, roles, responsibilities and tasks of agencies and individuals be in one Part of the Bill so that the inter-relationships can be seen and understood.

In carrying out proactive public health functions agencies should specifically place a priority on actions that contribute to improving, promoting or protecting the health of children and young people, including the health of women prior to conception.

That the Precautionary Principle should be explicitly included in the guiding principles of the Bill.

That the Public Health Bill needs to explicitly contain the same powers to develop regulations as s117[1]a of the Health Act 1956 which gave power to make regulations for “*The improvement, promotion, and protection of public health*”.

3 Systemic approaches needed in the Bill

3.1 Principles for the Bill

Replace s3[3] by the following principles and the requirement that all persons involved in the administration of this Act should perform their functions with due regard to these principles.

Māori self management principle

(a) Decisions and actions that affect Māori should, wherever possible be made by Māori through Māori institutions

(b) *Territorial Authorities, DHBs the Minister and the Ministry of Health should consult with Māori in developing and implementing all proactive public health actions.*

Empowerment principle

(a) Actions taken under this Bill should always respect individuals and communities

(b) Actions taken under this Bill should enable people to have greater control over their lives whenever possible

(c) Proactive public health actions should be developed and implemented in a way that supports increased participation in decision making processes.

Precautionary principle

(a) Action should be taken to manage public health risk when there is uncertainty or incomplete information about that risk

(b) When there is uncertainty or incomplete information, the type and extent of public health action should be guided by

- i) a careful evaluation to avoid, where practicable, serious harm to public health; and
- ii) an assessment of the risk-weighted consequences of the options.

Equity principle

Actions taken under this Bill should, wherever possible, be directed towards increasing equity of health outcomes for Māori and all other population groups.

Proportionality principle

The exercise of powers should be a response that is in proportion to the nature and seriousness of the risk to public health.

3.2 General duty

That the Bill explicitly poses a general duty on individuals and organisations to take all reasonable steps to prevent or minimise harm to public health.

3.3 Checks, balances, transparency and independence

Transparent, independent advice on public health to decision makers at DHB and Territorial Authorities level, similar to the role of the PHAC at a national level is needed. Community and Public Health Advisory Committees of DHBs (established under the NZ Public Health and Disability Act 2000) need to be strengthened so that they are able to carry out this role in relation to DHBs.

Guidelines on Community and Public Health Advisory Committees of DHBs should indicate a similar range of expertise as the Public Health Advisory Committee.

Statutory officers, such as Medical Officers of Health and Inspectors of Health need the ability to report independently to their Boards and Councils in a manner similar to the Director of Public Health at a National level

DHB statutory officers, such as Medical Officers of Health need the ability to provide advice and report independently to the Councils in their Health Districts, not simply be entitled to attend meetings.

Statutory officers, such as Medical Officers of Health and Inspectors of Health need the ability to report independently to the Director of Public Health.

3.4 Information systems

That the Bill provide for a public health information system that enables:

- the management of acute risks to public health
- planning and policies for public health
- monitoring of both public health outcomes and public health processes

That the Bill ensures that comprehensive information for public health is able to be collected, analysed and reported. This will include information on:

- health events
- hazards to public health

- determinants of public health
- interventions.

That the Public Health Bill, the NZ Public Health and Disability Act (2000) and the Local Government Act (2002) are aligned to ensure:

- minimisation of the consultation burden on communities on related issues by different agencies
- regular surveillance of and reporting on each district and region for hazards to public health
- explicit connections between Territorial Authority cultural, economic, environmental and social well beings, community outcomes and public health
- aligned public reporting by Territorial Authority and DHBs on community outcomes, public health outcomes and hazards to public health.

That DHB reports on health status and any factors that the DHB believes may adversely affect the health status of the population should include information subdivided by Territorial Authority wherever possible. Unless there is agreed joint reporting by the Territorial Authorities and the DHB the relevant report should be formally transmitted to the relevant Territorial Authorities.

Territorial Authorities should routinely report to their communities on public health hazards, determinants and public health interventions made. This report could be made in conjunction with their three-yearly report on community outcomes.

That a copy of the reports of Territorial Authorities on public health hazards, determinants and interventions should be forwarded to the relevant DHB and to the Director General of Health, unless there is agreed joint reporting by the Territorial Authorities and the DHB.

Territorial Authorities and DHBs should be encouraged to provide joint reports.

That there be investigation of ways to enable access to a wide range of data sources for public health research, with strict controls imposed to ensure confidentiality.

That the Annual Report on the State of Public Health explicitly covers not just public health outcomes but also:

- hazards to public health
- determinants of public health
- interventions.

That the Bill obliges both DHBs and Territorial Authorities to provide information to the Director General to enable meaningful reporting.

Section 23 (Duty to provide information for purposes of blood collection) needs to be totally reviewed.

Remove Part 2, Subpart 2 (Subsidy compliance verification) from the Bill.

3.5 Planning for public health

That the Minister of Health is required to determine a New Zealand Health Strategy to provide a framework for both the health sector and other sectors covered in the Public Health Bill. This will require:

- inclusion in the Public Health Bill and
- amendment of the New Zealand Health and Disability Act (2000).

As with the New Zealand Health Strategy the Minister should be obliged to consult before determining such a strategy.

DHBs and Territorial Authorities should be required under the Bill to have planning processes for public health similar to their obligations under the New Zealand Public Health and Disability Act (2000) and the Local Government Act (2002).

There needs to be alignment of the Public Health Bill, the New Zealand Public Health and Disability Act (2000) and the Local Government Act (2002) to ensure long term planning revised at least three yearly, by DHB and Territorial Authorities, on achieving improved public health outcomes and reduced inequalities. This planning needs to be co-ordinated between DHBs and Territorial Authorities and between the obligations of the three Acts.

Health Impact Assessments should explicitly consider Māori health and equity.

That the Bill include powers to require Health Impact Assessment to be undertaken.

That the bodies that may be required to undertake Health Impact Assessment be extended beyond the government sector.

3.6 Training, qualifications and competence

That the Bill should be explicit that there are to be national standards of competency (including continuing competency) for all public health practitioners with roles under the Bill, including that the regulations concerning qualifications of Inspectors of Health should explicitly cover continuing competency.

4 Comments on Parts

4.1 Controlling the spread of communicable diseases to others (Parts 2 and 4)

The Bill should only give a defence against recklessly spreading a notifiable disease or condition based on the consent of the person put at risk if that person:

- Knows the risk of contracting the condition
- Knows ways to protect themselves from contracting the condition
- Knows the range and probability of the consequences of the condition.

In line with the proportionality principle, delete from the Bill the provisions concerning residence orders for persons not posing health risks to others.

4.2 Healthy environments – non communicable diseases (Part 3)

Ensure that the Bill contains explicit powers to make regulations that can be used immediately to control risk factors for non-communicable diseases.

The timeframe for the report of the Director-General to the Minister should be able to be deferred by no longer than one year.

4.3 Healthy environments – territorial authorities (Part 5) and regulated activities (Part 6)

Ensure that the Bill is modified to:

- apply the definition of “risk factor” and “sector” to activities to be regulated
- be sure that Territorial Authorities are able to make bylaws concerning risk factors
- enable a wide range of regulatory approaches to risk factors within a principled framework as with the current processes in Parts 5 and 6.

In line with the concept of a general duty to not pose a public health risk and with the Health and Safety in Employment Act (1992) the operators of all commercial activities should be obliged to identify public health risks that their activities may pose and take all practicable steps to prevent risks to public health.

The term “nuisance” should be replaced by a more descriptive term, such as “hazard to public health”.

The proportionality principle needs to apply to Part 5 (preferably to the whole Bill) not just Part 6; in particular if there is no risk to public health then there should be no power for intervention.

In Part 6 there should be opportunities for Māori institutions, such as runanga to have the same range of powers and controls as Territorial Authorities.

4.4 Preventing conditions from getting worse (Part 2)

The provisions in the Bill concerning cervical screening (part 2, subpart 4) should be made available to apply to all population screening programmes, with a schedule to the Bill detailing the screening programmes.

That a designated officer may examine, test or screen any child at a school/centre (s328) without consent from parent or guardian where:

- extensive efforts have been made to obtain consent and
- consent has not been refused and
- the examination test or screening is not invasive.

That the Bill contain explicit mechanisms to ensure nationally consistent standards (including standards of continuing competency) for officers designated under this section.

1 Introduction

This submission first introduces ourselves then gives an overall assessment of areas that the PHA supports and those areas in which we recommend change.

This is followed by consideration of fundamental principles and approaches that should be reflected in this Bill.

The submission then comments on specific parts of the Bill and concludes with appendices and references.

About the Public Health Association of New Zealand

The Public Health Association of New Zealand (PHA) is a voluntary association which provides a major forum for the exchange of information and stimulation of debate about public health in New Zealand. Membership of PHA is open to all individuals interested in public health and covers more than 300 individual members from the public, private and voluntary sectors. The PHA is a member of the World Federation of Public Health Associations.

Public health can be defined as the improvement of the health of the whole population *'through the organised efforts of society'*¹.

The Public Health Association of New Zealand is funded from membership fees, fundraising, and a contract with the Ministry of Health to encourage and facilitate informed debate on key public health issues, to provide co-ordination for the development of public policy and to enhance development of the public health workforce.

General support for the Bill

The PHA is enormously supportive of the general thrust of the Bill and of the general trends reflected in the changes between the Health Act 1956 and the current Bill.

In particular the PHA supports the purpose of the Act (to improve, promote, and protect public health, to help attain optimal and equitable health outcomes) and the moves towards:

- **information systems** (local, regional and national information on identifying assessing and reporting health events, hazards to health, determinants and interventions) to enable both immediate responses (eg outbreak control) and proactive planning for public health
- attention to the **whole burden of preventable illness**² by including preventable non-communicable diseases and conditions as well as preventable communicable conditions and control of preventable hazards in the environment
- using a **range** of protective approaches (ie **primordial prevention** to prevent diseases arising by controlling states of affairs that are or can be hazardous to health, **primary prevention** to control, manage and remedy disease outbreaks and

emergencies and **secondary prevention** to support population-based detection and intervention to get in early and provide treatment before a condition becomes irreversible)

- **tiered legislation** that sets out principles in the Act and allows the subsequent development of regulations and codes in line with those principles
- reaffirmation that **health is everyone's responsibility** by emphasising the responsibilities and duties of governments at local, regional and national level as well as providing explicit requirements that individuals and businesses must not pose health risks to other people or communities
- substantial increases in the protection of **human rights** and increased provision of systemic **checks and balances**
- ensuring implementation of our **international obligations** in relation to the international health regulations, ensuring border protection and enabling adequate management of public health emergencies
- clarifying relationship with **other legislation.**

Improvements needed

There are a number of areas in which the Bill must be improved:

- recognising Māori as a Treaty partner with the Crown
- Requiring systems to support improving, promoting and protecting public health
- reducing inequalities
- protecting vulnerable populations
- better aligning legislation.

2 Fundamental principles and approaches

2.1 *Being proactive – or just responding?*

The most fundamental concern that the PHA has about the Bill is that most of the provisions in the Bill are powers to react when there are active threats to public health.

A person has a condition that poses a health risk. Activities in a sector pose a reducible risk factor. A contaminant is identified. A nuisance exists. A state of serious risk to public health exists. A place is affected by a quarantinable condition. These are all active threats.

In comparison with those substantial provisions of the Bill the number of proactive provisions is small. Territorial Authorities must survey their districts for nuisances. Information must be provided for understanding long term disease trends. The Director-General provides an annual report on the state of Public Health.

This can leave public health vulnerable to agencies that do have other competing priorities that may respond when they have to but may not feel it necessary to make long-term or strategic approaches to improve, promote and protect the health of their communities in an effective and co-ordinated way.

Recommendation

That the Bill contain powers for planning to protect public health in a co-ordinated manner, and that this is supported by the necessary information systems and workforce standards.

2.2 *Treaty of Waitangi*

Te Tiriti o Waitangi guaranteed Māori rangatiratanga and all the rights of citizenship. These have been variously interpreted into principles in recent decades, with most versions indicating specific roles for partnership, Māori self management, active protection and consultation.

These principles should be incorporated into the Public Health Bill. Equity for Māori as part of full citizenship will be dealt with below. This section focuses on partnership and Māori self management.

UN Declaration on the rights of indigenous people³

At the United Nations at the time of the adoption of the Declaration on the rights of Indigenous peoples the New Zealand government indicated specific concerns over four articles (26, 28, 19 and 32)ⁱ.

ⁱ article 26 on lands and resources, article 28 on redress, articles 19 and 32 on a right of veto over the State.

Māori and other New Zealanders can therefore expect that, as a minimum, there will be progressive realisation of all other articles of the Declaration. In this context we can expect that public health legislation will reflect the Declaration. While many of the articles speak directly to public health and healthy environments (see appendix) article 23 is particularly relevant for the proactive aspects of the Public Health Bill:

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

This article seems to be fully consistent with te Tiriti o Waitangi, whether considered as article 3 or considered as the principle of partnership.

Treaty clauses

The preliminary provision of the NZ Public Health and Disability Act (2000) include a section on the Treaty of Waitangi:

“In order to recognise and respect the principles of the Treaty of Waitangi, and with a view to improving health outcomes for Māori, Part 3 provides for mechanisms to enable Māori to contribute to decisionmaking on, and to participate in the delivery of, health and disability services.”

The Local Government Act (2002) includes a section on the Treaty of Waitangi:

“In order to recognise and respect the Crown’s responsibility to take appropriate account of the principles of the Treaty of Waitangi and to maintain and improve opportunities for Māori to contribute to local government decisionmaking processes, Parts 2 and 6 provide principles and requirements for local authorities that are intended to facilitate participation by Māori in local authority decisionmaking processes.”

