PUBLIC HEALTH LAW: ITS PROBLEMS AND CHALLENGES

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I. INTRODUCTION

This paper is a critical assessment of the state of the laws that relate to public health in Australia.[1] Public health concerns issues such as prevention and addressing the structures that affect the health of the community. Its focus is on the community rather than the individual. In doing this, public health engages and often challenges a range of other social values, especially those that support privatisation or call for less regulation. It also challenges the activities of those who have a vested interest in the things that cause ill health. To that extent public health is controversial; it is not seen as an unqualified social good in the way that heroic measures to preserve individual lives are typically seen. Yet public health has a capacity to prevent illness and to improve the quality of life to a far greater extent than any of these heroic individualised treatments. In Australia some 18,000 persons die each year from tobacco related diseases.[2] This is a huge burden of premature mortality and is quite avoidable. The application of public health laws - bans on advertising, pricing, the tightening of restrictions on point of sale - (and these are often controversial initiatives) stand to eliminate this vast burden of premature mortality. In doing so, the public health process can make a far more effective contribution to community health and well-being than any of the high profile 'one on one' medical treatments. This is the argument for public health - its reliance on legislation as a high

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1 "Public health" is a broad term that covers a range of areas including food, drugs, diseases and environmental hazards. This paper will focus on questions of food, water and environmental health hazards as the concrete application of the general ideas and issues under discussion

2 National Campaign Against Drug Abuse, *National Health Policy on Tobacco in Australia*, NCADA (1991) p 1.

profile way of implementing public health policy is also the argument for including the subject within this special issue.

It must also be added that the relationship between public health and law has always been very close in the sense that public health has always operated through regulation. Indeed, the first eminent public health practitioner was the barrister Edwin Chadwick, whose work on sanitary reform led to the commencement of public health legislation in England. The history of public health practice has always been, and remains, a legislative history. Public health therefore works in a context that lawyers are familiar with and understand. Further, the potential to reduce mortality and morbidity extends beyond a distinct group of public health laws into other legal fields such as the product liability provisions of the *Trade Practices Act* 1974 (Cth). At its widest, public health law covers many areas of legal practice that collectively affect the well-being of the Australian community. This fact needs to be appreciated more widely than it has been previously.

This paper argues that public health law, as a body of legislation expressed in Commonwealth, State and Territory statutes, is under threat from a variety of changes and government policies. It is further argued that the challenges for public health law in the new century will be to address the issues set out in this paper. If policy makers are unable or unwilling to do this, it will be to the detriment of the values that have long sustained public health practitioners in their work of helping Australians to lead healthier and happier lives.

II. THE CONTEXT AND DEVELOPMENT OF PUBLIC HEALTH LAW

A. Context

The cemetery at Moonta Mines in South Australia contains scores of small mounds; the unmarked graves of children who died in the nineteenth century from enteric diseases, caused by the lack of a reliable water supply to the community. It is a moving experience to walk among those graves and to read the simple memorial to their lives. They are also a poignant reminder of the inadequate public health standards of that time. Moonta's experience was not unusual. Across Australia, people were dying at an early age from a range of diseases associated with inadequate water supplies, poor food preparation and general squalor. The living conditions of most Australians are now vastly improved and life expectancies have increased. It is an ongoing issue, of course, that this has not been the case for indigenous Australians whose living conditions in remote areas mimic to a large extent those of the nineteenth century and whose life expectancies remain well below the national average.

The fact that most Australians now live longer and are much healthier than their counterparts one hundred years before is a tribute to a number of important environmental factors: living standards have improved; new technologies such as refrigeration have allowed food to be stored safely; public infrastructure, notably

water supply and sewage, are available for most communities; and society is better organised in terms of its regulation of the public's health.

B. Development

The origins of public health law were linked to the cities of nineteenth century Britain. The high death rates and general foulness of these places, now bulging from the effects of the Industrial Revolution, gave rise to the *Public Health Act* 1848 (UK).[3] The Act was rudimentary in its effect, but it did provide for local councils to remedy nuisances and to undertake public health works. It also provided basic sanitary requirements for new dwelling houses. Enduringly, it established a dual system of responsibility - central (state) and local government - for public health that continues today. The late nineteenth century saw, both in Britain and Australia, the adoption and refinement of the general public health principles written into the Act that also incorporated provisions for the control and notification of infectious disease. By the early twentieth century, it was as though a 'public health corner' had been turned. Life expectancy grew steadily and infant mortality reduced sharply. Most Australians could begin to look forward to reaching old age.[4] It was a trend that has continued through this century, checked only by the mortality of world wars, the road toll and the rise of 'lifestyle diseases' such as tobacco related deaths. Indeed, some argue that improvements in medical treatment played a relatively small part in this process. Even immunisations were not centrally responsible for the sharp decline in cases of childhood infectious disease.[5] The significant issue was that the public's health improved because the quality of life and level of public services (for example the Mothers and Babies Health Associations) improved. Legislation helped in this process in two ways. It established standards for food and drugs and established hygiene and sanitary requirements. It also required the provision of public health infrastructures such as water and sewerage. It seems to be a range of public health and welfare issues taken together rather than a single cause that improved public health outcomes to such an extent.

By and large the twentieth century has not been a period of active public health law reform. It was active at the turn of the century when the improvements in public health first commenced, but the 'core' public health Acts

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3 Hereafter 'the Act'

4 Between 1856 and 1900 life expectancy for males had increased by just over five years to 51 years Between 1900 to 1980 it increased 20 years In 1870, infant mortality in Australia was 111 per thousand By 1903 it was still at this level. After that infant mortality rates began to decline steadily and by 1980 they were ten per thousand See W Vamplew, *Australians - Historical Statistics*, Fairfax, Syme and Weldon (1988) p 58.

