

New Zealand experience with Section 126 of Health Act 1956

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About 35 years ago I started working as a general practitioner in the Far North of New Zealand. One day I was asked to visit an elderly gentleman from Dalmatia, who had worked on the gum fields from the 1930s. His house was rather run down, there were piles of rubbish, dirty dishes and old food in the living area. There were holes in the floor and I could see rats running along the ground. He was calmly sitting in his chair, oblivious to his surroundings. As a young general practitioner, I was at a loss to know what to do and asked my senior partner who told me there were lots of people like this one and really there was not a lot that a general practitioner could offer.

It must have been experiences such as this during the influenza epidemic of 1918 that acted as a trigger for a series of urgent amendments to the New Zealand Public Health Act. There was amazement at the poor living conditions and lack of support of many in the community at the time of the epidemic. It was considered that people should not live in substandard conditions that could jeopardise their health. A Public Health Amendment Bill was introduced into the House of Representatives on 8 November 1918

and one clause was entitled *Removals to Institutions*. **(SLIDE 3)** During the debate, one member supporting individual independence rather than institutionalisation quoted Milton is it... "*better to reign in hell than serve in Heaven*".¹ He continued "*There are thousands of people, especially on the goldfields, living in huts by themselves – people who would not think of going near a charitable-aid office.*" He pointed out "*...plenty of men living on the goldfields would rather live there in their houses and tents than in any other place in the world.*" The Legislative Council passed the Bill on 10 December 1918.

The original powers were modified in the 1920 Health Act to cover "... any aged, infirm, incurable or destitute person ... found to be living in insanitary conditions, or without proper care or attention..."

(SLIDE 4) This wording was incorporated unaltered as Section 126 of the current Health Act, which dates from 1956. **(SLIDE 5)** This Act also gives power of entry to investigate matters covered by the Act **(SLIDE 6)** This Act is currently not affected by subsequent legislation such as the Human Rights Act and the Bill of Rights but the intent of the more recent legislation certainly influences decision making when considering using the Health Act.

Personal experience

I will share my experiences since 1993 as a Medical Officer of Health working in the Canterbury, South Canterbury, Westland and Otago health districts. The 2006 census population of the region was about 730,000 with 102,000 (14 percent of the population) over 65 years of age. Over the past sixteen years, I have received at least 52 requests for action under Section 126 of the Health Act.

Figure 1 New Zealand, South Island health districts

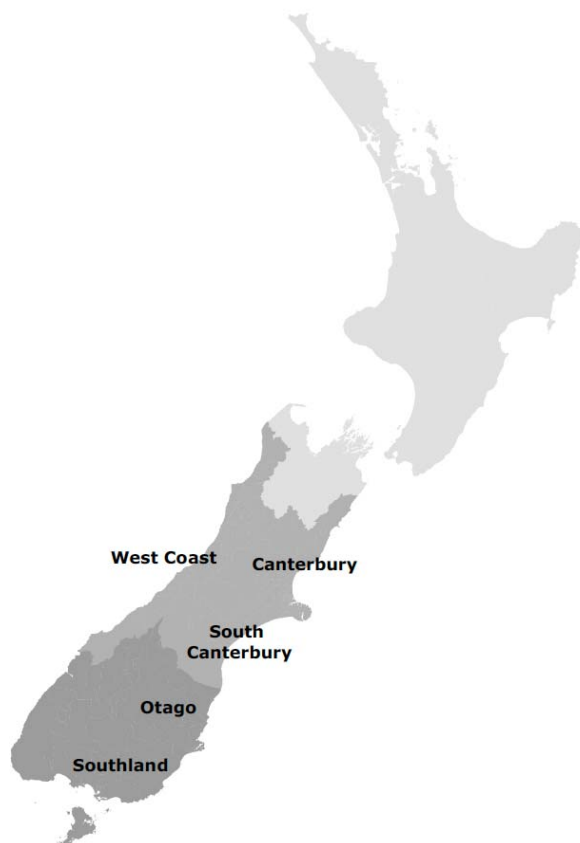


Table 1 Location of referrals 1993 to 2009

	Cases	Annual Cases	Rate per 100,000	Rate per 100,000 age 65+
Canterbury	34	5.7	1.1	7.5
Otago	18	1.8	1.0	6.9

It is of interest that the rate of notifications (1 per 100,000) is about the same as hepatitis B infection in New Zealand. A few of these referrals were considered outside the scope of the legislation

because the individuals did not meet the basic criteria of age, infirmity and living conditions.