Implementation

One of the most common issues raised by Māori public health practitioners during discussions in many different localities concerned implementation.

While there was recognition of the intent that the Bill should improve Māori health and equity there remained deep concern that the good intentions of the purpose statement of the Bill could be undermined by the way the Bill is administered.

One way that the good intention of the purpose statement could be carried across into implementation is to have principles that guide the actions of all people acting under the Bill.

Another, for the avoidance of doubt, is to be explicit that information sharing under the Bill should include Māori providers.

Recommendations

Include a section concerning te Tiriti o Waitangi into *Part 1 Preliminary provisions* similar to the NZ Public Health and Disability Act (2000) and the Local Government Act (2002). That section should read:

“In order to recognise and respect the principles of the Treaty of Waitangi, and in order to help attain optimal and equitable health outcomes for Māori, this Act provides for mechanisms to enable Māori to contribute to decisionmaking on all activities to improve, promote and protect public health, to issue guidelines, to appoint designated officers, environmental health officers and other officers and to otherwise participate in the delivery of public health services.”

That a principle that should influence all actions under this legislation is that decisions and actions that affect Māori should, wherever possible be made by Māori through Māori institutions.

That the Bill should make provisions to empower iwi rununga to hold statutory powers and employ officers with full powers (such as Inspectors of Health) under the Bill in relation to taonga Māori, if the rununga should choose.

Reiterate that, in relation to matters covered in this Bill that Territorial Authorities and DHBs have obligations concerning consultation with Māori as described in the Local Government Act (2002) and the NZ Public Health and Disability Act (2000).

Confirm that, in relation to matters covered in this Bill, DHBs have obligations to develop Māori capacity to participate in and provide for the needs of Māori under the NZ Public Health and Disability Act (2000).

That, in situations where Territorial Authorities or DHBs or the Ministry of Health takes proactive action to improve, promote or protect health, priority is given to Māori and where possible the action is carried out by Māori institutions.

That the Ministry of Health, Territorial Authorities and DHBs when developing and collecting information concerning hazards to health and/or health outcomes include data from iwi on risks to health from a Māori point of view.

That all statutory health officers have training and are obliged to maintain continuing competency in Māori Public Health and before being employed locally are assessed by iwi as competent to work in partnership with iwi.

2.3 Equity

The PHA supports the purpose statement:

(s3) Statement of purpose

—optimal and equitable health outcomes for Māori and all other population groups

—aiming to reduce health inequalities by improving health outcomes for Māori and other population groups

However the Bill is then silent on the ways in which agencies will act to reduce inequalities.

Recommendation

That there be greater detailed clarity in the way that the aim to reduce health inequalities will be achieved by specifying the relevant powers and duties further.

Inequalities or disparities?

The NZ Public Health and Disability Act (2000) poses an obligation on District Health Boards (DHBs) to reduce health disparities. This contrasts with the proposed obligation of the Bill to reduce inequalities. Clearly the two should be aligned.

The Commission on Social Determinants of Health uses the definition of health equity as: *'the absence of unfair and avoidable or remediable differences in health among social groups'*⁴. They focus on "inequalities" rather than "disparities" because "disparity" simply describes the differences. "Inequality" places value on equity and is clear that inequalities are disparities that should be eliminated.

New Zealand should follow the lead of the WHO Commission and be clear in relation to public health and in relation to health and disability services that, where there are unfair and avoidable or remediable disparities in health among social groups that these inequalities should not continue.

Reducing inequalities or heading towards elimination? (should this be formatted this way)

The NZ Public Health and Disability Act (2000) indicates that the objective is to reduce disparities "with a view to eliminating health outcome disparities"⁵.

Surely this view should be found in the Public Health Bill?

Recommendations

That there is consistency of policy intent under the NZ Public Health and Disability Act (2000) and this Bill concerning equity by aligning the language in both, to be reducing inequalities, where inequalities are defined as *"unfair and avoidable or remediable differences in health among social groups"*.

That there is consistency of policy intent under the NZ Public Health and Disability Act (2000) and this Bill concerning equity so that reductions are "with a view to eliminating" the inequalities.

The right to health

This Bill is an important part of New Zealand's commitment to human rights as agreed within the United Nations.

Everyone has the right to a standard of living adequate for the health and wellbeing of himself and his family, including food, clothing, housing and

medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same protection.

(Universal Declaration of Human Rights, Article 25)⁶

In addition to supporting the Universal Declaration of Human Rights, New Zealand is also party to the United Nations International Covenant On Economic, Social And Cultural Rights⁷, and is committed to supporting Article 12 :

1. *The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.*
2. *The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:*
 - a) *The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;*
 - b) *The improvement of all aspects of environmental and industrial hygiene;*
 - c) *The prevention, treatment and control of epidemic, endemic, occupational and other diseases;*
 - d) *The creation of conditions which would assure to all medical service and medical attention in the event of sickness.*

The New Zealand Human Rights Commission, in their 2005 report⁸ indicate that New Zealand has areas for improvement in relation to the right to health.

Where we need to do better - Kia piki ake te pai i roto i enei wahanga

Although New Zealand rates quite well according to a number of measures of quality of care and health outcomes, there is room for improvement in some areas.

- *With less than two percent of the total expenditure on health available for public health services (such as environmental health, communicable disease control and health promotion) the potential to improve health, and protect against preventable diseases, is severely limited.*
- *Of particular importance are the gaps associated with ethnicity and socioeconomic status. Māori life expectancy at birth is nine years lower than non-Māori for females and eight years lower for males. There are similar gaps in terms of socioeconomic status and disability.*
- *Although there has been a drop in New Zealand's infant mortality rate, this is not reflected among Māori⁹. The overall infant death rate is still unacceptably high in comparison to other OECD countries, and the rate at which children are hospitalised is increasing.*
- *Māori are less likely to access health services. When they do, they are less likely to receive high-technology interventions.*

- *Poverty plays an integral part in the right to health. Consideration should be given to the suggestion by the UN Committee on Economic Social and Cultural Rights (2002) that New Zealand adopt a national plan of action for the eradication of poverty, with clear indicators to assess the impact of poverty on disadvantaged and marginalised groups.*
- *Inadequate housing is a significant contributor to poor health, especially of children.*
- *Specific population groups for whom services are inadequate are Pacific peoples, people with early signs of mental illness (especially children and young people), and refugees with high and complex needs.*
- *New Zealanders also face some ongoing health challenges, such as clean air and safe water, as well as new ones through the re-emergence of familiar diseases associated with poverty and overcrowding.*
- *Issues that need to be addressed include the training and retention of the workforce, and some aspects of the quality of health care (notably the level of adverse events in hospitals).*
- *Despite the recent rounds of restructuring, services are still poorly integrated. Lines of accountability remain unclear.*
- *The International Covenant on Economic, Social and Cultural Rights requires that rights be provided on a non-discriminatory basis. It also provides that, where resources are limited, the available resources should be targeted to the groups that are most vulnerable. This provides a mechanism for reconciling a needs-based approach with a human-rights approach. A discourse that not only promotes an understanding of the right to health and the responsibilities of individuals and society, but clarifies the shared nature of obligations arising from a human-rights approach, would allow the most transparent way of distributing health resources to be identified.*

Particular ways that the Public Health Bill should implement the Human Rights Commission report are listed below.

A need for greater emphasis on public health services, including enhanced resources.

Recommendations

This Bill does (and should) pose additional duties on agencies. Any attempt to resist the additional duties on the grounds of costs should be strenuously opposed.

The additional cost of these duties needs to be noted and a range of ways to meet these costs should be investigated.

An explicit need to address the greater burden of disease for some groups, in particular Māori and poor families.

Recommendation

In carrying out proactive public health functions such as developing plans, collecting, analysing or reporting information, developing regulations or bylaws, agencies should specifically place a priority on actions that contribute to improving, promoting or protecting the health of Māori and poor New Zealanders.

The importance of housing to health

Recommendation

In carrying out public health *or other* functions related to housing, agencies should specifically place a priority on actions that contribute to improving, promoting or protecting health, particularly for families that include children.

An explicit need to address Māori infant mortality

Recommendation

In carrying out proactive public health functions agencies should specifically place a priority on actions that contribute to improving, promoting or protecting the health of Māori infants and their families, including the health of women prior to conception.

The importance of adequate information on health to inform policy decisions across a wide range of areas

Recommendation

The Bill should provide sufficient powers and obligations on agencies to ensure the collection and analysis of information on public health hazards, health events, determinants of health and public health interventions. (see below re information systems) in a way that enables understanding of the equity implications for the health of all of the people of New Zealand, or in communities or in sections of the general population or communities.

Training of the relevant public health workforce

Recommendation

The Bill should explicitly provide mechanisms that specify the professional competency (and ongoing competency) requirements for all statutory officers, and should also provide mechanisms that specify the organisational competency requirements of agencies that employ public health statutory officers (see below re training requirements).

The fundamental importance of clean environments for achieving the right to health

Recommendations

This Bill does (and should) pose additional duties on agencies in relation to environmental health. Any attempt to resist the additional duties on the grounds of costs should be strenuously opposed.

The additional cost of these duties needs to be noted and a range of ways to meet these costs should be investigated.

Empowerment

People cannot have equality done to them; equality requires governments and others to act – to take steps that increase all individuals’ chances of obtaining good health. The Public Health Bill is an essential part of the realization of this right, as it takes action on the social determinants of health.

The WHO Commission on the Social Determinants of Health¹⁰ describes the importance of empowerment both globally and at the level of local communities.

“At the heart of the concern with social determinants of health, and health inequity, is concern for people without the freedom to lead flourishing lives (Sen, 1999)¹¹. To make a fundamental improvement in health equity, technical and medical solutions such as disease control and medical care are, without doubt, necessary – but they are insufficient. There will need to be empowerment of individuals, communities, and whole countries.

We see empowerment operating along three interconnected dimensions: material, psychosocial, and political. People need the basic material requisites for a decent life, they need to have control over their lives, and they need political voice and participation in decision-making processes.”

As indicated below in the WHO approach to public health functions, empowerment is an essential function of public health.

The empowerment of individuals and communities is a task that is much wider than regulatory approaches to public health. However, as empowerment is so crucial to public health it is important that, wherever possible, regulation for public health is supportive of empowerment and does not undermine the empowerment of individuals and communities.

In the exercise of powers in relation to individuals with conditions posing health risks, empowerment of those individuals should be supported by the protection of freedoms and privacy to the maximum extent compatible with protection of public health. This is well covered in the Bill under the overarching principles and the detail in Part 4.

The Bill could reflect the obligations under the NZ Public Health and Disability Act (2000) and the Local Government Act (2002) to enable and develop political voice and participation.

As noted above under Treaty of Waitangi, the Bill should reflect the obligations in the NZ Public Health and Disability Act (2002) s23[1](d-f):

*“(d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:
(e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:
(f) to provide relevant information to Māori for the purposes of paragraphs (d) and (e)”*

In the Public Health Bill this requirement should be an obligation for the Ministry, DHBs and Territorial Authorities. As discussed above under Treaty of Waitangi, the Bill should make provisions to empower iwi rununga to hold statutory powers and employ officers under the Bill in relation to taonga Māori, if the rununga should choose.

In relation to the exercise of all other powers and duties, actions should be taken in a way that empowers and supports individuals and communities.

Recommendations

That empowerment of individuals and communities is a principle for the entire Bill and should guide the ways in which agencies and officers should carry out public health functions.

Confirm that, in relation to matters covered in this Bill, Territorial Authorities and DHBs have obligations concerning consultation in the Local Government Act (2002) and the NZ Public Health and Disability Act (2000)

Confirm that, in relation to matters covered in this Bill, DHBs have obligations to develop Māori capacity to participate in and provide for the needs of Māori under the NZ Public Health and Disability Act (2000).

That the Bill should make provisions to empower iwi rununga to hold statutory powers and employ officers with full powers (such as inspectors of Health) under the Bill in relation to taonga Māori, if the rununga should choose.

Contact tracing

Some groups of people have higher rates of infectious disease than the general population, in particular Māori¹². The PHA strongly supports actions that will help protect communities that are known to be at overall higher risk.

When there are active threats to health from a notifiable condition, public health staff make great efforts to trace and inform contacts.

Some families are hard to track because they move house a lot. This is usually due to the high cost of housing. High housing mobility is an independent risk factor for poor health. Even more extensive contact tracing efforts may be required by public health staff in situations of high housing mobility to prevent families being “lost to follow-up” as contacts of someone with a notifiable condition.

Recommendation

That additional intensive effort in contact tracing is applied and resourced to help achieve health equity for populations already at greater risk.

Regulation improves equity

Free-market approaches disadvantage the vulnerable and the poor. This may be of limited public policy concern when it relates to the choice of fashion clothing or the choice of amenity in a car. However when it influences life chances such as with poor housing or dangerous consumer goods, freedom of the market must take second place to regulations because of concerns for health, human rights and equity.

Over thirty years ago it was well demonstrated that the key factors involved in improving the health of populations were not medical technologies, the development of antibiotics or surgical techniques. Instead health is fundamentally improved as a consequence of improvements in the environment, sanitation, better nutrition, improved working conditions and good housing¹³.

In Dickensian England regulation and public health action on these factors led to improvement in the health of all in society, not just those with status and wealth¹⁴.

This is because minimum building standards provide better homes for those too poor to be able to choose to live other than in a slum, and, in general, the rich and famous did not live in slums. Legislated minimum wages meant that even the poor could afford to buy adequate calories and protein, and minimum food standards meant that contaminated food could not be sold. Mine safety legislation, fire regulations for factories, abolition of child labour and industrial hygiene protected all from unsafe workplaces – but had the greatest benefits for those who had few choices but work in the mills or in a sweatshop.

When regulation sets minimum standards this reduces inequalities by providing a floor that limits just how low health can fall for the most disadvantaged groups.

