Queensland Health

COVID-19 Public Health Rationale
COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction

10 DECEMBER 2021

DRAFT NOT GOVERNMENT POLICY

Overarching intent

The overarching intent of the *Workers in high-risk settings (COVID-19 Vaccination Requirements) Direction* (the Direction) is to protect the health of the community and workers in identified high-risk settings for COVID-19, reduce the risk of COVID-19 transmission and outbreaks and safeguard the provision of critical services in Queensland. The Direction sets out mandatory COVID-19 vaccination requirements for workers in high-risk settings, and extends to other persons who work as a volunteer, contractor, student, whether employed by the responsible person for the setting or performing the work under another arrangement. The Direction states that by 23 January 2022, workers must have received their second dose of a TGA approved COVID-19 vaccine to enter, work in, or provide services in a high-risk setting.

By mandating COVID-19 vaccination for workers in this way, the risk of COVID-19 transmission within high risk settings and into the Queensland community is reduced. This Direction builds on existing COVID-19 vaccine mandates for workers in healthcare and other related high-risk settings, like quarantine facilities.

In the current iteration of the Direction, the following settings are identified as high-risk:

- Schools and early education
- Correctional and detention facilities (including youth detention)
- Airports

A risk analysis for these settings is described in this rationale, and summarised in Table 2 at the end of this document. The Direction complements existing mandatory vaccination requirements in other Queensland Public Health Directions. The policy position aligns with mandates in place in nearly all Australian jurisdictions, as outlined in Table 1 at end of this document. This Direction is deliberately broad and will allow for additional high-risk settings to be declared going forward.

Where a worker at an identified setting is captured under an existing COVID-19 vaccine requirement (such as healthcare workers), this Direction does not extend the timeframes for these cohorts.

Agency and sector engagement for this Direction occurred with relevant areas within Government, including the Department of Education, Department of Communities, Youth Justice and Multicultural Affairs and Queensland Corrective Services. A range of external stakeholders were also engaged, including tourism and aviation representatives, including major airports and airlines. Feedback on the policy and approach was consistently supportive.

Broadening existing COVID-19 vaccination mandates to workers across a wider range of high-risk settings enhances protection against COVID-19 across Queensland and creates a uniform standard of protection for workers and the community.

Background and rationale at 10 December 2021

Queensland's response to the COVID-19 pandemic has been very successful to date. Large scale outbreaks in Queensland have been prevented with a rapid and decisive public health response. The emergence of the Delta variant early this year and its rapid spread around the globe changed the COVID-19 context and led to widespread outbreaks around the world. Nationally almost every State and Territory

in Australia has faced local transmission of the Delta variant and New South Wales (NSW) and Victoria (VIC) experienced widespread and sustained outbreaks of COVID-19 from June 2021.

Effective vaccines for COVID-19 that prevent severe illness and reduce transmission for current variants are now widely available and endorsed by Australia's Therapeutic Goods Administration (TGA). Queensland Health is strongly encouraging and promoting COVID-19 vaccination state-wide. High vaccination coverage is essential to protect the community, the health system, and the economy.

Prior to COVID-19, immunisation programs have been able to successfully achieve 'herd immunity' for many deadly diseases, including measles and pertussis (whooping cough). True herd immunity means enough of the population is immunised that vulnerable groups who cannot be vaccinated are safe from disease. It has become apparent that herd immunity may not be possible with COVID-19, and particularly the Delta variant, because of its highly infectious nature, breakthrough infections among vaccinated people, and emerging evidence of waning vaccine derived immunity after as little as six months.

The protective potential of vaccination against COVID-19 at a population level is also affected by differential vaccine uptake rates among cohorts or in some communities. This is particularly problematic for settings where vulnerable people are present, or where there is an increased risk of rapid and widespread transmission.

In response and to maximise baseline protection, COVID-19 vaccine mandates for workers, and in some cases, visitors to a setting, are becoming more common both in Australia and globally. These mandates support uniform protective coverage in settings that are higher risk for workers and the community. Vaccine mandates are widely accepted and are a safe, low-impost and high impact way of reducing the risk of COVID-19 transmission, illness, and death.

Vaccination for workers has been mandated by a number of industries that are impacted by COVID-19 exposure, including airlines (like Qantas and Jetstar; cabin crew, pilots and airport workers by November 15 and all other employees by March 31 2022) and mining corporations like BHP (all workers and people entering BHP coal mines from January 2022). On 23 October 2021, Woolworths and Aldi announced that all staff across Australia will be required to be vaccinated for COVID-19 (applying from 31 March 2022 for Queensland).

As Queensland transitions to an environment where COVID-19 is endemic, it is inevitable that every Queenslander will eventually be exposed to COVID-19.

High vaccination coverage among workers in settings with the potential for exposure to COVID-19, particularly those serving vulnerable cohorts, will be a key determinant of health outcomes for Queenslanders and the impact of COVID-19 across the State.

With effective and safe vaccines, the public health response can begin to shift away from widespread restrictive social measures and limits on business (like density and gathering limits), and towards population vaccination coverage as a more enduring protection of public health.

Current vaccine mandates

Mandates in healthcare, quarantine and critical services

In Queensland, aligned with National Cabinet and AHPPC endorsed recommendations, vaccination against COVID-19 is currently a requirement for workers in the following high-risk settings:

- Hospitals and healthcare settings
- Queensland Health residential aged care facilities
- Hotel quarantine facilities

Vaccination against COVID-19 has also been mandated for all employees of the Queensland Police Service (QPS) by the Queensland Police Commissioner. This mandate was based on the rationale that COVID-19 challenges the ability of QPS to fulfil its policing role, and rapid transmission of COVID19

through the QPS would take police officers and staff members out of service while they undertake quarantine periods or recover from COVID-19. Reduced availability of police officers and staff members for deployment could threaten the ability of the QPS to serve the community.

All Australian jurisdictions have introduced mandatory vaccination requirements for healthcare workers across the public and private health sectors.

Mandates for public venues to support reopening borders

On 9 November 2021, the *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond* (PHSM Plan) was released. From 17 December, following Queensland reaching 80% vaccination coverage, a requirement for COVID-19 vaccination will be introduced for workers at and visitors to pubs, clubs, cafés, cinemas, theatres, music festivals and a range of public-facing venues operated by the Queensland Government, including museums and galleries. The mandate will replace COVID-19 restrictions on density and gatherings at these venues.

The requirement is deliberately broad and focused on settings with high public attendance— focusing on recreational venues that are higher risk due to the nature of the setting (e.g. alcohol consumption, density, dancing), and those that attract a number of geographically and demographically diverse people, where COVID-19 exposure and transmission could lead to a widespread outbreak.

Achieving uniform vaccination coverage across workers and visitors at these locations provides a baseline level of protection against community transmission. It is intended to be preventive and are intended to mitigate risk to the community with an expected increase in cases and spread going forward. It is also likely that a meaningful proportion of patrons will be children under the age of 16 years, for whom a COVID-19 vaccine is currently not available. Ensuring uniform vaccination coverage among the adults in the identified settings will protect children and protect against more widespread outbreaks.

Unvaccinated visitors will not be able to enter vulnerable settings such as hospitals, residential aged care, disability care accommodation, and correctional facilities to further support a baseline level of protection. This requirement is distinct from accessing facilities to receive care, where vaccination will not be required. This requirement will introduce a baseline level of protection against COVID-19 ingress in these vulnerable facilities going forward, when it is expected that COVID-19 will be circulating more widely in the community, and reduces the likelihood of needing to introduce further restrictions at these facilities.

Identifying additional high-risk settings

Queensland borders are reopening, bringing an increased likelihood of COVID-19 ingress and outbreaks throughout the State, including in vulnerable communities and regions. It is critical that the potential for significant outbreaks is controlled to the maximum extent possible, particularly in light of emerging variants of concern (see section on Omicron below).

There is an immediate urgency for additional protections in settings with a high potential to seed an outbreak, affect vulnerable members of the community, and where an outbreak could directly impact on the delivery of critical services. Employers and workers in these settings also have a responsibility to ensure the safety of visitors, clients, patients, and people in their care.

There are discrete factors that affect the risk profile of any given setting for the transmission and wider potential impact of COVID-19.

From a public health perspective, COVID-19 transmission risk is directly affected by the ability to physically distance, air flow (i.e. whether the environment is enclosed or outdoors), and the use of infection prevention and control measures (i.e. non-pharmaceutical interventions - masks and hand hygiene). The impact of COVID-19 is amplified by the presence of people vulnerable to the effects of COVID-19 (like unvaccinated people, the elderly, immunocompromised, those with comorbidities, and people with a disability), or where people from a wide geographic spread are exposed and COVID-19 can be transmitted to multiple regions, including vulnerable or remote communities.

More broadly, from a 'systems impact' perspective, in some cases a COVID-19 outbreak in a workplace can have substantial impacts beyond those immediately affected and their families—where an outbreak occurs among workers who provide services critical to the public, like a health care or emergency services setting, the impact on the available workforce and service provision can be even more widespread and long-lasting.

While vaccination coverage continues to increase at a whole-of-population level, as noted above the protective potential of vaccination against COVID-19 is also affected by differential vaccine uptake. COVID-19 has demonstrated extraordinary efficiency in seeking out unvaccinated and vulnerable people within communities, workplaces and industries. This has been evident in the nature and setting of major outbreaks of the Delta variant in NSW and VIC—including aged care facilities, schools and prisons—and repeated waves of infection overseas.

With the above risk factors taken into account, this Direction provides a framework for additional vaccine mandates in Queensland.

In the current iteration, priority high-risk settings are identified in the education, corrections, and aviation sectors. These are settings that, despite individual uptake of vaccines and prioritisation in the vaccine rollout, are more susceptible to COVID-19 transmission, and where an outbreak will have a potentially significant impact on the community. Table 1 at the end of this document describes the risk profile and evidence for COVID-19 transmission at these settings, and Table 2 provides a jurisdictional comparison for these and other currently mandated settings.

Schools and early education

The Queensland Government takes the position that schools are an essential service and should remain open wherever possible. This is consistent with the view of the Australian Health Protection Principals Committee (AHPPC). With border closures and sustained public health measures since the national stay at home orders (including school closures) in March 2020, extended or widespread school closures in Queensland have so far been largely avoided.

The COVID-19 vaccine has recently been made available to children aged 12-15 years in Australia. As at 2 December 2021, 76.3 per cent of Australian children aged 12 to 15 years have received at least one dose of the vaccine and 66.7 per cent of children are fully immunised.

Children under the age of 11 years comprise 15.3 per cent of Queensland's population. In the absence of an approved vaccine for children under the age of 12 years, young children are the single largest unvaccinated cohort in Australia. As COVID-19 begins to circulate more widely in Australia, young children will become the new front line of the COVID-19 pandemic.

Schools are environments where physical distancing is difficult to maintain, where groups of people spend extended periods of time together in an enclosed environment, and where other public health measures such as physical distancing and mask wearing can be impractical, particularly in early childhood settings with very young children.

