

The State of Communicable Disease Law

Stephen Monaghan

Foreword by
John Wyn Owen



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The Nuffield Trust

The Nuffield Trust for Research and Policy Studies in Health Services was established by Viscount Nuffield in 1940. Today the Trust acts as an independent commentator on the UK health scene and the National Health Service. It has set out to illuminate current issues through informed debate, meetings and publications and has also commissioned research and policy studies aimed at the development of policy and improvement of health services.

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Foreword

The Nuffield Trust has a longstanding interest in public health, and over the last five years has been actively reviewing arrangements for safeguarding and promoting the health of the people of the United Kingdom. The Trust's 1997 Rock Carling Fellowship was awarded to Professor Walter Holland, and his monograph *Public Health: the vision and the challenge*, written jointly with Susie Stewart, was published by the Trust in 1998. Later that year the Trust marked the 150th anniversary of the Public Health Act 1848 by convening a high level workshop at Christ Church, Oxford, which concluded that there was a need to modernise and adapt the mission, structure and organisation of public health. In particular participants were struck by the realisation that there was no clear answer to the simple question 'who is responsible for the control of communicable disease in these islands?'

In response to the recommendations of the Christ Church workshop, the Trust commissioned a review of the current arrangements for public health, and the legal framework within which they operate, and established a UK Partnership for the Health of the People, with representatives from all the relevant interests, to act as a steering group for this project.

The project itself was carried out under the direction of Dr Stephen Monaghan, Deputy Director of Public Health and Policy and Consultant in Public Health Medicine at Bro Taf Health Authority. The researchers looked at current and recently proposed structures and the powers and duties of officers and organisations with explicit public health functions. They also undertook five exemplar public health case studies, in areas where it was considered that the UK performs poorly in comparison with other EU countries, and where it was thought gaps exist in inter-sectoral measures to prevent poor health. In each case study area the team investigated the public health evidence for effective policy interventions, and carried out legal research into the relevant European Union and United Kingdom statutory provisions and devolved country measures, particularly focusing on gaps and shortcomings in the law and on the potential for evidence-based policy measures that could be applied through legislation.

The fifth of these case study areas was communicable disease. In January 2002 Professor Sir Liam Donaldson, Chief Medical Officer for England, published *Getting Ahead Of The Curve*, a strategy for combating infectious diseases. This recognised that infectious diseases are a major global threat to health, to prosperity, to social stability and to security. In England, though the burden imposed by the major infectious diseases is much less than in the past, the problem is still important, as is shown by the major national crises of the last few years, for example BSE and vCJD, meningitis in children, the Lanarkshire E. coli 0157 outbreak. The potential threats to health from infectious diseases are diverse, and, in the aftermath of 11th September 2001, the possibility of bioterrorism has reinforced the need for an effective strategy to combat the threat of new and emerging as well as existing diseases.

As *Getting Ahead Of The Curve* shows, there are success stories as well as threats: in England the vaccination programme against meningococcal C infection, for example; at the

global level the campaign against poliomyelitis. The CMO acknowledges, however, that there is a need to strengthen surveillance measures in this country, and has put forward his proposals for doing so in England. It is a matter of concern that, following devolution, he can do so only for England, so that, for the strategy to be fully effective, parallel measures will be needed in Scotland, Wales and Northern Ireland; and it would clearly also be desirable that there should be a UK-wide coordinating mechanism, operating in a clear and transparent fashion, both to ensure uniformity of approach across the United Kingdom, and to reassure the public that there is an effective, UK-wide response to the threats posed by infectious diseases.

In the meantime, as a contribution to the development of Sir Liam's strategy, the Trust has decided that, ahead of the full report of the UK Partnership on the Health of the People, it should publish this separate report, by Stephen Monaghan, on the state of communicable disease law in England and Wales. In presenting this report, I should like on behalf of the Trust to thank the project team, Stephen Monaghan, Dyfed Huws and Marie Navarro, and the members of the UK Partnership on the Health of the People, for their contribution to the work of the Trust in this increasingly important area, and Max Lehmann, Deputy Secretary of the Trust, who organised the Christ Church Workshop and acted as Secretary to the Partnership.

John Wyn Owen CB
Secretary

The Author

Dr Stephen Monaghan is a Senior Associate of the Nuffield Trust and for the last two years has led the project team supporting the UK Partnership for the Health of the People. He is also Deputy Director of Public Health and Policy, Consultant in Public Health Medicine, and Clinical Governance Lead with BroTaf Health Authority in Cardiff, and a Board Member of the Rhondda, Cynon, Taff Local Health Group. He has been a member of a number of expert advisory groups to the National Assembly for Wales and was lead author of the Trust's publication *Freeing the Dragon: New Opportunities to Improve the Health of the Welsh People*.

Previously he authored *An Atlas of Inequalities in Health between Welsh Local Authorities* co-published by the Local Government Association and the Faculty of Public Health Medicine, and with a civil service colleague co-wrote the first draft of the Welsh Green Paper *Better Health, Better Wales* when seconded to the then Welsh Office. He also chaired the Outbreak Control Team for the UK's largest outbreak of Meningococcal Meningitis which occurred in the Taff Ely area just north of Cardiff in 1999; he is also a qualified General Practitioner.

Summary

The key piece of legislation for England and Wales is the Public Health (Control of Disease) Act 1984. Six 'notifiable diseases' are specified in the Act and twenty four more diseases in the associated Public Health (Infectious Diseases) Regulations 1988 which indicate the precise control powers that can be applied to individual diseases.

The Act requires doctors to notify the 'proper officer' of the local authority of any person he thinks is suffering from a notifiable disease. The local authority proper officer is usually the health authority's Consultant in Communicable Disease Control, so as to address the dilemma that whereas the responsible authority under the Act is the local authority, the epidemiological and medical expertise lies within the NHS. This lack of clarity regarding who is in charge is replicated regionally and nationally.

Notification exists for outbreak detection. The Act also provides powers of investigation, to ascertain outbreak size and causation, including provisions for mandatory medical examination. The Act provides for legal control powers, which divide between those directed at preventing person to person spread - such as exclusion from work or compulsory quarantine in hospital, and those directed at preventing environmental spread - including the disinfection of articles and premises. These latter provisions, in particular, are grossly outdated having originally been placed on the statute book in the 1870s, and would not be supported by modern scientific knowledge. Many potentially useful powers are absent and the powers that exist are inflexible.

There is need to modernise the legislative framework to make it more effective and also to take account of human rights and civil liberties considerations given the coercive nature of some public health powers. Pointers for reform are provided throughout and a framework, based on principles of public health and liberty, is provided to guide the construction of new legislation.

Preface

Infectious diseases have been a threat to people's survival, health and well being since human life began. Post-war optimism that their conquest was near has proved dramatically unfounded.

... Since the early 1970s at least 30 previously unknown infectious diseases have become prominent^{1,2}, for which there is no fully effective treatment. Infectious diseases recognise no international boundaries, so that a newly emergent disease in another part of the world must be assessed as a potential threat to this country.

... The terrorist attacks on New York City and Washington DC on September 11th 2001 and subsequent deliberate releases of anthrax have reinforced the need for measures against [bio] terrorism to be part of this strategy³,

For an accurate and yet terrifying assessment of the risks we face from communicable disease and bioterrorism see Laurie Garrett's book 'Betrayal of Trust: The Collapse of Global Public Health', for example:

The threat of bioterrorism is growing at an uncontrollable pace with smallpox, for example, being cultivated as a means of warfare.⁴

This study will argue that in England and Wales the legal framework for public health has been neglected, and specifically that the law dealing with the control of communicable disease is inadequate and outdated and in need of reform. It will also provide pointers for that reform.

¹ Garrett L. *The Coming Plague: Newly Emerging Diseases in a World Out of Balance*. Farrar, Strauss and Giroux. New York. 1994.

² Including HIV / AIDS, BSE / nvCJD, Ebola Fever, Marburg Fever, Hong Kong (Bird) Flu, E. Coli 0157.

³ Department of Health. *Getting Ahead Of The Curve. A strategy for combating infectious diseases (including other aspects of health protection)*. The Stationery Office. London. 2002,

⁴ Garrett L. *Betrayal of Trust: The Collapse of Global Public Health*. Hyperion Books. New York. 2000.

Introduction

Gostin⁵ defines public health law as:

the power and duty of the state to ensure conditions for people to be healthy and limitations on the state's power to constrain autonomy, privacy, liberty, and proprietary interests of individuals and businesses.

He also describes 5 essential characteristics of public health law as follows:

- the government's responsibility to defend against health risks and promote the public's health;
- the population-based perspective of public health, emphasising prevention;
- the relationship between government and the populace;
- the mission, core functions, and services of the public health system; and
- the power to coerce individuals, professionals, and businesses for the community's protection.

This study concentrates principally upon an important subset within public health law namely the public health legal aspects of communicable disease.

The focus is thus on measures to prevent and control the spread of disease between people rather than on treatment of infection in the individual patient. This area is considered from an English Law perspective applying thereby to England and Wales.

'Communicable diseases' are infections or illnesses caused by microbiological agents comprising bacteria (or bacterial toxins), viruses, fungi, parasites, or prions which are communicable from person to person either directly or indirectly. Direct transmission includes for example through respirable droplets or sexual intercourse and indirect spread includes for instance through faecal contamination of food or water or by the intervention of an insect or other vector.

Sexually transmitted disease - a discrete category both from the point of view of a very specific mode of spread (related to a particular set of behaviours) and also from a legal perspective where there is separate legislation - is not considered within this study.

The major focus of this study is the control of communicable disease outbreaks.

Because by their nature communicable diseases spread between individuals / through the environment they usually cannot be controlled simply by a focus solely on diagnosing and treating individual patients - further transmission will often have already occurred. Rather the population (and environmentally) based approach of public health is required in order to control communicable disease.

⁵ Gostin LO. Public Health Law in a New Century - Part I: Law as a Tool to Advance the Community's Health. JAMA. 2000;283:2837-2841.

Depending on the characteristics of the particular disease and the size of the outbreak the action needed to control further spread might include, for example:

- isolation and treatment of cases,
- contact tracing, and chemoprophylaxis or immunoprophylaxis,
- taking of blood or stool specimens,
- food controls,
- disinfection,
- securing safe water supplies,
- warning the public and
- advising foodhandlers.

The overall processes for the control of outbreaks of communicable disease as can be summarised in the following logical steps:

- Communicable disease surveillance and outbreak detection
- Outbreak Investigation
- Outbreak Control.

This study will examine the law relating to these three processes in order. First, however, it considers the shape of the overall legislative framework, the legal authority and organisational framework, and then the list of the actual diseases to which the legislation applies.

The overall legislative framework

According to McHale et al⁶, English law uses two main techniques to deal with communicable disease as follows:

The first can be described as 'control powers' These permit public health officials to take steps to reduce the risk of infection. They operate to identify and segregate those who may infect others. These powers seek to prevent infection by restraining risky behaviour.

