Department of
Health, Social Services
and Public Safety
www.dhsspsni.gov.uk

Review of the Public Health Act (Northern Ireland) 1967

Consultation document

September 2015

CONTENTS

	Page
Minister's Foreword	3
1. The Public Health Act (Northern Ireland) 1967	5
2. Main issues	
2.1 Structure and purpose	7
2.2 Organisational responsibilities	9
2.3. Public health powers	11
2.4 Protecting individuals	16
3. Options for reform	20
4. Conclusion	21
Appendix: Referenced public health legislation.	23

NOTE: TECHNICAL SUPPLEMENT TO THE CONSULTATION DOCUMENT

This consultation document is accompanied by a technical supplement which provides an overview and analysis of public health law in Northern Ireland and a number of other jurisdictions. The supplement is at http://www.dhsspsni.gov.uk/index/consultations.htm

MINISTER'S FOREWORD

This consultation is part of a review of the Public Health Act (Northern Ireland) 1967 which began in 2013.

The 1967 Act is one of the many and diverse laws that make up the field of public health law and is concerned primarily with the notification and prevention of certain infectious diseases. It gives some public bodies unusual powers for dealing with certain dangerous scenarios.

The Act has changed little since 1967. That fact does not of itself mean the Act is in need of reform, but the work done so far on the review points clearly to its limitations.

An examination of the Act is prompted also by events and planned developments during recent decades.

The Ebola crisis of 2014/15 has tested how well prepared we would be to deal with an imported case of Ebola. As it turned out we did not have an imported case but can we be confident that the 1967 Act would have been up to the task?

Part of the question is whether the 1967 Act is too narrow in its scope. The Act is about infectious diseases but the Chernobyl disaster and the poisoning of Alexander Litvinenko reminded the world of the dangers of radioactive contamination. Chemicals released into the air from fires and industrial accidents, or contamination of the land from spills or the illegal dumping of waste, can also pose serious threats to people's health. Other countries and the international community have modernised public health law to address such threats, and in doing so have adopted an 'all hazards' approach.

In some important respects public health law is a balancing act: it should ensure that when public authorities are given powers that can disrupt people's lives and interfere with their freedoms and rights – such as the power to quarantine or isolate someone – such powers are only as strong as is necessary to protect the health of the community. By modern standards, are the powers in the 1967 Act proportionate to the seriousness of the threats?

Other possible shortcomings have been identified in the course of this review, such as a lack of clarity about the roles and responsibilities of certain organisations with regard to the decontamination of premises.

We may conclude that the Act just needs a series of amendments. We may find that it needs a major overhaul.

This consultation is likely to be the first of two. The review of the 1967 Act is asking basic questions about our public health law, such as:

- Is it ever justified to compel someone to undergo medical treatment?
- Should we start again with a blank page?

The review will present recommendations for reforming the 1967 Act. If it is decided that a public health bill should be introduced in the Assembly, there will be a second consultation inviting views on specific proposals for change.

Public health law affects everyone. No government department has all the answers or all the ideas. This is a once-in-a-generation opportunity to shape public health law in Northern Ireland. That is why your views matter.

Simon Hamilton

Minister of Health, Social Services and Public Safety

1 THE PUBLIC HEALTH ACT (NORTHERN IRELAND) 1967

'*Health care is vital to all of us some of the time, but public health is vital to all of us all of the time*' - Former US Surgeon General, C.Everett Koop.

The term 'public health' has two meanings:

- the health of the whole population, including people's life expectancy and the burden of disease, (sometimes referred to as 'the public's health') and
- a field of human activity which includes public health medicine such as immunisation programmes, relevant scientific endeavour, and organised measures which prevent disease, promote the public's health and raise life expectancy.

With globalisation, we have seen greater movement of people between countries and by the same token, greater potential for diseases to spread. The continuous threat of a global pandemic requires constant effort by health professionals in preventing, detecting and responding to outbreaks of infectious disease, such as the 'swine flu' pandemic of 2009 or the Ebola outbreak in West Africa in 2014/15.

