



Robert Parsons
Health Protection Regulations Consultation
Department of Health
Room 514 Wellington House
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DH CONSULTATION ON HEALTH PROTECTION REGULATIONS

Dear Robert

NAT (the National AIDS Trust) is pleased to be able to make a submission to the Department of Health consultation on the Health Protection Regulations. Our submission is in two parts – the first addresses in detail the current provisions of the three draft Regulations and attempts more or less to follow the questions (where relevant) from the consultation form; the second part again argues that the DH should act to exclude sexual routes of transmission from the scope of these public health powers.

This submission from NAT has been widely circulated within the HIV and sexual health sector. It is formally supported by the following HIV and sexual health organisations (and we would ask this is taken into account when analysing the 'weight' of views and opinions on the consultation).

The Independent Advisory Group on Sexual Health and HIV
The British Association of Sexual Health and HIV (BASHH)
The British HIV Association (BHIVA)
The Children's HIV Association (CHIVA)
The All Party Parliamentary Group on AIDS
African HIV Policy Network
Body and Soul
Body Positive North West
Cara Trust
Crusaid
Diverse
Elton John AIDS Foundation
fpa (the Family Planning Association)
Freshwinds
George House Trust
Gay Men Fighting AIDS (GMFA)
Hertsaid
Leicestershire AIDS Support Services (LASS)
Liberty
MedFASH
NAM (the National AIDS Manual)

**National Children's Bureau
Naz Project London
Positive East
Positive Health Lincolnshire
Positively Women
PozFem
Sigma Research (University of Portsmouth)
Staffordshire Buddies
Terrence Higgins Trust (THT)**

Yours sincerely

**Yusef Azad
Director of Policy and Campaigns
NAT**

Part I

Detailed comments for the Consultation Response Form

Whilst NAT welcomes some aspects of the draft Regulations, for example inclusion of statutory reporting requirements, we remain strongly opposed to any application of coercive public health powers to sexually transmitted infection. We also question the lawfulness of these health protection processes in the context of current secondary legislation on confidentiality and STIs (see Part II below). Our broader arguments are set out in Part II to this submission. The following more detailed comments are submitted to the Consultation on the draft regulations as they currently stand.

Consultation Response Form

Chapter 2: The Health Protection (Notification) Regulations

2A

Is the list of notifiable diseases for clinical reporting at Schedule 1 to the draft notification regulations appropriate?

The Schedule 1 List is appropriate.

2C

Is the information to be reported by registered medical practitioners, as far as it is known to them, appropriate?

The Health Protection Regulations continue the requirement on medical practitioners to notify the 'proper officer' of a local authority (usually in fact a local official from the Health Protection Agency) of any patient with a notifiable disease. There is now a further requirement on diagnostic laboratories to notify the proper officer of patients with any from a list of 'causative agents'.

HIV continues **not** to be a notifiable disease (the list of such diseases is at Schedule 1) or notifiable causative agent (Schedule 2). This is welcome.

But there is a new requirement that a medical practitioner, in addition to those diseases etc named in Schedule 1, also notify the proper officer of any patient who 'has an infection which in the view of [the medical practitioner] presents or could present significant harm to human health'.

The explanatory material provided by the DH makes clear that this is intended to ensure notification also takes place of 'new and emerging' diseases/infections which are not as yet included in Schedule 1 but which in the view of the doctor may nevertheless constitute a public health threat.¹ It seems sensible that Regulations both allow for and require such notification.

But the wording of the Regulations would possibly require a doctor also to notify the proper officer of a patient with any other infection, including HIV or another STI not currently in Schedule 1, which in his/her view 'presents or could present significant harm to human health', even where the condition is well known and established and

¹ See 'Health protection regulations: A consultation' DH July 2009 paras.28 and 29

where a public policy decision has been taken by Government and Parliament not to include it in the list of notifiable diseases.

The danger of course is that widely divergent practice occurs across the country in relation to infections which are well known and established but which are not in Schedule 1 as notifiable diseases.

If the provision is in relation to 'new and emerging' infections then this should be stated in terms in the text of the Regulations. Not to do so, is to create inconsistency and confusion, and, as we discuss further below, to undermine trust in the confidentiality of HIV and sexual health services which is an essential component of effective public health.

Furthermore, we believe the 'notification' of HIV and other STIs under the proposed provisions of these regulations would be in most instances unlawful on the basis of other secondary legislation around confidentiality and STIs (see Part II below on 'Confidentiality and sexually transmitted infection').