The second approach operates after infection has occurred, or been irresponsibly risked. Here those who have jeopardised the health of others are made liable to criminal penalties or to compensate those who have been made ill. This approach is principally remedial, compensating for or punishing wrongdoing. However, it is hoped that it would also provide a deterrent effect, which would reduce the incidence of infection.

The key piece of primary legislation is the Public Health (Control of Disease) Act 1984. This Act along with the associated secondary legislation, notably the Public Health (Infectious Diseases) Regulations 1988, were largely consolidation measures, drawing together previous legislation relating to infectious disease. Most of the provisions date from the late 19th and early 20th century; some date back to the Sanitary Laws of the 1870s and to the original 1848 Public Health Act. Although some parts are still relevant and valuable much is out of date. A review of the relevant law was carried out in response to the report of the Committee of Inquiry chaired by the Government's Chief Medical Officer, 'Public Health in England' (1988) which had recommended that:

DHSS should revise the Public Health (Control of Disease) Act 1984 with a view to producing a more up-to-date and relevant legislative backing to control of communicable disease and infection.

The review was completed and published as a consultation document but never enacted. There has been no systematic 'root and branch' redrafting of the law since before the Second World War. Many of the provisions are probably contrary to modern conceptions of liberty, yet many measures are too weak and confused to be effective, while many others are simply irrelevant and out of keeping with the state of knowledge on communicable disease control. This study aims to examine all these issues and make suggestions for reform.

The 1984 Act includes provisions for the control of (the spread of) communicable disease in the following main areas:

⁶ McHale J, Fox M, Murphy J. Health Promotion and Disease Prevention. In: Health Care Law: Text, Cases and Materials. Sweet and Maxwell. London, 1997.

- General powers of the relevant authorities
- Procedures for notification of disease
- Powers to acquire information (including via medical examination)
- Exclusion of infected persons from school, workplace, etc.
- Dealing with infected articles and premises
- Removal to hospital and detention in hospital
- Disposal of dead bodies

The specific control powers that can be applied to individual diseases in the population are contained in the Public Health (Infectious Diseases) Regulations 1988. There is also legislation in a variety of other areas that have a bearing on communicable disease control including Water Quality, Food Safety, Health & Safety, Immigration, and Animal Health law.

As regards the entry of diseases into (and transportation around) the country a number of miscellaneous other powers appear in specific regulations related to ports and transport:

- Public Health (Aircraft) Regulations 1979⁷
- Public Health (Ships) Regulations 1979
- Public Health (International Trains) Regulations 1994⁸
- Public Health (Canal Boats Regulations) 1878⁹.

⁷ Public Health (Aircraft) Regulations 1979 (SI 1979 No 1434).

⁸ Public Health (International Trains) Regulations 1994 (SI 1994 No 311).

⁹ Canal Boats Regulations 1878. Reg 12.

Legal authority and organisational framework

Prior to 1974 the responsibility for infectious disease control lay clearly with local authorities and a public health doctor known as the Medical Officer of Health (MOH) discharged this responsibility. This post was abolished with the 1974 NHS reorganisation, which transferred public health doctors (renamed community physicians) and the responsibility for community health services to the NHS, while local authorities retained responsibility for environmental health. Environmental Health Officers who had formerly worked for the MOH remained in local authorities and continued to work on environmental inspection and control.

Transitional guidance issued by DHSS¹⁰ at the time outlined working arrangements, roles and responsibilities. Health authorities were to be responsible for a range of services contributing to the prevention, control and treatment of communicable disease. However, statutory powers for communicable disease control remained unchanged. Therefore, in law, the responsible authority for communicable disease control continued to be the local authority¹¹, rather than the health authority¹². The guidance therefore advised local authorities to appoint a doctor who would also be a community physician of the health authority, to be known as the Medical Officer of Environmental Health (MOEH), as 'proper officer' to enable them to effectively discharge their communicable disease control duties.

The Secretary of State¹³ may by order made by statutory instrument constitute port health authorities which are special single function local authorities responsible for administering the powers in the port health regulations (mentioned above) vis-a-vis the port area in question^{14,15}.

*Port health authorities were originally created to enable local authorities to discharge environmental health functions relevant to large seaports or a conglomeration of small seaports (as in an estuary) spread across the territory of more than one local authority.*¹⁶

¹⁰ Circular HRC(73)34.

¹¹ A district council, in Wales, a county council or county borough council, a London borough council, the Common Council of the City of London, and the Sub-Treasurer of the Inner Temple and the Under Treasurer of the Middle Temple.

¹² Public Health (Control of Disease) Act 1984 (c 22), s.1.

¹³ Functions of the Secretary of State, so far as exercisable in relation to Wales, transferred to the National Assembly for Wales, by the National Assembly for Wales (Transfer of Functions) Order 1999, SI 1999 No 672, art 2, Sch 1.

¹⁴ Public Health (Control of Disease) Act 1984 (c 22), s.2.

¹⁵ Note the Secretary of State retains default powers under section 71 of the Public Health (Control of Disease) Act 1984 to transfer functions to himself, or to another authority, should he be satisfied that any local authority, port health authority or joint board has failed to discharge its function under the Act. Under Section 70 he may also facilitate the setting up of a local inquiry in relation to any matter concerning the public health.

¹⁶ Department of Health. Review of Law on Infectious Disease Control (Consultation Document). HMSO. London, 1989.

The nearest parallel to the 'proper officer' in port health legislation is the 'authorised officer' appointed by the local authority or port health authority as appropriate.

A number of failures in communicable disease control during the 1980s - most notably the salmonella food poisoning outbreak at the Stanley Royd Hospital in Wakefield in 1984 and the legionnaires disease outbreak in Stafford in 1985. This led to the setting up of the Committee of Enquiry into the Future Development of the Public Health Function. Its report *Public Health in England* (The Acheson Report) described¹⁷ the problems which arose after 1974. These included:

- There were no clear statutory responsibilities to help local authority and the health authority (and especially the MOEH) to identify their respective roles.
- Effective co-operation between health authorities and local authorities had proved difficult to secure in others.
- The MOEH had divided accountability between health and local authorities, often had other more pressing responsibilities and did not fit into organisational structures.
- There was widespread confusion about roles and responsibilities.

Public Health in England also made recommendations to remedy the situation. However, the question of whether a health or local authority should have overall lead responsibility for the prevention and control of infectious disease remained undecided.

Public Health in England stated that responsibility for the surveillance, prevention and control of most communicable disease lay with health authorities, though it also acknowledged the local authority's continuing role in prevention and control of diseases that were food and water borne. Circular HC(88)64 reminded health authorities of their duties in this area. They were advised to appoint a Consultant for Communicable Disease Control (CCDC) to take over the infectious disease duties formerly carried out by the MOEH and with executive responsibility for the surveillance, prevention and control of communicable disease in a district. Each Health Authority was also advised to appoint a Director of Public Health to provide overall leadership of the public health function.

Circular HC(88)64 also made control of infection in hospitals clearly the responsibility of a hospital infection control doctor supported by the infection control nurse and infection control team. In addition the proper officer was given powers to insist on investigation of patients, premises, and records.

In practice, over the last decade, district communicable disease control has become largely the province of the health authority in the person of the Consultant in Communicable Disease Control using proper officer powers of the local authority. He is usually also the authorised officer where there is a port within the district.

On the whole, relations have improved between local authorities and health authorities. The latter have placed a high priority on communicable disease control under the public health leadership of the Director of Public Health, in spite of being increasingly drawn into the purchasing of healthcare services as a result of the 1990 NHS reforms that established the 'purchaser-provider split'.

¹⁷ Chapters 4 and 7.

The NHS in England (and Wales) is currently undergoing another re-organisation - probably more fundamental than 1974 or even 1990 - as a result of perceived problems in the delivery of personal healthcare services. Part of the solution this time is the abolition of health authorities and the increasing introduction of primary care trusts in England and Local Health Boards in Wales.

Although local communicable disease control has largely been a success¹⁸ in the last decade the abolition of district health authorities in England and Wales now throws the delivery of this function into uncertainty once again.

In England, the Government's response is a new strategy document *Getting Ahead Of The Curve*¹⁹ which has just been released for combating communicable disease. This proposes locating the communicable disease control function between a new England-wide central agency, The National Infection Control and Health Protection Agency²⁰ and a 'local health protection service' also delivered by the new Agency (employing the CCDCs as 'Field Officers'), which will work with the NHS and local authorities²¹. The Agency will subsume the existing Public Health Laboratory Service (an England and Wales - wide network of microbiology laboratories) and its existing Communicable Disease Surveillance Centre (CDSC) which currently provides expert support in informing policy, in co-ordinating surveillance activities and in the investigation of outbreaks and epidemics. The agency will also subsume the Centre for Applied Microbiology and Research (the biological warfare facility at Porton Down), the National Radiological Protection Board and the National Focus for Chemical Incidents, to provide public health protection nationally and locally right across biological, chemical and radiological hazards.

This latest restructuring should also provide the opportunity for the much needed and long delayed fundamental review of the law relating to communicable disease control.

Pointers for reform to legal authority and duty

Effective communicable disease control relies in part upon legal authority to underpin planning, co-ordination and leadership. Currently, no agency is clearly given this responsibility - no organisation is unambiguously 'in charge'. In practice, local and health authorities work together reasonably effectively - though not always. A re-definition of who is responsible - and for what - would facilitate more effective outbreak control. The risk of confusion of roles and responsibilities probably increases with the size and complexity, and the

¹⁸ The exceptions being the food related issues related to the Lanarkshire E. Coli outbreak (as summarised in the Pennington Report) and central government policy in the Bovine Spongiform Encephalitis (BSE) and New Variant Creutzfeldt Jacob Disease (nvCJD) affair (as summarised by the Phillips Enquiry) which have led to the setting up of the Food Standards Agency.

¹⁹ Department of Health. *Getting Ahead Of The Curve*. A strategy for combating infectious diseases (including other aspects of health protection). The Stationery Office. London, 2002.

²⁰ Combining the existing functions of the Public Health Laboratory Service and three other national bodies, the National Radiological Protection Board, the Centre for Applied Microbiology and Research, and the National Focus for Chemical Incidents, to provide an integrated approach to protecting public health against infectious diseases as well as chemical and radiological hazards.

²¹ To deliver specified functions relating to the prevention, investigation and control of infectious diseases as well as chemical and radiological hazards.

immediacy of the communicable disease threat and the tensions this brings. When the system is most needed may be when it is least dependable. The abolition of health authorities and the establishment of the new (English) National Infection Control and Health Protection Agency (NICHPA) gives the opportunity to reconsider this question.

A NICHPA lead would recognise the epidemiological expertise of a CCDC ('Field Officer') which is lacking within the local authority.