In Victoria (VIC) and New South Wales (NSW), numerous outbreaks were seeded in school and early childhood settings following easing of lockdown conditions. COVID-19 outbreaks reportedly closed more than 270 schools (two thirds of which were primary schools) and 300 childcare centres across NSW during October 2021, and in VIC dozens of schools have been linked to COVID-19 outbreaks.

A recent example of COVID-19 risk at the school setting for Queensland is the Indooroopilly Cluster earlier this year (August 2021). This outbreak—the biggest in Queensland to date—was seeded across four schools and over subsequent weeks resulted in 147 cases and 17,000 close and secondary household contacts in home quarantine.

At the beginning of the outbreak, although a large number of exposure venues were identified, with the exception of the index case and family, all community cases were detected in association with a limited

number of exposure venues, namely the affected Brisbane schools, and a karate class. Transmission had occurred not only within but across schools, with a high degree of crossover including siblings at different schools.

During this outbreak, affected contacts were rapidly identified and placed into home quarantine. Because of this, the flow-on effects of the outbreak could be observed by day five of the outbreak, where 80 per cent of new daily cases were known household contacts of cases. By day eight 100 per cent of new daily cases were being detected among known close contacts. The transmission rate of the Delta variant in households, and arguably any enclosed environment where people spend lengthy periods of time in close contact, has been estimated at between 70 to 100 per cent.

Fortunately, acute infection with SARS-CoV-2 is generally associated with mild disease in children. Compared to adults, children are 25 times less likely to develop severe disease.

However, the effect of an outbreak among and on-transmission from this cohort has the potential to be much more widespread, in terms of the impact within schools and on households, including inter-generational exposure, as well as student and staff absences and disruptions to schools with closures during outbreaks.

As at 08 December 2021, according to Queensland Health reporting of vaccines administered by Hospital and Health Services, 41,718 school and early childhood staff have received their second dose of the COVID-19 vaccine. This does not include doses administered by primary care providers (including General Practice), or other Commonwealth facilities, and the true figure is likely to be higher.

The total number of school and early childhood education workers in Queensland is not known. To illustrate the potential scale and impact of exposure to COVID-19 among workers in education, a 2020 report by the Queensland College of Teachers, the peak regulatory body for the teaching profession in Queensland, reports over 110,000 approved teachers, with over 68 per cent of these employed in permanent or long-term temporary teaching positions. According to the report, half of all teachers–51.3 per cent—are over 45 years of age and 16.5 per cent are 60 years or older.

The severity of COVID-19 increases with age. People in their 30s who are not vaccinated are at four times the risk of a teenager of becoming sufficiently unwell from COVID-19. For people in their 50s, the risk is 40 times higher than that of a teenager of becoming very unwell, being hospitalised, or dying. The death rate for COVID-19 starts to increase for those over 50 years of age. Those under 50 years of age who are infected have a death rate of 0.2–0.4 per cent of those infected, while for those 50–59 years it rises to 1.3 per cent of those infected, then 3.6 per cent for 60–69 years and higher again into the older years.

This means that as well as being at increased risk of exposure to COVID-19 at the setting, over half of the employed teaching cohort in Queensland is at increased risk of moderate to severe illness, or death, from COVID-19. The rates of severe illness or death are even higher for people who have underlying conditions like diabetes, hypertension, or asthma.

The AHPPC's *Statement on COVID-19, Schools and Reopening Australia* states that a primary goal for schools is to reduce transmission for the entire school community, protect the un-immunised population of students at school and maintain the ability of schools to remain open. Using actions from the hierarchy of controls, AHPPC notes that three specific principles apply to minimise disease in schools. These are (a) reducing opportunities for introduction of the virus, (b) reducing transmission of the virus if it is introduced, and (c) early use of containment measures if spread occurs.

Vaccination offers a high level of individual protection for workers in schools and early childhood settings. Uniform vaccination among workers at school and early education, including childcare settings would contribute meaningfully to principles (a) and (b) described above.

While children under 12, and those over 12 who are unvaccinated, remain susceptible to COVID-19, their opportunities to acquire infection are reduced if the adults around them are vaccinated. This is a process

called cocooning that is also used for other infectious diseases in infants. Notably, high vaccination rates amongst school family units are also a key protective factor.

All other Australian jurisdictions except for Queensland and Tasmania (TAS) have already introduced mandatory COVID-19 vaccination for workers in schools and early childhood settings (see Table 1 for a jurisdictional comparison at the end of this document).

In Queensland, for Department of Education employees, a range of vaccinations are strongly recommended depending on risk and exposure, but this would be the first mandatory vaccination for this cohort. Ensuring workers in schools and early education settings are uniformly vaccinated against COVID-19 will support AHPPC recommendations for schools, directly reduce risk to the workforce, help to protect against severe outbreaks and repeated school closures, sustain workforce capacity and reduce the risk of COVID-19 exposure to vulnerable people.

Correctional and detention facilities (including youth detention facilities)

Correctional and detention facilities provide an essential service for public safety, rehabilitation and enforcement of the law. These facilities are known to carry a higher risk of COVID-19 transmission due to the nature of the setting and the vulnerable cohorts they house. Additional protections at correctional facilities have been put in place during periods of higher COVID-19 risk in Queensland. These measures, to protect the health and wellbeing of people in correctional and detention facilities, include requirements for additional PPE and restrictions on visitors. From 17 December 2021, baseline protections will be embedded via the PHSM Plan and all visitors to these facilities must be fully vaccinated to enter.

Correctional and detention facilities, including youth detention, are enclosed environments where people are housed in close proximity, where communal indoor activities and dining are common, and where vulnerable cohorts are overrepresented. Some people at these facilities may face barriers to implementing basic hygiene measures and safely wearing face masks.

People detained in prisons and at detention facilities, including youth detention, are at higher risk from COVID-19. It has been estimated that almost one-third of people entering prison have a chronic medical condition like asthma, cancer, cardiovascular disease, diabetes, or live with disability.

Aboriginal and Torres Strait Islander people detained in these settings are also at increased risk from COVID-19, with a higher prevalence of chronic health issues than non-Indigenous people.

There is a high turnover among persons who are detained in correctional and detention facilities, as well as movement and transfers between facilities. Staff are also entering and leaving the facilities daily and are the most mobile within these facilities.

As noted above, Queensland has had few outbreaks of COVID-19 during the pandemic. Illustrating the unique risks of transmission and spread for cohorts in correctional and detention facilities, between 20 and 26 August 2020 there were 11 cases associated with an outbreak in the Brisbane Youth Detention Centre (BYDC). Over the following month, a total of 24 cases were associated with the BYDC, and 25 associated with an outbreak in association with the Correctional Services Training Academy. This is the second largest outbreak (outside the Indooroopilly Cluster) that Queensland has seen during the pandemic since border closures and public health measures were introduced.

According to figures released in November 2021 for NSW, over 550 inmates had tested positive across multiple COVID-19 outbreaks in prisons during the ongoing Delta outbreak—228 of whom were likely to have acquired COVID-19 while incarcerated—and 75 Corrective Services staff were infected.

In terms of the potential impact on Queensland's workforce, the total number of persons working at correctional and detention facilities in Queensland is not known. According to the Queensland Corrective Services annual report, 5,499 full-time equivalent corrective services officers were employed as at 30 June 2020. Of the workforce, 3.05 per cent identify as Aboriginal or Torres Strait Islander. Around 1 in 5 (20.2 per cent) of permanent corrective services officers are over the age of 55 years and the average age of

permanent employees is around 43 years. Like teachers, this workforce is likely to be at increased risk from exposure to COVID-19.

It is estimated that there have been over 11,500 COVID-19 vaccination doses delivered at Queensland corrections facilities (as at 26 November 2021). It is not known what proportion of corrections workers in Queensland is currently fully vaccinated against COVID-19. For comparison, figures from NSW in September 2021 (prior to announcement of a vaccine mandate) indicated about 65 per cent of prison staff had received one dose and 46 per cent had been fully vaccinated.

General vaccination uptake among workers and people detained in these settings is typically lower than in the general population, with higher rates of vaccine hesitancy. To illustrate, by late August when cases began to emerge in NSW prisons just 22 per cent of prisoners had been vaccinated. This was lower than the corresponding state-wide figure at the time.

As demonstrated in NSW and also seen overseas particularly in the United States, there is a strong likelihood that COVID-19 exposure in these settings will result in a rapidly spreading outbreak, particularly if there is a high proportion of unvaccinated people moving freely around the facility.

Workers in corrections and detention facilities are directly responsible for the care and wellbeing of the people housed in these settings. Like healthcare workers, frontline corrections and detention staff undertake their duties in close proximity to the people in their care, many of whom are vulnerable.

For this reason, mandatory immunisation for other vaccine-preventable diseases is already a condition of work for staff of Queensland correctional facilities, detention and immigration centres. Workers must be vaccinated against hepatitis B, influenza, MMR and tetanus.

Nationally, all other jurisdictions with the exception of the Australian Capital Territory (ACT) and TAS, have mandates in place for COVID-19 vaccination of workers at correctional and detention facilities.

Ensuring workers in correctional and detention facilities in Queensland, including youth detention, are uniformly vaccinated against COVID-19 will directly reduce risk to the workforce, help to protect against severe outbreaks, sustain workforce capacity and reduce the risk of COVID-19 exposure to vulnerable people.

For completeness, it should be noted that there have been views expressed in other national and international jurisdictions that a COVID-19 vaccine mandate in these settings should also extend to include people who are detained at the facility – citing concerns for their health, but also the risk that a COVID-19 outbreak poses for the facility and the community in general. This is a complex human rights issue and is beyond the scope of this Direction.

Airports

Airports and aviation perform an essential service and function as major drivers of regional economies and tourism throughout the State. Airports are settings that facilitate the transit of many thousands of people a day.

Supporting end-to-end protection of Australians from COVID-19, mandatory mask wearing on flights and in airports was agreed by National Cabinet on 8 January 2021. This was put into effect in Queensland on 12 January 2021, applying to all indoor areas of Queensland airports and to all people except for air crew and airport workers not interacting directly with passengers.

Public health restrictions and especially border closures significantly reduced air travel for most of 2020, with a decline of almost 27.7 million passenger movements across Queensland airports, representing a 66 percent decrease against 2019. With Queensland's borders reopening, the number of people travelling into Queensland is expected to increase substantially.

In 2019, 41.8 million passengers (33.7 million domestic and 8 million international) travelled through airports across the State. It has been estimated that across Queensland's international airports, under

current conditions, total passenger movements will increase from 11.5 million in 2021 to 41.7 million in 2026. This translates to a return to 2019 levels in 2024 for international passengers, and a recovery in 2023 for domestic aviation passengers.

It can be expected that going forward, travellers will arrive daily into Queensland from places with circulating COVID-19, and despite pre-flight testing and other restrictions (including a requirement for most travellers to be fully vaccinated), airports will be a central transit point for people arriving from higher-risk locations.

While it is expected that COVID-19 will eventually becoming endemic in Queensland, in the immediate future the primary source of COVID-19 in Queensland will continue to be from interstate and overseas travellers. To date, over 75 per cent of all Queensland COVID-19 cases have been overseas acquired, with travellers arriving by air. International arrivals in particular will always present the risk of introducing new and potentially vaccine resistant variants of concern.

