IN THE COURT OF APPEAL OF NEW ZEALAND

CA159/2014
[2016] NZCA 462

BETWEEN	NEW HEALTH NEW ZEALAND INCORPORATED Appellant
AND	SOUTH TARANAKI DISTRICT COUNCIL Respondent

CA615/2014

BETWEEN	NEW HEALTH NEW ZEALAND INCORPORATED Appellant
AND	ATTORNEY-GENERAL FOR AND ON BEHALF OF THE MINISTER OF HEALTH Respondent

CA529/2015

BETWEEN	NEW HEALTH NEW ZEALAND INCORPORATED Appellant
AND	ATTORNEY-GENERAL FOR AND ON BEHALF OF THE MINISTER OF HEALTH Respondent

Hearing:	5 and 6 July 2016
Court:	Randerson, Wild and French JJ
Counsel:	M T Scholtens QC, L M Hansen and J Watson for New Health New Zealand Inc D J S Laing and H P Harwood for South Taranaki District Council S V McKechnie, K G Stone and D R Taylor for Attorney-General on behalf of the Minister of Health A M Powell and A L Dixon for Attorney-General as Intervener
Judgment:	27 September 2016 at 10:00 am

JUDGMENT OF THE COURT

A **Leave is granted to the appellant to adduce further evidence on appeal.**

B **The appeal CA159/2014 is dismissed.**

C **The appellant in CA159/2014 must pay costs to the respondent for a complex appeal on a band A basis with usual disbursements. We allow for second counsel.**

D **The appeals CA615/2014 and CA529/2015 are dismissed.**

E **The appellant must pay the respondent one set of costs in CA615/2014 and CA529/2015 for a standard appeal on a band A basis with usual disbursements.**

REASONS OF THE COURT

(Given by Randerson J)

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Introduction

[1] The fluoridation of water has been undertaken in New Zealand since 1954 with the aim of improving dental health. Currently, 48 per cent of the New Zealand population lives in communities with water fluoridation programmes. Other countries have similar programmes but the practice is not universally adopted.

[2] These three appeals are brought by New Health New Zealand Inc, an incorporated society opposed to the fluoridation of water supplies. New Health's view is that fluoridation removes freedom of choice by the consumer, is potentially harmful to health, and is not an effective way of providing fluoride as a means of preventing dental decay.

[3] New Health has been pursuing litigation in relation to fluoridation on several fronts. First, in judicial review proceedings it sought declarations that the decision of the South Taranaki District Council to add fluoride to the water supplies in Patea and Waverley was ultra vires and in breach of s 11 of the New Zealand Bill of Rights Act 1990 (NZBORA). This section provides that everyone has the right to refuse to undergo medical treatment. Rodney Hansen J dismissed New Health's application.[1] The first appeal is against that decision. We refer to it as the Council appeal.

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1 *New Health New Zealand Inc v South Taranaki District Council* [2014] NZHC 395, [2014] 2 NZLR 834 [Council judgment].

[4] The other two appeals arise from separate proceedings brought by New Health in the High Court. In the first, Collins J dismissed an application by New Health for declarations that two compounds added to water supplies for fluoridation purposes, namely hydrofluorosilicic acid (HFA) and sodium silico fluoride (SSF), were medicines in terms of the Medicines Act 1981.[2] Collins J found that HFA and SSF were not medicines.

[5] While the Judge said he was confident this conclusion was correct, he suggested the Ministry of Health might wish to consider recommending a regulation to exempt HFA and SSF from the definition of medicines under the Medicines Act.

[6] The suggestion made by Collins J was adopted. The Medicines Amendment Regulations 2015 were promulgated with effect from 30 January 2015. HFA and SSF were declared not to be medicines for the purposes of the Medicines Act. New Health then brought judicial review proceedings challenging the validity of the amending regulations on a variety of grounds. Kós J dismissed New Health's application.[3]

[7] New Health appeals against the judgments of both Collins J and Kós J. We refer to these appeals as the Medicines Act appeal and the Regulations appeal respectively. The Medicines Act appeal was due to be heard before Kós J had determined the application to review the validity of the amending regulations. The Medicines Act appeal was adjourned until after the outcome of the proceedings before Kós J was known. This Court was satisfied the Medicines Act appeal would be moot if the amending regulations were found to be valid.[4]

[8] The Regulations appeal includes a challenge to a costs order made against New Health in the High Court.

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2 *New Health New Zealand Inc v Attorney-General* [2014] NZHC 2487 [Medicines Act judgment].

3 *New Health New Zealand Inc v Attorney-General* [2015] NZHC 2138, [2015] NZAR 1513 [Regulations judgment].

4 *New Health New Zealand Inc v Attorney-General* CA615/2014, 29 April 2015 (Minute of the Court).

[9] New Health now seeks to advance all three appeals, which, for convenience, were heard together. Counsel filed an agreed list of issues, which we have reduced for simplicity. The issue in the Council appeal is whether the Judge was correct to find that:

(a) The Council had statutory authority to fluoridate the water supplies for Patea and Waverley.

(b) The fluoridation of water is not medical treatment for the purposes of s 11 of the NZBORA.

(c) If the right to refuse medical treatment is engaged, fluoridation is a demonstrably justified limit prescribed by law in terms of s 5 of the NZBORA.

[10] As to the other two appeals, we propose to consider the Regulations appeal first. We do so because, if we were to uphold the validity of the amending regulations, the only real issue in the Medicines Act appeal is whether the judgment of Collins J is thereby rendered moot.

[11] Despite opposition by the Council, we grant leave to New Health to adduce further evidence on appeal in the form of a report known as the Cochrane Review 2015. We discuss below the extent to which weight may be given to this report.

THE COUNCIL APPEAL (CA159/2014)

[12] At the outset we note two points about the Council appeal. First, the Court is concerned with the lawfulness of the process of fluoridation. The merits of the process are at issue only in a broad sense as an aspect of New Health's argument that the process breaches the NZBORA. Secondly, we note that earlier this year the Government signalled its intention to shift the decision whether to fluoridate drinking water supplies from local authorities to District Health Boards.

The process of fluoridation

[13] It is not in dispute that fluoride occurs naturally as a trace element in water throughout the world but at varying levels. In New Zealand fluoride occurs at

relatively low levels (usually below 0.3 ppm).[5] Fluoridation is the process of increasing the level of fluoride in the water supply to between 0.7 and 1.0 ppm by the addition of the fluoride-releasing compounds HFA or SSF.

[14] Proponents of fluoridation believe it improves public health by reducing the incidence of dental caries (tooth decay) through promoting the mineralisation of tooth enamel. It is argued this helps to overcome social inequality by ensuring children are not disadvantaged by poor dental hygiene in their homes. For a number of years, it was believed fluoride worked systemically by the swallowing of fluoridated water. However, it is now generally accepted it works topically, that is, by direct contact with tooth surfaces.

[15] As the Judge found, there is ongoing debate as to the effectiveness of fluoridation and whether it poses any risk to human health. The view of many public health authorities and medical science bodies, among them the Ministry of Health and the New Zealand Dental Association, is that fluoridation is beneficial and safe. On the other hand, there are a number of organisations and individuals who oppose fluoridation on a range of grounds.

[16] On 10 December 2012 the South Taranaki District Council decided to add fluoride to the water supplies of Patea and Waverley, both small towns in South Taranaki. The Council did so after a process of consultation and with the support of the Ministry of Health. There is no challenge on appeal to the process by which the Council reached its decision. Rather, the appeal focuses on whether the Council has power to fluoridate drinking supplies and whether the fluoridation of water breaches s 11 of the NZBORA.

The legal power to fluoridate

[17] The Council relies on the Local Government Act 2002 (the LGA 2002) and the Health Act 1956 as the source of the power to fluoridate. We will shortly examine these statutes in detail but, before doing so, we discuss whether the 1965

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5 ppm = parts per million.

decision of the Privy Council in *Attorney-General v Lower Hutt City* continues to have significance in relation to the Council's power to fluoridate.[6]

The Lower Hutt City case

[18] The power of a local authority to fluoridate water supplies under the Municipal Corporations Act 1954 was unsuccessfully challenged in the *Lower Hutt City* case. Section 240(1) of the 1954 Act enabled the Council to "construct waterworks for the supply of pure water for the use of the inhabitants of the district".

[19] At first instance, McGregor J held that this section did not entitle the Council to add fluoride.[7] He held it would be straining the language of the 1954 Act to hold that, by implication, the legislature had empowered the Council to add fluoride to the water supply.[8] Such an act did not seem to him to be incidental or consequential to the supply of pure water when the water was already pure. However, McGregor J held that fluoridation was within the powers of the Council under s 288 of the 1954 Act which conferred separate powers on councils to do all things necessary from time to time for the preservation of public health and convenience and for carrying into effect the provisions of the Health Act 1956.[9]

[20] McGregor J's judgment was upheld by the majority of the Court of Appeal but for different reasons.[10] North P agreed that a local authority "must not attempt to introduce a substance which is foreign to the nature of water, for medicinal or other purposes, for this would render the water impure".[11] However, he considered a local authority acting in good faith should be entitled to take any reasonable steps it might think proper to improve the quality of its available water supply as water. By adding fluoride, the Council was doing no more than "rectifying a deficiency in the water which was available to it and was acting reasonably on expert evidence which had satisfied it that this step was desirable in the public interest".[12]

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6 *Attorney-General v Lower Hutt City* [1965] NZLR 116 (PC).
7 *Attorney-General v Lower Hutt City* [1964] NZLR 438 (SC/CA).
8 At 442.
9 At 445.
10 *Attorney-General v Lower Hutt City*, above n 7.
11 At 456.
12 At 456.

[21] McCarthy J noted that some people saw fluoridation simply as a medication but he thought it better not to do so.[13] Rather, it should be borne in mind that fluoride is normally present in New Zealand waters. All that was done in Lower Hutt was to increase the quantity. He added that the addition of fluoride did not render the water impure. It remained water despite the addition. Because it resulted in the water bringing to the inhabitants of the district the required element normally and best conveyed by humans through the water supply, it could be seen as an act reasonably and properly performed in the prosecution of the main purpose.[14] Turner J, dissented finding that fluoridation was not permitted by any of the statutory provisions relied upon.[15]

[22] The Privy Council agreed with the majority view expressed in this Court:[16]

> Their Lordships are of opinion that an act empowering local authorities to supply "pure water" should receive a "fair large and liberal" construction as provided by s. 5 (j) of the Acts Interpretation Act 1924. They are of opinion that as a matter of common sense there is but little difference for the relative purpose between the adjectives "pure" and "wholesome". Their Lordships think it is an unnecessarily restrictive construction to hold (as did McGregor J.) that, because the supply of water was already pure there is no power to add to its constituents merely to provide medicated pure water, i.e. water to which an addition is made solely for the health of the consumers. The water of Lower Hutt is no doubt pure in its natural state but it is very deficient in one of the natural constituents normally to be found in water in most parts of the world. The addition of fluoride adds no impurity and the water remains not only water but pure water and it becomes a greatly improved and still natural water containing no foreign elements. Their Lordships can feel no doubt that power to do this is necessarily implicit in the terms of s. 240 and that the respondent corporation is thereby empowered to make this addition and they agree with the observations of North P. and McCarthy J. already quoted. They think too that it is material to note that, while their Lordships do not rely on s. 288, nevertheless that section makes it clear that the respondent corporation is the health authority for the area and s. 240 must be construed in the light of that fact; that is an additional reason for giving a liberal construction to the section.
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> Their Lordships think it right to add that had the natural water of Lower Hutt been found to be impure it would of course have been the duty of the respondent corporation to add such substances as were necessary to remove or neutralise those impurities; but that water having been made pure they can see no reason why fluoride should not be added to the water so purified in order to improve the dental health of the inhabitants.

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13 *Attorney-General v Lower Hutt City*, above n 7, at 465.
14 At 466.
15 At 461.
16 *Attorney-General v Lower Hutt City*, above n 6, at 124–125.

> In these circumstances their Lordships do not think it necessary to express any opinion upon the question whether s. 288 of the Municipal Corporations Act or s. 23 of the Health Act by themselves empower the respondent corporation to add fluoride to the water.

[23] As Rodney Hansen J noted in the judgment under appeal, s 240 of the 1954 Act was superseded by s 379 of the Local Government Act 1974 (the LGA 1974). The parties accepted that, although not worded in identical terms, the two provisions were not materially different. The Judge inferred that the power to fluoridate was carried over into the LGA 1974.

[24] New Health sought to distinguish the *Lower Hutt City* case on a number of grounds. It was said the current legislation is expressed in materially different terms; the approach to interpretation under the Interpretation Act 1999 differs from that under the Acts Interpretation Act 1924 in force at the time: legislation must now be interpreted in accordance with its text and in light of its purpose rather than the fair, large and liberal construction provided by s 5(j) of the 1924 Act; the NZBORA was not then enacted and the current legislation should now be interpreted in a manner consistent with NZBORA; and the factual findings made by McGregor J were no longer valid in the light of present day knowledge. In particular, New Health does not accept the findings that the additional fluoride has a substantial effect in reducing the incidence of dental caries; that there are no deleterious or toxic effects on the human body from the absorption of fluoride in the minute proportion of 1.0 ppm; and that tablets or other means for the taking of fluoride are unsatisfactory.

[25] We agree that some of the conclusions reached in the *Lower Hutt City* case require revisiting in the light of the current legislation. However, in our view, the principal significance of the *Lower Hutt City* case is that the addition of fluoride to drinking water was regarded as lawfully authorised at least up to the introduction of the LGA 2002. It is reasonable to infer that, in enacting that legislation, Parliament proceeded on that assumption and with knowledge that fluoridation of drinking water was occurring in a number of districts.

The Judge's approach

[26] Rodney Hansen J carefully outlined the provisions of the LGA 2002 and the Health Act, with particular reference to pt 2A of the latter, introduced in 2008.

[27] The Judge relied particularly on s 130 of the LGA 2002, which provides that a local government organisation providing water services must continue to provide those services and maintain its capacity to meet its obligations in that respect. Noting the change from "pure water" in the LGA 1974 to "drinking water" in the LGA 2002, the Judge concluded:[17]

> [25] The change in terminology could not be understood as indicating an intention on the part of Parliament to narrow a local authority's power in relation to the supply of water. There is no obvious reason why the implied power to fluoridate found to exist in the 1956 and 1974 Acts should not also be implied in the 2002 Act. On the contrary, by requiring local bodies who had been supplying (in some cases) fluoridated water to maintain water services, Parliament must be taken to have intended to empower them accordingly. This is confirmed by the Health Act which makes detailed provision for the supply of drinking water and explicitly recognises that fluoride may be added.