A lead based on type of disease would give the local authorities powers for food borne disease, and the Agency responsibilities for other communicable diseases reflecting the expertise of both. However it may not immediately be clear in an individual case what type of disease is involved; nor whether it is spread from person to person or from an environmental source. Furthermore, the epidemiological expertise of the Agency would still be needed for an outbreak of food borne disease.

The position of the local authority is also complicated by the more recent creation of the Environment Agency and Food Standards Agency.

New legislation should probably move the legal authority from local authorities to NICHPA, which should also be given a specific statutory duty to provide a communicable disease control service to each and every local district. This would also remove the need for a defined local authority 'Proper Officer' though a named individual professionally and managerially accountable for communicable disease control in a particular district remains important in terms of leadership and accountability. This individual (Field Officer presumably) would also still need to be legally empowered to exercise the statutory powers essential for communicable disease control and to receive notifications (see later).

Regional directors of public health who are to be removed from NHS regional offices to regional government offices in the latest NHS reforms have had no formal role in communicable disease control. With the abolition of health authorities they ought to be given some statutory responsibility for co-ordinating health protection activities in their regions.

Notifiable diseases and their linkage to statutory control measures

The first step in the process of communicable disease control is the early detection of a possible outbreak via a process of public health surveillance. This involves the identification of individuals who have been infected by, or carry, an important infectious disease agent and this information being communicated to the relevant authority. Hence, as a centrepiece of the current legislation doctors are legally required to inform the proper officer when they diagnose or suspect a 'notifiable' disease. He is then legally empowered to investigate further by seeking information from other parties before taking measures as necessary to control spread including if required making use of selected specific statutory powers.

The specific procedures for notification, the general legal powers to obtain information and the specific control powers are all discussed in subsequent sections. This section deals with which communicable diseases are, or can be, notifiable and the relationship between particular diseases or categories of disease and the application of statutory control powers.

Current legislation

Section 10 of the Public Health (Control of Disease) Act 1984 designates five diseases (subject to the International Health Regulations) as being 'notifiable' diseases:

- cholera,
- plague,
- relapsing fever,
- smallpox,
- typhus²².

In addition food poisoning²³ is made notifiable in section 11 of the 1984 Act. The Secretary of State has the power under section 13 of the Act to extend the Act to other diseases and has done this under the Public Health (Infectious Diseases) Regulations 1988 which have also subsequently been amended²⁴.

²² Public Health (Control of Disease) Act 1984 (c 22), s.10.

²³ Unfortunately there several different definitions of 'food poisoning' in the 1984 Act and 1988 regulations. Ideally a common definition should be adopted.

²⁴ Public Health (Control of Disease) Act 1984 (c 22), s.13 as amended by the Local Government (Wales) Act 1994, s 22(3), Sch 9, para 13(2); the Health Authorities Act 1995, s 2(1), Sch 1, para 108(5); by SI 2000 No 90, art 3(1), Sch 1, para 17(1), (3). Modified, in relation to France and the United Kingdom, by the Channel Tunnel (International Arrangements) Order 1993, SI 1993 No 1813, art 7(1), Sch 4, para 2. Modified, in relation to its application to frontier controls between the United Kingdom, France and Belgium, by the Channel Tunnel (Miscellaneous Provisions) Order 1994, SI 1994 No 1405, art 7.

These provisions add a further 24 diseases which have to be notified by a doctor upon diagnosing them. Thus, in practice, the term 'notifiable diseases' is commonly used to cover all 30 diseases.

All the control powers set out in Part II of the 1984 Act apply only to the five diseases in Section 10 of the Act. For the other 25 diseases, (and also for AIDS which is not technically a notifiable disease in a legally mandated sense):

... a special selection of control powers exist, designed to limit legal powers strictly to what might be necessary in each case. But this has led to the confusion of 12 different 'packages' of powers and duties for the 30 diseases²⁵.

These are set out in Table 1.

It is important to note that not all diseases of public health importance (for example legionnaires' disease) are notifiable, thereby attracting statutory control powers.

Powers to order other diseases notifiable

There is also provision where necessary for the operation of the Act to be extended by local authorities to cover additional specified diseases for particular geographical areas. Normally this is with the approval of the Secretary of State and after advertising this in local newspapers. However, in an emergency an order can be made for one month without prior approval, though it may be revoked by the Secretary of State²⁸. It follows therefore that the list of diseases to which the powers under the Act apply can vary geographically and therefore be slightly different from those recorded in Table 1.

'Infectious diseases' and Port Health

Port Health legislation does not contain provisions for 'notifiable diseases', instead it uses the term 'infectious disease' which is defined as

a disease subject to the International Health Regulations [plague, cholera, yellow fever, smallpox] or any other infectious or contagious disease other than venereal disease or tuberculosis. Control powers apply to 'infectious disease'

Pointers for reform

Reform options which have been outlined²⁹ for deciding the scope of communicable disease notification and how this should link with control powers might include:

²⁵ Department of Health. Review of Law on Infectious Disease Control (Consultation Document). HMSO. London, 1989.

²⁶ See facing page.

²⁷ In addition: (a) s.11 shall apply where the opinion of the registered medical practitioner that a person is suffering from tuberculosis is formed from evidence not derived solely from tuberculin tests, and (b) ss.37 and 38 shall apply to tuberculosis of the respiratory tract in an infectious state.

²⁸ Public Health (Control of Disease) Act 1984 (c 22), s.16.

²⁹ Department of Health. Review of Law on Infectious Disease Control (Consultation Document). HMSO. London, 1989.

Table 1: The Enactments in the Act Applied to Particular Diseases²⁶

Diseases	Enactments applied
Acquired immune deficiency syndrome	Sections 35,37,38 (as modified by Regulation 5), 43 and 44.
Acute encephalitis	Sections 11,12,17 to 24,26,28 to 30,33 to 35 (as modified by Regulation 4), 37,38,44 and 45.
Acute poliomyelitis	
Meningitis	
Meningococcal septicaemia (without meningitis)	
Anthrax	Sections 11,12,17 to 22,24,26, 28 to 30,33 to 35 (as modified by Regulation 4), 37, 38 and 43 to 45.
Diphtheria	Sections 11,12,17 to 24,26,28 to 30,33 to 38,44 and 45.
Dysentery (amoebic or bacillary)	
Paratyphoid fever	
Typhoid fever	
Viral hepatitis	
Leprosy	Sections 11,12,17,19 to 21,28 to 30,35 (as modified by regulation 4), 37,38 and 44.
Leptospirosis	Sections 11,12,17 to 22,24,26,28 to 30,33 to 35 (as modified by Regulation 4), 37, 38,44 and 45.
Measles	
Mumps	
Rubella	
Whooping cough	
Malaria	Sections 11,12,18 and 35 (as Modified by regulation 4).
Tetanus	
Yellow fever	
Ophthalmia neonatorum	Sections 11,12,17, 24 and 26.
Rabies	Sections 11,12,17 to 26,28 to 30 and 32 to 38.
Scarlet fever	Sections 11,12,17 to 22,24,26,28 to 30,33 to 38,44 and 45.
Tuberculosis	Sections 12,17 to 24,26,28 to 30, 35 (as modified by regulation 4), 44 and 45 ²⁷ .
Viral haemorrhagic fever	Sections 11,12,17 to 38,43 to 45 and 48.

²⁶ Adapted From Schedule 1 To The Public Health (Infectious Diseases) Regulations 1988 (S.I. 1988 No. 1546).

1. Limiting control powers to those diseases requiring notification by a doctor - the status quo.
2. Making the full range of control powers available for all communicable diseases rather than only those classified as notifiable.
3. Restricting control powers solely to those notifiable diseases which require early action to prevent spread such as tuberculosis and food poisoning, thereby excluding those where notification is used mainly for evaluative statistical trends over time such as mumps and measles.

Option 1 would retain the current confusion of different packages of powers for different diseases.

Option 2 would allow the flexibility to respond to cases of disease which are not notifiable, but where some action is needed to control spread. However, this enlargement of powers might be seen as a substantial potential encroachment on civil liberties without relation to the severity of the disease threat. It might also be argued that, if control powers are necessary for a particular disease, that disease should be defined in statute. If an unexpected need for such powers arises in relation to a non-notifiable disease, the local authority already has emergency powers to make this disease immediately locally notifiable thereby attracting the various powers. Similarly, the Secretary of State can issue new regulations enabling this across the country as a whole.

Option 3 would mean a reclassification of notifiable diseases along these lines of Table 2³⁰ with those diseases requiring early action retaining the title 'notifiable diseases' and attracting associated control powers.

Diseases currently notified for purposes of surveillance could remain reportable by the doctor over particular time intervals. These might be renamed as 'reportable diseases'.

In all events, notifiable diseases should probably continue to be named in regulations rather than primary legislation, to allow flexibility.

In relation to Port Health arrangements for notification and control of communicable disease the term 'infectious disease' should probably be redefined on the same basis as notifiable disease to avoid unnecessary complication.

³⁰ Department of Health. Review of Law on Infectious Disease Control (Consultation Document). HMSO. London, 1989.

Table 2: Suggested division into notifiable and reportable diseases

'Early action' notifiable diseases	(Long-term) 'reportable' diseases
Acute poliomyelitis	Acute encephalitis
Meningitis / Meningococcal Septicaemia	Measles
Anthrax	Mumps
Diphtheria	Rubella
Dysentery	Whooping cough
Paratyphoid fever	Malaria
Typhoid fever	Tetanus
Viral hepatitis	Ophthalmia neonatorum
Leprosy	Scarlet fever
Leptospirosis	Yellow fever
Rabies	
Tuberculosis	
Viral haemorrhagic fever	
Cholera	
Plague	
Relapsing fever	
Smallpox	
Typhus	
Food Poisoning	
HIV/AIDS	

Notification procedures for communicable disease surveillance and outbreak detection

Surveillance is the foundation of any communicable disease control system. It enables the tracking of disease trends, the identification of new communicable disease threats, vaccine evaluation, the detection of outbreaks and the monitoring of control measures.

In the UK the system functions acceptably well; however much disease goes unreported or is severely under-notified so that routine surveillance information gives an incomplete picture of the nature and size of the threat. The level of under-reporting varies according to the disease concerned.

Notification to the proper officer

Notification by doctors to the proper officer

Under the Public Health Act 1984, a registered medical practitioner must notify 'forthwith' the proper officer of the relevant local authority regarding any patient whom he knows or suspects has a notifiable disease or food poisoning.

Public Health in England stated that in order to more accurately reflect the fact that in practice health authorities carried the lead responsibility for control of most communicable disease and infection, notification should be made to them rather than to local authorities.

The notifying doctor must send a certificate³¹ to the proper officer (at his health authority address) giving the patient's name, age, sex and address of residence. He must also state the disease or form of food poisoning from which the patient is (or is suspected to be) suffering and the date (or approximate date) of its onset.

