



## **REVIEW OF PARTS II, V AND VI OF THE PUBLIC HEALTH (CONTROL OF DISEASE) ACT 1984**

### **National AIDS Trust response to the Department of Health consultation**

#### **Introduction**

This response is submitted by the National AIDS Trust. It is also supported by the Eddie Surman Trust, and Sigma Research.

#### *The case for reform*

The National AIDS Trust (NAT) welcomes the opportunity to comment on the Department of Health's proposals for reform of relevant sections of the Public Health (Control of Disease) Act 1984. There is a strong case, as the consultation document makes clear, for streamlining and updating of legislation to remove inconsistencies and anachronisms, and to ensure public health powers can meet contemporary challenges of infection and contamination as they occur.

#### *The public health context*

The structure of NAT's response attempts to follow as far as possible that of the 'form for responding to this consultation' as set out at Annex M. It is, however, important to begin with some preliminary remarks both on the national response to public health challenges and on the content of the consultation document.

Any discussion of coercive public health powers must be situated in the context of the wider public health response to infectious disease. There is a brief mention at the outset that 'advising or supporting' those infected will continue to 'account for the majority of activity undertaken to prevent and control disease'. But nothing is then said of how such supportive and cooperative measures interact with the right to take coercive action.

Should, for example, people living with HIV be penalised for risk-taking when there has been no significant investment in or provision of long-term psychosexual support for HIV positive people around reducing risk-taking behaviour, or dealing with issues of depression or low self-esteem?

How does the penalisation of infected individuals equate with the withdrawal of needle-sharing provision for injecting drug users entering the prison system? or with the refusal of affordable HIV treatment to undocumented migrants, denying them the chance to substantially reduce their infectiousness?

More broadly, if we see the restriction of civil liberty as a 'last resort', can it ever be justified to apply such restrictions in the absence of wider public health interventions such as adequate levels of investment in health promotion?

These issues are not discussed in this consultation document. But we consider it important to raise these fundamental ethical questions at this stage. They will certainly be a necessary aspect of any debate around any future proposed legislation.

The second striking absence from the consultation document is any discussion of how current coercive powers have been used to date, where and on whom. Nor is there any evidence provided either from the UK or internationally of the public health effectiveness of the measures proposed. This is a fatal omission from a document which claims to be about public health benefits. The powers proposed could as much be an expression of the frustration of authorities in wayward human behaviour as an actually effective response which significantly mitigates the risk of infection or contamination.

Overall, it is difficult to get a sense of whether the proposed powers will be used in only the most exceptional of circumstances or whether the consultation is also advocating a greater and more widespread use of these powers to control disease and behaviour. It would have been useful to have had a stronger account of the public health successes of past decades, especially in response to HIV, which have been based on a human rights based and voluntary model of care and support.

#### *Our focus on HIV*

NAT is the UK's leading independent policy and campaigning organisation on HIV. We develop policies and campaign to stop the spread of HIV and improve the lives of those affected by HIV, both in the UK and internationally. As an HIV-focussed organisation our comments inevitably concern the appropriateness of the proposed powers to deal with the HIV epidemic in England.

Whilst NAT argues strongly in this submission that none of the powers in the proposed public health legislation should apply to people living with HIV, we nevertheless comment as appropriate on the detailed questions and recommendations of the consultation document. One reason is in case HIV is not excluded from the scope of the Act as we recommend. But more broadly, we are concerned as a human rights based organisation that public health powers are appropriately designed and used – and of course there will be many people living with HIV who are co-infected with other conditions such as TB and to whom, therefore, the powers proposed could nevertheless apply.