[28] After setting out in detail the relevant provisions of the Health Act and the new pt 2A, the Judge particularly noted s 69O(3)(c), which provides that drinking water standards adopted by the Minister of Health "must not include any requirement that fluoride be added to drinking water".

[29] Rodney Hansen J concluded by reference to relevant parliamentary materials that this provision indicated that Parliament contemplated fluoride being added to the water supply:[18]

> [36] The Health Act does not expressly authorise the addition of fluoride to drinking water but it plainly contemplates that it may be. The stipulation in s 69O(3)(c) that standards must not include any requirement that fluoride be added to drinking water is consistent only with a legislative intention that fluoride may be added. If the intention was that fluoride could not be added, the provision would be redundant. This is confirmed by the report of the Select Committee which considered the Bill which contained the following passage:[19]

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17 Council judgment, above n 1 (footnote omitted).
18 (footnote in original).
19 Health (Drinking Water) Amendment Bill 2006 (52-2) (Select Committee Report) at 5.

> **Issue, adoption, amendment and revocation of drinking-water standards – new clause 69O**
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> New clause 69O sets out the process by which the Minister may issue, adopt, amend, or revoke drinking-water standards. Although new clause 69O or the standards were never intended to enable the mandatory fluoridation of water, in theory it is possible that they might be applied in this way. To prevent such a possibility we recommend insertion of a new subclause (3)(c).
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> Subparagraph (3)(c) has the purpose of countering any suggestion that the inclusion of fluoride as a contaminant in drinking water standards may be interpreted as requiring a drinking-water supplier to fluoridate. This is consistent with the expectation that such decisions are quintessentially a function of local government.

The arguments on appeal

[30] New Health does not dispute that the Council has the power to supply drinking water within its district. However, it submitted the Judge had erred in finding that the LGA 2002 and the Health Act, whether separately or in combination, appeared to establish a clear legislative mandate for local authorities to add fluoride to drinking water supplies. It was submitted that, in the absence of any explicit power in the legislation, councils were not authorised to add fluoride or other therapeutic substances to the water supply. An interpretation to that effect was not consistent with the text and purpose of the legislation.

[31] On behalf of the Council, Mr Laing supported the Judge's findings for the reasons the Judge gave.

The Local Government Act 2002

[32] As the Judge noted, the LGA 2002 replaced the LGA 1974. It constituted a comprehensive reform of local government legislation. Whereas the LGA 1974 and the Municipal Corporations Act 1954 were highly prescriptive, the approach in the LGA 2002 was described in the Explanatory note to the Local Government Bill 2001 as:[20]

> ... [a] shift from a detailed and prescriptive style of statute (that focuses councils on compliance with detailed legislative rules) to a more broadly

[20] Local Government Bill 2001 (191–1) (Explanatory note).

> empowering legislative framework that focuses councils on meeting the needs of their communities.

[33] The Judge noted the broad purposes of local government as stated in s 3 and amplified in ss 10 and 11. In performing its role, a local authority must have particular regard to the contribution that specified core services make to its communities.[21] These include network infrastructure, a term defined to include the provision of water.[22]

[34] The status and powers of a local authority (sometimes referred to as the general power of competence) are set out in s 12. Relevantly, it provides:

> **12 Status and powers**
>
> (1) A local authority is a body corporate with perpetual succession.
>
> (2) For the purposes of performing its role, a local authority has—
>
> (a) full capacity to carry on or undertake any activity or business, do any act, or enter into any transaction; and
>
> (b) for the purposes of paragraph (a), full rights, powers, and privileges.
>
> (3) Subsection (2) is subject to this Act, any other enactment, and the general law.
>
> (4) A territorial authority must exercise its powers under this section wholly or principally for the benefit of its district.
>
> …

[35] Part 7 sets out specific obligations and restrictions on local authorities, including those relating to the delivery of water services, including water supply. The latter term is defined as meaning:[23]

> … the provision of drinking water to communities by network reticulation to the point of supply of each dwellinghouse and commercial premise to which drinking water is supplied.

[36] By s 125 local authorities are obliged to assess the provision of water services within their districts. In terms of s 126, the purpose of an assessment of this kind is

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21 Section 11A.
22 Section 197(2).
23 Section 124.

to assess, from a public health perspective, the adequacy of water and other services in light of:

> (a) the health risks to communities arising from any absence of, or deficiency in, water … services; and
>
> (b) the quality of services currently available … ; and
>
> …
>
> (d) the extent to which drinking water provided by water supply services meets applicable regulatory standards; …
>
> …

[37] This provision is of some significance since it emphasises the role of local authorities in the delivery of water supplies from a public health perspective. In particular, there is a direct link made with applicable regulatory standards for drinking water. We discuss these in more detail below.

[38] Finally, we draw attention to s 130, cited at [27] above. This section provides that it is the duty of a local government organisation to continue to provide water services and to maintain its capacity to meet its obligations under subpart 2 of pt 7. Given our conclusion about the significance of the *Lower Hutt City* case in assessing the presumed intention of Parliament, we agree with the Judge's conclusion that, by requiring local bodies, including those that have been supplying fluoridated water, to continue to maintain water services, Parliament must be taken to have intended to empower them accordingly.

The Health Act 1956

[39] Local authorities have long had specific responsibilities in relation to public health. In terms of s 23 of the Health Act, local authorities have a duty to improve, promote and protect public health within their districts. Amongst other things, local authorities are empowered and directed to cause all proper steps to be taken to secure the abatement of any condition likely to be injurious to health or offensive within their district;[24] to enforce within their districts the provisions of all regulations under

[24] Section 23(c).

the Health Act for the time being in force;[25] and to furnish to the medical officer of health from time to time such reports as to diseases, drinking water and sanitary conditions within their districts as the Director-General or the medical officer of health may require.[26]

[40] Prior to the commencement of pt 2A of the Health Act in 2008,[27] compliance with drinking water standards was voluntary. This changed with the introduction of pt 2A, which contains detailed provisions directed to promoting the supply of safe and wholesome drinking water. These provisions include duties imposed on the suppliers of drinking water to take all practicable steps to comply with New Zealand drinking water standards (the New Zealand Standards). We discuss these standards in detail below. It is sufficient to note at this point that the New Zealand Standards stipulate that fluoride may not exceed a level of 1.5 ppm (described in pt 2A as a maximum acceptable value).

[41] The broad purpose of pt 2A is stated in s 69A:

> **69A Purpose**
>
> (1) The purpose of this Part is to protect the health and safety of people and communities by promoting adequate supplies of safe and wholesome drinking water from all drinking-water supplies.

[42] Section 69A(2) provides that the Minister of Health is to issue or adopt drinking-water standards[28] and imposes a range of duties on drinking water suppliers, including duties to monitor drinking water; to take all practicable steps to comply with the drinking water standards; and to implement risk management plans.[29]

[43] Section 69G contains a number of definitions. Relevantly, drinking water is defined as meaning water that is "potable". In order to be potable, drinking water must not contain or exhibit any "determinands" to any extent that exceeds the

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25 Section 23(d).
26 Section 23(f).
27 By s 7 of the Health (Drinking Water) Amendment Act 2007.
28 Section 69A(2)(b).
29 Section 69A(2)(c).

maximum acceptable values specified in the drinking-water standards. In turn, a "determinand" is defined in the section as:

> (a) a substance or organism in water in circumstances where the extent to which any water contains that substance or organism may be determined or estimated reasonably accurately; or
>
> (b) a characteristic or possible characteristic of water in circumstances where the extent to which any water exhibits that characteristic may be determined or estimated reasonably accurately.

[44] Fluoride is a determinand because the extent to which it is contained in water can be accurately determined. The expression "maximum acceptable value" (MAV) is defined in s 69G in relation to a determinand as meaning:

> … a value stated in the drinking water standards as the maximum extent to which drinking water may contain or exhibit that determinand without being likely to present a significant risk to an average person consuming that water over a lifetime.

[45] We have already mentioned s 69O and the provenance of s 69O(3)(c). We agree with the Judge's conclusions about the significance of this provision which we have cited at [29] above. In particular, we agree with the Judge that this provision strongly indicates that Parliament specifically authorised the inclusion of fluoride in drinking water and that the purpose of s 69O(3)(c) was to avoid any suggestion that Parliament was requiring a drinking water supplier to fluoridate.

[46] This conclusion is reinforced by recognition in the New Zealand Standards that the addition of fluoride up to the maximum level of 1.5 ppm is specifically contemplated and authorised. If Parliament had intended that fluoride would no longer be a permissible additive to drinking water we would have expected it to say so explicitly. To the contrary the clear legislative intention in the LGA 2002 and pt 2A of the Health Act was to continue the status quo allowing local authorities to continue to fluoridate drinking water, subject to compliance with the relevant standards.

[47] Before discussing the New Zealand Standards, we note the pt 2A duties of drinking water suppliers so far as they are relevant. These are to take all practicable

steps to ensure that an adequate supply of drinking water is provided;[30] to take reasonable steps to contribute to the protection from contamination of the source of drinking water;[31] to take all practicable steps to comply with drinking-water standards;[32] and to take reasonable steps to supply wholesome drinking water.[33]

[48] We pause here to note the definition of the term "wholesome". In relation to drinking water, it means:[34]

> (a) being potable; and
>
> (b) not containing or exhibiting any determinand in an amount that exceeds the value stated in the guideline values for aesthetic determinands in the drinking-water standards as being the maximum extent to which drinking water may contain or exhibit the determinand without being likely to have an adverse aesthetic effect on the drinking water.

[49] Local authorities are also required by pt 2A of the Health Act to test new sources of drinking-water;[35] to monitor drinking-water for compliance with drinking-water standards and to detect and assess public health risks generally;[36] to prepare and implement public health risk assessment plans in relation to the supply of water;[37] to investigate complaints about the quality and wholesomeness of the drinking water[38] and to take remedial action if a breach of the drinking-water standards is detected.[39]

The New Zealand Standards

[50] Mr Paul Prendergast provided expert evidence about the New Zealand Standards based on his 30 years of experience in water management with both central and local government, including as the Principal Public Health Engineer employed by the Ministry of Health. The New Zealand Standards were prepared by an expert committee comprising over 30 of the country's most experienced drinking-

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30 Section 69S.
31 Section 69U.
32 Section 69V.
33 Section 69W.
34 Section 69G.
35 Section 69X.
36 Section 69Y.
37 Section 69Z.
38 Section 69ZE.
39 Section 69ZF.

water personnel, covering a wide range of expertise. The New Zealand Standards are based on the current version of the World Health Organisation (WHO) Guidelines For Drinking-Water Quality 2011.

[51] Many western countries, including Australia, have drinking-water standards based on the WHO Guidelines. The Australian guidelines are comparable to the New Zealand Standards and have the same MAV for fluoride. In Australia approximately 90 per cent of the population on reticulated water supplies receives fluoridated drinking-water.

[52] The current version of the New Zealand Standards was prepared in 2005 and revised in 2008. Public water suppliers are expected to test the water regularly to demonstrate compliance. Samples are taken at specified intervals to measure whether certain chemical substances, microbiological organisms or other characteristics (determinands) exceed the MAVs specified in the Standards. Any exceedance of a determinand must be reported immediately to the Drinking-Water Assessor and appropriate action taken.

[53] The MAVs apply to any determinand that is in the source water but not fully removed (for example, micro-organisms, pesticides and industrial waste); determinands added during the treatment process (for example, fluoride and impurities in water treatment chemicals); and determinands produced in the distribution system (for example, bacteria and disinfection by-products); and determinands arising from plumbing (for example, copper and lead).

[54] The MAV of a chemical determinand is the highest concentration of a determinand in the water that, on the basis of present knowledge, is considered not to cause any significant risk to the health of the consumer over 70 years of consumption of that water. The MAVs (including for fluoride) are based on an assessment of a wide variety of potential adverse effects, including the capability of any such substance to cause defects, genetic mutation or the risk of cancer. Also considered are effects such as organ failure, behaviour change, metabolic changes, body or organ weight changes, effects on the nervous system, cardiovascular, haematological and blood pressure effects, gastrointestinal effects and skeletal

effects. The assessment also takes into account the likely effects on children, pregnant women or other susceptible people. Most MAVs are very conservative, incorporating a safety factor from 100 to 3,000, depending on the level of uncertainty of effects.[40]

[55] The MAV for fluoride was set at 1.5 ppm in 1984, based on the WHO Guideline in that year. The WHO Guideline has remained unchanged for over 30 years. The MAV is based on a value to ensure long-term usage does not result in mild mottling of teeth (dental fluorosis). The health-based value of 1.5 ppm has also been adopted in other countries, including Australia and Great Britain. The equivalent in the United States is currently set at a level of 4 ppm because ground water supplies in that country have naturally occurring higher fluoride content.

[56] In May 2014 Water New Zealand[41] produced a guideline on the supply of fluoride chemicals, specifying impurity limits to cover all metallic determinands that have MAVs assigned to them in the New Zealand Standards. These limits (known as SILs) are calculated using the MAV for each metal, the maximum fluoride dose rate, the purity of the products, and a safety factor of 10. The maximum fluoride dose rate used is 1.0 ppm. In reality, most water suppliers use doses closer to 0.7 ppm, so the safety factor for SILs is nearer to approximately 14.

[57] Mr Prendergast summarises his evidence by saying that the New Zealand Standards and the industry standards recently published by Water New Zealand comprehensively cover the monitoring and testing applied to fluoridated water in order to regulate the addition of fluoride compounds to water supplied to consumers. As his evidence makes clear, MAVs are established for a wide range of parameters, including fluoride and are conservatively based on levels developed internationally. The Health Act and the New Zealand Standards require monitoring and steps to ensure the MAVs are not exceeded.

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40 In other words, the MAVs are 100 to 3,000 times the value at which the chemical determinand is considered to cause any significant risk to the health of the consumer.

41 Water New Zealand is the water industry's association and includes membership from water and wastewater suppliers (mainly local government), Crown research institutes and other scientists, several government departments and equipment manufacturers and suppliers.