5 This argument is most famously expressed in McKeown's studies of falling death rates for a range of common diseases in the United Kingdom, a decline which was most significant before medical interventions such as drug treatment or immunisation was available McKeown argues that this decline was the result of general environmental improvements See T McKeown, *The Role of Medicine*, Blackwell (1979) and S Szreter, *Mortality and Public Health 1815 - 1914* in A Digby et al, *New Directions in Economic and Social History*, Vol 2, Macmillan (1992) ch 10 Conversely, the same argument might also be made for the very poor level of Indigenous health which is more a function of poor environments than it is a function of medical interventions and hospitalisation rates

were in most States, until quite recently, relics of that early period. Five Australian jurisdictions continue to operate public health laws that are over 60 years old.[6] Similarly, food and drug laws were, until relatively recently, also turn of the century enactments. The interest in upgrading these controls since 1970 seem to have been driven more by industry pressure (who understandably wanted uniform food standards across Australia), and in the case of drugs, by a view that the newly discovered 'illicit drug problem' (always minor compared with the 'legal drug problem') could be effectively addressed by increasingly stringent criminal penalties. Concern for the public's health can easily become lost against these more immediate issues.[7]

However, by the 1990s, the States, Territories and Commonwealth were in the process of reviewing and modernising their public health legislation. Some jurisdictions adopted laws that were influenced by prevailing ideas of community involvement and the argument that health was a positive state of well being rather than merely the absence of a definable illness. In particular, local councils are required to prepare 'health plans' which require a pro-active view - about the things that keep communities healthy - rather than simply remedying the things that make them sick.[8] Other jurisdictions adopted more traditional public health responses, allowing more powerful intervention and investigation of actual and potential public health problems. They still continue to maintain a reactive legislative model of public health regulation.[9]

In one sense then, the state of public health law in Australia is healthy. Reform and revision are now more active in this area of governmental activity than in many others. Yet there are also threats to the future of public health law which stand to shape its practice into the next century. Some of these threats go to the organisation and content of public health law and the values that are shaping its organisation and content. Others go to the broader changes that, while not specifically focused on public health legislation, stand to exercise a powerful influence over it. This paper now considers four aspects of public health law that reflect this threat.

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6 At the commencement of 1997, the following 'old' health laws were still in force: *Health Act* 1937 (QLD), *Public Health Act* 1962 (TAS) - a consolidation of earlier legislation, *Health Act* 1911 (WA), *Public Health Act* 1928 (ACT) and *Health Act* 1952 (NT). These Acts still retain their original structure and subsequent amendments were generally to 'tidy up' the laws or to add new provisions In many cases though, the regulations made under them are recent and up to date. These jurisdictions are all reviewing and updating their Acts at time of writing.

7 See for example the recommendations relating to food in the *Report of the Small Business Deregulation Task Force (Time for Business)*, Commonwealth Government (1966) and the discussion of the development of Australian drug legislation in CS Reynolds, "Can We Make Sense of Drug Laws in Australia?" (1995) 1 *Flinders Journal of Law Reform* 73 at 73-84.

8 Health plans are required under both the Victorian *Health Act* 1958 and the South Australian *Public and Environmental Health Act* 1987 The Victorian Act sets out detailed requirements. Under s 29B Councils must prepare a "Municipal Public Health Plan" every three years. The contents of the Plans are set out in s 29B(2) and they focus on both specific public health questions and more general 'well-being' issues. Councils are required to evaluate the programs and strategies set out in the plans and to review them annually Both jurisdictions have guidelines and manuals that assist Councils in this process.

9 This is best seen in the New South Wales *Public Health Act* 1991, corresponding sections of the *Local Government Act* 1993, and the public proposals for a new Tasmanian *Public Health Act* (published by the Tasmanian Department of Community and Health Services)

III. ECONOMIC POLICY AND PUBLIC HEALTH

A. Introduction

Both in Australia and elsewhere there has been a long involvement by governments in the provision of public health services and infrastructure. This has been part of a broader governmental reformist agenda. In 1949 Labor Prime Minister Ben Chifley made his famous allusion to the "light on the hill" which he saw as the great objective of the Labor movement. He made the statement in the context of what he saw as the betterment of humankind, better standards of living and greater happiness. He made it against a backdrop of his own reforms, to health and welfare, and his attempts to nationalise the banks. For Chifley, the role of government was to intervene and provide leadership and service to the community. It was a view that many of his colleagues, Labor and conservative, shared. Most notably, the 35 years of conservative government of Sir Thomas Playford in South Australia was marked by public involvement in housing, urban development and the creation and strengthening of public utilities. The result has been that most Australians have grown up with the expectation that government departments and instrumentalities would provide water and sewerage, public transport, power, and, where necessary, shelter, as a legitimate part of the functions and responsibilities that governments exercise on behalf of their citizens. These services, especially the provision of water and sewerage, can be shown to have played a principal role in reducing public health problems.[10]

Such certainties no longer hold true. Three areas of prevailing economic policy in Australia now challenge the accepted notions of how public health is provided to the community. They are: the privatisation of public health services; the diminishing role of governments in public health delivery; and the governmental agreements to reform laws that restrict competition.[11] Together, these issues challenge the idea that governments should be involved in the regulation of public health principally by way of legislation.

B. The Privatisation of Public Health Services

The first issue relates to privatisation. In a number of Australian jurisdictions, governments are now committed to a process of selling off their infrastructure or privatising services, including core public health services such as water.[12] It can be argued that governments have a general responsibility to the community for the outcomes of the services they provide and the welfare of the users of those

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10 In South Australia for example, deaths from diarrhoeal diseases began to fall after 1881 at the same time that households in much of metropolitan Adelaide were first connected to the sewage system (up to that date deaths were in fact rising). Though deaths fluctuated, they were down to a third of the 1881 figure some ten years later. See P Woodruff, *Two Million South Australians*, Peacock Pub (1984) p 11.