Recommendation: That the text of the Health Protection (Notification) Regulations should be amended at 2 (b) to make it clear that the aim of this provision is to require medical practitioners to notify proper officers of an infection which is new and so could not have been considered for inclusion in the Schedule 1 list of notifiable diseases.

For example, at 2 (1) (b) the text could be amended to read – 'has an infection which, in the view of R, is a new or newly emerging infectious disease which presents or could present a significant harm to human health'.

Chapter 3: The Health Protection (Part 2A Orders) Regulations

Our proposals in relation to the Health Protection (Part 2A Orders) Regulations arise from our conviction that coercive public health powers should not be applied to HIV or indeed any other sexually transmitted infection. The reasons for this position are set out in Part II of this submission.

It is true that primary legislation does not exclude any infection from the scope of the powers. But this is far less clear for specific modes of transmission. The Act requires that, for a Part 2A order to be applied, the JP must be satisfied that it is 'necessary' to make the order to reduce the risk. The Act requires that 'necessity' be interpreted within a public health context. We do not question that some sexually transmitted infections may significantly harm human health but we believe that for an infection transmitted sexually it is never necessary from a public health perspective to make the sort of orders available under the Act to JPs.

The Act states that 'A power to make regulations under this Part [2A] includes power to make different provision for different cases or different areas [45P]. Sexually transmitted infection is precisely the 'different case' this provision is designed to address – a fundamentally different mode of transmission to usual social contact, shared agency from both parties, substantial issues of stigma which affect how and whether coercion should ever be used, a distinct clinical culture with very strong confidentiality provisions.

For that reason we argue that evidence to satisfy the JP of the ‘necessity’ of the order must include evidence in the case before the JP that the risk of infection does not relate to sexual transmission.

Recommendation: That the text of the Health Protection (Part 2A Orders) Regulations 2010 should be amended so as effectively to exclude sexual routes of transmission from the scope of Part 2A orders.

For example, the text could be amended so as to read at 3 (2) (b) (i) **‘the mechanism by which the infection or contamination spreads *in the absence of sexual contact*’.**

3F

Will the proposed requirements for evidence to be given to a JP be helpful to the JP?

[We set out in a box at the end of this section the relevant para of the regulations as amended by our proposals below]

No, in their current format, they will not be helpful (they require some essential additions).

There is a requirement that the Secretary of State identify by Regulations the evidence which must be presented to a JP in order for them to make a Part 2A order.

The list of evidence found at (2) is useful and clearly responds to concerns expressed at various stages of the debate on these measures (which is appreciated), but is incomplete and provides no guidance as to how the evidence is to be used or interpreted.

The additional detail in evidence which we call for is for the most part required because the current text still applies coercive public health powers to sexually transmitted infection, which raises a host of different ethical, social and clinical issues from infections which are highly contagious and/or communicable through everyday social contact.

Our understanding is that in relation to public health powers to date it is almost unheard of for an application not to be granted.² But it makes it all the more important that the evidential demands are exacting, to protect civil liberties and human rights, and to ensure that only genuine and significant threats to public health are addressed.

The ability of others to avoid risk of infection

In relation to the risk that ‘P might infect or contaminate others’ [Part 2A 45G 1 (c)] evidence is required at 2 (c) and (d) of ‘acts or omissions’ of the relevant person (‘P’ (or ‘related party’) ‘which affect that risk’ but not of acts or omissions of anyone else. In other words, there is an assumption that those at risk from P are engaged in

² ‘there have been no known instances of any applications which did not result in an order..’
DH Impact Assessment 4.5.4 (b)

everyday social behaviour where it would be difficult to imagine how they might avoid infection. The case for sexually transmitted infections is very different, which are readily avoidable by people heeding safer sex public health messages.

Recommendation: That the text of the Health Protection (Part 2A Orders) Regulations 2010 be amended at (3) (2) (c) to read ‘including a description of any acts or omissions, or anticipated acts or omissions, of P, or of those in contact with P, which affect that risk’. And with comparable amendment to (d).

