



2015-07/007
T:/D102

30 July 2015

Geoffrey Roche
Advisor, Communicable Disease Surveillance and Response
Ministry of Health
PO COX 5013
WELLINGTON 6145
By email: Geoffrey_Roche@moh.govt.nz

Tēnā koe Geoffrey

Proposed new regulations for inclusion in the Health (Infectious and Notifiable Diseases) (HIND) Regulations 1966

The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the above. Within the limited timeframe allowed, we have consulted with available members and staff, including senior nurses with relevant experience and expertise consultation, the College of Infection Prevention and Control Nurses College NZNO (IPCNC), and policy and legal advisers. We have also discussed the regulations with Family Planning New Zealand (FPNZ), and support their submission. Specific feedback on relevant sections of the HIND Review consultation questions is appended; in general, we have not commented where we agree with the Ministry's preferred option. Some general comments follow.

Consultation

The Health Protection Amendment Bill has been substantively changed by the Committee with regard to the mandatory notification of Section C diseases – AIDS, HIV, gonorrhoea, syphilis - on a non-identified basis. We believe that those affected by the regulations implementing the legislation i.e. both clients and health practitioners need a further opportunity to comment. In particular, we find it remiss that neither the AIDS Foundation nor nurses were consulted on the draft regulations.

Non-identifying information

NZNO supported the introduction of non-identifying mandatory notification of gonorrhoea, syphilis and HIV, and was confident that a good balance could be achieved between protecting individual privacy on the one hand, and on the other, protecting public safety by mitigating the risks of non-reporting of socially sensitive infectious diseases. That was partly based on the bill's affirmation of the principles of the right to be treated with respect and kept informed, and for the least restrictive measures be applied to an individual to minimise risks to public. However, the regulations indicate that the most unambiguous identifier, the National Health Index (NHI) number should be included in the information disclosed, and there is no indication of how this information will be protected when there are many in authority, including a wide array of health practitioners, who routinely have access

to NHI numbers. Without the guarantee of anonymity, the objective of having non-identifying mandatory notification to improve surveillance and public health protection, will be unattainable. Current attempts to protect identification eg using a special code for AIDS, have not worked. A very high degree of trust is needed and, in this case, that needs to be based on something more than words; examples of the documentation forms and processes need to be developed so practitioners can see how, and if, they would work in practice. Practitioners cannot assure clients of anonymity if they are not confident identities can and will be protected.

Amend HIND or proceed with entirely new regulations.

NZNO recommends proceeding with new regulations as the language and substance of the current ones are inconsistent and outdated. Health practice has changed and regulations need to be more flexible and less prescriptive. They also need to be readily understandable – section 5 on court orders is particularly opaque. It would be more appropriate to replace the title and interpretation of the environmental health officer (EHO) with a health practitioner in the public health unit or health protection officer. We particularly draw your attention to “notification by a medical practitioner” which would exclude nurse practitioners with a relevant scope of practice being able to notify. A more relevant reference would be to “health practitioner” as defined by Section 5 of the Health Practitioners Competence Assurance Act 2003; it is disappointing that the Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill does not cover the Health Act 1956 and that this barrier to fully utilising nurses will remain.

Nāku noa, nā



Marilyn Head
Senior Policy Analyst
DDI 4 494 6372
marilynh@nzno.org.nz

NEW ZEALAND NURSES ORGANISATION (NZNO)

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 46,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

i) *New regulations proposed to support the Health (Protection) Amendment Bill*

1 **Notification of Infectious Diseases**

Title: Section C Diseases – AIDS, HIV, Gonorrhoea, Syphilis - Notifiable on a Non Identified Basis		
Background & problem definition		
<p>For the purposes of the Bill (clause 5, section 74(3C), “identifying information” includes information that would otherwise enable a person to be identified and which must not be disclosed in notifications: Name, address, place of work or education. The list of “identifying information” which cannot be disclosed could be added to by the Regulations. The Bill provides for this. Additional information which cannot be disclosed could include:</p> <ul style="list-style-type: none"> - Phone and fax numbers, electronic mail addresses, medical record numbers, health beneficiary numbers, account numbers, certificate/licence numbers, vehicle identifiers and serial numbers, including licence plates, device identifiers and serial numbers, web universal resource locators (URLs).¹ 		
Existing regulations		
None – as the new category of Section C diseases is newly introduced by the Bill		
Options	pros	cons
(a) Make no additions to the list of identifying information which cannot be disclosed	Simpler	The list in the Bill does not recognise that we live in an electronic age, and may not be sufficient to prevent people tracing identity
(b) Make a small number of additions to the list – such as phone and fax numbers, email address and URLs	Utilising the power in the Regulations to add to the list, and recognising the electronic age	Does not guarantee significantly more protection than options (a)
(c) Include all of the examples above in the list under the Background & problem definition, and/or others	Cumbersome	Does not guarantee much more protection than (a) and (b) as inevitably some identifying information not specified will likely exist
The Ministry’s preferred option		
First preference (b). Second preference (a).		
Questions for reviewers		
<p>1. Should the list of notification information about the person which cannot be disclosed be added to by the Regulations? No. There is no point in listing information which cannot be disclosed, it adds confusion.</p> <p>2. If yes, what should be added and why?</p>		
Further comments		
<p>NZNO’s preferred option is option a), though we are not happy about any of the options. It is difficult to predict what new technologies may be introduced and those mentioned in b) are inherently insecure and subject to change. As indicated in our letter, what is needed is</p>		