Good regulation can improve equity even more

The WHO Commission on Social Determinants of Health has commissioned analysis of interventions to improve health and reduce inequalities. One commissioned report¹⁵ notes the value of:

- universal actions with targeted follow through
- targeting and tailoring interventions
- appropriate nuances to universal interventions
- focus on the determinants of the inequities.

For the Public Health Bill to more effectively reduce inequalities it must do more than simply provide a minimum floor. It needs to require the agencies and officers to carry out their actions in a way that provides targeted and tailored interventions.

Recommendation

That when agencies and officers are carrying out proactive functions of public health (such as planning, information systems, development of regulations, bylaws and codes) they must specifically consider impacts and act in a way that not only improves health but also reduces health inequalities.

Vulnerable populations

The WHO Commission on the Social Determinants of Health Knowledge Networks have identified social disadvantage and marginalisation as fundamental to health inequalities¹⁶

While there may be some disagreement over the exact composition of the list there is reasonable consensus that the following groups have, at this time, particular health vulnerabilities:

- children and young people
- pregnant women
- people in poverty
- people with disabilities, particularly mental illness
- refugees and asylum seekers with high and complex needs
- isolated people
- people in institutions
- those experiencing discrimination.

Recommendation

In carrying out proactive public health functions (such as developing plans, collecting, analysing or reporting information, developing regulations or bylaws) agencies and officers should specifically place a priority on actions that contribute to improving, promoting or protecting the health of vulnerable groups including but not restricted to:

- children and young people
- pregnant women
- people in poverty
- people with disabilities, particularly mental illness
- refugees and asylum seekers with high and complex needs
- isolated people
- people in institutions
- those experiencing discrimination.

Populations with sub-optimal and inequitable health outcomes

The purpose of the Bill (s3) refers to optimal and equitable health outcomes for Māori and all other population groups and aims to reduce health inequalities by improving health outcomes for Māori and other population groups.

There are several essential things needed to reduce health inequalities. The first is to plan to act in a proactive way to reduce inequalities. This requires good knowledge and understanding of which population groups have sub-optimal and inequitable health outcomes. This is needed at local, regional and national levels.

Agencies and their communities then need good information on options for ways to improve (or contribute to improving) health outcomes for these populations. The ways to reduce inequalities could be actions taken by the agency alone or in conjunction with one or more others. This information is again needed at local, regional and national levels.

The second essential thing to reduce inequalities is to establish processes so that when there is a need to respond to a hazard to public health there are mechanisms to ensure that the response is done in a way that will reduce inequalities. It is hard when responding to an acute event to ensure that all the nuances necessary to take into account the needs and situations of different populations; this can only be consistently achieved if there is careful consideration given in advance.

The final essential thing to reduce inequalities is that agencies then need to act in line with the plans and processes and subsequently monitor and report on the impact of their actions and then repeat the cycle of planning, action monitoring and improving over again.

Mechanisms exist for this well known cycle of quality improvement sometimes under other legislation. At the moment they are poorly recognised and are not well coordinated. The Bill needs to oblige agencies to adopt a systems approach to reducing health inequalities

Recommendation

The Bill should require agencies to adopt a quality-improvement cycle including planning, processes, action monitoring and review including collecting, analysing or reporting information, developing regulations or bylaws, to contribute to achieving optimal health and equitable health outcomes.

Equity-based health impact assessment

Both the Bangkok Charter¹⁷ and the reports of the Evidence Networks for the WHO Commission on the Social Determinants of Health place importance on equity-based Health Impact Assessment.

The latter identifies equity-based Health Impact Assessment as a way to “equity-proof”. “Equity proofing” is key to the effective implementation of policies and programmes. It is also crucial for the sustainability of an overall approach to reducing health inequalities.

Recommendation

That the Bill specifies that Health Impact Assessment carried out under the Public Health Bill should be equity-based.

2.4 Definitions

Health

The Bill needs to be explicit about which definition of health is intended for inclusion in “Public Health”.

The World Health Organisation (WHO) 1948 definition is "*Health is the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*"

Māori definitions of health have been wider and have added whanau and spirituality to the WHO definition¹⁸.

One Māori model which has gained wide acceptance as ‘a Māori health perspective’ has been the whare tapa wha (four-sided house) model¹⁹. This recognised Wairua/Spiritual,

Hinengaro/Mental, Tinana/Physical and Whanau/Extended Family as key components of health.

As the Bill has the purpose “...in order to help attain optimal and equitable health outcomes for Māori and all other population groups” it would be appropriate to use a Māori definition of health.

Public health - Populations, communities and/or sections?

There are different descriptions of groups of New Zealanders included in a range of definitions through the Bill:

- (s4) public health
health of all of the people of New Zealand; or a community or section of those people
- (s4) Health Impact Assessment
assess health of a population or part of a population and the distribution
- (s79) risk factor
incidence of non-communicable diseases in the general population or in communities or in sections of the general population or communities

The PHA prefers the wording used in relation to risk factor – ie “*in the general population or in communities or in sections of the general population or communities*”

This wording allows for greater clarity that subsections of the population may be differently affected. For example there may be conditions that are more prominent in relation to, say, Māori children, that may not be so evident when considering either “all children” or “all Māori”.

Current practice in Ministry of Health and academic reports to disaggregate data by age and ethnicity; this current practice should be supported in legislation by the definitions.

Recommendations

Use the following as definition of Public Health (s4)

Health of all of the people of New Zealand, or in communities or in sections of the general population or communities.

Use the following definition of Health Impact assessment (s4)

...assess...health of all of the people of New Zealand or in communities or in sections of the general population or communities and the distribution...

Risk, hazard, injury, harm, risk factor, severity and seriousness

There is a collection of words and phrases used in this Bill that, colloquially, have overlapping meanings. Within the Bill any shades of meaning, if they are intended to be different, are not clarified.

Risk and Hazard

The Bill appears at times to confuse “hazard” with “risk”.

A hazard poses a level of threat to life, health, property or environment²⁰. Hazard is intrinsic to the thing.

Risk is the possibility of an event occurring that will have an impact on the achievement of objectives. Risk is measured in terms of impact and likelihood.²¹

Risk = Likelihood of Occurrence x Seriousness if incident occurred.

The purpose of risk management is to modify the situation so that the hazard poses less of a risk. This can be done in many ways. Examples are making the occurrence less likely (eg regulating an activity) or reducing the susceptibility of people to the hazard (eg immunisation, prophylactic antibiotics for people exposed to a communicable disease).

For example s2b “...*risk identification, risk assessment, and reporting*...” is more correctly about “...*hazard identification, risk assessment, and reporting*...”

Recommendation

Make appropriate use of “hazard” and “risk”.

Risk, injury and harm

It is unclear if there is intended to be a difference between:

- “risk to public health” (eg s4 contaminant, reservoir, vector, s31[1]b notification, s153d, s240[1]b)
- “harm” (s186 Bylaws) and
- “likely to be injurious to public health” (s166 nuisances).

Recommendations

Consistently use “risk to public health” or “public health risk”.

Define “risk to public health” or “public health risk” perhaps as *a risk of harm to public health*²².

Seriousness, severity, significance, substantial

“Seriousness” is one of the criteria for deciding if a condition or activity should be on a schedule (s37, 240) and if contact tracing should be done (s143). “Severity” is also used in this way (s196 regulated activities).

Conceptually it is also built into the proportionality principle balancing the seriousness of the risk with the extent of intervention.

However “serious” also appears, along with “substantial” and “significant” as an indicator that some threshold of risk has been exceeded.

It is difficult to determine the degrees of seriousness, if any, intended between:

- substantial risk (s4d),
- serious risk (s70[2] cervical screening, s178 insanitary dwellinghouse, s259 and 263 emergencies, s280 quarantine),
- significant risk (s37[5]b amendment to schedule, s151 disclosure, s178[1] insanitary dwellinghouse).

If these terms are intended to denote different things then this needs to be clarified by definition/interpretations. If not then language needs to be consistent and defined.

Options would be a definition such as²³ :

“Serious public health risk” means a public health risk involving potential harm to public health that is irreversible, of a high impact or on a wide scale.

One example of particular confusion is about an insanitary dwellinghouse²⁴

“Serious condition” appears in s151 disclosure and appears to be a subset of communicable conditions, but with no guidance on level of seriousness.

Recommendations

Consistently use “serious risk to public health”.

Define “serious risk to public health” as a public health risk involving potential harm to public health that is irreversible, of a high impact or on a wide scale²⁵.

Define “serious communicable condition” as a communicable condition involving potential harm to public health that is irreversible, of a high impact or on a wide scale.

Risk factor

Wider use of the phrase “risk factor” may help. If the definition of “risk factor” (s79) is not restricted to non-communicable diseases it could be placed in Interpretation (s4).

“Risk factor” could then be defined as:

“A thing or substance that, on its own or together with other things or substances or conditions, may, whether immediately or over time, give rise to, or increase the incidence of disease in the general population or in communities or in sections of the general population or communities”.

This may then simplify terminology across the entire Bill. It could be narrowed where necessary, such as in Part 3, to “risk factors for non-communicable diseases (such as cancer, cardio-vascular disease, or diabetes)”.

Recommendation

Define “risk factor” in generic way and specify narrower uses (eg for only non-communicable diseases) where necessary.

Health risk

The language of “health risk” (s4d) and “public health risk” poses a problem for people not trained in law.

Adjectives usually restrict the meaning of the word they are attached to and indicate a more specific meaning (eg “grey cars” are fewer and more specific and “cars”). Common English usage therefore leads the reader to think that a “public health risk” is a more specific risk than “health risk”. However it is the other way around as defined - “health risk” (s4d). It would be helpful for the majority of readers if “health risk” was renamed.²⁶

Communicable and non-communicable diseases

The majority of the Bill concerns powers and duties enabling action for public health. Some of the actions cover control of diseases. Some cover control of hazards and risk factors. Some cover communicable diseases or conditions, others non-communicable, and yet others cover unknown conditions.

Distinguishing between “communicable” and “non-communicable” diseases is not particularly clear-cut, as some cancers (usually considered “non-communicable” in that you don’t catch cancer) are the result of infectious diseases.

Many of the duties and powers in the Bill, such as notification, activity consents, emergency powers or power of entry cover situations that apply to both communicable and other conditions.

However as the Bill has adopted aspects of this terminology the following section of our submission will use the terminology “communicable” and “non-communicable”.

2.5 Public Health approaches

There are a small number of principles and approaches that are fundamental to public health internationally and need to be reflected in the Bill.

The international public health focus on equity and for the health and rights of indigenous peoples has been considered above.

Public Health is everybody’s business

Public Health is everybody’s business. We reflect this in our PHA Strategic Plan 2004-2009²⁷ when we say that the PHA values collective action to improve public health and wellbeing and note the responsibility of the wider society (including national and local government), local communities, families, and individuals for the health of people.

The Health Act 1956 was clear that public health is everybody’s business. There were responsibilities specified for central and local government, and for operators of particular industries that pose high public health risk, including air and water pollution. It required employers to ensure healthy working conditions. Regulations were developed under the Act that specified actions to be taken concerning consumer products that posed risks to public health, when these were the results of emerging technologies (such as plastic

wrapping and microwave ovens) or in relation to the recognition of the impact and preventability of a problem (children's sleepwear).

The Health Act 1956 set the scene. Since then there has been the development of a range of legislation that has developed more specific controls in particular sectors:

- the Resource Management Act 1991 has taken the lead from the clean air and water provisions
- the Health and Safety in Employment Act 1992 has adapted the occupational health provisions
- the Hazardous Substances and New Organisms Act 1996 has followed from the toxic substances regulations
- the Fair Trading Act 1986 and the Consumer Guarantees Act 1993 have adopted the principle that products should be fit for purpose, and that includes safety.

The PHA supports the way that the Public Health Bill intends to:

- clarify interfaces with other legislation
- ensure that where there are possible gaps or overlaps with other legislation, action can be taken under this Bill to protect public health.

Essential functions of public health

One of the key policy objectives for this Bill is to update public health legislation in line with the major development in laws affecting hazards to public health, and to clarify interfaces. The Bill has made some advances in this, but more can be done.

The key areas of interface are with laws concerning public health objectives, roles and functions of District Health Boards (NZ Public Health and Disability Act 2000) and Territorial Authorities (Local Government Act (2002)). The Bill seems to have done little to clarify these interfaces.

The Bill is erratic in describing the roles and functions of the various agencies. Most are included under *Part 1 Preliminary provisions, roles and responsibilities*, while the roles, functions and responsibilities of Territorial Authorities are in *Part 5 Public Health role of Territorial Authorities*.

There is no coherence between the way the functions of the Minister, Director General and Director of Public Health are described in Part 1 and the way that the functions of Territorial Authorities are described in Part 5. Also some of the aspects listed as either role or responsibilities or function read like a list of tasks.

International developments offer a way to think of the functions of public health, and from those functions to then ascribe roles and tasks to different agencies and individuals.

This decade has seen the World Health Organisation (WHO) sponsor several meetings in regions to work on essential functions of public health²⁸. Participants from countries in our region of the WHO identified nine Essential Functions of Public Health:²⁹

- health situation monitoring and analysis
- epidemiological surveillance/disease prevention and control
- regulation and enforcement to protect public health
- health promotion, social participation and empowerment

- development of policies and planning in public health
- human resources development and planning in public health
- research, development and implementation of innovative public health solutions
- ensuring the quality of personal and population-based health services
- strategic management of health systems and services for population health gain.

Each of the Essential Functions of Public Health has specific outcomes identified for each function and each function has specific tasks. For example *Function 2: Epidemiological surveillance/disease prevention and control* has six tasks including *to investigate disease outbreaks and injury patterns, and the associated risks and hazards and to undertake case finding, diagnosis and treatment of diseases of public health significance, such as tuberculosis.*

This framework offers a logical, comprehensive way to describe and allocate functions and tasks rather than the chaotic manner used in the Bill.

