8. PROPOSED SUBMISSION ON THE PUBLIC HEALTH BILL 2007

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PURPOSE OF REPORT

1. The purpose of this report is to report to the Committee on the Public Health Bill and for them to recommend to Council to make a submission on the Bill.

EXECUTIVE SUMMARY

2. The Public Health Bill will largely replace the Health Act 1956 and the Tuberculosis Act 1948 in order to update the public health legislation. Consultation on this update has been underway for the last 10 years, and the Council has made submissions on previous discussion documents, as has Local Government New Zealand.

3. Under the Health Act 1956 the Council has a number of powers to control and regulate issues relating to public/environmental health (eg nuisances, bylaws, sanitary works and the regulation of certain activities, such as hairdressing and camping grounds). These have largely been carried over into the Bill and are discussed in detail in the background section to this report. This report does not discuss aspects of the Bill that are not relevant to the Council. Staff have reviewed Local Government New Zealand's draft submission, and many of the Council's proposed submissions takes a similar approach to LGNZ.

4. The draft submission attached generally supports the provisions in the Bill that affect territorial authorities (such as the power to make bylaws, and the powers that are equivalent to those the Council currently has under the Health Act 1956), but specific submissions are included on certain aspects of the Bill, with the major matters relating to:

   - the definition of public health, and the need for it to cover small groups of persons in the community, such as one or two families (see paras 28 and 29 below, and para 11 of the draft submission);
   - the Bill needs to retain the term "offensive" in the definition of a nuisance not remove it (see paras 28 and 29 below and paras 28 and 29 of the draft submission));
   - there needs to be a clear relationship between all of the public health agencies, and a need for equality between central and local government. Plans that territorial authorities have made in conjunction with their communities should not be subject to being easily overridden by central government agencies(see paras 22 and 26 below, and paras 13 to 23 of the draft submission);
   - There should be an enforceable infringement offences regime operating within the Public Health Bill as an additional enforcement tool for councils (see para 33 below and paras 32 and 37 of the draft submission).

5. Submissions were due on this Bill on 7 March 2008, but Council staff have obtained an extension until 21 March 2008 for the Council to make its submission.

FINANCIAL IMPLICATIONS

6. No financial implications in making the submission other than the cost of having a Council representative go to Wellington to appear in support of the submission, if required.

7. In terms of the financial implications in relation to the introduction of the Bill in its present form, it is not anticipated that the proposed provisions will create any significant additional financial costs to Council. Although it is not clear, it is expected that any additional costs would be offset from revenue from the proposed consent fees, However, councils attention is drawn to the comments in paragraph 71 and the uncertain impact arising out of the likely need for Council assessors.

Do the Recommendations of this Report Align with 2006-16 LTCCP budgets?

8. Not applicable.

LEGAL CONSIDERATIONS

9. The legal considerations have been taken into account in drafting the submission on the bill.

Have you considered the legal implications of the issue under consideration?

10. The Bill proposes several changes to the legal requirements and duties on the Council under the Health Act 1956. The legal issues are identified and discussed in the submission.

ALIGNMENT WITH LTCCP AND ACTIVITY MANAGEMENT PLANS

11. Not applicable.

Do the recommendations of this report support a level of service or project in the 2006-16 LTCCP?

12. No.

ALIGNMENT WITH STRATEGIES

13. Yes.

Do the recommendations align with the Council's strategies?

14. Yes - the submission is consistent with the Council's strategies that incorporate or address aspects of public health.

CONSULTATION FULFILMENT

15. Internal consultation has been carried out between the Strategy and Planning Unit, the Inspection and Enforcement Unit and the Legal Services Unit.

STAFF RECOMMENDATION

It is recommended that the Committee recommend to Council to:

(a) Approve the draft submission to be sent to the Health Select Committee.

(b) Decide whether the Council wishes to appear in support of its submission on the Bill, and if so, who will represent the Council at the hearing.

BACKGROUND (THE ISSUES)

16. The Public Health Bill is the result of a long process of replacing the Health Act 1956 which commenced a decade or so ago. The Council has made submissions on a number of Ministry of Health ("the Ministry"), and other, discussion documents associated with public health and local government over the years.[1] One report[2] made the clear distinction of public health as relating to the health of the public as distinct from publicly-funded health care, a distinction often not understood widely. It was noted that major improvements in health status have resulted from the work of local authorities in water supply and waste disposal over the last century but could also have included the areas of housing and food hygiene improvements as determinants of health. In addition there have been matters related to physical and other recreational activities that are provided by territorial authorities that have influence on the health of the public.[3]