#### **Proposal 1 – General Approach**

**NAT accepts the need in the case of certain diseases which are serious or life-threatening and which can be transmitted through casual contact, to have coercive powers available for use in certain circumstances to control the spread of the disease. Therefore we accept the principle that there should be certain powers specified in primary legislation with this aim in mind. We do not accept that any of such powers should be applied to HIV, as we shall explain, and recommend that HIV be explicitly and permanently excluded from the scope of the proposed legislation.**

**We do not agree with the proposed general regulation making power for the Secretary of State which appears far too general in its possible reach.** The consultation document makes no attempt to explain why it considers certain powers to be appropriate to primary legislation and certain powers appropriate to secondary legislation. There seems according to the proposal to be nothing to stop the Secretary of State, for example, under such a power from making new regulations which would add to the possible ways in which a JP could require an individual to act or refrain from an action.

The consultation document promises further consultation on any new regulations. Even if we accept this commitment at face value, it is a mistake to see consultation, however indispensable, as a substitute for proper legislative scrutiny. The consultation document gives no information of the kind of parliamentary scrutiny of regulations envisaged – one subject to negative resolution, one subject to affirmative resolution or one subject to super-affirmative resolution.

Regulations which merely specify administrative details of a process can legitimately be dealt with through negative resolution. **But powers which, for example, require information or require actions of individuals, should either be in primary legislation itself or, failing that, be agreed as regulations through Parliament's new super-affirmative procedure.** The advantage of this super-affirmative procedure is that it allows Parliament to have a 60-day consultation period during which committees can review the draft order and propose amendments by resolution. After the 60-day review period the Minister lays the draft instrument for approval by Parliament, with an explanatory statement outlining representations received and any changes incorporated into the regulation. This enhanced and flexible form of parliamentary scrutiny appears to be well suited to regulations with serious human rights implications. Many of the public health powers discussed in the consultation paper are precisely of this nature and should be subject to such a procedure, perhaps with referral to the Joint Committee on Human Rights for consideration.

If a public health crisis requires emergency powers there is precedent (e.g parts of the Northern Ireland Act 1998) to allow a regulation to be effective immediately in case of emergency but with provision that it will cease to have effect if it is not approved by both Houses within a specified period. Thus the super-affirmative procedure could still apply, retrospectively.

### **Proposal 2 – Guiding principles**

NAT does believe that the inclusion of Guiding Principles could be a useful way of ensuring an appropriate use of these public health powers. But the idea remains rather unclear. It appears that a JP can make an order in relation to an individual under the special powers provided by the Act either when that individual has one of the named diseases specified in primary legislation or when the individual has any other disease apart from one explicitly excluded from the legislation. In both cases it will be necessary for the exercise of such power to conform with the Guiding Principles.

If the Guiding Principles are meant to inform all decision-making under the proposed legislation then they should apply as appropriate not only to the individual decisions of JPs but also to future regulation-making decisions of the Secretary of State. **The proposed Act should explicitly bind future Secretaries of State to make regulations under the Act in accordance with the Guiding Principles, allowing the Courts to overturn improper future use of these regulation-making powers as illegal.**

**It would be useful to be clear as to which Guiding Principle restate HRA requirements and which are additional to HRA requirements. There should also be clarity as to which Guiding Principles relate to individual decisions taken by JPs and local authorities under the provisions of the Act and those which apply to the decisions of the Secretary of State on the content of regulations made under the Act (many will apply in both circumstances).**

**There should be a Guiding Principle that in determining what action to take decisions must be informed by evidence that the action decided upon can reasonably be expected to achieve the intended public health benefit.**

NAT also believes it is necessary to have a more stringent requirement as to public health risk. At present the language is simply of 'a risk to public health'. Other phrases found in the Guiding Principles such as 'the appropriate level of health protection' and 'in cases where action is needed' are similarly general or vague. **There needs to be a concept of 'seriousness' included in the Guiding Principles. As Lawrence Gostin says, 'where individual liberty is at stake, the risk justifying regulation should be substantial'.** The concept of seriousness should include severity of harm from infection, likelihood of infection, costs of infection and impact on the development of the epidemic.

