Decree of 27 October 2008, laying down new requirements regarding public health matters (Public Health Decree)

We Beatrix, by the grace of God, Queen of the Netherlands, Princess of Orange-Nassau, etc., etc., etc.

Having regard to the provisions of Section 2, subsection 3, Section 5, subsection 4, Section 6, subsection 3, Section 15, subsection 2, Section 19, Section 49, subsection 1, and Section 62, subsection 2, of the Public Health Act;
Having heard the Council of State (report of 23 June 2008, number W13.08.0193/I);
In view of the further report of Our Minister of Health, Welfare and Sport of 21 October 2008, reference DWJZ/SWW-2885172;

Hereby decree and approve:

CHAPTER I GENERAL

Article 1

In the context of this decree, the following definitions shall apply:

a. the Act: the Public Health Act;
b. basic responsibilities for youth health care: the activities referred to in Section 5, subsection 2, of the Act;
c. the KNMG: the Royal Netherlands Society for the Advancement of Medicine.

CHAPTER II GENERAL PUBLIC HEALTH CARE RESPONSIBILITIES

Article 2

1. The activities referred to in the introduction and under a in connection with under g of Section 2, subsection 2, of the Act shall at least include the acquisition of insight by means of investigation into the health status of parties affected by a disaster.

2. The activity referred to in the introduction and under d of Section 2, subsection 2, of the Act shall at least include the maintenance of a system for collaboration between institutions that are responsible for health promotion.

3. The activity referred to in the introduction and under e of Section 2, subsection 2, of the Act shall at least include the following:
   a. highlighting undesirable situations,
   b. disseminating advice to the public regarding risks, including medical advice on hazardous substances, particularly in the event of a disaster or potential disaster,
   c. answering questions raised by the public and providing information,
d. undertaking research.

4. The activity referred to in the introduction and under f of Section 2, subsection 2, of the Act shall at least include the following:
   a. maintaining a list of institutions where, in view of the nature of the target group and the circumstances under which the activities are performed, there is an elevated risk of pathogenic micro-organisms spreading,
   b. advising the institutions referred to above in paragraph a regarding measures for structuring, laying out and managing activities to minimise the risk of pathogenic micro-organisms spreading,
   c. highlighting undesirable situations,
   d. answering questions raised by the public and providing information.

CHAPTER III YOUTH HEALTH CARE

Article 3

1. The basic responsibilities for youth health care shall consist of a uniform element and a bespoke element.

2. The uniform element of the basic responsibilities shall include the activities referred to in Articles 4, 5 and 6 of this Decree and shall be made available to all young people.

3. The bespoke element of the basic responsibilities shall include the activities referred to in the Articles 7, 8 and 9 of this Decree and shall be tailored to the particular care requirements of the young people as well as to the local or regional demographic and epidemiological circumstances.

Article 4

The activity referred to in the introduction and under a of Section 5, subsection 2, of the Act relating to the health status of young people and the health-influencing factors shall include the following:
   a. compiling a general anamnesis of the young person,
   b. assessing the young person’s physical appearance,
   c. measuring and assessing the young person’s growth,
   d. assessing the young person’s development,
   e. assessing the young person’s functioning,
   f. assessing the young person’s medical-biological parameters,
   g. assessing the young person’s behaviour,
   h. assessing the young person’s social environment,
   i. assessing the young person’s physical environment,
   j. mapping out the care system around the young person.

Article 5

The activity referred to in the introduction and under b of Section 5, subsection 2, of the Act relating to care requirements shall, in addition to the bespoke element referred to in Article 7 of this Decree, include the following:
   a. assessing the relation between the pressures upon a young person and his/her family and their capacity to cope with those pressures,
   b. estimating the need for information and advice of the young person and his/her family,
   c. establishing what care the young person is already receiving,
   d. establishing whether the young person belongs to one or more at-risk groups.
Article 6

The activity referred to in the introduction and under c of Section 5, subsection 2, of the Act relating to the detection and prevention of particular disorders shall include the following:
   a. establishing whether eye pathology is present in the young person’s case,
   b. establishing whether maldescensus testis is present in the young person’s case,
   c. establishing whether congenital heart defects are present in the young person’s case,
   d. establishing whether any speech or language disorders are present in the young person’s case,
   e. establishing whether perceptive hearing impairment is present in the young person’s case,
   f. making vaccination against hepatitis B available where necessary,
   g. making vaccination against tuberculosis available where necessary.

Article 7

The activity referred to in the introduction and under b of Section 5, subsection 2, of the Act relating to care requirements shall, in addition to the uniform element referred to in Article 5 of this Decree, include the following:
   a. assessing what bespoke care provision is necessary,
   b. assessing what at-risk group-specific care is necessary.

Article 8

The activity referred to in the introduction and under d of Section 5, subsection 2, of the Act, relating to information provision shall include the following:
   a. giving individualised information, advice, instruction and guidance,
   b. giving group-oriented information, advice, instruction and guidance.

