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The Law Reform (Epidemic Preparedness) Bill—a proper response to the pandemic threat?

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Abstract

The ethical frameworks for public health practice are not as clearly articulated as those used in clinical medicine. This poses problems when Medical Officers of Health are required to exercise coercive powers over individuals in the context of communicable disease control. Proposed legislation exacerbates this problem. The Law Reform (Epidemic Preparedness) Bill, recently introduced into Parliament, extends coercive powers but does not provide legal protection for individuals subject to such powers.

A framework exists to critique the legitimacy of coercive public health powers and includes the principles of necessity, effectiveness, proportionality, and fairness. The fairness principle is under threat in the draft Bill, which fails to provide "due process" procedures to protect the rights of individuals.

Experience in managing the SARS epidemic suggests that coercive powers alone will not enhance the response to public health crises. Respect for individual rights, a positive relationship between government and the community, and the scope for review of decisions are more consistent with modern public health practice and are likely to lead to improved outcomes. In our view, the Bill should be amended to include legal protection for individuals before it is passed into law.

In clinical medicine, doctors have the support of a well-developed and articulated set of ethical principles to inform their decision-making, complemented by legislation that protects patients' rights and ensures standards of practice. For doctors working in public health, the ethical framework for their practice is less clear, and current public health legislation does not provide essential protection for people in the community who may be subject to coercive public health action.

This situation is likely to become worse unless important amendments are made to the Law Reform (Epidemic Preparedness) Bill, recently introduced into Parliament. The purpose of the Bill is to provide Government with powers to ensure a "proper response" if the threat to human health materialises from the now global outbreak of avian influenza. The Bill also aims to address gaps in statutory public health powers under the Health Act 1956. Some of these gaps relate to coercive administrative public health powers that authorise the isolation, detention, examination, and treatment of communicable disease sufferers.

Protecting public health through the use of coercive public health legislation of the type envisaged by the draft Bill dictates that competing individual interests (such as autonomy, privacy, liberty, and freedom of association) must be curtailed in certain circumstances. Balancing the competing claims of human rights and the protection of the public poses an ethical dilemma for public health practitioners.

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This is a dilemma for which there is no easy resolution and analysis using a traditional bioethical framework is not always helpful, as others have found.[1] Bioethics has articulated clear principles that include beneficence, non-maleficence, autonomy, and justice in relation to **individuals** receiving treatment and care. For public health, the focus of intervention is based on outcomes for **populations**. Furthermore, according to Childress et al, 'the health of the public is the primary end that is sought and the primary outcome for measuring success.'[2]

Public health outcomes may be justified on the basis of communitarian principles or utilitarian values where the "greatest happiness of the greatest number" is sought.[3] Using these philosophical paradigms is necessary because a bioethical framework, in which patient autonomy is given 'pre-eminent moral status,' is 'arguably a poor fit for public health practitioners seeking ethics guidance for their community-oriented work.'[4]

The absence of an appropriate public health ethical framework has been highlighted by the avian influenza threat. However, groups have been working to fill this gap. In 2005, the University of Toronto Joint Centre for Bioethics[5] published an ethical framework for pandemic planning and we are aware that the New Zealand National Ethics Advisory Committee is currently working on a similar project.

There is, of course, a difference between law and ethics. The law is a body of rules and principles, governing the affairs of people, which is enforced by a political authority. Ethics, on the other hand, is a philosophical understanding of moral values and rules. While ethics may influence the content and elaboration of a legal rule, ethical principles are not in themselves legally binding.

Developing an ethical framework that can be used to critique the legitimacy of public health action (based on the scope of existing laws) is both important and necessary. However, in discussions about the state of influenza pandemic preparedness, debate about the character of the laws themselves has been notably absent. The introduction of the Law Reform (Epidemic Preparedness) Bill to Parliament is an opportunity to address this omission.

