

HIV/AIDS Legal Centre Submissions 19 April 2010

Centre for Health Protection
NSW Department of Health
Locked Bag 961
North Sydney NSW 2059

Re: Public Health Bill 2010 Consultation Draft:

Section 76 - Persons with sexually transmitted diseases to inform sexual partners

Division 3 Notification and treatment of Category 1, 2 and 3 conditions

Sections 52, 53, 54 and 55

HIV/AIDS Legal Centre

The HIV/AIDS Legal Centre (HALC) was established in 1992, evolving from the Australian Federation of AIDS Organisations (AFAO) and the then AIDS Council of NSW (ACON) Legal Working Party, and has since then been a Specialist Community Legal Centre (CLC) funded by the State and Federal Governments.

HALC in the HIV enabling environment

The work of HALC is an essential part of creating the 'enabling environment': an environment best allowing HIV positive people to live well and free from fear and risk of harm due to their HIV status, and for engendering freedoms and empowerment among the community, including those at most risk of contracting HIV, to reduce the incidence of HIV infection. The 'enabling environment' approach is a critical part of the Federal and NSW State HIV strategies, which reflects best practice and a world leading response to the HIV epidemic since the 1980's.

HALC has contributed to, and endorses the joint submissions prepared by the coalition of HIV/AIDS agencies with respect to section 76 of the proposed Bill.

We provide in this document our submissions with respect to section 76 (in addition to the joint submissions referred to above) and also with respect to 'Division 3 Notification and treatment of Category 1, 2 and 3 conditions'.

In summary, HALC's submissions regarding the Draft Bill are as follows:

1. The human rights based approach to the Government response to the HIV/AIDS crisis has been the most successful and is internationally recognized as the best practice model. The approach engenders the 'enabling environment' to allow, encourage and support self-care and treatment among those affected and effected communities.
2. NSW was historically a lead in public policy and Government action to address the problems HIV presents.
3. The current Public Health Act (1991) creates an architecture of protections and obligations, somewhat balanced to engender trust and the enabling environment.

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4. The circumstances have changed, making HIV no longer a terminal illness (as it was in 1991) however stigma and discrimination, fear and alienation persist in at risk communities and for those with HIV.
5. The suggested changes to the Act substantially reduced the protections and increase the obligations. They significantly impair the Department of Health's and the Government's ability to sustain the enabling environment.
6. Section 17 and 18 of the current Act ought be retained.
7. Section 13 of the current Act ought now be amended to promote a more sophisticated and effective health message, on of mutual obligations and self-care.
8. Amendment of the Public Health Act in terms suggested currently will seriously degrade the 'enabling environment' and the Government and NSW Health's ability to prevent and respond to HIV in a sophisticated way.

In summary, HALC's recommendations regarding the Draft Bill are as follows:

1. That section 76 be removed, or in the alternative be amended to better reflect the principles of mutual responsibility of all individuals to prevent catching a transmissible disease, and to prevent transmitting such a disease (possible drafting included at Annexure A);
2. That the increased penalties applicable to a breach of section 76 be removed, or in the alternative, be retained at the same levels as in the existing Act.
3. That section 55 be removed, and the existing section 18 and section 17 of the Act be retained unchanged. This is compatible with the summary in the Review of the Public Health Act which recommends that "the current arrangements for privacy protection in the Act be maintained"
4. That the lowering of the standard from "believes" to "suspects" in sections 52, 53, 54 and 55 be removed, and the existing standard of "believes on reasonable grounds" as per the current Act be retained.
5. That the significantly increased penalties in respect of medical practitioners in sections 52, 53 be removed, and the penalties in the existing Act be retained;
6. That the significantly increased penalty in respect to section 55 be removed and the penalty in the existing section 17 of the Act be retained. The draft Bill increases the penalty from 50 penalty units to 1000 penalty units and/or 12 months imprisonment.

Background

Australia's response to HIV is internationally esteemed. That response has been driven by strong leadership from government working in partnership with health care providers, academic researchers, community based agencies and affected communities. The estimated prevalence of HIV in adults in Australia is around one sixth of that in the United States, and one third that in Canada and France.

