

08-078

Doohan S (Sean)

From: Dave1maua@aol.com
Sent: 12 January 2007 23:05
To: Public Health Consultation
Cc: Eric.baijal@hnb.scot.nhs.uk; Erik.jespersen@nhs.net; susan.mair@argyll-bute.gov.uk; elaine.garman@nhs.net
Subject: Public Health Consultation Response

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Dear Mr. Doohan,

I attach my individual response to this Consultation. I have had the opportunity to discuss them with Molly Robertson, so they won't as a surprise to her!

My apologies for being a tad late, but as Molly knows, I have some difficulties with which to contend, at present. However, I am at least e-mailing it on the 12th!! I'll e-mail the Respondent Information Form separately.

Yours Aye,

Dr. D. Bell.

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INDIVIDUAL RESPONSE TO PUBLIC HEALTH LEGISLATION IN SCOTLAND: A CONSULTATION.

Preamble.

I am a Consultant in Public Health Medicine, with 28 years experience in Public Health, at present employed part-time with Highland Health Board. I am a Designated Medical Officer to Local Authorities, and an Independent Medical Advisor on Housing. Before entering Public Health, I had experience of hospital practice in "chronic condition management", initially in Dialysis and Transplant medicine, then in Rheumatology (to Specialist Registration). I have some experience of General Practice, all single-handed.

General Views.

When this Consultation was announced, I welcomed it with enthusiasm, as I believe it to be long over-due. Sadly, on reading the document, I was seriously disappointed, as it pertains only to Health Protection issues, which, while being an important part of Public Health practice, are only a small part of it.

That a review of Public Health Law is long over-due is beyond doubt. Much of what we are using at present dates back to Public Health legislation in the late 19th. Century, including the Police Acts. It is not only just the Microbiology which has changed (in great-great-Grandfather's day, germs were very recent discoveries), but also the developments in philosophy, ethics and International Law, which underlie really robust legislation, produces a completely different *milieu* now compared to then.

So, my feeling of having been let down can in part be ascribed to the fact that this Consultation doesn't do "what it says on the tin"! More seriously, I thought we were, in Scotland, going to be imaginative and bold, with political vision, courage and will. Instead, we have a document which appears to be a minimal reaction to the necessary changes required by the International Health Regulations, 2005.

At a time when many countries, whose Public Health Law is based on the same model that we are still using, are up-dating their legislation fundamentally, it seems to me that the present document is a major opportunity missed, at the very least. Such countries as varied as New Zealand, Australia, India, South Africa and the US of A spring to mind.

Professor Robyn Martin and Dr. Richard Coker have given as their opinion "...Current public health legislation fails on many fronts. It is administratively cumbersome, it fails to provide measures which are needed, and it provides obligations and offences which have no evidence base and which are no longer appropriate. Perhaps of more concern, our public health law no longer reflects either contemporary medical science or contemporary notions of social justice.

Law which is jurisprudentially flawed is bad law, and bad law can cause more harm than having no law at all.....it would be unfortunate if this (a Law review) resulted only in a tweaking of laws which are essentially flawed” (Martin, R. and Coker, R. Public Health (2006) 120 (Supplement) pp. 86 & 87).

Major Public Health Threats.

Besides the long-standing threats to the well-being of the Public -- War, Famine and Plague -- we face new challenges. These are most apparent in the West, but the rest of the World is catching up fast, and they can be listed as Globalisation of trade and of its regulation; Obesity; Longevity; a breakdown of Social Cohesion; Alcohol; Tobacco; Indolence and some new “Plagues”, HIV, Hepatitis C, and threats of pandemic infections, to which 21st Century world society’s structures and interdependencies render us peculiarly vulnerable.

These are not amenable to pharmacotherapy, even if the threat of Infection ever was. To meet these challenges, we require new Public Health initiatives, and it would be as well if we provided ourselves with some underpinning Legal framework which was fit for purpose, preferably with an evidence base. Many of the levers of potential action in these fields are in the Local Authorities, not in the Health Service. Much of the practice of Public Health is about risk management in communities, often with very little evidence base. That hasn’t really changed since the earliest public health practitioners. What has is the society in which this goes on.

Personal Professional Concerns.

The first of these is Alcohol. It seems to me to be dangerously disingenuous to regard people who are physically and psychologically dependent on Alcohol as having freedom and capacity of rational choice in their continuing use of an highly addictive chemical, especially given the huge amount of damage they do, not only to themselves, but to family, work and communities. A comparable situation obtains with smoking Tobacco, and the Scottish Parliament has lead the rest of the UK in recognizing that this is a public health, as well as a private, issue. It is inefficient to be using ancient procedures to limit freedom and break the cycle of addiction, which is itself a relapsing and remitting chronic state, although the Law as it stands provides robust protection to the subject of such actions.

The second is the housing of our people. Unless they have affordable, warm and appropriate homes, we will not be meeting Maslow’s bottom tier of the Hierarchy of Need. And it isn’t just a question of enough houses; it is also an issue of appropriate homes. At present, as an example, Communities Scotland reports that less than 1 in 5 Scottish wheel-chair users live in wheel-chair compatible houses. I believe that’s a national disgrace. We have here the legal responsibility. For both Social and Private

housing, it rests with the Local Authority, under the Housing (Scotland) Acts, 2001 and 2005. The link which I believe to be missing is with the predictive ability of public health epidemiology to forecast, pretty accurately for populations, what will be the need for, say, barrier-free houses in 20 years time. There is a further implication for the public well-being in this situation. The Scottish Parliament has, rightly, received international plaudits, including from the European Community, for its legislation pertaining to Homeless persons. But, if we don't have appropriate stock, that good work will inevitably be put at risk, not least by the reaction of the non-Homeless population, who see homeless people housed "ahead" of them

Problems.