11 The Competition Reform process is the general process put in place as a result of the Competition Principles Agreement signed by the States and Territories and the Commonwealth at COAG (11 April 1995). See R Miller *Annotated Trade Practices Act*, Law Book Company (17th ed , 1996) p 746.

12 See M Webber and ML Crooks, *Putting the People Last: Government Services and Rights*, Hyland House (1996) part 3, pp 109-59.

services. Thus services such as heating and water can be argued to be a 'right' and a 'public good' rather than a commodity that is simply bought and sold.[13] Private suppliers of these services can be required to operate efficiently and be expected to provide a safe service, but within the framework of the supply being a commodity rather than a 'good' or a 'right'. A private supplier needing to maximise efficiency and profits cannot be expected to adopt the community obligations that might be expected of governments and it is likely that a privatised resource is more likely to be withdrawn from consumers than if it remained in public hands.

Water supply is a good case in point; its quality and availability is a core public health issue. In this respect, the English experience with privatisation of the water supply needs to be examined. Initial criticisms included concerns about public health, service delivery and environmental degradation. Disconnections of households from the water supply are particularly concerning; a study in 1992 suggested that disconnections in England and Wales had tripled since privatisation to 21,000 households. Families were denied access to water and thus basic sanitation. There is also anecdotal evidence that there has been a rise in diseases such as dysentery, scabies and hepatitis A (which has increased fourfold).[14] All of these diseases are associated with personal hygiene and thus with the availability of water. On these analyses, the English experience of privatisation has not been a positive one and the future of privatisation of public health infrastructure in Australia needs to be considered, particularly as a wide range of governmental services are available for 'outsourcing', including core public health functions.[15]

C. The Diminishing Roles of Governments in Public Health Delivery

The second issue relates to reduced government involvement in public health. Thoreau's view "that government is best which governs least"[16] finds favour with many Australian supporters of leaner and less intrusive government. On this view it must also diminish the extent to which governments can discharge their statutory obligations. For example, it means that the ability, by routine inspections, to prevent problems from occurring is replaced with the ability to respond when they do. In particular, the enforcement of food laws appears to have reduced dramatically. In Victoria, it has been said that there has been a 40 per cent reduction in local council food inspectors. Food prosecutions fell even more dramatically, from 1877 prosecutions in 1993 to 103 in 1996.[17] Self-regulation is no substitute for regular enforcement of statutory requirements.

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13 See the argument in M Webber and J Ernst, *Privatisation in Review* in ML Webber and M Crooks, *ibid* p 109

14 H Price, "Yet not a drop to drink. disconnections of domestic water supplies" (June 1993) *Environmental Health* 173 See also R Lister, "Water Poverty" (April 1995) *Journal of the Royal Society of Health* 80.

15 See for example the competitive tendering provisions of the Victorian *Local Government Act* 1989 ss 208A-208G.

16 From the opening sentence of Henry David Thoreau, *Civil Disobedience* (first published as "Resistance to Civil Government" in E Peabody (ed) *Aesthetic Papers*, 1849).

17 "State Food Inspectors cut 40% says Labor" *The Age*, 8 April 1997, p A5.

There is clear evidence in the *Garibaldi* case for example that the manufacturers had received advice on safe manufacturing practice but had chosen not to apply it.[18] Thus arrangements that might be seen to foster self regulation such as the use of third party certificates (where independent professional consultants undertake the inspection or give approvals) should be viewed critically since they reduce the capacity to keep inspections objective and at arms length from those inspected.[19]

There also appears to have been a shift in the way in which public health legislation has been seen. Increasingly, laws that ought to be about (and only about) protecting the community's health can be read as industry facilitation laws. The issues associated with the regulation of food have highlighted issues such as harmonisation of standards and export enhancement.[20] This is not necessarily inconsistent with protecting public health,[21] especially in the case of a major health problem such wide scale food poisoning (in fact here the two are synonymous). However cases such as warning labelling for alcohol, where the public health issues are not so immediate, may well conflict with industry interests and create tensions within the regulatory authority making it unlikely that warning statements as strong as those allowed on tobacco products could ever be put in place. This is notwithstanding the fact that the public health problems of alcohol lie within the same general order of seriousness as tobacco. What is true of food is also true for therapeutics and drugs, where the industry questions of marketing efficiencies and the supply to the community of a range of drugs is a pressing issue, potentially set against the public health issues. This is not to suggest that public health questions are overlooked by these laws - they are not. But, the differing interests create a tension in laws whose prime purpose is public health.

D. Governmental Agreements to Reform Laws that Restrict Competition

Competition policy reform is the third issue of concern. At the Council of Australian Government (COAG) conference of 1995, all Australian Governments agreed to have reviewed their laws that restrict competition by the year 2000. Many public health laws will be included in this review. There is no obligation in this process to repeal public health laws and the *Competition*

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18 Inquest into the death of Nikki Dearne Robinson, South Australia Coroner's Court 28 September 1995, Inquest 19/95, pp 59-61. The *Garibaldi* case involved an outbreak of food poisoning in Adelaide in January 1995 The Garibaldi small goods company manufactured mettwurst which had been contaminated with a strain of e-coli bacteria The resulting outbreak of food poisoning caused the death of a child and serious illness to a number of other people.