### **Proposal 3 – Powers to cover contamination as well as infection**

NAT has no specific comments on the Proposal but accepts the need to have consistent and appropriate powers to meet this public health threat. It is, however, worth sounding one warning note. Contamination can spread even more rapidly and readily than the majority of infectious diseases. Those expert in contamination and how to contain it come from a different health background from those who understand the complex social realities of infectious disease. It would be a mistake to assume that the powers necessary and appropriate to deal with contamination are the same as those we should use to deal with infection.

### **Proposal 4 – Powers for disease generally or for specified diseases?**

The consultation document seems to propose the retention in primary legislation of named diseases to which the specific powers can apply ('the white list') but additionally the ability to apply the specific powers to control the spread of any disease if the power is applied in accordance with the Guiding Principles. It also suggests there could be a 'black list' of specified diseases explicitly excluded from the scope of these powers (and perhaps also from the scope of the Act altogether?).

**At the heart of NAT's submission is the strong recommendation that HIV be explicitly excluded from the scope of the proposed legislation altogether.**

**In summary, there are three reasons for this proposed exclusion of HIV from the scope of the Act:**

- **HIV is not transmissible through casual contact and is not therefore a disease which should be subject to powers designed for contagious and rapidly spreading diseases.**

It is extraordinary that in the body of the consultation document there is no attempt to distinguish between readily contagious diseases and other conditions which are not readily transmissible through everyday contact. Unlike TB or SARS, for example, or certain forms of food poisoning, HIV is not contagious, nor is it readily communicable except through very specific actions which ordinarily involve agency and deliberation by both persons. Why should coercive restrictions on the civil liberties of people living with HIV be imposed where those uninfected are as able and as responsible to look after their own health and avoid risk-taking behaviours?

- **None of the specific powers proposed should be applied to people living with HIV.**

This point links to the previous one. Most of the specific powers proposed such as quarantine and detention in hospital are not relevant to HIV since it is not a contagious disease which spreads rapidly through normal social contact. We discuss below the possible value of mandatory counselling sessions and argue against them.

- **HIV is a particularly stigmatised condition affecting in the UK mainly two already socially marginalised groups, men who have sex with men and black Africans. For this reason, any powers possibly restricting the civil liberties of people living with HIV should be addressed in primary legislation, and considered and debated separately.**

The use of coercive public health powers in relation to an already stigmatised condition such as HIV could well reinforce and deepen that stigma and further marginalise already vulnerable communities such as gay men and Africans. Indeed the fact of stigma and discrimination should encourage an approach which tends the other way, emphasising voluntary, confidential and supportive approaches.

There must obviously be care around HIV-specific legislation – singling out HIV in this way can itself be stigmatising. Our point is not that powers in relation to HIV should always be different or exceptional, but simply that the application to HIV of powers available for other diseases and conditions should only be done after very careful and separate consideration, involving people living with HIV, HIV sector organisations and clinicians, as well as human rights bodies such as the Commission for Equality and Human Rights. The issue is so sensitive that it should not be left to regulation-making power of the Secretary of State under the proposed legislation.

Whilst adding HIV to a 'black list' of exempted diseases is one way to ensure the exclusion of HIV from the scope of the proposed Act, the other is to retain the current system where relevant powers are only applicable to a list of named diseases in primary

legislation, added to if need be through secondary legislation – and then simply not include HIV on that list.

NAT is not convinced by the consultation document's argument that the serious powers envisaged should be applicable to any disease. This does not take account of the concept of 'seriousness' discussed above, and is itself, we believe, disproportionate as a result. **We believe the application of powers which affect the ordinary liberties of individuals should apply only to a list of named diseases which are recognised as both serious and contagious. Should a new public health threat emerge which is not on the list there should be the power for the Secretary of State to introduce an emergency regulation applying public health powers to the disease, which would have a strict time limit, during which period parliamentary approval would be sought, if necessary, to add the disease to the permanent list.**

We would add as a brief postscript here that we are unconvinced that use of the word 'spread' would necessarily limit future interpretation of the legislation to infectious disease.