Serious threats to public health emerge and evolve over time, for example the world-wide rise of new strains of super-bug that are resistant to antibiotics; bioterrorism, and sudden major events which cause widespread chemical and radiological contamination. These threats to people's health underline the need to make sure that our public health law is up to date, coherent and robust, and allows us to respond quickly and effectively to events that threaten the public's health.

Public health law needs to be systematic and has to define clearly the powers and responsibilities of the state and organisations and the rights and duties of individuals

The Public Health Act (Northern Ireland) 1967 ('the 1967 Act'), was passed at a time when life expectancy was much lower and fatal diseases such as smallpox and polio were common throughout the world. The focus at the time was understandably on protecting people's health against infectious diseases, rather than other threats. Almost fifty years on, it is arguable that the 1967 Act does not adequately reflect

"*contemporary scientific understandings of injury and disease (e.g., surveillance, prevention, and response) or legal norms for protection of individual rights*"[1].

Shared responsibility is critical in the field of public health, where services from different sectors, such as medical, non-medical, statutory, voluntary and community, are provided to improve the health of the population. A clear statutory foundation is necessary for the delivery of these services.

While voluntary cooperation is preferable to the use of powers, from time to time there is tension between, on the one hand, the duty of the state to protect the health of the people and, on the other, a person's rights. Public health law in many countries includes unusual compulsory powers that are made available to authorities, so that they can deal with the spread of contagious diseases and other hazards. Such powers, for example quarantine or exclusion from certain activities, can interfere with a person's freedom, rights or beliefs, so there must be a clear benefit for the population as a whole as well as adequate protection for all individuals.

The age of the 1967 Act does not of itself mean it is not fit for purpose, however, certain features underline the need to review and update the Act systematically: a lack of clarity; limitations in its scope; doubts as to whether the Act enables Northern Ireland to comply with the International Health Regulations 2005 (IHR 2005); outdated references; and the fact that the Act does not reflect the requirements of the Human Rights Act 1998.

[1] Gostin, L "*Public Health Law Reform*" AM J Public Health, 2001 September; 91(9):1365-1368

2 MAIN ISSUES

2.1 STRUCTURE AND PURPOSE

2.1.1 Principles, statement of intent and objectives

Some pieces of legislation, such as the UK Mental Capacity Act 2005, open with a statement of the principles that the legislation is based on. Spelling out the underpinning principles can make the will of the parliament clearer and help the courts, public authorities, individuals and organisations to understand and interpret the law.

The 1967 Act does not set out principles. By contrast, the states of South Australia and Victoria have incorporated principles to act as a guide to every decision made in relation to their public health legislation. This keeps the focus of the legislation on achieving the highest standard of public health and well-being through protection, promotion and the reduction of health inequalities. A similar approach has been adopted in Norway, where five fundamental principles underpin policies and actions intended to improve population health.

Examples of principles might include the '*proportionate regulation principle',* where measures take into account adverse impacts on business and members of the community, or the '*equity principle',* which reinforces the premise that any action should not unfairly or unduly disadvantage individuals.

There are alternatives to setting out principles, such as a statement of intent. Although this may be less detailed than a set of principles, it can provide an effective foundation for the legislation that follows. Such a statement is contained in the preamble of the South Australian 2011 Act, where the legislation is intended *'...to promote and to provide for the protection of the health of the public of South Australia and to reduce the incidence of preventable illness, injury and disability*...'

Sweden has gone further and has underlined its focus on promoting good health and preventing ill-health, as well as reinforcing society's common responsibility for the health of its people, by listing 11 objectives which cover the main determinants of the public's health in Sweden.

Q1: Should new legislation include:

- ***(i) a set of principles,***
- ***(ii) a statement of intent,***
- ***(iii) a list of objectives,***
- ***(iv) a combination of any of the above, or***
- ***(v) none of the above?***

Please give reasons for your response.

2.1.2 All hazards

The 1967 Act is firmly focused on the notification and prevention of diseases, contained in the list of notifiable diseases[2]. This lack of an 'all hazards' approach means the Act is inflexible and ineffective in dealing with a wide range of hazards that occur in the 21st Century and which may emerge in the future.

