Aide-Mémoire

Overview of the notifiable infectious diseases system

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To:	Hon Dr Shane Reti, Minister of Health		
Consulted:	Health New Zealand: ☒ Māori Health Authority: ☐		

Contact for telephone discussion

Name	Position	Telephone
Dr Andrew Old	Deputy Director-General, Public Health Agency | Te Pou Hauora Tūmatanui	s 9(2)(a)
Dr Nicholas Jones	Director of Public Health, Public Health Agency | Te Pou Hauora Tūmatanui	s 9(2)(a)

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Purpose: This aide-mémoire responds to your request for information on notifiable infectious diseases, including information on what is currently required to be notified, the process for notifying, the powers it confers, and improvements that could be made.

Summary:

- New Zealand's primary legislation for managing infectious diseases is the Health Act 1956 (the Act) and its associated Health (Infectious and Notifiable Diseases) (HIND) Regulations 2016. Part 1 in Schedule 1 of the Act contains a list of infectious notifiable diseases.
- Unlike non-notifiable diseases, the Act requires health practitioners and laboratories to report a suspected or diagnosed case of a notifiable disease and provides the public health service, mainly the Medical Officer of Health, with a range of powers to contain disease spread, such as conducting contact tracing.
- A person who has, or is suspected of having, a notifiable infectious disease (regardless of immigration or residency status) is eligible for publicly funded services under the Health and Disability Services Eligibility Direction 2011. These are services specifically for surveillance, diagnosis, treatment, follow-up, and contact tracing.
- Many components of the current notifiable disease system are working well, but there are some areas where the system could be strengthened. Three key issues are:
    - the currency of the list of notifiable and quarantinable diseases, with the last comprehensive review occurring in 2007
    - the absence of a standardised process, including decision-making criteria to add, remove, or amend notifiable diseases from the Act
    - the notification process relating to 'Section C diseases', which must be reported without identifying information, which impacts the coverage, quality, and timeliness of information collected.

- The Public Health Agency (PHA), in collaboration with the National Public Health Service (NPHS) in Health New Zealand – Te Whatu Ora, is planning to review the list of notifiable diseases and develop a robust process to address these issues. This will include consideration of those notified anonymously, criteria for the inclusion or removal of a notifiable disease from the Schedules, and the impacts of any changes.

Dr Andrew Old
Deputy Director-General
Public Health Agency | Te Pou Hauora Tūmatanui

Overview of the notifiable infectious diseases system

Background and context

1. In New Zealand, health practitioners[1] are required under the Health Act 1956 (the Act) to report any suspected or diagnosed cases of a notifiable disease to the public health service and, for some diseases, local authorities. Since 2007, laboratories must also notify the requesting health practitioner as well as the public health service of actual and suspected cases of a notifiable disease.

2. This system serves 2 purposes:

    a. understanding of disease trends and rates over time (which informs the design and delivery of services)

    b. public health action, which refers to action taken by public health services to investigate cases and outbreaks.

3. A list of notifiable infectious diseases is outlined in Part 1 of Schedule 1 of the Act and non-infectious diseases, such as poisoning from chemical contamination in the environment, is outlined in Schedule 2.

4. Part 1 (attached as Appendix 1) is split into the following sections:

    a. section A diseases – infectious diseases that are notifiable to the Medical Officer of Health and local authority

    b. section B diseases – infectious diseases that are notifiable to the Medical Officer of Health

    c. section C diseases – infectious diseases that are notifiable to the Medical Officer of Health without identifying information of the patient or deceased person.

Notifiable and non-notifiable diseases

5. There are several key distinctions between notifiable diseases and non-notifiable diseases. Unlike non-notifiable diseases:

    a. reporting of notifiable diseases is mandatory (required by law) and overrides some restrictions contained in patient privacy laws, such as the Privacy Act 2020 and the Health Information Privacy Code 2020

    b. the Act provides a wide range of powers to the public health service, in particular the Medical Officer of Health, to contain disease spread and

    c. a person who has or is suspected of having a notifiable infectious disease (regardless of immigration or residency status), is eligible for publicly funded services relating to surveillance, diagnosis, treatment, follow-up services, contact tracing services under the Health and Disability Services Eligibility Direction 2011.

[1] **This includes medical practitioners, nurses (with a relevant scope of practice), and midwives.**

This is to the extent that it is appropriate to the circumstances to address risks to other people.

6. Cancer is a non-notifiable disease; however, it is mandatory for laboratories in New Zealand to report any new diagnosis of cancer to the Director-General of Health for the purposes of the Cancer Registry Act 1993.

7. The registry is managed by Health New Zealand – Te Whatu Ora and is the most complete record of cancer diagnoses in New Zealand. The purpose of the registry is to provide information on the incidence of, and mortality from, cancer and a basis for cancer survival studies and research programmes. The registry is a population-based tumour registry whose primary function is to collect and store cancer incidence data.

