SPICe briefing

6 December 2007

07/65

PUBLIC HEALTH ETC. (SCOTLAND) BILL

KATHLEEN ROBSON

On 25 October 2007, the Scottish Government introduced the Public Health etc. (Scotland) Bill to the Scottish Parliament.

The Bill aims to modernise the legislative framework governing the practice of health protection as, at present, much of the statute dates back to the late 19th century.

The Bill includes provisions regarding:

- clarifying the roles and responsibilities of NHS boards and local authorities
- a new system of statutory notification for diseases, organisms and health risk states
- powers for public health investigators
- orders for medical examination, quarantine, exclusion, restriction and hospital detention
- the Implementation of International Health Regulations
- information on the health effects of sunbeds
- changes to the statutory nuisance regime
- offences and penalties for non-compliance with aspects of the Bill

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SUMMARY OF THE BRIEFING

- The Bill aims to modernise the legislative framework for public health in order to adequately meet modern day public health challenges. The provisions within the Bill relate mainly to the sub-discipline of public health called 'health protection' i.e. protecting the public from communicable diseases and health hazards (e.g. radiation, chemicals, poisons).

- Few of the provisions within the Bill relate to entirely new functions. Instead most provisions aim to update and clarify the existing public health powers and duties.

- At present the responsibility for health protection is broadly divided between NHS boards and local authorities. NHS boards take responsibility for medical matters while local authorities are responsible for environmental health concerns.

Organisational Authority (pp7-9)

- The Bill proposes to clarify the responsibilities of NHS boards and local authorities by giving the NHS the responsibility for people, and local authorities the responsibility for premises and things that pose a public health risk. The Bill would require the functions assigned to NHS boards and local authorities to be carried out by "competent persons" and both organisations would have a duty to cooperate. Boards and local authorities would also be required to produce joint health protection plans.

Statutory Notifications (pp9-12)

- The Bill proposes to introduce a new system of notification for communicable diseases and organisms. There would be one list for notifiable diseases and another for notifiable organisms. The Bill also introduces the concept of 'health risk states' which would also be notifiable. This would be where a person was known or suspected to have been exposed to a highly pathogenic infection, contamination, poison or other hazard. There would be a duty on medical practitioners to notify the authorities of any relevant disease or health risk state, as well as a duty on directors of laboratories (public and private) to report any relevant organism.

Public Health Investigations (pp12-14)

- The Bill proposes to introduce powers for investigators of public health incidents. These powers would include powers to enter premises, to take samples, measurements and other relevant recordings, to ask questions and to require the production of records. Powers of entry would normally be used with the consent of the owner/occupier or with a warrant, but could be used in an emergency without either.

Functions of NHS Boards – Exclusion, Restriction, Quarantine, Removal and Detention Orders (pp14-17)

- The Bill proposes to transfer a number of existing powers from local authorities to NHS boards and to extend and add to the powers available to manage public health incidents and outbreaks. The functions of NHS boards would include the ability to obtain an order from a sheriff to have persons medically examined, quarantined or removed and detained in hospital if they were thought to pose a significant public health risk. A health board competent person may also issue an order excluding a person from certain places or restricting the activities they undertake. With the exception of a medical examination order, an individual would be able to appeal any of these orders. The NHS would be responsible

for compensating anyone who had suffered a financial loss as a result of being subject to certain orders.

Functions of Local Authorities (pp17-18)

- The functions assigned to local authorities by the Bill already exist in legislation and pertain to premises and things that pose a public health risk. These functions include the provision of equipment and facilities for disinfection, disinfestations and decontamination and the power to serve notices to cleanse premises.

Mortuaries (pp18-19)

- The Bill would assign a duty to provide (or ensure the provision of) mortuary and post-mortem facilities to both local authorities and NHS boards. NHS facilities would be used for deaths in hospitals and local authorities for all other deaths.

International Health Regulations (pp19-20)

- The Bill would give Ministers the power to make regulations necessary to implement any obligations from the International Health Regulations. These regulations are aimed at containing the threat from diseases that may spread internationally.

Sunbeds (pp21-23)

- Currently, sunbed premises are not subject to any regulation. The incidence of skin cancer in Scotland has been rising in recent decades and research has linked skin cancer with the use of sunbeds by those in their teens and twenties. The Bill would give Ministers the power to make regulations requiring operators of sunbed premises to provide information on the health effects of sunbeds. If the Bill passes stage 1, this provision is likely to be amended at stage 2 by the Scottish Government (in collaboration with Kenneth MacIntsoh MSP, who lodged a proposal for the Sunbed Licensing (Scotland) Bill), to introduce a package of measures related to the regulation of sunbeds.

Changes to the Environmental Protection Act 1990 (pp23-24)

- The Bill proposes to amend the list of statutory nuisances by adding insects, artificial light and land covered in water that is prejudicial to health. Ministers would also be given a power to make regulations to add to the list. The Bill would also introduce the option of fixed penalty notices for enforcing abatement notices.

Offences and Penalties (pp24-25)

- The Bill proposes to create a number of offences which may be punishable by fines or imprisonment. These offences would include the failure of a Laboratory Director to notify the relevant authorities of a notifiable organism; the failure of a person to comply with the requirements of a public health investigation and for the breach of a public health order (i.e. quarantine, exclusion, restriction orders).

Financial Memorandum (p25)

- The memorandum identifies the main costs as arising from the transfer of functions from local authorities to the NHS (i.e. from the various public health orders and the duty to compensate). The main savings from the Bill are identified as those which would occur as a result of abolishing the fees paid to medical practitioners for notifications.

INTRODUCTION

On 25 October 2007, the Scottish Government introduced the Public Health etc. (Scotland) Bill [as introduced] Session 3 (2007) to the Scottish Parliament. One of the key policy objectives of the Bill is to modernise the legislative framework in recognition of changes in public health challenges.

'Public health' is often defined as:

> *"The science and art of preventing disease, prolonging life and promoting health and wellbeing through the organised efforts of society"* (The Acheson Committee Report 1988)

Despite the Bill using the more generic term 'public health' in the title, its provisions relate predominantly to 'health protection'. Health protection is a branch of public health, tasked with protecting the public from communicable diseases and external health hazards (e.g. biological, chemical or radiological).

As a result of a number of high profile public health incidents, and issues regarding how they were handled, a review of the adequacy of existing public health legislation was prompted which culminated in the present Bill. Few of the provisions in the Bill relate to entirely new functions. Most of the provisions are aimed at replacing and updating the existing powers and duties of the Scottish Government, NHS boards and local authorities, some of which date back to the late 19th century.