17. The Council has previously accepted the concept of the general powers and duties of territorial authorities to improve, promote and protect public health in its district both under the Health Act 1956 and in submissions on the Public Health Legislation Review.[4] The Council also indicated its support for the introduction of public health management plans which are risk related and suggested that the Act should bind the Crown, particularly in relation to Crown owned operational or regulatory organisations. A submission made suggested that a general duty, similar to that contained in section 17 of the Resource Management Act 1991, related to public health should be included. The Bill as currently proposed does not include some matters that were raised in the above discussion document so other submissions made at that time are largely irrelevant. For example the discussion document did not spell out any role for territorial authorities while the current Bill does so. The Council supported the concept of declarations of public health emergencies which could cover the cases of emerging diseases in addition to pre-existing conditions. Support was expressed for the requirement of consultation as part of public health policy development and this has been included in the Bill as a duty of the Director-General.

18. The Bill is based on decisions made by the Cabinet as to elements and a general framework in 2001. These were as follows:

- It provides for a responsible Minister and functions
- It provides for the designation of public health services by the Director-General
- It enables effective management of all significant risks to public health
- It provides for an explicit methodology for assessing risks to public health and actions
- It provides for some activities with public health significance or risks to have consents or licences
- It provides for what may happen in a public health emergency.

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1 These included submissions on *The Public Health Role of Local Government* in October 1996. In 1998[2] the Council made submissions on the Discussion Document *Public Health Legislation Review* prepared by the Ministry and subsequently on a further discussion paper in 2003[3] which had further developed the concepts to be included in the reviewed Act. These views were in addition to a report on a Local Government New Zealand ("LGNZ") commissioned document for the analysis of future public health reform which fed into the 1998 submission.[4] This was entitled *Localising Public Health – A Background Document* and the purpose was to assist LGNZ members towards developing an agreed policy on the role of local authorities in the provision of public health services.

2 *Localising Public Health – A Background Document,* Strategic Alignment and Ingrid van Aalst and Associates, Local Government New Zealand, 1998

3 For *example*

Population-based services and facilities

- *Utilities such as water and sewerage reticulation contributed historically towards large improvements in population health in New Zealand.*
- *Maintenance of these services, which should not be taken for granted, is essential to protecting population health and should be a high priority.*
- *The funding and provision of these basic utilities has changed in the past few years in New Zealand and issues of maintenance, infrastructure development and user charges have implications for health.*
- *Transport, recreational facilities and environmental protection are also important for improving and protecting health.*
- *Public transport and recreational facilities are absent or missing in some new residential areas in New Zealand.*

Social cohesion

- *People with strong family, cultural and community ties have better health than people who are socially isolated.*
- *Social cohesion or 'connectedness' is related to the health of individuals and communities.* The Social, Cultural and Economic Determinants of Health in New Zealand, The National Health Committee, June 1998

4 Submission of the Christchurch City Council on the Public Health Legislation Review, September 1998

19. The Bill continues the traditional public health focus on communicable disease control (such as tuberculosis and HIV/AIDs) and environmental health (such as sewerage and insanitary dwellings); expands health emergency provisions, which currently deal only with epidemics of communicable diseases, to all actual or potential public health emergencies irrespective of cause; take account of changes in international travel patterns, and threats such as SARS and pandemic influenza, to enable the range of risks to public health, to be managed at our borders; include new guideline provisions aimed at reducing risks of non-communicable disease (risk factors such as those that can lead to diabetes). The Bill is based on the Health Act 1956, but modernises and updates approaches and terminology to reflect life in the 21st century. The principles of risk management and proportionality underlie the Bill as a whole. Public health powers are to be exercised within a human rights framework. This is reflected in the powers of entry provisions, the provisions for dealing with people "at risk" (Infirm or neglected persons) and the requirement that abatement of nuisances and the issue of Closure Orders on dwellings must be confirmed by the Court rather than simply be subject to appeal as at present.

Territorial authorities (TAs) duties (paras 15 to 20 of the draft submission)

20. The explanatory note to the Bill identifies the role of TAs as follows:

"The Bill continues the Health Act 1956's mandate for a significant role for TAs, principally in relation to environmental health (that is, public health matters related primarily to the physical environment). Territorial authorities will have duties and discretionary powers to improve, promote, and protect public health within their districts. As with the current Health Act 1956, the TA role will span nuisances, bylaws, sanitary works, and, subject to regulations, activity consents and assessor/verification functions. As under the Health Act 1956 at present, TAs will have a duty to employ or otherwise provide for the employment of 1 or more environmental health officers. Territorial authorities will also be required to inspect their districts for nuisances and to take steps to manage them. In addition, as now, TAs will be required to comply with any direction by the Minister of Health relating to provision for sanitary works."