Article 9

The activity referred to in the introduction and under e of Section 5, subsection 2, of the Act relating to health hazards shall include the following:
   a. defining the individual measures, appropriate for the young person’s family, that are required,
   b. defining the measures, appropriate for the group of families to which the young person’s family belongs, that are required,
   c. defining the individual measures, appropriate for the young person’s neighbourhood or school, that are required,
   d. defining the measures, appropriate for the group of neighbourhoods or schools to which the young person’s neighbourhood or school belongs, that are required.

Article 10

If the municipal executive applies the provisions of Section 14, subsection 2, of the Act, the executive shall place the same requirements upon the municipal health service as laid down in Article 17, clause 2, of this Decree.
CHAPTER IV INFECTIOUS DISEASE CONTROL

Article 11

For performance of the duties referred to in Section 6, subsection 1, of the Act, the municipal executive shall at least ensure:

a. the permanent availability of the municipal health service to enable the reporting duties referred to in the Act,
b. the continuous collection, analysis and application of epidemiological data on infectious diseases,
c. the identification from the data referred to above in paragraph b of relevant trends and risks within the population or particular groups, and the anticipation of such trends and risks,
d. the provision of information and guidance, and the answering of questions raised by the public,
e. the provision of preventive source treatment for the control of tuberculosis,
f. the promotion of collaboration between the municipal health service and general practitioners, medical specialists, hospitals, laboratories and other organisations involved in the control of infectious diseases,
g. the general preparation for measures to control an epidemic of an infectious disease,
h. the availability of vaccinations to at-risk groups,
i. participation in applied scientific research.

Article 12

The infectious diseases belonging to group C are: anthrax, mumps, botulism, brucellosis, yellow fever, hantavirus infection, haemophilus influenzae infection, pneumococcal infection, legionella, leptospirosis, listeriosis, malaria, meningococcal infection, MRSA infection, psittacosis, Q fever, tetanus, trichinosis, West Nile virus infection and Creutzfeldt-Jakob disease.

Article 13

1. A port or airport designated as category B pursuant Section 48 of the Act shall have a plan to control infectious diseases in emergency situations, which shall make provision for the appointment of a coordinator.

2. The plan referred to above in clause 1 shall specify at least:

a. how access to medical-diagnostic facilities is to be provided, in order that sick travellers may be promptly and properly examined, and how personnel are to be deployed to the same end,
b. how protection against infection is to be provided for care personnel,
c. how facilities for the quarantine of potentially infected travellers are to be provided,
d. how equipment and personnel are to be deployed for the transportation of sick travellers to appropriate medical facilities,
e. how information is to be communicated to personnel, travellers and the general public,
f. how contamination (including vector contamination) of the port or airport and of vessels or aircraft at the port or airport is to be provided,
g. how cooperation with the relevant instances and organisations is to be organised in connection with the duties described above in paragraphs a to f.
Article 14

A port or airport designated as category A pursuant Section 48 of the Act shall make the provisions referred to in Article 13 of this Decree and shall additionally ensure:

a. the permanent availability of an emergency service that can be deployed to implement the emergency plan referred to in Article 13 of this Decree,

b. an area, complete with sanitary facilities, where incoming travellers may be quarantined or subjected to medical checks, away from other travellers.

Article 15

1. Upon application from the municipal executive, Our Minister shall subsidise the costs the municipality has incurred as a consequence of being required by Our Minister to implement the measures as referred to in Section 62, subsection 1, of the Act.

2. The amount payable shall be determined on the basis of the actual costs arising out of implementation of the measures and their implications, less:
   a. costs for which the municipality has received or can secure funding through other mechanisms,
   b. costs that a municipality charges or has the facility to charge.

3. No subsidy shall be payable if the costs referred to in clause 2 amount to € 45,000 or less.

Article 16

1. An application, as referred to in Article 15, clause 1, must be made no later than twelve months after implementation of the measures has ceased.

2. Contrary to the provisions of clause 1, if implementation of the measures continues for over a year, an application can be made within twelve months after the first year of implementation has been completed.

3. The application must be accompanied by a statement of the costs and supporting evidence. Costs that cannot be accurately determined yet must be estimated.

4. Our Minister shall decide on the application within six months of its submission.

5. At the request of the applicant, Our Minister may advance funds against a subsidy as referred to in Article 15, clause 1. A request for advance funds must be accompanied by a provisional statement of the costs.

6. Our Minister may withdraw a subsidy or reduce the amount payable:
   a. on the grounds of facts or circumstances Our Minister could not reasonably have been aware of when determining the subsidy, and which would have led to the subsidy being set at a lower level, or
   b. if the subsidy was incorrectly determined and the recipient knew or should have known that this was the case.

CHAPTER V MUNICIPAL HEALTH SERVICES

Article 17

1. With regard to performance of the duties referred to in Section 2 of the Act, the experts referred to in Section 15 of the Act shall satisfy the following requirements:
a. the public health expert shall be registered with the KNMG as a public health physician and, insofar as he or she is active in the field of environmental medicine, he/she shall have formal training in this field,

b. the expert in the field of public health nursing shall be a public health nurse with an appropriate higher vocational qualification,

c. the epidemiologist shall be registered with the Netherlands Epidemiological Society as a category-A epidemiologist or registered with the SMBWO as a category-B epidemiologist.