Variations in infectiousness in relation to the same condition

There is a requirement for ‘an assessment of the risk to human health that P presents’. This can be relevant both to the JP being satisfied that P might infect others and also that the order is necessary to remove or reduce that risk. It is extremely important that the JP is provided with accurate information on the degree of P’s infectiousness and its variation according to specific behaviour. How easily an infection spreads will depend on a number of factors, and will vary very significantly according to context. Importantly for the use of these powers, an individual’s infectiousness, to take the example of HIV, may vary from being very infectious to being as good as non-infectious. An individual is very infectious immediately after infection and at a late stage of disease if it has progressed to AIDS. But effective anti-retroviral therapy not only prevents progression of the condition to AIDS but also significantly reduces infectiousness.

Furthermore, likelihood of infection can vary enormously according to behaviour and transmission route (anal, vaginal or oral sex, insertive or receptive partner, and so on).

Whilst we might hope these facts were set before a JP, we are not confident they always will be in the absence of clearer requirements in the Regulations.³ We suggest the wording should be amended to emphasise the individual context.

Recommendation: That the text of the Health Protection (Part 2A Orders) Regulations 2010 be amended at (3) (2) (c) to read ‘an assessment of the risk to human health that P presents, including an explanation of how easily P may pass on his infection or contamination to another human or humans, and a description of any acts or omissions, or anticipated acts of omissions of P, or of those in contact with P, which affect that risk’. And with comparable amendment to (d).

Evidence that the order is ‘necessary’

There is then the wider question of how transmissibility relates to necessity of the order. An individual may pose a risk to one other person – but that is not the same as a public health threat which requires an order aimed at ‘public health protection’.

There is an unhappy confusion in the Act between ‘public health’ and ‘human health’ – they appear to be deemed interchangeable. However, not every threat to an

³ see for example NAT poster at the British HIV Association Conference April 2009 (www.nat.org.uk) ‘Do judges understand HIV?’ for an analysis of the many misunderstandings of the courts of the clinical facts around HIV in criminal proceedings

individual human's health is a threat to public health, even where the epidemic at a population level is considered a public health threat.

One of the great authorities on public health law is Lawrence Gostin who in his book on the subject makes it clear that 'government carries out its public health duties to benefit *populations* [his emphasis]'. He quotes the definition of public health from the Institute of Medicine, 'Public health is what we, as a society, do collectively to assure the conditions for people to be healthy'.⁴

To take the example of HIV, even where an individual may possibly pose a threat to one other person's human health, what is the public health significance of that one possible transmission? This will depend on a number of factors. How well established is the infection? HIV in the UK is already well established as a concentrated epidemic in the relevant sub-populations (mainly gay and bisexual men, and black African communities). Given this fact, is it really an act of public health protection to intervene with a Part 2A order or is it not more likely to be a surrogate ethical sanction for what is thought 'irresponsible' behaviour? Public health powers should not be used to express social disapproval – they should be used to achieve appropriately a legitimate public health outcome.

None of this detracts from the significance of infection to the person concerned, but it is criminal law, not public health law, which is currently the available process to address any personal 'wrong'.⁵

Similarly, if the substantial majority of infections are from those undiagnosed, as appears to be the case with HIV, or if the infection has a low reproductive ratio (i.e. one or two infections will not in themselves make a significant public health impact), the public health benefit of an individual intervention for a condition such as HIV is going to be limited (particularly when we are assured the orders will be exceptional), and we would question whether it can be proportionate given the restrictions on liberty usually involved.

On occasion an action undertaken to protect an individual's health might itself harm public health – Gostin gives an example, 'The exercise of compulsory powers ... may prevent individuals from, say, transmitting a communicable infection. But the social decision to coerce affects group behaviour and, ultimately, the population's health. By provoking distrust in, or alienation toward, medical and public health authorities, coercion may shift behaviours to avoidance of testing, counselling or treatment'.

Evidence of the 'necessity' of the order should not only be that there is no other means possible to remove or reduce the risk but also that there is a public health necessity to remove or reduce the risk (the wording in the Act can, and should, be read both ways).

Recommendation: That the text of the Health Protection (Part 2A Orders) Regulations 2010 be amended to add at (3) (2) (b) a new item (iii), '*the impact of the infection or contamination on public health (by reference to how easily the infection or contamination spreads amongst humans, and to the possible*

⁴ Lawrence O Gostin 'Public Health Law' University of California Press 2000

⁵ NAT are also opposed to prosecution for reckless HIV transmission – but the fact is that prosecutions do currently take place under the Offences Against the Person Act 1861. The public health proposals involve people with HIV in a further and unclear spectrum of legal responsibilities.

significance of P's acts or omissions for the incidence and wider spread of the infection or contamination).