It would also be useful for there to be a clearer explanation of what in practice the difference would be between a 'white list' disease in relation to which any particular action would need to be in accordance with the Guiding Principles and a non-specified disease in relation to which any particular action would need to be in accordance with the Guiding Principles. Would certain facts not need to be proved before a JP in relation to 'white list' conditions?

#### **Proposal 6 – Decisions on individuals to be taken by a justice of the peace**

**It is sensible for decisions on an individual of such a sensitive nature to be taken according to due and transparent process by a justice of the peace.**

What needs to be considered, however, is whether justices of the peace have, or will have, the necessary expertise to consider critically, and possibly reject, the request for an order put to them by a local authority with the backing of the Health Protection Agency or a Primary Care Trust. As things currently stand, we would argue that it is very unlikely that a JP would feel competent to question or second-guess such a request. This is not satisfactory. NAT believes that such decisions on individuals should only be made by a cadre of JPs who are effectively trained in the public health and human rights issues they will need to consider in such cases.

**NAT recommends that a special cadre of JPs be trained extensively in the public health and human rights issues relating to these public health powers, and that only such JPs make decisions on individuals.**

A related question we wish to raise at this point is the overall monitoring of how these public health powers are exercised, of possible local variation in their application, and of how they meet equalities and human rights standards. There is no proposal for central data collection or monitoring in the consultation document and we consider this to be a dangerous omission.

**NAT recommends that there be a requirement to report centrally on local exercise of the public health powers contained in the proposed legislation, in particular on**

**applications for specific orders in relation to individuals or groups of individuals and on the outcome of such applications. Data should be collated into a report to be considered by an independent advisory group established by the Department of Health, with an opportunity for third parties, and in particular bodies such as the Commission for Equality and Human Rights, to comment on the report.**

**Proposal 7 – Who should be able to apply to a justice of the peace for an order?**

NAT agrees that it is important to have clear lines of responsibility in this regard. It makes sense, in order to ensure appropriate action is taken, that there be one body with an overall duty in this area. We do not have a fundamental objection to it being the local authority but do believe the local authority must be required to act on the basis of advice from the local Primary Care Trust and that there be a designated person, ideally the Director of Public Health, with this responsibility to propose action and/or advise on action to the local authority.

NAT prefers that the PCT rather than the HPA have this responsibility because of the stronger links with local and vulnerable communities in the PCT, and the greater degree of local accountability. We would envisage, of course, that the Director of Public Health would be in regular contact with the HPA and the local CCDC on relevant matters.

**Given the centrality of the PCT and the local Director of Public Health to this process, we consider that a viable alternative to the application coming from the local authority is for it to come from the PCT, and we would recommend this option to the Department of Health for active consideration.**

**Proposal 8 – Circumstances in which a justice of the peace can require action**

**NAT believes that the only circumstances in which a JP should be able to require action from an individual is when that individual poses a serious risk to others which those people cannot reasonably be expected to foresee and avoid.**

**Proposal 9 – Procedure when making orders**

NAT has grave concerns at the use of powers to detain an individual where the person subject to the order is not present. This goes against the ordinary process of natural justice. The consultation document is concerned that individuals given notice of such proceedings might go underground or flee, possibly increasing their risk to public health. We understand this concern, but would point out that it is in any event hard to avoid such a contingency. Even if orders can be made *ex parte*, there would in the first instance be a requirement to persuade the individual to act voluntarily to minimise risk to others, with, presumably, a warning that failing to do so could result in a mandatory order. This could in itself trigger flight.

**NAT believes that it is inappropriate to make decisions on orders which involve the detention of an individual without the individual being present. If it is believed such a power is essential in certain circumstances, NAT recommends that any order made *ex parte* should have a strict and very limited duration, with a requirement that a further hearing is necessary with the individual present if the local authority wishes the JP to make a further order of longer duration.**

### **Proposal 10 – Costs and compensation**

NAT is very concerned at the proposal that all costs relating to an order be borne by the individual subject to the order. Certainly and at the very least NHS input should be free of charge and the JP should be able to require the applicant body to bear costs in cases of hardship. But this does not go far enough.