2. With regard to performance of the duties referred to in Section 5 of the Act relating to health risks for young people, the experts referred to in Section 15 of the Act shall satisfy the following requirements:

a. the public health expert shall be registered with the KNMG as a public health physician and shall have formal training in youth health care,

b. the expert in the field of public health nursing shall be a public health nurse with an appropriate higher vocational qualification,

c. the behavioural scientist shall have a university degree in psychology or pedagogy or an appropriate higher vocational certificate in pedagogy.

3. With regard to performance of the duties referred to in Section 6 of the Act, the experts referred to in Section 15 of the Act shall satisfy the following requirements:

a. the public health expert responsible for infectious disease control shall be registered with the KNMG as a public health physician specialising in infectious disease control and shall have formal training in the latter field,

b. the public health expert responsible for tuberculosis control shall be registered with the KNMG as a public health physician specialising in tuberculosis control or pulmonology and shall have formal training in the relevant field,

c. the expert in the field of public health nursing shall be a public health nurse with an appropriate higher vocational qualification.

CHAPTER VI SUNDARY PROVISIONS

Article 18

Article 1, paragraph b, of the Royal Decree of 11 December 1996, implementing Section 1, subsection 2, of the Care Institutions Quality Act and amending certain Decrees issued pursuant the National Health Insurance Act and the Exceptional Medical Expenses Act (Bulletin of Acts, Orders and Decrees 639), is hereby amended to read as follows:

b. public health care as defined in or pursuant the Public Health Act;

Article 19

The General Public Service Regulations is hereby amended to read as follows:

A

In Article 36a, clause 1, under e, the words 'the Contagious Diseases Act' shall henceforth be replaced with: 'the Public Health Act'.

B

In Article 70, clause 1, the words 'the Contagious Diseases Act' shall henceforth be replaced with: 'the Public Health Act'.
Article 20

The Civil Service Regulations of the States General is hereby amended to read as follows:

A

In Article 71a, clause 1, under e, the words ‘the Contagious Diseases Act’ shall henceforth be replaced with: ‘the Public Health Act’.

B

In Article 105, clause 1, the words ‘the Contagious Diseases Act’ shall henceforth be replaced with: ‘the Public Health Act’.

Article 21

In Article 89, clause 1, of the Civilian Defence Service Regulations, the words ‘the Infectious Diseases Act’ shall henceforth be replaced with: ‘the Public Health Act’.

Article 22

This Decree shall come into effect at a time to be announced by Royal Decree.

Article 23

This Decree shall be cited as ‘the Public Health Decree’.

We order and command that this Decree and the associated explanatory memorandum be entered in the Bulletin of Acts, Orders and Decrees.

The Hague, 27 October 2008

Beatrix

The Minister of Health, Welfare and Sport,

A. Klink

Issued on the eighteenth of November 2008

The Minister of Justice,

E.M.H. Hirsch Ballin
EXPLANATORY MEMORANDUM

I GENERAL

This Order in Council is based on the Public Health Act (Proceedings of the Lower House 2007-2008, 31 316). The Public Health Act was formulated in order to implement the International Health Regulations adopted at the World Health Organization’s World Health Assembly on 23 May 2005 (Treaty Series 2007, 34; referred to below as the IHR). These new international infectious disease control arrangements necessitated the modification of the Netherlands’ national infectious disease control regulations. This necessitated the integration of three Acts: the Public Health (Preventive Measures) Act, the Infectious Diseases Act and the Quarantine Act. These three Acts were repealed and replaced by the Public Health Act. The repeal of these Acts implied in turn the withdrawal of the regulations based upon them, including three Orders in Council: the Public Health (Preventive Measures) Decree (based on the Public Health (Preventive Measures) Act), the Youth Health Care Decree, and the Granting of Free Pratique to Aircraft Decree (based on the Quarantine Act). The provisions of the latter Decree have now been incorporated – albeit in an amended form – into the Public Health Act as part of the implementation of the IHR. The provisions of the Public Health (Preventive Measures) Decree – again with certain material changes to align them with the IHR – are incorporated into the Order in Council accompanying this memorandum. The provisions of the Youth Health Care Decree are also included in the accompanying Order in Council, but materially unchanged. The accompanying Order in Council additionally contains certain new provisions regarding infectious disease control, formulated as part of the implementation of the IHR. The provisions in question relate mainly to ports and airports designated under the Public Health Act. They have been drafted in consultation with representatives of the ports and airports sector and their value is generally recognised within that sector.

This Decree does not expand upon Section 5a of the Public Health Act, concerning health care for older people, which was added to the Act by amendment. The reason being that it has yet to be decided how municipalities should discharge their duties in this field. Article 5a will consequently not take effect until conclusions are reached.