The Law Reform (Epidemic Preparedness) Bill

New Zealand's public health laws are currently contained in disparate and antiquated legislation. This legislation includes the Tuberculosis Act 1948, the Health Act 1956, the Health (Quarantine) Regulations 1983, and other subordinate secondary legislation. Since the early 1990s, there have been various attempts to amend and consolidate these laws. The most recent proposals for reform were contained in a Ministry of Health discussion paper, published in 2002, which was expected to culminate in a new Public Health Act. However, this has not yet happened.

In the absence of a new Public Health Act, the Law Reform (Epidemic Preparedness) Bill offers wider powers for public health officials (backed up by new police enforcement powers) to meet threats from infectious diseases. In addition, commendably, the Bill also amends a range of other laws that deal with matters such as death certification, notification of death to the coroner, immigration, taxation, welfare provision, parole hearings, and the sentencing of prisoners (which could be adversely affected by an influenza pandemic or any such similar disease).

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The Bill will insert a number of new provisions into a wide range of legislation. These provisions will become operative if the Prime Minister issues an “epidemic notice”. The “trigger” for issuing such a notice is a requirement that the Prime Minister is satisfied that the effects of an outbreak of a stated infectious disease are ‘likely to disrupt essential governmental and business activity in New Zealand (or stated parts of New Zealand) significantly’ (Clause 5). The disease need not yet have reached New Zealand for a notice to be issued.

The current definition of a quarantinable disease (a term which at present applies to the three diseases covered by the International Health Regulations 1969—cholera, plague, and yellow fever) will be extended by adding avian influenza to the list in a new Part 3 to the 1st Schedule of the Health Act 1956. Quarantinable disease will also include any disease stated in an epidemic notice that is in force (Clause 17).

Emergency powers available to a Medical Officer of Health acting under Sections 70 and 71 of the Health Act, applicable to persons residing in New Zealand, will be expanded. The Bill leaves essentially untouched powers of compulsory medical examination [Section 70 (1) (e) of the Health Act] and detention powers through the use of isolation and quarantine [Section 70 (1) (f)].

Police are to be granted new powers to do anything reasonably necessary (including the use of force) to assist Medical Officers of Health acting under Sections 70 and 71 of the Health Act. Police will also have immunity from personal liability (providing they act in good faith), and people failing to comply with orders made under Sections 70 or 71 of the Health Act will face imprisonment for up to 6 months, a fine of up to $4,000, or both (Clause 20).

The Bill does not amend the existing power under Section 77 of the Health Act, enabling a Medical Officer of Health to enter any private residence and examine anyone whom he or she suspects to be suffering from a notifiable infectious disease for the purpose of the Act. While suspected criminals have some protection against entry without warrant in New Zealand, a person who may be suffering from a notifiable infectious disease does not.

The Bill also clarifies and extends the public health powers available to officials at the border. A person is liable to quarantine upon arrival in New Zealand if a Medical Officer of Health believes or suspects (on reasonable grounds) that the person is suffering from, or has been exposed within the previous 14 days to, a quarantinable disease (regardless of whether or not the disease was so classified at the time of suspected exposure). Persons liable to quarantine are required to give information , submit themselves for examination, and are liable to detention for up to 28 days (Clause 23).

The detention of people suspected of suffering from a communicable disease involves questions of both law and ethics. As Bernheim points out, officials must first ask if there is legal authority to act, and then decide how to do so ethically in the particular situation they face.[6] However, the idea that such ethical analysis can provide additional justification and legitimacy for public health authority presupposes that the law upon which such action is based is itself legitimate.

Of course, under New Zealand’s unwritten constitution, Parliament can pass any law it likes, including laws that contravene international human rights conventions, and

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not even the New Zealand Bill of Rights Act 1990 affects the supremacy of Parliament in this regard.[7] However, today's society is very different from that of 1956, when the Health Act was passed, and principles of human rights protection have developed significantly. Therefore, legal legitimacy must also incorporate social expectations about protecting such rights. In our view, this is the crucial "missing debate" and we question whether New Zealand's communicable disease laws (whether current or proposed) reflect a modern understanding of human rights protection.