19 Food laws are now being extensively and nationally reviewed. This presents an opportunity to strengthen, rather than diminish, existing regulatory arrangements

20 Australia, House of Representatives 1991, Debates, vol 177 14 May 1991, p 3653 In this case, the second reading speech prominently extolled the significance of the food industry and. in particular, attempted to reconcile the sometimes irreconcilable interests of enhancing an efficient and competitive industry with the regulation of public health

21 The objectives of the Australia New Zealand Food Authority place the protection of public health and safety as its first priority, and the promotion of trade and commerce in the food industry as its fourth priority (*Australia New Zealand Food Authority Act* 1991, s 10).

Principles Agreement under which this work is to be completed specifies community service and environmental issues to be considered as significant in any assessment of public health laws.[22] But the spirit of competition reform allows public health law, and its enforcement, to be viewed as a potential impediment to economic activity and as amenable to reform and deregulation.

Allied to this process is the fact that new public health legislative proposals are subject to general Cabinet requirements such as reasons why non-regulatory alternatives are not appropriate, and a cost-benefit analysis of the proposal. These analyses are notoriously difficult to perform in areas where the benefits are measured in terms of social goods and ethical values. While the costs may be more obviously quantifiable, the benefits will not be - a fact that makes the proponent's case more difficult, and potentially delays or prevents new initiatives.[23]

The assumptions underlying Cabinet requirements such as these, is that the market place can adequately regulate activities and only that a case for regulation arises where there is a demonstrable failure of the market. The problem with this argument is not that proponents of regulation must state a case - they have always had to do that - it is that the lack of regulation is prioritised over regulation. That is, it privileges self-regulation and related responses above regulatory initiatives.

E. Conclusion

It may seem unrealistic to argue against the prevailing economic and competition policy wisdom, yet those who defend public health values and administer its laws must recognise that market place driven values are not compatible with the collective 'goods' that public health has long sought to protect. Also, the public has an expectation that its health will be safeguarded. For example, when outbreaks of food poisoning occur, the community will not necessarily see self-regulation as an acceptable substitute.[23] The fact that we are so much healthier than a century ago is a tribute to the early legislative reform and the provision of public health infrastructure. Those reforms were opposed then: there were those who objected to laws which required persons to sewer their houses or prevented factory owners from discharging whatever toxins they wished into the air.[24] There are people today whose vested interests in ill health prompt them to oppose new public health initiatives. The rear-guard action fought by the tobacco industry in Australia and overseas in relation to issues such as 'passive smoking' is a good case in point. We should never take our public health for granted. A return to our public health past is possible; a vision

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22 See cl 1(3) (d) - (j) of the *Competition Principles Agreement* (April 1995).

23 See the arguments made in A Teuber, "Justifying Risk" (1990) 119 *Daedalus* 229 at 246-50.

23 The public criticism by the South Australian Coroner in relation to the inspection of premises and enforcement of food laws, which came out in the Garibaldi food poisoning inquest is a case in point See the discussion in CS Reynolds, "Lessons from the Garibaldi Food Poisoning Epidemic" (1996) 1 *Food Monitor* 10, (1996) 2 *Food Monitor* 1

24 See CS Reynolds, "The Promise of Public Health Law" (1994) 1 *Journal of Law and Medicine* 212 at 215

of people queuing for water from public stand pipes, as they did over a century ago, is, for example, the end point of a privatised water supply that ultimately owes no obligation to the community.

IV. REDEFINING THE 'NATURE' OF PUBLIC HEALTH PROBLEMS

For most of this century public health and environmental legislation were inseparable concepts; the protection of air, soil and water quality were seen as issues of public health and were dealt with by general powers in health acts, or by specific regulations made under them. By the 1970s this position began to change. The Australian states started to pass environmental legislation, a process that has gathered impetus to the extent that today, most jurisdictions have comprehensive environment protection laws that provide detailed controls over a range of environmental issues. These Acts are also administered by specialist environmental agencies with little formal input from areas of public health.[25] Significantly, they are far more sophisticated enactments than the core public health laws currently in operation. The penalties are far higher and range up to one million dollars for corporate environmental offenders. By comparison, maximum penalties for public health offences are almost always less than $50,000. In addition, environmental legislation contains a wide variety of remedies and options for control for both administering authorities and complainants.

Overall, environmental law has a far more sophisticated range of options and a far stronger repertoire of controls than does public health law. Environmental legislation of the type currently in operation in Australia must be seen as substantially more powerful and diverse than public health legislation. It also appears to be enforced more effectively, to the extent that prosecutions occur with sufficient regularity to allow sentencing principles to be developed and analysed.[26] Prosecutions for public health environmental offences are rare and analysis of them is even rarer.

There are also areas of competing jurisdiction: traditional minor environmental offences, confined to a particular area or focusing on a particular condition, have long been dealt with in public health legislation as a statutory nuisance or an insanitary condition. They either attract an order to remedy the condition or are prosecuted by local authorities under public health offences. However, environmental legislation now contains 'environmental nuisance'

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25 Membership of the Environmental Protection Agencies established under state laws (with the exception of Tasmania) specifically require that a public health representative be included. See *Protection of the Environment Administration Act* 1991 (NSW), s 15; *Environment Protection Act* 1970 (VIC), s 9; *Environment Protection Act* 1993 (SA), s 12, *Environmental Protection Authority Act* 1986 (WA), s 7. In Queensland, the *Environmental Protection Act* 1994 is administered by an administering authority, rather than a formal EPA. See also *Environmental Management and Pollution Control Act* 1994 (TAS) s 13

26 See for example, D Mossop, "Sentencing Environmental Offenders in New South Wales" (1996) 13 *Environmental and Planning Law Journal* 423.

offences which are similar in their scope and can provide alternative remedies to these traditional public health powers.[27]