II NOTES ON THE INDIVIDUAL ARTICLES

Article 2

This Article expands upon Section 2, subsection 3, of the Public Health Act, insofar as it concerns the formulation of further regulations on the matters covered by Section 2, subsection 2, of the Act.

Clause 1 specifies what the acquisition of epidemiological analysis-based insight into the health status of the population should be understood to entail in association with the promotion of psychosocial assistance in the event of a disaster. The provisions of the clause have been aligned with established practice, as undertaken in compliance with the Public Health (Preventive Measures) Act. The activities concerned involve dedicated health research, which must be undertaken in addition to the general research that has to be carried out to comply with Section 2, subsection 2(a), of the Act. It is made clear that the activities in question include acquiring insight into the health status of disaster victims by means of research. Certain preparations are also necessary in order to make the continuation of such research possible after a disaster.
The provisions of clause 2 replace those of Article 2, paragraph a, of the Public Health (Preventive Measures) Decree. There is no new equivalent of Article 2, paragraph b, of the Public Health (Preventive Measures) Decree, because no use was ever made of that passage and this is not expected to happen in the future.

Clause 3 specifies what the promotion of environmental medical care should be understood to entail. The wording was previously included in Section 2, subsection 2(d), of the Public Health (Preventive Measures) Act. Environmental medicine is considered to be the study of the influence of the physical environment on human health. By way of clarification, clause 3 also states that advising the public about risks should include providing medical advice on hazardous substances.

Clause 4 specifies what the promotion of technical hygiene should be understood to entail. The wording was previously included in Section 2, subsection 2(e), of the Public Health (Preventive Measures) Act. Caring for technical hygiene consists of establishing where there is an elevated risk of the spread of pathogenic micro-organisms (such as legionella, hepatitis B or bacteria that cause gastro-intestinal infections) and proposing measures to address such risks. Such activities may be undertaken by actors other than the municipal health service. The municipality has a responsibility to ensure that businesses and institutions – including children’s day nurseries, primary schools, piercing and tattoo studios, brothels, saunas, kitchens in catering establishments, overnight shelters and asylum-seekers’ centres – take appropriate measures. Technical hygiene should also be addressed in places where large-scale events are organised.

Like the Public Health (Preventive Measures) Decree before it, the Public Health Decree makes no provision for the (compulsory) provision of information to the municipal executive by people or institutions active in the field of health care. The current voluntary arrangements provide municipalities with sufficient information to enable them to build up a picture of the health status of the population.

Article 3

Articles 3 to 10 deal with the provision of youth health care and incorporate the wording previously contained in the Youth Health Care Decree. The object of youth health care is to promote, protect and secure the health and physical, cognitive and psychosocial development of children and young people. In the provision of such care, it is necessary to focus not only on children, but also on their parents or guardians, and to consider the child’s surroundings. Children’s development needs to be monitored in order to pick up problems early, thus enabling effective intervention.

The provisions of Article 3 correspond to those previously made in Article 2 of the Youth Health Care Decree. The basic responsibilities for youth health care consist of the five municipal activities referred to in Section 5, subsection 2, of the Public Health Act. Clause 1 of Article 3 requires that these responsibilities be divided into a uniform element and a bespoke element. The uniform element is made up of the forms of care that should be made available to all young people in the target group. The basic responsibilities for youth health care will further be performed on the basis of regulations. The bespoke element is tailored to the particular care requirements of individual clients and to local or demographic and epidemiological circumstances, i.e. to the local public health situation. The provision mechanisms may address individual clients or groups of clients.
Article 4

The provisions of Article 4 correspond to those previously made in Article 3 of the Youth Health Care Decree. The activities referred to are intended to identify developments in health status, including potentially health-promoting and health-impairing developments.

When compiling a general anamnesis – the young person’s personal history, insofar as relevant to the case, – consideration should be given to the composition of the young person’s family and any hereditary problems that the young person may have.

When assessing the young person’s physical appearance, consideration should be given to the general impression that he or she makes, his/her posture, movement, personal hygiene standards and skin, and the condition of his/her head, neck, trunk, abdomen, sex organs and extremities.

When assessing the young person’s growth, consideration should be given to age-related height (infants, toddlers and schoolchildren), age-related weight (infants), head circumference (infants) and height-related weight (toddlers and schoolchildren).

When assessing the young person’s development, consideration should be given to psychological, motional, cognitive and social aspects, to speech and language and to sexual development.

When assessing the young person’s functioning, consideration should be given to the young person’s physical, psychological, emotional and social functioning.

When assessing medical biological parameters, consideration should be given to monitoring physical growth, vaccination status, possible referrals and the occurrence of diseases and abnormalities.

When assessing the young person’s behaviour, consideration should be given to his/her eating pattern, possible addictions, bullying, violence, truancy, abnormal behaviour, and to his/her recreational and sporting activities.

When assessing the young person’s social environment, consideration should be given to his/her living accommodation, child-minding/nursery situation (where relevant), school situation, changes, discrimination, abuse and crime.