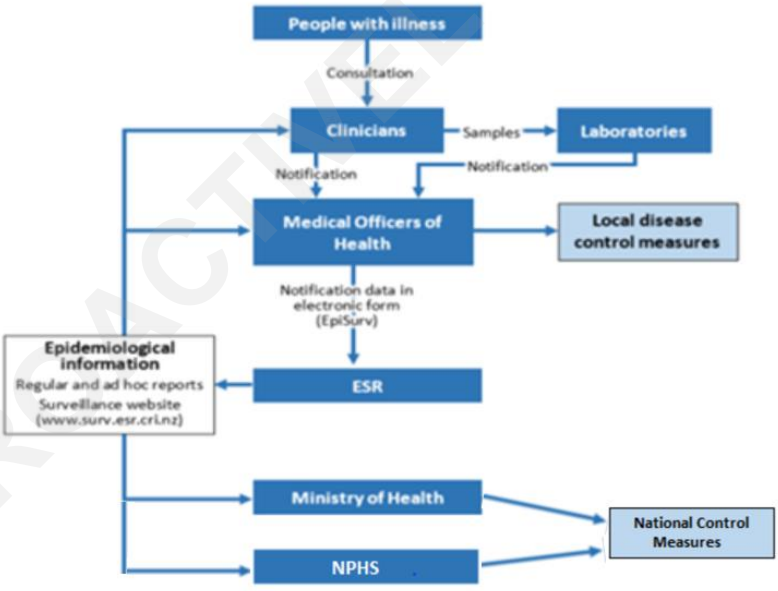
8. The registry is separate to the notifiable diseases system but, unlike notifiable diseases, there are no further implications regarding publicly funded health care and powers provided to the public health service to investigate and contain the spread of disease.

Section A and B diseases

9. This section sets out the process for infectious diseases that are notifiable to Medical Officers of Health and local authorities (section A) or just to Medical Officers of Health (section B), and is illustrated in Figure 1 below.

10. Section A provides a legal basis for sharing personal information with local authorities and enables assistance and collaboration with Environmental Health Officers working in those authorities.

Figure 1: Process for Section A and B diseases



Notification and response to a notifiable infectious disease

11. Once the health practitioner or laboratory notifies the public health service of a suspected or confirmed case, it is entered into EpiSurv – a real-time database for notifiable diseases operated by the Institute of Environmental Science and Research

(ESR) on behalf of the Ministry of Health - Manatū Hauora[2]. In practice, notifications of 'suspected' cases are only expected for a few diseases, such as measles, mumps, pertussis and invasive meningococcal disease.

12. Upon notification, NPHS and the Medical Officer of Health assess the public health risk to determine the appropriate action. Not every notification leads to immediate action; decisions are based on a risk assessment that considers diseases characteristics, such as transmissibility and severity, and specific circumstances of the cases. For instance, isolated enteric disease cases with low transmission risk may only require health advice, however a meningococcal case would require prompt case investigation, contact tracing and management.

Powers under the Health Act

13. Part 3A of the Health Act (the Act) provides the Medical Officers of Health with a range of powers to investigate and contain the spread of notifiable diseases. The Medical Officers of Health must balance the protection of public health (the paramount consideration) with the following overarching principles outlined in the Act:

    a. trying voluntary measures first if likely to be effective
    b. choosing proportionate measures and applying them for no longer than necessary
    c. choosing the least restrictive measures required in the circumstances
    d. fully informing the case or contact of the steps to be taken and clinical implications
    e. treating individuals with dignity and respect for their bodily integrity and taking account of their special circumstances and vulnerabilities.

14. The Act also provides specific powers related to quarantinable diseases[3] (listed in Part 3 of Schedule 1 of the Act) and significant 'special powers'[4] that require authorisation by either the Minister of Health, an epidemic notice issued by the Prime Minister under the Epidemic Preparedness Act 2006, or a State of Emergency being declared under the Civil Defence Management Act before they can be used.

Section C diseases

15. Section C contains infectious diseases that are notifiable to the Medical Officer of Health without identifying information of the patient or deceased person. For this reason, the notification process differs to the general process as outlined above, with a separate process for each disease. The original rationale for anonymously notifying these diseases was to avoid stigma or fear from patients of their Sexually Transmitted Infection (STI) being recorded in a database that may prejudice their future treatment, and may limit the uptake of testing.

[2] The HIND regulations 2016 contain prescribed notification forms for health practitioners and minimum information requirements for laboratory notifications.
[3] For example, authorising quarantining ships, aircraft, and associated travellers coming into New Zealand where there are grounds to believe there may be a quarantinable disease case.
[4] For example, providing the Medical Officer of Health to require any person who has been isolated or quarantined to remain where they are until they have been medically examined and found to be free from infectious disease, and until they have undergone such preventative treatment as the officer prescribers.