I recognise that there is pressure, as the Scottish Parliament has to respond timeously to the International Health Regulations, but I hope, in responding to them legislatively, Parliament will give a commitment to revise the whole of the old Public Health legislation, and put in place some new Law, which will give my successors an underpinning to meet the Public Health challenges of the next 100 years, taking into account the changing ethical and philosophical (such as J. Rawls' work on theories of Justice) nature of Society, and Legal changes, of which a very significant development is the Human Rights legislation.

I recognise also that what I am suggesting would lead to a prolonged debate, in and out of Parliament, which would be similar to the decades of debate which eventually gave us our present public health Laws. Those struggles have been forgotten, but they were fierce, and I believe we will need to have them again as Society decides what power it will concede to those of us charged with protecting and improving the public well-being in general, at a cost of some curtailment of personal autonomy and loss of complete individual freedom.

One small consideration of which account needs to be taken is of the use of Tort to correct failures of public health legislation. Although I would not discount this as a last resort, I am not in favour in general, taking the view that in this field, Tort distorts. This is because, in Britain, where there is no possibility at present of Class actions, it is random, and not strategic, as it depends entirely on the motivation of an individual in taking such action.

Another reason for a proper revision of public health legislation by Parliament is that, partly in a response to mass supply of goods, globalization and the economic power of international corporations, a response has been to establish Regulatory bodies. This can give a false sense of security, but Parliament must be encouraged to find ways of preventing the so-called "regulatory capture" activities of the allegedly regulated.

The Law should, as far as is possible, be “future proofed”. I only mention a few points. The public’s health, and particularly that of the poorest, and the children, is quite likely to be a casualty of rapid increases in fuel price. The demographic change will have a major impact, especially if the proposed “compression of morbidity” fails to materialize, as age “does not come alone”. I would like to believe that it will come about, but know of no evidence in favour, and so believe it is wishful thinking! What is certain is that with ever increasing numbers of well off “silver surfers”, we will have a population of increasingly well informed people, especially if they grasp that you can’t “kite mark the west wind”, and become discriminating in what they acquire from the internet.

A final point. The Law pertaining to Public Health is found in a very large number of branches of Legal Practice. Most lawyers specialise, and even in the Legal Departments of, for instance, Local Authorities, I would need to be convinced that there was the sheer breadth of expertise needed to back-up public health practitioners. Further, if the Law is amended, even to the limited suggestions of this Consultation, the transfer of responsibilities to the Health Service would require attention to be paid to the capacity of the Central Legal Office of the Common Services Agency of the NHS in Scotland.

Specific Questions in the Consultation Paper.

As I could not claim to have the insights afforded by a mass consultation, I will limit my specific observations to particularly numbered questions.

Question 1.

1.1 I believe that what appears to be a suggestion of clarity, is to so over-simplify, what is frequently an highly complex situation and one which is frequently dynamic, as to carry a considerable risk of it failing to work in practice.

1.3 If there were such a requirement, I believe they would be best placed in Community Plans, as most of the levers here are in the LA. If not outwith both the LA. and NHS

1.5 Yes. There is a far bigger problem with Hepatitis C, which is Notifiable, and we haven’t really got an handle on that, even so.

1.6(a) Yes. 1.6(b) Yes. And I’d like to see the Directors of Public Health as Joint appointments with all the Local Authorities in their Health Board area, if there’s more than one. 1.6(c) Consultant in Public Health Medicine.

1.7 Regulations.

1.8 Status quo.

Question 2.

2.1(g) Whether or not a “reportable hazard” constitutes a significant risk would have to remain a matter of professional judgment, as whether it is or not, is at least as much determined by history, nature and size of the particles as by absolute numbers, and this would, I suggest be impossible to put in Regulations.

2.3(d) No. Not unless I knew a great deal more about said “commercial considerations” of confidentiality. I find the text of the Document less than convincing. I do not believe we should start by putting Public Health in hock to commercial considerations. Note the Fen-Phen story (“Dispensing with the Truth”, A. Mundy (2001) New York; St. Martin’s Press) or the story of Vioxx (Frith, M. The Independent 22 August 2005, p1).

Question 5.

5.3 Recommend retaining all, except Ss 49, 53, 90, 92, 93, 94.

5.6 Recommend adding that the Local Authority has powers, on the recommendation of the DMO, to clean up a dwelling which is occupied and is in an insanitary condition and that the LA can request that the DMO arranges admission to hospital of an individual whose cleanliness, and/ or behaviour is offensive, and is causing a regular public nuisance.

Question 8.

8.2(d) and 8.3. Yes, provided both, and at least part of the “defined audience” must be in an influential position, but outwith the institution. In the Health Service, as long as DsPH and DMOs are not fire-proof, as was the case with MsOH, there has to be a comprehensive system of checks and balances to protect NHS employees who may level serious criticism at their own managers.

Question 9.

I don’t think enough thought has been given to the issue of penalizing an individual, the subject of a restraining Order. Two points: - would such a person go to prison? I think not, but if that’s what is suggested seriously, then the Act will need to be written very clearly, and the legal process be water-tight, otherwise the Police will not be in a position to assist. And what about the public health risk posed by the individual to inmates and staff in the Prison?

9.5 (a) and (b). No.

9.5 (c) Yes, but *vide supra*, penalties for breach.

Yours Sincerely,

Dr. David Bell.

BSc, MSc, MBA, FRCPE, FRIPH, MFPHM, MIRH, Cert. Drug & Alc. Studies, Affiliate
CIH.