Table 2 – Source of referrals

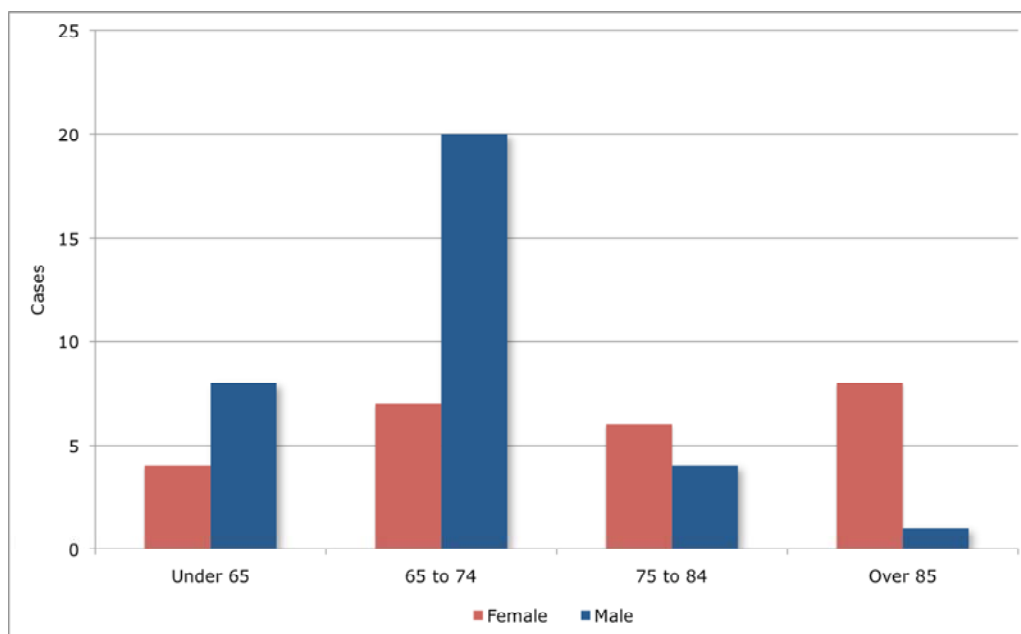
Referral source	Female	Male	Grand Total
Carpet Cleaner	1		1
Church pastor	1		1
Council	3	4	7
District Nursing		1	1
Family	1		1
General Practitioner	2	2	4
Health Care of Elderly	5	3	8
Housing NZ	1	2	3
Landlord	1	1	2
Lawyer	1		1
Mental health	1	1	2
Neighbours	4	4	8
Police		1	1
Public Health Nurse		2	2
Sister in law	1		1
Social Worker	1	7	8
Social Worker ?		1	1
Grand Total	23	29	52

Health professionals referred sixty percent the cases, the majority coming from hospital based services for the elderly. General practitioners are doing fewer house visits and so are not always aware of the living conditions of their patients. I remember one call from Health Care of the Elderly physician who was doing a domiciliary visit and found an elderly woman was stuck because she had fallen through a hole in the rotten floor. Local authority environmental health officers made 7 referrals. but also referrals came from social workers, concerned neighbours as well as a range of others. The most recent referral was from a carpet layer who was horrified and concerned about the amount of faeces on the carpets he had been called to clean. When I called the general practitioner, I was

told that the person had an old and faithful canine companion that had problems but the person was devoted to the animal. The GP promised to visit and explore whether some home help would alleviate the situation.

The majority of referrals were men (56 percent) this is a higher proportion than their representation in the community (44 percent of those over 65 years). In 45 cases (87.0 percent) the individuals were living alone in the community. There were five married couples plus a mother and daughter (aged 93 and 67 years) and two brothers (aged 73 and 65 years).

Figure 2 Age and gender of people referred



What were the complaints?

It is difficult to pinpoint a single reason but I have tried to highlight the main reason for the referral in Table 4. Over half (28 cases) were because the person was considered to be in need of additional care.

21 cases (38 percent) related the house being considered to be poor condition or the people were living in insanitary conditions.