The full WHO region report is attached as Appendix 2.

Public Health functions of the Minister, Director General and Director of Public Health

The public health functions of the national authorities are described in a piecemeal manner.

Public Health objectives and functions of DHBs

Under the NZ Public Health and Disability Act (2000) there are a large number of public health objectives and functions of DHBs. These are listed in Appendix 3.

However the DHB public health functions under Public Health Bill are very few.

(1) *The public health functions of a DHB are to---*

(a) *employ a sufficient number of those persons appointed by the Director-General as a Medical Officer of Health or a Health Protection Officer to implement and enforce this Act in the geographical area in respect of which the DHB is constituted; and*

(b) *monitor and identify (whether through routine surveillance, investigations by Health Protection Officers, data collection, or other means) risks to public health in the geographical area in respect of which the DHB is constituted; and*

(c) *assess and, where appropriate, report to the Director-General on those risks; and*

(d) *where appropriate, and reasonable in the circumstances, take steps to contain and manage those risks.*

(2) *A DHB may, with the agreement of the Director-General, arrange for another DHB to carry out some or all of its functions under this Act or any regulations made under this Act.*

(3) *Subsection (2) does not limit ways in which a DHB can carry out its functions under this section or the persons it may employ or engage in that task.*

It is important that the NZ Public Health and Disability Act (2000) is being amended to ensure that the DHB public health obligations include the functions of a DHB under this Bill. However it is not appropriate that the Public Health Bill does not note the range of public health functions that DHBs are responsible for under another Act.

Recommendation

That the public health functions and objectives of DHBs should be the same in both the NZ Public Health and Disability Act (2000) and the Public Health Bill; these functions should be based on the Essential Functions of Public Health.

Public Health objectives and functions of Territorial Authorities

Unfortunately the movement to put the responsibility for protecting public health explicitly into a range of different laws has resulted in some bodies not recognising, to the extent that they should, the importance of the current Health Act.

One of the most consistent comments that has come up in talking with PHA members about this Bill has been along the lines of:

“When we talk to our local authority they tell us that their responsibility is set out in the Local Government Act, and that they have responsibility for four wellbeings, and that does not include health; they say that health is the responsibility of the DHBs”

Clearly this is not the view of many Territorial Authorities. However the number of times that this idea has been expressed by PHA members in very different geographical locations suggests that there are also many Territorial Authorities that focus on the Local Government Act (2002) and do not willingly embrace their public health responsibilities.

Recommendation

That the Local Government Act (2002) *Part 2 Purpose of local government, and role and powers of local authorities* be amended to explicitly include the purpose of improving, promoting and protecting public health, with reference to the Public Health Bill.

Public Health functions under the Public Health Bill

Public Health functions of Territorial Authorities are not described in the Bill. Part 5 indicates roles for Territorial Authorities:

- duties include to improve, promote, and protect public health (elsewhere described as functions) but only so far as the powers and functions conferred on it by this Bill enable it to do so
- provision of sanitary services
- control of nuisances (which we believe should be called hazards to public health)
- carry out regulations
- make bylaws.

However the Local Government Act, the Resource Management Act, the Building Act, the Hazardous Substances and New Organisms Act all outline public health functions for Territorial Authorities.

When this is considered in the light of the Essential Functions of Public Health, Territorial Authorities are responsible for (at least aspects of) the following Essential Public Health Functions:

- health situation monitoring and analysis
- epidemiological surveillance/disease prevention and control
- regulation and enforcement to protect public health
- health promotion, social participation and empowerment
- development of policies and planning in public health
- human resources development and planning in public health
- research, development and implementation of innovative public health solutions.

Recommendation

That the public health functions of Territorial Authorities should be described in a similar way to the public health functions of other agencies in the Bill. In particular they should be described in a way that reflects the role of Territorial Authorities in carrying out the Essential Functions of Public Health.

For avoidance of doubt there should be consequential amendments to various other Acts to be clear that the actions of Territorial Authorities under those Acts are part of the public health functions of Territorial Authorities.

Summary of public health functions of agencies

The following table indicates which of the Essential Functions of Public Health the various agencies named in the Bill are responsible for.

Essential Functions of Public Health and responsible organisations

	DG of Health	DHBs	TAs
Health situation monitoring and analysis	☺	☺	☺
Epidemiological surveillance/disease prevention and control	☺	☺	☺
Regulation and enforcement to protect public health	☺	☺	☺
Health promotion, social participation and empowerment	☺	☺	☺
Development of policies and planning in public health	☺	☺	☺
Human resources development and planning in public health	☺	☺	☺
Research, development and implementation of innovative public health solutions	☺	☺	☺
Ensuring the quality of personal and population-based health services	☺	☺	
Strategic management of health systems and services for population health gain	☺	☺	

Recommendations

That the Bill uses the WHO Essential Functions of Public Health as an organising framework to describe the roles and responsibilities of relevant agencies and individuals in the Bill.

That the functions, roles, responsibilities and tasks of agencies and individuals be in one Part of the Bill so that the inter-relationships can be seen and understood.

Prevention - action for public health

Public health is about prevention in the broadest sense. Prevention can work at a range of points along the spectrum of disease development. The most fundamental form (“primordial prevention”) is to ensure the conditions needed for health are met. Primary prevention is to prevent disease from occurring, while secondary prevention accepts that the disease has occurred, but that we may be able to act in time to stop the disease causing real harm to the individual. Tertiary prevention accepts that the disease is established in the individual and works to prevent worsening outcomes or recurrence³⁰.

The Public Health Bill concerns itself with aspects of primordial, primary and secondary prevention. Tertiary prevention is the intent of the majority of health treatment services.

Life Course approach

The intuitive understanding that what happens to a person in their childhood is likely to affect them for the rest of their life had much study and gained descriptions such as “the cohort effect”. Life course epidemiology³¹ is shining light on the way that social and biological factors in childhood affect health in later life, particularly in relation to chronic, non-communicable disease.

This has been further elaborated within public health as an approach that points out that many public health outcomes (eg life expectancy, disability-adjusted life years) are the consequence of insults, injuries and benefits experienced across the course of life.

The WHO Commission on the Social Determinants of Health note:³²

“The seeds of adult health and health inequity are sown in early childhood.”

They go on to conclude:

“Better housing and living conditions, access to safe water and good sanitation, efficient waste management systems, safer neighbourhoods, food security, and access to services such as education, health, welfare, public transport, and child care are examples of social determinants of health that can be addressed through good urban local governance.”

The particular implication of this for the Public Health Bill is the need to place specific priority on children in the proactive aspects of public health work.

Recommendation

In carrying out proactive public health functions agencies should specifically place a priority on actions that contribute to improving, promoting or protecting the health of children and young people, including the health of women prior to conception.

Precautionary principle

While evidence is a crucial component for public health action there are times when it is important to act to protect health in the absence of definitive evidence. For example most societies knew of the importance of separating drinking water from sewage long before the development of the microscope and the identification of enteropathic organisms. In public health this is called “the precautionary principle”.

The basis of this principle is that it is better to be safe than sorry, particularly where there is limited information: the consequences could be dire and the effects may be irreversible.

The following is a way that the precautionary approach could be incorporated in legislation:³³

(1) If there is a serious public health risk, lack of full scientific certainty should not be used as a reason for postponing measures to prevent, control or abate that risk.

(2) In the application of the precautionary principle, decision-making should be guided by —

(a) a careful evaluation to avoid, where practicable, serious harm to public health; and

(b) an assessment of the risk-weighted consequences of the options.

Recommendation

That the Precautionary Principle should be explicitly included in the guiding principles of the Bill.

Regulation as part of a comprehensive approach

Most public health issues require comprehensive approaches that involve education of individuals, changes to public and private organisations, monitoring of both process and outcomes, health services funded from the government and regulation. For example, even though there is generally good regulation to ensure that the food sold in New Zealand is wholesome there is still a need for the “clean-cook-cover-chill” educational programme.

Similarly, while there was a good response to the campaigns for car seat-belt use it was still necessary to have legislation.

Thus it is not a question of *either* education *or* regulation; it is a question of what type of regulation and what regulatory escalation path is needed in a particular circumstance. As a result there needs to be power to make regulations under the Public Health Bill to improve, promote and protect health.

The PHA strongly opposes the removal of 117[1]a of the Health Act 1956 which gave power to make regulations for “*The improvement, promotion, and protection of public health*”.

Public health arguments for regulation

The key public health argument for appropriate regulation is *effectiveness*.

Countries regulate for car warrants of fitness to make sure that the cars on the road are well maintained and not likely to cause injury to their drivers or others as a result of machine failure. Regulating for this (and everyone bearing the cost of the large infrastructure of testing stations and inspection regimes) is a more effective way to control damage to life and limb than campaigns exhorting car owners to keep up maintenance on the brakes.

We have regulation of the quality of food and water, the safety of buildings, the level of training of doctors, nurses and plumbers because they are the most effective way to

ensure a safe and healthy community in relation to the issues covered. Similarly we have laws concerning tax evasion as the most effective way to achieve the outcomes society wants to see.

It is therefore important that the Public Health Act allows regulations to be made to protect public health when regulatory controls are the ones that work well to improve, promote and protect health.

We emphasise this as there will be other submitters who will argue against regulation. Amongst other things they will say that education is more effective. We agree that *at times* education can be the most effective way to improve health.

However the Public Health Bill needs to maintain the power for regulations to be developed for the times when regulation is the more effective.

Economic arguments for regulation

Free market economists argue that people make rational choices, and there should not be government interference when people make particular choices, as individuals have accepted risks to their own and their families' health.

However economic textbooks provide a generally consistent list of when government intervention is desirable based on "market failure". They may be expressed in a variety of ways but usually cover situations when:

- there is not good information readily understood (information asymmetry and/or search costs)
- people can be affected unknowingly and unwillingly - there are impacts (including costs) on others (externalities)
- there are limited options (monopoly, monopsony, cartel etc, but health agencies also note that addictions also limit rational decision-making)
- the item is a public good that anyone can use for free
- the inequalities that result from the market offends human dignity and human rights.

The history of the Public Health Bill and other laws to protect public health in relation to communicable diseases, environmental contamination, worker protection and injury control is based predominantly on the economic arguments of externalities and information asymmetry. The disproportionate impact on the poor is also an important reason to regulate.

When the World Bank considered the case of tobacco³⁴ it identified the following and considered that these issues provided reasons for government intervention:

- disproportionate impact on the poor
- there is limited knowledge of the risks and marketing can further mask public understanding of the risks
- use is well established in early life when decision-making is in the control of others (as a child) or when sound decision making may be limited (adolescence)
- addiction makes the situation hard to reverse
- costs are borne, at least in part, by others.

There are very similar reasons for regulating the sale of Breast Milk Substitutes (baby formula) and for regulating alcohol. Similar reasons exist for the regulatory requirement for “this product may contain traces of nuts” notes on foods and a myriad of other regulatory controls.

In summary there are sound economic reasons for existing regulation of products, services and processes that pose risks to public health, both as hazards for communicable diseases, worker safety and environmental contamination as well as risk factors for non communicable diseases.

We need to bear in mind that the Health Act 1956 had the ability to develop regulations that were able to place controls on products that had not been invented in 1956.

Recommendation

That the Public Health Bill needs to explicitly contain the same powers to develop regulations as s117[1]a of the Health Act 1956 which gave power to make regulations for “*The improvement, promotion, and protection of public health*”.

Bangkok Charter

One of the reasons that the Public Health Bill needs to update the 1956 Health Act is because of the significant changes in globalisation that have occurred in the latter half of the 20th century. The Bangkok Charter for Health Promotion In A Globalised World³⁵ was developed under the auspices of the WHO in 2005 in response to the same changes. The Bangkok Charter gives guidance to governments on approaches needed.

The Bangkok Charter identified, amongst others, the need to “**regulate and legislate** to ensure a high level of protection from harm and enable equal opportunity for health and well-being for all people”. Of relevance to this Bill is the essential integrated policy approach reflected in two particular areas:

“ All levels of government should make the health consequences of policies and legislation explicit, using tools such as equity-focused Health Impact Assessment”

“Make the promotion of health a requirement for good corporate practice”.

Clear guidance in the Public Health legislation on Health Impact Assessment (s323-325) and on expectations of the corporate sector (parts 3,4,5,6) are consistent with the Bangkok Charter. The provisions of the Bill in these areas need to be strengthened.

3 Systemic approaches needed in the Bill

3.1 Principles for the Bill

Principles are scattered throughout the Bill. Some of the principles identified as applying to specific Parts of the legislation could also apply to other Parts but are either not stated or not stated clearly. For example, the Principles in Part 3 Non-communicable Diseases subpart 2 Principles could apply to the whole of the Bill.

Section 3 *Purpose* subsection 3 states:

In seeking to achieve its purpose, the provisions of this Act reflect the need to---

(a) take into account concerns by Māori in relation to public health and consult with Māori in developing and implementing public health policies and measures

(b) protect public health when managing health risks where there is uncertainty or incomplete information about health effects

(c) ensure the exercise of powers under the provisions of this Act involves a response that is in proportion to the nature and seriousness of the risk to public health

(d) complement other legislation that seeks to improve, promote, and protect public health.

This subsection needs to be replaced by a set of principles that should guide the behaviour of all agencies and individuals acting under this Bill. This set includes:

- Māori self management
- empowerment
- precautionary principle
- equity
- proportionality.

Most of these issues have been discussed above. Proportionality is the principle described in s3[3]c above.

Recommendation

Replace s3[3] by the following principles and the requirement that all persons involved in the administration of this Act should perform their functions with due regard to these principles.