STATUTORY FRAMEWORK

At present the main statutory responsibility for protecting and promoting public health is broadly divided between NHS boards, local authorities and Scottish Ministers, although there are a number of other bodies charged with specific public health functions (e.g. Scottish Environmental Protection Agency, Health Protection Scotland). The Public Health (Scotland) Act 1897 (c. 38) initially gave local authorities the powers and duties in relation to protecting public health although, following the creation of the NHS, subsequent legislation provided complementary powers and duties to Scottish Ministers and NHS boards. The main pieces of legislation that the Bill proposes to repeal in their entirety are:

- The Infectious Diseases (Notification) Act 1889 (c. 72)
- The Public Health (Scotland) Act 1897 (c. 38)
- The Public Health (Scotland) Amendment Act 1907 (c. 30)
- The Public Health (Scotland) Act 1945 (c. 15)

BILL CONSULTATION

The proposals in the Bill originate from the deliberations of the 'Public Health Legislation Review Group' which was convened by the Scottish Executive to review the current legislation and consider whether or not it is able to meet modern public health challenges. The proposals of the review group were set out in a national consultation (Scottish Executive 2006) and presented at seminars which were held across the country. The analysis of responses to the consultation and the seminars was published in March 2007 (Scottish Executive 2007).

After taking into consideration the findings of the consultation, further consultation was undertaken by the Scottish Executive to clarify and refine the proposals. This involved seeking

the views of a 'Public Health Legislation Reference Group' (established by the Scottish Executive) which consisted of various stakeholders such as representatives of health protection professions, local authorities and the NHS. The group's views were sought prior to the drafting of the Bill but responses from its members are not readily available.

BRIEFING STRUCTURE

The following sections detail the main provisions of the Bill and outline the present situation with regards to the particular issue it is dealing with. These sections do not strictly follow the structure of the Bill as it is laid out. Instead it is structured in a way that loosely groups together the related parts. In addition, the briefing is only intended to cover the main provisions of the Bill as opposed to being a comprehensive overview of all provisions.

At the time of writing, the Health and Sport Committee's call for evidence is still open. As a result, reaction to the Bill is not available and, as proposals have changed, the national consultation gives limited insight into where there may be areas of contention or consensus.

However using the Scottish Executive consultation analysis, this briefing will aim to outline if the Bill is in line with the consultation findings or where there are issues that may warrant further scrutiny. For example, where proposals are new or different, or where the majority view in the consultation has not been reflected in the Bill.

ORGANISATIONAL AUTHORITY

PRESENT SITUATION

The day to day management of health protection matters is split between NHS boards and local authorities. NHS boards are generally responsible for medical services and local authorities for environmental health matters.

Within NHS boards, most staff responsible for health protection will be employed within a department of public health under the auspices of the Director of Public Health. A large proportion of the staff will be medically trained consultants in public heath medicine, and within this discipline there will be a number of Consultants in Communicable Diseases and Environmental Health. These consultants will be tasked specifically with the role of health protection and many act in the role of Designated Medical Officer (DMO) to advise local authorities on medical matters.

The main local authority resource for health protection consists of Environmental Health Officers. The principal areas within Environmental Health include food safety and standards, occupational health and safety, waste management and pollution control.

The Local Government (Scotland) Act 2003 (asp. 1) placed a duty on key public sector agencies to participate in 'community planning'. This also included the requirement for local authorities and NHS boards to develop Joint Health Improvement Plans.

In relation to the specific function of managing public health incidents, again this generally falls to NHS boards and local authorities. For something deemed an actual or potential major incident, then the Police have responsibility for the overall co-ordination of those involved in responding, while non-major incidents would be handled locally by the NHS and local authorities. In the case of non-major incidents, an Incident Control Team (ICT) would be convened and a DMO within the NHS board normally has the responsibility for chairing the ICT.

They would also lead the NHS board's response and co-ordinate that of other agencies. Membership of the ICT would depend on the nature of the incident (Scottish Executive 2003).

The consultation document outlined that while the current arrangements had generally worked well, there had been occasions when there was disagreement between bodies about the correct course of action to take. As a result the Scottish Executive sought views on whether the roles and responsibilities of NHS boards and local authorities needed to be clarified.

BILL PROVISIONS

Part 1 of the Bill starts by giving Scottish Ministers, NHS boards and local authorities a duty to continue to protect public health. The Bill defines 'protecting public health' as:

> *"[T]he protection of the community, or any part of the community, from infectious diseases, contamination or other such hazards which constitute a danger to human health and includes the prevention of, the control of and the provision of a public health response to such diseases, contamination or other hazards" (section 1(2))*

The provisions in Part 1 also state that the health board and local authorities should designate 'competent persons' to carry out the functions assigned to them (mainly in parts 4 and 5 of the Bill). Who is considered competent would be set out in regulations by Ministers.

Greater detail on the specific functions of NHS boards and local authorities are outlined in Part 4 and part 5 of the Bill. Essentially these parts of the Bill split the roles and responsibilities into people and premises. The Bill proposes to give NHS boards the responsibility for health protection measures related to people, and local authorities the responsibility for health protection measures related to premises and things that pose a public health risk. This division of responsibilities, and the provision for local authority and health board competent persons, would negate the need for the designation of medical personnel to work directly with local authorities (i.e. DMOs).

The Bill also proposes to give NHS boards and local authorities a duty to cooperate and to require health boards and local authorities to prepare joint health protection plans. The Bill would allow health boards to decide whether the plan should be a stand-alone document or part of another plan. Ministers would also have the power to intervene and direct NHS boards and local authorities.

CONSULTATION

Dividing Responsibility for People and Premises

The Bill would divide the responsibility for people and premises between NHS boards and local authorities. This proposal brought about some conflicting views in the consultation. Of those who commented, 51% were in favour, 30% against and the remainder did not explicitly make their view known. Of those in favour, comments included that it would provide greater clarity and was a logical and practical division, although some expressed provisos such as the NHS needing more resources.

Those against commented that it is an over-simplistic split and does not represent the situation on the ground. Some also felt that not a strong enough case has been made for changing the current arrangements and the current flexibility was valuable. One other concern expressed was that it could erode accountability as it would remove powers from an elected body and place them with an appointed body.