It should be noted that this recommendation would remove the old (2) (b) (ii), repeating its wording and applying it to one of its possible applications, population-level public health considerations.

Making the assessment

In relation to the necessity to make the order, at 2 (e) and (f) there is reference to 'an assessment of the options available to deal with the risk' but no mention of the need to demonstrate the effectiveness of various options discussed or the option recommended, nor that it is the least intrusive necessary to achieve the public health objective. In other words, the draft Regulations set out **areas** of evidence but no **criteria or standards** by which to assess their relevance, quality or persuasiveness.

Whilst some of the issues where the JP has to be 'satisfied' are relatively straightforward (e.g 'P is or may be infected or contaminated'), the final requirement (that 'it is necessary to make the order in order to remove or reduce that risk' [Part 2A 45G 1 (d)]) is far more complex and open to differing judgements.

There needs to be far greater emphasis on the proper use of supportive public health interventions in advance of any consideration of use of coercion. The guiding principle of 'least intrusive, most effective' means there should be a graduated approach to public health interventions. It is particularly important that public health orders are not used in lieu of good quality and accessible voluntary interventions such as peer support, counselling, one-on-one support for example.

Both proper officers and JPs should be making their judgements in relation to some basic and agreed standards as to what constitutes 'necessity'. This should include, for example, evidence that:

- voluntary and supportive public health interventions have first been appropriately and comprehensively provided and attempted, without success
- the proposed order will be effective in achieving the desired public health outcome
- the proposed order is the least intrusive possible to the human rights of P to achieve the desired public health outcome.

Recommendation: That the text of the Health Protection (Part 2A Orders) Regulations 2010 be amended at para. 3 (2) (e) to read, 'an assessment of the options to deal with the risk that P presents (*including reference to the attempts made, and the provision and support previously offered to P to secure voluntary cooperation, the effectiveness of the proposed order to achieve the desired public health outcome, and the impact and proportionality of the order in relation to the human rights of P*).' And with comparable amendment to (f).

Guidance from the Health Protection Agency/Department of Health

It is most important that these powers are used with an appropriate degree of consistency across the country, to protect public health, avoid arbitrary decision-making and ensure a just and consistent approach. The Health Protection Agency (HPA) has a vital role to ensure consistency in the judgements made in this area of

law, given its statutory function to protect the community against infectious disease⁶ and the fact that HPA officials may well be consulted by local authorities in coming to a decision as to whether to apply for a Part 2A order.

Whilst not a requirement of the Act or for inclusion necessarily in the regulations, it is essential the HPA, in collaboration with the Department of Health, should provide guidance for all relevant parties as to how to ascertain relevant threats to public health which might justify public health orders and as to what orders are appropriate in what circumstances.

Guidance from the HPA/DH on the use of these powers will also need to address what kind of support should be provided in advance of any recourse to coercion. We would note simply that there are no consistent national standards currently available for psychosocial support and no consistent provision across PCTs. It is hard to see how such orders can be just when in one area someone will have been offered intensive counselling and support and in another simply instructed to alter behaviour.

Given the complexity and sensitivity of this issue, and the possible impacts of these orders on already vulnerable communities, the HPA/DH should in preparing such guidance fully consult interested parties and affected communities, and take into account not just clinical and epidemiological information but issues of community impact.

We believe such guidance should be drafted before the laying of the draft regulations before Parliament.

Recommendation: The Health Protection Agency and Department of Health should agree guidance on how to assess public health threats and appropriate responses, fully consulting and involving relevant parties and affected communities in this process.

⁶ Health Protection Agency Act 2004 s 2(1)(a)

Proposed amended version of para 3 (2) of the draft Health Protection (Part 2A Orders) regulations 2010 – Evidence required for a Part 2A application in relation to persons

[changed text in italics]

That evidence is –

(a) a report which details (insofar as known to the local authority and relevant to the application)—

(i) the symptoms of the person (P) who is the subject of the application,

(ii) P's diagnosis,

(iii) the outcome of clinical or laboratory tests,

(iv) P's recent contacts with, or proximity to, a source or sources of infection or contamination, and

(v) where information listed in any of sub-paragraphs (i) to (iv) is omitted from the report, the reason for this.