The response has been further assisted by ensuring the existence of a supportive legal environment where the rights of HIV positive persons are respected and protected. Australia's successful response has been underpinned by the 'enabling environment': an environment

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where people living with HIV are encouraged and supported to participate in social, policy and legal decisions relating to HIV prevention. – that is, support and information being a more effective means of preventing the spread of HIV than coercive and/or punitive legal interventions. The 2002 ANCAHRD paper, *Reforming the Law to Ensure Appropriate Responses to the Risk of Disease Transmission*, states that ‘punishment under public health or criminal law should be reserved for the most serious cases of culpable behaviour as a last resort’¹.

NSW has long been a leader in adopting this human rights approach to HIV by creating a supportive social and legal environment where rights are respected and protected, and the equitable right to health is achieved. NSW has encouraged testing with privacy protections, facilitated access to treatment and care, and reduced the impact of stigma and discrimination; all essential to the public health management of HIV.

Ensuring this continues means eliminating legal barriers to prevention programs by encouraging people who engage in high risk behaviours to engage with services and safely discover and/or address their health status early, without fearing breaches of human rights, discrimination and stigmatisation. The current approach recognises that a minority of mainstream health care workers and yet more among the general community still discriminate against people based on HIV status. Effective health and public policy is directed to lessening the existence and impacts of HIV stigma and discrimination².

*HIV Futures 6*³ notes that more than 25% of those surveyed have experienced discrimination in a health care setting.

The stated objectives of the draft Bill are:

- (a) to promote, protect and improve public health,
- (b) to control the risks to public health,
- (c) to promote the control of infectious diseases,
- (d) to prevent the spread of infectious diseases,
- (e) to recognise the role of local government in protecting public health.

HALC submits that Sections 52, 53, 54, 55 and 76 fail to embody objectives (a), (b), (c), and (d) and undermine existing best practice in relation to public health objectives.

Section 76 of draft Bill

NSW is one of only two Australian states specifically mandating disclosure of HIV status prior to sex (the other being Tasmania).

Section 76 (1) of the draft Bill states:

- 1) A person who knows that he or she has a sexually transmitted disease is guilty of an offence if he or she has sexual intercourse with another person, unless before the intercourse takes place, the other person:

¹ ANCAHRD (2002), *reforming the Law to Ensure Appropriate Responses to the Risk of Disease Transmission* at p2.

² Paraphrased from National HIV Strategy 2010 [DRAFT]

³ Grierson J, Power J, Croy S, Clement T, Thorpe R, McDonald K, Pitts M. *HIV Futures 6: Making Positive Lives Count. The Living with HIV Program*. Melbourne: The Australian Research Centre in Sex, Health and Society, La Trobe University; 2006.

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- (a) has been informed of the risk of contracting a sexually transmitted disease from the defendant, and
- (b) has voluntarily agreed to accept the risk.

Maximum penalty: 100 penalty units or imprisonment for 6 months, or both.

'sexual intercourse' is defined as:

- (a) sexual connection by the introduction into the vagina, anus or mouth of a person of any part of the penis of another person, or
- (b) cunnilingus.

'sexually transmitted disease' means any scheduled medical condition that is transmissible by means of sexual intercourse.

The important differences between Section 76 (1) and section 13 (1) of the current Act are:

1. Use of 'sexually transmitted disease' to replace 'sexually transmissible medical condition'. 'Sexually transmissible medical condition' is currently undefined in the Public Health Act. The draft Bill proposes a definition of 'sexually transmitted disease' as a 'scheduled medical condition that is transmissible by means of sexual intercourse'.
2. Section 76 (1) increases the maximum penalty to 100 penalty units and/or 6 months imprisonment. Under the current section 13 (1), the maximum penalty is 50 penalty units and no provision for a term of imprisonment.