When assessing the young person’s physical environment, consideration should be given to physical circumstances that may influence his/her health status, both positively and negatively: living accommodation, schools, out-of-school care, play opportunities, access to green space, environment and traffic safety.

When mapping out the care system around the young person, consideration should be given to the local network of facilities for children and young people.

Article 5

The provisions of Article 5 correspond to those previously made in Article 4 of the Youth Health Care Decree. Assessment of the relationship between the pressures upon a young person and his/her family and their capacity to cope with those pressures is a precondition for the provision of individualised care.

When making such an assessment, and when assessing the advice and information needs of a young person and his/her family, consideration should be given to all relevant information and circumstances.

Article 6

The provisions of Article 6 correspond to those previously made in Article 5 of the Youth Health Care Decree. Infants and toddlers receive standardised eye
In this context, the primary concerns are amblyopia and acuity problems related to age and development.

Boys undergo standardised testicular localisation tests.

Some congenital heart defects can be detected in the first year of life by systematic testing within the youth health care system.

The screening of preschool children for speech and language development disorders is governed by a national standard.

Vaccination against hepatitis B or tuberculosis is provided only where the young person is suspected to be at risk.

Article 7

The provisions of Article 7 correspond to those previously made in Article 6 of the Youth Health Care Decree. Bespoke care provision is related to the assessment of care requirements, since the care that is provided reflects the findings of the general anamnesis, the assessment of the young person’s physical appearance, growth, development and functioning, the assessment of the relationship between the pressures upon the young person and his/her family and their capacity to cope with those pressures, the assessment of the information requirements, and the analysis of previous and ongoing consumption of care and medical support. Insofar as this care is not part of the uniform element, it is by definition part of the bespoke element.

The determination of care requirements at target group and population level leads to the identification of at-risk groups. Care can then be provided that is tailored to the characteristics of that group.

Article 8

The provisions of Article 8 correspond to those previously made in Article 7 of the Youth Health Care Decree. Information provision is tailored to the needs of the client, so these need to be established beforehand. There is no clear boundary between information, advice, instruction and guidance, but the emphasis is in all cases on prevention. The information provided may be divided into risk-reducing, development-supporting and care-oriented information.

Risk-reducing information is generally anticipatory: it is provided primarily with a view to preventing problems connected with hazardous situations inherent to the development phases that lie ahead for the child. Examples include information about diet, safety, and the risks of alcohol, tobacco and drugs.

Development-supporting information is concerned mainly with the promotion of healthy development during childhood and with the role that parents or carers play in a child’s upbringing. Such information provision may be anticipatory, or secondarily aimed at prevention following signals or questions. There is no clear boundary between information provision and advice. Since information provision is a bespoke process, the subjects addressed may vary considerably.

Care-oriented information provision mainly involves telling clients about the forms of care available to them and explaining referrals and treatments to them. Such information provision is always a bespoke process, as every parent’s information needs are different.

Article 9

The provisions of Article 9 correspond to those previously made in Article 8 of the Youth Health Care Decree. The formulation of measures to address health hazards within the family depends on the nature of the hazards identified. Generally speaking, measures tailored to the individual will be adopted, with
referral to institutions and facilities within the youth health care network wherever possible.

Groups that are potentially at risk can be identified on the basis of characteristics such as low socio-economic status, single parenthood and developmental and language impairment. Depending on the hazards identified in the particular situation, a measure appropriate for the relevant group will be selected.

The formulation of measures to address health hazards in the neighbourhood or school depends on the nature of the hazards identified; the measures adopted may focus on the individual or on the at-risk group.

**Article 10**

The provisions of Article 10 correspond to those previously made in Article 9 of the Youth Health Care Decree. If the municipal executive decides to delegate or partially delegate the activities or component-activities referred to in Section 5, subsection 2(a-d), of the Public Health Act to a body other than the municipal health service, the provisions of Article 10 apply. Under such circumstances, the municipal executive are obliged to impose upon the outside body in question the same requirements regarding the expertise of the youth health care practitioners which would otherwise apply to the municipal health service.

**Article 11**

This Article expands upon Article 6, clause 3, of the Public Health Act. Its provisions correspond partially to those previously made in Article 3 of the Public Health (Preventive Measures) Decree; however, certain amendments have been made to the wording and certain new elements have been introduced.