Legal power to fluoridate — conclusions

[58] We conclude that Rodney Hansen J was correct to find that the LGA 2002 and the Health Act authorised local authorities to fluoridate public water supplies within the prescribed New Zealand Standards. In summary, the *Lower Hutt City* case established the lawful authority to fluoridate water in 1965 under the Municipal Corporations Act 1954. That authority continued under similar legislation at least until the passage of the LGA 2002. In providing under the LGA 2002 that local government organisations were required to continue to provide water services, Parliament must be taken to have been aware of the *Lower Hutt City* case and to have authorised the continuation of the practice of fluoridating water, which by that time had been established for almost 50 years.

[59] The matter was put beyond any doubt by the introduction in 2008 of pt 2A of the Health Act. During the Select Committee's consideration of this measure, the issue of fluoridation of water was raised. Concerns that local authorities might construe pt 2A as requiring the fluoridation of water supplies led to the introduction of s 69O(3)(c) to clarify that point. The absence of any provision prohibiting the use of fluoride in drinking water is a powerful indicator that Parliament intended to authorise local authorities to fluoridate water supplies if they wished to do so. It follows that, by necessary implication, Parliament clearly authorised but did not compel the fluoridation of drinking water.[42] The inclusion of a MAV for fluoride in the New Zealand Standards required by pt 2A supports this conclusion.

Is the s 11 right to refuse to undergo medical treatment engaged by the fluoridation of drinking-water?

The approach in the High Court

[60] Rodney Hansen J found that the fluoridation of drinking water supplies does not amount to medical treatment that would engage s 11 of the NZBORA. He accepted that the process of fluoridation has a therapeutic objective. Although the Council resisted that notion in the High Court, the finding is not challenged on appeal. While noting there were differences of opinion as to whether the compounds

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[42] *Cropp v Judicial Committee* [2008] NZSC 46, [2008] 3 NZLR 774 at [25]–[28].

used for fluoridation are to be characterised as a medicine, a dietary supplement, a nutrient or merely as recreating fluoride levels naturally occurring in water, the Judge found that:[43]

> … fluoridation has a therapeutic medical purpose, preventing tooth decay, and a known pharmacological effect, namely the mineralisation of tooth enamel.

[61] The Judge considered it was the means by which the therapeutic purpose was achieved that lay at the heart of the controversy between the parties. He reviewed a number of overseas authorities but found them to be of little assistance since the right to refuse to undergo medical treatment has no parallel in equivalent international instruments. Rather, the overseas authorities had focused on the broader right to bodily integrity, privacy or liberty. As the Judge saw it, the right to refuse medical treatment in s 11 was a somewhat narrower right.

[62] He was unable relevantly to distinguish fluoridation from other processes such as the addition of chlorine to drinking water or the addition of iodine to salt, folic acid to bread or the pasteurisation of milk:[44]

> [80] In my view, fluoridation cannot be relevantly distinguished from the addition of chlorine or any other substance for the purpose of disinfecting drinking water, a process which itself may lead to the addition of contaminants as the water standards themselves assume. Both processes involve adding a chemical compound to the water. Both are undertaken for the prevention of disease. It is not material that one works by adding something to the water while the other achieves its purpose by taking unwanted organisms out.
>
> [81] The addition of iodine to salt, folic acid to bread and the pasteurisation of milk are, in my view, equivalent interventions made to achieve public health benefits by means which could not be achieved nearly as effectively by medicating the populace individually. The fact that iodine is an essential nutrient, necessary for the function of the thyroid gland as Professor David Menkes pointed out, does not alter the fact that it is added to salt in order to prevent thyroid disease. All such measures have a therapeutic purpose. All are intended to improve the health of the populace. But they do not, in my view, constitute medical treatment for the purpose of s 11.

[63] In elaborating on his view that s 11 was of more limited scope than the broader rights incorporated in international instruments, the Judge did not consider

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43 Council judgment, above n 1, at [58].

44 Council judgment, above n 1 (footnotes omitted).

that a person drinking fluoridated water or ingesting iodised salt would naturally be described as "undergoing" medical treatment. That was to be contrasted with undergoing a course of treatment that included taking fluoride.

[64] Rodney Hansen J also reasoned that the language of s 11 in context appeared strongly to suggest that the right to refuse medical treatment was only engaged when the treatment took place in the context of a therapeutic relationship in which medical services are provided to an individual. Developing this point, he said:[45]

> [84] … That is the only context in which the right has been invoked in New Zealand and, as an element of the broader rights relied on in the overseas authorities to which I was referred. That is not, of course, decisive. It does, however, serve to underline that to extend the right to refuse medical treatment to public health measures intended to benefit all or a section of the populace is a significant step.

[65] The Judge considered that the language of the NZBORA did not support such an extension nor did internationally recognised human rights norms require it. He accepted submissions made on behalf of the Attorney-General as intervener as to why extending s 11 in this way was inappropriate. We will discuss these reasons in more detail below. For the present it is sufficient to record the Judge's conclusion on this point:

> [89] Section 11 ensures that within the context of a therapeutic relationship there is a right to refuse medical treatment. To the extent that public health measures may lead to therapeutic outcomes and constitute medical treatment in the broad sense, an individual has no right to refuse, at least not so as to produce outcomes that will deny others the benefit of such measures. In the case of fluoridation that does not necessarily lead to unwanted outcomes. As I will shortly discuss in more detail, and as has been acknowledged in the overseas jurisprudence, a resolute consumer who does not want to ingest additional fluoride can employ a range of measures to avoid doing so.

[66] The Judge then canvassed submissions made to him that no one is compelled to consume drinking water supplied to their homes. On that issue, he tended to the view that if the supply of fluoridated water were to be regarded as medical treatment, a consumer would not have the practical ability to refuse treatment. Nevertheless, the Judge considered that any such intrusion on an individual's rights would be minimal. He saw this as being relevant for the purpose of determining whether the

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[45] Council judgment, above n 1.

s 11 right was engaged in the first place rather than whether the infringement was trivial or technical in nature. That issue was viewed as being more appropriately addressed in the analysis under s 5. We deal separately with that issue below.

The arguments on appeal

[67] Ms Scholtens QC challenged the Judge's findings, submitting on behalf of New Health that a generous and purposive approach should be taken to interpreting the s 11 right.[46] She submitted that s 11 encapsulates the idea that every individual has the right to determine what they do or do not do to their own body. That was so whether or not, objectively considered, the refusal of treatment was medically unwise or contrary to the individual's best interests.

[68] Relying on dictionary definitions of medical treatment, counsel submitted it was clear that, at its core, "medical treatment" meant a medical procedure for the purpose of treating or preventing disease or injury. Reference was made to *M v Attorney-General* in which Potter J rejected a submission that a medical examination did not amount to medical treatment.[47] Counsel also referred to other High Court judgments in which medical treatment has been held to include confinement in an abortion clinic;[48] and the psychological assessment of a prisoner.[49]

[69] Noting that the Judge had accepted that the fluoridation of water supplies was undertaken for a therapeutic purpose, Ms Scholtens submitted that the Judge had erred in finding that it was the means by which the therapeutic purpose was achieved that determined whether fluoridation qualifies as medical treatment for the purposes of s 11. In particular, the Judge's comparisons with other public health measures was inapt; the finding that the process of drinking fluoridated water did not amount to medical treatment being undergone for the purposes of s 11 was wrong, as was the finding that medical treatment for the purposes of s 11 should be confined to the provision of medical treatment within a therapeutic relationship. In that respect, counsel submitted that protection of the right to refuse medical treatment should not

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46 Relying on *Ministry of Transport v Noort* [1992] 3 NZLR 260 (CA) at 268–69, 277 and 286 and *R v Big M Drug Mart Ltd* [1985] 1 SCR 295 at 344 per Dickson J.

47 *M v Attorney-General* [2006] NZFLR 181 (HC) at [107].

48 *Re a case stated by the Abortion Supervisory Committee* [2003] 3 NZLR 87 (HC).

49 *Smith v Attorney-General* HC Wellington CIV-2005-485-1785, 9 July 2008.

depend on the mode of delivery. Finally, counsel submitted the High Court was wrong to exclude public health interventions from the application of s 11 on the ground that the individual's right to refuse would become the individual's right to decide outcomes for others.

[70] For the Council, Mr Laing relied on the Judge's reasoning on this issue, as did Mr Powell for the Attorney-General as intervener.

Analysis

[71] As already noted, s 11 of the NZBORA has no direct equivalent in international human rights instruments, although it has been recognised in some domestic constitutions.[50] Rather, it appears to have developed as an element of the general right to privacy and the right to bodily integrity, which the common law has long recognised as a fundamental right.[51] For example, in a context not directly concerned with s 11, this Court has recognised that a complainant in a criminal case has a right to have her privacy, dignity and bodily integrity protected from non-consensual medical procedures.[52]

[72] As Rodney Hansen J noted, s 11 is one of four sections included in the NZBORA relating to the life and security of the person. These are the rights not to be deprived of life,[53] the right not to be subjected to torture or cruel treatment,[54] the right not to be subjected to medical or scientific experimentation,[55] and the right to refuse to undergo a medical treatment.[56] Sections 9 and 10 of the NZBORA can be related directly to art 7 of the International Covenant on Civil and Political Rights, which provides:[57]

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50 See Andrew Butler and Petra Butler *The New Zealand Bill of Rights Act: A Commentary* (2nd ed, LexisNexis, Wellington, 2015) at [11.3.1]–[11.3.4].

51 Manfred Nowak *UN Covenant on Civil and Political Rights: CCPR Commentary* (2nd revised ed, NP Engel, Kehl, 2005) at 387.

52 *R v B* [1995] 2 NZLR 172 (CA) at 177 per Cooke P, at 182 per Richardson J and at 185 per Hardie Boys J.

53 New Zealand Bill of Rights Act 1990, s 8.

54 Section 9.

55 Section 10.

56 Section 11.

57 International Covenant on Civil and Political Rights 999 UNTS 171 (opened for signature 16 December 1966, entered into force 23 March 1976), art 7.

> No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.

[73] It is not in dispute that the inclusion of the right not to be subject to medical or scientific experimentation without consent was a specific response to the atrocities of the Nazi concentration camps.[58] In the parliamentary process leading to the passage of the NZBORA a change was made to the grouping of the rights now comprising ss 8 to 11 of the NZBORA. The Judge explained this in these terms:[59]

> [51] In the draft Bill attached to the White Paper, the right to refuse to undergo medical treatment was initially grouped with the rights now found in ss 9 and 10 under the heading "No Torture or Cruel Treatment". The Interim Report of the Justice and Electoral Law Subcommittee recommended including those rights with the separate right to life under s 8 under the broader heading "Life and Security of the Person". The relevant passage of this report reads:[60]
>
> > The effect of including the right not to be subjected to medical or scientific experiments without consent in article 7 [of the ICCPR] was to require that any infringement reached the threshold of degrading or inhuman treatment. If the three rights proposed in article 20 of the Draft Bill of Rights attached to the White paper had remained in that form, it would have suggested a similar alignment of the right to refuse medical treatment to the torture threshold.

[74] As the Judge said, by following the recommendation in the Report of the Justice and Electoral Law Select Committee, Parliament made it clear that s 11 stands on its own.

[75] The Judge accepted that the White Paper preceding the passage of the NZBORA made it clear that medical treatment would not be confined to interventions which interfered with physical bodily integrity. The White Paper said:[61]

> The word "medical" is used in a comprehensive sense. It would certainly include surgical, psychiatric, dental, psychological and similar forms of treatment.

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58 Manfred Nowak, above n 51, at 188.

59 Council judgment, above n 1 (footnote in original).

60 Interim Report of the Justice and Electoral Law Select Committee — Inquiry into the White Paper — A Bill of Rights for New Zealand (1987) 1 AJHR 8A.

61 Geoffrey Palmer "A Bill of Rights for New Zealand: A White Paper" [1984–1985] I AJHR A6 at [10.167].

[76] We accept Ms Scholtens' submission that a generous and purposive approach should be taken to interpreting the s 11 right.[62] However, we endorse the fuller description of the approach to be taken in interpreting the NZBORA articulated by Dickson J (as he then was) in *R v Big M Drug Mart Ltd*, including his observation that it was important not to "overshoot" the actual purpose of the right in question:[63]

> 116. This Court has already, in some measure, set out the basic approach to be taken in interpreting the Charter. In *Hunter v. Southam Inc.*, [1984] 2 S.C.R. 145, this Court expressed the view that the proper approach to the definition of the rights and freedoms guaranteed by the Charter was a purposive one. The meaning of a right or freedom guaranteed by the Charter was to be ascertained by an analysis of the purpose of such a guarantee; it was to be understood, in other words, in the light of the interests it was meant to protect.
>
> 117. In my view this analysis is to be undertaken, and the purpose of the right or freedom in question is to be sought by reference to the character and the larger objects of the Charter itself, to the language chosen to articulate the specific right or freedom, to the historical origins of the concepts enshrined, and where applicable, to the meaning and purpose of the other specific rights and freedoms with which it is associated within the text of the Charter. The interpretation should be, as the judgment in *Southam* emphasizes, a generous rather than a legalistic one, aimed at fulfilling the purpose of the guarantee and securing for individuals the full benefit of the Charter's protection. At the same time it is important not to overshoot the actual purpose of the right or freedom in question, but to recall that the Charter was not enacted in a vacuum, and must therefore, as this Court's decision in *Law Society of Upper Canada v. Skapinker*, [1984] 1 S.C.R. 357, illustrates, be placed in its proper linguistic, philosophic and historical contexts.

[77] Approached in this light, we have found Mr Powell's submissions helpful. While he accepted that the underlying norms of s 11 included the notion of integrity of the human body, he submitted it also reflected the concept of autonomy, which he described as the right to self-fulfilment through actions that do not affect the rights of others. We would add that human dignity also underlies s 11. Both personal autonomy and human dignity support the right of an individual to make personal decisions about medical treatment.[64]

[78] Bearing in mind the absence of any general right to security of the person under s 11, Mr Powell posed the question: "Why was specific protection given

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62 *Ministry of Transport v Noort*, above n 46.
63 *R v Big M Drug Mart Ltd*, above n 46.
64 Paul Rishworth and others *The New Zealand Bill of Rights* (Oxford University Press, Melbourne, 2003) at 252.

against the one form of intrusion into personal autonomy that is generally therapeutic?" His answer to this question was that Parliament must have sought to give effect to a right already recognised at common law.