HALC notes that section 13 (1) has only ever been used on two occasions in almost 20 years. Neither charge has resulted in a conviction. In the most recent instance, the person charged was referred to HALC. The client pleaded guilty to not disclosing his HIV status to his sexual partner, however, safe sex (use of condoms) was practiced at all times. The man had taken all precautions to prevent the transmission of HIV, and no transmission occurred. The magistrate decided a conviction and penalty would be inappropriate in the circumstances, and the matter was dealt with under section 10(1)(a) of the Crimes (Sentencing Procedure Act) 1999, and a discharge without conviction was recorded.

In the case of the person charged in 2005, it appears that there was insufficient evidence to sustain a hearing or conviction and the matter was dismissed by the court.

Finalised Charges under section 13 (1), *Public Health Act 1991 – 1991 to 2009.*

Year	Plea	Result	Factors
2005 ⁴	Not guilty	Dismissed	No evidence
2009	Guilty	Discharged without conviction	Mitigating factors: <ul style="list-style-type: none">• Use of condoms• Disclosure when recognised risk episode• Follow up phone call to advice of PEP

The importance of 'mutual responsibility' in relation to HIV prevention

⁴ Data obtained from the NSW Bureau of Crime Statistics and Research.

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Many working on HIV policy, support and primary health care have noted a breakdown of the key public health message of 'mutual responsibility' fundamental to HIV prevention efforts. Those observations have been backed up by behavioural research.

Notably, the new Victorian *Public Health and Wellbeing Act 2008* specifically names the responsibilities of all people in minimising the chance of infection, by including in its principles (at section 111):

(b) a person at risk of contracting an infectious disease should take all reasonable precautions to avoid contracting the infectious disease

That Act has removed the requirement for disclosure prescribed by the previous Public Health Act, and also any penalty for failure to disclose.

Similarly, South Australia's *Public Health Bill 2009* includes a specific principle in relation to controlled notifiable conditions (at section 14):

(4) A person must not, insofar as is reasonably practicable, act in a manner that will place himself or herself at risk of contracting a controlled notifiable condition that is capable of being transmitted.

In 2007, the Griew Review of policies for the management of people with HIV who risk infecting others found that

"the number of individuals whose behaviours require intervention utilising coercive public health management strategies is small and that these individuals do not drive Australia's HIV infection rate."

The National Guidelines for the Management of People with HIV who Place Others at Risk were developed as a result of the Griew Review. The third principle in the National Guidelines states that:

"every individual has a responsibility to prevent themselves and others from becoming infected and preventing further transmission of the virus".

This principle is included in NSW's Policy Directive "HIV - Management of People with HIV Infection Who Risk Infecting Others' (at 1.)

Importantly the principle is not found anywhere in the Public Health Act. Instead, Section 76 provides grounds for a false sense of security for those engaging in unsafe sex with the belief that an HIV positive person must and would disclose. Section 76 runs directly counter to the optimal public health policy and message.

Problems with the current proposals

Definitions:

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The definition of sexually transmitted disease is overly broad, improperly defined, and likely leads to perverse outcomes. The broad definition fails to clearly exclude those conditions with very low transmission risk during sexual intercourse. For example, it is generally accepted that Hepatitis C cannot be sexually transmitted except under very limited circumstances, but it is clear that Hepatitis C would be covered by the definition; as would influenza, Meningococcal type C to name but two on the Schedule.

As the definition does not allow for usual judicial practices of definition, but refers to a schedule of diseases, there is little room for judicial discretion as to which diseases are covered by the Section. It is hard to see how the current definition could or would be read down to a sensible level. We acknowledge there may be some room for judicial constriction of the operation of the section via a strict approach to the term 'sexual intercourse', however it is far from certain that this approach would be taken by the courts.

Further still the definition (current and proposed) of sexual intercourse if read strictly does not include several widely practiced sexual interactions which may present a risk of HIV or other STI transmission. Fisting, toy play, rimming and gag holding, to name but four would not be included if the current definition was strictly interpreted.