¹ On the advice of submitters and the Ministry, the Select Committee decided that sex, date of birth, and national health index number should be included in the notifying information disclosed. So, these things will not be added to the Regulations as matters which cannot be disclosed.

an example of what the standard forms will look like, and particularly whether they will include the NHI number and how identities will be protected.

Title: Section A – C Diseases Notifiable by Medical Practitioners		
Background & problem definition		
The Ministry is proposing that the HIND will expressly authorise use of a web-based system, fax, email and letter, for medical practitioners to notify Section A - C infectious diseases. New notification forms will need to be developed for this purpose. Section C notifications could be done as a subset to the main notification form, suitably protecting identity. The forms could also identify those diseases which should initially be notified by phone – because of their urgency.		
Existing regulations		
Section 74 HA; regulation 4 of the HIND; VD Regulations relating to syphilis and gonorrhoea, particularly regulation 7, and Forms 1 and 2 which provide for notification of VD and notification of contact – regarding who is or has been under treatment by a medical practitioner.		
Questions for reviewers		
<ol style="list-style-type: none"> 1. What should the notification forms look like? We assume that all information will be part of the shared and secure electronic health information platforms being developed by the IT Health Board, so the forms would need to be consistent with that. It is difficult to comment further without examples. 2. What could usefully be included on the forms for notifiable, infectious diseases generally? Information about contact notification / tracing: what has been done and what follow up needs to be done. If there is a risk to public safety 		
Further comments		
<p>Medical practitioners should be replaced with health practitioner as defined by s5 HPCA Act as this excludes NPs who would be ordering tests and receiving results and should be able to notify accordingly.</p> <p>With regard to the section we have highlighted, we suggest that it is not necessary or desirable to prescribe the means of notification; this is something that should be left to the clinical judgment of the practitioner.</p>		

Title: Section C Diseases – AIDS, HIV, Gonorrhoea, Syphilis - Notifiable on a Non Identified Basis by Laboratories		
Background & problem definition		
<p>The Bill provides that Section C diseases must be notified, and identity protected, both by medical practitioners and labs.</p> <p>The HA does not refer to prescribing a form for lab notifications; nor does the HIND. Neither AIDS nor HIV is currently entered on EpiSurv – a database operated by ESR. (The national surveillance database which the Ministry has contracted with ESR to provide)</p> <p>How should the Section C diseases be notified by labs, if not using a prescribed form protecting the identity of the individuals concerned?</p>		
Existing regulations		
Section 74AA HA		
Options	Pros	Cons
(a) Prescribe notification forms protecting identity for the Section C diseases– for both medical practitioner and laboratory notifications	Enabling standard notification forms which consistently protect identity	Reduces flexibility for laboratories in making their notifications, and it begs the question whether there should be prescribed lab notification forms for other notifiable diseases as well

		(ie, Section A and B diseases)
(b) Prescribe notification forms protecting identity for the Section C diseases – for medical practitioners only . However, agree standard notification content/mode with stakeholders (eg, include GP contact details in lab notifications)	Consistent with the letter of the HA – referring to “prescribed forms” to be used by medical practitioners rather than also for labs	Risk that labs notifying section C diseases will breach the Bill’s identify protections. That risk is off-set to a degree by agreeing/detailing content of such lab notifications
The Ministry’s preferred option		
(b)		
Questions for reviewers		
<p>1. Should a form be included in the regulations for laboratory notifications of Section C diseases? No</p> <p>2. What should be included by laboratories in notifying all the Section C infectious diseases on a non identified basis? Laboratory notifications need only contain sufficient identifying information to enable the health practitioner ordering the test to match results to the client i.e. gender, name of practitioner, date of birth</p> <p>3. What should be included by laboratories in notifying specific of the Section C infectious diseases on a non identified basis? Gender, name of practitioner, date of birth</p>		
Further comments		
<p>Contact details should not be included.</p> <p>Again “medical practitioner” should be changed to health practitioner under s5 HPCA Act.</p>		