[79] In that respect the common law had long accepted that the consent of a patient was a fundamental pre-requisite to any medical or surgical treatment. This was recognised, for example, by the House of Lords in *F v West Berkshire Health Authority*, dealing with the lawfulness of a proposed sterilisation operation on the plaintiff who, by reason of her mental incapacity, was disabled from giving her consent to the operation.[65] Lord Goff referred to the well-established general rule that the performance of a medical operation on a person without consent is unlawful as constituting both the crime of battery and the tort of trespass to the person.[66]

[80] Some support for Mr Powell's submission may be found in the White Paper. Discussing the right now enshrined in s 11, the White Paper said:[67]

> … This right is of course subject to Article 3 [now s 5 of the NZBORA], but it is anticipated that this would permit persons to be treated against their will only where this is necessary to protect the health and safety of other persons, and not simply where their refusal of treatment will detrimentally affect their own health. Like paragraph (2), this paragraph raises the question of consents to medical treatment on minors and others who are incapable of consenting on their own behalf. The general rule under existing law is that minors are incapable of consenting to medical treatment on themselves, and the law provides that parents, guardians, and certain other persons may consent on their behalf. …

[81] Clearly the authors of the White Paper had in mind the interrelated issues of consent to medical treatment or the refusal of such consent in a therapeutic setting, as Rodney Hansen J found. There is nothing in the White Paper discussion to suggest that the idea of medical treatment was being entertained in any broader context than the common law already contemplated. While Mr Powell accepted that the content of the guaranteed rights in the NZBORA is not confined to concepts recognised in the common law, he submitted that, in order to take s 11 beyond the confines of treatment of an individual and into the sphere of public health measures

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65 *F v West Berkshire Health Authority* [1989] 2 All ER 545 (HL).

66 At 564. See also *S v S; W v Official Solicitor* [1970] 3 All ER 107 (HL) at 111 per Lord Reid, referring to the protection of personal liberty as the reason that a person of full age and capacity cannot be ordered to undergo a blood test against that person's will.

67 Above n 61, at [10.166].

undertaken for the common good, something more was needed. There was, he said, no support for the view expressed by the learned authors of *The New Zealand Bill of Rights Act: A Commentary*:[68]

> The right to challenge public health measures is one of the most important rights within the ambit of the right to refuse medical treatment.

[82] Supporting the Judge's conclusion that to take that step is significant, Mr Powell submitted that to do so would necessarily engage a conflict of rights. As he put it, in the individual context the state is able to guarantee the inviolability of the human mind and body because within that sphere there are no competing interests that must be moderated or resolved. However, an extension of the s 11 right into areas where the rights and interests of others are engaged demands balancing so that the expression of the right is not so widely drawn as to interfere with the rights of others.

[83] In that respect, public health measures, such as the fluoridation of drinking water, raise other issues affecting the population at large. The right to a minimum standard of health guaranteed by art 12 of the International Covenant on Economic, Social and Cultural Rights is engaged. Article 12 provides:[69]

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

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68 Butler and Butler, above n 50, at [11.9.8].

69 International Covenant on Economic, Social and Cultural Rights 933 UNTS 3 (opened for signature 16 December 1966, entered into force 3 January 1976), art 12. New Zealand is a signatory to this Covenant.

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

[84] New Zealand gives effect to the human rights obligation in art 12 through the New Zealand Public Health and Disability Act 2000. So far as it is relevant, the purpose of this Act is set out in s 3:

> **3 Purpose**
>
> (1) The purpose of this Act is to provide for the public funding and provision of personal health services, public health services, and disability support services, and to establish new publicly-owned health and disability organisations, in order to pursue the following objectives:
>
> (a) to achieve for New Zealanders—
>
> (i) the improvement, promotion, and protection of their health:
>
> (ii) the promotion of the inclusion and participation in society and independence of people with disabilities:
>
> (iii) the best care or support for those in need of services:
>
> (b) to reduce health disparities by improving the health outcomes of Maori and other population groups:
>
> …
>
> (d) to facilitate access to, and the dissemination of information to deliver, appropriate, effective, and timely health services, public health services and programmes, both for the protection and the promotion of public health, and disability support services.
>
> …

[85] The definitions of "public health" and "public health services" in s 6 are also material to the extent they emphasise that such services embrace the public generally or particular sections of the public:

> **public health** means the health of all of—
>
> (a) the people of New Zealand; or
>
> (b) a community or section of such people
>
> **public health services** means goods, services, and facilities provided for the purpose of improving, promoting, or protecting public health or preventing population-wide disease, disability, or injury; and includes—

(a) regulatory functions relating to health or disability matters; and

(b) health protection and health promotion services; and

(c) goods, services, and facilities provided for related or incidental functions or purposes

[86] Although art 12 and the New Zealand Public Health and Disability Act place responsibility for public health interventions on the state, we accept Mr Powell's submission that the principle that public health interventions necessarily engage the potential for a conflict of rights applies whether the public power is exercised by local or central government. We also accept his overall submission that where public health measures do not involve direct interference with bodily integrity and personal autonomy, the s 11 rights are not engaged. As Mr Powell submitted, were it otherwise, the law would allow an individual an unwarranted veto power in decision-making that affects the whole community and would constitute an interference with the rights of others.

[87] Summarising this point, we agree with the Judge for the reasons he gave that the right guaranteed by s 11 to refuse to undergo medical treatment does not extend to public health measures such as the fluoridation of drinking water intended to benefit the public at large. As the Judge said, it would be a significant step to extend the s 11 right beyond its application to medical treatment in a therapeutic relationship. To take such a step is not justified for three reasons: the language of the provision itself; the common law as it stood at the time the NZBORA was enacted; and the human rights values underlying s 11.

[88] As to the first, we agree with the Judge that to interpret s 11 as conferring on an individual the right to refuse the addition of fluoride to drinking water is a significant strain on the language of s 11. To describe a person drinking fluoridated water as "undergoing" medical treatment is inapt. We agree with the Judge that the ordinary and natural meaning of undergoing medical treatment describes a process in which something is "done" to a patient in a therapeutic setting.

[89] As to the second, we acknowledge that the rights and freedoms guaranteed by the NZBORA are not to be confined to those existing under the common law. But,

as Dickson J noted in the *Big M Drug Mart* case, the Charter must be placed "in its proper linguistic, philosophic and historical contexts".[70] As the White Paper identified, the focus was on the circumstances in which people could be treated against their will, as well as related issues, such as the capacity of minors to consent. These concerns are consistent with the common law relating to consent for the purposes of both the criminal and civil law.

[90] Of course, medical treatment in terms of s 11 is not confined to medical procedures involving physical interventions to bodily integrity. As the White Paper contemplated, it includes other forms of medical treatment, such as psychiatric and psychological treatment. But there is nothing in the Parliamentary materials to suggest the legislature intended s 11 to embrace public health measures of the kind at issue here as medical treatment.

[91] Dealing with the third point in [87] above, there is nothing in the human rights norms underlying s 11 to suggest or require that the right should be extended to measures such as the fluoridation of drinking water. As the Judge found, s 11 stands on its own and is not reflected in any of the international human rights instruments. There have been a number of challenges to the fluoridation of drinking water in overseas jurisdictions on various grounds, alleging the practice breaches rights of bodily integrity, privacy and liberty. These were canvassed by the Judge but, as he found, none of the challenges was successful. The consequence, as Mr Powell put it, is that when Parliament enacted the NZBORA there was no heritage of case law or recognised human rights norms to suggest the legislature intended the s 11 right to extend to public health measures of the type at issue here.

[92] To extend s 11 as New Health advocates would immediately lead to a clash between the rights of the individual and those of the population at large in the way developed by Mr Powell in his submissions and accepted by the Judge. It would also conflict with the statutory obligations of central and local government to promote the health of citizens generally.

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70 *R v Big M Drug Mart Ltd*, above n 46, at [117].

[93] The final topics we address on the scope of the s 11 right are how the process of fluoridation should be characterised and the Judge's view that fluoridation of drinking water is indistinguishable from a range of other public health measures.

[94] As to the first, much ink was spilt in New Health's submissions and in the evidence before the High Court as to whether the fluoridation of drinking water should be characterised as a dietary nutrient, a medicine or in some other manner. We agree with the Judge that the descriptor should not be decisive. The Judge's acceptance that fluoride is a compound added to water for therapeutic purposes is no longer in issue and we see little merit in further exploring this issue in the context of the Council appeal.

[95] As to the second topic, we repeat for convenience the Judge's finding:[71]

> [81] The addition of iodine to salt, folic acid to bread and the pasteurisation of milk are, in my view, equivalent interventions made to achieve public health benefits by means which could not be achieved nearly as effectively by medicating the populace individually. The fact that iodine is an essential nutrient, necessary for the function of the thyroid gland as Professor David Menkes pointed out, does not alter the fact that it is added to salt in order to prevent thyroid disease. All such measures have a therapeutic purpose. All are intended to improve the health of the populace. But they do not, in my view, constitute medical treatment for the purpose of s 11.

[96] Ms Scholtens submitted these conclusions were wrong: the addition of chlorine to drinking water was not for a therapeutic purpose. Rather, it was to make water safe to drink. The pasteurisation of milk has a similar purpose. In contrast, the fluoridation of drinking water was to protect against dental caries. While we accept there may be a semantic distinction between measures to preserve health and those designed to improve health, we agree with the Judge that the difference is immaterial for present purposes.

[97] As to the comparisons with adding iodine to salt or folic acid to bread, Ms Scholtens submitted that the fluoridation of water could be distinguished from the practice of fortifying foods because fluoride was not a dietary nutrient. Again, we find ourselves in agreement with the Judge's reasoning on this point. Fine distinctions of the kind suggested cannot avoid the inevitable conclusion that

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[71] Council judgment, above n 1 (footnote omitted).

measures of this kind are all taken in one way or another for the benefit of the health of the general population.

[98] The discussion of these issues serves to illustrate the difficulties that would arise should medical treatment for the purposes of s 11 be interpreted in the way advocated by New Health. The legislature could not have contemplated outcomes of this kind.

If the fluoridation of drinking water is medical treatment in terms of s 11, is it possible for an individual to refuse such treatment?

[99] The Council submitted in the High Court that an individual could avoid drinking fluoridated water in various ways. These included filtering the water, using tank water or drinking only non-fluoridated bottled water. While measures such as these may be technically possible, we agree with the Judge's view that if the fluoridation of drinking water is regarded as medical treatment then, from a practical standpoint, it is not realistic to suggest an individual could avoid consumption of the fluoridated water. To do so in the ways suggested by the Council would likely be expensive, inconvenient or both.

The application of s 5 of the NZBORA

[100] Rodney Hansen J went on to consider whether, if he were wrong in his conclusion that s 11 of the NZBORA was not engaged, the fluoridation of drinking water proposed by the Council was a justified limit in terms of s 5 of the NZBORA:

> **5 Justified limitations**
>
> Subject to section 4, the rights and freedoms contained in this Bill of Rights may be subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Prescribed by law

[101] The Judge cited the well-known remarks of McGrath J in *Hansen v R*:[72]

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[72] *Hansen v R* [2007] NZSC 7, [2007] 3 NZLR 1 at [180] (footnotes omitted).

> To be prescribed by law, limits must be identifiable and expressed with sufficient precision in an Act of Parliament, subordinate legislation or the common law. The limits must be neither ad hoc nor arbitrary and their nature and consequences must be clear, although the consequences need not be foreseeable with absolute certainty.

[102] The Judge had no difficulty in rejecting a submission made on behalf of New Health that, at best, the legislation conferred only an imprecise discretion to fluoridate drinking water. He was satisfied there was clear statutory authority to fluoridate water supplies deriving from the broad power to supply water in the LGA 2002 and from what the Judge regarded as an express recognition in the Health Act that such water may contain added fluoride.

[103] Ms Scholtens submitted that the relevant legislation neither expressly permitted the fluoridation of drinking water nor did so by necessary implication. Mr Powell submitted by reference to authorities we discuss below that, where an action that limits a right guaranteed by the NZBORA is taken within the bounds of a discretionary power conferred by statute, it is nevertheless prescribed by law for the purposes of s 5, whether or not the limitation was specifically contemplated by the enactment.

[104] The issue was discussed by the Ontario Court of Appeal in *Wynberg v Ontario*.[73] The question was whether a Minister had breached rights under the Canadian Charter in relation to an early intervention programme for autistic children. The programmes were established under a broad discretionary statutory power. Addressing the equivalent in the Canadian Charter of our s 5, the Court found the requirement that a limit on a Charter right be prescribed by law did not mean the limit must be found in a statute or regulation — it was sufficient if the limit was authorised by the statute or regulation.[74]

[105] In reaching this conclusion, the Ontario Court of Appeal adopted the reasoning of Lamer J in the decision of the Supreme Court of Canada in *Slaight*

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73 *Wynberg v Ontario* (2006) 269 DLR (4th) 435 (ONCA).
74 At [151] and [159].

Communications Inc v Davidson.[75] Lamer J distinguished between two types of situation:

> (a) Where an order is made by an administrative tribunal pursuant to legislation which confers the power to infringe a protected right either expressly or by necessary implication.
>
> (b) Where the legislation pursuant to which the order is made confers an imprecise discretion and does not confer, either expressly or by necessary implication, the power to limit the rights guaranteed.[76]

[106] In the first case, it is necessary to examine the legislation to ascertain whether there is a justified limit on the protected right. In the second, the focus is on the order or decision made pursuant to the discretion.

[107] The Ontario Court observed that much governmental action is undertaken by means other than statute or regulation and endorsed the view of the trial Judge that a restrictive approach to the phrase "prescribed by law" could force government to enshrine in legislation or regulation all programmes where there might be a prospect of a Charter violation.[77]

[108] We agree with these observations. We are satisfied this case falls within the first of the categories articulated by Lamer J. Our conclusions on the statutory powers available to the Council are summarised at [58] and [59] above. To reiterate, we are satisfied that the LGA 2002 and the Health Act, at least by necessary implication, clearly authorise but do not compel the fluoridation of drinking water. In these circumstances, we agree with Rodney Hansen J that any infringement of the s 11 right is a limit prescribed by law for the purposes of s 5. The same conclusion must follow from the inclusion of a MAV for fluoride in the New Zealand Standards, which constitute subordinate legislation authorised by the Health Act.