(b) a summary of the characteristics and effects of the infection or contamination which P has or may have which includes an explanation of—

(i) the mechanism by which the infection or contamination spreads *in the absence of sexual contact*,

(ii) the impact of the infection or contamination on human health (by reference to pain, disability and the likelihood of death), and

(iii) the impact of the infection or contamination on public health (by reference to how easily the infection or contamination spreads among humans, and to the possible significance of P's or a related party's acts or omissions for the incidence and wider spread of the infection or contamination);

(c) in relation to applications seeking an order under section 45G(2), an assessment of the risk to human health that P presents, including *an explanation of how easily P may pass on his infection or contamination to another human or humans, and a description of any acts or omissions, or anticipated acts or omissions, of P, or of those in contact with P, which affect that risk;*

(d) in relation to applications seeking an order under section 45G(4), an assessment of the risk to human health that the related party(a) presents, including *an explanation of how easily the related party may pass on his infection or contamination to another human or humans, and a description of any acts or omissions, or anticipated acts or omissions, of the related party, or of those in contact with the related party, which affect that risk;*

(e) in relation to applications seeking an order under section 45G(2), an assessment of the options available to deal with the risk that P presents (*including reference to the attempts made, and the provision and support previously offered to P to secure voluntary cooperation, the effectiveness of the proposed order to achieve the desired public health outcome, and the impact and proportionality of the order in relation to the human rights of P*); and

(f) in relation to applications seeking an order under section 45G(4), an assessment of the options available to deal with the risk that the related party presents (*including reference to the attempts made, and the provision and support previously offered to the related party to secure voluntary cooperation, the effectiveness of the proposed order to achieve the desired public health outcome, and the impact and proportionality of the order in relation to the human rights of the related party*).

3H

Does the list of 'affected persons' in the Act cover everyone who might be personally affected by a JP order?

The list of affected persons does not include a child or children of P (or other dependant minors). There are a number of single parent families where orders could have significant repercussions for children (and indeed there will be such impacts also for two parent families). Of course it is expected that the court in making a judgement on an application and an order will bear in mind the welfare of any children. But this provision is about the right to appeal and it seems that a child of P has a very genuine interest possibly in such a right.

Recommendation: That there be consideration of how children of P might be given rights as affected persons for the purpose of applying for the revocation of an order.

3K

Is a regulation requiring that local authorities consider the welfare needs of anyone whose liberty is restricted by an order necessary or desirable as an extra safeguard for vulnerable people?

This regulation is both desirable and necessary given the vulnerability of many affected by infectious disease. It is frequently also the case for people living with HIV that the same reasons the individual is unable to heed public health advice voluntarily also contribute to poor coping skills and high levels of need.

Whilst the most frequent reason for paying specific attention to welfare of P and P's dependants will be orders relating to detention, isolation or quarantine, we note that the Act states that a JP may additionally include in an order 'such other restrictions or requirements as the justice considers necessary for the purpose of reducing or removing the risk in question' [Health and Social Care Act 2008 s129 45K (2)]. It seems therefore too narrow to limit such consideration of welfare to the specified circumstances of the consultation draft.

We are concerned that the Department consider that the person subject to the order should bear the costs of any welfare provision. This will be not possible for many of the vulnerable people most likely to be affected by these orders, and could well encourage people to 'disappear' altogether. We welcome the possibility of financial support from a local authority in relation to requests for voluntary cooperation. But given how few orders are expected, it would also seem to be an appropriate use of local authority funds to bear welfare-related costs in relation to orders if there really is a public health threat.

Recommendation: That the text of the Health Protection (Part 2A Orders) Regulations 2010 be amended at para 9 (1) adding '(c) is subject to any other order which may affect P's welfare or that of P's dependants'.

Recommendation: That costs relating to meeting the welfare needs of someone subject to Part 2A orders should be borne by the local authority.

3L

Do the proposed contents of the report of an application for a JP order cover all the relevant information?

NAT argued strongly for this provision during the passage of the Bill through Parliament and are grateful for its inclusion in the Regulations. The purpose of this provision is to monitor the consistency, appropriateness and effectiveness of the use of these powers. To that end, whilst it is important that identifying information is not published, it is also important that relevant details are included in the report. It is not clear whether the application from the local authority will include the 'evidence' submitted to the JP as required in the draft Regulations, but this evidence must be included in the reporting requirement.