Poor Focus of definitions:

The definition issues are symptomatic of the poor focus of the proposed section. The core failing of the current and proposed sections is that it doesn't seek to penalise transmission or even the behaviours that lead to transmission. It penalises being HIV+. It makes sex problematic for HIV positive people. The section requires disclosure by HIV positive people in circumstances where there is little or no privacy protection and a high risk of sexual rejection and shaming. At the same time it gives HIV negative people a false sense of security relying on the requirement of disclosure by HIV positive persons. As such, the disclosure requirement tends to normalise and promote unsafe sex practices.

Unreasonable requirements:

Public health policy on HIV has been most effective when it seeks to change behaviours, not penalise those infected. The best outcomes occur when policy and Health services don't require disclosure and compliance, but rather engage it, engender it and enable it.

It must be acknowledged that disclosure of HIV status remains a considerable obstacle for HIV+ people, not merely in the context of sexual encounters, but in general disclosure. Futures 6 indicates that HIV status is still not freely disclosed in many instances. Only 90% reported disclosure within their relationship. While 80-60% disclosed to close friends, siblings or other Positive friends, the numbers goes down from there. The reason for the guarding of disclosure likely lies in fear of stigma and discrimination. 51.4% of respondents said that their HIV status had been disclosed without their permission, with 22.0% saying that this had happened in the last two years. When asked if this disclosure had a negative effect, 63.4% agreed.

In respect of disclosure in the context of sex the picture on disclosure is guarded. Over half (55.3%) of the sample reported that in the six months prior to completing the survey they had

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had sex with one or more casual partners. When asked the HIV status of their casual partners most respondents (44.7%) who had had casual sex reported that they did not know the HIV status of their casual partners⁵.

Clearly legal issues are important to people, with 42.4% agreeing with the statement, *I am worried about disclosing my HIV status to sexual partners because of the current legal situation*. There was less concern about the legal implications of disclosure of sexual practices to service providers, however, 28.4% expressed some concern and 13% were uncertain.

In circumstances where there is still much perceived and real risk of negative consequences from disclosure of HIV status, it is unreasonable to require and expect all HIV positive people to disclose prior to sex. There is too much at stake for them: the risk of rejection and stigma too great; the risk of being caught out too low. Simply out of self-care, HIV+ persons are unlikely to always observe this requirement.

Further the requirement tends to make sex itself a misdemeanour for HIV positive people. By requiring disclosure where there is no real benefit and lots of risk to the HIV+ individual, the likelihood of compliance with this law is low. By problematising the very act of sex for HIV positive people the likely effect is to channel HIV positive people into encounters where sex is anonymous. It may generate a 'free for all' atmosphere, where less care is taken for the sexual partner as the interaction is already 'outlawed' and there is nothing to lose.

The position was neatly summed up by a defendant witness in a HIV discrimination matter we prosecuted recently. A doctor working in a sexual health setting, effectively said 'all HIV positive men with an erection are a public safety risk'. That is essentially what section 13 and section 76 say.

The requirement also has consequences in diluting and marring the trust and confidence the HIV positive person and those at risk have with their medical and other health professionals. Corruption of this relationship starts when the healthcare professional has to advise and warn an HIV+ person of their requirement to disclose and the consequences of failure to disclose. Any practical softening of this message available to practitioners due to the penalty level in the current act is truly lost under the tough new penalty indicating custodial sentence. HIV+ persons are unlikely to confide in their healthcare providers where they are told their own self-care activity is unlawful. If this section was properly directed to mutual obligation and safe sex practices this degradation of the healthcare relationship would not ensue.

False sense of security:

By requiring disclosure the Act generates in individuals a false sense of security that a sex partner will accurately disclose their HIV status. The security is false for at least two reasons. First the sex partner is properly very unlikely to know their status unless they were tested recently and had no sexual or other contact in the six weeks prior which might lead to infection. Simply stated, only those who are HIV positive are 100% accurately likely to know their status. Many others (particularly the vast bulk of people who engage in casual sex) are unlikely to know their status with the desired accuracy.

⁵ The survey provides data about condom usage in those casual sex interactions. Beyond a merely superficial interpretation of this data, it seems that other *safer* sex (risk reduction) practices are employed *sans* condoms. There is a wealth of literature and research on sero-sorting sex practices, and the issue has been covered in the joint submissions on section 76.