Article 6, clause 2, of the Public Health Act makes the mayor responsible for the implementation of appropriate control measures in the event of the outbreak or immediate threat of an epidemic. This responsibility embraces not only the compulsory measures, referred to in Chapter V of the Public Health Act, but also any other measures that might prove necessary and that can be implemented on the basis of voluntary public cooperation. Measures of the latter kind might include making vaccination or prophylactic treatment available to certain population groups. The mayor is not responsible for general infectious disease control or for any preventive measures that might be necessary or appropriate in that context. Section 6, subsection 1, of the Public Health Act assigns responsibility for such activities – which may also be regarded as preparation for any outbreak management activities that the mayor might need to undertake – to the municipal executive. The municipal executive is additionally responsible for, amongst other things, measures to control tuberculosis and sexually transmissible diseases, including source and contact detection. These responsibilities are detailed in this Article. The material changes made to the wording of the Public Health (Preventive Measures) Decree are intended to improve infectious disease control activities, and were triggered by the need to implement the IHR. Furthermore, the provisions of this Article also reflect the advice of the Infectious Disease Control Infrastructure Reinforcement steering committee (VISI, under the auspices of Netherlands Association of Municipal Health Services, the Association of Netherlands Municipalities and the Ministry of Health, Welfare and Sport), as contained in the report *The Standardisation of General Infectious Disease Control* (Netherlands Association of Municipal Health Services, 2004).
Paragraph a requires the municipal executive to ensure that the municipal health service is always available to carry out its reporting duties referred to in the Public Health Act.

Paragraph b requires the municipal executive to make appropriate surveillance arrangements, i.e. to ensure the continuous collection, analysis and application of epidemiological data on infectious diseases. A similar requirement was previously contained in Article 3 of the Public Health (Preventive Measures) Decree. However, the Public Health Decree contains no requirements regarding active source and contact detection by the municipal executive in response to incoming reports, as was the case previously. This is because such responsibilities – being considered core responsibilities in infectious disease control – are specifically referred to in Section 6, subsection 1(c), of the Public Health Act itself.

Paragraph c requires the municipal executive to ensure that an active, anticipatory control policy is pursued, particularly in relation to certain at-risk groups or risk-related installations. Such a policy might for instance include research into trends in sexual behaviour and the identification of risks, in order to facilitate the provision of information about sexually transmissible diseases aimed at young people. Other appropriate activities might include the establishment of needle exchange programmes for drug users and the registration of all wet cooling installations in the municipality for legionella control purposes. Paragraph i provides a related requirement, being that the municipal executive should ensure participation in applied scientific research. Effective means of controlling infectious diseases cannot be developed without municipal involvement.

Paragraphs d and e correspond to paragraphs f, i and j of Article 3 of the Public Health (Preventive Measures) Decree. In the context of tuberculosis control, preventive source treatment implies the provision of diagnostic and curative care for tuberculosis sufferers. Such treatment should include directly observed therapy (DOT), which should be adhered to in situations of prolonged medication regime in order to prevent relapse into a contagious state or the development of resistance to medication. In exceptional circumstances, the municipal health service may have to temporarily assume responsibility for the coordination of care to and the supervision of socially less adequate individuals, if other care organisations are not involved and there is a need to address the infection risk for the wider community.

Paragraph f stipulates that the municipal executive must provide coordination between medical bodies involved and the municipal health service in case of infectious disease control. Such coordination is vital for the effectiveness of the surveillance and reporting system, and for communication and implementation in the event of (large-scale) intervention. It also underpins public information provision, coordination and consultation amongst care organisations active in combating particular infectious diseases, such as sexually transmissible diseases and AIDS.

Paragraph g requires the municipal executive to make adequate general preparations for the outbreak management activities to be undertaken by the mayor and the municipal health service in the event of an epidemic of an infectious disease. Although these activities may not necessarily involve the deployment of other instances and organisations, there is a distinct possibility that such deployment will prove necessary. Therefore, adequate general preparation for controlling an epidemic of an infectious disease should include planning for and practising coordinated response action with police and fire brigade, as well as with the institutions responsible for the provision of medical assistance following accidents and disasters. This may for instance include preparation for mass vaccination, as in the meningococcal C campaign of 2003,
preparation for response to widespread food poisoning, and preparation for complex contact tracing and warning. Such situations are covered by general contingency plans. Also, Article 8 of the Public Health Act states that, in the discharge of its preventive duties, the municipal executive should implement the measures ordered by the Minister of Health, Welfare and Sport to prepare for the control of infectious diseases in group A or a new subtype of the human influenza virus, where there is a serious risk to public health. This provision allows the Minister in principle to prescribe the implementation of particular measures.

Paragraph h deals with the provision of vaccination to at-risk groups. The provision regulated by the Decree is concerned with particular groups and is not connected to the National Immunisation Programme. Possible recipients might include children at elevated risk of tuberculosis infection, adults at elevated risk of hepatitis B infection, and children with at least one parent from a country where hepatitis C is endemic.

The provisions concerning the prevention of AIDS previously made in Article 3, clause 3, of the Public Health (Preventive Measures) Decree have not been carried forward to the Public Health Decree. There is now a general consensus that HIV/AIDS prevention is integral to the control of sexually transmissible diseases. Hence, the guidance of patients, the coordination of care organisations and other preventive activities previously regarded as elementary to programmes targeted at HIV/AIDS are now implicit in the general control duty created by Section 6, subsection 1, of the Public Health Act and an integral part of the activities referred to in paragraphs b, c, d and f above. No further specification is therefore required.

Article 12

This Article expands upon Section 19 of the Public Health Act and covers the control of infectious diseases in group C.