21. Clause 153 sets out the general powers and duties of territorial authorities in respect of public health. A territorial authority must have as many environmental health officers and other officers and employees as, in its opinion, are necessary for the proper discharge of its duties under this Act. A territorial authority must inspect its district regularly for nuisances and stop nuisances. If premises present a risk to public health, it must take any remedial action required to prevent that risk. It is also required to make bylaws, where appropriate, to protect public health.

22. Under clause 155 a territorial authority may be required to give the relevant DHB a report on any matter within an area of that district that affects or may affect public health. Clause 157 provides that every territorial authority must be able to access the services of a sufficient number of environmental health officers. The Director-General may direct a territorial authority to appoint, or make arrangements for the appointment of, a minimum number of environmental health officers. Clause 158 provides for the appointment of environmental health officers. Clause 159 sets out the functions of environmental health officers (EHOs), which include taking action under Part 5 of the Bill any bylaws, and under clause 329 (which provides for the service of compliance orders) to detect, prevent, stop, and prosecute nuisances, and to assist any medical officer of health or health protection officer responsible within an area in the district, on request, to take such action. This appropriately gives the powers directly to the EHOs rather than to the Council.

23. In respect of TA and EHO duties, little has changed from the 1956 Act, but there appears to be greater emphasis (or clarification) of the duty of TAs to comply with the requirements of the proposed new Act. The powers of the Director-General in clauses 157 and 158 inappropriately appear to override TAs LTCCP processes, carried out in conjunction with its communities, and there is no recognition of whether or not the labour market will provide for sufficient EHOs for TAs to appoint. In addition there should be equality between EHOs and health protection officers – both should be required to met specified qualifications.

Sanitary Services (paras 21 to 27 of the draft submission)

24. Sanitary services include facilities to procure raw water and supply drinking-water; works for the treatment, reticulation, or safe disposal of sewage; the collection and disposal of human waste; public toilets; activities and facilities to manage storm-water; activities and facilities to manage solid waste and other refuse; mortuaries, cemeteries, and crematoria; and disinfecting stations. (clause 160) The Minister of Health may direct a territorial authority to provide for or amend provisions for a particular type of sanitary service in the water and sanitary services assessment undertaken under Part 7 of the Local Government Act 2002, or provide for or amend provisions for a type of sanitary work specified in the LTCCP, or to undertake a sanitary service to meet any standards or level of performance specified by the Minister.

25. Before deciding to give a direction as above the Minister must consider whether the direction is likely to address a risk to public health in the district, any evidence-based analysis of the risk, costs and benefits arising from the proposed direction, and any alternative courses of action that could be taken to address the risk. In considering the above matters the Minister must consult with the territorial authority and other interested persons and be guided by the interests of public health. Provision exists for grants or subsidies to be provided by the Minister for the investigation, planning, or construction of "(a) public water supplies; (b) refuse disposal works; (c) sewerage works; (d) works for the disposal of sewerage (sic)". The term "sewerage" refers to the pipes and associated equipment for handling and transporting "sewage", which term needs correcting.

26. Provisions exist that enable territorial authorities to establish mortuaries for the reception of dead bodies pending post mortem examination and to establish disinfecting stations or provide vehicles for the conveyance of material that has been exposed to a communicable condition or are a public health risk. Duties of local authorities relating to the disposal of bodies where it is considered there is a risk to public health are dealt with in clause 165. The submission suggests that issues relating to burials might be better incorporated as an amendment to the Burial and Cremation Act 1964 rather than included in the Public Health Bill.

27. Again there are issues about the power to direct inappropriately overriding a level of service determined, with the community, through the LTCCP process. Clause 164 does not require the TA to provide mortuary facilities so it is not considered necessary that it be included in the Bill, and clause 165 needs to clearly articulate the TA role, and provide greater clarity on how costs can be recovered.

Control of nuisances (paras 11, and 28-41 of the draft submission)

28. Clause 166 defines what a nuisance is. It is an activity or state of affairs that is, or is likely to be, injurious to public health. A nuisance may arise from or be constituted by any one or more of the following:- buildings or structures; land, air, water, or land covered by water; animals, insects, or birds; refuse or accumulations of material; noise or vibrations; emissions or discharge. A nuisance may arise from, among other matters, human or animal waste, defective toilets, sewers, or drains, locations that are breeding grounds for rats, mosquitoes, or other vectors and vermin, dwellings that are overcrowded or otherwise insanitary, dirt or odour, animal carcasses and composting.