Recommendation: That it be clearly stated that the report of an application include the evidence provided to the JP under para 3 (2) of the Regulations.

Other issues

NAT support the submission of Liberty which goes in detail into some of the broader provisions of the regulations as they affect human rights. Of particular concern to NAT are the following points:

There is no requirement in the regulations for expert medical advice in provision of evidence for Part 2A orders, and the evidence can be provided orally. -

Recommendation: Evidence provided to satisfy a JP for the purposes of a Part 2A order must include evidence from a suitably qualified medical expert and must be provided in writing, except in cases of emergency where oral reports can satisfy for the purposes of an interim order.

There is no maximum time limit for Part 2A orders other than those involving detention. Of course at the end of a specified time period an order can be renewed by a JP. – **Recommendation: Regulations should specify that no Part 2A order can have a specified period for which the order is in force of more than 28 days.**

There is no right of appeal in the draft Health Protection (Local Authority Powers) Regulations 2010 in the case of a child being excluded from school. As we have stated in previous evidence, NAT has come across a number of instances in the UK of attempted exclusion from school of children with HIV. Neither internal review nor judicial review meets the need for accessible and independent consideration of an appeal. We envisage the circumstances when such an appeal might occur to be extremely rare. **Recommendation: Appeal to a JP should be an available review mechanism in relation to local authority powers to exclude children from school.**

Part II

1. The application of coercive public health powers to sexually transmitted infection

In recent history, coercive or mandatory public health powers have **not** been applied in England to sexually transmitted infections.⁷ There have been good reasons for such an approach, in particular the very specific mode of transmission and the stigma surrounding such infections.

The public health response to sexually transmitted infection has instead emphasised voluntary cooperation, counselling and support, population-based and targeted safer sex messages, and a strong culture of confidentiality. As will be demonstrated below, much of this approach is not compatible with the proposals in the Health Protection Regulations.

This approach is radically and fundamentally altered by Part III (Public Health Protection) of the Health and Social Care Act 2008 which inserts a new 'Part 2A' into the Public Health (Control of Disease) Act 1984. Instead of specified powers being made available in relation to a list of named diseases/infections, the powers can apply to any infection or contamination 'which presents or could present significant harm to human health'.

Thus any sexually transmitted infection may come under the potential reach of such powers if they cause 'significant harm to human health'. It would certainly appear that HIV falls into this category, as well as hepatitis B and C, and a case can quite probably be made for a number of other STIs in certain circumstances.

2. The 'all hazards' approach

The generalised application of public health powers to infectious disease or contamination has been described as the 'all hazards' approach. Why has this approach been taken?

The Government has cited the WHO International Health Regulations as one reason. These WHO Regulations apply, however, to international movement and traffic, to ensure an effective and timely global response to public health threats. They do not require any actions in relation to domestic public health powers.

A further reason for an 'all hazards' approach is the need to address new or emerging public health threats. But powers could be framed to meet this specific contingency – for example, we have recommended earlier explicit reference to 'new or emerging' disease in relation to notification. Furthermore, there are powers in the Act for the Secretary of State to make further regulations immediately to protect public health, should new and unexpected circumstances arise which require it (see sections 45C and 45R).

⁷ The only exceptions have been notification of acute viral hepatitis, which in some circumstances is sexually transmitted, but where treatment does not take place in GUM; and a power for a JP to order medical examination of someone with suspected 'AIDS', which was little known and hardly used. The power in relation to AIDS was used early on in one notorious case in Manchester. The resulting community uproar and demonstrations resulted in a prompt reversal of the order.

The question, however, is whether even a new infection, or mutation of a current infection, would ever justify application of these public health powers in relation to sexual transmission. Before the advent of anti-retroviral therapy in 1996, HIV had caused terrible suffering and death for over a decade but it was wisely considered that public health powers were inappropriate as an intervention.

NAT does not object to any infection or contamination being subject to powers where that infection can readily be transmitted to others through ordinary social contact. But where the infection is sexually transmitted we do not consider public health powers to be necessary since population-based safer sex interventions are the effective response.

3. Adequate professional, public and parliamentary consideration

The Department of Health, in advance of the public consultation on reform of public health powers, did not approach any clinical professional body involved in HIV or sexual health, any relevant voluntary sector organisation, the Independent Advisory Group on Sexual Health and HIV or the Expert Advisory Group on AIDS to discuss the merits of applying coercive public health powers to sexually transmitted infection, despite the significance of this change. Nor has there been any meeting with Ministers or senior officials during or since the consultation where the question of application of these powers to sexually transmitted infection has appeared open for reconsideration.