During peak periods, physical distancing at airports can be difficult to maintain, particularly at locations where passengers interface with airport workers. Workers at airports are likely to have direct and indirect contact with many people, including travellers from non-hotspot areas who may on-travel into regional and remote parts of Queensland.

An airport worker who contracts COVID-19, including a new variant of concern, could unknowingly transmit the virus to a number of people in a single shift and seed a widespread outbreak across multiple regions of the State.

Airport workers have been eligible for the COVID-19 vaccine since May 2021 and have been strongly encouraged to be vaccinated. It is not known what proportion of this cohort are currently vaccinated.

Major Australian airlines have already announced mandatory full vaccination policies for workers – Qantas, Jetstar, and Virgin require frontline employees to be fully vaccinated by 15 November 2021 and the remainder by 31 March 2022. Frontline customer-facing employees of Rex airlines must be fully vaccinated by 1 November 2021. Prior to the announcement in September, a survey of staff conducted by Rex with a 90 per cent response rate, showed that about 9 out of 10 staff will already have been voluntarily vaccinated by November 2021.

Nationally all other jurisdictions with the exception of TAS have mandates in place for COVID-19 vaccination of workers at airports. The ACT mandate was put in place by Canberra Airport, and in SA the mandate currently only applies to an identified high-risk ‘red zone’.

Ensuring workers at airports are uniformly vaccinated against COVID-19 will directly reduce risk to the workforce, help to protect against widespread outbreaks across the State, and other parts of Australia, and help to sustain workforce capacity for this important service. With existing mandates in place by airlines and with the support of the sector (see below), it is not expected that this requirement will create a major imposition for workers at airports.

Engagement with the sector

Department of Education (DoE; Director-General and DDG) - conveyed the scope and rationale for the inclusion of ‘Schools’. DoE undertook to engage with the broader private and independent sector to convey the policy intent.

Department of Communities, Youth Justice and Multicultural Affairs - Youth Justice raised queries relating to the scope of the settings around community offices and child safety officers. It was clarified that the Direction would apply to Youth Detention Centres in Queensland and with the inclusion of schools as an identified high risk setting, would also include all Child Safety Officers either entering a facility or a school as part of their work.

Queensland Corrective Services - conveyed the scope and rationale for the policy and clarified the definition of Prisons.

Tourism and Aviation Reference Group, including major Airport and Airline industry stakeholders – advised the policy intent and rationale, and timing for implementation. Industry voiced appreciation.

Major airports and airlines including Brisbane, Gold Coast and Cairns as well as Virgin, Qantas and Alliance - discuss the definition of an Airport and the responsibility of the employer and responsible person to ensure operationally the Airports can meet the obligations outlined. No concerns raised. Similarly, Queensland Health engagement with the Australian Airports Association and the Brisbane Airport Corporation in early November 2021 reflected high levels of support for a policy of mandatory vaccination for workers at airports.

Overall, all agencies and industry representatives were very supportive, and the primary outcomes of the meetings were to ensure that the definitions were appropriate for the settings and appropriately reflected the scope and intent of the policy.

Mandating vaccination for workers in identified high-risk settings

The Direction provides a framework to mandate vaccination for workers in high risk settings and sets these out in a Schedule. Consistent with the risk factors described earlier in this document, the Direction applies to workers in settings where:

- there is a higher risk of transmission of SARS-CoV-2, the virus that causes COVID-19
- the setting is accessed by a large number of vulnerable persons as service users, and/or
- a sudden reduction in available workforce due to COVID-19 impacts at the setting would significantly affect the continuity of critical services to the community with consequential public health and safety risks.

Settings in the Schedule in this iteration of the Direction are:

- Schools, childcare and early childhood education facilities
- Corrective service facilities (including police watch houses) and youth detention centres
- Airport premises and associated precincts

A vaccination requirement will apply to all workers who enter, work in, or provide services in a high-risk setting. The direction defines how a high-risk setting is identified by the Chief Health Officer and specifies the COVID-19 vaccination requirements and related obligations for workers and employers operating in a high-risk setting. The direction recognises that an employer may mandate vaccination for employees, where otherwise permitted at law, based on the requirements of a role.

It is expected that any staff who enter a high-risk setting for the purposes of work, even if not their primary workplace would be in-scope for the vaccination requirement. This would include but not be limited to union officials, regulators, and contractors like maintenance staff.

However, a person engaged or employed to undertake work in an area of the high-risk setting that is not co-located, will not be required to meet COVID-19 vaccination requirements. This provision only applies where the area is not occupied by the users or workers of the high risk setting; is physically separated from the occupied part of the high-risk setting and users or workers cannot gain access to the area; and has no shared points of access with users and workers of the high risk setting. Under these requirements, the risk of COVID-19 transmission is substantially minimised as the users and workers of the high risk setting are physically excluded from the work site.

For example, part of a school's grounds are fenced off while construction of a gym is undertaken. While the construction work progresses, school staff and students are not permitted to enter the construction site and the construction company has control of the site. The construction site is not co-located with the school and is therefore not subject to the COVID-19 vaccination requirements that apply to the high-risk setting.

To be clear the intent is not to mandate vaccination of the worker but to mandate that in certain higher-risk settings, only vaccinated persons may work.

It is recognised that in rare circumstances, a worker may be genuinely unable to be vaccinated due to a medical contraindication. Accordingly, and provided the contraindication is certified, the worker may continue to work in a high-risk setting where their work cannot be performed outside the setting. For their own and others' protection when at the setting, they will need to comply with PPE requirements consistent with requirements as set by the responsible person for the setting. They must also undertake daily COVID-19 PCR testing before commencing each work shift. A permanent vaccine exemption can only be granted on the grounds of previous anaphylaxis or severe adverse event attributed to the COVID-19 vaccine or vaccine component across all vaccines available for use in Australia, and it is not expected that many people will fall into this category. Staff with a temporary contraindication will be expected to complete their vaccination following the exclusion period.

An exception to vaccination requirements is also provided for workers in a high risk setting who are active participants in a COVID-19 vaccine trial. Participation in clinical trials is important to ensure the continued availability of safe and effective COVID-19 vaccines and forms an integral component in the transition from elimination to 'living with COVID-19'. This provision will ensure that the current Direction does not create unnecessary barriers to the participation in such trials, and to remove any contradiction with similar exceptions for vaccination mandates in other Queensland Public Health Directions or Queensland Health Employment Directives.

This exception only applies where the person engaging or employing the worker has assessed the risk to other staff, users, clients and other persons in the high-risk setting and determines that the worker may continue to work in that setting. The worker must provide a medical certificate or letter from a medical practitioner to confirm active participation in the trial and that the worker has received at least one dose of the COVID-19 vaccine being trialled. The requirement for at least one dose of the trial vaccine is expected to provide a level of protection against COVID-19 and will assist to reduce the risk of transmission.

The COVID-19 vaccine trial exception ceases when the trial vaccine is recognised, approved or rejected for use in Australia by the TGA at which time mandatory vaccination requirements apply.

From time to time there may be exceptional circumstances that result in a critical workforce shortage, such as illness, high demand or another emergent event, and there may be an occasion where there is a shortage of vaccinated workers. In this event, and to allow for the continued and safe delivery of services, the Direction provides that an unvaccinated worker may be permitted to enter, work in or provide services in the setting, for a short period until vaccinated workers can be recruited. This is subject to strict standards, including a risk assessment by the person responsible for the healthcare setting, PPE use and daily COVID-19 PCR testing by the worker.

It is expected that this option only be exercised in extreme and sustained circumstances, where the shortage means a direct impact on patient or client care or the effective operation of the setting. An example is a shortage of more than 10 per cent of staff for a sustained period of 7 days or more among a small staff cohort, with the remaining skills mix and rostering unable to compensate for the shortage. Similarly, in an emergency where it is absolutely necessary, other unvaccinated workers, including contractors, may enter a high-risk setting to respond to an emergency, but must comply with PPE requirements.

The Direction is not intended to restrict visitors to the settings, or for users of the service to gain access – for example, students or parents at a school, or a person accessing an airport as a traveller. It should be noted that visitors to corrections facilities are required to be vaccinated under the PHSM Plan, with corrections considered a vulnerable facility in the same way as hospitals, aged care and disability accommodation facilities.

Further, the Direction is not intended to mandate COVID-19 vaccination for support people who are directly providing legal, advocacy, social welfare, mental health and wellbeing supports for vulnerable clients or users of a service, and is subject to PPE use as required by the responsible person and modified PCR surveillance testing. An example is an unvaccinated mental health support worker regularly provides support to a person detained at a corrective services facility who relies on continuity of face to face contact

for their mental health and wellbeing and their health outcomes would be adversely impacted by a change in support arrangements. This arrangement is considered an exception and is at the discretion of the responsible person. The exception is provided for as in these circumstances, the risk to the individual is considered to outweigh the public health benefit of the policy.

Uniform vaccination coverage will protect staff and safeguard the community by minimising the risk of COVID-19 transmission within the workforce as well as to and from vulnerable cohorts (for schools and correctional facilities) and travellers (for airports) as COVID-19 becomes more widespread. Limiting transmission within these workplaces will also reduce the likelihood of workplace outbreaks and staff shortages that can impact on the delivery of these essential services.

Future implementation

As Queensland transitions to a 'living with COVID-19' future, COVID-19 will begin to be managed more like other vaccine-preventable diseases—public health restrictions are expected to reduce, and regulatory requirements will become more targeted. During the transition to endemic COVID-19, and particularly during the early stages, it will remain critically important to limit the transmission and spread of COVID-19, protect the health of Queenslanders, and sustain health system and contact tracing capacity.

Mandating uniform vaccination coverage for workers in identified high risk settings ensures that the spread of the virus among vulnerable cohorts and in higher-risk settings is slowed. This will safeguard against broader impacts on the community, industry, and the health system.

It is likely that high-risk settings will continue to be identified as the virus moves through the population. As noted above, without available vaccines, children are becoming new front line of the pandemic and schools and early childhood settings are increasingly recognised as key high-risk settings. The impact of waning immunity has not yet been tested in Queensland, and this may have unpredictable consequences across a range of settings and workplaces where vaccination may have been prioritised or seen rapid uptake early in the vaccine rollout.

Omicron variant

On November 26, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern. The first known confirmed infection was from a specimen collected on 9 November 2021 and the variant was first reported to the WHO from South Africa on 24 November 2021.

In recent weeks in South Africa infections have risen steeply, coinciding with the detection of this variant. It appears to be taking over dominance in some South African regions in less than two weeks.

The variant has a large number of mutations – 32 on the spike protein alone, compared to only 9 on the Delta variant, and preliminary evidence is suggesting that this variant may produce an increased risk of reinfection among people who have had COVID-19 previously. The transmissibility of the variant is currently unknown, although some early indications are that it is highly transmissible. The severity of disease is also unknown, although on balance it is considered unlikely that it causes more severe disease than other known variants. The effectiveness of vaccine against the variant is still under investigation, although current vaccines appear to remain effective against severe disease and death. Pfizer have indicated they expect to know within two weeks whether the variant is vaccine resistant. An advantage is that should another vaccine be required it is likely that a new mRNA vaccine could be produced and made available within months.