In contrast, neighbouring jurisdictions have adopted an 'all hazards' approach which means that action is based on an assessment of cases of human infection or contamination and whether they present a significant public health hazard.

England and Wales have specifically included '*radiation*' in the definition of '*contamination*', as well as extending public health protection beyond a list of infectious diseases, to infections and contamination which present, or could present, significant harm to human health. This connection between disease, contamination and significant harm to health broadens the scope of the protection, away from specific conditions towards an encompassing 'all hazards' approach which could include microbiological, radiological and toxicological hazards.

Scotland has also adopted an 'all hazards' approach by defining the protection of public health to include '*infectious diseases'*, '*contamination*' and – perhaps most importantly – '*other such hazards*' which constitute a danger to human health. Furthermore, Scotland has chosen a broad definition of '*infectious diseases'*: '*an*

[2] A disease that is required by law to be reported to official health authorities

illness or medical condition caused by an infectious agent'. This is a safeguard against infectious organisms that have yet to be identified.

Also, by including definitions such as '*health risk state*[3]', Scotland strengthens its ability to deal with not only infectious disease, but other hazards that could range from SARS[4] to the threat of an Influenza pandemic or bio terrorism.

***Q2*: How could new legislation best be future-proofed in order to protect the public's health against threats that are as yet unknown?**

Q3: In new legislation, what categories of threat to human health should be grounds for state interventions? Such categories could include 'contamination', 'infectious diseases' and 'health risk state'.

2.2 ORGANISATIONAL RESPONSIBILITIES

2.2.1 Demarcation

Although the 1967 Act contains an outline structure stating the powers and duties of medical practitioners or District Judges, there is no clear framework that sets out the public health functions of Ministers and relevant statutory agencies or their key responsibilities.

All organisations and individuals with responsibilities for public health need to be able to work cohesively together in fulfilling their respective roles. It is important also to consider a whole-system approach whereby clear lines of communication and accountability clarify how the governance and implementation of public health protection is to work. The clear demarcation of responsibilities in legislation could help to strengthen the protection of public health by enabling public health officials to work more effectively together and to respond more quickly and cohesively to new threats.

[3] A term used within the Public Health etc. (Scotland) Act 2008: section 14 (7), which refers to highly pathogenic infections or any contamination, poison or other hazard, which is a significant risk to public health.
[4] Severe Acute Respiratory Syndrome is a viral respiratory disease of zoonotic origin caused by the SARS coronavirus (SARS-CoV)

The Scottish 2008 Act provides a clear example of a demarcation framework that sets out the responsibility and public health functions of Ministers, Health Boards and Local Authorities, from which specific powers, needed to provide health protection, can issue.

In Scotland, Ministers also have power to intervene when Health Boards or Local Authorities have failed or are failing to exercise a function to protect public health, whilst duties are placed on Health Boards and Local Authorities to cooperate in exercising their functions.

2.2.2 Monitoring and surveillance

The 1967 Act does not contain any explicit provisions for monitoring or surveillance of diseases, but it does confer powers to control the spread of disease and to protect public health through the activities of the Public Health Agency (PHA), which include disease surveillance.

The PHA was set up with the specific agenda *'to improve health and social wellbeing and protect the community*' and has, as one of its goals, '*effective surveillance of communicable diseases.'* The PHA's surveillance function includes participating in various national and international enhanced surveillance systems, such as those for meningococcal disease, tuberculosis and legionella, as well as receiving data from various sources such as clinicians and hospital laboratories.

However, the question arises as to whether the 1967 Act provides a sufficient statutory basis for this role, and whether a specific reference to 'monitoring' or 'surveillance' should appear in the body of the statute, as it does in other jurisdictions and countries.

The England & Wales 1984 Act confers on local authorities or others functions in relation to '*the monitoring of public health risks...*', thus providing a surveillance function which can result in '*imposing or enabling the imposition of restrictions or requirements on or in relation to persons, things or premises in the event of, or in response to, a threat to public health*'.

Similarly the South Australian 2011 Act provides for the '*monitoring of any disease or medical condition of public health significance*', while British Columbia clearly establishes the powers, duties and function of the Minister and public health officials for public health monitoring and surveillance and communicable disease control.