Replacing the Role of Designated Medical Officer

Due to the way in which the Bill's provisions would split the responsibilities for people and premises, there would no longer be a need for DMOs to provide support to local authorities on medical matters. Of the 56% of respondents who addressed the question in the consultation of whether the post should be retained, 73% were in favour of keeping the post of DMO as they felt it was:

- crucial to maintaining close partnership working
- important to retain the formal avenue of unsolicited advice to local authorities
- valuable to have one person known to the public with a professional responsibility for public health, viewed as more trustworthy than an organisation

However, comments from those against included that Health Protection Plans would make the role of DMO redundant as they would provide sufficient clarity on which post holders should take the lead in different circumstances. Others also thought that the post should be repealed in favour of 'competent persons' and in light of health boards taking on responsibility for issues relating to people.

The proposed content of the regulations which will set out the classes of person, qualifications and experience of local authority and NHS board 'competent persons' will be made available by the Scottish Government for scrutiny at Stage 2 of the Bill (Scottish Government 2007).

NOTIFICATION OF INFECTIOUS DISEASES, HEALTH RISK STATES AND ORGANISMS

PRESENT SITUATION

Notifications of infectious diseases and organisms are an important aspect of health protection as adequate surveillance flags up potential public health threats and allows for a timely response.

In Scotland at present, there are two lists of notification, one statutory and one non-statutory. NHS boards feedback notifications to Health Protection Scotland which compiles a weekly surveillance report. The statutory list dates back to the Infectious Diseases (Notification) Act 1889. This Act allows for diseases to be added to the list but does not allow for their removal. At present there are 33 diseases which are notifiable under the 1889 Act. General practitioners are usually paid a fee for each notification they provide, with the majority of notifications being made for chicken pox and food poisoning (Health Protection Scotland 2007).

The non-statutory list has been in existence since 1974. This list is for reportable organisms which have been confirmed in a laboratory. However, notification is not statutory and is only undertaken by NHS-affiliated laboratories and not laboratories who undertake private work.

BILL PROVISIONS

Part 2 of the Bill proposes to create two new lists, one for notifiable diseases and the other for notifiable organisms. The lists are outlined in Schedules 1 and 2 of the Bill and unlike the present statutory list, the proposed lists and all aspects of notification would be amendable by regulations.

Notifiable Diseases and Health Risk States

The Bill wishes to place a duty on all medical practitioners to notify the relevant health board in writing if they suspect that a patient has a notifiable disease (as listed in Schedule 1). The Bill provides a 3 day time limit for this but if the medical practitioner considers the case is urgent then they must, as soon as is reasonably practicable, notify the NHS board orally. Deciding which cases are urgent would be left to the discretion of the medical practitioner although the Bill does set out the rough criteria for determining those that are urgent (s13(4)):

- the nature of the disease
- the ease of transmission of the disease
- the patient's circumstances (including age, sex and health)
- any guidance issued by Scottish Ministers

The Bill also introduces the concept of a 'health risk state' and wishes to place a duty on registered medical practitioners to notify the relevant health board in writing, within 3 days, if they suspect that a patient has been exposed to a 'health risk state'. The Bill defines a health risk state as an individual who has come into contact with or been contaminated by

a) a highly pathogenic infection; and
b) any –
    i) contamination;
    ii) poison
    iii) other hazard

It would also apply to people who had been in physical contact with or contaminated by another person deemed to have been exposed to a health risk state.

As with notifiable diseases, if the practitioner considers the case to be urgent then they must, as soon as is reasonably practicable, orally inform the relevant health board.

Notifications received by an NHS board would be forwarded to the Common Services Agency (CSA) (the legal entity of Health Protection Scotland) within the week in which the information is received, or as soon as practicable thereafter. The return should contain information such as the suspected disease or health risk state, the patient's NHS identifier, postcode, occupation, sex and date of birth. Notification would not require the consent of the individual as it would be a statutory duty for a medical practitioner to notify the relevant authorities. The Bill would also discontinue the fee paid to medical practitioners for notifications.

The list excludes Sexually Transmitted Infections (STIs) (including HIV), although all the Hepatitis viruses, however transmissible, (which may include sexual and intravenous drug use) will be notifiable. Non-communicable diseases, such as Coronary Heart Disease, will also not be notifiable. Diseases that were previously notifiable that would no longer be, include Chicken Pox, Lyme Disease and Food Poisoning (although the relevant organisms will be notifiable from laboratories), while new additions include Severe Acute Respiratory Syndrome (SARS) and Necrotising Fasciitis.

Notifiable Organisms

Section 16 would place a duty on the Director of all diagnostic laboratories to notify the local health board and the CSA of confirmed notifiable organisms within 10 days of identification. If the case is considered 'urgent' then the Director must notify the health board and CSA orally, as soon as it is reasonably practicable. They must provide an explanation of why the case is

considered urgent as well as the information expected of any typical notification (i.e. patient details and type of organism).

This provision would signify a change from the current situation whereby only NHS-affiliated laboratories comply with the non-statutory list of reportable organisms. The provision would mean that laboratories which undertake work for private businesses would also have to report those results centrally.

The list of organisms is outlined in Schedule 2 and contains a range of organisms of varying clinical seriousness. The schedule also includes:

> *"Any other clinically significant pathogen found in blood"*

Section 17 would make it an offence for a diagnostic laboratory to fail to comply with the duties set out in S16. See Offences and Penalties for more information.

CONSULTATION

The consultation proposals in relation to the notification lists differ from what is set out in the current Bill due to further work with key stakeholders on feasibility. Much of the detail of this part stems from the deliberations of a short-term expert working group, the outcomes of which were circulated to the Public Health Legislation Reference Group for consultation. As a result, some issues discussed in the consultation are not included in the Bill and some provisions now in the Bill were not discussed in-depth during the consultation e.g. the concept of a 'health risk state'.

The following also outlines issues included in the Bill where the majority view on the consultation proposals has not been reflected in the Bill.

Notification of Non-Communicable Diseases

One of the proposals put forward in the consultation was to have a separate statutory notification system for non-communicable diseases. Of those who gave a clear indication of their view, 62% were in favour of the proposal and 32% were against. However this has not been included in the Bill.

Comments in favour included that reporting such information is vital and would aid detection and control of such diseases. One respondent likened it to the Cancer Registry and highlighted that reliable cancer registrations are vital for monitoring the effectiveness of the Cancer Strategy and other policies. A general proviso that was expressed by many was that there would need to be assurances on the confidentiality of the data.

Those against felt that it raised serious ethical, human rights and data protection issues, and also that it could diminish the public's trust in medical confidentiality. Some felt that as they would be chronic conditions they are not a health protection issue and there is no need for urgent reporting. Others mentioned that there are existing systems in place for data collection and therefore it could be a duplication of effort and a waste of resources.