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[75] *Slaight Communications Inc v Davidson* [1989] 1 SCR 1038 at 1079–80. Although Lamer J dissented, his reasoning on this issue was approved by the majority and by Beetz J at 1048 and 1058 respectively.

[76] See the discussion on this point in the New Zealand context by Mallon J (along with two lay members of the Court) in *Attorney-General v Idea Services Ltd (in stat man)* [2012] NZHC 3229, [2013] 2 NZLR 513 at [176]–[193].

[77] *Wynberg v Ontario*, above n 73, at [157].

If the s 11 right is infringed, is the fluoridation of drinking water a reasonable limit that can be demonstrably justified in a free and democratic society for the purposes of s 5?

The Judge's approach

[109] The Judge adopted the approach to the s 5 analysis articulated by Tipping J in *Hansen v R*:[78]

> [104] This approach can be said to raise the following issues:
>
> "(a) does the limiting measure serve a purpose sufficiently important to justify curtailment of the right or freedom?
>
> (b)
>
> (i) is the limiting measure rationally connected with its purpose?
>
> (ii) does the limiting measure impair the right or freedom no more than is reasonably necessary for sufficient achievement of its purpose?
>
> (iii) is the limit in due proportion to the importance of the objective?"

[110] Rodney Hansen J dealt with this issue relatively briefly, reflecting no doubt the observation he made at the commencement of his judgment that he was not required to pronounce on the merits of fluoridation. In summary, he found that the objective of improving the dental health of New Zealanders, particularly children, was unarguably of sufficient importance to justify curtailment of the s 11 right; there was a clear rational connection between fluoridation and its objectives; fluoridation was within the range of reasonable options available to Parliament to address the problem of dental decay, particularly in low socio-economic areas; and the power conferred on local authorities to fluoridate water was a proportionate response to what he described as the "scourge" of dental decay, particularly in socially disadvantaged areas.

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[78] *Hansen v R*, above n 72.

The standard of review

[111] During the hearing of the appeals we expressed some reluctance to enter the debate about the merits or otherwise of fluoridation of drinking water. This was in recognition of the fact that the courts are not equipped to determine disputed issues of scientific or technical opinion, particularly in the context of an appeal from a decision made in judicial review proceedings. Ms Scholtens acknowledged as much in the course of her submissions.

[112] As discussed by Tipping J in *Hansen v R*, the courts perform a review function in this field, rather than simply substituting their own view.[79] How much latitude the courts give to Parliament's appreciation of the matter depends on a variety of circumstances. As Tipping J said:

> [116] … There is a spectrum which extends from matters which involve major political, social or economic decisions at one end to matters which have a substantial legal content at the other. The closer to the legal end of the spectrum, the greater the intensity of the court's review is likely to be. …

[113] Further, as this Court observed in *Ministry of Health v Atkinson*, the context of the case will affect the type of evidence required to meet the standard of proof.[80]

[114] Similar points were made by the House of Lords in *Wilson v First County Trust Ltd (No 2)* in the context of the Human Rights Act 1998 (UK) and the European Convention on Human Rights.[81] As noted by Lord Nicholls:[82]

> … courts should have in mind that theirs is a reviewing role. Parliament is charged with the primary responsibility for deciding whether the means chosen to deal with a social problem are both necessary and appropriate. … The readiness of a court to depart from the views of the legislature depends upon the circumstances, one of which is the subject matter of the legislation. The more the legislation concerns matters of broad social policy, the less ready will be a court to intervene.

[115] Here, Parliament has, by necessary implication, authorised local authorities to fluoridate drinking water subject to the requirements of the New Zealand Standards.

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79 *Hansen v R*, above n 72, at [116].

80 *Ministry of Health v Atkinson* [2012] NZCA 184, [2012] 3 NZLR 456 at [166].

81 *Wilson v First County Trust Ltd (No 2)* [2003] UKHL 40, [2004] 1 AC 816.

82 At [70]. See also *R (SB) v Governors of Denbigh High School* [2006] UKHL 15, [2007] 1 AC 100 at [30] per Lord Bingham of Cornhill and *Ghaidan v Godin-Mendoza* [2004] UKHL 30, [2004] 2 AC 557 at [19] per Lord Nicholls.

Given the nature of the subject matter and the appropriate degree of deference to Parliamentary decisions of this nature, our approach will be to outline the principal evidence before the Court.[83] Necessarily, in view of the limitations just discussed, this will amount to a broad assessment of the preponderance of the evidence sufficient to address the key issues in terms of the test laid down in *Hansen v R*.

The evidence

[116] We refer first to the evidence adduced by the Council so far as it relates to the s 5 issues.

Dr Whyman

[117] The most pertinent evidence for the Council is that of Dr Whyman. He is the Clinical Director of Oral Health Services at the Hawkes Bay District Health Board and the principal dental officer for the Whanganui District Health Board. He has an impressive list of qualifications, including the practice of dentistry for some 26 years. He has also held a number of positions connected with dental health, including the Executive Director of the New Zealand Dental Association and Chief Dental Officer of the Ministry of Health. He is also engaged as an advisor to the National Fluoridation Information Service operated under the Hutt Valley District Health Board in terms of a contract from the Ministry of Health. In this capacity he provides up-to-date sources of information and critical commentary on research relating to water fluoridation.

[118] Dr Whyman's evidence is that a significant proportion of New Zealanders has poor oral health. He cited the 2009 New Zealand Oral Health Survey,[84] which reported that:

(a) Among children aged 2–11 years, 41 per cent have experienced dental decay in their primary teeth and 17 per cent have untreated decay or caries.

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83 We note this approach accords with the "variable level of intensity of review" outlined in Butler and Butler, above n 50, at [6.14.2]–[6.14.3].

84 Ministry of Health *Our Oral Health: Key findings of the 2009 New Zealand Oral Health Survey* (December 2010).

(b) Among children aged 5–17 years, 39 per cent have already experienced dental decay in their permanent teeth and 8 per cent have untreated decay or caries.

(c) Among adults, over 35 per cent have untreated decay, while over 75 per cent have had dental decay at some point.

[119] Dr Whyman refers to a number of international scientific reviews of fluoride and water fluoridation, as well as studies published in scientific journals, to support his opinion that fluoridation is effective in reducing both the incidence and severity of tooth decay among children and adults. Prominent amongst these studies is the York Review undertaken in 2000.[85] According to Dr Whyman's evidence, this was a systematic review of the international literature on the effect of water fluoridation on dental caries undertaken in England by the University of York's National Health Service Centre for Reviews and Dissemination. Dr Whyman's summary of this study is as follows:

> The York Review reported that the best available evidence suggests that fluoridation of drinking water supplies does reduce caries prevalence, both as measured by the proportion of children who are caries free and by the mean change in dmft/DMFT[86] score. The median difference in the proportion of children decay free in the 26 studies accepted for inclusion in their review was 15%.

[120] Of particular relevance to New Zealand is a 2004 study by Lee and Dennison comparing the children of Canterbury and Wellington.[87] Canterbury water does not have a fluoridated water supply while Wellington does. Water fluoridation was associated with a 31 per cent lower dental caries severity score in primary teeth for five-year-old children and a 41 per cent lower dental caries severity score in permanent teeth for 12-year-old children.

[121] Dr Whyman also considers potential adverse effects of fluoridation. These included dental fluorosis; risks to infants consuming powdered infant formula

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85 McDonagh and others "Systematic review of public water fluoridation" (2000) 321 British Medical Journal 855.

86 These acronyms refer to decayed, missing and filled primary teeth and permanent teeth respectively.

87 J M Lee and P D Dennison "Water fluoridation and dental caries in 5- and 12- year old children from Canterbury and Wellington" (2004) 100 New Zealand Dental Journal 10.

reconstituted with fluoridated water; skeletal fluorosis and reduced brain functioning. We will refer here only to the level of risk of dental fluorosis. Dr Whyman reviewed studies in New Zealand and Australia. Most studies had shown an increase in the prevalence of diffuse opacities in teeth enamel. This is equivalent to very mild or mild dental fluorosis in children from areas with water fluoridation compared to those from areas without water fluoridation. In these studies, the prevalence was increased by about 15 per cent, to about 30 per cent of children having one tooth or more affected by diffuse opacities. None of the studies had reported any difference in the prevalence of dental enamel hypoplasia, the category in which moderate or severe fluorosis would be included.

[122] On the other hand, the 2009 New Zealand Oral Health Survey had assessed specifically for the presence of dental fluorosis in the upper front permanent teeth of children and adults aged 8 to 30 years. The survey found there was no significant difference in the prevalence of any type or severity of enamel fluorosis between people living in fluoridated and non-fluoridated areas.

[123] Dr Whyman considers the known risks from fluoridated water supplies at the level of 0.7 to 1.0 ppm of very mild or mild dental fluorosis are minor, while other purported health risks associated with water fluoridation are not supported by medical and dental literature.

[124] Dr Whyman addresses the alternative of regular tooth brushing with fluoridated toothpaste. He agrees this could provide a complementary effective means of protection from tooth decay and is standard oral health advice. Dr Whyman considers it is reasonable to expect that children, adolescents and adults would have received advice to brush twice daily with a fluoridated toothpaste, particularly given that all children up to the age of 18 years are eligible for free dental care in New Zealand and that enrolment levels are very high.

[125] However, his view is that reliance on brushing teeth with fluoride toothpaste is likely to be a substantially less effective strategy for improving the dental health of the general population. He notes that the 2009 New Zealand Oral Health Survey reported that only about 43 per cent of New Zealand children aged 2 to 17 years and

65 per cent of adults aged 18 years or over had stated they brushed their teeth twice daily with a fluoridated toothpaste.

[126] Dr Whyman is firmly of the view that water fluoridation is a proportionate response to the undoubted problem of public dental health. The concrete and significant benefits in his view are the reduction of the incidence and severity of dental caries; long term public health cost savings; and reduced health inequalities.

[127] Dr Whyman's evidence is that community water fluoridation is supported by numerous reputable national and international bodies, including the WHO, the US Surgeon-General, the US Center for Disease Control, the Australian National Health and Medical Research Council, the Royal Society of New Zealand, the New Zealand Cancer Society, and the American, Australian, British and New Zealand Dental Associations.

Dr Haisman-Welsh

[128] Dr Haisman-Welsh is the Chief Dental Officer for the Ministry of Health. The Ministry is the government's agent and key advisor on health and disability issues. The Ministry recommends water fluoridation as a safe, effective and affordable way to prevent and reduce tooth decay. The Ministry (including its predecessor, the Department of Health) has supported water fluoridation in New Zealand since March 1952, when it gave approval to the Hastings Borough Council to implement fluoridation. The Ministry has reaffirmed its position on water fluoridation and specifically recommends the adjustment of fluoride to between 0.7 and 1.0 ppm in drinking water as the most effective and efficient way of preventing dental caries in communities receiving reticulated water supplies. It strongly recommends the continuation and extension of fluoridation programmes where technically feasible and provides a subsidy to local authorities for this purpose.

[129] The Ministry's principal role with respect to water supplies is to administer the requirements of the Health Act to mitigate any risks to public health. The Ministry takes a leading role in reviewing the literature on the safety and effectiveness of the fluoridation of water supplies in New Zealand and overseas. In that capacity, it analyses local and international evidence, including the advice of key

health bodies. The Ministry has funded the National Fluoridation Information Service, the consortium of experts in community water fluoridation referred to by Dr Whyman in his evidence. This Service conducted a review in 2011[88] and had advised the Ministry that the beneficial effects of fluoridation were evident as was the importance of retaining fluoridation as a public health intervention. Dr Haisman-Welsh confirms that Dr Whyman's evidence is consistent with the advice the Ministry had received on the benefits, safety and cost-effectiveness of community water fluoridation.

Dr Simmons

[130] Dr Simmons is a public health physician for the Taranaki District Health Board. He is one of two witnesses who gave specific evidence relating to the dental health of the Taranaki community and the anticipated effects on the dental health of the Patea and Waverley communities through the proposed fluoridation of drinking water. Dr Simmons expresses the opinion that fluoridation helps decrease oral health inequalities, particularly in children, Māori and lower socio-economic communities. He deposes that, on a national level, oral health inequalities exist between Māori and Pacific Islanders on the one hand, and non-Māori New Zealanders. Inequalities also exist between lower and higher socio-economic communities and between children who have access to fluoridated drinking water and those who do not.

[131] Dr Simmons refers to a survey conducted in 2009 by the Taranaki District Health Board.[89] This established that Māori children in non-fluoridated areas had a mean DMFT score of 3.7, whereas non-Māori had a mean score of 1.4. The difference between Māori and non-Māori children was smaller in areas where the drinking water was fluoridated. Dr Simmons also points out that a health survey conducted by the Ministry of Health in 2008 had highlighted the oral health inequalities between Māori and non-Māori.[90] In Taranaki it was estimated that 19.7 per cent of Māori had an unmet oral health care need, compared with 9.8 per cent for non-Māori.

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88 National Fluoridation Information Service *Review of Scientific Reviews Relating to Water Fluoridation Published between January 2000 and July 2010* (National Fluoridation Information Service Advisory, February 2011).

89 Taranaki District Health Board Community Oral Health Service 2009.

90 Ministry of Health 2008, 2006/07 New Zealand Health Survey.

[132] Dr Simmons' evidence is that the Patea and Waverley communities were examples of populations suffering some of the worst tooth decay in Taranaki and New Zealand. These two towns were among the 10 per cent of the most socio-economically deprived populations in New Zealand. As well, the proportion of Māori in both towns was substantially higher than for the whole of Taranaki.[91]

[133] Based on data systematically collected by community dental therapists in Taranaki, Dr Simmons estimates the expected impact of introducing community water fluoridation to Patea and Waverley to be a 50 per cent reduction in the level of tooth decay.

[134] In his view, the benefits of community water fluoridation are greatest where the population has the least means to access other sources of health care. Alternative techniques for improving oral health, such as brushing teeth daily, regular dental check-ups and a low sugar diet, were either not attainable or not a priority for many people in communities of low socio-economic status.