Q4: Should new legislation describe, for Ministers and for each of the statutory bodies concerned, their functions, duties and powers in relation to public health?

2.3 PUBLIC HEALTH POWERS

2.3.1 Powers of entry and investigation

The 1967 Act gives an authorised officer of the PHA the right of entry to any premises, however, the term 'authorised officer,' which is defined by the 1967 Act as "*the Director of Public Health of, or any other officer authorised...",* has caused difficulties as to whether it means an officer of the PHA or an officer from another organisation, such as local government, authorised by PHA to act on its behalf. There may be benefit in widening its definition to include '*any other person'* authorised by the PHA. This could be an employee of PHA or of another organisation.

The 1967 Act provides limited powers of entry and investigation. These can be contrasted with the position in Scotland, England and Wales whereby basic powers are supplemented by a wide range of powers such as: applying for a warrant in specified circumstances; using reasonable force when necessary; directing that premises be left undisturbed; taking measurements or photographs; making recordings; requiring a person to answer questions, or dismantling any article or substance.

Q5: What powers should statutory agencies have to investigate public health risks?

Q6: What powers should statutory agencies have to enter premises?

2.3.2 Quarantine and isolation

Quarantine means separating, or restricting the movement of, a person or persons who may have been exposed to an infectious disease to see if they become ill. The term is often confused with *isolation*, which is the act of separating ill persons who have an infectious disease from those who are healthy. Separating from society a healthy person is a serious step, even for the limited duration of the incubation period of a particular disease, however, it could arguably be justified in the event of a pandemic or other emergency situation.

There are no references to quarantine or isolation in the 1967 Act and it could be argued that in any updating of the Act, specific references to quarantine and isolation should be included to provide powers, to be used in strictly controlled situations, to deal with healthy people who may have been exposed to infection or contamination, as well as ill persons who have been diagnosed with an infectious disease.

In Scotland, strict criteria must be fulfilled when a heath board applies for orders for medical examination, exclusion and restriction or quarantine. Powers to quarantine individuals and powers to require a person to be disinfected, disinfested or decontaminated as part of a quarantine or detention order can be seen as draconian, however, these powers would be exercised rarely and only when a person's consent was not forthcoming. Furthermore, the Scottish 2008 Act provides for the right to an explanation and a requirement that authorised steps contain the least invasive and least intrusive procedures.

In the England and Wales 1984 Act, there are several references to the quarantine of persons, and a mention of the quarantine of things. '*Quarantine*' is noted in conjunction with medical examination, detention and isolation, as one of a range of procedures, although restrictions apply, such as the requirement to meet specific criteria, as well as the presence of a significant threat to public health.

The law in England and Wales provides that the length of time for any restriction or requirement imposed by detention in a hospital etc, or quarantine or isolation of a person, is for a maximum period of 28 days. This applies both to the initial period specified in the order and to any extension of it. There is also a power to prescribe a shorter period, whilst restrictions or requirements imposed upon persons, premises

or things must also be reviewed after a specified period. Importantly, the legislation in England and Wales makes provision for appeals from and reviews of decisions taken, with the right of an appeal to a Magistrate's Court or Crown Court regarding restrictions or requirements imposed on or in relation to a person, thing or premises.

Q7: What powers, if any, should statutory agencies have to quarantine individuals, and how should such powers be limited and controlled?

Q8: What powers, if any, should statutory agencies have to isolate individuals, and how should such powers be limited and controlled?

Q9: What powers, if any, should statutory agencies have to detain individuals, and how should such powers be limited and controlled?

2.3.3 Compulsory medical treatment

Under the 1967 Act a District Judge may, under prescribed conditions and in relation to a person with a notifiable disease, order a medical investigation, removal to hospital and detention in hospital for a specified period. These powers are clear examples of the individual's freedom and right to a private and family life being subordinated to the need to protect the community. The 1967 Act does not contain a power to order medical treatment; medical treatment can only be provided with the consent of the affected person.

A key question is whether, at the present time, threats from emerging or re-emerging diseases present such dangers to the public's health that future reforms should include a power to order compulsory medical treatment, in addition to the powers described above.