Notification of Sexually Transmitted Infections

The Bill does not include Sexually Transmitted Infections (STIS), including HIV, in the notification list, although it does include the Hepatitis viruses which may be transmitted sexually. The question as to whether STIs should be notifiable was addressed in the consultation, with 59% agreeing that they should.

Comments given in support of including STIs included that any infection which causes a significant burden of morbidity and mortality should be included and that it is important to have a comprehensive system which is not undermined by opt-outs.

Those against felt that there was already an abundance of data on STIs and HIV. Others felt that the public may worry over the confidentiality of the information and it may discourage people from presenting for diagnosis, therefore having an overall detrimental effect on the surveillance system. Others also commented that there did not appear to be any clear health benefits for including STIs in the notification system.

PUBLIC HEALTH INVESTIGATIONS

PRESENT SITUATION

Current public health legislation contains no provisions governing the investigation of public health incidents. Practice in this area is covered by Scottish Executive guidance (Scottish Executive 2003) although there are some statutory powers for investigations contained within food standards, health and safety, and environmental health legislation.

BILL PROVISIONS

The Bill defines a public health incident as existing if there are reasonable grounds to suspect that there is a significant risk to public health from any of the following circumstances:

- a person has (or is suspected to have) an infectious disease
- a person has (or is suspected to have) been exposed to an organism which causes infectious disease
- a person has (or is suspected to have) been contaminated
- a person has (or is suspected to have) been exposed to a contaminant
- any premises or thing in or on such premises has (or is suspected to have) been infected, infested or contaminated

If any of the above circumstances were evident then a public health investigation could be undertaken to establish the cause(s). The Bill does not set out who an investigator should be, other than to say they may be appointed by one or more of the following; Ministers, an NHS board, the Common Services Agency (i.e. Health Protection Scotland) and a local authority. It then sets out what powers an investigator would have.

Powers of Entry and Public Health Investigation Warrants

The Bill would allow an investigator to enter premises 'at any reasonable time' if they believe it is necessary as part of the investigation. If the premise is a dwellinghouse[1], the investigator must provide 48 hours notice to the occupier and obtain their consent for entry. An individual suffering loss or damage as a result of an investigator gaining entry, would be entitled to compensation from whoever appointed the investigator.

If entry is refused, likely to be refused or if the occupier is absent and the situation is urgent, the investigator may make an application to a sheriff or justice of the peace for a warrant to enter the premises. A warrant may also be granted if seeking admission to the premises 'would defeat the object of the public health investigation' (s27(1)(e))

[1] Any premises or part of premises which are wholly or mainly occupied as a person's dwelling (s26(4))

Section 28 of the Bill also proposes that in emergency situations a public health investigator, with reasonable grounds, has the power of entry to any premises (including dwellinghouses) which may be exercised at any time, without a warrant and could include the use of reasonable force. They would also be able to exercise any of their other powers during an emergency. An emergency is defined in the Bill as when there is deemed to be a significant risk to public health, and the nature of that risk is such that immediate action is necessary:

i to verify the existence of the risk;
ii to ascertain the cause of the risk; or
iii to take action to prevent, or prevent the spread of, infectious diseases or contamination

An investigator would also be allowed to take any other person that they authorise, as well as any equipment or materials they require. If the investigator expects their access to be obstructed then they would be able to take a police constable.

Other Investigatory Powers

Section 23 of the Bill sets out proposals that would allow an investigator to undertake various actions such as the taking of samples, photographs and recordings. It would also allow an investigator to take and detain any article or substances found in premises being investigated in order to examine them, ensure they are not tampered with before examination and also for evidence in any legal proceedings. An investigator would also be allowed to dismantle or test any article or substance, but not to damage or destroy it unless necessary. If an article damaged or destroyed in the course of an investigation is found not to be the cause of the public health incident, compensation for the article would be paid by the person who appointed the investigator.

The investigator could also require the production of records for inspection and copying, unless the document is subject to legal privilege.

Section 24 of the Bill would give an investigator the power to ask questions of any person thought to have information relevant to the investigation and to require that person to answer the questions. The individual being questioned would be allowed to have one other person present during questioning although their answers would be not be admissible in evidence during any criminal proceedings.

Scottish Ministers would be able to amend the powers of an investigator by regulation.

There are also offences associated with this part of the Bill. These are set out in more detail in the section ‘Offences and Penalties’.

CONSULTATION

Some of the provisions within the Bill relating to public health investigations were not addressed in the consultation e.g. appointment of investigators, powers of entry. Much of the consultation on public health investigations focused on the inclusion of a duty for a person to divulge information during a public health incident or outbreak, and appropriate appeal mechanisms.

The majority of respondents agreed with the inclusion of such a duty and appeared to support some kind of appeal mechanism. The Bill as introduced does not contain a specific duty to divulge information although it contains provisions giving investigators the power to require a person to answer questions and to require the production of any records considered necessary

for the investigation. The Bill does not contain a specific appeal mechanism against this provision.

FUNCTIONS OF HEALTH BOARDS - EXCLUSION, RESTRICTION, QUARANTINE, REMOVAL AND DETENTION ORDERS

PRESENT SITUATION

As stated previously, the Bill would divide responsibility for people and premises between health boards and local authorities. Part 4 of the Bill therefore, details the functions specific to health boards in relation to people. Some of the powers set out in this part of the Bill currently rest with local authorities and therefore the Bill would reassign them to the NHS. However, some of the provisions are new or an extension of existing powers and could impose new restrictions on civil liberties.

Current powers in relation to the movements and treatment of people during a public health incident are fairly limited and rarely used. They include the power to remove and detain sick people in hospital where they pose a risk to public health, the exclusion of children and people with infectious diseases from school and work and quarantining people on aircraft and ships thought to have specific diseases.

Quarantine powers are available in other countries and most notably were used in incidents like the SARS outbreak in Canada. It would appear that models of quarantine differ from country to country, for example, some countries such as Australia limit quarantine to specified diseases as opposed to having a general power to quarantine anyone posing a public health risk. Many countries are in the process of modernising their quarantine legislation and England and Wales also recently published the Health and Social Care Bill [Bill 9] (2007) which contains similar provisions to those proposed in the Scottish Bill.

BILL PROVISIONS

Firstly, in carrying out any of the functions outlined in Part 4, the Bill sets out that the NHS board has a duty to explain to the person on whom the action is being carried out that there is a significant risk to public health, the nature of that risk and why the action is deemed necessary.