Public health considerations – 10 December 2021

Epidemiological situation

Queensland

- Queensland reported nine new COVID-19 cases in the previous 24 hours including:
    - 1 case is locally acquired, contact not identified and detected in community.
    - 4 cases are locally acquired with interstate travel, 2 were detected in hotel quarantine and 2 were detected in the community.
    - 2 cases are locally acquired, contact of a confirmed case and detected in community.
    - 1 case is overseas acquired and detected in hotel quarantine.
- Today's new cases have not been linked to recent cases on the Gold Coast.
- The total number of cases in Queensland stands at 2,166.
- Queensland is managing a total of 45 active cases, with 25 in hospital (nil in ICU), 11 in Hospital in the Home and nine awaiting transfer. There are currently no active First Nations cases in Queensland.
- Queensland has recorded two cases of the Omicron variant of COVID-19, one case reported on 6 December was detected in hotel quarantine in Cairns and the second case reported on 4 December was detected in Brisbane.
- There has been a significant increase in the number of people entering home quarantine, now permitted for many domestic arrivals under the Vaccine Plan after Queensland achieved 70 per cent vaccination coverage on 14 November.
- There are currently 9,309 people in quarantine: 5,699 people in home quarantine (including 4,404 from interstate hotspots), 3,456 people in government hotel quarantine and 154 in alternate quarantine.
- As at 9 December 2021, a total of 3,294,626 Queenslanders aged 16 and over have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 80.11 per cent of this cohort; 3,615,247 people – 87.90 per cent – have had at least one dose.
- As at 9 December 2021, a total of 148,330 Queenslanders aged 12-15 years have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 54.91 per cent of this cohort; 178,058 people – 65.91 per cent – have had at least one dose.

Emergence of Omicron variant

- On 26 November, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern.
- The first known confirmed infection was from a specimen collected on 9 November 2021.
- The variant was first reported to the WHO from South Africa on 24 November 2021.
- The variant has a large number of mutations (including 32 on the spike protein alone, compared to only nine on the Delta variant), and preliminary evidence is suggesting this variant may produce an increased risk of reinfection among people who have had COVID-19 previously.
- Omicron is being urgently investigated by researchers globally, with the WHO announcing it could take weeks for sufficient data and analysis to draw preliminary conclusions.
- There is currently insufficient information available to make conclusions on the transmissibility and disease severity of the variant. The effectiveness of available vaccines against the Omicron variant is also under investigation. The variant is detectable through current PCR testing.
- As at 10 December, there are over 1,400 cases of the Omicron variant of concern in over 57 countries, including at least 45 cases in Australia.
- At this stage, the primary risk of Omicron incursion into Queensland is from other Australian jurisdictions with minimal quarantine requirements (Victoria, New South Wales) for international arrivals.
- On Saturday 27 November, the Commonwealth announced a range of new measures in response to the new variant. Anyone who is not an Australian citizen or their dependents and who has been in nine countries in Southern Africa in the past 14 days cannot travel to Australia. Australian citizens and their

dependents are required to go into supervised quarantine on arrival. The nine countries are South Africa, Namibia, Zimbabwe, Botswana, Losoto, Eswatini, The Seychelles, Malawi and Mozambique.
- Australia has also suspended flights from these countries and several jurisdictions have tightened travel restrictions.
- On 29 November, the Australian government they have been in discussions with the CEOs of Pfizer and Moderna and have prepared a contract for variants.
- On 3 December ATAGI recommended that there is to be no change to booster timeframes in light of the Omicron variant.

National

- As at 9 December, in the 24 hours prior jurisdictions have reported 1,669 newly confirmed cases, including locally and internationally acquired. There are at least 14,807 active cases nationwide.
- As at 9 December, Australia has reported 88.71 per cent of the eligible population aged 16 years and over as fully vaccinated; 93.13 per cent has had at least one dose.
- As at 9 December, Australia has reported 68.91 per cent of the eligible population aged 12-15 years as fully vaccinated; 77.09 per cent has had at least one dose.
- On 10 December the Australian Government confirmed that Australia's COVID-19 vaccination program will be extended to all children aged 5 to 11 years from 10 January 2022, after the Australian Government accepted recommendations from the Australian Technical Advisory Group on Immunisation (ATAGI).
- NSW and Victoria, with sustained and widespread outbreaks of the Delta variant since June-July, are seeing a reduction in daily new cases in recent weeks with fluctuating, but generally downward trajectory. Noting wide-ranging lifting of restrictions and lockdown conditions, Queensland is monitoring case numbers in these jurisdictions as well as in the Australian Capital Territory (ACT) where daily positive cases have also been gradually falling since the start of the latest outbreak.
- As at 8 December 2021, at least 45 Omicron cases have been detected in Australia, including 42 in NSW, two in Queensland and one in the Northern Territory.
- Quarantine requirements for Australians returning from overseas to NSW, Victoria, ACT and South Australia had started to ease in November. However, following the emergence of the Omicron variant, these jurisdictions have re-introduced restrictions for arrivals from countries of concern.
- South Australia opened its borders to NSW, Victoria and the ACT on 23 November. Since then, there have been 61 new cases.

New South Wales

- NSW reported 516 new COVID-19 cases and nil new deaths in the past 24 hours; there have been 78,907 locally acquired cases and 580 deaths reported since 16 June.
- NSW is currently managing 158 cases in hospital, with 24 people in ICU (nine requiring ventilation).
- As at 9 December, NSW has reported that 93.01 per cent of the eligible population aged 16 years and over is fully vaccinated and 94.72 per cent have received at least one dose.
- As at 9 December, NSW has reported that 77.46 per cent of the eligible population aged 12-15 years is fully vaccinated and 81.38 per cent have received at least one dose.
- NSW has now recorded 42 cases of the Omicron COVID-19 variant, with the multiple cases infectious in the community. At least 21 of these cases are linked to a cluster related to schools and a gym in Regents Park.
- NSW has a range of movement and gathering restrictions in place for unvaccinated people, which will remain in effect until 15 December when NSW is expected to reach 95% vaccination coverage of its population aged 16 years and over.

Victoria

- Victoria has reported 1,203 new locally acquired cases and two deaths in the last 24 hours; there now have been 112,987 locally acquired cases and 591 deaths reported since 16 June.

- Victoria is managing 313 cases in hospital, including 61 active cases and 43 cleared cases in intensive care (25 of whom require ventilation).
- As at 9 December, Victoria has reported that 91.53 per cent of its eligible population aged 16 years and over is fully vaccinated and 93.53 per cent have received at least one dose.
- As at 9 December, Victoria has reported that 80.62 per cent of its eligible population aged 12-15 years is fully vaccinated and 87.45 per cent have received at least one dose.
- There are currently no restrictions in place for Victorians who are fully vaccinated.

Australian Capital Territory

- ACT has reported six new locally acquired cases and nil new deaths in the last 24 hours; there have been 2,061 locally acquired cases and 12 deaths reported since 12 August.
- ACT is managing five cases in hospital, with two people in intensive care, neither of whom requires ventilation.
- As at 9 December, ACT has reported that 98.88 per cent of its eligible population aged 16 years and over is fully vaccinated and >99 per cent have received at least one dose.
- As at 9 December, ACT has reported that 96.42 per cent of its eligible population aged 12-15 years is fully vaccinated and >99 per cent have received at least one dose.

Northern Territory

- The NT has reported nil new community cases in past 24 hours. The Katherine and Robinson River outbreak now totals 64 cases since 15 November 2021.
- The first Omicron case in the Northern Territory was reported on 29 November. This case was a traveller who returned to Australia on a repatriation flight from South Africa on 25 November 2021. This case was in quarantine at the time of detection.
- As at 9 December, NT has reported that 80.17 per cent of its eligible population aged 16 years and over is fully vaccinated and 88.19 per cent have received at least one dose.
- As at 9 December, NT has reported that 59.23 per cent of its eligible population aged 12-15 years is fully vaccinated and 74.00 per cent have received at least one dose.
- Katherine moved to a lockout from 27 November. During the lockout period, people inside the designated area are not permitted to leave and people outside are not able to enter, except for essential workers. Following an extension, Katherine, Binjari and Rockhole exited lockdown on 8 December with a mask mandate in place until 15 December.
- Due to the occurrence of community transmission of COVID-19 and persistent positive wastewater results in Katherine East, targeted COVID-19 testing stations will be established to help identify undetected cases.

Global

- As at 10 December, there have been over 268 million confirmed COVID-19 cases, 5.28 million confirmed COVID-19 related deaths and 8.324 billion COVID-19 vaccine doses administered (Source: John Hopkins University).
- In the week to 5 December, weekly COVID-19 case incidence plateaued, with over 4 million confirmed new cases. However, new weekly deaths increased by ten per cent compared to the previous week, with over 52,500 new deaths reported (Source: WHO).
- In the week to 5 December, cases increased in two of the six WHO regions – America and Africa Regions. An increase in weekly deaths was reported in two of the six regions - by 49 per cent in the South-East Asia region and 38 per cent in the America region (Source: WHO).

Living with COVID-19

- The Queensland Government continues to progress its state-wide campaign to encourage Queenslanders to get vaccinated. There is a particular focus on encouraging increased uptake in regional and remote areas. Many of these areas currently have lower vaccination coverage than the Queensland average.
- From Monday 1 November, Designated COVID-19 Hospitals in Queensland are offering booster COVID-19 vaccination doses for people who received their second dose at least six months ago.
- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.
- From 70% of Queensland's eligible population fully vaccinated (19 November), anyone who has been in a declared domestic hotspot in the previous 14 days can travel into Queensland provided they:
    - are fully vaccinated
    - arrive by air
    - have a negative COVID-19 test in the previous 72 hours
    - undertake home quarantine for 14 days, subject to meeting conditions.
- At 80% of Queensland's eligible population fully vaccinated (80% milestone reached 9 December, measures to commence 13 December):
    - Fully vaccinated travellers from a domestic COVID-19 hotspot can arrive by road or air, with no quarantine required but must have had a negative COVID-19 test in the previous 72 hours and agree to get a further COVID-19 PCR test on day five of their stay in Queensland.
    - Fully vaccinated direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90% of Queensland's eligible population fully vaccinated, there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas.
    - Unvaccinated travellers will need to apply for a border pass, enter within the international arrivals cap, and undertake a period of quarantine.
- On 9 November 2021, the Queensland Government released its *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond*, which sets out measures variously applying to vaccinated and unvaccinated people aged 16 years and over. The associated Direction was published on 7 December and will come into effect on 17 December.
- Under the Plan, there will be no COVID-19 density restrictions on pubs, clubs, cafés, cinemas, theatres, music festivals if all staff and attendees are fully vaccinated.
- On 9 December, Queensland's *Quarantine for International Arrivals (No.16)* was published, regarding the above noted changes to the requirements for international arrivals from 13 December.
- On 9 December, Queensland's *Border Restrictions Direction (No.56)* was published, regarding the above noted changes to arrivals from domestic COVID-19 hot spots from 13 December.

