



AMA Victoria's response to the HIV pre and post testing legislative requirements – Options Paper

7 April 2017

The Australian Medical Association (Victoria)



Introduction

AMA Victoria welcomes the opportunity to provide feedback to the *Options Paper: HIV pre and post testing legislative requirements* (the Options Paper).

We thank the Department of Health and Human Services (DHHS) for providing an extension to submit to this review until **Friday, 7 April 2017**.

HIV pre and post testing legislative requirements are currently included in the following legislation:

- Divisions 4 and 5 of the *Public Health and Wellbeing Act 2008* (the Act); and
- Regulations 77, 78 and 79 of the *Public Health and Wellbeing Regulations 2009* (the Regulations).

AMA Victoria supports cost-effective public health interventions aimed at improving the health outcomes of HIV-positive Australians and reducing future transmissions.

Our concern, however, is that singling out HIV testing in Victorian legislation as requiring special and additional testing requirements distinguishes HIV from other communicable diseases. No other Australian jurisdiction has comparable legislative requirements regarding HIV-testing policies.

AMA Victoria's position is that testing requirements for HIV should not be above and beyond those contained in standard medical care. In the ordinary course of practice, medical practitioners would provide pre- and post-testing counselling including information on the limitations of any test, the risks of false positive and false negative results, as well as advice on benefits, contraindications and implications of any test.

Preferred Option

AMA Victoria prefers the first option proposed in the Options Paper, to amend the Act and make consequential amendments to the Regulations, specifically:

- repeal sections 131 and 132 of the Act¹;
- remove reference to 'person of prescribed class' from s134(1)(b) of the Act²; and
- amend s78(a) and 79 to redefine 'person of prescribed class'.³

These proposed changes to the Act would bring HIV testing into line with other blood-borne viruses and sexually transmissible infections (STIs) and reduce the stigma associated with HIV testing.

These proposed changes to the Regulations would remove the requirement for peer-based testing.

HIV Testing Policies and Competency Training

Training for the purposes of meeting competency requirements should be aligned with other health sector training. Professional standards and responsibilities for the care of patients should be covered by professional standards and overseen by the Allied Health Practitioner Regulation Agency (AHPRA).

¹ Refer Appendix 1

² Ibid

³ Refer Appendix 2



AMA Victoria submits that the Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) is well-placed to advise on testing policies and any additional competency requirements for medical staff.

The Options Paper notes that ASHM policies are more modern and far more responsive to changes in testing technologies than is legislation.

Pre-testing Counselling

The Act requires that medical practitioners provide 'prescribed information' to people who receive HIV testing and in certain circumstances the information must be given by a 'person of a prescribed class'.

'Prescribed information' is defined in the Regulations as:

*Information about the medical and psychosocial consequences of the test and the meaning of possible results of the test.*⁴

Under the Regulations, a 'person of prescribed class' is either a medical practitioner or a person whose competencies and training qualifications have been determined by the Secretary of the DHHS.⁵

The medico-legal burden placed on medical practitioners to provide patients with 'prescribed information' is time-consuming and not aligned with existing professional requirements for other communicable diseases. Other communicable diseases such as syphilis, gonorrhoea, hepatitis C and tuberculosis are not subject to the same legal controls regarding pre-testing counselling. This is despite the fact that there is a diverse range of public health and personal implications for all communicable diseases.

The burdensome professional requirements might also discourage general practitioners (GPs) in primary care settings from offering HIV testing due to time constraints, reducing the opportunities for members of the public to access care from their primary health professional. This might represent a barrier to high or at-risk Victorians accessing voluntary HIV testing.

Post-testing Counselling

If a test result is negative, there are no specific legal requirements around how that test result should be delivered to the patient.

If the test result is positive, a medical practitioner or another 'person of prescribed class' must provide the patient with prescribed information.

Section 138 of the Act relates to post-testing or authorisation counselling. Specifically, it states that if a person makes an order under s134, or s135 (testing a sample of blood or urine), the patient must be counselled by a registered medical practitioner.⁶

Section 138(4)⁷ of the Act specifies that the person counselled must be provided with:

- details of the test conducted;
- the reasons why the test was conducted;
- the results of the test; and

⁴ Public Health and Wellbeing Regulations 2009 - Regulation 77

⁵ Public Health and Wellbeing Regulations 2009 - Regulation 78

⁶ Refer Appendix 3

⁷ Ibid



- if the test indicated the presence of an infectious disease, the effects of the disease on the:
 - infected patient; and
 - the risk to public health of the infectious disease.