The specific actions proposed in the Bill include:

- powers to medically examine people
- powers to exclude people from certain places
- powers to restrict the activities of people
- powers to quarantine people
- powers to remove people to, and detain them in, hospital

Actions that can be carried out by the NHS board under this part of the Bill are explained in greater detail below. These orders would only be used in situations where an individual had not voluntarily consented to the action and anyone subject to an order outlined below (with the exception of a medical examination order) would have the right of appeal to a Sheriff. There are also offences associated with this part of the Bill (see Offences and Penalties for more details).

The Bill does not contain any provisions that would impose medical treatment on an individual against their will.

Medical Examination Orders

The Bill would allow NHS boards to apply to a sheriff for an order to medically examine a person (or groups of people) because they are known or suspected to have:

- an infectious disease,
- been exposed to an organism which causes disease,
- been contaminated, or
- been exposed to a contaminant

and, it appears to the NHS board that there is, or may be, a significant risk to public health and it is necessary to avoid or minimise that risk for the person to be medically examined. This power already exists under the Health Services and Public Health Act 1968 but according to the policy memorandum to the Bill is very rarely used (Para 50).

In the application, the board must explain the reason why the examination is felt necessary, the nature of the examination proposed and the class of health care professional who will carry it out. The application must be supported by a certificate from a 'health board competent person' stating that the criteria outlined above have been met.

If an order is granted the health professional charged with carrying out the examination must use the least invasive and intrusive examination necessary. Various procedures set out in S35(2) of the Bill are specifically deemed to be 'non-invasive' (e.g. external collection of urine, faeces or saliva, blood pressure measurement, examination of the ear, nose or mouth).

The policy memorandum outlines that this power would be used in circumstances where ascertaining the cause of a person's illness may help ensure that further action to reduce risk to public health is appropriate and proportionate. There would be no right of appeal against a medical examination order due to the nature of the urgent circumstances in which it would be used.

Exclusion and Restriction Orders

The Bill wishes to extend the exclusion powers that are currently limited to those attending school or work. Under the Bill, if a person was thought to pose a significant risk to public health (due to that person having an infectious disease; being exposed to such a disease; being contaminated; or exposed to a contaminant) then a health board competent person may issue an exclusion order prohibiting that person from entering or remaining in any specified place, with the exception of their place of residence.

Similar provisions apply to restriction orders and in the same circumstances, a health board competent person may make an order prohibiting a person from carrying out any activity in order to minimise the public health risk. The competent person issuing either type of order may also impose any other conditions as they consider appropriate and vary the order if they consider it appropriate. The health board would also have a duty to keep any order under review.

Quarantine Orders

The Bill contains new proposals for quarantine powers. At present, the only powers of quarantine relate to aircraft and ships and can only be used for a limited number of diseases. The Bill proposes a more general power that, where a person was thought to pose a significant risk to public health (due to that person having an infectious disease; being exposed to such a disease; being contaminated; or exposed to a contaminant), then the NHS board may apply to a

sheriff for a quarantine order. The Bill does not contain a definition of 'quarantine' other than to say that references to 'quarantined' are:

> *"[R]eferences to the person being detained in that person's residence or in another place (not being a hospital)" (s39(4))*

The policy memorandum states that the decision to seek a quarantine order 'would not be taken lightly' but would be sought if the individual did not voluntarily comply (Para 59).

If satisfied of the need for quarantine, the sheriff may grant an order authorising the quarantining, the removal of the person to the appropriate place and any necessary disinfection, disinfestation and decontamination. Other conditions imposed in the order could include who can have access to the place and person quarantined, and the purpose of that access. The order would initially be for 3 weeks but an NHS board may apply to a sheriff for an extension if the person is deemed to still pose a public health risk. However, the NHS board would also have a duty to keep the order under review and the individual would have the right of appeal at each stage.

Removal and Detention Orders

The Bill proposes that if a person was thought to pose a significant risk to public health (due to that person having an infectious disease; being exposed to such a disease; being contaminated; or exposed to a contaminant), then the health board may apply to a sheriff for an order to have the person removed to, and detained in, hospital. This power already exists and would be used in circumstances where a person could not be effectively quarantined outwith hospital, for example, if they share a residence. An order may also authorise a person to be disinfected, disinfested or decontaminated

Detention would be for a period not exceeding 3 weeks, although the Bill also contains provisions that would allow for the longer-term detention of an individual in hospital if that person continues to pose a significant public health risk. The NHS board would have a duty to keep the order under review and the individual would have the right of appeal at each stage.

Compensation

The Bill sets out that an NHS board must compensate a person who has voluntarily agreed to quarantine, exclusion or restriction of activity and as a result has suffered a financial loss. A board may also compensate any other person who has suffered a loss as a result of those subject to quarantine, exclusion or restriction (e.g. carers). Those who are the subject of exclusion, restriction or quarantine orders (i.e. who have not voluntarily complied) *may* be compensated for proven loss.

CONSULTATION

Most of the provisions within this part of the Bill met with the approval of the consultation respondents, however the following summarises areas that may be of further interest.

Application of Quarantine Orders

The consultation posed specific criteria of when quarantine may be used, namely where a disease has a high mortality rate, is spread from person to person through casual contact, is highly infectious and cannot reasonably be controlled by means other than quarantine. The report on the consultation stated that all respondents who addressed this question agreed with the criteria to some extent. However, the Bill provisions could be seen to differ from what was in

the initial consultation. In the Bill, the criteria for applying to a sheriff for an order would be where a health board knows or suspects that a person who is present in that board's area:

i has an infectious disease;
ii has been exposed to an organism which causes such a disease;
iii is contaminated; or
iv has been exposed to a contaminant; and

it appears to the board that as a result –

i there is or may be a significant risk to public health; and
ii it is necessary, to avoid or minimise that risk, for the person to be quarantined

Given that the Health and Sport Committee's call for evidence has not concluded, it is, as yet, unknown whether the criteria above will be received in the same way as the initial proposals.

Transfer of Compensation Duty to the NHS

The Bill proposes to transfer to the NHS the duty to pay compensation to those who have suffered a financial loss as a result of measures such as quarantine, exclusion and restriction. This duty is presently situated with local authorities for the provisions that already exist to some extent (e.g. exclusion from work).

17% of respondents opposed this proposal, arguing that the NHS has no experience of such payments or systems in place and it should be the responsibility of other agencies more suited to the task (e.g. Department of Social Security). Others argued that it could result in a conflict of interest if the NHS was responsible for both the decision to apply an order that may lead to a loss, and paying the subsequent compensation for that loss.

However, the majority of respondents favoured this transfer if the responsibility for powers in relation to people were also to be transferred to the NHS.