Public Health System capacity

- Currently, Queensland Public Health Units are working to ensure the Queensland community is complying with public health controls. Another key focus for Queensland's Public Health Units is to ensure that those directed to undertake quarantine, including home quarantine, comply with all requirements, including the testing regime.
- Additional restrictions are imposed and lifted in response to evidence of community outbreaks to ensure the safety of Queenslanders, and more specifically our most vulnerable people in residential aged care facilities, hospitals, and disability accommodation services.

- While cases of COVID-19 in the Queensland community have been managed well to date, it is important to mitigate against widespread outbreaks. It is particularly important to quickly bring clusters under control with effective contact tracing and other protective measures to maintain the integrity of the health system to respond to non-COVID-19 related care.

Health Care System capacity

- Queensland will soon transition to the next phase of the COVID-19 response, which will involve wider circulation of COVID-19 in the Queensland community. Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts to hospital capacity and workforce. This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is critical. It is expected that with increased vaccine protection, the number of people requiring hospitalisation and intensive care in the event of an outbreak are likely to remain within hospital and health system capacity.
- As Queensland's response to COVID-19 has evolved, expert advisory groups, particularly the COVID-19 Response Group (CRG) have further developed and refined Queensland Health's response plans. Particular consideration has been given to the impacts of the Delta variant and an increasing likelihood of a surge in cases as Queensland transitions to living with COVID-19.
- To support health system delivery in this new phase of COVID-19, Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met. This response includes expanding to hospitals and settings (such as homes) beyond the Designated COVID-19 Hospital Network, postponing elective surgeries, and leveraging private hospital capacity as required.
- The established Designated COVID Hospital Network can accommodate a moderate surge in cases, across both inpatient and at home care through Hospital in the Home (HITH) placements.
- Strategies are in place with private providers to minimise the interruption to urgent elective services should a wider community outbreak across Queensland impact on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.

Community acceptance and adherence

- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been accepting and supportive of public health measures.
- There are ongoing concerns of 'pandemic fatigue', particularly in vulnerable sections of the community, and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions is expected to reduce dramatically with increased vaccination coverage. Queensland, like other jurisdictions, is preparing to move into a new 'living with COVID-19' phase of the pandemic.
- With lengthy periods of restriction in some jurisdictions (i.e. NSW and Victoria), as well as new vaccine-related mandates and public health and safety measures coming into effect, a number of protests have been held in recent months, principally in east-coast states.
- The key issue in the medium-term is likely to be in relation to vaccine mandates, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates vary with local context. For example, Victoria and NSW, managing widespread outbreaks and health systems at capacity have mandated vaccination across many industries and settings, including construction, education, and other authorised workforces including retail. In the context of very low case numbers and strict requirements throughout the pandemic, Western Australia has announced mandatory vaccine requirements across almost every sector, estimated to affect up to 75% of the population, with similar vaccine requirements also announced by the Northern Territory.

Wastewater monitoring

- To strengthen surveillance capabilities and increase confidence that transmission is not occurring, Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.
- There have been positive wastewater detections at the Merrimac, Coombabah, Pimpama and Capalaba wastewater treatment plants on 8 December 2021.

Table 1. Jurisdictional comparison of COVID-19 vaccine mandates for workers in key high-risk settings (26 November 2021)

Cohort	Jurisdictional comparison [Note: date of second vaccination provided, unless otherwise specified]								
	National position	**QLD**	**NSW**	**ACT**	**VIC**	**SA**	**TAS**	**WA**	**NT**
Health care workers (public)	AHPPC recommendation: by 15 Dec	✓ 15 Dec	✓ 30 Nov	✓ 1 Dec	✓ 1st dose by 29 Oct	✓ Booked 2nd dose by 1 Nov	✓ Sufficiently vaccinated by 31 Oct	✓ 1 Nov	✓ 24 Dec
Health care workers (private)	AHPPC recommendation: by 15 Dec	✓ 15 Dec	✓ 30 Nov	✓ 1 Dec	✓ 1st dose by 29 Oct	Booked 2nd dose by 1 Nov	✓ Sufficiently vaccinated by 31 Oct	✓ 1 Nov	✓ 24 Dec
Residential aged care workers	AHPPC recommendation: by 17 Sept	✓ 15 Dec	✓ 4 Dec	✓ 1 Dec	✓ 15 Nov	✓ Booked 2nd dose by 17 Sept	✓ Sufficiently vaccinated by 17 Sep	✓ 17 Nov	✓ 31 Oct
Disability support workers	AHPPC recommendation: by 31 Dec	✓ 15 Dec	✓ 29 Nov	✓ 13 Dec	✓ 26 Nov	✓ Booked 2nd dose by 30 Nov	✓ Sufficiently vaccinated by 21 Nov	✓ 31 Dec	✓ 24 Dec
Aged care in-home and community aged care workers	AHPPC recommendation: by 31 Dec	✓ 15 Dec	✓ 29 Nov	✓ 13 Dec	✓ 2nd dose by 26 Nov	✓ Booked 2nd dose by 30 Nov	✓ Sufficiently vaccinated by 30 Nov	✓ 31 Dec	✓ 24 Dec
Private provider facilities (GPs, pharmacies)	AHPPC recommendation by 15 Dec	✓ 15 Dec	–	✓ 1 Dec	✓ 1st dose by 29 Oct	✓ Booked 2nd dose by 8 Nov	✓ Sufficiently vaccinated by 31 Oct	✓ 1 Nov	✓ 24 Dec
Education and childcare workers	Vaccination of staff encouraged by AHPPC	–	✓ 8 Nov	✓ 29 Nov	✓ 29 Nov	Booked 2nd dose by 11 Dec	–	✓ 31 Jan	✓ 24 Dec
Correctional services and prison workers	–	–	✓ 31 Jan	–	✓ 26 Nov	✓ 1st dose by 17 Sept	–	✓ 31 Dec	✓ 24 Dec
Quarantine facility workers	Vaccination of staff encouraged by AHPPC	✓	✓ 1 Nov	–	✓ 26 Nov	✓ 1st dose by 17 Sept	✓ Sufficiently vaccinated by 17 Sep	✓ 31 Dec	✓ 26 Nov
Workers at airport setting	–	–	✓ 1 Nov	✓ Mandated by Canberra Airport	✓ 26 Nov	✓ Red Zone only 1st dose by 17 Sept	–	✓ 31 Dec	✓ 24 Dec*
Definition of fully vaccinated	TGA: when required doses received	Date of 2nd dose	Date of 2nd dose	Date of 2nd dose	Date of 2nd dose	Date of 2nd dose	Sufficiently vaccinated	Date of 2nd dose	Date of 2nd dose

*Airport setting not specifically mandated in NT but appears covered under provisions in *Directions for mandatory vaccination of workers to attend the workplace*.

Table 2 - Risk factors and evidence of COVID-19 transmission at critical settings serving the Queensland population

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	
Health care (hospitals) *Essential service*	*High staff movement and client contact*	*Shared wards, high mobility*	*Enclosed environment windows do not open*	*Highly trained clinical environment*	*People attend when unwell*	*People receiving medical treatment*	*Visitors vaccinated (17 Dec 2021)*	**AHPPC statement on mandatory vaccination of all workers in health care settings[i] (endorsed by National Cabinet (1 October 2021)** **NSW Delta Outbreak (June 2020)** - COVID-19 infection in multiple hospital outbreaks e.g. Concord Hospital, Liverpool Hospital; Bella Vista private health clinic, Liverpool private health clinic, Lakemba GP clinic and St Vincent's Hospital (> 5 cases). **United Kingdom** - 11.3% of patients in UK hospitals became infected after hospital admission[ii.]
Aged care *Essential service*	*High staff movement and client contact*	*Residential style accomm Communal dining*	*Residential style accomm may be adaptable*	*Varied standards; can be impractical*	*Primary risk from carers/visitors (vaccination required)*	*Elderly people with comorbidities*	*Visitors vaccinated (17 Dec 2021)*	**AHPPC recommends mandatory vaccination of aged care in-home and community aged care workers (endorsed by National Cabinet 5 November 2021)[iii]** **Victoria 2nd wave (June – July 2020)** - Led to Australia having one of the highest rates worldwide of deaths in residential aged care as a percentage of total death (October 2020). Over half of active cases related to outbreaks in residential facilities. **NSW Outbreak (July 2021 - ongoing)** - Involved at least 34 Aged Care Facilities
Disability *Essential service*	*High staff movement and client contact*	*Residential style accomm Communal dining*	*Residential style accomm may be adaptable*	*Varied standards; can be impractical*	*Primary risk from carer/visitors (vaccination required)*	*People with disability*	*Visitors vaccinated (17 Dec 2021)*	**AHPPC statement on mandating vaccination for disability support workers (endorsed by National Cabinet 5 November 2021)[iv]** - People with disability are at higher risk as they are more likely to live in a long-term care home, need to have close contact with care providers, have difficulty wearing a mask, physical distancing and personal hygiene[v]. - People with Down Syndrome are more likely to have more severe COVID-19 infection[vi]. - Many people with disabilities have diabetes, cancer, heart disease, or obesity - these conditions may put them at higher risk of severe illness due to COVID-19. **United Kingdom** - 58% of all COVID-19 deaths involved cases with disability - People with disability significantly higher likelihood of death (age adjusted)[vii]

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	
Correctional and detention facilities *Essential service*	*High staff movement and contact with detained persons*	*Restricted residential style accommodation; limited space and freedom of movement*	*Enclosed environment, windows do not open*	*Can be impractical, difficult to enforce / ensure compliance*	*Movement of prison staff and detained persons between facilities and their communities*	*Overrepresentation of vulnerable cohorts*	*Visitors vaccinated (17 Dec 2021)* *Cohort movements into the community if case undetected*	**Corrections setting identified as a high-risk setting for COVID-19 by CDNA, priority population for vaccination rollout in Australia.** - Vaccination uptake alone will not prevent outbreaks and disease in prisons, but increased vaccination coverage will reduce their severity and protect those who are vaccinated from moderate and severe illness and death. - Vaccination uptake among workers and people detained in these settings is typically low, with higher vaccine hesitancy than the general population[4] **QLD** - Uptake in Qld may be higher than in other jurisdictions, over 11,500 doses delivered at facilities to date. - BYDC / Corrections Academy Training facility outbreak August 2020 was Qld's second largest outbreak at 49 cases. **NSW** - Outbreak in NSW prisons (including Parklea) in September 2021; over 300 cases, Aboriginal and Torres Strait Islander making up one quarter of cases. - Figures given at a budget estimates hearing suggest over 550 inmates tested positive to 5 November 2021; 228 of whom likely to have acquired COVID-19 while incarcerated; 75 Corrective Services staff were infected. **University of NSW report[viii] on the impact of COVID-19 in prisons** - key risk factors: infection prevention protocols including mask wearing, hand sanitiser, vaccination coverage of staff and incarcerated persons, population density, within the setting, quality of air ventilation, extent of movement between sections within the prison and between prisons, and the health and demographic profile of the incarcerated population **US Study of COVID-19 cases among 1.3 million people in US prisons (June 2020; prior to Delta variant)[ix]** - Case rate for prison population was 5.5 times higher than general US population; death rate was 3 times higher. Study relied on officially reported data, but testing rates low, so likely an underestimate of cases.