Māori self management principle

(a) Decisions and actions that affect Māori should, wherever possible be made by Māori through Māori institutions

(b) Territorial Authorities, DHBs the Minister and the Ministry of Health should consult with Māori in developing and implementing all proactive public health actions.

Empowerment principle

(a) Actions taken under this Bill should always respect individuals and communities

(b) Actions taken under this Bill should enable people to have greater control over their lives whenever possible

(c) Proactive public health actions should be developed and implemented in a way that supports increased participation in decision making processes.

Precautionary principle

(a) Action should be taken to manage public health risk when there is uncertainty or incomplete information about that risk

(b) When there is uncertainty or incomplete information the type and extent of public health action should be guided by

i) a careful evaluation to avoid, where practicable, serious harm to public health; and

ii) an assessment of the risk-weighted consequences of the options.

Equity principle

Actions taken under this Bill should, wherever possible, be directed towards increasing equity of health outcomes for Māori and all other population groups.

Proportionality principle

The exercise of powers should be a response that is in proportion to the nature and seriousness of the risk to public health.

3.2 General duty

The Bill needs a general duty that individuals and organisations should not pose public health risks (ie risks to the health of others).

While the Bill in some ways implies a general duty by posing explicitly creating an offence to recklessly spread a notifiable condition (s126) and requiring operators of regulated activities to take all practicable steps to prevent risks to public health (s196) the bill could go further and make it clear that it is not acceptable for individuals or organisations to pose risks to public health.

A general public health duty could require that a person must take all reasonable and practicable steps to prevent or minimise any harm to public health that might foreseeably result from anything done or omitted to be done by the person³⁶.

Recommendation

That the Bill explicitly pose a general duty on individuals and organisations to take all reasonable steps to prevent or minimise harm to public health.

3.3 Checks, balances, transparency and independence

The Bill gives significant power, to officers and agencies. The PHA is very supportive of requirements for checks and balances.

There is a need for checks and balances in societies to constrain the risk of abuse of power. Good decisions not only need to be taken by political institutions, they have to be seen to be good decisions taken in the best interests of public health.

Transparency and independence are particularly important as many agencies have concerns in addition to improving, promoting and protecting health and reducing inequalities.

To ensure that there are checks and balances there need to be explicit obligations at each level of the system for independent and transparent advice and monitoring.

At the level of the Minister of Health there is annual advice on matters relating to public health from the Public Health Advisory Committee via the National Advisory Committee On Health And Disability (under the NZ Public Health and Disability Act 2000) and this advice must be tabled in Parliament.

The Director of Public Health has the ability to report direct to the Minister of Health, independent of the Director-General of Health under the Public Health Bill.

Similar duties and powers are needed at DHB and Territorial Authority levels.

While there are some provisions under a range of laws for structures that may appear to perform these roles they are inadequate in the current environment.

Recommendations

Transparent, independent advice on public health to decision makers at DHB and Territorial Authorities level, similar to the role of the PHAC at a national level is needed. Community and Public Health Advisory Committees of DHBs (established under the NZ Public Health and Disability Act 2000) need to be strengthened so that they are able to carry out this role in relation to DHBs.

Guidelines on Community and Public Health Advisory Committees of DHBs should indicate a similar range of expertise as the Public Health Advisory Committee.

Statutory officers, such as Medical Officers of Health and Inspectors of Health need the ability to report independently to their Boards and Councils in a manner similar to the Director of Public Health at a national level.

DHB Statutory officers, such as Medical Officers of Health need the ability to provide advice and report independently to the Councils in their Health Districts, not simply be entitled to attend meetings.

Statutory officers, such as Medical Officers of Health and Inspectors of Health need the ability to report independently to the Director of Public Health.

3.4 Information systems

Information flows are crucial to the timely management of acute risks to public health and to the effective long-term planning and implementation of effective public health interventions.

Only some of the information needed for effective public health functioning is personal information that would otherwise be private and covered by the Privacy Act.

While the provisions in the Bill cover transfer of personal information these provisions are not adequate in relation to other information needs for public health.

Recommendation

That the Bill provides for a public health information system that enables:

- the management of acute risks to public health
- planning and policies for public health
- monitoring of both public health outcomes and public health processes

Gathering routine public health information

There are four sorts of public health information that need to be gathered routinely. There is need for information about:

- health events
- hazards to public health
- determinants of public health
- interventions.

This may mean that there needs to be careful consideration of definitions of public health information. The current definitions in the Bill of public health would consider only health events to be “public health information”. Amendments may be necessary to ensure that hazards, determinants and interventions are considered to be part of public health information.

This has particular relevance for the annual report of the Director-General on the state of public health and on our proposed public health reporting obligations at regional and local levels.

The amount of information that is required for each depends on the need for the information. When there is an event that requires action there is the need for the greatest amount of information, with the greatest speed. Information for planning and monitoring (including policy development) is not so urgent nor does it need the same level of detail.

Recommendation

That the Bill ensures that comprehensive information for public health is able to be collected, analysed and reported. This will include information on:

- health events
- hazards to public health
- determinants of public health
- interventions.

Event-based information

Events that need public health action may relate to health events (such as diagnosis of a notifiable communicable disease) or to health risk events (such as a defective sewer).

Full details of place, time and person are needed for health events that require investigation of every event in relation to individuals posing health risks.

The Bill successfully poses obligations that when such a situation is identified it must be reported and that the person making the report is protected for what would otherwise be a breach of privacy (Part 2, subpart 3, Notification and reporting).

The PHA is very supportive of the improved notification provisions.

Information for policy and planning

It is essential to know the burden of disease to mount appropriate public health action. Therefore the PHA supports the ability to gain anonymous information concerning the condition or treatment of, or the services provided to, any individuals in order to obtain statistics for health information purposes (s22).

Similarly the PHA supports the improvement in the Bill for improved gathering and reporting of significant health event data – hospitalisations.

DHBs have obligations under the New Zealand Public Health and Disability Act (2000) to regularly (at least 3 yearly) monitor health status and any factors that the DHB believes may adversely affect the health status of the population.

Territorial Authorities have obligations (s153b) to regularly inspect for situations that may be injurious to public health. They also have to (s153b) intervene by taking all proper steps to stop the situation that may be injurious to public health and to intervene and take any remedial action required to prevent premises presenting a risk to public health.

However there is no obligation to report anywhere about those public health hazards, determinants or public health interventions. At the moment it is unusual for Territorial Authorities to analyse and report this information.

Indeed, although reports can be requested by DHBs and/or the Director-General of Health (s154, 155) the Territorial Authority may ask for payment for preparing the report (156).

As noted elsewhere, the public health obligations of Territorial Authorities could be better recognised if they were more effectively integrated with the provisions of the Local Government Act (2002)

The Territorial Authorities should be required to routinely report to their communities on the extent of public health hazards, determinants and public health interventions required in their district. The obligation to report could be aligned with the Territorial Authority obligation to report on community outcomes under the Local Government Act to minimise the administrative burden on Territorial Authorities.

Recommendations

That the Public Health Bill, the NZ Public Health and Disability Act (2000) and the Local Government Act (2002) are aligned to ensure:

- minimisation of the consultation burden on communities on related issues by different agencies
- regular surveillance of and reporting on each district and region for hazards to public health
- explicit connections between Territorial Authority, cultural, economic, environmental and social well beings, community outcomes and public health
- aligned public reporting by a Territorial Authority and DHBs on community outcomes, public health outcomes and hazards to public health.

That DHB reports on health status and any factors that the DHB believes may adversely affect the health status of the population should provide information subdivided by Territorial Authority wherever possible. Unless there is agreed joint reporting by the Territorial Authorities and the DHB the relevant report should be formally transmitted to the relevant Territorial Authorities.

Territorial Authorities should routinely report to their communities on public health hazards, determinants and public health interventions made. This report could be made in conjunction with their three-yearly report on community outcomes.

That a copy of the reports of Territorial Authorities on public health hazards, determinants and interventions should be forwarded to the relevant DHB and to the Director-General of Health, unless there is agreed joint reporting by the Territorial Authorities and the DHB.

Territorial Authorities and DHBs should be encouraged to provide joint reports.

Ad hoc sources of public health information

The Bill continues provisions concerning access to data of the national cervical screening programme. Similar provisions should apply to all screening programmes.

It may also be appropriate to use a similar provision to ensure that analysts and researchers have confidential access to a wide range of data gathered for other purposes. Strict security provisions to protect confidentiality will be needed. Confidentiality could be assured as with the national cervical screening programme or with access to

confidential data held by Statistics New Zealand. This type of provision would bring New Zealand in line with many OECD countries.

Recommendation

That there be an investigation into ways of enabling access to a wide range of data sources for public health research, with strict controls imposed to ensure confidentiality.

Reporting public health information

The earlier section of this submission on transparency and independence discussed the importance of transparently reporting public health analysis at national, regional and local levels.

Providing good evidence to communities and to decision makers is one of the most important functions of a public health information system. The Director-General is required to ensure that there is an Annual Report of the State of Public Health.

The Director-General can gather information from DHBs as under the New Zealand Public Health and Disability Act (2002) there is an obligation on DHBs to provide information. There should be a similar obligation on Territorial Authorities.

Recommendations

That the Annual Report on the State of Public Health explicitly covers not just public health outcomes but also:

- hazards to public health
- determinants of public health
- interventions.

That the Bill obliges both DHBs and Territorial Authorities to provide information to the Director General to enable meaningful reporting.

Blood collection

Section 23 (Duty to provide information for purposes of blood collection) is meaningless.

Recommendation

Section 23 (Duty to provide information for purposes of blood collection) needs to be totally reviewed.

Subsidy compliance verification

Part 2, Subpart 2 should be totally removed from the Bill. It is inconsistent with the purpose of the legislation.

As the New Zealand Public Health and Disability Act (2000) is concerned with funding the provisions may be more appropriately located there.

Recommendation

Remove Part 2, Subpart 2 (Subsidy compliance verification) from the Bill.

3.5 *Planning for public health*

Healthy environments do not come about by chance.

As written, the Bill is almost totally focused on reacting to public health risks. This is particularly so in relation to the functions of the Minister. Until there are substantive requirements to plan for healthy environments much public health resource will still have to focus on reactive efforts.

The lack of process for forward-looking preventive actions for public health is a significant omission from the Bill.

Public Health Strategy

The New Zealand Public Health and Disability Act (2000) requires the Minister to have a health strategy called the New Zealand Health Strategy, to provide the framework **for the health sector** in improving the health of people and communities. Clearly this strategy does not offer a framework for other sectors in line with their responsibility for public health.

New Zealand needs one strategy for improving health that covers both actions in the health sector and in other sectors, in particular the sectors with obligations in the Public Health Bill. The New Zealand Health and Disability Act (2000) will need to be amended to achieve this.

District and Regional public health strategies

The issue of planning for public health has many similarities with information gathering, sharing and reporting discussed above.

Under the New Zealand Public Health and Disability Act (2000) DHBs have obligations to have a District Strategic Plan looking five to ten years out that is revised at least every three years. DHBs also have to prepare District Annual Plans.

Territorial Authorities, under the Local Government Act (2002) must have Long Term Community Council Plans (LTCCPs). These have an outlook of up to ten years and must be revised at least every three years. Each Territorial Authority must have an annual plan to implement the LTCCP.

As both DHBs and Territorial Authorities have significant public health related planning responsibilities under their own legislation, it would be useful to have the planning obligations under the three laws aligned in both timing and process

Recommendations

That the Minister of Health is required to determine a New Zealand Health Strategy to provide a framework for both the health sector and other sectors covered in the Public Health Bill. This will require:

- inclusion in the Public Health Bill and
- amendment of the New Zealand Health and Disability Act (2000).

As with the New Zealand Health Strategy the Minister should be obliged to consult before determining such a strategy.

DHBs and Territorial Authorities should be required under the Bill to have planning processes for public health similar to their obligations under the New Zealand Public Health and Disability Act (2000) and the Local Government Act (2002).

There needs to be alignment of the Public Health Bill, the New Zealand Public Health and Disability Act (2000) and the Local Government Act (2002) to ensure long term planning revised at least three yearly, by DHB and Territorial Authorities, on achieving improved public health outcomes and reduced inequalities. This planning needs to be co-ordinated between DHBs and Territorial Authorities and between the obligations of the three Acts.

Health Impact Assessment

Health Impact Assessment is an essential tool in planning for improved public health.

The PHA is very pleased to see the inclusion of Health Impact Assessment in the Bill. In general we support the definition of Health Impact Assessment and the ability of the Director-General to specify criteria.

Some Territorial Authorities already see the relationship of Health Impact Assessment to their responsibilities under the Local Government Act (2002) for environmental, social and cultural wellbeing. These Authorities see the benefit for their communities and are taking the time and effort to carry out Health Impact Assessment.

However in the Bill:

- Health Impact Assessment is a purely voluntary activity; there are no obligations to carry out Health Impact Assessment
- there is no requirement for Health Impact Assessment to consider equity
- there is no requirement for Health Impact Assessment to consider Māori health
- Health Impact Assessment as it applies to the public sector does not apply to regulations or statutes
- Health Impact Assessment does not apply outside of the public sector.

Both the Bangkok Charter³⁷ and the reports of the Evidence Networks for the WHO Commission on the Social Determinants of Health place importance on equity-based Health Impact Assessment.

The latter identifies equity-based Health Impact Assessment as a way to “equity-proof”. “Equity proofing” is key to the effective implementation of policies and programmes. It is also crucial for the sustainability of an overall approach to improving health equity.

Excellent guidance is available. International materials^{38 39} show the wide applicability of the tools and local materials provide advice on specific approaches relevant to this country.^{40 41}

Mandatory Health Impact Assessment

Health Impact Assessment can be a significant undertaking. However, despite encouragement, many are not doing this voluntarily.