29. The definition of a nuisance is more general than the 1956 Act and in some ways more specific. All references to being "offensive" have been removed from the definition and "injurious to health" has been replaced with "injurious to public health". Public Health is defined in part 4 as:

    Public health means the health of all of—

    (a) the people of new Zealand; or
    (b) a community or section of those people.

30. The definition of public health may not deal appropriately with situations where the health of only a small group, such as one or two families, is affected (it is not clear whether they would constitute “a community or section” of the people of New Zealand). Although there is case law (in relation to nuisances under the Health Act) that says the threat to health must go beyond the occupier of the premises on which the nuisance arose and must involve a significant proportion or number of the public, the matters the Council controls should also apply to smaller groups of persons. There is also a lot of case law around the term "offensive" in the Public Health Act, and it is submitted that this term is still required, to provide for the enforcement of odours or other “lower level” annoyances that may not be injurious to public health but which materially diminish the comfort of a section of the community.

31. A territorial authority must regularly inspect its district for nuisances, and where it finds a nuisance, the territorial authority must take all proper steps to stop the nuisance (clause 167), although this provisions appears to overlap unnecessarily with clause 153(1). An environmental health officer is given power to enter any land or premises to inspect for nuisances (clause 168). It is a requirement (clause 355) that the occupier of the premises be given a copy of the authority that authorises the entry and produce evidence of identity (warrant of appointment), which is largely consistent with the requirement under the LGA 02 for enforcement officers.

32. It is an offence to do anything in the knowledge that it causes or continues a nuisance (clause 169(1)), or, having been convicted of an offence under clause 169(1), and the person is lawfully able to stop the nuisance, they fail to do so (clause 169(2)). It is recommended that the penalty of $10,000 should be increased to $20,000 for consistency with the majority of offences under the LGA 02. It is not clear whether, if a compliance order (under clause 329) is served on a person requiring them to stop the nuisance, ad the person fails to do so, whether the penalty of $1000 for failing to comply with a compliance order would apply, or the penalty for failing to stop a nuisance under clause 169(2) would apply (if the other requirements for that clause were met).

33. A District Court may also require an owner or occupier to stop a nuisance and prohibit its recurrence. Such an order is called a rectification order (clause 171). In making a rectification order, the Court may find that a dwelling or other building is unfit for human occupation. In that case, the Court may prohibit the use of the dwelling or building for human habitation until the nuisance has been effectively stopped (clauses 172 and 173). The subpart requires a territorial authority to undertake the remedial work required to stop a nuisance if the owner or occupier fails to do so (clause 176). Clause 177 authorises an environmental health officer to enter any land without notice to stop a nuisance if he or she believes on reasonable grounds that the nuisance poses a significant risk to public health in the area.

34. As soon as possible after stopping, or attempting to stop, a nuisance under this clause, the environmental health officer must apply for a rectification order under section 171. This differs from the 1956 Act which provides the power to abate a nuisance without notice and does not require the matter to be confirmed by the Court. However, a compliance order may be more similar to an abatement notice, but the link between compliance orders and rectification orders is not at all clear and the draft submission covers these matters. The range of enforcement tools available to TAs should also extend to infringement notices, to make it easier for Councils to enforce minor non-compliances.

35. If the insanitary condition of a dwellinghouse constitutes a nuisance that poses a significant risk to the health of the occupants, the environmental health officer may serve notice of a prohibition on the occupier of the dwellinghouse, prohibiting the use of the dwellinghouse for human occupation while occupants are subject to that risk (clause 178). An application must then be made to the Court for a rectification order in accordance with clause 177. This and/or clauses 172 and 173 appear to replace the cleansing order/closing order procedures under the 1956 Act (although as noted, clause 177 requires the involvement of the Court). The 1956 Act also provides authority for the Council to make advances to owners of properties served with a cleansing order or closing order – this does not appear to be the case in the Bill.

36. Clause 180 provides that all expenses incurred by or on behalf of a territorial authority in stopping a nuisance or in preventing its recurrence, together with reasonable costs in respect of the services of the territorial authority, are recoverable from the owner or the occupier of the land or premises concerned. The subpart authorises a medical officer of health to exercise the territorial authority's powers of stopping a nuisance if the territorial authority fails to do so (Clauses 181 and 182).

37. Clause 183 provides that the subpart does not affect any determination under an enactment (including a resource consent granted under the Resource Management Act 1991) by which an activity (a permitted activity) is permitted. No action or determination under this subpart may stop a permitted activity, but any such action or determination may mitigate any health risks posed by the activity. However, the activity may be stopped if the health risks posed by the activity were not foreseen at the time that the activity was permitted under an enactment.