Articles 13 and 14

Section 49, subsection 1, of the Public Health Act states that the level of provision referred to in Article 20, clause 1, and Appendix 1 of the IHR should be stipulated for ports and airports, and that the requirements that such provisions should meet should be detailed. The Minister of Health, Welfare and Sport, acting in consultation with the Minister of Transport, Public Works and Water Management or the Minister of Defence respectively, will decree which ports and airports are covered by this passage of the Act. Thus, the new Act and Decree regulate the matters previously regulated by the Quarantine Act.

Two levels of provision

Two separate levels of provision are recognised. The highest level is required at ports and airports belonging to category A; a slightly lower level is required at ports and airports belonging to category B. The (air)ports in category A are those deemed to represent the greatest risk in terms of the international spread of infectious diseases. Differentiation in the required levels of provision has been made so as to reflect the diversity of (air)ports’ risk profiles and the difference in feasibility of making certain provisions and implementing certain measures. It is not deemed necessary to require all (air)ports that handle international traffic to meet the highest level of standards. Nevertheless, since there is an element of risk associated with all international travel, it is felt to be sensible and reasonable to require a basic level of provision for all (air)ports handling any significant
volume of international traffic. It should also be noted that Chapter V, part 6, of the Public Health Act affords mayors greater powers to impose requirements on all designated (air)ports and obliges captains to report contagious diseases to the authorities.

To date, only Schiphol airport and the port of Rotterdam have been designated by ministerial decree as belonging to category A. However, in the field of infectious disease, new threats are emerging all the time. The designation of (air)ports as category A or B, and the definitions of the corresponding levels of provision, are based on the current circumstances and the current threat profiles. Although these are adequate for many potential infectious disease threats and outbreaks, it cannot be excluded that modifications will be required in the future.

Requirements for all (air)ports

Article 13, clause 1, of the Public Health Decree requires that every (air)port designated under the Public Health Act has a control plan for emergency situations, specifying what action is to be taken if (possibly) infected passengers or contaminated goods arrive at the (air)port. The relevant passage also states that a coordinator has to be appointed. The activities that, as a minimum, must be included in the plan are listed in Article 13, clause 2, paragraphs a to f. In addition, paragraph g of clause 2 requires that the plan should specify how cooperation with the relevant instances and organisations will be organised and how responsibilities for the implementation of the various activities will be divided. Obviously, one of the most important players in this context is the municipal health service, as it is primary responsible for implementing infectious disease control. For instance, it would be the municipal health service, under the auspices of the competent authorities, that would organise quarantine – if ever required, – rather than (air)port personnel. Similarly, it should deal with contaminated goods, either within the (air)port itself or on craft at the (air)port. The actual activities will be carried out by or under the directions of the municipal health service, or by the transport operator under the authority of the municipality. The emergency plan must make provision for all such situations, indicating how such activities may be undertaken at the (air)port and what the (air)port’s (supporting) role is. The plan should therefore in all circumstances be formulated in close consultation with the municipal health service. The department of the National Institute for Public Health and the Environment (RIVM, part of the Ministry of Health, Welfare and Sport) that is responsible for infectious disease control will support the relevant municipalities’ health services in the definition of activities for the plan.

Although the plan for a category-A (air)port has to describe the same process steps as the plan for a category-B (air)port, a different level of detail is required in each case. At category-A (air)ports, for example, more activities need to be undertaken at the premises themselves, whereas where category-B (air)ports are concerned, activities are referred to other service providers. This difference in approach is related to the requirement that category-A (air)ports must have a response service with certain functionalities on standby at all times. Furthermore, the two categories of facility differ in terms of the scale of the problems that they are likely to have to face. This is because category-A (air)ports handle larger volumes of international traffic and are governed by agreements regarding the provision of assistance. Another consideration is that measures recommended by the World Health Organization, such as the establishment of arrival and departure checks, are likely to be implemented at category-A (air)ports, but not at other facilities.
Relationship to the air transport sector

The International Civil Aviation Organization (ICAO) has laid down guidelines for airports regarding preparation for and control of infectious diseases. Again, planning is an important feature of the recommendations. It obviously makes sense for an airport to have a single plan for dealing with public health emergencies. Hence, the requirements of Article 13 have been formulated in such a way that they can be met by a plan that also satisfies the ICAO requirements.

The plan should also provide for situations in which an aircraft is required to divert to an airport other than that for which it is bound. Because Schiphol has category-A status, it may in exceptional circumstances be desirable that an aircraft bound for a category-B airport is diverted to Schiphol. Under Section 52 of the Public Health Act, the Minister of Transport, Public Works and Water Management is responsible for making such a decision, subject to consultation with the Minister of Housing, Welfare and Sport. Consequently, the element of the plan dealing with diversions should be formulated in consultation with representatives of both ministers.

It is particularly important that the chain of reporting (with the involvement of air traffic control) and decision-making is detailed in the plan.