Environmental law and policy has also developed at international, national and regional levels over the past twenty years. The high profile conventions relating to biodiversity, climate change, ozone depletion and the work at conferences such as at Rio de Janiero in 1992 (Agenda 21), are clearly seen as expressions of environmental concern, despite the fact that these questions are in effect about human health and that health was seen as a focus for many of these initiatives. At a national level the *Intergovernmental Agreement on the Environment* entered into by Australian governments in 1992 is a powerful document that both spells out the various responsibilities of national, state and local governments for environmental regulation and control, and incorporates a number of specific issues such as environmental impact assessment and climate change. This Agreement has been called up by state and national legislation and has formed the underpinning for the National Environment Protection Council, which is responsible for agreeing on a range of environmental standards imposed by state and territory legislation.[28]

Environmental laws also have well developed statements of principle and objects that take their language from the general environmental principles, including concepts such as ecologically sustainable development, and the precautionary principle. These ideas are designed to inform the legislation overall and set it within a coherent framework within which decision making should occur. The incorporation of general principles in state legislation integrates local environmental protection into a framework of national and international values. By comparison, public health legislation has not taken the opportunity to adopt such explicit principles in the text of its legislation, even though principles such as the World Health Organisation's *Ottawa Charter for Health Promotion* (1986) and the public health components of many of the environmental agreements are important underpinning's for public health practice.[29] Nor is the division of public health responsibilities among the various

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27 To give one example, in the *Environment Protection Act* 1993 (SA), s 82 A person who causes an environmental nuisance by polluting the environment intentionally or recklessly and with the knowledge that an environmental nuisance will or might result is guilty of an offence Section 3 defines an environmental nuisance as.

(a) any adverse affect on the amenity value of an area that -
  (i) is caused by noise, smoke, dust, fumes or odour, and
  (ii) unreasonably interferes with or is likely to interfere unreasonably with the enjoyment of the area by persons occupying a place within, or lawfully resorting to, the area, or

(b) any unsightly or offensive condition caused by waste

See also *Environmental Management and Pollution Control Act* 1994 (TAS), s 53.

28 The *Intergovernmental Agreement on the Environment* is called up as a Schedule to the *National Environment Protection Council Act* 1994 (Cth)

29 Victoria has set out a series of objectives in s 5A of the *Health Act* 1958 (though the section has never been proclaimed). They are as follows.

- to ensure equity in health,
- to help people live as full a life as possible no matter what their pre-existing level of health;
- to reduce the incidence of disease, disability, distress and symptoms of ill health,
- to reduce the incidence of untimely death.

Australian governments set out with the same clarity as it is with the environmental issues in the *Intergovernmental Agreement*.[30] Indeed, the position is quite unclear. The fact is, that while local and state governments have always played an important role in public health practice, the demarcation of responsibilities for particular aspects of public health practice has not always been clear (for example, in the case of immunisation). The Federal government is also an increasingly important player in public health legislation, especially where national uniformity and harmonisation is involved as it is in food standards or therapeutics controls.[31]

It can be argued that the development of strong environmental laws must advance public health regulation in Australia since the two interests are so closely linked.[32] But environmental assessments do not necessarily address human health questions, especially if they are not considered by public health practitioners. In some jurisdictions there have been attempts to incorporate environmental health impacts either as stand alone provisions relating to developments and activities, or as part of the environmental impact assessment process overall. The long term effectiveness of these procedures as a way of addressing public health remains to be measured.[33]

Overall, the recent development of strong environmental legislation has shifted the legislative focus and its administration away from public health and towards environmental issues. By comparison with the environmental Acts, the public health laws seem rudimentary and inconsequential and are less obviously enforced. This is no less the case where 'modern' public health law is in force compared with jurisdictions which continue with antiquated laws. Public health law has lost much of its traditional areas of responsibility to the new environmental law. For example, air quality standards are the province of environmental agencies rather than public health, yet air quality is fundamentally

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The new Australian Capital Territory legislation will be informed by the principles of the *Ottawa Charter for Health Promotion* and takes a broad view of entitlements to health. "The fundamental conditions and resources for health are peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity. Improvement in health requires a secure foundation in these basic prerequisites." The *Charter* emphasises the need to develop healthy public policy, the creation of healthy environments and the strengthening of community action.

30 See clauses 2.2 - 2.4 of the *Intergovernmental Agreement on the Environment*.

31 The Commonwealth has long been involved in public health through the *Quarantine Act* 1908 (Cth) and the *Customs Act* 1901 (Cth) In addition, the following more recent Commonwealth Acts provide an indication of the range of public health responsibilities exercised currently by the Commonwealth *Australian New Zealand Food Authority Act* 1991, *Therapeutic Goods Act* 1989, *Tobacco Advertising Prohibition Act* 1992, *Narcotic Drugs Act* 1967 and the *Psychotropic Drugs Act* 1976 .

32 Environmental statements of principle do recognise that human health is an integral component of the environment. For example, Schedule 3 of the *Intergovernmental Agreement on the Environment*, which sets out general principles of Environmental Impact Assessment, emphasises the point that human health is a relevant component of the process Paragraph 2 provides that "impact assessment in relation to a project, program or policy should include, where appropriate, assessment of environmental, cultural, economic, social and health factors"

33 In Tasmania health impacts will operate through s 74 of the *Environmental Management and Pollution Control Act* 1994 as a component of the Environmental Impact Assessment process.

about human health.[34] One of the greatest challenges for public health practitioners is to develop stronger and more sophisticated legislation that adopts the style of environmental legislation and uses the language of public health policy as its explicit guiding principles.