Power to make bylaws (paras 42 to 44 of the draft submission)

38. This subpart authorises territorial authorities to make public health bylaws. A public health bylaw is defined in clause 184 as a bylaw made under this Bill or under the Local Government Act 2002 or under any other enactment for any of the purposes specified in this subpart.

39. Clause 185 requires a territorial authority to consult with the relevant District Health Board before making a public health bylaw. The purposes for which public health bylaws may be made are substantially carried forward from the Health Act 1956 (see clause 186), but the level of prescription is unnecessary particularly when compared with the bylaw making powers in sections 145 and 146 of the LGA02. The subjects of the bylaws in a) – (c) and (p) provide appropriate generic clauses, but (d) – (f) are largely RMA/Building Act matters, and the other sub-clauses do not need to be so specific.

40. If national consistency is sought in relation to those specific matters, then the performance standards could be specified in the Act (or regulations). However, the matters listed are considered to be matters of local discretion and generic enabling powers are adequate to provide for bylaws to be made for local situations as appropriate.

Review of TAs (paras 45 to 47 of the draft submission)

41. These clauses are not required because there is a clear process for the review of Councils under schedule 15 of the LGA. No equivalent review provisions are provided in the Bill for other parties with functions, duties and powers eg DHBs, assessors.

42. Clause 192 is not necessary as it reflects common sense and the Council's statutory requirements under the LGA02: ie where a range of statutory responses are available to a TA, it will choose the most appropriate option, as assessed following consideration of more than just the matters in clause 192(2), but also the matters in part 6 of the LGA02.

43. Clause 193 provides that bylaws made under the Bill/new Act will prevail over other bylaws, which provides some certainty in case there is any inconsistency, although it is not clear whether this also applies to bylaws made under section 64 of the Health Act compared to other Acts. Arguably it should since the bylaw making powers are the same under the Bill as the Health Act. Clause 382 provides that a bylaw made under section 64 continues in effect "as if it had been made" under clause 186. If the clause said a s64 Bylaw was deemed to be a bylaw made under this Act then there would be no doubt that clause 193 also applies to s64 bylaws.

Regulated Activities (paras 48 to 51 of the draft submission)

44. Section 194 sets out the objective of this Part, which is to prevent, reduce, or eliminate the risks to public health associated with regulated activities. These are activities specified in Schedule 3. Schedule 3 currently specifies services connected with camping grounds, mortuaries and hairdressing as Class 1 activities and microwave ovens, plastic wrapping, and needles and syringes as Class 2 activities. This will replace the existing provisions for registering hairdressers, camping grounds and mortuaries.

45. As with food premises under the Domestic Food Review, the emphasis is moving from inspection of the premises to ensuring that the person responsible for the activity has the knowledge to identify any risks and prevent those risks.

46. Persons undertaking a regulated activity must comply with the Act and regulations made under it. Some activities will be subject to a consent requirement. In that case, operators must comply with the conditions attaching to the consent. An additional or alternative requirement for an activity may be a public health risk management plan approved for the activity (clause 195 in conjunction with clause 243). Every person responsible for carrying on a regulated activity must identify all reasonably identifiable risks to public health that may arise from the activity and must take all practicable steps to prevent those risks (which are appropriately defined - clause 196). Regulations may require an operator of a regulated activity to obtain a periodic assessment by an assessor of the operator's compliance with relevant requirements (clauses 199 and 243(e)).

47. The Bill updates the existing regulation-making powers in the Health Act to enable various controls to be set on a specified 'activity' in order to prevent, reduce or eliminate the risks to public health associated with that activity. These provisions have the potential to have wide application and cover activities relating to goods and services with potential to pose public health risk.

48. The Bill sets out a framework for managing risks by ensuring a range of approaches can be used depending on the nature of the activity and extent of the risk. When regulations are made about an activity, a determination will be made whether it requires a consent from a consent authority and/or whether the activity requires an approved public health risk management plan and/or whether the activity needs to be periodically assessed by an assessor. The Bill allows for a 'mix and match' approach so that a high risk activity may require the full range of interventions but lower risk activities may require only a consent.

49. There are a large number of regulations that have been made under the Health Act, which include regulations for the following activities which the Council administers, which are proposed to be continued under the Bill until 1 July 2012; camping grounds; hairdressing; burials/funeral directors. (Other regulations being continued that are relevant to the Council relate to, environmental health officers qualifications, registration of premises, and housing improvement regulations.)

50. After the Bill is enacted, these regulations will be reviewed under the new framework provided for in the Bill. No additional activities are included in the Bill, but any that might be in the future, for example tattooing, will be included only after a consultation process.