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The requirement and act of disclosure provides a false security that encourages parties to engage in unsafe sex practices, where both parties believe or state that they are HIV negative. As indicated above, one or both parties are unlikely to really know their status with accuracy.

Conversely in many circumstances the ability to prosecute for breach would be very low in any case. As the consequences of breach leading to infection are so great, this is another disjunction between the efficacy and desired outcome of the section.

Summary – section 76

HALC strongly opposes the inclusion of section 76 in its current form, and seeks its removal from NSW's *Draft Public Health Bill*. That is not to argue that HIV-positive persons should not disclose their HIV status prior to engaging in risk behaviours, but that disclosure is ill-conceived as the core of HIV prevention policy. Instead, risk minimisation and safe sexual practice must form the basis of HIV prevention efforts. Further, disclosure is most likely in an enabling environment where HIV-related stigma is minimised: an environment facilitated by understanding of HIV and messages of mutual responsibility.

We propose that in line with public health objectives and the Australian response to HIV,

- a. That section 76 (1) be removed from the draft Bill, **or**
- b. That section 76 (1) be replaced with a section that entrenches the public health message of mutual responsibility. Such a section would include guiding principles of the type recently adopted by Victoria in its Public Health and Wellbeing Act 2008 at section 111. Suggested drafting is annexed at A, **or**
- c. That section 76 (1) be replaced with a section that replaces the requirement for disclosure with a requirement for prevention of transmission through safe sex practices. Any penalty for breach of this section should remain as in s13 of the current Act. Suggested drafting is included at Annexure A.

Division 3 Notification and treatment of Category 1, 2 and 3 conditions Sections 52, 53, 54 and 55

The proposed sections 52-55 substantially reduce safeguards and balances in the Public Health Act and administration of Public Health. By analogy, the new sections are tantamount to doing away with the requirement for judicial sanction and oversight of warrants in the criminal jurisdiction. Such a radical curtailment of judicial oversight and protections is not warranted by the consultations and review of the operation of the Act leading to the proposed legislation.

The proposed changes, in tandem with those proposed for section 76 significantly tip the balance of the Public Health Act against HIV positive persons. Together they seriously undermine the store of trust, developed with the community, in Public Health administration. They jeopardise the enabling environment.

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Disclosure of a patient's identity

We note with concern that there are significant changes to this Division, with no apparent justification from NSW Health.

1. The lowering of the threshold from "believes" to "suspects" for disclosure of identifying details of a person diagnosed with HIV, and for reporting requirements by medical practitioners of people diagnosed with HIV.
2. The removal of the requirement for the District Court to authorize the Director General to receive notification of the name and address of a person infected with HIV from the person's medical practitioner.
3. The dramatic increase in penalty under section 55 of the Bill in respect of medical practitioners who fail to disclose a patient's identity, under request, to the Director General.

The draft Public Health Bill changes the circumstances under which a medical practitioner may disclose information about a person's HIV status and their name and address.

In the current Public Health Act, sections 17 and 18 provide as follows:

17 Protection of identity

- 1) *A medical practitioner must not state the name or address of a patient:*
 - a) *in a certificate sent to the Director-General under section 14 in relation to a Category 5 medical condition, or*
 - b) *except as may be prescribed, in a written or oral communication made by the medical practitioner for the purpose of arranging a test to find out whether the patient suffers from a Category 5 medical condition.*
- 2) *A person who, in the course of providing a service, acquires information that another person:*
 - a) *has been, or is required to be, or is to be, tested for a Category 5 medical condition, or*
 - b) *is, or has been, infected with a Category 5 medical condition,*

must take all reasonable steps to prevent disclosure of the information to another person.
- 3) *Information about a person that is of a kind referred to in subsection (2) may be disclosed:*
 - a) *with the consent of the other person, or*
 - b) *in connection with the administration of this Act or another Act, or*
 - c) *by order of a court or a person authorised by law to examine witnesses, or*
 - d) *to a person who is involved in the provision of care to, or treatment or counselling of, the other person if the information is required in connection with providing such care, treatment or counselling, or*
 - e) *in such circumstances as may be prescribed.*
- 4) *A medical practitioner or other person who fails to comply with the requirements of this section is guilty of an offence.*