V. CONFUSION ABOUT PUBLIC HEALTH VALUES: RISKS AND EXPECTATIONS

All regulatory systems are obliged to take account of the question of risk, which is the likelihood that an adverse event will occur. Stated or unstated, ideas about risk permeate our process of standard setting: speed limits which reduce the risk of road accidents are an obvious example where the association between a standard (the speed limit) and the reduction of risk can be stated with some clarity. Other risks are less straight forward, especially where outcomes are uncertain. In the environmental area, for example, it may be unclear whether a particular activity or exposure will lead to the decline of a species or cause an adverse effect, thus the risk of the activity or exposure is uncertain. Standards and controls can also be more complicated than the view that they are simply protecting the community from harm. They can serve a number of purposes including the regulation of the marketplace and the protection of trade. Indeed, issues such as the need to protect the meat export market may well drive public health controls more powerfully in this particular area than if it were just the domestic market that was in issue.

Also, there is not - and can never be - an agreed level at which legislation should intervene. We have no ready way of assessing what distinguishes an acceptable risk (for which legislation will *not* be put in place) from an unacceptable level of risk that demands legislation.[35] Even if we agree on a level can we apply it uniformly? For example, what might be an acceptable air quality standard for a 'normal' population may well be unacceptable for those within it who suffer from asthma. These are issues that affect all regulatory systems and in this sense the particular problems for public health are no different from other areas such as environmental or occupational health and safety practice.

However, for a variety of reasons, the process of regulating risk is particularly perplexing for public health practitioners. Most importantly, health questions demand a high priority for the community and public health therefore receives more publicity, and generates more anxiety, than other areas of social concern. Public health practice also ranges over areas where discourses about risk are

34 Ambient Air Quality levels are set by the National Environmental Protection Council as National Environmental Protection Measures.

35 Travis et al describe two levels of risk - *de manifestis* - that level of risk above which regulators ought to be concerned and in respect of which standards ought to be developed and *de minimus* - that threshold of risk below which regulation is not warranted. The point at which these levels are set will always be controversial. A risk of less than one in one million chance of dying from a lifetime of exposure to the toxic substance was considered as below the threshold However, for a variety of reasons, societies regularly fail to prevent activities that carry risks greater than this. See Travis et al, "Cancer Risk Management" (1987) *Environmental Science and Technology* 21 at 415.

quite different, prompting different issues and tensions.

A. Risk and Environmental Health

Public health incorporates environmental health issues. Typically these encompass the questions of unhealthy environments imposed on communities by nearby industrial activities, which may bring both threats to health, and impact in other undesirable ways. Communities under pressure in this way, understandably express their anxieties in the language of health, in the sense that the risk to health is emblematic of an unsatisfactory environment. Thus, an unpleasant environment is argued by the persons living in it to be an unhealthy environment. It may sometimes be the case that a formal health analysis that measures exposures against known data about the health effects of those exposures, will suggest that the risks of living in a polluted environment are not measurably greater than for those who do not live in such an environment. However, that is not the point, the residents *know* what is making them and their children sick, in the same way that they *know* that governments and their officials deny or minimise health problems for political reasons.

Australia has had ongoing issues where outbreaks of disease in communities (such as higher than expected numbers of cancer) are associated by the residents with particular undesirable activities such as crop dusting or highly chlorinated water. In many of these cases there appears to be no apparent connection with disease and the exposures, yet the community, who see these environments as inflicted on them, believe that there is a connection and are inclined to reject 'expert' medical advice to the contrary as simply wrong or part of an official cover up.[36] They also have the appearance of 'expert' decision making and are less likely to be trusted by the community than an analysis that is developed through community participation.[37] To say in these cases that the residents are simply wrong is to miss the point. Regulators need to accept the validity of anxieties prompted by environments that no one would voluntarily accept. The 'official public health' response to risk requires the 'social eye' as much as it requires the 'scientist's eye'. If not, the residents and the regulators will be engaging in parallel narratives that will never meet.[38]

B. Risk and Lifestyle

Public health also incorporates the regulation of 'lifestyle issues' such as the tobacco control laws whose purpose is to reduce the burden of smoking related death and disease within the Australian community. Yet lifestyle controls such

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36 Clearly, though, any concern needs to be investigated and measured against the best information available on known and possible causes of disease. Concerns relating to exposure to radiation from transmission lines and mobile telephone towers are a good example of the need to develop better knowledge about whether or not hazards exist. See B Hocking et al, "Cancer Incidence and Mortality and Proximity to TV Towers" (1996) *Medical Journal of Australia* 165 at 601. See also the discussion and references in CS Reynolds, *Public Health Law in Australia*, Federation Press (1995) p 269

37 Note 23 *supra.*

38 See the discussion in J Auer, "Assessing Environmental Health: Some Problems and Strategies" (1989) *Community Health Studies* 13 at 441

as these have always been controversial. They raise fundamental questions about the role of governments in regulating the activities of their citizens and the extent to which they should intervene in activities voluntarily entered into by citizens. For example, the tobacco industry has strongly promoted the argument that it was not the business of the State to regulate things such as advertising and sponsorship and to limit freedom of choice as a way of opposing tobacco control laws in Australia.[39] It is likely that many Australians would support this argument. There is also an important distinction between what are seen by the community as risks that are voluntarily imposed (smoking or drinking) and those that are involuntarily imposed (such as exposure to asbestos in the workplace). The former are seemingly less deserving of regulatory action. Thus, the argument might be put that if people drink at hazardous levels it is their choice and the government should not intervene. We need to reconsider such assumptions. The consumption of alcohol occurs in an environment that is completely free of any meaningful restriction on the advertising of the product. This allows unconstrained promotion that normalises, glamorises and in effect encourages alcohol consumption. In such an environment, it is not sensible or meaningful to label hazardous consumption of alcohol as a voluntary activity and there is as great a case for regulating its promotion and marketing, as there is for dealing with the involuntary risks of exposures to asbestos in the workplace, or the risk of purchasing contaminated food.