There should be powers to *require* a Health Impact Assessment in a small number of crucial activities that affect public health. Perhaps there could be a schedule to the Act of topics on which HIA is required. These topics could be based on the Public Health Strategy.

Health Impact Assessment in the Bill is restricted to government agencies. There should be careful examination of the advantages of obliging commercial organisations to conduct Health Impact Assessment under certain circumstances.

Recommendations

Health Impact Assessments should explicitly consider Māori health and equity.

That the Bill includes powers to require Health Impact Assessment to be undertaken.

That the bodies that may be required to undertake Health Impact Assessment be extended beyond the government sector.

3.6 Training, qualifications and competence

The effectiveness of public health interventions are crucially dependant on the ability of the people who carry it out. The Bill needs additional provisions to ensure the competence of the public health practitioners in general and in particular the practitioners who have responsibilities under the Act.

The lack of such provisions is a major deficiency in the Bill. It is another example of the way that the Bill, as currently drafted, focuses on responses to public health crises rather than providing for comprehensive, proactive protections.

Health Practitioners Competency Assurance Act (2003)

A major change in ensuring public health and safety in recent years has been the introduction of the Health Practitioners Competency Assurance Act (2003). Most public health practitioners are not covered by this Act.

One of the key features of this Act has been a requirement for the continuing competence of practitioners in addition to requirements for initial competence. In practice this means that initial qualifications are not sufficient, there must be a system to ensure ongoing education and review of practice.

The Public Health Bill needs to be explicit that either public health practitioners are included under the Health Practitioners Competency Assurance Act or that the Public Health Bill itself imposes similar requirements public health practitioners.

At present the public health workforce is significantly underskilled and under-trained⁴². At present there is no consensus as to whether a workforce regulating regime such as the Health Practitioners Competency Assurance Act (2003) is either necessary or desirable for all public health practitioners.

Competency of statutory public health practitioners

What is abundantly clear however is that those practitioners with specific responsibilities under the Public Health Bill should have specific training and skills and that there needs to be a requirement for ongoing competency assurance.

The Bill identifies the ability to continue to have regulations concerning Inspectors of Health. This provision is inadequate in that it only requires initial qualifications and requires no assurance of ongoing competency.

The only other requirement for any qualifications, training or competency of any other practitioner is that Medical Officers of Health must be suitably qualified and experienced medical practitioners. Assuming that “medical practitioner” means “registered medical practitioner” the Health Professional Competency Assurance Act (2003) ensures that the medical practitioner is suitably qualified and is maintaining continuing professional development and competence.

There is no obligation concerning the competency of any other practitioners with roles under the Bill. The Bill should be explicit that there are consistent national standards of competency for all public health practitioners with roles under the Bill.

Recommendation

That the Bill should be explicit that there are to be national standards of competency (including continuing competency) for all public health practitioners with roles under the Bill.

That the regulations on qualifications of Inspectors of Health should explicitly cover continuing competency.

4 Comments on Parts

4.1 Controlling the spread of communicable diseases to others (Parts 2 and 4)

The control of the spread of communicable disease is an important form of primary prevention. It does not address the cause of disease but it does prevent individuals from being affected.

The PHA is very supportive of the provisions for control of conditions posing public health risks (Part 4).

We are particularly pleased that there is inclusion of the offences concerning recklessness (s126). This is consistent with our recommendation that there should be a general duty to not pose public health risks.

In relation to the defences (s127) we have considerable concern. The major concern is the need for *informed* consent.

The phrase “voluntarily accepted the risk of contracting the condition” is inadequate to convey the obligation that the person with the condition has to ensure adequate informed consent.

Recommendation

The Bill should only give a defence against recklessly spreading a notifiable disease or condition based on the consent of the person put at risk if that person:

- knows the risk of contracting the condition
- knows ways to protect themselves from contracting the condition
- knows the range and probability of the consequences of the condition.

A number of PHA members consider that there should be no defence of “voluntarily accepted the risk”. This comes by analogy with drunk driving. The comparable situation is that a person driving while drunk has a crash and kills the passenger. It is not usually a defence against manslaughter that the passenger knew that the driver was drunk and that a crash was more likely and could be fatal.

Notification

Discussion of notification is included here as it is such an important aspect of the control of communicable conditions.

We strongly support the more flexible framework in the schedules concerning notification. It is important to enable notification of not just cases but also conditions, clusters or contaminants (s31).

We also support the extension of groups of people obligated to notify (s33-36), the option for temporary notification (s38).

Notification concerning non-communicable diseases

As described above concerning information systems for public health, the notification requirements also contain provisions for notification about non-communicable disease contaminants.

We are supportive of notification of the non-communicable disease conditions (such as lead poisoning) or contaminants (such as substances identified in Drinking Water Standards).

Contact tracing and case finding

The PHA supports the new provisions for contact tracing that authorises contact tracing where it doesn't happen voluntarily (s138-149) and permits Medical practitioner / Medical Officer of Health to approach employers etc for contact details (s145).

We also support the provision that allows examination of individuals on suspicion (s97).

See also the comment above under “equity” on the importance of intensive contract tracing for people in population groups suffering an inequitable burden of infectious disease.

Least restrictive means

The PHA is very supportive of the wide range of disease containment options (s95). Conditions vary in the way and ease with which they are spread. It is sensible for biological reasons to have a range of options to control the spread of conditions.

This is consistent with the proportionality principle that should underpin the entire Bill (instead of being focussed only on Part 6 Regulated Activities).

When there is a range of options for containing the spread of a condition the requirement for the use of least restrictive option (s91) offers increased respect for human rights.

We also support, within the range of options to control the spread of conditions, that a Medical practitioner / Medical Officer of Health may disclose information on risks posed by them to sexual partners / household members (s150-152).

Similarly the ability to have urgent orders (s106) are ways to offer greater protections for public health.

Respect for individuals

We are also supportive of the approach that gives greater respect for individuals (s92-93) and which make provisions for stronger safeguards eg appeals (s112-123) and time restrictions (s96).

Residence orders

The provision for residence orders in respect of persons needing care (part 4 Conditions posing health risks) should be examined very carefully. It appears that these sections apply to person who are not posing health risks to others.

Actions under the Public Health law should be to improve, promote or protect public health. The living conditions of competent adults should not be subject to public health provisions unless they pose health risks to others.

If the person is posing health risks to others then public health provisions should be able to control those risks.

If however the person is posing a risk to only themselves then there should be assessment of the competence of the person to make decisions for themselves.

If they are incompetent by reason of mental illness then the provisions of the Mental Health (Compulsory Assessment and Treatment) Act may be relevant to ensure that the person does not pose risks to themselves.

Alternatively the Protection of Personal and Property Rights Act (1988) is available to ensure that people incompetent to make decisions for themselves are safe.

Recommendation

In line with the Proportionality Principle, delete from the Bill the provisions concerning residence orders for persons not posing health risks to others.

4.2 Healthy environments – non communicable diseases (Part 3)

The PHA is very pleased to see that the Bill is explicit that risk factors for non-communicable diseases are to be subject to public health legislative control. This is because non-communicable conditions pose the major burden of preventable disease facing the country. A strong Part 3 is essential to be able to deliver on the intent of the Act to improve, promote and protect the health of new Zealanders.

The PHA strongly supports the definitions of risk factor and of sector.

The principles (s80) should be modified as noted above under Treaty of Waitangi and Equity.

Health Act 1956 and non-communicable disease

As noted above (*Public Health is everybody's business*) the Health Act (1956) was routinely used to control non-communicable hazards to public health. The ability to do so, and the expectation that the Public Health Bill will be used to control non-communicable diseases as the Health Act (1956) had done needs to continue.

The fundamental provision enabling regulations to be made for the purpose of that Act (as noted above in *Regulation as part of a comprehensive approach*) must continue.

Implementing the Health Committee report on Obesity and Type II Diabetes

The most immediate need of the Part 3 provisions of the Bill is to control risk factors for diabetes and its complications. In particular the first need is for the ability to control marketing of energy dense foods.

The Health Select Committee in your report on the inquiry into Obesity and Type II Diabetes recommended that there is an initial opportunity for voluntary compliance and industry self-regulation followed, if necessary by regulation.

The PHA considered the Select Committee report on Obesity and Type II Diabetes too weak. The Food Accord has been in place since September 2004. This is ample time to note that this has not been effective in protecting public health and regulations should be made immediately.

Part 3 subpart 4 (Review) seems to suggest that no action beyond voluntary codes and guidelines should be taken until after the Director-General has reported to the Minister. It could also be interpreted (s88e) as meaning that the Bill does not currently contain the power to make regulations for the purpose of preventing, or reducing the impact of, non-communicable diseases or improving the management of risk factors.

To be sure that the Bill can be used as a regulatory mechanism envisaged in the Health Committee report, Part 3 should be strengthened. For the avoidance of doubt Part 3 should explicitly include the ability to make regulations for the control of risk factors for non-communicable diseases.

It should also be made clear that:

- regulations for the control of risk factors for non-communicable diseases can be made at any time and
- there is no requirement to wait until after the s88 report to make regulations.

The timeframe for the report of the Director-General to the Minister should be able to be deferred by no longer than one year. The current wording allows for infinite delay.

While there is no harm in the Bill containing the ability for the Director-General to issue non-binding codes or guidelines there is no advantage in those provisions. Non-binding advice can be offered at any time.

The Bill needs to contain:

- Interpretation (definitions of risk factor and sector, both of which may be applicable to more than just Part 3)
- Principles (modified as noted above)
- Explicit regulation-making powers.

Recommendations

Ensure that the Bill contains explicit powers to make regulations that can be used immediately to control risk factors for non-communicable diseases.

The timeframe for the report of the Director-General to the Minister should be able to be deferred by no longer than one year.

4.3 Healthy environments – Territorial Authorities (Part 5) and regulated activities (Part 6)

Relationship with Part 3 (non-communicable diseases)

Parts 5 and 6 of the Bill are excellent updates of the provision of the Health Act (1956). However Parts 5 and 6 sit uncomfortably with Part 3.

To be a coherent legislative approach to public health this Bill needs to combine Parts 3 (Non communicable disease) into Part 5 and Part 6 (regulated activities).

Recommendation

Ensure that the Bill is modified to:

- apply the definition of “risk factor” and “sector” to activities to be regulated
- be sure that Territorial Authorities are able to make bylaws concerning risk factors
- enable a wide range of regulatory approaches to risk factors within a principled framework as with the current processes in Parts 5 and 6.

Improving the 1956 framework

The enabling regulatory framework proposed for Parts 5 and 6 is a major improvement on the parallel provisions of the current Health Act (1956). The PHA is very supportive of this development.

The range of options that follow the proportionality principle is an important development.

Protecting employee health; protecting public health

While the PHA is very supportive of the provision concerning operators of regulated activities the obligations should apply to all commercial activities.

As noted above (General Duty) there should be a general duty on all persons to avoid posing a risk to public health.

The Health and Safety in Employment Act (1992) requires employers to identify risks to employee health and safety and to take all necessary steps to mitigate those risks.

As all employers are already carrying out these obligations to identify risks for employees it should be a relatively simple matter to extend the identification of risks to neighbours and customers.

Recommendations

In line with the concept of a general duty to not pose a public health risk and with the Health and Safety in Employment Act (1992) the operators of all commercial activities should be obliged to identify public health risks that their activities may pose and take all practicable steps to prevent risks to public health.

“Hazards to public health” not “nuisances”

The PHA supports the change in definition of “nuisance” in the Bill.

Public Health legislation should not be used as a dumping ground for miscellaneous ways to intervene in communities. The 1956 Health Act nuisance provisions had the ability to be used that way.

The Health Act (1956) generally views nuisances as those things that are “offensive or likely to be injurious to health.”

Since the “nuisance” provisions were established in 1956 there has been the development of the Resource Management Act and a new Local Government Act which give Territorial Authorities powers to control many situations previous covered under the Health Act.

The restriction of nuisances in the Bill to “an activity or state of affairs that is, or is likely to be, injurious to public health” where public health is “the health of all of--- (a) the people of New Zealand; or (b) a community or section of those people” means that nuisances are now much more clearly related to harm to public health.

It would be preferable, if the definition of “nuisance” is to change that the word not be retained. This is in part because of the possible confusion that could be caused because the definition has changed. The other reason is that “nuisance” in colloquial English has, as one meaning, the sense of annoyance or inconvenience. Thus in common language a “nuisance” is relatively trivial.

It would be better to replace “nuisance” with “hazard to public health”.

Recommendations

The term “nuisance” should be replaced by a more descriptive term, such as “hazard to public health”.

The proportionality principle needs to apply to Part 5 (preferably to the whole Bill) not just Part 6; in particular if there is no risk to public health then there should be no power for intervention.

Part 6: Regulated Activities

The te Tiriti principle that, decisions and actions affecting Māori should, wherever possible be made by Māori through Māori institutions should be applied in Part 6 as elsewhere in the Bill.

Recommendation

In Part 6 there should be opportunities for Māori institutions, such as runanga to have the same range of powers and controls as Territorial Authorities.

4.4 Preventing conditions from getting worse (Part 2)

An important aspect of preventive health interventions is secondary prevention – early identification of disease when there is still time to intervene before the disease takes over and damages the individual.

Screening programmes are the classic example of secondary disease prevention.

Screening programmes

Forty years ago the WHO identified a set of principles for screening programmes.

When well organised, screening programmes have the ability to significantly reduce inequalities. Population-based screening programmes ensure that everyone has the opportunity to benefit from early intervention.

However as noted above under “Equity”, universal programmes need to have targeted follow-up or similar implementation to make a significant impact on the burden of disease or significant reduction in inequality. This has been the New Zealand screening experience with cervical and breast cancer screening, and childhood vision hearing screening.

Cervical screening provisions should apply to all population screening programmes

To achieve effective reductions in inequalities the principles of population screening should be incorporated into this legislation.