FUNCTIONS OF LOCAL AUTHORITIES

PRESENT SITUATION

Most specific functions pertaining to public health currently rest with local authorities as the legislation pre-dates the existence of the NHS. However, as outlined previously, the Bill wishes to split the responsibility for people and premises between health boards and local authorities in order to clarify roles and lines of accountability. Part 5 of the Bill therefore complements part 4 (which sets out the functions of health boards) in that it specifies those functions related only to premises and things which pose a public health risk, and confers them on local authorities. The provisions in this part of the Bill are not new and will update provisions found in the legislation that would be repealed by the Bill.

BILL PROVISIONS

Provision of Facilities and Equipment

Section 67 states that local authorities must provide or ensure the provision of facilities and equipment for disinfection, disinfestation and decontamination of premises and things which are infected, infested or contaminated. They must also provide or ensure the provision of facilities

and equipment for the destruction of infected or contaminated things and the means for transporting things to such facilities.

Mobile facilities would also be suitable and any service need not be physically located within the local authority area responsible.

Notice to Disinfect, Disinfest and Decontaminate

Sections 68-74 deal with the cleansing of infected and contaminated premises, both private and commercial.

If the local authority knows or suspects that any premises in its area, or things within such premises, are infected, infested or contaminated, then with the purpose of preventing infection or contamination, they would have the powers to serve notice on the occupier or owner of the premises, requiring them to disinfect, disinfest or decontaminate the premises or things on or in the premises. Such things may also be destroyed.

The notice would need to be certified by a local authority competent person that the steps were necessary. Once a notice had expired, an 'authorised officer' (not specified in the Bill) would also be allowed to inspect the premises on which the notice was served to ensure compliance.

The local authority may also undertake any disinfection, disinfestation or decontamination on behalf of the owner or occupier of the premises. However, if the owner or occupier does not carry out the work themselves or allow the local authority to carry out the work, the local authority may apply to a sheriff or justice of the peace for a warrant to enter the premises and undertake the work.

Local authorities would be liable to pay compensation for any unnecessary damage caused while exercising these powers.

CONSULTATION

Aside from the proposal to remove from local authorities the responsibility for public health issues related to people, the consultation did not seek views on the specific functions proposed for local authorities. However, the consultation did ask whether the various provisions within the 1897 Act should be retained and updated, to which the majority agreed.

MORTUARIES

PRESENT SITUATION

The 1897 Act provides that local authorities *may* provide mortuaries, as well as make byelaws with respect to the management and charges for their use. As a result, neither local authorities nor the NHS have a statutory duty to provide or ensure their provision, and arrangements differ across the country. At present there are just two city mortuaries owned and operated by local authorities (Aberdeen and Edinburgh), while another two former local authority city mortuaries are owned and operated by the police (Glasgow and Dundee). Elsewhere, the NHS is the main provider of mortuary and post-mortem facilities and is paid a fee for their use.

BILL PROVISIONS

Provision of Mortuary Facilities

Section 82-84 of the Bill would give both local authorities and NHS boards a duty to provide, or ensure the provision of, mortuary and post-mortem facilities for their area. The Bill would also place a duty on both organisations to cooperate when meeting this duty.

However, the Bill does make a distinction between the two duties as it sets out that NHS board facilities would be used for deaths that occurred in hospital (or occurred elsewhere but were subsequently brought to hospital), while local authority facilities would be used for all other deaths.

Local authority mortuary facilities may be located outwith the area of the authority responsible for providing them.

Public Health Risk Arising from Bodies

Sections 85-88 relate to the handling of bodies of people who have died of an infectious disease, or who were infectious or contaminated before death and would therefore be considered a public health risk. In such circumstances, an NHS board could authorise that the body must not be released without its written permission and must only be released for immediate disposal.

The Bill also gives NHS boards a duty to inform those handling bodies (e.g. undertakers) of any potential health risks so that they can take necessary precautions to reduce the risk to themselves and others.

If a body is retained within premises and therefore posing a public health risk, a local authority would be able to apply to a sheriff for an order to remove the body and dispose of it by burial or cremation.

CONSULTATION

The Bill would give a duty to both the NHS and local authorities to provide mortuary and post-mortem facilities. However, the consultation initially proposed to give this duty solely to the NHS, with the majority of respondents in favour of this. However, further consultation was undertaken with the Public Health Legislation Reference Group (which included all Chief Executives of local authorities and NHS boards) as it was felt that the proposals set out in the consultation did not adequately reflect the complexities of current mortuary provision[2]. A number of alternatives were proposed to members of the reference group, but the proposals in the Bill have not been subject to consultation beyond this group.

INTERNATIONAL HEALTH REGULATIONS

PRESENT SITUATION

The International Health Regulations (IHR) are legally binding regulations adopted by most countries in a bid to contain the threat from diseases that may spread rapidly internationally. Such diseases include emerging infections like SARS, or a new strain of the human influenza virus. They also cover threats from other sources that may affect populations across borders

[2] Communication to the Public Health Legislation Reference Group

such as chemical hazards and radiation. As the UK is a signatory, Scotland is therefore required to implement the regulations.

The recent regulations (2005) are an update of the IHR 1969, which addressed just four diseases; cholera, plague, yellow fever and smallpox. These regulations focused on the control of these diseases at borders, whereas the newly revised regulations seek to contain health emergencies at the source.

The newly revised regulations were adopted by the World Health Assembly in May 2005, and came into force on 15 June 2007. They include all diseases and health events that may constitute a public health emergency of international concern. The regulations set out the rights, obligations and procedures for ensuring international health protection. They also require countries to improve national surveillance, reporting mechanisms and the capacity to respond.

BILL PROVISIONS

Section 89 of the Bill would provide Ministers with a general power to make regulations necessary for implementing any obligations arising from the IHR (2005). However, as noted in the policy memorandum, many other parts of the Bill could already be seen as seeking compliance with articles within the IHR (2005). For example, the new notification arrangements may meet the requirement to strengthen surveillance and the provisions relating to orders for medical examination and quarantine are also in line with the IHR (2005) provisions for travellers.