Justifying coercive legislation

How are we to critique the legitimacy of our laws by the standards of these expectations? Professor Lawrence Gostin[8] offers a framework to assess the legitimacy of coercive public health powers based on four principles that are consistent with human rights norms.

Necessity—Necessity implies that the risk to public health must be significant before public health powers are invoked. While there may be sceptics who view the emergence of avian influenza A H5/N1 as "Y2K with feathers," balanced opinion acknowledges that the current outbreak is unprecedented and that there is significant potential for a devastating impact upon human health.[9]

Effectiveness—Gostin's second principle demands that the proposed intervention envisaged by the legislation is effective. There is little robust international evidence to demonstrate the effectiveness of coercive public health interventions for pandemic influenza and "proving" effectiveness is problematic. However, it would be reasonable to invoke the precautionary principle and argue that having coercive powers is a sensible and prudent measure in the context of the risk posed by avian influenza A H5/N1. We support such a view.

Proportionality—Proportionality means that the least restrictive alternative should be employed to protect the public health and that the intervention should not exceed what is necessary to address the level of risk posed to the public. For example, there has been recent debate in Scotland about compulsory HIV testing of suspects following criminal incidents where there has been an assessed risk of infection to police officers.[10] The National AIDS Trust, in response, cited evidence showing that such orders would provide no treatment benefit and would have only a marginal impact on society. Furthermore, they argued that mandatory testing would be a disproportionate measure, and that less coercive approaches would be equally as effective.[11]

Proportionality however, is not fixed. As Harrington points out, also in relation to HIV/AIDS, the emergence of more effective interventions may in fact encourage a more coercive, but yet more proportionate, response.[12] In the case of pandemic influenza it is possible to argue that depriving individuals of their liberty is a proportionate response if the level of harm to the public is on the scale of the 1918 pandemic.

Fairness—Fairness is said to be a feature of good government that comprises three features: equity, natural justice, and transparency.[8] Equity in this context means that the benefits and burdens of public health law are applied equally across society. While there is nothing inherently unequal in either existing or proposed public health legislation in New Zealand, there are indications that such laws were applied

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unequally in the past. For example, in past smallpox and influenza epidemics, travel restrictions were imposed solely on Māori.[13,14]

Respect for the rules of natural justice suggests that coercive powers be tempered by procedures that allow for the review of an individual's rights in a timely fashion by an independent and impartial judicial body. New Zealand public health laws fall well short of this ideal, and the draft Bill does little to address this deficiency. In terms of transparency, administrative and police public health powers in the Bill are strengthened without providing adequate checks or balances on their use.

Detention in the context of infectious disease does not involve a question of establishing guilt. However, it has been argued that administrative orders for detention in this context are punitive in character (because people are deprived of their liberty), and such orders should only be made by the judiciary.[15]

Nevertheless, a cumbersome judicial process should not impede effective and urgent public health action where such action is needed. It is important that public health officials have emergency powers available that can be used without application to the courts. However, an independent judicial body should review the use of such powers within a timely period; review by a magistrate within 24 hours has been recommended in Canada.[16]

The absence of any review and appeal procedure in the new Bill is remarkable, given that it extends coercive powers that are now at least 50 years old and society has changed greatly in the interim. Furthermore, a lack of provision for "due process" in public health legislation has been a "gap" in our laws that has been recognised previously by the Ministry of Health. The 2002 Ministry discussion paper observed that current public health legislation fails to reflect a modern understanding of rights protection for individuals enshrined by more recent legislation such as the New Zealand Bill of Rights Act 1990, the Human Rights Act 1993 or the Privacy Act 1993.[17]

This is not just a theoretical issue. Section 79 of the Health Act 1956, a provision devoid of any inbuilt right to appeal or review, has been used on several occasions to detain people suffering from infectious disease. The most notable cases were of two HIV-positive men detained under this Section in 1999. One of these men is still detained and no court has ever considered the appropriateness of his detention. Balancing the rights of this man with the need to protect the public is a heavy responsibility. Some public health officials have indicated to us that this is a responsibility they would prefer to share with the judiciary.