The provisions concerning cervical screening in the Bill offer an excellent model for other screening programmes that could be named in a schedule to the Bill. This schedule could then be subsequently amended, as with other schedules.

As noted above under “Information systems for Public Health” there should be provisions for access to screening data for quality assurance and public health research with a high level of security for confidentiality.

“Opt-off” registers are a way to increase equity. They enhance use of the programme by people in vulnerable groups and are a way to develop tailored provisions to increase equity within a universal programme while retaining full autonomy for individuals and communities that do not want to participate.

The kaitiaki provisions for Māori data is an option to allow Māori control over Māori taonga.

Recommendation

The provisions in the Bill concerning cervical screening (part 2, subpart 4) should be made available to apply to all population screening programmes, with a schedule to the Bill detailing the screening programmes.

Wellchild screening

The PHA is concerned at the proposed changes to the Health Act (1956) provisions concerning the examination of children at schools and early childhood centres (s328 of the Bill).

The focus of the Health Act (1956) examination of children provisions was to enable health examinations of children with or without consent. The powers of compulsion under the Act are only needed when organisations, communities and families do not willingly partake in screening.

The Bill:

- gives powers of entry without consent of the school or centre to a wider range of places (private as well as public facilities)
- gives powers to authorise which persons can have powers of compulsory entry to a much wider number of people (Medical Officers of Health as opposed to only the Minister)
- eliminates the ability to provide universal screening.

Bill allows forced entry but children unlikely to benefit

This is a curious change. Powers of compulsory entry are only required if the school or early childhood centre does not invite the service to come in, or refuses entry when the service is offered. But the only reason that there is any purpose for entry against the wishes of the school or centre is to provide screening or other examinations for the children.

Under the provisions of the Bill, once the public health practitioner has entered against the wishes of the school or centre, the practitioner may not examine any child without explicit consent of the parent or guardian. The reality of schools and centres is that explicit consent is only ever able to be obtained with the active support of the school or centre management.

This does not appear to assist in providing examinations and screening for all children.

It is unlikely that this is the policy intent of the change; whatever the reason the wording must change to benefit children.

We support the idea that screening and examination of children should happen in all schools and early childhood centres, not just in public institutions. This is a public health

activity that should be for the benefit of all children irrespective of the type of facility they attend.

However the barrier to children getting the examinations or screening is almost never that the school/centre refuses access. The major barrier is that many families are in such difficult circumstances that the family may not even know that a consent form has come home in the bottom of a school bag, let alone know of the due date to have it signed and returned by.

The PHA does not oppose the change concerning powers of compulsory entry but we are deeply concerned at the change that denies children screening and examination in the absence of explicit consent.

Respect parent/guardian wishes

Current practice is that consent is strenuously sought, and that practice should be continued. If the parent or guardian refuses examination then the examination, testing or screening should not be permitted.

However children should be able to benefit from non-invasive examinations and screening unless their parent or guardian refuses consent. If the designated health practitioner and the school /early childhood centre have made reasonable efforts to obtain consent and the parent or guardian has not refused consent the child should not be penalised because consent has not been obtained.

This approach that allows parents to “opt out” is consistent with the principles for the cervical screening register and also with the identification of immunisation status in the Health (Immunisation Regulations) 1995.

In particular “opt-off” provisions will reduce inequalities. Public health practitioners are very clear on the practical implications. The children who are most vulnerable are also the children for whom the parent or guardian is most likely to have not responded to the request for consent.

The particular examples of examination, screening or testing that are envisaged here are well child examinations, vision hearing tests and dental checks. Invasive testing (eg blood testing, sexual health examinations) is clearly outside of the scope of this recommendation.

To be clear, this recommendation concerns examination, testing or screening and in no way covers treatment of a child without consent.

Authorisation powers

The Health Act (1956) was very strict in who could enter schools and centres and examine children without consent. In general the person has to be authorised by the Minister.

The increased flexibility of permitting Medical Officers of Health to authorise practitioners to enter schools/centres adds flexibility and gives the opportunity for

making use of local knowledge about the suitability of practitioners to exercise these compulsory powers.

However it removes the element of national consistency and standards. While the health reforms that introduced Area Health Boards made some significant improvements in some areas of public health one of the losses was the national standards and training of some statutory officers, in particular public health nurses. This needs to be remedied urgently.

If the power to designate is to be delegation to the local level there needs to be a mechanism for central control of standards. This may need to be done by regulation; it may be able to be done by other mechanisms. Whichever mechanism is to be used must be explicit in the Bill.

Recommendations

That a designated officer may examine, test or screen any child at a school/centre (s328) without consent from parent or guardian where:

- extensive efforts have been made to obtain consent and
- consent has not been refused and
- the examination test or screening is not invasive.

That the Bill contain explicit mechanisms to ensure nationally consistent standards (including standards of continuing competency) for officers designated under this section.

Retaining a restricted version of the powers in the current Health Act (1956) to examine children without the explicit consent of parent/guardians is particularly important if the most vulnerable children are not to miss out on programmes such as the supportive, systematic checks proposed by the Children's Commissioner for all children.

4.5 Border health protection and emergencies(Part 7)

The PHA has little comment on this Part and is generally supportive. However this area reflects the importance of planning for public health.

Appendix 1-Extracts for the UN Declaration of the rights of indigenous peoples

Article 21

1. Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.
2. States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities.

Article 22

1. Particular attention shall be paid to the rights and special needs of indigenous elders, women, youth, children and persons with disabilities in the implementation of this Declaration.
2. States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children enjoy the full protection and guarantees against all forms of violence and discrimination.

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions.

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

Article 25

Indigenous peoples have the right to maintain and strengthen their distinctive spiritual relationship with their traditionally owned or otherwise occupied and used lands, territories, waters and coastal seas and other resources and to uphold their responsibilities to future generations in this regard.

Article 26

1. Indigenous peoples have the right to the lands, territories and resources which they have traditionally owned, occupied or otherwise used or acquired.
2. Indigenous peoples have the right to own, use, develop and control the lands, territories and resources that they possess by reason of traditional ownership or other traditional occupation or use, as well as those which they have otherwise acquired.

3. States shall give legal recognition and protection to these lands, territories and resources. Such recognition shall be conducted with due respect to the customs, traditions and land tenure systems of the indigenous peoples concerned.

Article 27

States shall establish and implement, in conjunction with indigenous peoples concerned, a fair, independent, impartial, open and transparent process, giving due recognition to indigenous peoples' laws, traditions, customs and land tenure systems, to recognize and adjudicate the rights of indigenous peoples pertaining to their lands, territories and resources, including those which were traditionally owned or otherwise occupied or used. Indigenous peoples shall have the right to participate in this process.

Article 28

1. Indigenous peoples have the right to redress, by means that can include restitution or, when this is not possible, just, fair and equitable compensation, for the lands, territories and resources which they have traditionally owned or otherwise occupied or used, and which have been confiscated, taken, occupied, used or damaged without their free, prior and informed consent.
2. Unless otherwise freely agreed upon by the peoples concerned, compensation shall take the form of lands, territories and resources equal in quality, size and legal status or of monetary compensation or other appropriate redress.

Article 29

1. Indigenous peoples have the right to the conservation and protection of the environment and the productive capacity of their lands or territories and resources. States shall establish and implement assistance programmes for indigenous peoples for such conservation and protection, without discrimination.
2. States shall take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior and informed consent.
3. States shall also take effective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

Appendix 2 Essential Public Health Functions

WORLD HEALTH
ORGANIZATION



ORGANISATION MONDIALE
DE LA SANTÉ

REGIONAL OFFICE FOR THE WESTERN PACIFIC
BUREAU RÉGIONAL DU PACIFIQUE OCCIDENTAL

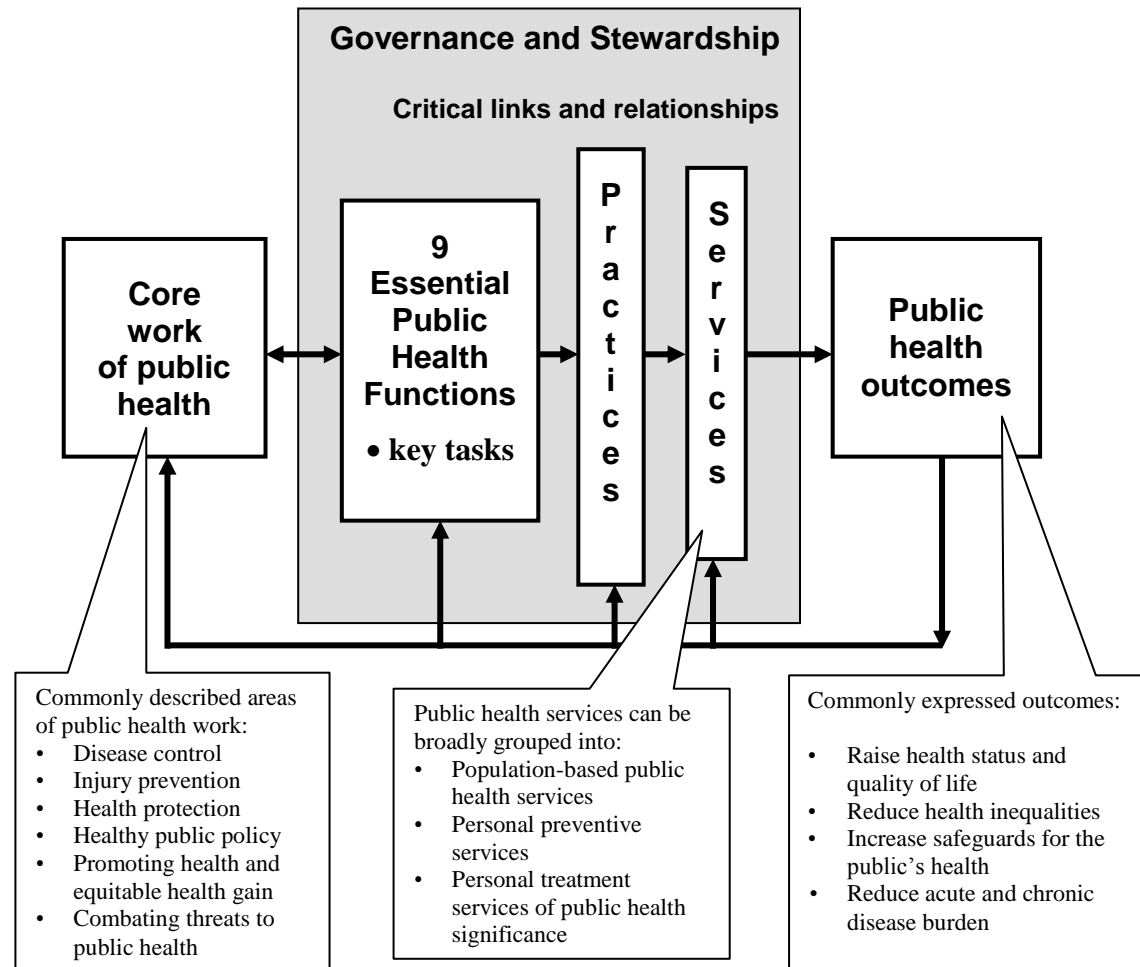
CONSULTATION ON ESSENTIAL PUBLIC HEALTH FUNCTIONS WITH
AUSTRALIA, NEW ZEALAND AND PACIFIC ISLAND COUNTRIES

WPR/ICP/HRF/6.4/001/HSD(1)/2003/INF./2 20 November 2003

8 to 11 December 2003 **Nadi, Fiji** ENGLISH ONLY

The 9 Essential Public Health Functions, tasks and practices
developed for the three-country study in the Western Pacific Region[1]

The Framework



FUNCTION 1:

Health situation monitoring and analysis

Outcomes

The outcomes of this function are the measurement, monitoring and analysis of changes in health status, including quality of life and health inequalities, and the acute and chronic disease burden. The function results in confidence that safeguards exist for the protection of the public's health and provides early warning of problems.

Tasks

1.1 Assess health status of the country, both accurately and on-going, for larger administrative units within the country, and for specific groups that are of higher risk for health threats than the general population.

Practices: assess; analyze; set priorities; evaluate; communicate; collect and use evidence.

1.2 Analyze, in addition to (1), **trends** in socio-demographic variables, mortality, morbidity, risks and hazards (personal and environmental), barriers to access to personal preventive services and *personal treatment services of public health significanceⁱⁱ* and coverage of population-based public health services.

Practices: analyze.

1.3 Identify current and potential threats to health.

Practices: assess; investigate; analyze; communicate; collect and use evidence.

1.4 Periodically assess health services needs (and/or targeted assessments).

Practices: assess; analyze; evaluate; collect and use evidence.

1.5 Identify resources and assets (in communities and in other sectors) to support public health.

Practices: investigate; assess.

1.6 Profile health status - the production and distribution of a health status profile including 1-5 above.

Practices: analyze; communicate; collect and use evidence.

1.7 Manage information - development of technology, expertise, and methods for management, analysis, quality control, and communication of information to all those with responsibilities for improving the public health.

Practices: develop plans; manage; implement; evaluate; collect and use evidence.

1.8 Integrate information systems, by collaborating within the public health system, with other parts of the health sector, and with other sectors, including the private sector.

Practices: negotiate; communicate; advocate; integrate.

FUNCTION 2: Epidemiological surveillance/disease prevention and control

Outcomes

The outcomes of this function contribute to improving health status and the quality of life, reducing health inequalities, safeguarding the public's health and reducing the burden of disease.

Tasks

2.1 Conduct surveillance of outbreaks and patterns of communicable and noncommunicable diseases, injuries, and exposure to environmental agents harmful to health.

Practices: assess; investigate; analyze; develop plans; manage resources; evaluate; communicate; collect and use evidence; ensure compliance.