If the patient is an inpatient in hospital, he should in addition provide information on the day of admission, and whether in his opinion the disease or poisoning which the patient is, or is suspected to be suffering, was contracted in the hospital.

A fee is paid to a doctor for each notification certificate³², and criminal penalties and fines³³ apply for failure to notify though prosecutions of doctors for failure to notify are very rare. In practice, only a small proportion of cases are notified.

Once he has identified or suspected a notifiable disease the doctor is to notify 'forthwith'. This term, however, can be variously interpreted and consideration should be given to fix a time limit of 48 hours from the point of diagnosis or suspicion to the dispatch of a notification³⁴.

³¹ The form in schedule 2 of the regulations.

³² Public Health (Control of Disease) Act 1984 (c 22), s.12 as amended by the Health Authorities Act 1995, s 2(1), Sch 1, para 108(4).

³³ Public Health (Control of Disease) Act 1984 (c 22), s.15.

³⁴ As a reform tighter time limits and methods of communication (by telephone or email) could be allowed or required where necessary. If the time limit was breached, the fee might be withheld.

Reporting by microbiology labs to the proper officer

Over recent years the surveillance function of the notification system has been supplemented by other methods of reporting, notably the reporting of laboratory isolations of significant pathogenic micro-organisms through the Public Health Laboratory Service (PHLS) network. These and other microbiology laboratories, are however under no statutory requirement to report infections for public health purposes.

Others obliged to notify the proper officer

Other specific statutory obligations to notify the proper officer of infectious diseases do exist in relation to keepers of common lodging houses. In addition to notification in accordance with the 1984 Act and 1988 regulations, children's homes and remand homes are also obliged by statute to notify the proper officer of confirmed cases of certain communicable diseases.

COMMON LODGING HOUSES

Keepers of common lodging-houses³⁵ must notify local authorities if one of their customers is suffering from a notifiable disease³⁶ as follows:

Where a person in a common lodging-house is suffering from any infectious disease, the keeper of the lodging-house shall immediately give notice of the case to the local authority for the district. A keeper of a lodging-house who fails to comply with the requirement above shall be liable on summary conviction to a fine ...

CHILDREN'S HOMES

... the responsible authority shall forthwith notify ... the outbreak in the home of any notifiable infectious disease to which the 1984 Act applies or disease to which provisions of that Act are applied by Regulation made under that Act³⁷.

REMAND HOMES

The Superintendent of a remand home shall report at once any death and any case of serious illness, infectious diseaseTM ... to the council³⁹.

³⁵ A common lodging-house is a place for the overnight accommodation of the poor, not being a public assistance institution, in which people share the same room for sleeping or eating.

³⁶ Public Health (Control of Disease) Act 1984 (c 22), s.39 as amended by the Health Authorities Act 1995, s 2(1), Sch 1, para 108(7). See further, as to the power of the court to cancel registration or to disqualify for re-registration: the Housing Act 1985, s 409.

³⁷ Children's Homes Regulations 1991 (SI 1991 No 1506) s.19.

³⁸ 'Infectious disease' means Enteric fever (typhoid), Scarlet fever, Diphtheria, Chickenpox, Smallpox, Measles, Epidemic conjunctivitis, Venereal disease, Acute rheumatism, Chorea, Scabies, Cerebro-spinal meningitis (spotted fever), Encephalitis lethargica, Influenza, German measles, Mumps, Whooping cough, Granular conjunctivitis (trachoma), Tubercular disease, Erysipelas, Ringworm.

³⁹ Remand Home Rules (SR 8c 0 1939 No 12) s.20. As amended by SI 1970 No 1510.

OTHER NOTIFICATION SYSTEMS TO THE PROPER OFFICER

Under food law meat and dairy workers and food handlers should report food poisoning to the proper officer. CDSC have also recommended that employers should notify the proper officer of suspected outbreaks of food borne diseases as well as confirmed cases. Employers have other statutory duties to report occupational diseases to the Health and Safety Executive under the law of health and safety at work. These are beyond the scope of this study.

Notification by the proper officer*Notification to the local authority*

The proper officer must within 48 hours of receiving the certificate within the health authority send a copy to the relevant local authority, in order to keep it informed especially of food and water borne diseases that occur in the community. If the address of the patient is a ship situated in a port where a port health authority is constituted then the notification must also be copied to its 'authorised officer'.

Notification to the Chief Medical Officer

In certain cases the Government's Chief Medical Officer must also be notified immediately in relation to⁴⁰:

- a case or suspected case of a disease subject to International Health Regulations (cholera, plague, smallpox and yellow fever)
- a case of leprosy or viral haemorrhagic fever.
- a case of malaria or rabies contracted in Britain;
- a serious outbreak of any disease, including food poisoning;

In addition where a local or port health authority have reason to believe that rats in its district are infected with plague, or are dying in unusual numbers, it must notify the Chief Medical Officer⁴¹. As recommended in *Public Health in England* these notifications are copied to CDSC, well as to the Chief Medical Officer.

Notification to the Registrar General

The Act also mandates the proper officer to send weekly and corrected quarterly collated statistical notification returns to the Registrar General of the Office for National Statistics (ONS)⁴²⁻⁴³.

⁴⁰ Public Health (Infectious Diseases) Regulations 1988 (SI 1988 No 1546) s.6.

⁴¹ Public Health (Infectious Diseases) Regulations 1988 (SI 1988 No 1546) s.11.

⁴² The Regulations specify that the reports must be sent in a manner that ensures confidentiality and may only be revealed in so far as is necessary to prevent the spread of disease. However, if a court order has been made under the 1984 Act and the time for challenging it has expired, then there is no power for the court to restrict the publication of the subject's name in the interests of confidentiality.

⁴³ Public Health (Infectious Diseases) Regulations 1988 (SI 1988 No 1546) s.8.

Pointers for reform of the notification procedures

The current notification system, with all its imperfections, is based on notification by doctors following a clinical diagnosis. This system should be retained however, it should be supplemented with statutory notification by laboratories of specified micro-organisms. Because labs identify micro-organisms rather than diseases, the list of notifiable diseases may need slight amendment on this basis. The current notification system also has a major gap in that it is impossible to track antimicrobial resistance. This should be made notifiable by labs.

Presumably in future notifications will need to be directed to the field officers of the new Agency. The notification procedure should be set out in regulations instead of primary legislation, to allow flexibility for change in the future - particularly with a view to .more sophisticated electronic forms of communication.

Legal provisions for investigation of outbreaks

For the most part, compulsory measures to investigate an outbreak of communicable disease are not necessary. If legal powers are needed, the 1984 Act and 1988 Regulations give a wide range of powers and duties to local authorities to facilitate enquiries in an outbreak investigation. These fall under the following headings:

1. Identification of cases via:
 - Notification (as already discussed).
 - Mandatory medical examination to assist identification.
2. Measures to assist epidemiological survey:
 - Powers for compulsory provision of information.
 - Powers of entry and investigation.

Mandatory medical examination

Under section 35 of the 1984 Act, the local authority's proper officer can issue a written certificate seeking and justifying a mandatory medical examination. A justice of the peace⁴⁴ can then require a person to be medically examined if he is persuaded that there is reason to believe that the person is carrying, a 'notifiable disease' or carries an organism capable of causing it, and when this is in:

- the interests of that person, or
- the interests of his or her family, or
- the public interest

and has the consent of the person's doctor (if he or she has one).

'Medically examined' specifically includes submitting to bacteriological and radiological tests and similar investigations.

In combination with this order, a warrant may also be issued under these sections to authorise the entry into private premises in order to carry out the examination.

A power also exists under section 36 of the 1984 Act to order the examination of a group of persons, believed to comprise a carrier of notifiable disease. This operates in much the same way.

A number of separate provisions also exist relating to specific situations:

- All the inmates of a common lodging-house, in which there is or was a person reasonably believed to suffer from a notifiable disease, may be examined on the authority of a

⁴⁴ acting, if necessary, ex parte.

magistrate's warrant, to see if they are infected. There are no statutory criteria governing the issue of the warrant, which is therefore a matter for the magistrate's discretion⁴⁵.

- Midwifery regulations provide for midwives to be compulsorily required to undergo an examination by their supervisors if they deem it necessary for preventing the spread of infection. This now seems inappropriate and outdated.
- Food regulations give a power to require a medical examination where dairy workers are suspected of presenting a risk of infection to milk. Compulsion may be heavy handed, applying only to milk now seem a little odd.
- Where those who prepare food may be the source of an infection that has caused food poisoning, their employer may be required to provide reasonable assistance in their being medically examined. However, the Regulations do not provide a power for the person to be examined without their consent. This is reasonable.

Powers for compulsory provision of information

Where further information needs to be obtained for example through completion of questionnaires, recourse can be made to a range of powers to investigate and of duties to co-operate with the medical officers.

These include obligations (with legal sanctions in the form of fines) on the occupiers of premises^{46,47}, employers, and head teachers to provide information that is reasonably required.

Schools

The principal of a school in which any pupil is suffering from a notifiable disease shall, if required by the proper officer of the local authority for the district, furnish to him within a reasonable time fixed by him a complete list of the names and addresses of the pupils .. .If the principal of a school fails to comply with the provisions of this section, he shall be liable on summary conviction to a fine⁴⁸.

Occupiers

The occupier of any building in which a person is suffering from a notifiable disease shall, if required by the local authority, furnish to them the address of any laundry, wash-house or other place to which articles from the house have been or will be sent during the

⁴⁵ Public Health (Control of Disease) Act 1984 (c 22), s.40.

⁴⁶ 'Occupier', in relation to any premises, includes a person having the charge, management or control of the premises, or of a building of which the premises form part, and in the case of premises consisting of a building the whole of which is ordinarily let out in separate tenements, or of a lodging house the whole of which is ordinarily let to lodgers, the person receiving the rent payable by the tenants or by the lodgers, as the case may be, either on his own account or as the agent of another person.

⁴⁷ Public Health (Control of Disease) Act 1984 (c 22), s.18.

⁴⁸ Public Health (Control of Disease) Act 1984 (c 22), s.22.

continuance of the disease for the purpose of being washed or cleaned. A person who ... fails to comply ... shall be liable to a fine⁴⁹.

This provision seems particularly outdated, as does much of the law related to infected articles - as discussed later.

Power to enter premises

An authorised officer of a local authority has the right to enter any premises at all reasonable hours in connection with the enforcing its powers under the Act⁵⁰. If a justice of the peace is satisfied that admission to any premises has been refused and that there is reasonable ground for entry into the premises under the Act then he may by warrant authorise entry to the premises, if necessary by force⁵¹. There are less stringent rights of entry to and inspection of, common lodging-houses and canal boats⁵², provisions that again seem somewhat anachronistic.

Pointers for reform of the investigative powers

At first sight some of these powers seem draconian and out of keeping with modern notions of civil rights - a theme which will be discussed later.

However, it probably is necessary to retain a power to require medical examination in the public interest. A number of safeguards are built in - that a medical examination is required in someone's interests and with the consent of the person's doctor - though the ex-parte decision making is controversial.