51. If the activity is to be considered by an assessor, and the assessor is satisfied that the operator complies, the assessor must issue to the consent holder a certificate to that effect and send a copy to the relevant consent authority (either the territorial authority or the DHB of the locality). If the assessor considers that a regulated activity fails to comply, the assessor must report that assessment to the consent holder and to the relevant consent authority. As previously noted, greater responsibility must be taken by the owner/operator in terms of how the regulated activity is carried out. If required by regulations, the operator must arrange for an assessor (see subpart 9) to conduct an assessment of the activity.

Applications for, and granting of, consents (paras 52 to 55 of the draft submission)

52. This applies to those regulated activities that require a consent (which, for some, the TA will be the consent authority). Applications for a consent are made to the relevant consent authority (clause 201). Regulations may also require the completion of a public health risk management plan for the activity. In that case, a duly completed plan must accompany the application (clause 202).

53. The relevant consent authority must obtain a report on the application from an EHO (if the consent authority is a territorial authority) or a medical officer of health or health protection officer (if the consent authority is a DHB). The report assesses the compliance of the application with applicable requirements (clause 203). A consent authority may issue the consent subject to any conditions that, in the opinion of the consent authority, are necessary to minimise any risks from the activity to public health (clause 204).

54. If a non-complying application is not brought into compliance, or any further information requested by the relevant consent authority is not supplied, within 6 months or within such further time as the consent authority allows, the application lapses (clause 206). Consents are granted for stated periods and may be renewed. On a renewal, amendments to the public health risk management plan may be required (clauses 207 and 208).

55. A consent authority may fix charges payable by applicants for a consent or renewal of a consent. All applications for regulated activities specified by regulations as requiring a consent the Council (where it is the consent authority) must obtain a report on the application from an EHO. If the activity requires a public health risk management plan, then the report must state if this has been duly completed and approved by an assessor. The charges payable by applicants for a consent or renewal of a consent may be fixed only after using the special consultative procedure set out in section 83 of the Local Government Act 2002. It is appropriate for fees to be set at a local level rather than nationally because distances travelled vary by district and within districts services can be contracted out and costs may vary.

Cancellation of consents by consent authority and surrender of consents (paras 52 to 55 of the draft submission)

56. This subpart provides for mandatory cancellation of a consent on the detection of certain occurrences, such as fraud on the part of the applicant (clause 211). It also provides for discretionary cancellation of consents by the relevant consent authority if, after giving notice to the consent holder and considering any submissions made by the consent holder, the authority is satisfied that the consent holder has breached 1 or more applicable requirements and that cancellation is in the interests of protecting public health (clause 212).

57. A consent holder whose consent has been cancelled may apply to the chief executive of the consent authority for a review of the cancellation or of a condition imposed on a consent (clause 215). The review must be undertaken by a person who may be an employee of the consent authority but who must not have had any previous involvement in the case. The reviewer must act independently. The reviewer may confirm the decision.

58. If the reviewer does not consider the decision well-founded, the reviewer must direct the consent authority to reconsider the decision, and to have regard to any matters specified by the reviewer (clauses 216 and 217). The test of whether the decision is “well founded” introduces an additional test that may not be necessary. The decision would more appropriately be based on a reconsideration of the statutory requirements for granting or refusing an application or cancelling a consent.

59. The subpart also confers a right of appeal to the District Court against the refusal of a consent or for a renewal of a consent or against the cancellation of a consent (clauses 218 to 224). Applications for a review of the cancellation of a consent or of a condition imposed on a consent must be made to the chief executive who must appoint a person to conduct the review. This potentially adds to the work for TAs, as the “review” provision is new, but it is an appropriate step. The Chief Executive will need to appoint several persons as reviewers under the Act.

Public health risk management plans (paras 56 to 58 of the draft submission)

60. This deals with those regulated activities for which a public health risk management plan is required. The Director-General may publish guidelines on the completion of such plans (clause 226). Every public health risk management plan prepared for a regulated activity of a particular kind must identify the risks to public health that may arise from that activity, identify mechanisms for preventing risks to public health arising from that activity and for reducing and eliminating those risks if they do arise, and set out a timetable for managing the risks (clause 228).

61. Every public health risk management plan must be submitted by the person proposing to carry on the regulated activity to an assessor for approval. An assessor may approve the plan and issue to the operator a certificate to that effect (clause 229). The subpart makes provision for the duration of plans and for their review and renewal (clauses 230 and 231). If the introduction of public health risk management plans is intended to control lower risk activities, then it is not clear that the process of an assessor approving a plan will be any less complex than a consent authority approving a consent (particularly if the assessor is also an employee of the Council)

62. Care will need to taken to ensure separation of the roles of the EHO who reports on a consent application, the person appointed to conduct any reviews, and any Council employee appointed as an assessor who approves a public health risk management plan.