Table 3 Reason for referral to Medical Officer of Health

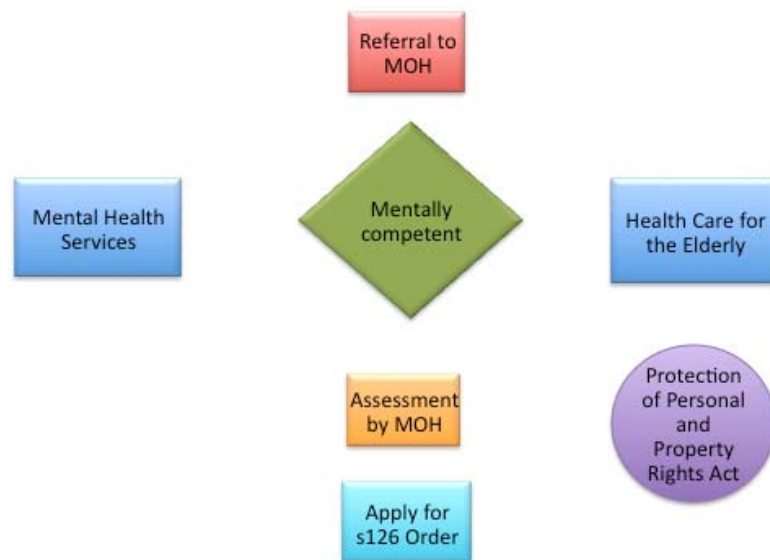
Main complaint	Female	Male	Grand Total
Living conditions & state of house	2	8	10
In need of care	5	4	9
Living conditions	3	5	8
House + young children	1		1
State of house	5	4	9
State of house + animals	3	2	5
State of house + hoarding	2	3	5
Safety & state of house		1	1
State of house + need for assistance	1		1
Dirty clothes		1	1
Flies and maggots		1	1
Hoarding of clothes	1		1
Grand Total	23	29	52

Process

The process is clearly defined in the legislation and the associated Regulations. ⁱⁱ The Medical Officer of Health must investigate the case before deciding whether or not it case falls within the jurisdiction of Section 126. In the majority of referrals, this requires at least one visit to the house and meeting with the person mentioned in the complaint. On these visits, I have been accompanied by Health Protection Officers, local authority Environmental Health Officers, public health nurses, geriatricians, social workers, general practitioners and also Police officers. In making a community

assessment, I rely on input from the range of health professionals working with the individual.

Figure 3 Process around investigation



In 50 of the 52 cases, I did not make an application to Court. There were only two cases in which hospital admission was the only option. They were presented to the Court and considered by a District Court Judge. In both cases the Court decided that it was appropriate for the individual to be admitted for institutional care. These two patients initially did well in hospital but after about a year they both died from bronchopneumonia.

In several cases, once the individual realised that "officialdom" was involved and there was the possibility of action under the Health Act, they decided to enter rest home accommodation. At least three patients were admitted under the Mental Health (Compulsory

Assessment and Treatment) Act (1992) because they were not considered mentally competent. The Protection of Personal and Property Rights Act (1988) provides for the protection and promotion of the personal and property rights of persons who are not fully able to manage their own affairs. The Act is another important piece of legislation which uses the Family Court process to reach an agreed solution in cases where there is a person willing to seek an order for supervision of some activities of daily living.

Working with the legislation

The Act poses two questions – is the person aged, infirm, incurable or destitute AND are they living without proper care and attention? It refers to insanitary conditions but I am unaware of a legal definition of “insanitary” so the Oxford Dictionary definition must be taken as a guide – “not sanitary or healthful” or “injurious to health”. This dates from 1874 and perhaps should be read in conjunction with the Nuisance provisions in section 29 of the Health Act (1956). Nuisances are defined as various conditions that are considered to be “*injurious to health*”. These are very subjective terms when it comes to putting together a case for the removal of a person to an institution.

There are few published judgments that help when putting together a case but in a 1988 case, Judge McElreaⁱⁱⁱ listed six points that should be considered before making any application made under Section 126.

1. Onus of proof on applicant
2. Individual’s welfare is only concern

3. Situation at the time of the application
4. Adequacy of care and attention
5. Individual's views not decisive
6. This patient in these circumstances

These points have been helpful in focusing concerns on the individual and their particular circumstances. In another (unpublished) hearing the Judge pointed out that the Act does not provide for compulsory treatment of the person removed into care. I am aware of a case where the person refused to allow their dirty clothing to be removed. This raises the debate about personal autonomy and poses several important questions:

- What is proper care and attention?
- What overriding public health concern requires a Medical Officer of Health to request institutional care for a person living in insanitary conditions
- When should individual autonomy be compromised by the Court acting in the interests of the wider community?

The Health Act reflects the feelings of the late nineteenth and early part of the twentieth century when public health was considered to offer solutions to many of society's ills. In the health service of 2009 the involvement of a public health physician in the provision of personal health care for individual elderly people could be questioned from a human rights perspective. The presence of Section 126 on the statute book enables the Medical Officer of Health to be involved as a person of last resort in dealing with very difficult cases.

We must recognise that we may be called on to use our legal powers as instruments for the control of social deviance. On several occasions I have used my powers of entry conferred by s128 of the Health Act (1956) and asked the Police to enter premises so that I might undertake an inspection.

When considering “This patient in these circumstances” we must tread the fine line of *Primum non nocere* (First do no harm) while at the same time realising the person may not appreciate the precariousness of their situation and be unaware of the hidden efforts of their family, friends and neighbours which have enabled them to remain in their own home. The time may come when somebody has to blow the whistle and challenge the situation.