8 Contact Tracing

Title: Information Requirements of Contacts
Background & problem definition
<p>The Bill authorises contact tracing in relation to any infectious disease on the HA Schedules. Contact tracing can be done in relation to a person who has an infectious disease or is suspected of having it. This is for the purpose of identifying the source of the disease, to make contacts aware they may also be infected and to get them to seek testing and treatment where necessary (section 92ZR). While the Medical Officer of Health and DHB Managers are authorised to contact trace, in practice they will often nominate others to do so on their behalf (section 92ZT). Nominees can include STI clinicians and other suitably qualified health professionals and community workers – whether or not attached to the particular DHB.</p> <p>Cabinet agreed: “That amendments to the HIND Regulations specify in more detail processes relevant to contact tracing, including details of information that might be required (eg, age, sex, contact details) and details to be provided to the person with the condition, consistent with respect for privacy and autonomy, as far as possible, while achieving public health objectives.”</p>
Existing regulations
<p>Regulation 11 of the HIND authorises isolation of a contact within premises or a hospital or other place specified by the Medical Officers of Health if such action is considered necessary to prevent the spread of infection. Regulation 12 provides specifically for isolation of carriers of diphtheria. Regulation 13 says certain contacts are not to engage in</p>

certain occupations. Regulation 14 authorises exclusion of contacts from schools. None of these specifically provide for contact tracing or partner tracing.

Options	Pros	Cons
<p>(a) Provide an indicative list in the Regulations of what information may be asked of a contact, tailored to the particular disease risk. This could be in the nature of an inclusive checklist – such as:</p> <p>(i) Degree, timing, frequency of exposure to infected person and risk of exposure to other people if a carrier;</p> <p>(ii) How long since any check-up/diagnosis (if any) for the suspected infection or a related infection;</p> <p>(iii) Related, existing conditions;</p> <p>(iv) Occupation, and any relevant recreational or risk activities;</p> <p>(v) Possible drug use (relevant to Hep C and drug users more susceptible to STIs);</p> <p>(vi) Protective and risk factors: (eg, immunisation/immunity status; sexual activity (type/protection used))</p>		May still be too rigid for specific circumstances of contact or disease risk
<p>(b) Provide a mandatory list in the regulations of what information must be asked of a contact</p>	Consistency	May be inapplicable or excessively intrusive for individuals suffering from some types of disease or where the public health risk is not significant
<p>(c) Do not include either in the regulations but provide in an updated version of the <i>Communicable Diseases Control Manual 2012</i></p>	More flexible and can tailor to circumstances of individual and disease risk, and can be updated more easily	Not a legal requirement then to follow the best practice
The Ministry's preferred option		

Either (a) or (c).	
Questions for reviewers	
<p>1. Do you agree a checklist of questions for contact tracing is useful? We do not favour a prescriptive list of questions for highly trained and regulated clinicians who can be expected to know how to obtain the necessary information. However, 'community workers' are an unknown quantity. We would like some indication as to the intention to use community workers in this role, and the criteria for selection. Nevertheless we suggest that this should be addressed in the training needed for contact tracing. .</p> <p>2. Do you agree with the list of questions? Are there any others which should be asked? Individual circumstances dictate what information is required and it is best left up to clinical judgment discretion.</p> <p>3. Which option do you prefer and why? c) for the reasons stated; the manual would need to be updated.</p>	
Further comments	
NZNO recommends the Australian Contact Tracing model to your attention.	

Title: Information Provision to Contacts		
Background & problem definition		
As mentioned under "directions" above		
Existing regulations		
None		
Options	Pros	Cons
<p>Include a requirement in the regulations that a contact tracer shall provide the following information to the contact:</p> <p>(i) Disease that they are suspected of having/have come into contact with and its symptoms, diagnosis and treatment;</p> <p>(ii) Counselling options (if applicable);</p> <p>(iii) Ways of minimising disease onset or transmission (eg, staying at home/exclusion, hygiene practices, treatment options, quarantine, education);</p> <p>(iv) Advice of potential next steps to contain disease risk (eg, includes follow up when risk material, or symptoms present and diagnosis/treatment suggested)</p>		
Questions for reviewers		

1. Are these the things contacts most need to know?

Yes. Note the above comments apply: this should not be necessary for a clinician but may not be for others.

2. Is anything else required?

Information about where to seek investigations and/or treatment.

Further comments

To make this work well the regulations must ensure that nominees are appropriate.