AMA Victoria's position is that post-testing requirements to provide counselling for HIV should not be above and beyond those contained in standard medical care. The prescribed information requirements specified in s138(4) of the Act should be repealed.

Minors and Capacity to Consent to Testing

The proposed HIV pre- and post-testing legislative requirements do not include consideration of minors. As per the Gillick test⁸, AMA Victoria supports that minors should have a right to confidentiality with regard to self-testing and the results of any medical testing. The Gillick test is a legal test of competence, which provides that minors can consent to medical treatment without their parent's knowledge or consent, if the minor is sufficiently mature to 'understand fully what is proposed'.

AMA Victoria supports that if a minor is assessed by a medical practitioner as not having capacity, parental consent should be obtained.

Stigma and Discrimination associated with HIV

AMA Victoria supports the removal of discrimination and stigma associated with HIV. Specific and burdensome legislation requirements that single out HIV as requiring additional testing policies only add to the stigma around HIV.

Historically, specifically from the late 80s to the mid-90s, there was increased public angst around HIV and the risk of public infection. Further, HIV was a terminal illness. With increasing public education and better health management of HIV as a condition, HIV is now viewed as a chronic condition.⁹

Until recently, there was no treatment for hepatitis C and yet medical practitioners have not been subject to the same competency and qualification requirements when providing information to individuals receiving hepatitis C testing.

AMA Victoria supports a right to confidential and sensitive handling of personal and medical information but believes that HIV pre- and post-testing legislative requirements only exacerbate the stigma for Victorians diagnosed with HIV or those high at-risk, such as gay men and men who have sex with men¹⁰ and Indigenous persons.¹¹

Medical practitioners report that many of the new HIV diagnoses are increasingly associated with methamphetamine (meth) use.¹² Meth use amongst young gay men continues to increase. In 2015, the University of NSW carried out a Melbourne Gay

⁸ In *Gillick v. West Norfolk (Gillick case)*, this principle was the basis for the House of Lords' decision that a girl under the age of 16 years (the statutory age for consenting to medical treatment in England) was legally entitled to be given contraceptive advice without her parents' knowledge or consent if she was sufficiently mature to 'understand fully what is proposed'.

⁹ *Medicine Today*. "HIV as a chronic disease: optimising outcomes." 2014

¹⁰ *ABC News*. "World Aids Day: Stigma of living with HIV strong inside gay community, as experts battle 'epidemic'." 2013

¹¹ *Queensland Positive People*. "HIV stigma and lateral violence within Indigenous communities." 2014

¹² *VIC Doc*. "Association between known recent HIV diagnoses and Methamphetamine use – in MSM, Melbourne 2011- 2013." 2014



Community Periodic Survey. The results revealed that there was an increase in crystal meth use in gay men living with HIV from 24.2 percent in 2014, to 35.3 percent in 2015.¹³

Increasing drug use is also a HIV risk-factor in Indigenous communities, with rates of injecting drug use at 16% for the Indigenous population compared with 3% for the non-Indigenous population.

Further, more Indigenous women (22%) are infected by HIV, compared with non-Indigenous women (5%). More Indigenous persons identifying as heterosexuals are also impacted by HIV (20%), compared with heterosexual non-Indigenous Australians (13%).¹⁴

The presence of other STIs increases the chance of contracting HIV if exposed. STIs affect Indigenous Australians at higher rates than non-Indigenous Australians. For example, Indigenous persons are infected with chlamydia at three times the rate of non-Indigenous people and gonorrhoea notifications in the Indigenous community are up to 18 times higher.

In Indigenous communities, HIV stigma can be fuelled by the effects of lateral violence, which includes behaviour such as malicious gossip, shaming, bullying and shunning. These community attitudes are prevalent in Australia's Indigenous communities and create challenges for Indigenous Australians diagnosed with HIV. These can include being discriminated against for their HIV status and lacking an adequate support network. It can become difficult for someone to remain within their community and live peacefully without fear, and it is likely that stigma and lateral violence is a reason that treatment uptake is so incredibly low in Indigenous communities in Australia.¹⁵

Singling out HIV testing in Victorian legislation is likely to further perpetuate the idea that high-risk populations, for example gay men and men who have sex with men, as well as Indigenous Australians living with HIV, are inherently dangerous and place their communities at risk of harm.

Conclusion

AMA Victoria supports screening tests intended to aid in the diagnosis of HIV. A reduction in ongoing HIV transmission through self-identification is likely to lead to resultant behaviour modification and a reduction in morbidity overall.