63. The use of the word "certificate", issued by an assessor to state that a plan has been approved, may cause confusion as to whether this constitutes a consent for the activity. This is particularly likely where the assessor issuing the certificate is an employee of the consent authority. A "record" or "report" of the plan approval may cause less confusion than a "certificate".

Records of consents (para 59 of the draft submission)

64. This subpart requires consent authorities to keep records of the consents they issue (clause 232).The Director-General may keep a nationwide record of consents (clause 233). A consent authority must keep a published form of the record open for public inspection. If the Director-General keeps a nationwide record, the Director-General must keep a published form of the record open for public inspection (clause 238).

Amendments to Schedule 3 and regulations (paras 60 to 63 of the draft submission)

65. Schedule 3, which lists the regulated activities, may be amended by Order in Council on the recommendation of the Minister of Health. Consultation is required before the Minister makes a recommendation (clause 239). In deciding whether to recommend that an activity be added to Schedule 3, the Minister must consider, among other matters, whether the activity poses a risk to public health and, if so, the nature and magnitude of the risk, and whether the risk of that harm is likely to be prevented, mitigated, or adequately managed by regulations (see section 240).

66. At this stage Schedule 3 currently specifies services connected with camping grounds, mortuaries and hairdressing as Class 1 activities and microwave ovens, plastic wrapping, and needles and syringes as Class 2 activities. No provision is made for the regulation of tattooing and body piercing. It is not recommended that Council make a submission suggesting that these things be added to Schedule 3, but instead the submission will remind central government that this council in the past has made submissions for the inclusion of tattooing and body piercing in particular and request that central government investigate the addition of these activities in accordance with clause 240.

67. It should also be noted that the licensing and control of offensive trades previously contained in the Health Act 1956 has been continued in the Bill (clause 392) but they expire 12 months from the date of commencement. Currently there are some 77 offensive trades listed for registration in the district, including 61 around refuse collection and disposal; 13 relating to septic tank desludging; 2 for nightsoil collection and disposal; 1 relating to the collection of used bottles for sale; 1 concerning dag crushing; 2 around tanning; 1 for fellmongering; and 1 relating to the slaughtering of animals for any purpose other than human consumption. It appears that the reason for their removal is that these "trades" can be, or are, dealt with under the RMA in district plans, and other legislation/bylaws. However, it is not clear whether or not, once an offensive trade licence has expired, the existing use provisions in the RMA will allow operators to continue with their activities. It is not clear whether an existing use with a licence is regarded as the same use if it does not have a licence, or whether the operators will be required to apply for a resource consent. This could have the potential to be unfair to these operators unless it is made clear in the new Act, or by amendment to the RMA that they do have existing use rights.

68. Clause 243 authorises, among other matters, regulations that prescribe requirements, standards, criteria, mandatory objectives, functional requirements, performance measures, or objectives that must be observed or attained; prescribe the premises in which a regulated activity is carried on; require a current consent from the relevant consent authority; require a current public health risk management plan approved by the relevant consent authority for the activity; require periodic assessments by an assessor of the activity; and determine whether the relevant consent authority for any district is the territorial authority for the district or the DHB for the district.

Assessors (paras 64 to 70 of the draft submission)

69. The Bill provides for the appointment of assessors to assess compliance with the requirements for regulated activities (clause 253). The Director-General of Health or a consent authority may appoint an assessor. This subpart provides assessors with powers, including powers to inspect and seize the records of those conducting regulated activities (clause 253). Assessors have powers of entry in order to exercise their powers. The power of entry for Assessors under clause 253 is restricted by clause 255 which provides that an assessor may not exercise the powers conferred by clause 253 to enter a dwellinghouse or a marae unless that assessor has obtained a warrant in accordance with subsection (2). Subsection (3) provides that this section is subject to sections 346 to 351 (general provisions about search warrants)

70. There are a number of activities described in the City Plan as "Small Scale Home Based Employment in Living Zones" or "other activities" that are currently registered under regulations made under the 1956 Act and located within a dwellinghouse. These include hairdressers and some food based activities, and there may well be similar activities located on a marae. Entry to these premises is normally "by invitation" to conduct a routine inspection or assessment so power of entry is not normally an issue. However, if an assessor has received information of an illegal activity occurring at such a premises, or he or she wishes to conduct a revisit to ascertain if areas of non-compliance have been rectified, then a warrant must be obtained. Although this reduces the power under the existing Health Act, it is consistent with other more recent legislation and the New Zealand Bill of Rights Act.