SETTING	Risk factors within setting				Likelihood~	Consequence		EVIDENCE
	Worker mobility	Close proximity	Indoor environment	Other infection control measures*		Individuals	Community (outbreak)	
Schools and early education *Essential service*	*Moderate educator movement across setting; often cohorted*	*Cohorted groups in classrooms, spread within cohorts likely, gyms, canteens, assemblies*	*Enclosed spaces, classrooms may have improved airflow, outdoor learning*	*Can be impractical in early childhood settings; difficult to enforce*	*Multiple household contacts, widely connected community, children more likely asymptomatic*	*Unvaccinated children; impacts for older unvaccinated teaching staff higher*	*Household transmission, high crossover, family impact*	**QLD** - High transmission between students, staff and families in the Indooroopilly Cluster. - Qld's largest COVID-19 outbreak of 147 cases. In this cluster, 60 cases (40%) were students and 80 cases (54%) were household contacts. **NSW** - More than 270 schools and 300 childcare centres closed due to COVID-19 cases during October 2021; two thirds were primary schools. **National Centre for Immunisation Research and Surveillance (NCIRS) report (September 2021)[x]** - During the recent NSW outbreak (to end July 2021) there was a 5-fold higher rate of transmission (secondary attack rate 4.7%) than in 2020 (secondary attack rate 0.9%) in educational settings—reflective of increased transmissibility of Delta variant. - ECEC services experienced the highest rate of transmission (6.4%), as they remained fully open with high attendance rates. Transmission was highest between ECEC staff members (16.9%) and from an ECEC staff member to a child (8.1%). - High population-level rates of COVID-19 vaccination, including vaccination of school/ECEC staff, are critical. **United States** - The opening of schools contributed to a growth of COVID-19 cases by 5 percentage points—vaccines and mask-wearing in this setting identified as critical[xi] - CDC recommends that all teachers, staff and eligible students be vaccinated as soon as possible[xii]
Airports *Voluntary attendance*	*Potential for contact with many travellers*	*During peak periods, physical distancing is more difficult to maintain*	*Enclosed but spacious buildings*	*National mask-mandate, established procedures*	*Travellers from international hotspots, high traffic* *(Cases even with high proportion of passengers vaccinated)*	*Predominately vaccinated passengers, variable risk profile of travellers*	*High traffic and high mobility, wide geographic spread*	- Airports have high traffic of travellers from across the globe. In 2019, Queensland saw 41.8 million passengers (33.7 million domestic and 8 million international). - Across Queensland's international airports, under current conditions, total passenger movements are forecast to increase from 11.5 million in 2021 to 41.7 million in 2026. - To date, over 75% of all Queensland cases have been overseas acquired. With low COVID-19 transmission relative to other countries, international arrivals present the highest risk of incursion of a new, potentially vaccine resistant variant of concern. - Further to this, domestic and international arrivals will be permitted to travel anywhere in the State. In the event of a positive COVID-19 case in an airport setting, the potential for widespread transmission to regions and vulnerable communities is increased.

*PPE, Mask wearing, hand hygiene
~Mobility of cohort and extent of community access

[i] Australian Health Protection Principal Committee (AHPPC) statement on mandatory vaccination of all workers in health care settings | Australian Government Department of Health
[ii] Hospital-acquired SARS-CoV-2 infection in the UK's first COVID-19 pandemic wave - The Lancet
[iii] Australian Health Protection Principal Committee (AHPPC) statement on mandatory vaccination of aged care in-home and community aged care workers | Australian Government Department of Health
[iv] Australian Health Protection Principal Committee (AHPPC) statement on mandating vaccination for disability support workers | Australian Government Department of Health
[v] COVID-19 Vaccines for People with Disabilities | CDC
[vi] People with Certain Medical Conditions | CDC
[vii] Deaths involving COVID-19 by self-reported disability status during the first two waves of the COVID-19 pandemic in England: a retrospective, population-based cohort study - The Lancet Public Health
[viii] https://www.publicdefenders.nsw.gov.au/Documents/updated-report-impact-of-covid-19-on-nsw-prisoners-september-2021.pdf
[ix] https://jamanetwork.com/journals/jama/fullarticle/2768249
[x] https://www.ncirs.org.au/sites/default/files/2021-09/NCIRS%20NSW%20Schools%20COVID_Summary_8%20September%2021_Final.pdf
[xi] The association of opening K–12 schools with the spread of COVID-19 in the United States: County-level panel data analysis | PNAS
[xii] Guidance for COVID-19 Prevention in K-12 Schools | CDC

Public Health Directions – Human Rights Assessment

COVID-19 Vaccination Requirements for workers in a high-risk setting Direction

Title	*COVID-19 Vaccination Requirements for workers in a high risk setting Direction*
Date effective	10 December 2021

Background

The *COVID-19 Vaccination Requirements for workers in a high-risk setting Direction* (Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the Public Health Act 2005.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the *COVID-19 Vaccination Requirements for workers in a high-risk setting Direction* is to reduce the impact of COVID-19 on individuals and the Queensland Health system by providing an operational framework for vaccination requirements for workers in identified high risk settings.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the Direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

Widespread COVID-19 transmission in high risk settings where there are high numbers of vulnerable people or where the nature of the setting increases the risk of transmission can significantly increase the risk of transmission within the setting and into the community, and has the potential for significant adverse effects for vulnerable patients and clients accessing high risk settings.

Mandatory vaccination can help reduce the risk of transmission and the impacts on those who access services at the high-risk setting.

How the Direction Achieves the Purpose

Outlining the vaccination requirements for workers in high risk settings will help to reduce the impacts on individuals, particularly vulnerable individuals, with the anticipated spread of COVID-19 once Queensland borders open to other Australian States and Territories

The Direction achieves this by identifying settings considered by the Chief Health Officer to be high risk settings based on specified criteria and by providing COVID-19 vaccination requirements for those settings, and requiring proof of COVID-19 vaccination, or evidence of medical contraindication, for compliance with those requirements or for eligibility for an exemption. The Direction does not affect an employer's right to require COVID-19 vaccination of employees where their role requires it.

Human Rights Engaged

The human rights engaged by the Direction are:

- Right to equality (section 15)
- Right to life (section 16)
- Consent to medical treatment (section 17)
- Freedom of movement (section 19)
- Freedom of thought, conscience, religion and belief (section 20)
- Freedom of expression (section 21)
- Peaceful assembly and freedom of association (section 22)
- Right of equal access to the public service (section 23)
- Right to privacy (section 25)
- Right to non-interference with family and protection of family (sections 25 and 26)
- Right of children to protection in their best interests (section 26)
- Cultural rights of Indigenous and non-Indigenous peoples (sections 27 and 28)
- Right to humane treatment when deprived of liberty (section 30)
- Right to education (section 36)
- Right to health services (section 37)

- Right to equality (section 15): Every person has the right to recognition as a person before the law and the right to enjoy their human rights without discrimination. Every person is equal before the law and is entitled to equal protection of the law without discrimination. Every person is entitled to equal and effective protection against discrimination. Discrimination includes direct and indirect discrimination on the basis of a protected attribute under the *Anti-Discrimination Act 1991*, such as age, pregnancy, impairment or religious belief. Because the definition is inclusive, discrimination under the *Human Rights Act* also likely covers additional analogous grounds, which may include conscientious belief (however, it is considered that vaccination status or employment status in a particular industry will not be protected attributes as these are not immutable characteristics: *Miron v Trudel* [1995] 2 SCR 418, 496-7 [148]). The direction may result in people with protected attributes being treated differently (for example, a person with a genuine religious objection to vaccines may not be able to continue their employment working in a school or business in an airport precinct). But not all differential treatment amounts to direct or indirect discrimination.

  However, it is considered that the direction does not directly or indirectly discriminate on the basis of any other protected or analogous attribute. A person with an impairment in the form of a medical contraindication will be treated by the direction in the same way as a person who is vaccinated (provided they are able to provide proof). Further, the policy prevents people from entering and remaining in, working in or providing services in certain businesses because they are unvaccinated, not because they have one of those protected or analogous attributes. This means there is no direct discrimination on the basis of an impairment, pregnancy, religious belief or conscientious belief.

  Broadly, indirect discrimination is an unreasonable requirement that applies to everyone but has a disproportionate impact on people with an attribute (such as a religious or conscientious objection to vaccines). Preventing unvaccinated people from entering and remaining in, working in or providing services in certain businesses may have a disproportionate impact on people who are pregnant or who have a religious or conscientious objection to vaccines. However, it is considered that the requirements under the direction are reasonable in light of the public health rationale. Because the requirement is reasonable, there is no indirect discrimination on the basis of an impairment, pregnancy, religious belief or conscientious belief.

- Right to life (section 16): The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. This right is an absolute right. The Direction promotes the right to life by protecting the health, safety and wellbeing of people in the Queensland, in particular vulnerable Queenslanders, by placing vaccination requirements on those who work in high risk settings.

  On the other hand, as with any medical intervention, requiring a person to be vaccinated may come with a small risk of unintended consequences, some of which may be life threatening. Presently, in Australia, the Therapeutic Goods Administration has found that 9 deaths were linked to a COVID-19 vaccination (not necessarily caused by a COVID-19 vaccination) (of the more than 39 million doses that have been administered so far).[1]

  Human rights cases in Europe have held that the possibility that a small number of fatalities may occur does not mean that the right to life is limited by a compulsory vaccination scheme (*Application X v United Kingdom* (1978) 14 Eur Comm HR 31, 32-3; *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 33). Arguably, the right to life is engaged (that is relevant), but not limited, by the proposed direction. As noted above, the right to life is promoted by the proposed direction.

- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c)): Section 17(c) of the Human Rights Act provides that a person must not be subject to medical treatment without the person's full, free and informed consent.

  Medical treatment for the purposes of section 17(c) includes administering a drug for the purpose of treatment or prevention of disease, even if the treatment benefits the person (*Kracke v Mental Health Review Board* (2009) 29 VAR 1, 123 [576]; *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647, 707 [158]-[160]). While the direction will prevent workers from entering a high risk setting for work if they are not vaccinated, the direction will not compel anyone to be vaccinated without their consent. Arguably, this means that the right in section 17(c) is not limited (*Kassam v Hazzard* [2021] NSWSC 1320, [55]-[70]). However, international human rights cases suggest the right may be limited in circumstances where a person is left with little practical choice but to receive the treatment (*GF v Minister of COVID-19 Response* [2021] NZHC 2526, [70]-[72]). It is possible that the proposed direction will leave people with little practical choice but to receive a vaccine, so that while consent is given, that consent may not be full and free for the purposes of section 17(c).

- Freedom of movement (section 19): Every person lawfully within Queensland has the right to move about freely within Queensland. The Direction limits the freedom of movement by restricting who may enter and work in high risk settings according to their vaccination status. While freedom of movement is limited, the restriction on movement is not so severe that the right to liberty in section 29 is also limited (*Loielo v Giles* (2020) 63 VR 1, 59 [218]).