Ms Pryor

[135] The evidence of Dr Simmons is supported by a Hawera dental surgeon who has operated a private dental practice for some 18 years, mainly treating patients from Hawera and Patea. The significance of her evidence is that Hawera has a fluoridated water supply, whereas Patea does not. Ms Pryor conducted two informal comparative studies, using data collected in her dental practice. In the first study, she compared the DMFT scores in 15 to 17 year olds for the years 2007 to 2010 in both Hawera and Patea. This study showed that the average DMFT scores for 15 to 17 year olds in Patea were two to three times worse than those in Hawera. While acknowledging some limitations of her study, Ms Pryor considers, based on her own experiences and the survey results, that tooth decay amongst teenagers from Patea is considerably worse than in Hawera, where the water is fluoridated. The DMFT scores for 17 year olds in Patea indicated an extremely high incidence of tooth decay.

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[91] 51 per cent Māori in Patea and 31 per cent Māori in Waverley, compared with 15 per cent Māori in Taranaki as a whole.

[136] The second study conducted by Ms Pryor related to the effect of a temporary (three-year) absence of fluoride in the Hawera water supply. In her view, the absence of fluoride in drinking water appears to have had a harmful effect on the oral health of Hawera children during that period. Ms Pryor acknowledges that water fluoridation is only one of many factors influencing dental health but, in her experience, she regards water fluoridation as most beneficial to those who have less access to other dental health measures. The fluoridation of public water supplies is, in her opinion, the most effective and safe way that some of the inequalities in dental decay could be improved in communities such as Patea and Waverley. Fluoridated water would also benefit the rest of the community.

[137] We now turn to review the principal evidence on the s 5 issues placed before the High Court by New Health.

Dr Menkes

[138] Dr Menkes is a psychiatrist and an Associate Professor at the Waikato Clinical School of the University of Auckland. He is also the honorary consultant psychiatrist at the Waikato District Health Board. He was asked to express an opinion as to whether the fluoridation of community water supplies constituted medical treatment and on issues of informed consent. On this topic, his views are disputed by Dr McMillan, a witness called by the Council. We need not deal with the evidence of these witnesses as to what constitutes medical treatment in view of the conclusions we have already reached. However, in some respects, Dr Menkes' evidence supports the Council's case in relation to the s 5 issue. In particular, Dr Menkes accepts that the practice of fluoridating public water supplies has a rational basis. This is based on the known properties of fluoride, the effects on dental physiology and the mineralisation of tooth enamel, as well as observed changes in the incidence of caries in treated populations. Dr Menkes also accepts that the current target range of 0.7 to 1.0 ppm in tap water is based on evidence that this range offered the optimum balance between a desired effect and unintended adverse or toxic side-effects.

Dr Thiessen

[139] Dr Thiessen is a senior scientist at the Oak Ridge Center for Risk Analysis in Tennessee. The Oak Ridge Center investigates the environmental fate of radiological and chemical contaminants and evaluates human doses and the health risks associated with exposures to those contaminants. During the course of her work, Dr Thiessen became acquainted with the scientific and medical literature on fluoride exposure and toxicology in the mid-1980s and has taken an interest in this subject since. In 2003 she served on a subcommittee of the National Research Council charged with reviewing fluoride exposure and toxicology and with evaluating whether the United States of America's Environmental Protection Agency's drinking water standard was sufficiently protective.

[140] In a report issued in 2006 the subcommittee concluded that the Environmental Protection Agency's maximum contaminant level goal set at 4 ppm was not protective.[92] This conclusion was based on evidence of severe dental fluorosis, stage II skeletal fluorosis, and increased risk of bone fracture. The subcommittee did not review the assumed benefits of fluoride exposure or of water fluoridation or make any finding as to whether the practice of fluoridation was safe. Dr Thiessen deposes that the US Department of Health and Human Services has recently proposed a new recommendation regarding fluoride concentrations in drinking water at a level of 0.7 ppm. If adopted, she said this would be consistent with the level adopted by Canada in 2009.

[141] Dr Thiessen's overall conclusions are that available data would not support a role for community water fluoridation in improving dental health; there are a variety of adverse health effects associated with exposure to fluoridated water; and that by the fluoridation of drinking water, governments and water suppliers are indiscriminately administering a drug to the population without individual evaluation of need, appropriate dose, efficacy or side-effects.

[142] Dr Thiessen refers to the University of York study from 2000, which we have already mentioned. She notes the report referred to a surprising lack of high quality

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[92] National Research Council *Fluoride in Drinking Water: A Scientific Review of EPA's Standards* (National Academies Press, Washington DC, 2006).

studies demonstrating the benefits of fluoridation. The study had concluded that there was about a 15 per cent difference in the proportion of caries-free children in consequence of the fluoridation of water supplies. Dr Thiessen considers this to be only a modest benefit. In her opinion, the available data, responsibly interpreted, indicated little or no beneficial effect of water fluoridation on oral health. On the other hand, Dr Thiessen refers to potential adverse effects, including dental and skeletal fluorosis, increased risk of bone fracture and the lack of research into the potential risks of carcinogenicity.

[143] Her overall conclusion is that it is irresponsible to promote or encourage uncontrolled exposure of any population to a drug that, at best, is inappropriate for many individuals and for which the risks are inadequately characterised and disclosed in public. In her opinion, elimination of community water fluoridation would be in the best interests of public health.

Mr Litras

[144] Mr Litras is a dentist practising in Wellington. He has over 30 years experience and was the past President of the Wellington branch of the New Zealand Dental Association. Mr Litras comments on the topical mechanism of fluoride action. His view is that the relatively recent realisation that fluoride worked topically rather than systemically calls into question the whole basis of water fluoridation. In his opinion, fluoride has no effect on intact enamel. Fluoridated water passes fleetingly over the teeth, meaning that its topical effect is likely to be negligible compared to other topical applications, such as fluoridated toothpaste, mouth rinses or gels. By these methods, the action of fluoride could assist the mineralisation of early cavities in tooth enamel.

[145] Mr Litras is also critical of the Lee and Dennison study referred to by Dr Whyman and other witnesses, raising various issues regarding the accuracy of the data and the methodology used. He notes that, currently, the average caries rate in 12 year olds in New Zealand is less than 2 DMFT out of 24 to 28 teeth. He says that reducing DMFT by even 30 per cent is less than one filling. Based on Ministry of Health data in 2011, Mr Litras says the percentage of caries-free five year olds and

eight year olds does not differ materially between fluoridated and non-fluoridated areas. He maintains the same applies to Taranaki.

[146] Mr Litras' view overall is that even assuming water fluoridation reduces decay by 15 per cent, this is of little benefit in reducing decay for people who do not clean their teeth and have a poor diet. A more effective solution would be targeted preventive policies, including banning soft drinks and sugary snacks in schools, fluoridated salt in fast foods and soft drinks in at-risk areas, supervised tooth brushing programmes in schools, diet and oral hygiene education for low socio-economic families and improved access to dental care.

Subsequent reports

[147] We were referred to two reports published after the High Court judgment.

The Gluckman/Skegg report

[148] In August 2014 a report prepared on behalf of the New Zealand Prime Minister's Chief Science Advisor (Sir Peter Gluckman) and the President of the Royal Society of New Zealand (Professor David Skegg) was published.[93] The report was prepared by Dr Anne Bardsley, a researcher in the Chief Science Advisor's Office. Dr Bardsley worked in close collaboration with an expert panel comprising five scientists from New Zealand and Australia. The report was peer-reviewed by international experts and others within New Zealand. We set out the summary of conclusions:[94]

> The World Health Organization (WHO), along with many other international health authorities, recommends fluoridation of water supplies, where possible, as the most effective public health measure for the prevention of dental decay.
>
> A large number of studies and systematic reviews have concluded that water fluoridation is an effective preventive measure against tooth decay that reaches all segments of the population, and is particularly beneficial to those most in need of improved oral health. Extensive analyses of potential adverse effects have not found evidence that the levels of fluoride used for

[93] Peter Gluckman and David Skegg *Health effects of water fluoridation: A review of the scientific evidence* (Office of the Prime Minister's Chief Science Advisor and Royal Society of New Zealand, Wellington, 2014).

[94] At 10 (emphasis in original).

> community water fluoridation schemes contribute *any* increased risk to public health, though there is a narrow range between optimal dental health effectiveness and a risk of mild dental fluorosis. The prevalence of fluorosis of aesthetic concern is minimal in New Zealand, and is not different between fluoridated and non-fluoridated communities, confirming that a substantial proportion of the risk is attributable to the intake of fluoride from sources other than water (most notably, the swallowing of high-fluoride toothpaste by young children). The current fluoridation levels therefore appear to be appropriate.
>
> This analysis concludes that from a medical and public health perspective, water fluoridation at the levels used in New Zealand poses no significant health risks and is effective at reducing the prevalence and severity of tooth decay in communities where it is used. Communities currently without CWF[95] can be confident that this is a safe option that is cost saving and of significant public health benefit – particularly in those communities with high prevalence of dental caries.

The Cochrane Review

[149] The Cochrane Review was published after the Gluckman/Skegg report in 2015.[96] We understand it does not refer to the Gluckman/Skegg report. The review panel appears to comprise 10 experts drawn from the Cochrane Oral Health Group of the School of Dentistry at the University of Manchester and others from the Universities of Dundee and Ottawa. The plain language summary of the report states:

> …
>
> **Study characteristics**
>
> Researchers from the Cochrane Oral Health Group reviewed the evidence — up to 19 February 2015 — for the effect of water fluoridation. They identified 155 studies in which children receiving fluoridated water (either natural or artificial) were compared with those receiving water with very low or no fluoride. Twenty studies examined tooth decay, most of which (71%) were conducted prior to 1975, before use of fluoride toothpastes became widespread. A further 135 studies examined dental fluorosis.
>
> **Key results**
>
> Data suggest that the introduction of water fluoridation resulted in a 35% reduction in decayed, missing or filled baby teeth and a 26% reduction in decayed, missing or filled permanent teeth. It also increased the percentage of children with no decay by 15%. These results indicate that water fluoridation is effective at reducing levels of tooth decay in both children's

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95 Community water fluoridation (footnote added).

96 Z Iheozor-Ejiofor and others "Water fluoridation for the prevention of dental caries" (2015) 6 Cochrane Database of Systematic Reviews.

> baby and permanent teeth. However, since 1975 the use of toothpastes with fluoride and other preventive measures such as fluoride varnish have become widespread in many communities around the world. The applicability of the results to current lifestyles is unclear.
>
> There was insufficient information available to find out whether the introduction of a water fluoridation programme changed existing differences in tooth decay across socioeconomic groups.
>
> There was insufficient information available to understand the effect of stopping water fluoridation programmes on tooth decay.
>
> No studies met the review's inclusion criteria that investigated the effectiveness of water fluoridation for preventing tooth decay in adults, rather than children.
>
> The researchers calculated that, in areas with a fluoride level of 0.7 ppm in the water, approximately 12% of the people evaluated had fluorosis that could cause concern about their appearance.
>
> **Quality of the evidence**
>
> The review authors assessed each study included in the review for risk of bias (by examining the quality of the methods used and how thoroughly the results were reported) to determine the extent to which the results reported are likely to be reliable. This showed that over 97% of the 155 studies were at a high risk of bias, which reduces the overall quality of the results. There was also substantial variation between studies in terms of their results.
>
> Our confidence in the size of effect shown for the prevention of tooth decay is limited due to the high risk of bias in the included studies and the fact that most of the studies were conducted before the use of fluoride toothpaste became widespread.
>
> Our confidence in the evidence relating to dental fluorosis is also limited due to the high risk of bias and variation in the studies' results.

[150] We can do little more than note the existence of this Review since it was only in evidence in CA529/2015, a proceeding to which the Council was not a party. It would be unfair to the Council to place any weight upon it when the Council has had no opportunity to evaluate it or provide any expert response. Nor are we in a position to make any useful assessment of its validity. We note, however, that the Review does not dispute that the studies it analysed show water fluoridation has resulted in a reduction in tooth decay. Rather, it challenges the quality of the studies on which that conclusion is placed.

The s 5 analysis — conclusions

[151] We now address the issues identified in *Hansen v R*.[97]

Does fluoridation of drinking water serve a purpose sufficiently important to justify curtailing the s 11 right?

[152] It is not in dispute that New Zealand, in common with other countries worldwide, has a serious problem with regard to tooth decay in both adults and children. This is particularly prevalent in lower socio-economic communities. We have no difficulty agreeing with the Judge that the objective of preventing or reducing tooth decay is sufficiently important to justify the fluoridation of drinking water.

Rational connection

[153] The question under this heading is whether any limit on the protected right is rationally connected with its purpose. We are satisfied there is a substantial body of research both in New Zealand and elsewhere to support the proposition that the fluoridation of community drinking water has a beneficial effect in reducing the incidence of tooth decay. While there may be some room for debate about the extent of that reduction, the evidence produced in this case shows it is significant.

[154] Despite the criticisms of the York Report made by Dr Thiessen, she accepted it showed at least some reduction in tooth decay was achieved as a result of the fluoridation of water. The Cochrane Review produced and relied upon by New Health confirms this, concluding that data suggested that the fluoridation of drinking water has resulted in dmft/DMFT reductions of 35 per cent and 26 per cent respectively. New Zealand's Gluckman/Skegg report also confirms that the fluoridation of water is an effective preventive measure against tooth decay. To the extent the authors of the Cochrane Review advocate for further research, we note the Ministry of Health accepts this.

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97 Above n 72.

[155] We conclude, as Dr Menkes accepted, that there is a rational connection between the fluoridation of drinking water and the objective of preventing or reducing tooth decay.

Is the fluoridation of drinking water no more than is reasonably necessary to achieve its purpose?

[156] We agree with the Judge that the question is whether fluoridation falls within the range of reasonably available alternatives.[98] As the Supreme Court of Canada noted in *RJR-MacDonald Inc v Canada*:[99]

> [160] … the law must be carefully tailored so that rights are impaired no more than necessary. The tailoring process seldom admits of perfection and the courts must accord some leeway to the legislator. If the law falls within a range of reasonable alternatives, the courts will not find it overbroad merely because they can conceive of an alternative which might better tailor objective to infringement … On the other hand, if the government fails to explain why a significantly less intrusive and equally effective measure was not chosen, the law may fail.

[157] Our review of the evidence shows there are alternative measures that could result in the reduction of tooth decay such as the use of fluoridated toothpaste, good dental hygiene practices and reducing the consumption of sugary foods and drinks. However, the evidence, particularly that of Dr Whyman, shows these measures, while beneficial in themselves, are of limited efficacy, particularly in lower socio-economic communities, since they ultimately depend on the willingness of individuals to accept such measures and to persist in applying them.