2.2 Investigate disease outbreaks and injury patterns, and the associated risks and hazards.

Practices: set priorities; negotiate; develop plans; manage resources; implement; communicate.

2.3 Undertake case finding, diagnosis and treatment of diseases of public health significance, such as tuberculosis.

Practices: investigate; negotiate; manage patients; communicate; ensure compliance.

2.4 Access information and support services for better management of health problems of interest.

Practices: assess; negotiate; collect and use evidence; communicate.

2.5 Respond rapidly to control outbreaks and emerging specific health problems or risks.

Practices: assess; analyze; negotiate; set priorities; develop plans; manage; collect and use evidence; ensure compliance.

2.6 Implement mechanisms to improve surveillance systems and disease prevention and control.

Practices: assess; analyze; negotiate; develop plans; implement; evaluate; communicate.

ⁱⁱ Country-specific interpretation of that part of this task specified in italics.

FUNCTION 3: Development of policies and planning in public health

Outcomes

The outcomes of this function are the development of policies and planning for the improvement of health status and quality of life, reducing health inequalities, safeguarding the public's health, and reducing the burden of disease.

Tasks

3.1 Develop policy and legislation to guide the practice of public health

Practices: analyze; advocate; negotiate; set priorities; develop plans; collect and use evidence; communicate.

3.2 Develop and evaluate plans to promote and protect public health.

Practices: assess; analyze; negotiate; integrate; set priorities; develop plans; manage; evaluate; communicate.

3.3 Review and update regulatory frameworks, policy, and their implementation, regularly and systematically in the light of health status and assessments of health needs.

Practices: assess; set priorities; develop plans; evaluate; collect and use evidence.

3.4 Advocate for population-based perspectives in health services policy and the development of health sector regulation.

Practices: advocate; negotiate; communicate; collect and use evidence.

3.5 Develop and track measurable indicators of health.

Practices: assess; investigate; analyze; implement; evaluate.

3.6 Evaluate jointly with relevant health care systems so as to plan and to define policies regarding personal preventive and treatment services.

Practices: advocate; negotiate; develop plans; evaluate; collect and use evidence; communicate.

FUNCTION 4: Strategic management of health systems and services for population health gain

Outcomes

The outcomes of this function contribute to implementation of strategies to improve health status and the quality of life, reduce health inequalities, safeguard the public's health, and reduce the burden of disease.

Tasks

4.1 Promote and evaluate effective access by all citizens to the health services they need.

Practices: assess; investigate; evaluate.

4.2 Resolve and reduce inequities in the use of health services by multisectoral collaboration that facilitates working with other agencies and institutions.

Practices: advocate; integrate; implement; evaluate.

4.3 Overcome barriers to access to necessary health services by individuals and communities by population-based public health actions.

Practices: investigate; develop plans; integrate; implement; evaluate.

4.4 Facilitate the linkage of vulnerable groups to health services

Practices: advocate; negotiate; integrate; implement; evaluate.

4.5 Develop competence in evidence-based decision-making that incorporates resource management, leadership capacity, and effective communication.

Practices: negotiate; set priorities; manage; communicate.

4.6 Advise on priorities of publicly funded health services.

Practices: analyze; set priorities; negotiate; communicate; collect and use evidence.

4.7 Use evidence on safety, effectiveness and cost effectiveness to assess the utility of health technology and interventions.

Practices: assess; evaluate; collect and use evidence; communicate.

4.8 Manage public health to build, implement, and evaluate organized initiatives to address public health problems.

Practices: manage; develop plans; integrate; implement; evaluate; set priorities.

4.9 Prepare for disaster and emergency response by the health system.

Practices: assess; negotiate; integrate; set priorities; develop plans; implement; communicate; ensure compliance.

FUNCTION 5: Regulation and enforcement to protect public health

Outcomes

The outcomes of this function contribute to the development and compliance with regulation that improves health status and the quality of life, reduces health inequalities, safeguards and protects the public's health, and reduces the burden of disease.

Tasks

5.1 Promulgate and implement laws and regulations in public health.

Practices: investigate; negotiate; collect and use evidence; communicate; ensure compliance.

5.2 Review, develop and update regulations in public health and develop capacity to regulate.

Practices: assess; set priorities; develop plans; manage; collect and use evidence.

5.3 Ensure enforcement of regulations and develop capacity for enforcement.

Practices: assess; analyze; manage; collect and use evidence; communicate.

5.4 Assess and promote compliance

Practices: assess; investigate; analyze; advocate; negotiate; integrate; communicate; collect and use evidence; ensure compliance.

FUNCTION 6: Human resources development and planning in public health

Outcomes

The outcomes of this function provide the workforce to improve health status and the quality of life, reduce health inequalities, safeguard the public's health, and reduce the burden of disease.

Tasks

6.1 Assess, perform and maintain an inventory of the human resource base including the professional attributes and distribution.

Practices: assess; investigate; analyze; evaluate.

6.2 Project workforce requirements in terms of quantity and quality.

Practices: develop plans; set priorities; communicate.

6.3 Ensure adequate human resource base for public health activities.

Practices: advocate; manage; implement.

6.4 Ensure workers are adequately educated and trained with demonstrable certification and recertification.

Practices: evaluate; ensure compliance.

6.5 Coordinate between educational institutions and the workforce, with employers and employees, in the design and delivery of training programs.

Practices: negotiate; integrate; communicate; develop plans; implement.

6.6 Promote and encourage continuing professional education.

Practices: negotiate; communicate; advocate.

6.7 Monitor and evaluate education and training programs.

Practices: advocate; manage; implement.

FUNCTION 7: Health promotion, social participation and empowerment

Outcomes

The outcomes of this function make communities healthier by advocating for health and empowering citizens through access to relevant, high quality and effective information.

Tasks

7.1 Contribute to improving the capacity and capability of communities and decreasing their vulnerability to risks and damages to health.

Practices: develop plans; set priorities; implement; communicate; evaluate; manage; collect and use evidence; negotiate; advocate.

7.2 Create supportive environments to make the healthy choices the easy choices, by building coalitions, promoting relevant laws and policies, working intersectorally to make health promotion programs more effective, and advocating with government authorities in relation to health priorities.

Practices: advocate; negotiate; integrate; communicate; develop plans; collect and use evidence; implement.

7.3 Empower citizens to change lifestyles and play an active role in changing community norms about particular behaviors to achieve permanent, large-scale behavior change.

Practices: advocate; negotiate; communicate; set priorities; collect and use evidence.

7.4 Facilitate and convene partnerships among groups and organizations to promote health.

Practices: advocate; communicate; negotiate; integrate; manage.

7.5 Communicate through social marketing and targeted media communications.

Practices: advocate; communicate.

7.6 Provide accessible health information resources at community levels.

Practices: assess; communicate; develop plans; manage; implement; evaluate.

FUNCTION 8: Ensuring the quality of *personalⁱⁱⁱ* and population-based health services

Outcomes

The outcomes of this function ensure the quality of *personalⁱⁱⁱ* and population based health services to improve health status and the quality of life, reduce health inequalities, safeguard the public's health, and reduce the burden of disease.

Tasks

8.1 Define appropriate standards for the quality of both personal and population-based health services.

Practices: assess; investigate; analyze.

8.2 Develop models of quality evaluation.

Practices: set priorities; develop plans.

8.3 Identify valid and reliable measurement instruments to monitor quality.

Practices: investigate; analyze; evaluate.

8.4 Monitor and ensure safety and ongoing improvement in quality.

Practices: develop plans; manage; implement; evaluate.

ⁱⁱⁱ Country-specific interpretation for the part of this function specified in italics

FUNCTION 9: Research, development and implementation of innovative public health solutions

Outcomes

The outcomes of this function contribute to innovative ways to improve health status and the quality of life, reduce health inequalities, safeguard the public's health, and reduce the burden of disease.

Tasks

9.1 Develop a public health research agenda.

Practices: investigate; analyze; set priorities; develop plans; communicate; collect and use evidence.

9.2 Identify adequate sources of research funding.

Practices: communicate; develop plans; manage.

9.3 Encourage cooperation and joint approaches between public health agencies and organizations to address funding and the conduct of research for the research agenda.

Practices: communicate; manage; negotiate; integrate

9.4 Ensure appropriate ethical safeguards for public health research.

Practices: develop plans; communicate; implement; ensure compliance

9.5 Develop processes for dissemination of research findings.

Practices: communicate; negotiate; develop plans; implement; manage

9.6 Encourage participation of public health workers in research at all levels.

Practices: communicate; develop plans; set priorities

9.7 Develop innovative programs to address the identified problem.

Practices: develop plans; manage; implement

Definitions of ‘practices’ for Essential Public Health Functions

Advocate is to use a combination of individual and social actions designed to gain political commitment, policy support, social acceptance and systems support for a particular health goal or program [2].

Analyze is to examine in detail the determinants of identified health needs [3,4].

Assess is to undertake the regular systematic collection, assembly, analysis, and dissemination of information on the health of the community [5].

Collect and use evidence – refer **Use evidence**

Communicate is the practice of conveying information or evoking understanding in health issues[3].

Develop plans is the practice of formulating methods by which priority health needs are to be addressed [3,4].

Ensure compliance with regulation is the practice of making certain acquiescence to regulation [3].

Evaluate is the assessment of the effect that health services or programs have on the population’s health [3,4].

Implement is the practice of putting into effect a health policy or program [3].

Integrate is the practice by which different partners or stakeholders may have to give up some of their authority and prerogatives as they converge their efforts to improve health, but they retain their identity and specificity [6].

Investigate is to undertake a systematic inquiry into the occurrence of health effects and health hazards in the community [3,4].

Manage (resources) is the practice of planning, organizing, staffing, and controlling the work and financial resources needed to undertake essential public health functions [7].

Manage (patients) is the practice of planning, organizing and controlling the personal preventive care and personal treatment of patients whose illnesses are of public health significance.

Negotiate is to confer with others in order to reach a compromise or agreement [3].

Set priorities is the practice of choosing which health needs have prior claim to consideration when there is a gap between the availability of resources and the demand for health services [3,4, 8]

Use evidence is the practice of conscientiously, explicitly and judiciously using current best evidence in making decisions related to public health [9].

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Appendix 3 Public Health objectives and functions of DHBs under the New Zealand Public Health and Disability Act (2002)

DHB Public Health objectives

- (a) to improve, promote, and protect the health of people and communities:
- (e) to reduce health disparities by improving health outcomes for Māori and other population groups:
- (f) to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand by developing and implementing, in consultation with the groups concerned, services and programmes designed to raise their health outcomes to those of other New Zealanders:
- (h) to foster community participation in health improvement, and in planning for the provision of services and for significant changes to the provision of services:

DHB Public Health functions

- (a) to ensure the provision of services for its resident population and for other people as specified in its Crown funding agreement:
- (b) to actively investigate, facilitate, sponsor, and develop cooperative and collaborative arrangements with persons in the health and disability sector or in any other sector to improve, promote, and protect the health of people, and to promote the inclusion and participation in society and independence of people with disabilities:
- (c) to issue relevant information to the resident population, persons in the health and disability sector, and persons in any other sector working to improve, promote, and protect the health of people for the purposes of paragraphs (a) and (b):
- (d) to establish and maintain processes to enable Māori to participate in, and contribute to, strategies for Māori health improvement:
- (e) to continue to foster the development of Māori capacity for participating in the health and disability sector and for providing for the needs of Māori:
- (f) to provide relevant information to Māori for the purposes of paragraphs (d) and (e):
- (g) to regularly investigate, assess, and monitor the health status of its resident population, any factors that the DHB believes may adversely affect the health status of that population, and the needs of that population for services:
- (h) to promote the reduction of adverse social and environmental effects on the health of people and communities:
- (i) to monitor the delivery and performance of services by it and by persons engaged by it to provide or arrange for the provision of services:
- (j) to participate, where appropriate, in the training of health practitioners and other workers in the health and disability sector:

(k) to provide information to the Minister for the purposes of policy development, planning, and monitoring in relation to the performance of the DHB and to the health and disability support needs of New Zealanders:

(l) to provide, or arrange for the provision of, services on behalf of the Crown or any Crown entity within the meaning of the Crown Entities Act 2004:

(m) to collaborate with preschools and schools within its geographical area on the fostering of health promotion and on disease prevention programmes

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- ¹⁸ Tirohanga Māori Available at <http://www.teiho.org/MāoriHealthPerspectives/TirohangaMāoriByMasonDurie.aspx> extracts from Chapter five of the book by Mason Durie. May 2001. *Mauri Ora: the Dynamics of Māori Health: India*
“A study of Māori health must follow more than two strands. Tinana is the physical element of the individual and hinengaro the mental state, bur those do not make up the whole. Wairua, the spirit and whānau the wider family complete the shimmering depths of the health pounamu, the precious touchstone of Māoridom'.”
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- ²⁰ Modified from <http://en.wikipedia.org/wiki/Hazard> accessed 6 March 2008
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- ²² Western Australia Legislative Assembly *Draft Public Health Bill 2008*
- ²³ Western Australia Legislative Assembly *Draft Public Health Bill 2008*
- ²⁴ 178 Interim closure of dwellinghouse posing **serious risk** to public health

(1) If the insanitary condition of a dwellinghouse constitutes a nuisance (*is, or is likely to be, injurious to public health* italics added) that poses a **significant risk** to the health...
- ²⁵ Western Australia Legislative Assembly *Draft Public Health Bill 2008*
- ²⁶ A (long winded) possibility is “persons with conditions posing public health risks” but there a likely to be many ways to help with plain English.
- ²⁷ <http://www.pha.org.nz/documents/StrategicPlan2004-09.pdf>
- ²⁸ McCracken H *Essential Public Health Functions; Carpe Diem Time for New Zealand?* Ministry fo Health 2004 Wellington
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