In Australia, the Victoria 2008 Act provides the Chief Medical Officer (CMO) with the power to make an examination and testing order relating to an infectious disease, which requires a person to comply with the requirements. These can include: undergoing a specified examination; undergoing a specified test; and being detained or isolated for the purpose of undergoing the specified examination or test if the person has not complied with a previous request to undergo an examination.

In addition, the CMO may make a public health order that requires the person to comply with any of the following: participate in counselling; refrain from carrying out certain activities; or receive specified prophylaxis[5], including a specified vaccination.

Norwegian legislation provides legal authority for a range of infection control measures including vaccination orders. In addition, any person who has reason to believe that they have been infected with a communicable disease that is hazardous to public health, must consult a physician; undergo an examination; accept infection control counselling and assist in tracing the source of the infection.

Q10: Are there any circumstances in which compulsory medical treatment would be justified? Please provide reasons for your response.

2.3.4 Employment and restriction on sales

The 1967 Act contains a number of provisions that deal with employment issues. These appear at various points in the Act with no obvious cohesion.

Under the Act the PHA can prohibit certain types of work on premises where a notifiable disease occurs. This is restricted to work that relates to the making, cleaning, washing etc. of '*wearing apparel, bed clothing, handkerchiefs and napery',* although other classes of work may be prescribed for. Such archaic terms appear in other sections where restrictions on sales are placed on persons dealing in rags and similar articles. Clearly sections which include outdated terms and provisions and which have no stated link with disease are ripe for review.

The 1967 Act creates an offence of knowingly carrying on or participating in work where there is a risk of spreading a notifiable disease. However, there is no detail in this section as to any sanction that would apply, or how this would be enforced. In addition, to prevent the spread of a disease, the Director of Public Health can request that a trade, business or occupation be discontinued. If this request is not complied with, a notice requiring such action is served on the person in question, which may be enforced, if necessary, by a District Judge.

[5] A measure taken to maintain health and prevent the spread of disease.

Q11: Where it is deemed necessary to place employment restrictions on a person or premises, in order to protect the public's health, what restrictions would be legitimate and proportionate?

2.3.5 Cleansing and disinfection of premises, articles and persons

The 1967 Act gives powers to the PHA to clean or disinfect premises and to destroy articles in order to prevent infectious disease. It could be argued that references to '*cleansing and disinfection of premises and articles therein*' should be extended to cover disinfestation and decontamination of premises and articles (as in the Scottish 2008 Act), as well as persons affected.

Q12(a): Should new legislation contain provisions for public health measures in relation to premises and things, with powers to disinfect, disinfest and decontaminate?

Q12(b): Should equivalent provisions apply to persons?

2.3.6 Lack of emergency powers

There are no provisions for emergency orders under the 1967 Act or in the 2008 regulations (made under the 1967 Act) in relation to ships and aircraft.

Under the England and Wales 1984 Act, regulations may be made and brought into immediate effect if they contain a declaration that the person making them is of the opinion that because of the urgency it is necessary for them to be made through an urgent procedure.

In South Australia, officials' power to undertake their duties and responsibilities during emergencies has been established under the South Australian 2011 Act. Special powers can be used to respond to an epidemic, the threat of an epidemic, or other significant public health emergency. The South Australian 2011 Act also provides for the management of significant emergencies.

Q13: Should new legislation include provision for emergency subordinate legislation? Please provide reasons for your response

2.3.7 Deceased persons

The 1967 Act places a restriction on the removal of the body of a person who has died in hospital from a notifiable disease. Scotland goes further than this, in requiring an explanation to be given by a person responsible for the removal and disposal of a body of significant risk to public health, regarding the nature of that risk, any precautions and any other matter.

A District Judge also has the power to order that a deceased person be removed to a mortuary or buried forthwith. This provision refers to "*the retention of a dead body in any building*", but it could be argued that the reference to '*any building'* is unnecessarily restrictive and could be widened to '*in any place'* as in the England and Wales 1984 Act.

Q14: What powers should be conferred upon a statutory agency to restrict the removal of the body of a deceased person from any place?