There was a public consultation on the public health proposals. We are not aware of any organisation with specific expertise in sexual health which has called for the extension of coercive public health powers to address STIs.

The response to the public consultation was sent out by the DH the day after the Health and Social Care Bill, containing the relevant legislative provisions, had its first reading in the House of Commons. The Health and Social Care Bill had been referred to in the Government's draft legislative programme, published in July 2007 – but there was no reference in discussion of the Bill in that document of the fact that it would be used to implement any provisions arising from the public health powers consultation.

In other words, interested parties only learned of the Government's plans after the relevant legislation was introduced, with very limited time to develop a response and engage parliamentarians on this complex issue.

In relation to the application of the Health Protection Regulations to HIV, the Equality Impact Assessment to the current consultation states that 'This argument was considered fully during the passage of the Bill'. In total the Health and Social Care Bill was considered and debated during its passage through Parliament for well over 90 hours. Our generous estimate of the amount time during which this argument was debated is 9 minutes. This is wholly inadequate attention to such a fundamental shift in how we approach sexual health.

In summary, just as with criminal prosecution for sexual transmission of infection, we again see people with HIV, and those with other sexually transmitted infections, becoming subject to serious legal obligations and sanctions without any focussed and inclusive consideration by the Department of Health or Parliament as to how this furthers the objectives of the national sexual health strategy, how consistent it is with

current professional, clinical and ethical practice and how it affects the equality and social inclusion of those infected and their communities.

4. The 'reckless' individual

There is some evidence from the Chief Executive of Health Protection Agency (HPA) of the circumstances where use of coercive powers may be appropriate for someone with HIV.

Dr Pat Troop, then Chief Executive of the HPA, told the Commons Public Bill Committee that whilst educational approaches were the preferred and usual route to reduce HIV-related harm to public health – ‘We would want to use the legislation only if there was an individual who was behaving recklessly or was unwilling to cooperate. If two men or women came forward and said, “We think we may have contracted HIV from an individual” and that person was unwilling to come forward to be tested or to give information about themselves, and we thought more partners might be at risk, we might want to have recourse to law. However, generally, if we are trying to modify behaviour, the educational approach is usually the more effective’.⁸

This view was reiterated by the new HPA Chief Executive, Justin McCracken, in a letter to Deborah Jack, Chief Executive of NAT, on 20 April 2009, referring to Dr Troop’s evidence, ‘She explained that use of an order by a Justice of the Peace would only be considered as a last resort, and if an individual was behaving recklessly or was unwilling to cooperate. She also made clear that she would expect such powers to be used only on a very small number of occasions – as is the case at present’.

These comments could apply to a number of scenarios.

- One is where an individual is identified through contact tracing to be a possible source of infection for two or more individuals. He or she refuses however to be tested or cooperate with GU. To use law in these circumstances would be a significant departure from current practice and in NAT’s view compromise fatally the current voluntary system of contact tracing/partner notification. It effectively becomes a form of coerced testing and treatment – utterly incompatible with international norms.
- A second scenario is where someone has already received a diagnosis and has disclosed this fact to sexual partners. Is someone reckless even where sexual partners are told of the risk and consent to it? For the law to intervene in such circumstances is a significant intrusion into the free decision-making of consenting adults in relation to their private sex lives.
- A third scenario is when sexual partners were not informed of the person’s infection and transmission then takes place. In such circumstances there is recourse to criminal law for the infected party. Should local authorities act even where those ‘harmed’ do not wish to go to the police with a complaint?
- A fourth scenario is where someone with HIV presents repeatedly with other STIs, suggesting continuing unsafe sex but with no information on infected sexual partners. Is it really in the best interests of public health to deter such people from presenting for treatment and care?

⁸ House of Commons Hansard Health and Social Care Bill, Public Bill Cttee 8 Jan 2008 col 33 Q.59

This is not the place to discuss in detail the pros and cons of applying JP orders to these different circumstances. Our point is rather that there is no information at all as to which if any of these examples are in the mind of the HPA Chief Executive when arguing for these powers to apply to HIV and other STIs. Nor is there any clarity as to what sort of order would be an appropriate and effective response to risk of STI or HIV harm to others. Nor what persuasive or supportive actions are necessary in advance of a 'last resort'. Nor the circumstances in which **no** coercive action will be taken against an individual who may possibly be putting others at risk.