CONSULTATION

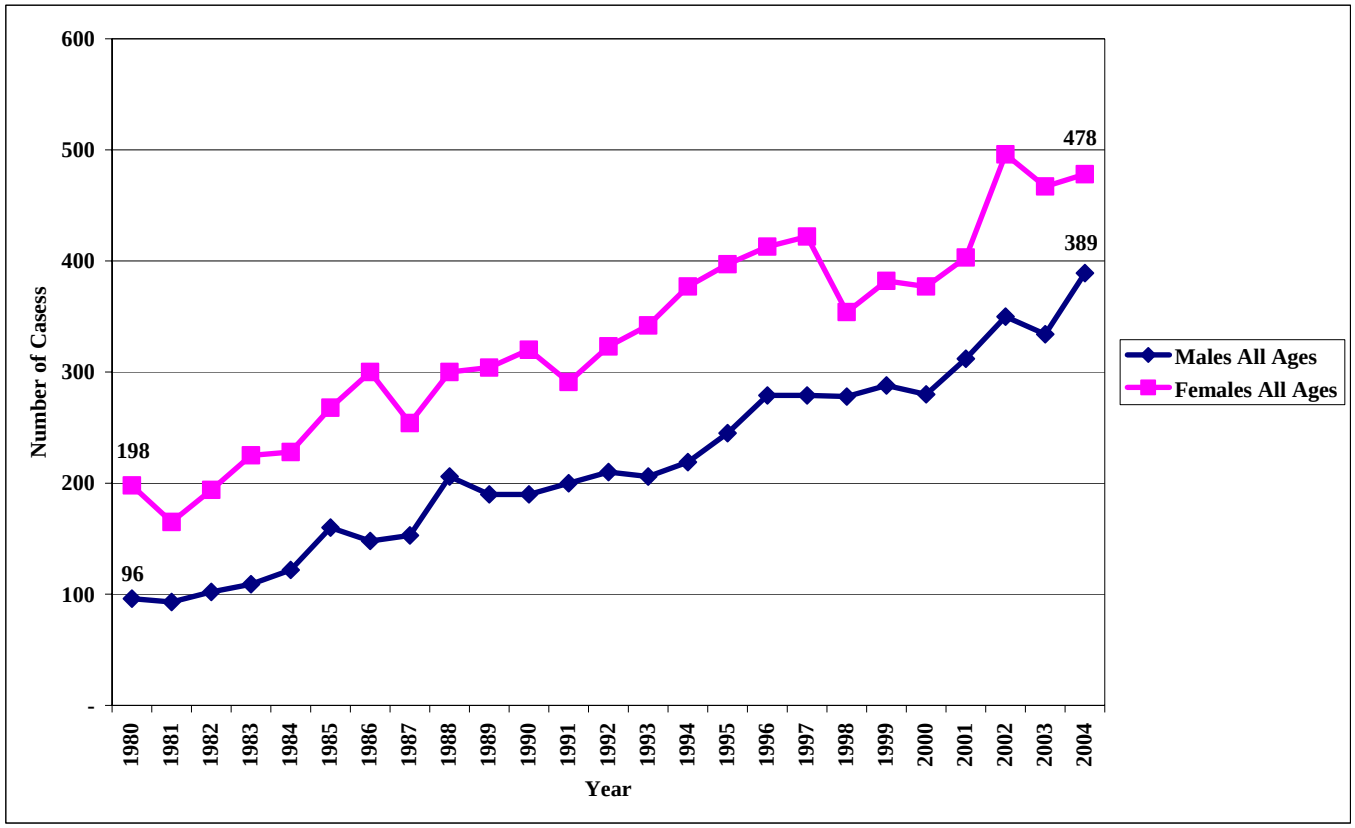
The IHR (2005) were not consulted on as part of the review of public health legislation. As part of the UK, Scotland is required to implement the regulations. The proposed content of the Regulations to be made under section 89 of the Bill to fully implement IHR 2005 would be available for parliamentary scrutiny at stage 2 of the Bill (Scottish Government 2007).

SUNBEDS

PRESENT SITUATION

In Scotland, the incidence of skin cancer has been rising in recent decades. The graph below shows the trend in incidence of malignant melanoma since 1980.

Figure 1: Number of Registered Cases of Malignant Melanoma by Sex and Year of Diagnosis, Scotland 1980-2004



Source: ISD Scotland

Factors that have been associated with this trend include an increase in foreign holidays and increased use of indoor tanning facilities.

In 1992, a working group convened by the International Agency for Research on Cancer (IARC - part of the World Health Organisation) conducted a review of the scientific evidence and concluded that solar radiation is carcinogenic to humans. However, the position with regards to artificial sources of UV radiation was uncertain and so the IARC established an international working group to ascertain the health effects, good and bad, of artificial sources of UV radiation. The report of the working group (International Agency for Research on Cancer – Working Group on Artificial UV Light 2007) concluded that:

- there is a clear increase in melanoma risk associated with the use of sunbeds in teens and twenties
- there is an increased risk of squamous cell cancer of the skin associated with use of sunbeds in teens
- the use of sunbeds can have a detrimental effect on the immune response of the skin and possibly on the eyes

- artificial tanning confers little, if any, protection against solar damage to the skin, nor does it grant protection against vitamin D deficiency

In 2005, prior to the publication of the above report, the WHO had already recommended that no-one under the age of 18 should use a sunbed.

Current Regulation of the Indoor Tanning Industry

At present, the indoor tanning industry is not subject to any form of statutory regulation, although under the Health and Safety at Work Act 1974, employers have a duty to protect members of the public on their premises. The main organisation representing the industry in the UK is the Sunbed Association, which operates a code of practice that members must comply with and undergo inspection against. As well as providing guidance on equipment safety and maintenance, the code of practice recommends against the use of sunbeds by fair skinned people and under 16s. It also requires that premises are supervised by appropriately trained staff. As a result, the Sunbed Association does not grant membership to unsupervised parlours. The association estimates that 20% of cosmetic sunbed premises in the UK are members of the Association, although this proportion may be lower in Scotland (The Sunbed Association 2007).

Indoor Tanning in Scotland

There is little information available on the use of sunbeds by Scots or the number of commercial premises in Scotland. However, in 2006, the Royal Environmental Health Institute for Scotland (2006) updated a survey of sunbed premises in Scotland and found that:

- there were 810 sunbed salons across the country in 2006 – 16 more than in 2003
- 44 premises were known to be unsupervised
- 8 councils had a local scheme in place to require registration or licensing of sunbed parlours – 3 intended to implement such a scheme and a further council stated a preference for a national scheme
- 4 local authorities permitted the use of sunbeds on council premises
- there were 49 complaints to local authorities with regards to sunbed parlours. These included complaints about burning and ‘underage’ use.

BILL PROVISIONS

The Bill proposes to give Ministers the power to create regulations that would require operators of sunbed premises to provide information to users on the health effects of sunbeds. However, this is a provision which the Scottish Government intends to build upon to introduce a package of measures at Stage 2 of the Bill, in collaboration with Mr Kenneth MacIntosh, MSP (Scottish Government, 2007).