Current powers of mandatory medical examination extend only to suspected 'carriers', rather than suspected cases. This needs to be remedied.

There are few powers to require individuals to provide information that may be required to properly investigate a communicable disease incident or outbreak. Provisions might be made requiring information from others who may be able to help an epidemiological survey including employers and owners or occupiers of buildings and managers of places used by people, e.g. schools, colleges, hospital and prisons. The Health and Safety Executive has such powers in relation to industrial accident investigations.

Statutory rights of access to premises (including residential homes and businesses) could be given to specified officers to help control spread of notifiable diseases in order to enable access to people for questioning.

Powers of investigation need also to allow for examination and inspection of buildings, sampling of water, food, cooling towers etc during outbreaks and enforcement of orders⁵³.

⁴⁹ Public Health (Control of Disease) Act 1984 (c 22), s.24.

⁵⁰ Admission to any premises, other than a factory or workplace, shall not be demanded as of right unless twenty-four hours' notice of the intended entry has been given to the occupier.

⁵¹ Public Health (Control of Disease) Act 1984 (c 22), s.61.

⁵² Public Health (Control of Disease) Act 1984 (c 22), s.62.

⁵³ Department of Health. Review of Law on Infectious Disease Control (Consultation Document). HMSO. London, 1989.

Legal provisions for outbreak control

Generally, compulsory measures to control an outbreak of communicable disease will not be needed. They may, however, provide an incentive for voluntarily co-operation and occasionally will be required.

The legal provisions directed to control outbreaks of communicable disease under the 1984 Act and 1988 Regulations can be grouped into 2 categories:

- Provisions to control person to person spread.
- Provisions to control environmental spread.

Legal provisions to control person to person spread

An offence of exposing others to an infected person

A person, who knowing that he is suffering from a notifiable disease, ... or who has in his care a person whom he knows to be suffering from a notifiable disease, ... exposes other persons to the risk of infection by his presence ... or conduct... shall be liable on summary conviction to a fine ..⁵⁴.

This offence has not been extended to AIDS by the 1988 regulations.

Offences of related to travelling on public transport

No person who knows that he is suffering from a notifiable disease shall enter any public conveyance ... without previously notifying the owner or driver....

No person having the care of a person whom he knows to be suffering from a notifiable disease shall permit that person to be carried in any public conveyance, without previously informing the owner or driver.

A person who contravenes any above provision shall be liable on summary conviction to a fine... and in addition ... shall be ordered by the court to pay... any loss and expense incurred by him in connection with the disinfection of the conveyance⁵⁵.

The owner, driver or conductor of a public conveyance used for the conveyance of passengers at separate fares shall not convey in it a person whom he knows to be suffering from a notifiable disease.

⁵⁴ Public Health (Control of Disease) Act 1984 (c 22), s.17.

⁵⁵ Public Health (Control of Disease) Act 1984 (c 22), s.33.

If a person suffering from a notifiable disease is conveyed in a public conveyance, the person in charge of the conveyance shall as soon as practicable give notice to the local authority for the district in which the conveyance is usually kept, and before permitting any other person to enter the conveyance, cause it to be disinfected.

A person who contravenes any of the foregoing provisions shall be liable on summary conviction to a fine⁵⁶.

Proper officer powers of exclusion of infected persons

Legal powers allow people with notifiable diseases to be isolated from those they might infect. The provisions relate to exclusion from work, from school, from using public transport and from 'places of assembly'. In detail the legislation is as follows:

EXCLUSION FROM THE WORKPLACE

A person who, knowing that he is suffering from a notifiable disease, engages in or carries on any trade, business or occupation which he cannot engage in or carry on without risk of spreading the disease shall be liable on summary conviction to a fine⁵⁷.

In addition, the 1984 Act provides for the proper officer of the local authority to formally exclude a person from working to prevent spread. This power relates to the 5 diseases notifiable under the Act and also to enteric fever (including typhoid and paratyphoid fevers); dysentery; diphtheria; scarlet fever; acute inflammation of the throat; gastro-enteritis; and undulant fever under the Public Health (Infectious Diseases) Regulations 1988.

The local authority has a duty to compensate an individual, who is excluded, or voluntarily excludes himself from work at the request of the proper officer⁵⁸, for financial loss he experiences as a result.

EXCLUSION OF CHILDREN FROM SCHOOL

Infected children may be excluded by the local authority from school as follows:

A person having the care of a child who is or has been suffering from a notifiable disease, or has been exposed to infection of a notifiable disease, shall not, after receiving notice from the proper officer of the local authority for the district that the child is not to be sent to school, permit the child to attend school until he has obtained from the proper officer a certificate that in his opinion the child may attend school without undue risk of communicating the disease to others. ... A person who contravenes shall be liable on summary conviction to a fine⁵⁹.

⁵⁶ Public Health (Control of Disease) Act 1984 (c 22), s.34.

⁵⁷ Public Health (Control of Disease) Act 1984 (c 22), s.19.

⁵⁸ Public Health (Control of Disease) Act 1984 (c 22), s.20 as amended by the Food Safety Act 1990, s 59(1), Sch 3, para 28.

⁵⁹ Public Health (Control of Disease) Act 1984 (c 22), s.21.

EXCLUSION OF CHILDREN FROM PLACES OF ENTERTAINMENT OR ASSEMBLY

In order to prevent the spread of a notifiable disease, a local authority may prohibit or restrict the admission of persons up to 16 years of age to any place of entertainment or assembly⁶⁰ for a specified period of time. If the person responsible for the management of a listed place, fails to comply he shall be liable on summary conviction to a fine⁶¹.

Powers of removal to hospital and detention in hospital

REMOVAL TO HOSPITAL

Under section 37 of the 1984 Act⁶², a magistrate⁶³ may order that a person who is suffering from a notifiable disease, or any other disease to which the section has been extended (see Table 1), shall be removed to hospital.

Before such an order can be made, the magistrate must be satisfied on the application of the local authority, that a person is suffering from a notifiable disease and that:

1. The circumstances are such that proper precautions to prevent the spread of disease cannot be, or are not being, taken.
2. Serious risk of infection is thereby caused to other persons⁶⁴.
3. Suitable hospital accommodation is available.

Magistrates cannot order that people be removed to hospital unless the hospital authority agrees to accept them.

An order under section 38 can be made ex-parte, meaning those to be removed may have no opportunity to challenge the case made against them, though an appeal is possible to the Crown Court.

A special provision permits the removal to hospital of a person lodging in a 'common lodging-house' without the need to show that precautions are not being taken. Otherwise the criteria for removal are the same as under section 37, though there is no need to seek a magistrate's order, as the local authority itself may order a person's removal:

If a local authority are satisfied that a person lodging in a common lodging-house is suffering from a notifiable disease, and that serious risk of infection is thereby caused

⁶⁰ Exclusion can be from any theatre, cinema, public hall, public concert-room or lecture room, public dance room or public gymnasium or indoor swimming baths, and any sports ground, outdoor swimming baths, outdoor swimming pool, or skating or roller skating rink, and any circus, show, fair, fete, amusement arcade or other public place of entertainment which is not in a building.

⁶¹ Public Health (Control of Disease) Act 1984 (c 22), s.23.

⁶² Public Health (Control of Disease) Act 1984 (c 22), s.37 as amended by the National Health Service and Community Care Act 1990, s 66, Sch 9, para 26(2), Sch 10; by the Health Authorities Act 1995, s 2(1), Sch 1, para 108(6); by SI 2000 No 90, art 3(1), Sch 1, para 17(1), (4)(a), (4)(b).

⁶³ If he deems it necessary, ex parte.

⁶⁴ It is unclear whether seriousness is to be judged only in relation to the probability of contagion, or whether the seriousness of the disease itself may be taken into account. If the latter is possible, then a small risk of a lethal infection could constitute a 'serious' risk within the meaning of the section.

to other persons, and that accommodation for him is available in a suitable hospital... they may, with the consent of the Health Authority ... order him to be removed to the hospital⁶⁵.

DETENTION IN HOSPITAL

Once people suffering from a notifiable disease (including HIV⁶⁶) are in hospital, they are subject to a power to detain them there. Under section 38 of the 1984 Act, a magistrate, acting ex-parte if necessary, and on the application of a local authority, may order such detention if the patient would not be going to accommodation in which proper precautions could be taken to prevent the spread of the disease.

The order authorises the staff of the hospital and the proper officer to 'do all acts necessary' to give effect to the order⁶⁷, and may direct detention for a period specified in the order. A justice of the peace may extend the order for a (specified) period he deems necessary.

A person who leaves a hospital contrary to an order for his detention is liable to be convicted and fined, and the court may order him to be taken back to the hospital.

Provisions related to immunisation and treatment

IMMUNISATION PROVISIONS

There is a power to provide immunisation under the 1988 regulations. Where a case of any of the 30 notifiable diseases (other than tuberculosis) occurs the proper officer may, if he considers it in the public interest, arrange for the vaccination or immunisation, without charge, of any person in his district who has come, or may come, into contact with the infection and is willing to be vaccinated or immunised⁶⁸.

Note that this power is not coercive. There are no powers for compulsory immunisation.

TREATMENT PROVISIONS

There are no powers for compulsory treatment in the Public Health (Control of Diseases) Act 1984.

However there is a power, which remains on the statute book, to treat someone without consent under section 85 of the Public Health Act 1936⁶⁹ as follows:

Upon the application of any person, a county council or a local authority may take such measures as are, in their opinion, necessary to free him and his clothing from vermin.

⁶⁵ Public Health (Control of Disease) Act 1984 (c 22), s.41 as amended by the National Health Service and Community Care Act 1990, s 66, Sch 9, para 26(3), Sch 10; the Health Authorities Act 1995, s 2(1), Sch 1, para 108(8); SI 2000 No 90, art 3(1), Sch 1, para 17(1), (5)(a), (5)(b).

⁶⁶ Public Health (Infectious Diseases) Regulations 1988 (SI 1988 No 1546) s.5.

⁶⁷ Public Health (Control of Disease) Act 1984 (c 22), s.38.

⁶⁸ Public Health (Infectious Diseases) Regulations 1988 (SI 1988 No 1546) s.10.

⁶⁹ Public Health Act 1936, s.85.1-4.

Where it appears to a county council or a local authority, upon a report from their medical officer of health or, in the case of a local authority, from their sanitary inspector, that any person, or the clothing of any person, is verminous, then, if that person consents to be removed to a cleansing station, they may cause him to be removed to such a station, and, if he does not so consent, they may apply to a court of summary jurisdiction, and the court, if satisfied that it is necessary that he or his clothing should be cleansed, may make an order for his removal to such a station and for his detention therein for such period and subject to such conditions as may be specified in the order.

Where a person has been removed to a cleansing station in pursuance of the last preceding subsection, the county council or local authority shall take such measures as may, in their opinion, be necessary to free him and his clothing from vermin.