Extra requirements for category-A (air)ports created by Article 14

Apart from an emergency response plan, (air)ports designated as category A are required to have an emergency service that is contactable and ready to act at all times. This service has to have at its disposal sufficient well-trained and prepared personnel to ensure that it can at any time:

– provide such medical assistance as may be immediately required (diagnosis and treatment);
– immediately report to the competent authorities situations covered by the Public Health Act’s compulsory reporting requirements;
– transport sick travellers to a suitable medical facility;
– implement the emergency response plan where appropriate.

Under the Quarantine Act, various designated (air)ports in the Netherlands were already required to maintain a health service. Ideally, the emergency service and the medical service should be a single body that is capable of performing all the functions described above. If this is not possible, the (air)port is expected to take other steps to ensure that it can provide any medical services for which there is an acute need.

Category-A (air)ports are additionally required to have an area where people with (or suspected of having) infectious conditions can be kept and questioned apart from other travellers and, if necessary, quarantined. It is not necessary to require all (air)ports to have such facilities, because the likelihood of quarantine proving necessary is not very great. The area at Schiphol airport provides short-term accommodation for travellers who are deemed to require testing or quarantine. If prolonged quarantine is required, the travellers involved should be moved to an off-site facility designated by the mayor as soon as possible. The municipality has already taken steps to provide a suitable location. The emergency plan referred to in Article 13 needs to cover these matters.

Articles 15 and 16

Section 62 of the Public Health Act allows the municipality to apply to the national government for reimbursement of the costs of implementing the
measures necessary. Articles 15 and 16 of the Public Health Decree set out the rules governing such reimbursement.

It is desirable that, wherever possible, the government applies the same principles and procedures in comparable situations. The wording of Articles 15 and 16 is therefore as similar as possible to that of the Decree on National Government Subsidisation of Assistance and Control Costs (Bulletin of Acts, Orders and Decrees 50, 2002).

Article 15 links the provision of financial support to any situation in which the Minister of Health, Welfare and Sport has required the mayor to implement measures for the control of category-A infectious diseases and for the adoption of World Health Organization recommendations. The availability of subsidies under the Decree on National Government Subsidisation of Assistance and Control Costs is linked to the term ‘disaster’. Although the circumstances covered by Section 62 of the Act may not necessarily involve a disaster, they are serious nonetheless.

Like the Decree on National Government Subsidisation of Assistance and Control Costs, the Public Health Decree provides only for the subsidisation of costs arising out of the actual implementation of measures and the consequences of such implementation. For instance, the cost of control measures such as vaccination or the isolation of affected individuals would be subsidisable. The basic principle is that the municipality should be protected against the financial implications of unpredictable events that it cannot reasonably be expected to budget for. Only extra-budgetary expenditure qualifies for reimbursement and any sums received from other sources are set off against the amount of subsidy payable.

Furthermore – again in line with the Decree on National Government Subsidisation of Assistance and Control Costs, – a threshold of € 45,000 is applied; expenditure below this threshold is not reimbursable. In the context of the latter decree, the existence of a threshold reflects an important principle: that responsibility is shared by the national government and the municipalities. However, that principle is not relevant in the context of the Public Health Act: here, municipalities take action, and as a consequence incur costs, because they are required to by the Minister of Health, Welfare and Sport. The motivation for including a threshold provision in Article 15 is the desire to manage the administrative burden. In the event that the cost of implementing measures exceeds the threshold value, the entire amount (including the initial € 45,000) is reimbursable.

The subsidy application procedure and the application processing procedure have also been adopted from the Decree on National Government Subsidisation of Assistance and Control Costs. The municipality has to submit its application to the Minister no later than twelve months after the period of implementation has ended. The Minister must then decide within six months whether to honour the application. However, the application and decision-making procedures provided for in the Public Health Decree do differ from the Decree on National Government Subsidisation of Assistance and Control Costs in one respect. This is because outbreaks of infectious disease, unlike disasters, are liable to be prolonged. They can be difficult to control, particularly in less developed parts of the world, and can create a serious global threat for a considerable time. Under such circumstances, the World Health Organization may likely recommend that certain (preventive) measures remain in place for a lengthy period. To address such eventualities, the second clause of Article 16 has been included: if measures have to remain in place for a full year, clause 2 allows a subsidy application to be submitted and processed within twelve months of the end of that year. Thus, in the event of prolonged implementation, the municipality does
not have to wait until the response can be stood down before it applies for a subsidy.

**Article 17**

The provisions of this Article correspond to those previously made in Article 5 of the Public Health (Preventive Measures) Decree. However, latter Decree’s requirement regarding the training of the dentistry expert has not been carried forward, as this expertise is no longer required under the Public Health Act. Furthermore, there is no explicit requirement in the Public Health Decree that the clinic doctor who provides youth health care should have followed an application course to that end. The course in question is now an integral part of the youth health care training referred to in clause 2, paragraph a.

**Articles 18, 19, 20 and 21**

The amendments provided for in these articles are necessary as the Public Health Act supersedes the Public Health (Preventive Measures) Act and Infectious Diseases Act.

The Minister of Health, Welfare and Sport,

A. Klink