There is no attempt to acknowledge the disproportionate burden of infectious disease on the poor, and in particular on many migrant communities. Nor is there any attempt to think through the interface between immigration policy and the need to encourage infected persons, who may be undocumented migrants, to access NHS treatment and/or limit their activities voluntarily.

The main concern of the consultation document is that any compensation to someone subject to an order for loss of income etc inevitably deters that person from acting voluntarily, without compensation, to minimise their risk to others.

The thinking here seems to be very much the wrong way round. Surely the question is how to incentivise those with serious and contagious conditions to make themselves known to health authorities and agree voluntarily to significant, if time-limited, restrictions on their ability to travel and work.

One idea to consider might be offering compensation for the costs of *voluntary* restrictions on movement etc, with the threat of uncompensated mandatory orders in instances of non-compliance. Of course, a process would need to be established to ensure such a system worked properly, and, most importantly, there would have to be assurance of confidentiality to the individuals concerned, in particular in relation to immigration authorities and other state agencies. The priority is public health and nothing in the consultation document at the moment addresses how to encourage people with very limited resources to forego much needed income for the wider social good. The current expectation of a totally uncompensated system does not meet the needs of the most vulnerable and therefore will not address the needs and actions of the many thousands who live 'below the radar' in our society.

**NAT does not believe that a system which fails to offer at any stage compensation for the costs of restrictions on activity is fair or workable.**

### **Proposal 11 – Review of orders**

**NAT strongly believes that a review of an order should in all circumstances be possible and is surprised that no details of a possible process are included in the consultation document.**

Similarly, it seems obvious that orders affecting individuals should not be of unlimited duration. Such orders would be disproportionate in their effect. **On the basis of the Guiding Principles there should always be a time-limit placed on the order which relates to the nature of the infection, its responsiveness to treatment, risk to others and the behaviour of the individual concerned. There should also be a maximum time limit for any order, towards the end of which the local authority would need to apply for another order if it was deemed to be really necessary.**

NAT is an HIV organisation and we trust none of the powers will be applied to people diagnosed with HIV on the basis of their HIV infection. We are not in a position to comment definitively on the various conditions to which orders could apply and appropriate time limits, though we consider six months to be the very maximum duration defensible without the need to apply for a further order. It should always be possible to require a review of the duration specified in an order.

### **Proposal 12 – Detailed matters associated with orders**

**NAT accepts that detailed matters of process in relation to orders could be more readily specified in secondary legislation. It will be very important to ensure that it is genuinely ‘detailed matters’ and not matters of principle which are left to secondary legislation.** NAT would not, for example, consider that details of which bodies or designated individuals are to be involved in the application for or decision on an order to be a ‘detailed matter’.

### **Proposal 13 – Power to require medical examination**

This power currently exists in public health law and is, strangely, the one power which applies to people with ‘AIDS’. The Public Health (Infectious Diseases) regulations 1998 applies the powers of section 35 of the Public Health (Control of Disease) Act 1984 under which a JP can order a medical examination to suspected cases of AIDS.

We do not have information on the extent to which this power to order medical examination has been used in relation to people living with HIV, and would be very interested to find out. We cannot see its usefulness as a statutory provision.

More generally, whilst we do not oppose the power to order examination, we do not believe that can be extended to the power to order blood tests. The taking of blood is an invasive procedure which we do not believe it is ever appropriate to make mandatory in the proposed circumstances. Without such a blood test, the power to order an examination for HIV infection becomes pointless.

**NAT proposes, in line with its recommendation that HIV be excluded from the scope of the proposed legislation, that the power for a JP to order a medical examination for HIV/AIDS be repealed.**

**NAT does not believe that the power to order a medical examination should extend to invasive procedures.**

### **Proposal 14 – Power to require risk-reduction measures**

NAT does not object to the power to require risk-reduction measures per se but does not believe that the powers should apply to HIV. Many of the powers proposed such as quarantine, removal to and/or detention in hospital, reporting of temperature, avoidance of casual contact with vulnerable people, are not relevant to the risk of HIV infection.