The cleansing of females under this section shall be carried out only by a registered medical practitioner, or by a woman duly authorised by the medical officer of health.

Clearly this power only relates to infestation with vermin rather than any internal pharmaceutical treatment. In terms of legal principle the issue is the same, though clearly the power is specific. This provision is something of an aberration in current English Law.

Legal provisions to control environmental spread

Many important diseases are transmitted via environmental means including food, water, insects, rodents and other animals.

The main provisions relating to environmental control are contained in other legislation such as the Control of Pollution Act, the Food Safety Acts and the Health and Safety at Work Act. This wider legislation is beyond the scope of this study, which limits itself to the provisions related to the control of communicable diseases contained within the public health acts.

An offence of exposing others to environmental spread

A person, who knowing that he is suffering from a notifiable disease,... or who has in his care a person whom he knows to be suffering from a notifiable disease, ... exposes other persons to the risk of infection by his presence. ..or conduct ...or who gives, lends, sells, transmits or exposes, without previous disinfection, any clothing bedding or rags which he knows to have been exposed to infection from any such disease, or any other article which he knows to have been so exposed and which is liable to carry such infection, shall be liable on summary conviction to a fine ..⁷⁰.

This would include being a food handler while knowingly suffering from a food-borne disease.

⁷⁰ Public Health (Control of Disease) Act 1984 (c 22), s.17.

Provisions related to 'infected premises' and disinfection

DISINFECTION OF PREMISES

Disinfection is in the first instance the financial responsibility of occupiers, and the local authority must give them a reasonable opportunity have this carried out to a set standard, before doing the work itself and charging for it. The statute is worded as follows:

If on a certificate of the proper officer of the local authority for a district, the local authority are satisfied that the cleansing and disinfection of any premises, and the disinfection or destruction of any articles there likely to retain infection, would tend to prevent the spread of any infectious disease, the authority shall give notice to the occupier of the premises that they will at his cost cleanse and disinfect the premises, and disinfect or, as the case may require, destroy any such articles, unless, within 24 hours ... he informs them that ... he will take such steps as are specified in it⁷¹.

TEMPORARY REMOVAL OF RESIDENTS FROM AN INFECTED HOUSE

It may also be necessary to require those who are not themselves sick to vacate premises, and be accommodated elsewhere, so that they can be disinfected. The local authority has a power has a power to require this, as follows:

Where any infectious disease occurs in a house, or the local authority deem it necessary to disinfect any house, the authority may,... cause any person who is not himself sick and who consents to leave the house, or whose parent or guardian, where the person is a child, consents to his leaving the house, to be removed to any temporary shelter or house accommodation provided by the authority, or cause any such person to be so removed without any consent, if a justice of the peace (acting, if he deems it necessary, ex parte) is satisfied, ... of the necessity for the removal..⁷².

LETTING OF INFECTED PREMISES

Letting of infected premises is prohibited as follows:

If a person who is concerned in the letting of a house or part of a house, or in showing a house or part of a house with a view to its being let, or has recently ceased to occupy a house or part of a house, ... is questioned by any person negotiating for the hire of the house or any part of it as to whether there is, or has been within the preceding six weeks, in any part of the house a person suffering from a notifiable disease, and knowingly makes a false answer to that question, he shall be liable on summary conviction to a fine ... or to imprisonment for a term not exceeding one month.

A person who lets [or ceases to occupy] any house or part of a house in which a person has to his knowledge been suffering from a notifiable disease without having the house,

⁷¹ Public Health (Control of Disease) Act 1984 (c 22), s.31.

⁷² Public Health (Control of Disease) Act 1984 (c 22), s.32.

or the part of the house, and all articles in it liable to retain infection, properly disinfected shall be liable on summary conviction to a fine ...

The keeper of a hotel or inn who allows a room in it in which a person has to his knowledge been suffering from a notifiable disease to be occupied by any other person before the room and all articles in it liable to retain infection have been properly disinfected shall be liable on summary conviction to a fine ..⁷³.

The local authority shall give notice... to the occupier and also to the owner of any house in which they are aware that there is a person suffering from a notifiable disease⁷⁴.

INFECTED COMMON LODGING-HOUSES

The closure of a infected common lodging-house may be ordered by a magistrates court until the proper officer certifies that it is free from infection.

If, on the application of a local authority, a magistrates' court is satisfied that it is necessary in the interests of the public health that a common lodging-house should be closed on account of the existence, or recent occurrence, in it of a case of notifiable disease, the court may make an order directing the lodging-house to be closed until it is certified by the proper officer of the local authority for the district to be free from infection. Any person who fails to comply with such an order shall be liable on summary conviction to a fine ..⁷⁵.

The only challenge to a decision under this provision would appear to be by judicial review.

TENTS, VANS, SHEDS AND SIMILAR STRUCTURES

Presumably because it was thought such structures can be 'infected':

A local authority may make byelaws for preventing the spread of infectious disease by the occupants or users of tents, vans, sheds and similar structures used for human habitation. The[se] ... include power to make an order prohibiting the use for human habitation of the tent, van, shed.. ,⁷⁶

WORK IN INFECTED PREMISES

The law forbids the manufactures of what are assumed would become 'infected articles' within 'infected premises' as follows:

If a case of a notifiable disease occurs on any premises, then, whether the person suffering from the disease has been removed from the premises or not, the local authority for the

⁷³ Public Health (Control of Disease) Act 1984 (c 22), s.29.

⁷⁴ Public Health (Control of Disease) Act 1984 (c 22), s.30.

⁷⁵ Public Health (Control of Disease) Act 1984 (c 22), s.42.

⁷⁶ Public Health (Control of Disease) Act 1984 (c 22), s.56.

district may make an order forbidding any of the following works.. .the making, cleaning, washing, altering, ornamenting, finishing or repairing of'... apparel... and to such other classes of work as may be specified by order of the Secretary of State_____

If any occupier or contractor on whom an order under this section has been served contravenes the provisions of the order, he shall be liable on summary conviction to a fine⁷⁷.

Provisions related to 'infected articles' and disinfection

A local authority may provide a free disinfecting station⁷⁸. There are various detailed provisions covering 'infected articles' and their disinfection as follows:

LAUNDRIES AND WASH-HOUSES

A person shall not send or take to any laundry or public washhouse for the purpose of being washed, or to any place for the purpose of being cleaned, any article which he knows to have been exposed to infection from a notifiable disease, unless that article has been disinfected by or to the satisfaction of the proper officer of the local authority for the district or a registered medical practitioner... A person who ... fails to comply... shall be liable to a fine⁷⁹.

LIBRARY BOOKS

A person who knows that he is suffering from a notifiable disease shall not take any book ... from any public ... library.

A person shall not permit any book which has been taken from a public or circulating library ... to be used by any person whom he knows to be suffering from a notifiable disease.

A person shall not return to any public ... library a book which he knows to have been exposed to infection from a notifiable disease,

A local authority... shall cause the book to be disinfected ...or... cause it to be destroyed.

A person who contravenes any of the above provisions shall be liable on summary conviction to a fine⁸⁰.

⁷⁷ Public Health (Control of Disease) Act 1984 (c 22), s.28.

⁷⁸ Public Health (Control of Disease) Act 1984 (c 22), s.27.

⁷⁹ Public Health (Control of Disease) Act 1984 (c 22), s.24.

⁸⁰ Public Health (Control of Disease) Act 1984 (c 22), s.25.

INFECTIOUS MATTER NOT TO BE PLACED IN DUSTBINS:

A person who places, or causes or permits to be placed, in a dustbin or ashpit any matter which he knows to have been exposed to infection from a notifiable disease, and which has not been disinfected, shall be liable on summary conviction to a fine⁸¹.

Pest control - destruction of rats (in the case of plague)

Where a local authority or port health authority have reason to believe that rats in their district or port health district are threatened by or infected with plague, or are dying in unusual numbers, they shall... take measures for destroying all rats in the district or port health district and for preventing rats from gaining entry to buildings⁸².

This provision is disease specific and does not cover the destruction of rats for the prevention of other rodent borne diseases e.g. leptospirosis. For this purpose local authorities rely on general rodent control powers in the Prevention of Damage by Pests Act 1949.

Disinfestation - delousing (for typhus and relapsing fever)

Upon notification of a case of typhus or relapsing fever, the local authority may take measures to completely destroy lice in the building the case occupies and on the person and clothing of other occupants, and recent contacts, who may also be temporarily segregated⁸³.

Powers over workers posing risk of environmental spread

FOOD HANDLERS

The Public Health (Infectious Diseases) Regulations 1988 provide specific powers to stop people continuing to work preparing or handling food when a case of food poisoning has been reported. Under the 1984 Act, the local authority may also prohibit certain types of work relating to making, cleaning and repairing clothes on premises where there has been a case of a notifiable disease.

As discussed previously, the local authority has a duty to compensate an individual, who is excluded or voluntarily excludes himself from work at the request of the proper officer⁸⁴, for financial loss he experiences as a result.

In addition, local authorities are required to compensate a person who is prevented from working in a dairy in accordance with food law.

⁸¹ Public Health (Control of Disease) Act 1984 (c 22), s.26.

⁸² Public Health (Infectious Diseases) Regulations 1988 (SI 1988 No 1546) s.11.

⁸³ Public Health (Infectious Diseases) Regulations 1988 (SI 1988 No 1546) Sch 3 (reg 9(1)).

⁸⁴ Public Health (Control of Disease) Act 1984 (c 22), s.20 as amended by the Food Safety Act 1990, s 59(1), Sch 3, para 28.

DEALERS IN RAGS AND OLD CLOTHES

No person who collects or deals in rags, old clothes or similar articles, and no person assisting or acting on behalf of any such person, shall... sell or deliver ... any article of food or drink to any person, or any article whatsoever to a person under the age of 14 years. 'Article' includes any animal, fish, bird or other living thing. A person who contravenes any of the provisions shall be liable on summary conviction to a fine⁶⁵.

Provisions related to the disposal of human corpses

It is possible for the body of a person infected with some diseases to be a source of infection for others. For this reason several powers relating to the disposal of human corpses are included in the 1984 Public Health (Control of Disease) Act.

DEATH OF A PERSON SUFFERING FROM NOTIFIABLE DISEASE

If a person dies in hospital while suffering from a notifiable disease, and the proper officer of the local authority for the district or a registered medical practitioner certifies that in his opinion it is desirable, in order to prevent the spread of infection, that the body should not be removed from the hospital except for the purpose of being taken direct to a mortuary or being forthwith buried or cremated, it shall not be lawful for any person to remove the body from the hospital except for such a purpose.... A person who contravenes any such provisions shall be liable on summary conviction to a fine⁸⁶.