Fewer deaths and better overall health takes a burden off the healthcare system, and enables HIV-positive people to work and contribute to their families and communities.

AMA Victoria's position is that testing requirements for HIV should not be above and beyond those contained in standard medical care.

AMA Victoria supports that voluntary HIV testing should be undertaken in the same manner as testing for other infectious diseases. It should only occur after informed consent has been obtained within the context of ordinary pre- and post-testing counselling to minimise the trauma of positive results.

¹³ Gay News Network. "Concern Over Rise in Gay Men Using Crystal Meth." 2015

¹⁴ Australian Federation of AIDS Organisations. "HIV and STIs among Aboriginal & Torres Strait Islander People." 2015

¹⁵ Queensland Positive People. "HIV stigma and lateral violence within Indigenous communities." 2014



AMA Victoria is not seeking to take away the counselling responsibilities of medical practitioners. Appropriate pre- and post-testing counselling should apply in all testing circumstances. AMA Victoria submits that counselling responsibilities are more adequately and appropriately encapsulated in professional standards and overseen by professional bodies and AHPRA as regulator.

AMA Victoria prefers the first option proposed in the Options Paper:

- 1. to amend the Act (repeal s131, s132 and s134(1)(b) of the Act); and**
- 2. make consequential amendments to the Regulations (amend s78(a) and 79 to redefine 'person of prescribed class').**

In addition, AMA Victoria submits that:

- 3. the prescribed information requirements specified in s138(4) of the Act should be repealed.**



APPENDIX 1

Public Health and Wellbeing Act 2008

SECT 131

Information to be given to a person requesting a test for HIV or any other prescribed disease

- (1) A registered medical practitioner must not carry out or authorise the carrying out of a test for HIV or any other prescribed disease on a person who has requested the test unless the registered medical practitioner is satisfied that the person has been given the prescribed information in accordance with the regulations.
- (2) Subsection (1) does not apply to the authorising or carrying out of a test for HIV or any other prescribed disease by a pathologist if the pathologist authorises or carries out the test on the authority of another registered medical practitioner.

SECT 132

Information to be provided if results of test are positive

A registered medical practitioner or person of a prescribed class must not advise a person who requested a test for HIV or any other prescribed disease of the results of the test if the results of the test are positive unless the registered medical practitioner or person of a prescribed class is satisfied that the prescribed information has been given in accordance with the regulations.

Note

*The **Health Records Act 2001** applies to and in respect of the privacy of information acquired about a person requesting a test.*

SECT 134

Orders for tests if incident has occurred

- (1) Subject to subsection (11), the Chief Health Officer may make an order under this section if the Chief Health Officer believes that—
 - (b) any of those persons to whom the disease could have been transmitted—
 - (i) has been counselled by a person of a prescribed class about the risk of transmission of the disease in the particular circumstances and about the medical and social consequences of being infected with the disease; and
 - (ii) has consented to be tested for that disease.



APPENDIX 2

Public Health and Wellbeing Regulations 2009

DIVISION 3—HIV tests

REG 78 Positive test results

For the purposes of section 132 of the Act—

- (a) the prescribed classes of persons are—
 - (i) persons who, after 1 January 2010, successfully complete or demonstrate proficiency in the units of competency approved by the Secretary and published in the Government Gazette for the purpose of this regulation;
 - (ii) persons who, before 1 January 2010, successfully completed a course approved by the Secretary or were recognised as having demonstrated proficiency in pre-test and post-test counselling in relation to the Human Immunodeficiency Virus Antibody test.

REG 79 Classes of persons who may provide counselling about the risk of transmission

For the purposes of section 134(1)(b) of the Act, the prescribed classes of persons are—

- (a) registered medical practitioners;
- (b) persons who, after 1 January 2010, successfully complete or demonstrate proficiency in the units of competency approved by the Secretary and published in the Government Gazette for the purpose of this regulation;
- (c) persons who, before 1 January 2010, successfully completed a course approved by the Secretary or were recognised as having demonstrated proficiency in pre-test and post-test counselling in relation to the Human Immunodeficiency Virus Antibody test.

**APPENDIX 3**

Public Health and Wellbeing Act 2008

SECT 138**Post test or authorisation counselling**

- (4) The person counselled must be provided with—
- (a) details of the test conducted;
 - (b) the reasons why the test was conducted;
 - (c) the results of the test;
 - (d) if the test indicated the presence of an infectious disease—
 - (i) the effects of the infectious disease on an infected person; and
 - (ii) the risk to public health of the infectious disease.