The proposed power which seems to be possibly relevant to, or even aimed at, people living with HIV is the power to require an individual to attend ‘counselling sessions on how to reduce the risk to others’. Counselling and support certainly have a role in enabling people living with HIV to maintain safer sexual behaviours. But there is

currently insufficient availability of such support, even on a voluntary basis, in HIV clinics, which are often pressed for time and staff resources. Mandatory sessions, we believe, cannot be anything like as effective as those voluntarily attended.

Such mandatory sessions also run counter to the important public health message that we all need to engage in safer sex – the undiagnosed person with HIV who continually engages in unsafe sex could well pose much more of a risk to others than the diagnosed person who discloses, or otherwise acts to minimise likelihood of infection.

In summary, **NAT does not believe that it is appropriate to introduce mandatory counselling sessions in safer sex, particularly given the absence of such comprehensive and expert provision integrated into treatment and care on a voluntary basis.**

**Proposal 15 – What risk-reduction measures might be required?**

NAT agrees that it should not be possible to require a person to undergo treatment or vaccination or prophylaxis. We do believe that there should be an obligation on the Government to provide such treatment to those who need it affordably and accessibly on a voluntary basis – the Government currently does not meet this duty.

**Proposal 16 – Combined orders, conditional orders and group orders**

NAT accepts that it should be possible to apply for more than one order at a time, but only on the basis of evidence that they meet distinct public health needs. NAT also accepts that conditional orders might be useful.

**Proposal 17 – Power to require action in relation to premises, human remains and things**

NAT has no comment on this proposal.

**Proposal 18 – What action should it be possible to require in relation to premises etc?**

NAT has no comment on this proposal.

**Proposal 19 – Powers to require the provision of information**  
**Proposal 20 – Information requirements set at national level**

This section is hampered by the absence of discussion as to why information powers are needed and how they have been used to date to protect from the spread of disease. In particular, there is no explanation of the advantages of a mandatory over a voluntary information system, nor of why for the purposes of surveillance named notification is necessary. In particular, it would have been useful to see discussion of the implications of human rights law and data protection law on information requirements in public health legislation introduced at an earlier date.

A difficulty with this consultation is the sense of shadow-boxing with proposals which are not fully stated in the document but which the proposed powers would make easier to introduce. Such a feeling is supported by the repeated invitation in the document that

whilst details of proposed regulations have not been included 'we would nevertheless welcome any comments at this stage' on what regulations might or might not be desirable.

**NAT wishes to make clear its opposition to making HIV a notifiable disease on the current basis with named and personally identifiable information being available. The current confidential and effectively anonymous voluntary system serves us well and encourages attendance for HIV tests. Were it to become known that someone diagnosed with HIV had their status, with name and address, reported both locally and then centrally we are sure this would act as a deterrent to HIV testing.**

The exclusion of HIV from the scope of the proposed Act would of course meet our immediate concerns that the powers proposed are a prelude to making HIV a notifiable condition.

Local and central notification that an identifiable individual has a specific disease is a breach of the ordinary rules of medical confidentiality which should only be agreed to in exceptional circumstances. We are not convinced that a simple regulation-making power is appropriate in these circumstances. We do not see why regulations allow for better 'targeting' of information requirements than primary legislation. **NAT believes information requirements should be specified at the very least through super-affirmative statutory instruments.**

#### **Proposal 21 – Information requirements to be applied at local level**

Again, **NAT has serious concerns about information powers available to local authorities and possible infringements of civil liberties.** There seems to be no proposal for an independent process of approval for a local authority wishing to require personal or sensitive information from individuals or institutions (apart from JP approval for an individual's own medical information). What information would be accessed to identify patrons of, say, a restaurant, or a sauna or club? – credit card bills? CCTV footage? computer-held subscription data? Certainly, any such regulation-making powers available to the Secretary of State would need to be very carefully defined and circumscribed in primary legislation.