ISOLATION OF THE BODY OF A PERSON DYING WITH NOTIFIABLE DISEASE

Every person having the charge or control of premises in which is lying the body of a person who has died while suffering from a notifiable disease shall take such steps as may be reasonably practicable to prevent persons coming unnecessarily into contact with, or proximity to, the body, and if he fails to do so he shall be liable on summary conviction to a fine .. .⁸⁷.

RESTRICTION OF WAKES

It shall not be lawful to hold a wake over the body of a person who has died while suffering from a notifiable disease; and the occupier of any premises who permits or suffers any such wake to take place on them, and every person who takes part in the wake, shall be liable on summary conviction to a fine .. .⁸⁸.

⁸⁵ Public Health (Control of Disease) Act 1984 (c 22), s.55.

⁸⁶ Public Health (Control of Disease) Act 1984 (c 22), s.43.

⁸⁷ Public Health (Control of Disease) Act 1984 (c 22), s.44.

DISPOSAL OF DEAD BODIES: BURIAL AND CREMATION

*It shall be the duty of a local authority to cause to be buried or cremated the body of any person who has died or been found dead in their area, in any case where it appears to the authority that no suitable arrangements for the disposal of the body have been or are being made otherwise ...*⁸⁹.

*The Secretary of State may make regulations imposing any conditions and restrictions with respect to means of disposal of dead bodies otherwise than by burial or cremation, as to the period of time a body may be retained after death on any premises, or with respect to embalming or preservation, which may appear to be desirable in the interests of public health or public safety*⁹⁰.

REMOVAL OF BODY TO MORTUARY OR FOR IMMEDIATE BURIAL

*If a justice of the peace (acting, if he deems it necessary, ex parte) is satisfied... that the retention of the body in any building would endanger the health of the inmates of that building or of any adjoining or neighbouring building, he may order that the body be removed ... and ... that it is buried*⁹¹.

Pointers for reform of outbreak control powers

The existing law for the control of communicable disease is based on the Public Health (Control of Disease) Act 1984. However, this Act simply consolidated a number of earlier statutes. Many of its control provisions have remained essentially unchanged since the Sanitary Laws of the 1870s which were themselves piecemeal responses to crises or impending threats such as from cholera or smallpox. Many also appear inappropriate in light of contemporary living standards and social norms and current medical knowledge about disease transmission.

Some provisions are unnecessarily strict for example the offences around using public transport. Many potentially useful provisions are simply absent. The law clearly needs modernisation and simplification. It is also too rigid and a degree of flexibility to circumstances is required.

Reform of provisions to control person to person spread

In the past, with less advanced technology, the main objective was to isolate infected persons to prevent person-to-person spread. Today, however, there should be a much greater emphasis upon limiting infectivity via early administration of effective treatment and immunisation.

⁸⁸ Public Health (Control of Disease) Act 1984 (c 22), s.45.

⁸⁹ Public Health (Control of Disease) Act 1984 (c 22), s.46 as amended by the Social Security Act 1986, s 86(2), Sch 11.

⁹⁰ Public Health (Control of Disease) Act 1984 (c 22), s.47.

⁹¹ Public Health (Control of Disease) Act 1984 (c 22), s.48.

Nevertheless, isolation still has a place today. Previous provisions identified particular places from which a person might be excluded from going. This is still be appropriate for children vis-a-vis schools, creches and nurseries but not in most other situations. Rather, it would be better infrequently to have recourse to powers to restrict movement and contact with others by a time-limited order⁹² to the individual outbreak⁹³. This could include preventing a sufferer, contact, or carrier from working, limitations on travel, restrictions on gatherings, closure of schools and public places, and more rarely quarantine of cases, contacts or asymptomatic carriers. Legal sanctions would apply for breach of an order.

The power to be removed to and to detain in hospital where necessary for the purpose of quarantine should remain. It is important from the point of view of effectiveness and of civil rights (see later) that the criteria for making these orders are sufficiently precise and that they give the right weight to the interests of the infected person. The present law is probably adequate on these scores. The current provisions only apply to cases suffering from disease. Consideration should be given to whether the powers should be expanded to cover carriers of a disease.

The current law provides for a person suffering from a notifiable disease to undergo mandatory medical examination (see previous section), to be removed to hospital involuntarily, and once there, to be detained against their will - principally for the purposes of isolation or quarantine. There is, however, no provision for compulsory treatment under the Act. Though this issue is obviously also very sensitive in civil liberties terms, it might be more logical in the modern era of effective immunisation and treatment than some of the other provisions. This is evidenced by the emergence of multi-drug resistant TB (which is untreatable, and fatal in 50% of cases) as a result of failure of patients to complete full courses of treatment. The public interest favours compulsion or incentivisation of directly observed therapy (DOT), an avenue pursued in the United States.

Also in the United States, compulsory routine vaccination has been found to be consistent with constitutional rights and school entry is dependent upon prior vaccination. Compulsory vaccination was tried in the UK in the Nineteenth Century but aroused widespread public opposition and was withdrawn. It is therefore unlikely that compulsory vaccination (routine or emergency) would be acceptable in the UK where the law rarely provides for coercive health measures.

Reform of provisions to control environmental spread

It has already been mentioned that most of the legislative provisions for the control of environmental spread are not contained in the public health acts but in environmental and food law. Those environmental provisions which are within the public health acts including the sending of infected articles to a laundry, disinfecting library books, restricting traders in rags and clothes, wakes, and the detailed delousing and disinfection powers, now seem anachronistic and irrelevant. The measures need updating.

⁹² The time period would be specified in advance and would depend upon the incubation period and period of infectiousness.

⁹³ Department of Health. Review of Law on Infectious Disease Control (Consultation Document). HMSO. London, 1989.

For instance, during epidemics of cholera, plague, anthrax or viral haemorrhagic fever the corpses of victims maybe a source of infection and require special precautions. However, assuming a legal power is still required relating to disposal of human bodies, it could be limited solely to victims of these diseases rather than applying more widely to a long list of notifiable diseases.

A communicable disease control order?

In order to address the perceived rigidity of the current legal framework, the 1989 Department of Health consultation paper on communicable disease control law proposed replacing the current range of specific control powers with a single flexible 'Infectious (Communicable) Disease Control Order'⁹⁴. However, nothing was ever implemented.

The single order, served on individuals or groups of persons, or on employers and owners of buildings, would be simpler than requiring each power to be exercised individually.

*However, if such orders are to be enforced by criminal sanctions for disobedience it will be necessary for the order-making power to be clearly defined. If not, there would in effect be an open-ended criminal offence, the character of which could be completely and arbitrarily altered, and this would be unacceptable.*⁹⁵

The order would therefore need to be served upon the recipient and this would give him notice of what was required or prohibited. This would be an improvement on the current position where the person is uncertain of the range of offences that are against the law.

An appeal mechanism (which would need to operate rapidly) would be needed to balance the flexibility afforded to the public health officer in the public interest over the rights of the individual.

⁹⁴ Department of Health. Review of Law on Infectious Disease Control (Consultation Document). HMSO. London, 1989.

⁹⁵ Department of Health. Review of Law on Infectious Disease Control (Consultation Document). HMSO. London, 1989.

Wider issues and conclusions regarding communicable disease law

This study has thus far focused largely upon the detail of the legislation for England and to a slightly lesser extent Wales. It has focused, as does the legislation, largely upon the control of communicable disease at the local level. This section widens the discussion to higher-level philosophical issues including human rights and high-level practical control issues at the regional and national level in the context of the devolved countries in the UK and of Europe. It then moves on to reach some wider conclusions.

It has been demonstrated that the current legal framework, which was drafted in the 19th century, with no reasoned reform since 1945, is not based on a modern understanding of communicable disease control, nor does it adequately address the main communicable disease problems of today.

Because the provisions have changed so little over so many years they have also largely been bypassed by modern ideas on civil rights in complete contrast to the position regarding Mental Health Law with its myriad safeguards to protect against abuse.

Human and civil rights

Philosophically, the right to health and the right to life underpin legal powers to control communicable disease in the public interest. Similarly, limiting the freedom of individuals raises questions about their rights.

Article 5 of the European Convention on Human Rights and Fundamental Freedoms (1950) recognises that it maybe legitimate for someone suffering from or carrying a communicable disease to be detained against their will. The provisions of the European Convention were incorporated into domestic UK law in the Human Rights Act (1998). The relevant extracts from Article 5 are as follows:

1. Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

... (e) The lawful detention of persons for the prevention of the spreading of infectious diseases ...

4. Everyone who is deprived of his liberty by arrest or detention shall be entitled to take proceedings by which the lawfulness of his detention shall be decided speedily by a court and his release ordered if the detention is not lawful.

5. Everyone who has been the victim of arrest or detention in contravention of the provisions of this Article shall have an enforceable right to compensation⁹⁶.

⁹⁶ Human Rights Act 1998 (c 42) Sch 1 Art 5.

This is the most precise statement of the argument that public health considerations may need to place limits on basic individual rights.

The degree of limitation to individual freedoms which can be justified in the interest of public health was examined in the judgement of *Acmanne v. Belgium* (1985)⁹⁷ which found that interference was necessary to protect health within a democratic society under Article 8(2) of the Convention. Proportionality to the aim was to be the key concept. The Commission's explanation was as follows:

Therefore a restriction on a Convention right cannot be regarded as necessary in a democratic society - two hallmarks of which are tolerance and broadmindedness - unless, amongst other things, it is proportionate to the legitimate aim pursued . . . In assessing the necessity of the interference with the applicants' private life, the Commission takes into account the reasoning in the Liege Court of Appeal... the Court held that the individual had a social duty to defer to the general interest and not endanger the health of others where his life was not in danger.

A key defence for some of the provisions of the UK's public health laws that limit individual freedoms would be: are there sufficient safeguards built in to the legislation and is there a right of appeal? The latter is probably lacking more often than the former though both aspects might be found wanting.

Disease control, devolution and Europe

Public health law currently lags behind the recent general reforms in both the health service and local government. It has also been affected by devolution. Under the new constitutional structure of the UK, it is possible to make different provisions under the same public health legislation applying to different parts of the UK.

Different Acts of the UK Parliament, as well as Acts made by the Northern Ireland Assembly and the Scottish Parliament can apply to different aspects of public health. This is also the position for subordinate legislation (statutory instruments and regulations) made by different UK government departments as well as by the Northern Ireland and Scottish Executives and the National Assembly for Wales.

In addition, each government department and devolved body is continually issuing advice and guidance on public health matters which can now not only differ from one government department to another, but also from one UK country to another. There will be up to four different sets of rules applying for exactly the same matter throughout the UK. The differences are already evident, with resultant duplication and inconsistencies becoming more obvious almost by the day, adding complexity in the future.

Legislation produced by the centre will often apply to England with the result that now many areas will be excluded from central legislation. Furthermore, there is no one body overseeing the application of and the development of the law, both primary and

⁹⁷ *Acmanne v. Belgium* (1985) 40 DR 251.

subordinate, relating to public health right across the UK. Following devolution, there will also be no central legally based structures relating to public health covering the whole of the UK.