Q15: If a person is restricted from removing the body of a deceased person, should that person have a statutory right to a timely explanation as to why they may not remove the body?

2.4 PROTECTING INDIVIDUALS

2.4.1 Appeals, reviews and revocation in the context of compliance with the European Convention on Human Rights

Apart from a provision regarding a person discontinuing trade, the 1967 Act does not contain provisions for appeals from, or reviews of, possible orders made.

This position is in contrast to England and Wales where extensive powers to make regulations regarding appeals or reviews constitute a counter-balance to the range of powers available, to ensure that the England and Wales Act 1984 is compliant with

the European Convention on Human Rights (ECHR). Scotland also enshrines an individual's rights to have exclusion and restriction, hospital detention and quarantine orders reviewed or revoked, whilst enabling appeals to be brought against medical examination orders, as well as exclusion, restriction, quarantine and hospital detention orders.

2.4.2 Proportionality

The 1967 Act contains no requirement for public authorities to assess risks or to apply the principle of proportionality and balance the making of public health orders with the effects of such measures upon their recipients. In England and Wales an assessment of risk, to ensure that any action is proportionate, forms an integral part of the England and Wales 1984 Act.

2.4.3 Safeguards placed on domestic health protection powers

The 1967 Act does not contain safeguards that restrict health protection powers. The law In England and Wales does restrict the exercise of these powers. For example, when someone is being removed to and detained in hospital, such serious restrictions on an individual's liberty may only be imposed if there is '*a serious and imminent threat to public health*'.

Scotland has further safeguards, such as the need to adopt the least invasive and least intrusive procedures practicable, as well as the statutory right for an explanation to be provided to a person affected by removal or detention orders.

2.4.4 Necessary criteria for seeking Orders

The 1967 Act contains detailed criteria that must be fulfilled before a medical investigation is carried out, however, other orders, such as the removal to hospital and detention therein, can be made without any such requirement.

In contrast, the England and Wales 1984 Act establishes detailed criteria that the Judge must be satisfied upon, for example, that a person or thing is infected or

contaminated; that such infection or contamination is one that presents or could present significant harm to human health; that there is a risk that the person or thing might contaminate others, and it is necessary to make the order to remove or reduce that risk. This emphasis on the risk to human health and the use of the concept of necessity constitute broader and more all-encompassing criteria. Such requirements safeguard individual rights and ensure that basic rights and values remain enshrined in legislation.

Q16: What powers, if any, should statutory agencies have to subject individuals to compulsory medical examination, and how should such powers be limited and controlled?

Q17: How should new legislation safeguard a person's rights of review and appeal from public health orders?

Q18: Whenever a person is being detained, quarantined, isolated or required to undergo compulsory medical examination or treatment, should they have a statutory right to a timely explanation of the interference with their rights?

2.4.5 No clear balance between individual and collective responsibility for protecting health

Whilst individuals are primarily responsible for their own health, it is recognised that public health incorporates the field of human medicine that safeguards and improves the physical, mental and social well-being of all people in Northern Ireland. Therefore, the state must be involved if a person's health has been affected, voluntarily or negligently, knowingly or unknowingly, by a hazard that could put other people's health at risk.

Q19: The Department would welcome your ideas on

(a) how best to balance, on the one hand, the need to protect the public's health, and, on the other hand, the rights, needs and dignity of the individual, and

(b) how best to ensure that, where an intervention impinges on a person's rights, the interference is proportionate to the threat to public health.

Q20: The Department has identified a number of apparent or possible gaps and deficiencies in the Public Health Act (Northern Ireland) 1967. The Department would welcome your views on what issues or gaps – whether identified in this document or not – should be considered for future possible reforms to the 1967 Act.

3 OPTIONS FOR REFORM

In the course of the Review the Department has identified two options for reform of the 1967 Act as follows:

Reform Option One: a bill to amend the 1967, concerned exclusively with health protection*.

Reform Option Two: a ‘fresh start’ bill concerned exclusively with health protection.