C. Australia's Drug Laws: A Case Study in Risk

These two perspectives in which public health risks are addressed help us to understand one of the major problems in public health law; namely, our drug legislation. Drug laws in Australia have been characterised by extremely stringent controls over a small group of drugs such as cannabis, amphetamines and heroin. These laws impose among the most stringent penalties available to Australian courts, including life imprisonment, and have a range of other penalties including seizure of assets. One would expect the public health problems presented by this group of drugs to be our most serious public health problem. Yet they are not: illicit drugs amount to two to three per cent of the total drug deaths in Australia.[40] The most lethal drugs in Australia are tobacco and alcohol, both legal drugs and while one (tobacco) is subject to a range of controls - though incomplete and poorly enforced - the other (alcohol) is subject to virtually no public health controls at all. The point is that in this important area of public health we have not responded in any sensible way to the various risks that drugs present to the community.

This public health conundrum is powerfully maintained by the community and governments who are more reactive to the 'dark and alien' threats of illicit drug use and the stereotypes that are associated with it, than they are to the more

39 See S Chapman, "Anatomy of a Campaign. the attempt to defeat the New South Wales (Australia) Tobacco Advertising Prohibition Bill 1991" (1992) 1 *Tobacco Control* 50

40 Commonwealth Department of Health, Housing and Community Services, *Statistics on Drug Use in Australia in 1992*, AGPS (1992).

prevalent, normalised, but more dangerous (in a public health sense) drugs: tobacco and alcohol. This general point can be illustrated very clearly in the extensive publicity which is given to a death associated with an illicit drug.[41] Yet there are 60 deaths that occur in Australia every day from tobacco and alcohol and these are largely ignored. Seemingly they are part of the background noise of acceptable risk that we are all exposed to. Illicit drug dealers are stigmatised outcasts. By comparison, both the alcohol and the tobacco industry can adopt the persona of good corporate citizens with powerful lobby groups that have been successful in preventing or delaying public health restrictions on their products.

Dealing with risk remains a great challenge for public health regulators. There is a need to make the process of risk assessment and the values on which it is based more explicit. There is a need to understand community views and to incorporate them into this process. There is a need to make public health the highest priority where there is doubt about the risks to health associated with a particular activity. In this regard, public health laws could usefully adopt the precautionary principle that "[w]here there are threats of serious or irreversible environmental damage, lack of full scientific certainty should not be used as a reason for postponing measures to prevent environmental degradation".[42] The concept is well known in environmental protection and has been the subject of judicial decisions and academic debate.[43] However, there are also many industries whose interests and activities are not in the public health interest, and policy makers must be prepared to recognise that they are obliged to make difficult decisions in terms of regulating these activities. In the case of alcohol for example, a major public health problem amounting to the premature deaths of 3,660 people a year.[44] At the very least, this means stringent public health restrictions on the marketing and promotion of the product.

VI. THE 'PRIVATISATION' OF PUBLIC HEALTH LAW

Public health law has always been seen as the expression of statutory law. Its content is to be found in statutes and its enforcement through the operation of those statutes. In practice, the enforcement of public health law has been through the officials responsible for the administration of the public health laws. Typically, this has been environmental health officers (health inspectors) employed within local government or state and territory health agencies. In

41 The very widely publicised 'ecstacy' related death of Sydney teenager, Anna Woods, is a good case in point.

42 *Intergovernmental Agreement on the Environment*, cl 3 5 1

43 See for example *Environment Protection Act* 1993 (SA), s 10(1)(b)(iv), and its application by Stein J in *Leatch v National Parks & Wildlife Service* (1993) 81 LGERA 270 in the context of species protection. See also (1997) 14 *Environmental and Planning Law Journal* 1 - "Special Issue Focus on Threatened Habitats and the Precautionary Principle". The precautionary principle was cited in the Draft Report of the NHMRC on *The Health Effects of Passive Smoking* (October 1996), chapter 8.

44 Australian Department of Health and Family Services, *National Alcohol Action Plan*, CDH&FS (1996) p 2.

many respects, and for some of the reasons discussed earlier in this paper, the levels of enforcement vary and in particular cases, such as the policing of the sale of cigarettes to children, are so low as to be virtually non-existent. In other cases, administrations may not be inclined to act on a complaint and even if they do, penalties for most public health offences generally remain small. Even where a penalty is imposed, persons injured by the breach receive no compensation other than the knowledge that the offender has been successfully prosecuted.

This raises the final challenge to public health law described in this paper. It relates to the extent to which private litigation will pre-empt and overshadow the traditional response of statutory law. It is suggested that private law remedies for public health issues will become more common (particularly since changes to litigation such as class actions and 'no win no fee' arrangements facilitate them). The development and administration of future public health legislation will be substantially affected by this.

This issue is already facing public health practitioners. In 1996, peanut butter and other products made from contaminated peanuts were linked with salmonella poisoning which affected a range of consumers across Australia. Penalties for food standards requirements exist in all states and territories and a traditional (public health) response would be a prosecution under these laws. Generally, if successful they would have attracted relatively small fines though the stigma of a conviction and associated bad publicity would also have been likely. A custodial sentence is very rare in public health law.[45] However, this traditional (public health) response to a public health problem of food hygiene was overshadowed by the commencement of a representative proceeding (that is a 'class action') brought under Part IVA of the *Federal Court of Australia Act* 1976 for damages on behalf of all those injured by consuming the product. In addition, the product liability provisions of the *Trade Practices Act* 1974 now make it easier for consumers to bring such an action in relation to damages resulting from a defective product. Class actions are very powerful; it is easier for consumers to bring them and costs are less of an obstacle. Also, the costs by way of civil damages to a defendant company will almost always be far greater than if it was simply prosecuted and fined.