- Freedom of thought, conscience and religion (section 20) and freedom of expression (section 21): Section 20 of the *Human Rights Act* provides that a person has the right to freedom of thought, conscience, religion and belief. Some people have deeply held religious or conscientious objections to vaccines. For example, the Catholic Church has previously advised against using vaccine products that use cell lines derived from an aborted foetus (such as AstraZeneca), unless another vaccine (such as Pfizer) is not available. The effect of the direction is that people with a conscientious or religious objection to vaccines will not be able to enter and remain in, work in or provide services in

[1] <https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-02-12-2021>.

a high-risk setting if they have not received a first dose of a COVID-19 vaccine, after 17 December 2021, and have not received the prescribed number of doses by midnight 23 January 2022.

Freedom of religion in section 20 also encompasses a right not to be coerced or restrained in a way that limits the person's freedom to have or adopt a religion or belief (separate from the freedom to manifest their religion or belief). Similarly, freedom of expression in section 21 encompasses a right to hold an opinion without interference. At international law these are absolute rights (*Christian Youth Camps v Cobaw Community Health Service* (2014) 50 VR 256, 395 [537]). However, nothing in the proposed direction would coerce a person to believe a particular thing or not to hold a particular opinion. It would only limit a person's manifestation of that belief or opinion. Accordingly, those aspects of those rights are not limited by the proposed direction.

- Right to peaceful assembly and freedom of association (section 22): Freedom of assembly and association upholds the rights of individuals to gather together in order to exchange, give or receive information, to express views or to conduct a protest or demonstration for any peaceful purpose and to associate with each other. The freedom of association includes a right to form and join trade unions. The Direction may limit the rights to peaceful assembly and association through the vaccination requirements placed on workers in high risk settings. For example, people who are not vaccinated will not be able to associate through their work with like-minded people in high-risk settings, and unvaccinated union officials will not be able to visit unions members in high-risk settings.

- The right of access to the public service (section 23): Under section 23(2)(b) of the *Human Rights Act*, everyone has a right of equal access to the public service and public office. A risk of dismissal from the public service may engage this right (UN Human Rights Committee, *Communication No 203/1986*, 34th sess, UN Doc Supp No 40 (A/44/40) Appendix (4 November 1988) [4] ('*Hermoza v Peru*')). The effect of the proposed direction is that some public service employees may need to be vaccinated in order to be able to continue in their role, such as people working at schools and corrective services facilities, including youth detention centres.

- Right to property (section 24): Everyone has the right to own property and to not be arbitrarily deprived of that property. 'Property' encompasses all real and personal property interests. One right in the bundle of rights which make up 'ownership' is the right to decide who to allow onto one's property. The proposed direction interferes with that right by stipulating that certain businesses which are high-risk settings cannot allow unvaccinated workers to enter and remain in, work in or provide services in the property owned or occupied by the business. 'Property' may also include the right to practise a profession (*Malik v United Kingdom* [2012] ECHR 438, [89]-[93]). The right to property will only be engaged where the relevant property interest is held by a natural person. Section 24(2) also only protects against deprivations of property which are 'arbitrary'. As arbitrary in this context means (among other things) disproportionate, it is convenient to consider whether the impact is arbitrary below when considering whether the impact is justified (following the approach in *Minogue v Thompson* [2021] VSC 56, [86], [140]).

- Right to privacy (section 25): There are a number of different aspects of the right to privacy that may be engaged.

  First, the proposed direction would require workers to share personal information, such as their vaccination status. Requiring a person to disclose personal information interferes with privacy (*DPP (Vic) v Kaba* (2014) 44 VR 526, 564 [132]). Arguably, the freedom to impart information under section 21(2) includes a freedom not to impart information (*Slaight*

Communications Inc v Davidson [1989] 1 SCR 1038, 1080). However, a limit on this right would add no more to the interference with privacy.

Second, the right to privacy includes a right to bodily integrity (*Pretty v United Kingdom* (2002) 35 EHRR 1, [61]; *PBU v Mental Health Tribunal* (2018) 56 VR 141, 179 [125]). This right will be limited by compulsory vaccination, whether as an involuntary treatment, or where there are repercussions for failing to vaccinate, such as an inability to access services (*Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [263]).

Third, because the right to privacy encompasses an individual's right to establish and develop meaningful social relations (*Kracke v Mental Health Review Board (General)* (2009) 29 VAR 1, [619]-[620]), the right to privacy may also incorporate a right to work of some kind and in some circumstances (*ZZ v Secretary, Department of Justice* [2013] VSC 267, [72]-[95]). The direction may engage this right by interfering with the ability of people to make and maintain social and professional connections and may engage a person's right to work by requiring that they be fully vaccinated to work in certain businesses.

The right to privacy in section 25(a) will only be limited if the interference with privacy is 'unlawful' or 'arbitrary'. As these raise questions that are addressed in considering whether any limit is justified, it is convenient to consider these questions at the next stage when considering justification (following the approach in *Minogue v Thompson* [2021] VSC 56, [86], [140]).

- Right to non-interference with family (section 25) and protection of families (section 26): Section 25(a) of the *Human Rights Act* protects a right not to have one's family unlawfully or arbitrarily interfered with. The proposed direction may interfere with a person's family, for example, by preventing an unvaccinated family member from working in the same school as their child, and the direction may also interfere with a parent's decision about their child's education and childcare arrangements. However, the direction makes clear that a worker is not prevented from using the services of the high-risk setting as a client or visitor, so any such impact is likely to be minimal if it arises at all. Again, whether the interference is lawful and non-arbitrary will be considered below when considering whether the interference is justified. The proposed direction may also limit the support available to vulnerable children in education settings by requiring vaccination of workers who visit them within the education setting.

  Section 26(1) of the *Human Rights Act* recognises that families are the fundamental group unit of society and are entitled to be protected by society and the State. That right is an 'institutional guarantee'. Compared to the individual protection of families in section 25(a), '[t]he true significance of [section 26(1)] lies not in the warding off of State interference but rather in the protected existence of the family' (Schabas, U*N International Covenant on Civil and Political Rights: Nowak's CCPR Commentary* (NP Engel, 3rd ed, 2019) 633-4 [1]-[2], 639 [12]). The proposed direction does not limit the right of families to be protected under section 26, because the proposed direction does not threaten the existence of the family as an institution of society.

- Best interests of the child (section 26): Under section 26(2) of the *Human Rights Act*, every child has the right, without discrimination, to the protection that is in their best interests as a child. The right recognises that special measures to protect children are necessary given their vulnerability due to age. The best interests of the child should be considered in all actions affecting a child, aimed at ensuring both the full and effective enjoyment of all the child's human rights and the holistic development of the child. 'The child's right to health … and his or her health condition are central in assessing the child's best interest.' In all decisions about a child's health, 'the views of the child must also be given due weight

based on his or her age and maturity' (UN Committee on the Rights of the Children, *General comment No 14*, UN Doc CRC/C/GC/14 (29 May 2013) 9). The proposed direction seeks to safeguard the best interests of the child by requiring vaccination of those who work closely with children, and are in regular close proximity with them in education settings.

The proposed direction protects the best interests of the child by preventing unvaccinated persons from entering or remaining in, working in or providing services in youth detention centres (with some exceptions), in order to prevent the risk of an outbreak amongst youths in the youth detention centre. However, by doing so, the direction may also limit other aspects of the right of children to protection in their best interests by, for example, preventing visits from support workers.

- Cultural rights – generally (section 27) and Cultural rights – Aboriginal peoples and Torres Strait Islander peoples (section 28): Section 27 of the *Human Rights Act* protects the rights of all people with particular cultural, religion, racial and linguistic backgrounds to enjoy their culture, declare and practise their religion, and use their language in community. It promotes the right to practise and maintain shared traditions and activities and recognises that enjoying one's culture is intertwined with the capacity to do so in connection with others from the same cultural background. Section 28 provides that Aboriginal and Torres Strait Islander peoples hold distinct cultural rights as Australia's first people and must not be denied the right, together with other members of their community, to live life as an Aboriginal or Torres Strait Islander person who is free to practise their culture.

  The proposed direction may limit cultural rights in a number of ways. For example, it requires workers who visit prisoners and students to be vaccinated. In some areas, there may be limited numbers of specialist workers available to effectively support vulnerable students and prisoners in a culturally appropriate way. Requiring them to be vaccinated may further reduce the available culturally appropriate support options.

- Right to humane treatment when deprived of liberty (section 30): Under section 30(1) of the *Human Rights Act*, any person deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person. That right is relevant whenever prisoners are 'subjected to hardship or constraint other than the hardship or constraint that results from the deprivation of liberty'. The right is relevant to this direction because it may impact a prisoner's connection to family and the community through support workers with some exceptions to ensure continuity of care and support for mental health and wellbeing and for legal and advocacy support. A similar point applies to youth detention centres. However, whether the right is in fact 'limited' must take into account that 'although prisoners do not forgo their human rights, their enjoyment of many of the rights and freedoms enjoyed by other citizens will necessarily be compromised by the fact that they have been deprived of their liberty' (*Castles v Secretary, Department of Justice* (2010) 28 VR 141, 169 [108]-[110]; *Owen-D'Arcy v Chief Executive, Queensland Corrective Services* [2021] QSC 273, [239]). As the exceptions are designed to provide essential supports, it is considered that the right not to be subjected to cruel, inhuman or degrading treatment or punishment under section 17(b) is also not limited.

- Right to education (section 36): Every child has the right to have access to primary and secondary education appropriate to the child's needs. Every person has the right to have access, based on the person's abilities, to further vocational education and training that is equally assessable to all. The value underlying the right to education is empowerment:

'as an empowerment right, education is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities' (Committee on Economic, Social and Cultural Rights, *General Comment No 13: The right to education (article 13 of the Covenant)*, 21st sess, UN Doc E/C.12/1999/10 (8 December 1999) 1 [1]).

As the direction applies to schools and other education settings designated as high-risk settings, it may impact on the right to education of students attending those settings, by potentially reducing the availability of teachers and other persons providing support in the delivery of education. On the other hand, the right to education is strengthened by reducing the risk of education delivery being interrupted by an outbreak in those settings.

- Right to health services (section 37): Every person has the right to access health services without discrimination and must not be refused necessary emergency medical treatment. An objective of the proposed direction is to avoid a surge in hospitalisations once borders reopen. Preventing hospitals from being overwhelmed ensures access to health serves and thereby protects the right in section 37.

In summary, the proposed direction seeks to protect and promote the right to life, the right to protection in the best interests of the child and the right of access to education and health services (sections 16, 26, 36 and 37). On the other hand, the proposed direction limits or may limit the right not to receive medical treatment without full, free and informed consent (section 17(c)), freedom of movement (section 19), freedom of conscience and religion (section 20(1)), the freedom not to impart information (section 21(2)), freedom of peaceful assembly and association (section 22), the right of equal access to the public service (section 23), property rights (section 24), the right to privacy (which may include privacy of personal information, a right to bodily integrity and aspects of the right to work) (section 25(a)), the right to non-interference with family (section 25(a)), cultural rights of Indigenous and non-Indigenous peoples (sections 27 and 28) and the right to education (section 36).