18 District Court may authorise disclosure of name and address

- 1) *The Director-General may apply to the District Court, in accordance with the rules of the District Court, for an order authorising the service on a medical practitioner of a notice under section 19 requiring disclosure of a name and address that would otherwise be protected by section 17 from disclosure.*
- 2) *An application under this section may be made in relation to a medical practitioner only if the Director-General has reasonable grounds for believing that:*

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- a) *the person whose name and address are sought is suffering from a Category 5 medical condition, and*
- b) *identification of the person is necessary in order to safeguard the health of the public.*
- 3) *An application to the District Court under this section is to be heard and determined in the absence of the public but is to be otherwise heard and determined in accordance with the rules of the District Court.*
- 4) *The District Court:*
 - a) *is to make an order applied for under this section if satisfied that there are reasonable grounds for making the order, or*
 - b) *is to dismiss the application if not so satisfied.*

One of the important messages in the Public Health Act 1991 is that whilst disclosure of HIV status by an individual is required under section 13 of the Act, section 17 and 18 provide for privacy and confidentiality in respect of service providers disclosing a person's HIV status. Confidence in privacy protection is key to creating an enabling environment in which HIV positive people and those at risk will engage with others (particularly service providers) and feel confident to disclose HIV status.

We submit that sections 54 and 55 of the draft Bill significantly undermine the requirement for confidentiality embodied in the current Act. This is extremely worrying and detrimental to the doctor/patient relationship fundamental to prevention of HIV transmission in Australia.

It is also contrary to the recommendations in the Report of the Review of the Public Health Act 1991 which states at page 5 under the summary of recommendations that

“the current arrangements for privacy protection in the Act be maintained”

Reduction of protections

Section 18 of the current Act allows a District Court to make an order compelling a medical practitioner to disclose the name and address of a person, information that would normally be subject to the confidentiality requirements of section 17. Under s18 of the current Act, the Director General can only make an application to the District Court when he/she “has reasonable grounds for believing that identification of the person is necessary to safeguard the health of the public”.

We note with concern that the draft Bill removes all requirement for a District Court order, and reduces the threshold at which the Director General can under section 54 require that a medical practitioner disclose the information. The new threshold is if the Director General “suspects that failure to disclose the information would be likely to be a risk to public health” (section 54(4)(c)). At its height, the new draft Bill would merely require a notice from the Director General requiring a practitioner to provide patient information (section 55).

Even more worryingly, the penalty under section 55 of the draft Bill, where a medical practitioner fails to comply with a direction from the Director General to disclose identifying information has been increased to 1000 penalty units and/or 12 months imprisonment.

The new provision with its attendant severe penalties open the door to arbitrary, unmediated breach of doctor/patient confidentiality by the Director General. The provision substantially unfetters information gathering powers of the State without the requirement of judicial

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oversight. In turn it tends to degrade the relationship of trust between patients and their practitioners, and the health system generally as privacy is no longer assured.

The new provisions are not shown to be necessary. There are already ample requirements at common law and in regulation and professional ethics to address issues of 'public health risk' presented to a medical practitioner. The 'Management of People at risk...' policy provides still more remedies. These harsh and retrograde new provisions are not given any justification based on practice or outcomes of the previous provisions.

Reduction in threshold from "believes on reasonable grounds" to "suspects"

The removal of the requirement for "reasonable grounds" as a threshold for the basis of forming a belief that a person poses a risk to public health is extremely concerning. It widens the powers of the Director General with respect to HIV patients considerably and inappropriately.

The relationship of trust between a patient and a medical practitioner is fundamental to HIV prevention and treatment. Any erosion of this trust, caused by placing inappropriate reporting obligations on medical practitioners would have extremely detrimental effects on HIV prevention and treatment.