CONSULTATION

This provision did not form part of the consideration of the legislation review group or the subsequent consultation.

However, in May 2007, Kenneth MacIntosh MSP lodged a proposal for a Sunbed Licensing (Scotland) Bill. The proposals within the Bill are more wide-ranging than the provisions contained within the Public Health (Scotland) Bill in that, for example, it also proposes to implement a licensing scheme for tanning premises. However, the Member’s Bill did contain a proposal to provide health risk information to users and this formed part of his consultation.

There were 54 responses to the consultation conducted by Kenneth MacIntosh in May 2006, a third of which thought one of the main benefits of his Bill would be enabling users to make informed decisions about sunbed use through the mandatory provision of health risk information. In relation to the proposed Bill in general, 77% of respondents were supportive of its proposals.

CHANGES TO THE ENVIRONMENTAL PROTECTION ACT 1990

PRESENT SITUATION

Things considered to be a statutory nuisance are set out in Part III of the Environmental Protection Act 1990 (c. 43) (s79(1)) and include smoke, fumes, gas and noise that are considered to be prejudicial to health or a nuisance.

The local authority is under a duty to inspect its area for any statutory nuisances and serve an abatement notice if they are satisfied a nuisance exists. A notice could require a person(s):

- to reduce or lessen the nuisance
- prohibit or restrict the nuisance
- to carry out other works or steps to abate the nuisance

Non-compliance could lead to the local authority carrying out any works itself or seeking prosecution.

BILL PROVISIONS

Additions to the List of Nuisances

The Bill wishes to amend the list of statutory nuisances to add;

- any insects emanating from premises
- artificial light emitted from premises or any stationery object (with the exception of lighthouses)
- any land covered with water which is in such a state as to be prejudicial to health

Insects and light have been included in the English and Welsh nuisance regime for some time but according to the policy memorandum, this is the first primary legislative opportunity that has arisen to bring Scotland in to line. In recognition of the potential need to amend nuisances in the future, the Bill would also allow for the addition of statutory nuisances by giving Ministers the power to make regulations to add to the list or change the conditions associated with existing nuisances.

Enforcement of Notices

In response to criticisms of the existing enforcement regime, the Bill would give local authorities the option of issuing fixed penalty notices for those failing to comply with an abatement notice. Fixed penalty notices served on industrial, trade or retail premises would be £400 and all others would be £150.

CONSULTATION

Gaps in the Legislation

The consultation proposed that there may be gaps in the current legislation for dealing with environmental health threats and that the Bill could include new statutory provisions separate to the Environmental Protection Act 1990 based on the concept of an 'environmental health concern'. The definition of environmental health concern proposed was:

> *Any exposure pertaining to the physical environment of any premises, which is:*
>
> *a) discernable to the unaided senses;*
> *b) of such a nature, so located; and*
> *c) having such temporal characteristics as to engender material discomfort or be prejudiced to the psychological or physical health and wellbeing of a person without unusual sensitivity to that particular exposure*

As a result, such a provision would be less prescriptive than the list of statutory nuisances. The majority of respondents (86%) agreed that there were gaps in the legislation to deal with health threats from the environment and almost all those who commented supported the introduction of provisions on 'environmental health concerns'.

However, the original proposals are not reflected in the Bill as introduced. The Scottish Government advises that this was the result of further work with stakeholders, in particular Environmental Health Officers, on the feasibility of the proposals. Subsequent to this it was felt that in light of the changes to the existing statutory nuisance regime, there were few, if any, remaining issues which could not be addressed by the amended statutory nuisance regime (Scottish Government 2007).

OFFENCES AND PENALTIES

The Bill creates a number of new offences and associated penalties. These are summarised below.

BILL PROVISIONS

Section 101 of the Bill sets out that any offences committed under the Bill would incur a penalty on summary conviction not exceeding level 5 on the standard scale (i.e. £5,000) or 12 months in prison, or both. On indictment, the penalty could be an unlimited fine or up to 5 years in prison.

Offences that would be established by the Bill are:

- ***Notifiable Organisms*** - Section 17 would make it an offence for a Laboratory Director to fail in his duty to notify the relevant authorities of an identified notifiable organism within the appropriate time period.
- ***Public Health Investigations*** - Section 29 would create an offence when a person fails to comply with the requirement of a public health investigation or obstructs an investigator in exercising their powers.
- ***Breach of Orders*** - Sections 62-65 would make it an offence to breach an order issued to authorise a medical examination, an exclusion order, a restriction order, a quarantine order and a short-term or exceptional detention order. It would also be an offence to intentionally obstruct a person authorised to carry out a medical examination or remove a person to hospital.

- ***Local Authority Functions*** - Section 75 would make it an offence to obstruct any local authority authorised person entering premises, carrying out inspections and taking any steps to cleanse a premise of infection, infestation or contamination.

CONSULTATION

The issue of offences and penalties was covered separately in the consultation. The consultation proposed the creation of two lists for dealing with non-compliance, one for 'internal tasks' (i.e those undertaken by statutory organisations and employees) and the other for 'external tasks' where non-compliance could be considered an offence and may be subject to criminal proceedings (e.g. breaching a quarantine order). The consultation sought views on:

- Whether penalties should only be applied to non-compliance with 'external tasks'
- Whether non-compliance with 'internal tasks' should be dealt with through the usual governance arrangements of an organisation

The majority of respondents were in agreement that penalties should be applied to non-compliance with 'external task', this is in line with what is set out in the Bill.

FINANCIAL IMPLICATIONS

The financial memorandum to the Bill sets out the expected costs and savings if it was enacted. The memorandum identifies the main costs as arising from the transfer of functions from local authorities to the NHS (i.e. various public health orders and duty to compensate). The main savings from the Bill are identified as those which would occur as a result of abolishing the fees paid to medical practitioners for notifications.

Table 1: Expected costs and savings of the provisions of the Public Health etc. (Scotland) Bill

	Estimated Costs	Estimated Savings
Local authority functions	None expected	
Applications and appeals against orders	NHS - £66,000 per annum Courts - None expected	
Compensation to individuals excluded from work	NHS - £60,000 per annum	
Mortuaries	None expected	None expected
Notification of Diseases and Organisms		Depends on the number of notifications. Previous years could have resulted in payments of between £82,500-£95,000
Sunbeds	Not quantified – expected to be 'minimal'	None expected
Statutory Nuisances	Local authorities – expected to be 'minimal'	Courts – expected savings due to the introduction of fixed penalties, but not quantified in the memorandum

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