** The Faculty of Public Health defines health protection as the domain of public health that is concerned with infectious diseases; chemicals & poisons; radiation; emergency response, and environmental health hazards.*

Both of these options for reform:

- could accommodate the ‘all hazards’ approach;
- could enable the legislation to be compliant with the International Health Regulations 2005, and
- could establish a balance between the exercise of public health powers by the State and respect for the rights and dignity of the person.

Q21: Should a public health bill for Northern Ireland be in the form of an amending bill, i.e. one that would make multiple amendments to the 1967 Act, or a ‘fresh start’ bill that would be a combination of new provisions and ‘savings’ from the 1967 Act?

Q22: The Department would welcome any observations on the two options for reform.

4 CONCLUSION

The Department would welcome your response to this consultation and hopes to receive a wide range of perspectives on the questions. The views expressed by consultees will inform the recommendations in the final report of the review.

Whilst this summary document contains the main themes for consideration of this Review, consultees are encouraged to read the technical supplement where many of the provisions referred to above are discussed in more detail, as well as other features that may be of interest to consultees.

The Department welcomes the views of consultees in respect of any other public health matter that may not have been addressed explicitly in the consultation.

Statutory equality duties

With the exception of the intention to adopt the 'all hazards' approach, this consultation document is concerned with questions, rather than with proposals for reform. When the review of the 1967 Act has been completed, the Department will bring forward specific, detailed proposals for reforming public health law in Northern Ireland. Those proposals will be the subject of a second public consultation before a public health bill is introduced in the Assembly. As the second consultation will be about concrete proposals, it will be possible then to include detailed consideration of the statutory equality duties and any potential adverse impacts on any groups of people that may be defined by reference to the nine distinctions in section 75 of the Northern Ireland Act 1998. The second consultation will therefore help to inform the equality-screening of each proposal for reform.

Any other matters

The Department would welcome any other views, issues or proposals that you wish to raise and which may not correspond directly to any of the questions above.

Freedom of Information Act 2000 – confidentiality of consultations

The Department will publish a summary of responses following completion of the consultation. Your response and all other responses to the consultation may be disclosed on request. The Department can only refuse to disclose information in exceptional circumstances. Before you submit your response please read the paragraphs below on the confidentiality of consultations and they will give you guidance on the legal position about any information given by you in response to this consultation.

The Freedom of Information Act gives the public a right of access to any information held by a public authority, namely DHSSPS in this case. This right of access to information includes information provided in response to a consultation. The Department cannot automatically consider as confidential information supplied to it in response to a consultation. However, it does have the responsibility to decide whether any information provided by you in response to this consultation, including information about your identity, should be made public or be treated as confidential. If you do not wish information about your identity to be made public please include an explanation in your response.

This means that information provided by you in response to the consultation is unlikely to be treated as confidential, except in very particular circumstances. The Secretary of State for Constitutional Affairs' Code of Practice on the Freedom of Information Act provides that:

- the Department should only accept information from third parties in confidence if it is necessary to obtain that information in connection with the exercise of any of the Department's functions and it would not otherwise be provided;
- the Department should not agree to hold information received from third parties "in confidence" which is not confidential in nature, and
- acceptance by the Department of confidentiality provisions must be for good reasons, capable of being justified to the Information Commissioner.

For further information about confidentiality of responses please contact the Information Commissioner's Office (or see web site at: http://www.informationcommissioner.gov.uk/).

Closing date

The Department should receive your response by Friday 18 December 2015.

APPENDIX

Referenced Public Health Legislation

Northern Ireland

Public Health Act (Northern Ireland) 1967 (The 1967 Act)

Scotland

Public Health etc. (Scotland) Act 2008 (The Scottish 2008 Act)

England and Wales

Public Health (Control of Disease) Act 1984 as amended by the Health and Social Care Act 2008 (The England and Wales 1984 Act)

Australia - Victoria

Public Health and Wellbeing Act 2008 (The Victoria 2008 Act)

Australia - South Australia

South Australian Public Health Act 2011 (The South Australian 2011 Act)

Norway

Norwegian Public Health Act 2011

Sweden

Swedish Public Health Policy 2008

Canada – British Columbia

Public Health Act [SBS 2008] Ch 28