It is likely that lawyers will continue to bring proceedings for these kind of incidents. It will make civil action a high profile response to a public health incident that will inevitably overshadow the public health law response reflected in the modest penalties currently written into food legislation.

It may well be that there are some advantages associated with these kinds of

45 *Food Act* 1992 (ACT), s 24 sale of unsafe food attracts a maximum penalty of $10,000 and one year imprisonment; *Food Act* 1989 (NSW), s 9 preparation or sale of adulterated or sub-standard food attracts a maximum penalty of 50 penalty units and imprisonment for 6 months; *Food Act* 1981 (QLD), ss 9, 10: sale of food that is unfit for human consumption or adulterated attracts 50 penalty units, preparation of food for sale that is unfit for human consumption or adulterated attracts 100 penalty units (1 penalty unit equals $75), *Food Act* 1985 (SA), s 18: manufacturing food for sale that is unfit for human consumption or that does not comply with a prescribed standard attracts a maximum penalty of $2500; *Food Act* 1984 (VIC), s 10: sale of food not complying with prescribed food standard attracts a maximum penalty for a first offence of 20 penalty units, and for a second or subsequent offence 40 penalty units.

actions and the potential to bring them. They widen access to justice. They may also be potent reminders to food manufacturers and others to maintain their standards and thus prevent further incidents and further litigation. For example, one might speculate that it was the threat of civil action or workers compensation claims that have been responsible for the increasing creation of smoke-free environments.[46] Public or occupational health laws have not really played a role in this process since there have been no successful prosecutions of smoky workplaces under the statutory requirements to provide a safe workplace (one was commenced in Western Australia but failed).[47] Another example relates to the responsible serving of alcohol, which is now encouraged within the clubs and hotel industry. The irresponsible serving of alcohol may, if the patron is intoxicated, lead to prosecution under state or territory licensing laws. More significantly though, there has been a concern (already realised in the United States) that licensees have a duty of care to their patrons and others who might be injured by their patrons. The concern about this liability and the financial consequences that could flow from it are likely to have been more significant in introducing principles of responsible service of alcohol in licensed premises than the possibility of prosecution.[48]

As indicated, there are some advantages to this expansion of remedies available to consumers: the range of sanctions are widened and there is a more tangible form of redress than the simple knowledge that justice was done. It may also be that actions will be brought in respect of persons who claim to have suffered loss of services from privatised utilities and that this will contain some of the problems alluded to earlier in this paper. Manufacturers may be forced to add civil litigation to their potential legal risk and resolve to act more carefully in the future. These may be positive outcomes. But there are also potential negative outcomes that need to be considered.

Most significantly, we are seeing in this process a 'privatisation of public health law' where regulators leave the field, and principles of self regulation and litigation are seen to provide the main remedies. This would weaken the traditions of public health law as an orderly and thought out process of community action. Litigation is also a haphazard and costly process. It is inefficient and its public health effectiveness - measured by its potential to modify behaviours in order to prevent future incidents occurring - must be qualified by the extent to which manufacturers and others can minimise the costs (and therefore the threats) of a successful action through insurance.

This process will also damage the work of public health regulators who will take on the role of expert witnesses and by-standers in a process that will essentially be 'lawyer driven'. Further, demands for information from

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46 For example, in 1992, Liesel Scholem was awarded $85,000 in the NSW District Court for damages she suffered as a result of her exposure to tobacco smoke in the course of her work as a psychologist with the State's Health Department This was a negligence action. There have also been a number of worker's compensation claims for passive exposures.

47 *Hintz v Burswood Resort* (September 1993) which related to exposure of employees at the Perth Casino. (Complaint no 19515-16 of 1992, WA Court of Petty Sessions)

48 See the discussion in CS Reynolds, note 37 *supra* p 189.

regulators, either through freedom of information requests or court's discovery orders, may shape the way that they do their work. They may be reluctant to undertake investigations if a discretion exists to do this, or to compile information in relation to complaints.

These possibilities are conjecture but they are offered here as issues that may well flow from the rise of civil actions in public health. This process is already occurring in a number of high profile public health incidents. Potentially, they will make the traditional public health laws secondary to civil action. This presents major issues for the future practice of public health law.

VII. CONCLUSION: PUBLIC HEALTH LAW IN THE 21ST CENTURY

This paper has argued that public health law as it exists and has operated over the past century is now under threat from a range of ideas and practices. In particular, it has been argued that:

- there have been shifts in notions of governmental responsibility for public health infrastructure and services to the potential detriment of the public's health;
- there has been a narrowing of the field traditionally covered by public health law in favour of the environmental regulatory model which may not adequately address health questions;
- public health practitioners and policy makers have been challenged by, and have often failed to understand, a variety of views about the world and this has distanced them from the community and has, in the case of drugs, led to laws that make no public health sense;
- the vacuum created by the failure to strongly support and administer public health law will be filled by private litigation which may well be to the detriment of public health practice.

None of these scenarios is inevitable in the sense that they can all be addressed. In particular, public health legislation can become a more powerful expression of community values. It can adopt the language of human betterment and collective action espoused by documents such as the *Ottawa Charter for Health Promotion* be more inclusive of community values in order to develop the trust and co-operation of the communities it serves, and can develop sensible policies in areas such as drugs even if this means challenging the vested interests that will oppose it. The case for the fundamental reform of public health law has never been so great.