Expansion of exemptions for disclosure of personal HIV information

Draft Bill section 54 (3), (4) and (5) roughly equates to the current section 17 (2), (3) and (4) with some significant and retrograde changes.

More and more vague exemptions are allowed under the proposed Bill. The exemptions blow a wide hole in the protection the current section 17 provides. For instance:

'(c) if the Director-General suspects that failure to disclose the information would be likely to be a risk to public health,'

It is difficult to understand how this might operate practically, other than to entirely obviate the provision under proposed section 55. Thereby simultaneously obliterating all protections of confidentiality currently provided under section 17 and 18.

'(e) for the purposes of any legal proceedings arising out of this Act or the regulations, or of any report of any such proceedings,'

This is again vague and maybe an open door to disclosure by any service provider about matters dealt with under this act. The circumstances and audience for the disclosure allowed here is not indicated. The phrase 'of any report of such proceedings' seems at odds with the direction of the proposed section 77 and is not covered by that section.

'(f) in accordance with a requirement imposed under the Ombudsman Act 1974, '

It is unclear why there would be a need for such disclosure unless requested by a complainant, in which case subsection (a) would apply.

'(g) with other lawful excuse.'

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This appear to be a Trojan horse for unspecified exemptions. Perhaps those would include, such disclosure as authorized under the Health Records and Information Privacy Act 2002 (HRIPA) or the Privacy and Personal Information Protection Act 1998 (PIPA). It is outside the scope of these submissions to comprehensively critique those Acts. Our experiences of complaints made under HRIPA and PIPA lead us to be wary of diminution of current protections to Privacy Act standards.

We have a decision of the Privacy Commissioner that disclosure of our clients HIV status by the employer to other employees was allowed as an Occupational Health and Safety requirement. The Commissioner went on to state it was unclear what the primary purpose of our client's original disclosure to the employer was, and therefore it could not be determined whether there was a privacy breach in disclosure. NSW Privacy laws are poorly overseen by the Privacy Commissioner and inadequate to protecting the information of HIV positive people. This current exemption under (g) may simply reduce current protections to the level of the HRIPA or PIPA.

The section concludes with yet further vagary. Rather than the announcement of an offence the proposed section requires compliance and suggests penalty.

'(5) A registered medical practitioner or other person must not, without reasonable excuse, fail to comply with the requirements of this section.'

This can be compared with the current section 17 (4) which states:

(4) A medical practitioner or other person who fails to comply with the requirements of this section is guilty of an offence.

It is far from clear what 'without reasonable excuse' means in this proposed subsection. There is nothing directive to curtail that phrase to the exceptions under subsection 54 (4) and in fact there is some logic to interpreting the phrase to be broader than those exemptions under subsection 54 (4), simply as that subsection could be, but isn't referred to. The phrase is neatly juxtaposed to 'any lawful excuse' under subsection 54 (4). Driving an interpretation that reasonable excuse would be broader still than subsection 54 (4) details.

This not only appears to be a Trojan horse – it is one.

Closure of court or Tribunal

The current Act section 37 and proposed Bill section 56 and 77 provide for closed court hearings.

We have noted the loophole in the proposed Act under section 54 (4) (e). Beyond that, while the provision is excellent in as far as it goes, it could be improved upon by:

- i. Providing for suppression of names in proceeding and reporting under this Act, or
- ii. Providing more comprehensive protections for HIV positive people in matters before the courts where evidence about HIV is proposed to be given.

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The Victorian Public Health and Wellbeing Act 2008 again serves as a valuable model for such provisions. The Victorian Act states:

'Closure of court or tribunal

133. Closure of court or tribunal

(1) This section applies if-

- (a) evidence is proposed to be given in a matter before a court or tribunal of any matter relating to HIV or any other prescribed disease; and*
- (b) the court or tribunal considers that, because of the social or economic consequences to a person if the information is disclosed, the court or tribunal should make an order under this section.*

(2) If this section applies, the court or tribunal may-

- (a) order that the whole or any part of the proceedings be heard in closed session; or*
- (b) order that only persons specified by it may be present during the whole or any part of the proceedings; or*
- (c) make an order prohibiting the publication of a report of the whole or any part of the proceedings or of any information derived from the proceedings.*

(3) The powers specified in subsection (2) are in addition to any other powers the court or tribunal may have.