71. However, overall, it is considered that the provision for assessors in the Bill is likely to place additional costs on the Council, as, given the Council's experiences in relation to food regulation, these independent assessors will more than likely be Council employees, carrying out an additional role as an assessor. The separation of assessors from Councils may also compromise a public good activity, as well as adding to the complexity for Councils carrying out its required public health functions. It also adds cost and duplication to the person using the regulatory system. For this reason it is suggested that the Council submit against the introduction of assessors, while also commenting on aspects of the Bill that need to be fixed if assessors are to be included.

Emergencies (no submission)

72. Clauses 259 to 279 deals with emergencies. It is based on and closely reflects many of the provisions of Part 3 of the Health Act 1956. The Minister may declare an emergency if he or she has reasonable grounds to believe that a serious risk to public health exists in any place or area within New Zealand and that the exercise of powers under this subpart will help to prevent, reduce, or eliminate that risk. A declaration of emergency by the Minister lasts for 90 days unless it is revoked or extended (only one period of extension is permissible). If a longer period of emergency is required, a declaration of emergency can be made by Order in Council (see sections 259 to 263). Emergency powers may be exercised by a medical officer of health when an emergency is declared by the Minister or by Order in Council, or when a state of emergency has been declared under the Civil Defence Emergency Management Act 2002 or an epidemic notice is in force (clause 264). Clause 265 deals with the interrelationship between the exercise of emergency powers under this subpart and the exercise of powers arising from a declaration of a state of emergency under the Civil Defence Emergency Management Act 2002.

73. The general emergency powers (clause 266) include the power to declare things to be insanitary, to prohibit or limit their use, or to require them to be disinfected, isolated, quarantined, destroyed, or otherwise disposed of. People may be required to report for examination or testing. They may be required to remain in isolation or quarantine until they have been medically examined and found to be free from a condition or until they have undergone preventive treatment (for example, vaccination). Freedom of movement of people, animals, and other things may be restricted. Clause 267 sets out certain safeguards in relation to persons who are isolated or made subject to quarantine under Clause 266. These sections only impact on the Council if the Medical Officer of Health requests that Council's EHOs assist his team for all or part of the Emergency.

Health Impact Assessments (para 71 of the draft submission)

74. Clauses 323 to 325 provide for the conduct of health impact assessments on a voluntary basis. The purpose of a health impact assessment is, in general terms, to enable departments of State, Crown entities, and local authorities to identify and assess whether proposed actions have a positive or negative effect on public health, before those actions are taken. If a health impact assessment is undertaken, it must be undertaken in accordance with criteria specified by the Director-General and a copy must be supplied to the Director-General.

75. This introduces into legislation for the first time the use of health impact assessments. The policy purpose is to encourage the use of health impact assessments in the development of new policy proposals or in decision-making processes. There is no requirement in the Bill that health impact assessments must be carried out. This Council has already been involved, with the DHB and others, in undertaking assessments that could be categorised as a health impact assessment. It has been able to do so under its general power of competence in section 12 of the LGA02, so it is not clear that this section is required, when it is simply an enabling power that already exists.

76. Clause 365 provides for the attendance of medical officers of health at the request of or with the consent of any local authority at any committee or meeting to take part in the discussion on matters related to public health or powers and duties of local authorities under the Bill.

General powers of entry and inspection (paras 72 and 73 of the draft submission)

77. No powers of entry and inspection are given to TA officers in relation to Part 6 (regulated activities). While it may be intended that assessors carry out a monitoring role, assessors should not be undertaking enforcement. EHOs need powers to undertake enforcement, on behalf of the consent authority, including the power of entry and inspection in relation to that enforcement power.

78. Due to the definition of "dwellinghouse" in the Bill, the requirement for a search warrant would also include the land associated with the dwellinghouse. This needs to be amended as under other legislation, entry on to land, without going into a dwellinghouse does not require a warrant.

Compliance orders (paras 74 to 76 of the draft submission)

79. Compliance orders have already been partly discussed in relation to rectification orders above. It is considered they will be a useful enforcement tool in relation to nuisances and other matters under part 5, but clause 329(4(b) needs to make it clear that it includes bylaws made under Part 5 and it should also include Part 6.

80. The consent regime being split between various Consent Authorities and assessors may also create confusion, duplication and gaps. A medical officer of health or HPO also has powers to issue compliance orders in relation to nuisances or bylaws.

81. A time limit for lodging an appeal against a compliance order is required to provide certainty for all parties.