16. These notifications contribute to public health surveillance and epidemiological analysis, but do not trigger the same level of response from the public health service as Section A and B diseases. Since the notification is anonymous, the diagnosing health practitioner (rather than the public health service) is typically responsible for initiating contact tracing and follow-up. However, should an individual be considered a significant risk to public health, a referral can be made to the Medical Officer of Health who can then formally request identifying personal information under section 74(3B) of the Act.

Issues and opportunities with the notifiable diseases system

17. Many components of the current notifiable disease system are well placed to support the investigation, response and control of notifiable diseases, but there are some areas where the system could be strengthened. For example, negative laboratory results are not currently required to be reported (which limits our ability to understand epidemiological disease patterns) and much of the system still relies on manual time-consuming processes.

18. Three priority issues are:

    a. the currency of the list of notifiable and quarantinable diseases

    b. the absence of a standardised decision-making criteria and process to add and remove notifiable diseases from the Act

    c. the notification process for Section C diseases.

19. The list of notifiable and quarantinable diseases was last comprehensively reviewed in 2007. Since then, decisions to add or remove notifiable diseases from the Act have occurred on an ad hoc basis. There have been 12 amendment processes for Part 1 Schedule 1 of the Act since 2007, with some amendment processes involving more than one change. Most amendment processes involved adding new diseases to the Schedule and some involved changing disease names, removing and replacing diseases, or moving diseases into different sections of the Schedule. A review is needed to ensure the list is appropriate for our current context.

20. While there are general considerations, such as the disease's public health importance (e.g. incidence, impact, and preventability), there is no standardised decision-making criteria or process that has been consistently applied. In comparison, the Communicable Disease Network Australia (CDNA) has a comprehensive process, which includes a panel of experts who recommend whether a disease should or should not be notifiable using standard criteria.

21. A separate issue is the requirement to notify Section C diseases – gonorrhoea, AIDS syphilis, and Human Immunodeficiency Virus (HIV) - anonymously. The requirement to anonymously notify these diseases has resulted in workaround systems being developed (rather than using the usual notifiable disease process) to collect information about these diseases, which reduces the coverage, quality, and timeliness of our surveillance information, and places additional burden on busy clinicians.

22. Note that substantial changes to the Act and Schedules, such as altering the scope and purpose of the Schedules, would be a decision for Parliament. Adding, removing, or replacing diseases from the Schedules requires a Cabinet decision and Governor-General Order in Council, but no parliamentary process.

Next steps

23. The PHA, in collaboration with the NPHS, is planning to review the list of notifiable diseases and develop a robust process to address these issues. This will include consideration of those notified anonymously, criteria for the inclusion or removal of a notifiable disease from the Schedule and the impacts of any changes.

24. Officials can provide further information about this topic at your request and will keep you updated on work to improve the notifiable infectious diseases system.

Appendix One: List of notifiable infectious diseases

Part 1 – notifiable infectious diseases

Section A – infectious diseases notifiable to the Medical Officer of Health and local authority

- Acute gastroenteritis
- Campylobacteriosis
- Cholera
- Cryptosporidiosis
- Giardiasis
- Hepatitis A
- Legionellosis
- Listeriosis
- Meningoencephalitis—primary amoebic
- Salmonellosis
- Shigellosis
- Typhoid and paratyphoid fever
- Yersiniosis

Section B – infectious diseases notifiable to the Medical Officer of Health

- Anthrax
- Arboviral diseases
- Brucellosis
- COVID-19
- Creutzfeldt Jakob Disease and other spongiform encephalopathies
- Cronobacter species
- Diphtheria
- Haemophilus influenzae b
- Hepatitis B
- Hepatitis C
- Hepatitis (viral) not otherwise specified
- Highly Pathogenic Avian Influenza (including HPAI subtype H5N1)
- Hydatid disease
- Invasive pneumococcal disease
- Monkeypox
- Mumps
- Neisseria meningitidis invasive disease
- Non-seasonal influenza (capable of being transmitted between human beings)
- Novel coronavirus capable of causing severe respiratory illness
- Pertussis
- Plague
- Poliomyelitis
- Q fever
- Rabies and other lyssaviruses
- Rheumatic fever
- Rickettsial diseases
- Rubella
- Severe Acute Respiratory Syndrome

Leprosy	Tetanus
Leptospirosis	Tuberculosis
Malaria	Verotoxin-producing or shiga toxin-producing Escherichia coli
Measles	Viral haemorrhagic fevers
Middle East Respiratory Syndrome	Yellow fever

Section C – infectious diseases notifiable to Medical Officer of Health without identifying information of patient or deceased person

Acquired Immunodeficiency Syndrome	Human Immunodeficiency Virus (HIV) infection
Gonorrhoeal infection	Syphilis