[158] Ideally, all measures that could be effective in reducing or preventing tooth decay should be considered since it is unlikely any one of them will be completely effective on its own. But we agree with the Judge that the preponderance of evidence demonstrates that the fluoridation of water is within the range of reasonable alternatives to address the problem of tooth decay, especially in low socio-economic areas. Other measures may be seen as complementary in nature.

[159] The evidence also supports the proposition that levels of fluoride at 0.7 to 1.0 ppm are designed to reflect the optimal level to be effective while minimising the

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98 *Ministry of Health v Atkinson*, above n 80, at [151].

99 *RJR-MacDonald Inc v Canada* [1995] 3 SCR 199 per McLachlin J.

potential for adverse effects. Again there may be room for debate about the appropriate levels but this does not detract from our overall assessment for s 5 purposes.

Whether the limit is proportionate to the objective

[160] Given our agreement with the Judge that the evidence supports the proposition that the reduction of tooth decay is an important objective and that the fluoridation of drinking water is an effective measure to achieve that outcome, the issue is whether there are any demonstrated disadvantages of fluoridation that outweigh the identified beneficial effects.

[161] We have outlined in some detail the potential adverse health effects that could result from the fluoridation of water. We accept that the potential for adverse effects is an issue upon which experts may disagree. However, we are satisfied on the preponderance of the evidence that there is sufficient evidence to support the conclusion that, in the New Zealand context, none of the potential adverse effects is such as to outweigh the advantages of the fluoridation of water. We refer particularly to the evidence of Dr Whyman and Dr Haisman-Welsh on this topic and the most recent findings in the Gluckman/Skegg report, which concluded that extensive analyses of potential adverse effects have not found evidence that the levels of fluoride used for community water fluoridation schemes contribute any increased risk to public health.

[162] Although that report acknowledged there is a narrow range between optimal dental health effectiveness and the risk of mild dental fluorosis, any concerns in that respect were considered to be minimal and no different between fluoridated and non-fluoridated communities. As the report noted, a substantial proportion of the risk of dental fluorosis is attributable to the intake of fluoride from other sources, most notably from high fluoride toothpaste used by young children. The report concluded that the current fluoridation levels appear to be appropriate.

[163] This last point is important because the New Zealand Standards specify the MAV for fluoride based on the WHO recommendations. The Standards also specify the MAVs for potentially toxic chemicals and contaminants, including any that may

be found in fluoride. The existence of these safeguards is relevant to an overall assessment of the proportionality of the fluoridation of drinking water.

[164] Viewed overall, we agree with the Judge that there is a sufficient evidential basis to support the conclusion that the significant advantages of fluoridation clearly outweigh the increased risk of fluorosis. There is also an evidential foundation for the conclusion that fluoridation does not give rise to any other significant health risks.

Council appeal — conclusions and result

[165] In summary, we agree with the Judge that the fluoridation of drinking water proposed by the Council does not infringe s 11 of the NZBORA. Even if it does, there is a respectable and sufficient body of evidence to support the conclusion that any such infringement is a justified and reasonable limit in terms of s 5 of the NZBORA.

[166] For the reasons given, New Health's appeal must be dismissed. We will set out the formal orders at the end of this decision.

THE REGULATIONS APPEAL (CA529/2015)

Introduction

[167] In the High Court New Health challenged the validity of the Medicines Amendment Regulations 2015 on a variety of grounds.[100] On appeal, only two grounds of alleged invalidity are pursued:

(a) The Regulations were made on the basis of a material error of law, namely that HFA and SSF were not medicines for the purposes of the Medicines Act; and

[100] Regulations judgment, above n 3.

(b) The Regulations were made for an improper purpose, namely to extinguish New Health's right of appeal against the judgment of Collins J.

The background facts

[168] The essential facts as found by Kós J are not in dispute. Collins J delivered his judgment on 9 October 2014. New Health promptly filed an appeal against that decision on 28 October 2014. New Health sought entry of the appeal onto the fast track in this Court. On 3 November 2014 the Crown filed a memorandum in this Court opposing the appeal being entered on the fast track and advising that the Ministry of Health intended to recommend an amendment to the Medicines Regulations 1984, as suggested by Collins J.

[169] This Court declined to fast track the appeal. Instead, in a minute dated 11 November 2014 it allocated a fixture for 12 March 2015. It reserved leave to the Crown to seek to have the fixture vacated if, by 6 February 2015, the Crown was in a position to satisfy the Court that the proposed regulations would be implemented and that they would have the effect of rendering the appeal moot.

[170] The process of passing the Regulations commenced on 20 November 2014, when the Minister received a report from officials recommending regulation. The report commenced by referring to the litigation brought by New Health and this Court's direction regarding the Medicines Act appeal. The passing of the Regulations was said to have the effect of rendering the appeal moot, an outcome that would save considerable legal costs for the Crown and free up valuable court time for other fixtures. The amendment was described as technically simple and did not involve a change in policy in view of the decisions made by Rodney Hansen and Collins JJ in the proceedings brought by New Health. A change to the Regulations was considered to be urgent. A reduction in the time usually allowed for consultation was sought on the ground it would be beneficial to provide early legal certainty.

[171] The Minister accepted the recommendation of the officials on 24 November 2014. The following day a consultation document was posted on the Medsafe

website. It noted the proposed amendment would provide legal clarity that the fluoride substances used to treat drinking water are not medicines. While it referred to the High Court proceedings relating to the Medicines Act, it did not refer explicitly to the appeal. It noted the benefits of regulation were the preservation of the status quo and the provision of legal clarity.

[172] After a consultation period closing on 9 January 2015, a draft Cabinet paper was put before the Minister on 16 January 2015. This summarised the submissions received and recommended the Minister agree that the Regulations be made to provide legal certainty that fluoride substances used to treat community water supplies were not medicines. Officials recommended the paper be taken directly to Cabinet when it met on 27 January 2015. This would enable the Regulations to be signed by the Executive Council around the end of January. This would also allow Crown Law to advise this Court by 6 February that the Regulations had been implemented. The report further noted this Court had advised that the passing of the Regulations would render moot the pending appeal by New Health. As Kós J noted, this advice was incorrect.

[173] The Cabinet paper explained the background to the Regulations. It recorded that Crown Law had recommended "as a matter of good public administration and to remove the basis for any further litigation on the matter, fast-tracking the making of the regulation to put the issue beyond doubt". It recommended Cabinet waive the ordinary 28-day rule, and concluded by asking Cabinet to:

> **authorise** the submission to the Executive Council of the Medicines Amendment Regulations 2015 for consideration at its first meeting of 2015 to remove the basis for further litigation.

[174] Cabinet approved the recommendation of the officials on 27 January 2015. An Order in Council was made the same day. As earlier noted, the amended regulations came into force on 30 January 2015.

[175] On 5 February 2015 the Crown filed a memorandum in this Court noting the Regulations had been made and asserting that the Medicines Act appeal was now moot. New Health initiated High Court proceedings challenging the validity of the Regulations on 31 March 2015. Finally, on 29 April 2015, after hearing argument,

this Court issued a further minute in the Medicines Act appeal stating that "assuming the amending regulations were validly made, this appeal would be moot". The Medicines Act appeal was then adjourned pending the decision of Kós J.

The regulating power

[176] The power to make the Regulations relied on by the Crown is found in s 105 of the Medicines Act:

> **105 Regulations**
>
> (1) The Governor-General may from time to time, by Order in Council made on the advice of the Minister tendered after consultation with such organisations or bodies as appear to the Minister to be representative of persons likely to be substantially affected by the regulations, make regulations for all or any of the following purposes:
>
> …
>
> (i) specifying, by name or description, substances or articles, or kinds or classes of substances or articles, that are, or are not, medicines or medical devices for the purposes of this Act:
>
> …

[177] The effect of a regulation specifying that a substance is not a medicine for the purposes of the Medicines Act is to remove it from the definition of "medicine" in s 3(1) of the Act:

> **3 Meaning of medicine, new medicine, prescription medicine, and restricted medicine**
>
> (1) In this Act, unless the context otherwise requires, **medicine**—
>
> (a) means any substance or article that—
>
> (i) is manufactured, imported, sold, or supplied wholly or principally for administering to 1 or more human beings for a therapeutic purpose; and
>
> (ii) achieves, or is likely to achieve, its principal intended action in or on the human body by pharmacological, immunological, or metabolic means; and
>
> (b) includes any substance or article—

(i) that is manufactured, imported, sold, or supplied wholly or principally for use as a therapeutically active ingredient in the preparation of any substance or article that falls within paragraph (a); or

(ii) of a kind or belonging to a class that is declared by regulations to be a medicine for the purposes of this Act; but

(c) does not include—

(i) a medical device; or

(ii) any food within the meaning of section 2 of the Food Act 1981; or

(iii) any radioactive material within the meaning of section 2(1) of the Radiation Protection Act 1965; or

(iv) any animal food in which a medicine (within the meaning of paragraph (a) or (b)) is incorporated; or

(v) any animal remedy; or

(vi) any substance or article of a kind or belonging to a class that is declared by regulations not to be a medicine for the purposes of this Act.

[178] This section makes it clear by subs (1)(c)(vi) that a substance declared by regulations not to be a medicine is excluded from the statutory definition.

The Judge's approach

[179] Kós J outlined the legislative framework governing the distribution and use of chemical substances including medicines. Fluoride, in dose form, intended for human consumption for a therapeutic purpose, qualifies as a medicine under the Medicines Act. Depending on concentration, it may be classified as a prescription, restricted or pharmacy-only medicine.

[180] The Judge then noted the Ministry's policy position with regard to dilute fluoride dosages in these terms:[101]

> [36] The policy position taken as to dilute dosages is different. It is that dilute fluoride within a concentration range of 0.7 to 1.5 parts per million (0.7 to 1.5 mg/l) does not constitute a "medicine". Such dosages are instead regulated separately, by the Health Act and its attendant Drinking Water

[101] Regulations judgment, above n 3 (footnote omitted).

> Standards. That has been the Ministry's stance throughout the existence of the Act. And Collins J agreed that the Ministry's interpretation conformed to the Act.

[181] The Judge considered that the Regulations confirmed a pre-existing policy position that fluorides were not medicines for the purposes of the Medicines Act. This had been confirmed in the judgment of Collins J. The Regulations did not seek to reverse either the policy position or the finding made by Collins J.

[182] Addressing the reasons for the regulation, Crown counsel's submission in the High Court was that they were threefold:

(a) To give certainty to those distributing and using the compounds for the purpose of water fluoridation that those activities would continue to be subject to controls under the Health Act and New Zealand Standards and would not instead be governed by the Medicines Act (and hitherto potentially in breach of it).

(b) To avert collateral challenges in the High Court to Collins J's judgment. (Indeed, as Kós J said, just such a collateral challenge was advanced in the proceeding before him.[102])

(c) To reinforce the conclusion in that judgment, including by rendering the appeal partially moot (at least prospectively for the period from 30 January 2015). Crown counsel accepted that the Regulations were not retrospective, and so could not render the appeal wholly moot. Whether New Health would still want to pursue it was, of course, another question.

[183] The Judge found that neither the first nor second purpose was improper in the sense of being inconsistent with, or beyond the ambit of, the power conferred by s 105.[103] The focus of the High Court judgment was on the third of these purposes. Kós J did not consider the third purpose to be improper. Noting the distinctions

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[102] Regulations judgment, above n 3, at [39](b).

[103] At [40] citing Ross Carter, Jason McHerron and Ryan Malone *Subordinate Legislation in New Zealand* (LexisNexis, Wellington, 2013) 261–263.

between the constitutional status of the legislature, the executive and the courts, the Judge said:

> [41] Is the third purpose improper? It is true that in *R (Reilly) v Secretary of State for Work and Pensions (No 2)* Lang J said that the power to legislate to overrule judgments should not as a matter of constitutional propriety be used retrospectively to "favour the executive in ongoing litigation in the courts brought against it by one of its citizens", absent compelling reasons.[104] But to the extent this executive action is (1) undertaken in a parallel executive declaratory stream, (2) is wholly consistent with, and merely reinforcing of, a judicial declaration arising from the parallel legislative stream, and (3) has prospective effect only, I do not consider the purpose improper.
>
> [42] In the present context, I do not think the executive is not bound to stand idly by on the bank when a judicial contest about the legislative stream is being undertaken. The advent of such litigation does not render the legislative stream suddenly exclusive. Or dry up the otherwise available executive stream.
>
> [43] The formulation of public policy is pre-eminently a legislative and executive act. Statutory power was conferred on the executive to determine status of these compounds altogether apart from s 3 of the Act. Two streams, not one. The legislature has already declared the status of these compounds to a degree, but in a manner admitting argument. The executive is entitled to speak still. And certainly in a manner that is wholly prospective in effect.

[184] After referring to the Legislation Advisory Committee guidelines[105] and the observations of Sir Geoffrey Palmer and Dr Matthew Palmer (as he then was),[106] the Judge said:[107]

> The focus here of course is (1) retrospectivity and (2) deprival of the fruits of victory. It is clear that for that to be done, legislative rather than executive intervention is almost certainly required.[108]

[185] After considering this Court's decision in *Canterbury Regional Council v Independent Fisheries Ltd*, in which there was an unsuccessful challenge to a Minister's decision under the Canterbury Earthquake Recovery Act 2011 (which had

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104 *R (Reilly) v Secretary of State for Work and Pensions (No 2)* [2015] 2 WLR 309 (QBD) at [82] (footnote in original).

105 Legislation Advisory Committee *Guidelines on Process and Content of Legislation* (October 2014) 44–45.

106 Sir Geoffrey Palmer and Matthew Palmer *Bridled Power* (Oxford University Press, Melbourne, 2004) at 315.

107 Regulations judgment, above n 3, at [44] (footnote in original).

108 Ross Carter, Jason McHerron and Ryan Malone *Subordinate Legislation in New Zealand* (LexisNexis, Wellington, 2013) at 34.

the effect of extinguishing extant appeals before the Environment Court),[109] the Judge said:[110]

> [46] In the present case the challenged action in the executive stream does not extinguish an appeal. It impairs the practical utility of one arising from the parallel legislative stream. That action the executive would have been at liberty to take in the absence of litigation. It is consistent with prior policy, consistent with the High Court's conclusion as to legislative action (so does not thwart it) and it is prospective only. It does not preclude continued challenge to action taken prior to 30 January 2015. It does not involve the "unjust abrogation of existing rights". It is not in my view an improper purpose.