The personal care physician either general practitioner or hospital specialist relies on trust in the therapeutic relationship. Obtaining a compulsory care order is a step that can easily break that trust. It is appropriate that a third party be involved in such applications and any patient anger over legal involvement in their care can be directed against the "outside authority" of the law, “the Ministry”, the Medical Officer of Health or the District Court Judge. The doctor / patient relationship is then allowed to continue to work to achieve optimal outcomes for the patient when anger has been deflected.

Section 126 specifically refers to admission to a hospital or institution but hospital admission was not indicated for some cases.

When considering the use of the legislation we must ask what are the reasons for seeking removal of the individual? Is it because there is a risk of personal harm if the individual continues to live in the situation? Is there a risk to the individual from inadequate support at

home? Does the individuals living conditions pose a risk to others? Or should the activities of the individual be controlled because they are upsetting others in the community –is the request to control deviance?

The majority of the people referred to me over the past sixteen years have needed supervised care but not necessarily the 24-hour nursing care that is provided in the hospital situation. In 1918 hospital care was the only form of care widely available in the community. That is not the situation today. Hospital care is mainly short duration intensive treatment of acute conditions. The two patients who were admitted by the Court were the only ones who really required more support than they were having or were willing to accept. One required 24-hour nursing care but her son would not permit home carers into the house, so removal of his mother was the only option. The second person required secure care but the only facility that could offer a secure environment had many people suffering from dementia and my person complained that he could not talk to the other residents.

The current New Zealand Health Act dates from 1956. Numerous attempts at reforming the legislation have occurred over the past 10 years. A Public Health Bill was introduced in 2007, public submissions were called and considered by Select Committee and a revised Bill was reported back to Parliament in June 2008. We have had a change in Government, there are new legislative priorities and so there is no indication of when the Bill will have its Second Reading. However the current s126 provisions are contained in a

modified way in the Public Health Bill (2007) as reported back to Parliament in July 2008.

128 District Court may make residence order

The District Court may, on the application of a medical officer of health, order a person to reside in a specified place or places and to be supervised or cared for by a specified person or organisation if the Court is satisfied that—

- (a) the person is unable to care for himself or herself; and*
- (b) as a result of that lack of care—*
 - (i) the health of the person is, or is likely to be, adversely affected; or*
 - (ii) the health of other persons is, or is likely to be, adversely affected;*
- and*
- (c) without the order, the person will not receive adequate care.*

The emphasis is placed on inability to care for themselves which may affect their health or the health of others AND they require a court direction to receive care.

Conclusion

In 1980 an English public health physician reported that applications for compulsory admission presented the most difficult ethical decisions faced in public health practice.^{iv} This dilemma was implied in the comment in 1918 debate with the reference to Milton is it "*better to reign in hell than serve in Heaven*". The philosophy of the present legislation runs counter to the present emphasis on "individual autonomy". In the majority of cases I have seen, societal concerns about the condition of the house or the lack of proper care

and attention have been the stimulus for Medical Officer of Health involvement. If "individual autonomy" is seen as the overriding ethical principle, societal demands can no longer be used to justify legal action. In the field of public health medicine, benefit for the wider population would seem to come before individual wishes or desires. Before deciding to commit an elderly man into care, the Judge posed the rhetorical question "*Is it better for him to die clean in hospital or dirty at home?*"

I have often been told that Section 126 is out dated and should be repealed because of conflict with other legislation. I believe it places a population perspective on problems associated with the care of individual patients. The Medical Officer of Health has a mandate for action whereas if the Section 126 were to be repealed, the ability to investigate and suggest assistance for people living without appropriate care would be very difficult. General practitioners, social workers, community nurses and others working in personal care do not have the same community perspective as public health physicians.

In 1918 the member of Legislative Council commented the proposed legislation "*...will have to be administered with a considerable amount of tact*". Over the past sixteen years, I have been asked about once every four months to invoke the powers contained in the legislation and they certainly need considerable tact in their application. I hope the quality of life of the people I have seen has been improved by my involvement. Any health gains can only come from working closely and co-operatively with a range of health care and social service providers. The health gains and improvement in individual quality of

life is facilitated by the legislative requirement for Medical Officer of Health involvement with aged, infirm or incurable people who are living in insanitary conditions or without proper care and attention. Perhaps the Medical Officer of Health has the answer to Genesis 4 verse 9 and is their brother's keeper.

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- i New Zealand Parliamentary Debates v 183 (24 October - 10 December 1918) p 1060
 - ii s126 Health Act (1956) and the Health (Infirm and Neglected Persons) Regulations (1958)
 - iii Cowan v Taylor *in* District Court Reports , Auckland (1989) p 168 -174
 - iv Muir Gray J A "Section 47": an ethical dilemma for doctors *Health Trends* 1980; **12**: 72 – 74