(4) If an order has been made under this section, the court or tribunal must cause a copy of it to be posted on a door of, or in another conspicuous place at, the place at which the court or tribunal is being held.

(5) A person must not contravene an order made and posted under this section.

Penalty: In the case of a natural person, 120 penalty units; In the case of a body corporate, 600 penalty units.'

Representing people in courts regularly on a range of matters which impact on a persons HIV status (but not under this Act) we are alive to the jeopardy HIV positive persons face by disclosure in court. Often sensitive material may be relevant to mitigation or to a fact in issue in a hearing. To have a provision which might allow for *in camera* hearings and/or suppression orders to protect HIV positive individuals would be a significant enhancement of the enabling environment.

Recommendations

HALC strongly opposes the following changes

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1. the removal of judicial oversight of the requirement to force medical practitioners to disclose identifying information relating to HIV positive people to the Director General,
2. The reduction of the threshold for forced disclosure and reporting requirements with respect to HIV from “reasonable grounds to believe” to “suspects”,
3. The increased and serious penalties imposed on medical practitioners in the draft Bill with respect to required disclosure of patient identify,
4. The increase in exemptions under section 54 (4) which largely obviate privacy protections,
5. The widening of excuses for disclosure to any reasonable excuse, further weakening the privacy protections.

HALC supports the proposed sections 56 and 77, however the sections should be enhanced to encourage suppression orders in such cases, and the Act ought to go further still to making general provision for protection of sensitive HIV related information in all matters before Courts and Tribunals.

Annexure A

HALC submits two possible drafting options for section 76 (1), which are identical to those submitted as part of the coalition of HIV organisations:

Option 1: Application of Principles (no penalty)

The following is based on the concept of principles recently introduced into the Victorian *Public Health and Wellbeing Act 2008*.

Possible text:

The following principles apply to the management and control of sexually transmissible medical conditions:

- (a) the spread of a sexually transmissible medical condition should be prevented or minimised with the minimum restriction on the rights of any person;
- (b) a person at risk of contracting a sexually transmissible medical condition should take all reasonable precautions to avoid contracting the sexually transmissible medical condition;
- (c) a person who has, or suspects that they may have, a sexually transmissible medical condition should:
 - (i) ascertain whether he or she has a sexually transmissible medical condition and what precautions he or she should take to prevent any other person from contracting the sexually transmissible medical condition and
 - (ii) take all reasonable steps to eliminate or reduce the risk of any other person contracting the sexually transmissible medical condition;
- (d) a person who is at risk of contracting, has or suspects he or she may have, a sexually transmissible medical condition is entitled-
 - (i) to receive information about the sexually transmissible medical condition and any appropriate available treatment

Option: Specific Offence (maximum penalty to remain as under current Act)

The following is based on accepted priority principles of HIV prevention

Possible text:

- (1) All persons who engage in sexual activity must take all reasonable steps to minimise the risk of acquiring or transmitting a sexually transmissible condition.
- (2) A person who is and is aware of being infected with sexually transmissible medical condition must not knowingly or recklessly place another person at risk of becoming infected with that condition unless that other person knew the risk of infection and voluntarily accepted the risk of being infected.
- (3) A person who contravenes subsection (2) is guilty of an offence.

Penalty: Fine not exceeding 50 penalty units.

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Failing of the section is that it doesn't seek to penalise transmission or even the behaviours that lead to transmission. It penalises being HIV+. It problematises having sex for HIV positive people. It tends to make sex itself a misdemeanour for HIV positive people.

Public health policy has been most effective when it seeks to change behaviours, not penalise those infected, not require disclosure and compliance but rather engage it, engender it, enable it.

Section 53,4,5 substantially reduce safeguards and balances in the Public Health Act and administration of Public Health. The new sections are tantamount to doing away with the requirement for judicial sanction and oversight of warrants in the criminal jurisdiction.