#### **Proposal 22 – Limits on information powers**

NAT has stated above its concern about extending information powers to HIV and the harm it will do to a public health response which has to date respected and closely guarded confidentiality.

**NAT strongly opposes the proposed right of local authorities to access personal information held by other public bodies for other purposes. The case has simply not been made for the right to override the presumption of consent to the use of personal information.**

#### **Proposal 23 – Power to make payment for information**

**NAT supports the ability to provide payment for information where the provision of that information results in a significant cost to the provider.**

### **Proposal 24 – Criminal offences**

NAT accepts that the logic of mandatory public health orders is that their breach should involve a criminal offence.

**NAT does not accept the need to provide the Secretary of State power to specify as criminal offences by regulation behaviours which ‘knowingly or recklessly put others at risk of infection or contamination’.** Surely there is already a process provided for which expects of an individual voluntary self-restraint to avoid infecting others – where this is not exercised appropriately a mandatory order can be made to constrain behaviour, which if breached can result in criminal sanction. As long as enough thought and care is put in to defining the possible actions which can be required by order, NAT does not see the need for an additional power to criminalise certain behaviours. Indeed, we believe it runs counter to the ethic and rationale of a gradualist approach of counselling, support and persuasion, followed by constraint as a last resort.

**NAT is firmly opposed to criminalising exposure to risk of HIV infection. This would be a radical step which would in our view deter people from accessing HIV testing, treatment and care, increase stigma and discrimination against people living with HIV, and quite inappropriately put all the responsibility for safer sex on one party in the sexual relationship.**

We accept that there are criminal offences around exposure to risk of infection under the current legislation, though we are unclear as to how relevant they remain or how often they have been applied. **NAT considers that any reassessment of criminal sanctions around exposure to risk of disease transmission should be in primary legislation, whether in the proposed bill currently under discussion or in some other bill.**

### **Proposal 25 – Penalties and sanctions more generally**

NAT has some concerns at the poverty experienced by so many vulnerable to not only HIV infection but also other serious diseases. Indeed poverty might be one of the reasons for their initial vulnerability to infection.

### **Proposal 26 – Secretary of State regulation-making power**

The consultation question is misleading – there is a general regulation-making power proposed which, at its broadest interpretation, would allow all future legislating by the Secretary of State in relation to public health to be done by regulation. The examples provided for in para.9.4 should not distract from how widely the regulation-making power is conceived. **We have stated above under Proposal 1 our disagreement with a general regulation making power as set out in the consultation document.**

**Further regulation-making power of the Secretary of State should be carefully defined and should not, for example include the ability to determine additional orders which a JP could make to constrain individual behaviour.**

**Additionally, no regulations should be possible which alter the content of the original piece of primary legislation (‘Henry VIII clauses’).**

**Proposal 27 – Specific power for a local authority to request a person to stop work**

NAT agrees with the proposed power of a local authority to request a person to stop work but does not agree that the current availability of compensation should end.

**Proposal 28 – Specific power for a local authority to require a child not to attend school**

NAT accepts there may be circumstances with particular diseases where it is advisable for a child to be kept away from school. This is never the case for a child living with HIV but we know of instances recently where schools have attempted or looked into the possibility of such an exclusion, however illegal. This proposal should therefore be examined with some care. It is not clear why an order which effectively deprives a child of his or her right to education should be mandatorily applicable on the order of the local authority without the decision of the JP. **NAT proposes that the local authority should be empowered to request that a child be kept away from school with the power to apply to the JP for an order where such a request is not acceded to.**

**Proposal 33 – Special considerations at borders**

**Proposal 34 – Power for local authority to require action in relation to people**

**Proposal 35 – What action should the power in relation to people cover?**

NAT does not believe that public health powers at borders, and in particular powers to require medical examination or refuse entry, should be applicable in relation to suspicion of HIV infection.

National AIDS Trust  
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