We do not believe there is a clear, single or settled view within the HPA on these matters. The result will be inconsistent judgements at the local level which reflect personal views around responsible behaviour and ethics, rather than a settled evidence-based public health approach.

Few cases?

We have been reassured by the DH that there will only be very few cases which go to court. But it is impossible to judge whether there will be few cases or not in relation to HIV or other STIs. Previous powers were in relation to a limited list of conditions where compliance with infection-control behaviours was usual and only needed for a limited period. The matter is much more complex in relation to a life-long condition which will soon be affecting about 100,000 people in the UK, and where evidence suggests risk-taking behaviour continues amongst a significant minority of diagnosed and undiagnosed, infected and uninfected people, both amongst the sexually active public as a whole and in the communities most at risk.

In other words, if there are very few cases, this will only underline the arbitrary injustice of the application of these powers. If the number of cases reflects the real 'distribution' of reckless sexual behaviour, the numbers taken to court will overwhelm the system and wholly undermine our current effective and consensual approach to sexual health.

People living with HIV

HIV presents a very different set of circumstances to the conditions which have historically come within the scope of public health powers in the UK. HIV is not curable and those living with HIV come under the scope of these powers for the rest of their lives. They have a right to know what is expected of them, on what basis and on whose authority.

It must also be noted that people with HIV (and conceivably some others with long-term sexually transmitted infections) are considered disabled for the purposes of discrimination law. In developing the Regulations the Department has a legal duty (the 'disability equality duty') to consider how its policy approach promotes the equality and inclusion of people with HIV.

The Equality Impact Assessment linked to these draft Regulations is inadequate. It does not address the significance of applying these powers to a lifelong disability as opposed to a time-limited infection, nor the application of these powers to often stigmatised sexual behaviour. It does not address the unequal burden of responsibility placed on the person with a diagnosis when compared both with the uninfected and the undiagnosed.

It also assumes that there will as a result of an order be wide health benefit to the relevant community and negligible publicity for the order itself. The opposite will in fact be the case. We know from criminal cases and local public health 'alerts' that even a few of such cases attract immense, stigmatising and sensationalised publicity when HIV or another STI is involved. We also know that public health orders, just like public health alerts and criminal prosecutions, will have no population-wide benefits in tackling the epidemic but cause immense harm and fear to vulnerable populations.

5. Confidentiality and sexually transmitted infection

The planned Health Protection Regulations apply to any infectious disease which can 'present significant harm to public health'. HIV certainly and probably a number of other sexually transmitted infections come into this category. The relevant public health powers cannot, however, be applied to someone without breaching that person's confidentiality.

Whilst the public interest may be used to justify such breaches of confidentiality in relation to other infectious conditions, the legal situation is far more complex in relation to HIV and other STIs.

In particular there is established secondary legislation which strictly prohibits the sharing of STI-related information to anyone other than another medical practitioner 'in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof'. The relevant Regulations are the National Health Service (Venereal Diseases) Regulations 1974 and the NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000. Whilst they allow for disclosure to prevent further spread of the disease it is specified that it can only be to another medical practitioner.

In other words, though there may be cases where Part 2A orders can be applied to HIV, we cannot see how this could happen without the law on confidentiality being breached.

Of course, even putting aside the current proposals in the Health Protection Regulations, there have been difficulties and inconsistencies in the interpretation of these confidentiality provisions. GMC Guidance, for example, permits disclosure by a doctor to a third party at risk of infection where consent from the patient is sought but refused. There have also been many developments both in how data is stored and shared, and in human rights, privacy and data protection law.

This led the DH to commence in August 2006 a public consultation process on 'confidentiality and disclosure of patient information: HIV and sexually transmitted infection'. The consultation process is not, we understand, as yet completed.

It is one thing to acknowledge that current legal provisions around GU confidentiality are unclear and in need of reform. But it is quite another in advance of the proper conclusion of a public consultation and amendment of previous Regulations, to legislate on the assumption that STI-related information will be shared, in the absence of a court order, with local authorities and the courts. This demonstrates a lack of a joined-up approach to sexual health. It is wholly wrong to consider public health powers in relation to STIs separately from a strategic approach to confidentiality in relation to GU clinics, HIV and STIs.