[186] Kós J went on to consider whether, if there were an improper purpose (contrary to his finding), it would necessarily taint the decision to proceed with the Regulations. He expressed his views on this issue in this way:[111]

> [47] If that view is wrong, however, the existence of an improper purpose is not determinative. A decision will be tainted by an improper purpose among proper purposes if, but for the improper purpose, it would not have been made.[112] In *Unison Networks Ltd v Commerce Commission* McGrath J put it this way:[113]
>
> > A power granted for a particular purpose must be used for that purpose but the pursuit of other purposes does not necessarily invalidate the exercise of public power. There will not be invalidity if the statutory purpose is being pursued and the statutory policy is not compromised by the other purpose.
>
> [48] In the present case the Minister had three motives. It is likely that even if the plaintiff had not filed the appeal, the regulations would likely still have been made. There have been a number of proceedings related to fluoridation. The issue has generated considerable public controversy. The process leading to the regulations discloses general legal certainty beyond the dispute between the present parties to be the primary motivation. It may have been that the Minister would have moved with less alacrity. But legal certainty through regulation would likely have been pursued in any event.
>
> [49] In terms of *Unison*, the third purpose identified at [39] is hardly a subversion of the first two. Rather it is a more specific implementation of the primary purpose. As [Crown counsel] put it: a consequence. Even if the tertiary purpose were improper, the Minister's decision would not be tainted by it.

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109 *Canterbury Regional Council v Independent Fisheries Ltd* [2012] NZCA 601, [2013] 2 NZLR 57.

110 Regulations judgment, above n 3 (footnote omitted).

111 Regulations judgment, above n 3 (footnotes in original).

112 *Poananga v State Services Commission* [1985] 2 NZLR 385 (CA) at 394.

113 *Unison Networks Ltd v Commerce Commission* [2007] NZSC 74, [2008] 1 NZLR 42 at [53].

[187] It was not necessary for the Judge to determine whether the Regulations were passed on the basis of an error of law. That was because he had determined that, in the proceedings before him, the doctrine of res judicata precluded a challenge to the decision made by Collins J.[114]

[188] Having rejected all the grounds advanced by New Health to challenge the Regulations, the application for judicial review was dismissed.

Analysis

Error of law

[189] Ms Scholtens' argument focused principally on the first ground of error of law. She submitted Collins J was wrong to find that HFA and SSF were not medicines for the purposes of the Medicines Act. Since New Health had appealed against the decision of Collins J it was open for this Court to take a different view. If we were to agree that HFA and SSF were medicines then the Regulations were invalid on the basis of error of law. That was because the advice to the Minister upon which he and the Executive Council had acted had been given on the erroneous assumption that the Regulations were simply confirming the status quo, that is, that HFA and SSF were not medicines for the purposes of the Medicines Act.

[190] It is unnecessary for us to determine whether Collins J was right to decide that HFA and SSF were medicines under the Medicines Act. The regulation-making power under s 105(1)(i) of the Medicines Act expressly authorises the Governor-General by Order in Council to specify that substances "are, or are not," medicines for the purposes of the Act. If the substances are specified not to be a medicine then they are excluded from the definition of medicine by s 3(1)(c)(vi) of the Medicines Act. The power to specify that substances are not medicines exists regardless of whether the substances would otherwise have been a medicine within the relevant definition. Whether the relevant substance was, or was not, a medicine as defined in the Medicines Act prior to the making of the Regulations is therefore immaterial.

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114 Regulations judgment, above n 3, at [78].

[191] This ground of challenge to the Regulations must fail accordingly.

Improper purpose

[192] New Health's essential argument on this ground of appeal is that the Regulations were made for an improper purpose and are therefore invalid. Counsel submitted that if we were to find that the Regulations were valid, then New Health had improperly been deprived of its right of appeal against the judgment of Collins J.

[193] We are satisfied that Kós J was right to dismiss this ground of challenge to the Regulations essentially for the reasons he gave.

[194] In her submission for the Attorney-General, Ms McKechnie summarised the relevant principles. Where Parliament has given the executive a broad power to regulate for the purpose of implementing the empowering legislation, the discretion of the executive is constrained by those purposes.[115] In the field of delegated legislation, matters are presumed to have been done regularly and lawfully and the courts will only interfere in a clear case. However, the presumption of validity may be overridden if the subordinate legislation is made for an improper purpose.[116]

[195] We agree with Kós J that there is nothing improper in the passing of regulations for the purpose of giving certainty to those distributing and using HFA and SSF for the purpose of water fluoridation or for the purpose of averting collateral challenges in the High Court to the judgment of Collins J. Indeed, Ms Scholtens did not submit otherwise. As Kós J noted, the Regulations would likely have been made irrespective of whether New Health filed an appeal against the judgment of Collins J. The issue of fluoridation of water had generated considerable public controversy. As well, Collins J had himself suggested that the Ministry might wish to consider recommending regulations. The executive could not be faulted for moving to clarify the position beyond doubt.

[196] While we agree that the executive would have been at liberty to make the regulations irrespective of the litigation then in train, there can be little doubt that a

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115 *Edwards v Onehunga High School Board* [1974] 2 NZLR 238 (CA) at 242.
116 *Harness Racing New Zealand v Kotzikas* [2005] NZAR 268 (CA) at [58]–[59].

third motivation for the urgent promulgation of the Regulations was the existence of the appeal against the decision of Collins J. The materials before us indicate that the existence of the appeal against Rodney Hansen J's decision was also mentioned in the reports to the Minister. Although, as Kós J found, the Regulations did not extinguish New Health's right of appeal against the decision of Collins J, he accepted the Regulations impaired the practical utility of the appeal. We agree, since it is common ground that the Regulations only had prospective effect from 30 January 2015 when they came into force. New Health could therefore pursue the Medicines Act appeal in relation to the period prior to that date unless this Court were to determine there would be no practical utility in doing so. We discuss this topic below.

[197] As Kós J noted, this Court has held that steps taken under legislation that have the effect of ending an appeal right are not necessarily unlawful. In *Canterbury Regional Council v Independent Fisheries Ltd*, the Court was considering steps taken by the Minister for Canterbury Earthquake Recovery under s 27 of the Canterbury Earthquake Recovery Act.[117] Under that provision, the Minister had power to revoke the whole or part of a "document" under the Resource Management Act 1991. The Minister made two decisions under this power amending or revoking parts of the Canterbury Regional Policy Statement relating to airport noise and urban limits. This had the effect of bringing to an end certain appeals then pending before the Environment Court.

[198] This Court accepted that the right of access to the courts was fundamental.[118] A statute could not abrogate a right of this nature except by express language or by necessary implication.[119] However, the Minister had power to revoke the whole or any part of a "document" under the Resource Management Act. Any such document could be the subject of an appeal. It followed that the empowering legislation contemplated that the Minister's exercise of the s 27 power could end appeals before the Environment Court. The Court's conclusion on this point was expressed in these terms:

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117 *Canterbury Regional Council v Independent Fisheries Ltd*, above n 109.
118 At [136].
119 At [140] and [141].

> [146] We have already decided that insofar as the Minister's decisions promoted planning certainty and allowed Council officers to focus on recovery, they were within the purposes of the Act. The ending of the appeals was therefore simply the consequence of the legitimate exercise of the Minister's powers and was not unlawful.

[199] Although the circumstances of the present case do not precisely parallel those of the *Canterbury Regional Council* case, the Medicines Act specifically authorised the making of the Regulations. On the evidence, they were made for the lawful purpose of promoting legal certainty on the understanding that to specify that the substances were not medicines was simply confirmatory of the status quo. Impairing New Health's right of appeal was a consequence of the legitimate exercise of the powers of the Executive Council and was not unlawful.

[200] Finally, even if there were any element of improper purpose in relation to New Health's right of appeal, the existence of an improper purpose is not determinative, as Kós J found.

[201] We have agreed with Kós J that the Regulations were likely to have been made irrespective of the existence of New Health's appeal against the judgment of Collins J. It follows that if there were any improper element in relation to New Health's right of appeal, this would not invalidate the Regulations.

[202] For the reasons given, this ground of challenge to the validity of the Regulations must also fail.

The costs order made in the High Court in relation to the Regulations appeal

Background

[203] In his decision dismissing New Health's application for judicial review of the Regulations, Kós J directed that costs must follow the event. Memoranda were to be filed if the parties could not reach agreement. By reason of the appointment of Kós J to this Court, it fell to Dobson J to determine costs. He ordered New Health to pay costs to the Attorney-General in the High Court on the 2B scale under the High Court Rules. After considering the memoranda submitted, Dobson J's costs finding was:

> It is not appropriate to revisit Kós J's decision that costs should follow the event. The only issue requiring any further consideration is quantum. The parties' earlier agreement that costs should be on a 2B scale was unexceptional and remains appropriate.

[204] New Health challenges Dobson J's decision, submitting that no costs should have been awarded. Counsel relied on r 14.7(e) of the High Court Rules, submitting that the proceedings were justified in the public interest. It was said this had been recognised in costs decisions made in the Council proceedings and in the proceedings before Collins J. It was also submitted that the Crown's conduct had disentitled it to costs. If the Medicines Act appeal had been heard on 29 April 2015, it was said the cost of the proceedings before Kós J might have been avoided. The proceedings before Kós J were required because the Crown had successfully argued that the Medicines Act appeal would be moot if the Regulations were found to be valid.

Conclusion on costs issue

[205] We have no difficulty in rejecting New Health's challenge to Dobson J's costs award. Quintessentially, an award of costs involves the exercise of discretion. This Court will not ordinarily intervene unless there is an error of principle or the decision is plainly wrong. Here, Kós J was aware of all the relevant circumstances which he took into account in ordering that costs were to follow the event. There is no suggestion of error in this respect. Nor is there any proper basis to challenge the exercise of discretion by Dobson J as to the quantum of costs.

[206] It does not follow that Dobson J was bound to take a similar approach to the costs award made in the earlier proceedings brought by New Health before Rodney Hansen J and Collins J. The application for judicial review before Kós J was the third set of proceedings brought by New Health in the High Court. The prospects of successfully challenging the validity of the Regulations were slight. We accept the submission made on behalf of the Attorney-General that the Crown was put to substantial cost in opposing the judicial review proceedings. It was appropriate that New Health be ordered to contribute towards those costs.

THE MEDICINES ACT APPEAL (CA615/2014)

[207] As already noted, it is common ground that the question as to whether HFA and SSF are medicines under the Medicines Act is no longer a live issue, at least from the time when the Regulations came into effect on 30 January 2015. The only issue is whether there is any live issue prior to that time or whether the issue is effectively moot.

[208] This Court reached the view in issuing its minute of 29 April 2015 that, if the Regulations were found to be valid, then the Medicines Act appeal would be moot.[120] We see no reason to differ from the conclusion reached on that occasion. Ms Scholtens accepted that the determination of the Medicines Act appeal could only apply to regulatory controls over water supplies already delivered. Nevertheless, she submitted it would be in the public interest to have the appeal determined. When pressed, Ms Scholtens was unable to advance any convincing reason to support this submission.

[209] In *Gordon-Smith v R* the Supreme Court clarified the principles applicable when an issue of mootness arises:[121]

> [16] … In general, appellate courts do not decide appeals where the decision will have no practical effect on the rights of parties before the Court, in relation to what has been at issue between them in lower courts. This is so even where the issue has become abstract only after leave to appeal has been given. But in circumstances warranting an exception to that policy, provided the Court has jurisdiction, it may exercise its discretion and hear an appeal on a moot question.

[210] The Supreme Court then summarised the rationale for this policy:[122]

> [18] The main reasons for the general policy of restraint by appellate courts in addressing moot questions are helpfully identified by the Supreme Court of Canada in *Borowski v Attorney-General*. They are, first, the importance of the adversarial nature of the appellate process in the determination of appeals, secondly, the need for economy in the use of limited resources of the appellate courts and, thirdly, the responsibility of the courts to show proper sensitivity to their role in our system of government. In general advisory opinions are not appropriate.

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120 See above at [7].
121 *Gordon-Smith v R* [2008] NZSC 56, [2009] 1 NZLR 721 (footnote omitted).
122 (footnote omitted).

[211] In *Gordon-Smith* the Supreme Court was willing to consider the legality of the practice of jury vetting despite the Court's determination that, on a case-stated appeal under s 380 of the Crimes Act 1961, the Court of Appeal did not have jurisdiction to consider the matter. It was willing to do so because the question was one of significant public importance and was highly likely to come before the Court again at some point.[123]

[212] Here, we accept Ms McKechnie's submission that there is no longer a live issue between the parties. In particular, the Medicines Act appeal does not involve an issue of significant public importance likely to come before the courts again at some point. The making of the Regulations has settled the controversy for the future and we see no utility in determining the issue for the period prior to 30 January 2015, which could only affect the supply of water that has already taken place prior to that date. The public interest does not require otherwise.

[213] Accordingly, we confirm this Court's earlier conclusion that the determination of the issue arising in the Medicines Act appeal is moot and does not require determination.

Summary

[214] In summary, we have found that:

(a) Rodney Hansen J was correct to find that the Council's proposal to fluoridate the water supplies of Waverley and Patea is lawful under the provisions of the Local Government Act 2002 and the Health Act 1956.

(b) Kós J was correct to find that the Medicines Amendment Regulations 2015 specifying that HFA and SSF are not medicines for the purposes of the Medicines Act 1981 were validly made.

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123 *Gordon-Smith v R*, above n 121, at [24].

(c) Dobson J was correct to award costs in favour of the Attorney-General on a 2B basis under the High Court Rules in the proceedings heard by Kós J.

(d) There is no longer a live issue requiring the determination of this Court in the appeal against the decision of Collins J that HFA and SSF are not medicines for the purposes of the Medicines Act.

Result

[215] Leave is granted to the appellant to adduce further evidence on appeal.

[216] The appeal CA159/2014 is dismissed.

[217] The appellant in CA159/2014 must pay costs to the respondent for a complex appeal on a band A basis with usual disbursements. We allow for second counsel.

[218] The appeals CA615/2014 and CA529/2015 are dismissed.

[219] The appellant must pay the respondent one set of costs in CA615/2014 and CA529/2015 for a standard appeal on a band A basis with usual disbursements.

Solicitors:
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