The 2002 discussion paper recognised that providing effective regulation for communicable disease control may create tensions with human rights values; it proposed finding a balance between protecting the public health on the one hand and the rights of people suffering from an infectious disease on the other. Despite this recognition by the Ministry of Health, the new Law Reform (Epidemic Preparedness) Bill does little to address the need for this balance.

Public health or public order—does this matter?

The World Health Organization recognises the importance of legal preparedness by calling on national governments to ensure that laws or regulations necessary to deal

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with a public health emergency are in place in advance of any pandemic.[18] The international public health community largely supports this call.

In 2005, the SARS Commission in Canada recommended strengthening relevant laws.[16] In the same year, the Centers for Disease Control and Prevention in the United States proposed regulations that would empower the Federal Government to isolate and quarantine an expanded category of unwell arriving passengers to the United States.[19]

However, unlike Canada or the United States, the New Zealand Government plans to strengthen coercive administrative public health powers while providing only minimal checks or balances in the legislation itself to prevent the abuse of administrative power. We are not aware of any similar initiative in jurisdictions whose legal traditions are similar to our own. Does this matter?

In our view, what is exemplified in the Bill is an over reliance on a "public order" approach to communicable disease control. This approach assumes that a recalcitrant population is likely and that a coercive response (where individual rights are subjugated) will best protect the public health. In the United States, the Model State Emergency Health Powers Act, a post-9/11 response to bioterrorism threats, takes a similar approach, and some commentators have suggested this unnecessarily erodes civil liberties.[20]

During SARS, the World Health Organization leadership endorsed strong public health measures to control the epidemic. The way different countries managed these measures provides evidence against the effectiveness of a public order approach. During a 3-day period in China, almost a quarter of a million people are estimated to have fled Beijing following rumours of quarantine and martial law, and there were reports of rioting in response to government measures. In Taiwan, officials now believe that aggressive use of quarantine contributed to public panic and was counterproductive.[21]

By contrast, in Toronto, Canada, almost everyone who was asked to submit to quarantine did so, with authorities having to seek a written order in only 27 cases.[16] Both Federal and Provincial Governments provided special insurance to protect the financial wellbeing of those quarantined, thus increasing the acceptance of public health measures taken. Civic duty and confidence in being treated fairly, and not the fear of legal consequences, were the main motivating factors for observing quarantine in Canada.[22]

These are important lessons for New Zealand, where success at mitigating the potentially devastating effects of an influenza pandemic will depend on public confidence and trust in our public health officials. Over-reliance on unfair coercive measures will only undermine that trust and ultimately have adverse effects on the public health.

A positive public health approach that respects individual rights, based on trust between the community and government, will be more effective in controlling epidemics than coercive powers alone. While such powers must be available to public health officials as a precaution, the laws upon which such powers are based must be "fair" and they must be applied within an appropriate ethical framework.

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With respect to Medical Officer of Health powers, the Law Reform (Epidemic Preparedness) Bill (as written) contains few inbuilt mechanisms to protect the rights of individuals; and an appropriate pandemic response relies upon officials adopting strict ethical public health practice. However, exactly what would constitute this practice is not yet well articulated.

Not only does this Bill provide little support for Medical Officers of Health who may be required to deprive people of their liberty, it also leaves wide open the potential for the abuse of power, however well-intended. As such, this Bill does not ensure a proper response if the pandemic threat materialises and does not protect public health.

We consider that legal protection for individuals must be included in the Bill before it is enacted into law.

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