In the future it is likely that the only time where there will be homogeneous legislation across the different countries of the UK, is when European Legislation prescribes obligations. This is because under the Treaty of Rome, European Law is superior to national law. This fact should be utilised in designing a better legal framework for communicable disease in the future, particularly given that the European Union has had a competence in relation to public health since the Maastricht Treaty, subsequently strengthened by the Amsterdam Treaty.

Wider conclusions regarding the legal framework

The legislation that applies today is fragmented mainly as a result of crisis measures that were taken to respond to particular events. Devolution is adding to this. English Law is admired for being pragmatic but its peculiarity whereby the law is built up piecemeal over many years is not suited to devolution.

The complexity of the legal base laid down in multiple layers serves to obscure the true legal position in relation to powers. This is especially difficult for non-lawyers - including those who are charged with protecting the people's health. Worse, at times the complexity has resulted in a loss of clarity of powers, even when interpreted by lawyers. As already indicated, this includes matters as fundamental as who is responsible for controlling communicable disease at the local level. There is no one individual or body unambiguously responsible and accountable for the surveillance and control of communicable disease at local level.

At best the relevant law can be described as untidy, not comprehensive, and in need of updating and streamlining. At the very least a tidying up of the existing statutory framework most directly relevant to public health is required. At worst:

- The United Kingdom Government may be in breach of its obligations under the European Convention on Human Rights in failing to provide adequate safeguards against the possible abuse of public health powers.
- There is genuine ambiguity about where leadership and responsibility lie - who has the duty at various levels to control communicable disease in the UK?

The problems highlighted by the Phillips Report in the wake of the BSE and CJD crisis demonstrated how government departments show a lack of clarity about who is responsible for specific cross-sectoral issues. The BSE episode raised questions about the role of government departments and their advisory committees, as well as the public's access to information. It also demonstrated the public's lack of confidence in the mechanisms for providing scientific advice independent from political and commercial interests. There is thus a lack of clarity at this level also concerning who is responsible for public health.

Structures for monitoring, protecting or improving different aspects of the public health are currently confused and lack co-ordination. The latest restructuring in England may

clarify the position but only at the cost of further diversity across the UK. This diversity and complexity may also make the enforcement of regulations and the provision of public health information and advice difficult.

Given that it is often unclear where the organisational accountabilities lie - often 'no-one is in charge'.

In a democracy it is important to know who is responsible for what. No one should be able to avoid blame and no one should be required to accept blame for matters beyond their control. We have come close to this, while at the same time, there is also an increasing need for transparency and accountability.

There is an unquestionable need for co-ordination, rationalisation and simplification. Given the advent of devolution, with the legislation, policies and structures applying across the UK becoming different, these problems are now likely to become more acute unless a fundamental legal rationalisation is considered. With continuing devolution, this problem is likely to increase and totally different systems and legislation could apply in the various entities of the UK.

This situation is not ideal given that communicable disease does not respect borders, and it is likely to result in a great risk of confusion of roles and responsibilities. This was experienced for instance for public health in Australia - which has a similar legal system but federal governmental arrangements with Australian Commonwealth and state levels.

To avoid wasted effort and duplication or alternatively the risks of certain responsibilities and matters falling into a vacuum between different government levels and therefore being no one's responsibility other administrative devices are likely to prove necessary.

For example in Australia: Commonwealth and State Agreements for health information and the Australian Public Health Partnership have been established. It is mechanisms such as these which need to be considered in the newly emerging government structure in the United Kingdom.

Towards a new legal framework for communicable disease

Worldwide, in recent years, considerable thought on how to design a framework for public health law has been given by Professor Larry Gostin⁹⁸. Any discussion of the way forward regarding communicable disease law, including this one, will be heavily reliant upon his work.

A philosophical basis for public health powers

Public health powers involve coercion and restriction of liberty. However, Gostin cites" Isiah Berlin's delineation of two kinds of liberty as follows:

There is a distinction between negative liberty, that which the individual must be allowed to enjoy without state interference, and positive liberty, that which the state permits by imposing regulations that, by necessity, limit some freedoms in the name of greater liberty for all. Both kinds of liberty are required for a just society.

Isiah Berlin (1959)

It follows therefore that:

The law safeguards individual interests in autonomy, privacy, liberty, and property. However, provided that they act justly and reasonably to avert a serious health threat, the state should cede to public health agencies the power to act for the communal good¹⁰⁰.

However, because they intrude on individual rights and incur economic costs, public health interventions must be justified. Gostin¹⁰¹ holds that coercive interventions can be justified in only 3 cases:

- to avert a risk of serious harm to other persons,
- to protect the welfare of incompetent persons, and, most controversially,
- to prevent a risk to the person himself/herself.

He proposes that all public health legal provisions should be systematically examined against these yardsticks. From this starting point he goes on to develop a set of principles for public health law reform.

⁹⁸ Head of the Joint Public Health Law Initiative between the Johns Hopkins School of Public Health in Baltimore and the Faculty of Law at Georgetown University in Washington DC, USA.

⁹⁹ Gostin LO. Public Health Law: Power, Duty, Restraint. University of California Press, 2000.

¹⁰⁰ Public Health Law in a New Century, Part II: Public Health Powers and Limits. Lawrence O. Gostin, JAMA. 2000;283:2979-2984.

¹⁰¹ Gostin LO. Public Health Law in a New Century Part III: Public Health Regulation: A Systematic Evaluation JAMA. 2000;283:3118-3122.

A set of principles for public health law reform

Gostin¹⁰² suggests that a model public health law should reflect three principles of public health and liberty. Each is important, but each conflicts with the other two to some degree, reflecting the balances between public interest and individual rights that must be struck.

Gostin's three principles necessary for sound and effective public health laws are as follows:

1. The law should give public health agencies ample power to regulate individuals and businesses, by giving it authority to set standards of health and safety and to assure compliance, in order to achieve the communal benefits of making people secure in the most fundamental part of their lives, their health and well-being.
2. In a democracy, the law should restrain the exercise of regulatory power in order to achieve the benefits of liberty and freedom. It should therefore set clear substantive and procedural limits on public health agencies, powers to ensure objective and fair decision-making.
3. The law should impose positive duties on government, and potentially therefore also on public health agencies, to promote the health and wellbeing of the people, while also ensuring adequate protection of privacy and against discrimination.

According to Gostin, therefore, sound public health law should be based on three principles of health and liberty: (1) adequate regulatory power, (2) appropriate restraints on power, and (3) positive duties to promote population health. This means that the law should ensure:

That public health authorities ... should have all the legal power they need, and the flexibility to exercise their professional judgement to prevent injury and disease and promote health.

... objective standards and ... fair procedures for the exercise of power. ... based on a significant risk to the public and that persons subject to regulation should be entitled to procedural due process.

... a clear mission for public health agencies, ensure that they perform essential functions, and provide adequate safeguards of privacy and against discrimination¹⁰⁵.

This will ensure an effective and just balance between each of the three principles of public health and liberty.

¹⁰² Gostin LO. Public Health Law: Power, Duty, Restraint. University of California Press, 2000.

¹⁰³ Gostin LO. Public Health Law: Power, Duty, Restraint University of California Press, 2000.

Applying the principles for effective and just reform

Gostin, Burris and Lazzarini have emphasised the importance of public health law and its reform as follows:

Law plays crucial roles in public health, from defining the powers of health agencies to influencing the social norms that shape individual behaviour. Despite its importance, public health law has been neglected. To help create the conditions in which people can be healthy, public health law must reflect an understanding of how public health agencies operate¹⁰⁴.

Gostin gives reasons why we need reform now in order to create modern, consistent, and uniform public health laws as follows:

Public health law ... should be reformed so that it conforms with modern scientific and legal standards, is more consistent within and among countries, and is more uniform in its approach to different health threats. Rather than making artificial distinctions among diseases, public health interventions should be based primarily on the degree of risk, the cost and efficacy of the response, and the burdens on human rights. A single set of standards and procedures would add needed clarity and coherence to legal regulation ..¹⁰⁵

Voluntary co-operation is the first resort in public health work. However, when this fails, Gostin advocates that public health agencies should have all the coercive powers they need. This means a full range of legal powers to assure compliance with health and safety standards, in order to safeguard the public's health. Furthermore, these tools need to be more flexible, ranging through incentives minimally coercive interventions and ultimately to very restrictive measures.

However, as a counterbalance Gostin's view is that statutes should place substantive limits on the exercise of those powers, stating clearly the circumstances under which agencies may curtail autonomy, privacy, liberty, and property interests. His view is therefore that the law should place the burden of justifying the level of coercion necessary with the agency rather than the individual having the burden of demonstrating the obverse. Specifically he feels¹⁰⁶ that the law should require the agency to demonstrate the following:

- A significant risk (not speculative, theoretical, or remote) based on objective and reliable scientific evidence¹⁰⁷, to ensure that the health measure is necessary for public protection.

¹⁰⁴ Gostin LO, Burris S, Lazzarini Z. The Law and the Public Health: A Study of Infectious Disease Law in the United States. Columbia Law Review, Vol 99, No1.

¹⁰⁵ Gostin LO. Public Health Law: Power, Duty, Restraint. University of California Press, 2000.

¹⁰⁶ Gostin LO. Public Health Law in a New Century Part III: Public Health Regulation: A Systematic Evaluation JAMA. 2000;283:3118-3122.

¹⁰⁷ In Gostin's view risk assessments in public health statutes should be based scientific evidence and made on an individualised (case-by-case) basis. Public health agencies should consider the nature of the risk, the duration of the risk, the probability that harm will occur, and the severity of the harm if the risk were to materialise.

- The intervention's effectiveness by showing a reasonable fit between means and ends.
- That economic costs are reasonable.
- That human rights burdens are reasonable; and
- That benefits, costs, and burdens are fairly distributed.

In making this demonstration the agency would be operating a fair (due) process in operating coercive powers. This process would thereby also be likely to be compliant with the Human Rights Act (1988). In cases of urgency, procedural due process would have to be demonstrated retrospectively.

If public health law also required agencies to choose the least restrictive alternative that will accomplish the public health goal, this would also help align it to discrimination law and to respect privacy.

Epilogue: a time for action on Public Health law reform

In his article 'When a Bioweapon Strikes, Who Will Be in Charge', Cole has said of the United States:

Laws are so antiquated and unclear that no-one even knows what our powers and duties are___For example ... it isn't clear whether any legal authority has the power to force people to be vaccinated, treated, quarantined, or isolated. ... These powers will almost certainly be needed in the event of a bioterrorist attack¹⁰⁸

I have demonstrated that the position appears worryingly similar in the UK. Public Health law reform is important and urgent. This is the time to act.

¹⁰⁸ Cole TB. When a Bioweapon Strikes, Who Will Be in Charge. JAMA 284, 8,946-948, 2000.

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