Compatibility with Human Rights

The direction will be compatible with human rights if the limits it imposes are reasonable and justified.

A limit on a human right will be reasonable and justified if:

- it is imposed under law (section 13(1));
- after considering the nature of the human rights at stake (section 13(2)(a));
- it has a proper purpose (section 13(2)(b));
- it actually helps to achieve that purpose (section 13(2)(c));
- there is no less restrictive way of achieving that purpose (section 13(2)(d)); and,
- it strikes a fair balance between the need to achieve the purpose and the impact on human rights (section 13(2)(e), (f) and (g)).

Are the limits imposed 'under law'? (section 13(1))

The Chief Health Officer is authorised to give the proposed direction under section 362B of the *Public Health Act* if they reasonably believe the direction is necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The nature of the rights that would be limited (section 13(2)(a))

What is at stake, in human rights terms, is the ability of all people to take part in all aspects of community life. The direction implicates the ability of people to lead dignified lives, integrated in their community. Requiring people to choose between vaccination and a life integrated in their community, including their work, brings into play the principle that people are entitled to make decisions about their own lives and their own bodies, which is an aspect of their individual personality, dignity and autonomy (*Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 121-2 [569], 123 [577]). When it comes to people with genuine religious and conscientious objections, one of the values that underpins a pluralistic society like Queensland is 'accommodation of a wide variety of beliefs', including beliefs about health and vaccinations (*R v Oakes* [1986] 1 SCR 103, 136 [64]). Creating consequences for a person's employment also affects a person's dignity and autonomy through work. Those values at stake inform what it is that needs to be justified.

Proper purpose (section 13(2)(b))

The purpose of the proposed direction is to reduce the impact on individuals (particularly vulnerable people in high-risk settings) as well as the impact on the health system from spread of the COVID-19 within the broader community once Queensland borders open to other States and Territories. This can only be achieved by setting vaccination requirements for high risk settings in order to contain and prevent the spread of the virus.

The aim of protecting public health is a proper purpose. As noted above, protecting people in the community from the risk of COVID-19 promotes their human rights to life (section 16) and access to health services (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) article 12(2)(c). The purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the *Human Rights Act*).

Suitability (section 13(2)(c))

The limits on human rights will help to achieve the intended purposes. The available evidence to date is that vaccination against COVID-19 helps to reduce the risk of being infected and transmitting the virus on to others (even if the vaccine is not 100 percent effective).[2] This means vaccinated workers in high risk settings will be less likely to be infected by other workers in their workplace. Further, they are less likely to transmit the virus on to others, particularly the vulnerable cohorts and community members in the high risk settings. If they do contract COVID-19, their symptoms will be less severe and less likely to result in hospitalisation reducing the flow on of critical impacts to vulnerable cohorts and the wider community.

Requiring people to provide proof of vaccination to their employer helps to provide an environment that limits the opportunities for transmission of COVID-19 and protects both vulnerable cohorts who are unable to be vaccinated, or are in an environment that has a higher risk of transmission due to limited freedom of movement and/or a large concentration of people with the potential for rapid transmission in the event of exposure to COVID-19.

[2] Australian Technical Advisory Group on Immunisation (ATAGI), *Clinical guidance on use of COVID-19 vaccine in Australia in 2021 (v7.4)* (29 October 2021) 26-32.

The rational connection is not undermined by providing exceptions for people with a medical contraindication. Even with those exceptions, it is still the case that a greater proportion of workers in high-risk settings will be vaccinated.

Necessary (section 13(2)(d))

The following less restrictive alternatives were considered:

- applying the vaccination requirement to fewer settings;
- allowing a wider range of exemptions (such as a genuine religious objection);
- requiring settings to adopt a range of control measures such as social distancing, face masks and improving ventilation.

As to the first alternative of applying the direction to fewer venues, the Policy Rationale for the proposed direction explains that each of the categories of venues are included in the direction because they are high-risk. For example, prisons are included because the risks of COVID-19 to prisoners are higher. Prisoners typically have a lower health status and the enclosed environment of prisons gives rise to the risk of super-spreader events[3]. Education settings are included because there are large numbers of children who are unable to be vaccinated, studying and participating in sport and other activities in close proximity. Airports have large numbers of people travelling from hotspots and gathering in relatively small spaces as they onward travel.

Removing any of these categories of high-risk setting would not achieve the purpose of reducing the risks of COVID-19 transmission to the same extent as the direction in its current form.

As to the second option of allowing a wider range of exemptions, any additional exemptions would come at greater risk of COVID-19 transmission. Accordingly, this option would not be as effective in achieving the public health objective. Further, assessing the genuineness of a person's religious or conscientious belief would be extremely difficult in each individual case and resource-intensive given the scope of the direction. Accordingly, this alternative option would also not be reasonably practicable.

The third option is to require the settings covered by the direction to implement an alternative suite of control measures, such as social distancing and face masks. However, these alternative control measures, alone or in combination, are unlikely to be equally as effective as a vaccination requirement. The Therapeutic Goods Administration advises that '[v]accination against COVID-19 is the most effective way to reduce deaths and severe illness from infection.'[4] Further, the precautionary principle applied by epidemiologists provides that, 'from a purely public health perspective, all reasonable and effective measures to mitigate th[e] risk should ideally be put in place', not merely some of those measures (*Palmer v Western Australia [No 4]* [2020] FCA 1221, [79]). In particular, vaccination and face masks are not mutually exclusive. It is true that face mask requirements have been relaxed in South East Queensland in advance of the borders reopening, but they may be reintroduced if necessary, alongside vaccination requirements. Further, it is not clear that face masks would necessarily be less restrictive of human rights. A requirement to be vaccinated may be more intrusive of

[3]< https://www.aihw.gov.au/reports/australias-health/health-of-prisoners>, <https://nypost.com/2021/02/06/federal-executions-were-likely-covid-19-superspreader-events/>.

[4] <https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-04-11-2021>.

human rights for an individual in the short-term (as it involves medical treatment). However, a requirement to wear a face mask would impact all people – whether vaccinated or not – on a day-to-day basis.

In considering whether the limits on human rights are the least restrictive means, it is relevant that a number of safeguards are built in.

- The direction includes safeguards on the collection of vaccination information, including only requiring evidence to be sighted and not retained and requiring that records be kept by the employer and not by others. This is reinforced by part 7A, division 6 of the *Public Health Act* which sets out safeguards for personal information collected, including protection against direct or derivative use of the information in criminal proceedings (thereby safeguarding the right not to testify against oneself in section 32(2)(k) of the *Human Rights Act*).
- There are exceptions to the requirement to provide proof of vaccination in emergency situations. The exceptions based on risk to physical safety promote the right to security of the person in section 29(1) of the *Human Rights Act*.
- The direction is also in effect for a temporary period. The vaccination requirements within the direction will be regularly reassessed by the Chief Health Officer, and in particular once the population reaches 90 per cent double vaccination, with the opportunity to open up the community and economy further to everyone regardless of vaccination status.

There is no less restrictive, equally effective and practicable way to reduce the risk of COVID-19 transmission in the community. Accordingly, the limits on human rights are necessary to achieve the direction's public health objective.

Fair balance (section 13(2)(e), (f) and (g)

The purpose of the Direction is to reduce the risk of COVID-19 spreading within vulnerable cohorts in high-risk settings and the community, as well as driving vaccination uptake. The benefits of achieving this purpose include reduced impacts on individuals and the health system as more COVID-19 circulates in the community. It also provides the opportunity to open up the Queensland community and economy further to everyone regardless of vaccination status. The benefit also translates to a reduced impact on the health care system by preventing the significant pressure on the health care system caused by the spread of COVID-19 in the community. Conversely, a failure to mitigate the risk of transmission would likely result in loss of life.

On the other side of the scales, these benefits come at the cost of deep and wide impacts on some people, especially people who are not vaccinated against COVID-19. Some people may be effectively locked out of their work. While incentivising vaccination protects public health, it may interfere with a person's autonomy to make decisions about their bodies and their own health, and it may effectively force people to go against their deeply-held conscientious or religious beliefs.

When considering the weight of the impact on human rights, it should be emphasised that human rights come with responsibilities (reflected in clause 4 of the preamble to the *Human Rights Act*). As human rights cases overseas have held, individuals have a 'shared responsibility' or 'social duty' to vaccinate against communicable diseases 'in order to protect the health of the whole society' (*Pl ÚS 16/14* (Constitutional Court of the Czech Republic, 27 January 2015) 17 [102]; *Acmanne v Belgium* (1984) 40 Eur Comm HR 251, 265; *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 35; *Solomakhin v Ukraine* [2012] ECHR 451, [36]; *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber,

Applications nos. 47621/13 and 5 others, 8 April 2021) [279], [306] (majority), [2] (Judge Lemmens)). That is, people have a choice not to get vaccinated, but if they exercise that choice, they are putting the health, livelihoods and human rights of others in their community at risk. The right to exercise that choice carries less weight on the human rights side of the scales.

On balance, the importance of limiting the spread of COVID-19 within Queensland (taking into account the right to life) and reducing the impacts on individuals and the health system outweighs the impact on other human rights. Indeed, it is difficult to overstate the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading within Queensland.

Queensland Health

COVID-19 Public Health Summary
Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 3) and *COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction (No.2)*

Summary of changes

Requirement	Type of change	Consistency	Rationale
Replaces references to COVID-19 PCR test with references to COVID-19 test, which includes both COVID-19 PCR test and COVID-19 RAT	Technical	Consistent with all other Public Health Directions	*Policy Rationale* for the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction*
Updated definition for COVID-19 PCR test and a definition for COVID-19 RAT	Technical	Consistent with all other Public Health Directions	*Policy Rationale* for the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction*
Requires unvaccinated workers to be tested and have a negative result a day prior to work and every second day thereafter (previously daily testing requirement)	Technical	Consistent with testing requirements for close contacts returning to work as critically essential workers	*Policy Rationale* for the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction*
Updates the vaccination requirements	Technical	-	The date for the first dose has now passed and the date for having received the prescribed number of doses will have passed by the publication of the direction
For high risk settings, at the request of Queensland Corrective Services, includes prisoner in the definition of vulnerable persons as they are included in an example in the Direction but may not currently meet the conditions in the definition	Technical	-	-
For workers in healthcare, clarifies that the exemption for participation in a clinical trial does not apply to a student undertaking an education placement	Technical	Consistent with existing policy applying to and mitigating risks posed by students undertaking education placements.	*Applies the same Policy Rationale as* for the other directions that regulate student placements in healthcare settings. Students do not receive an exemption from vaccination requirements to participate in COVID-19 clinical trials or for a medical contraindication.
For workers in healthcare, removes references to vaccination dates under other health or employment directions	Technical	-	All workers in healthcare are now required to be fully vaccinated irrespective of the instrument that applies

Public Health Directions – Human Rights Assessment

COVID-19 Vaccination Requirements for workers in a high-risk setting Direction (No.2)

Title	*COVID-19 Vaccination Requirements for workers in a high risk setting Direction (No.2)*
Date effective	4 February 2022

Background

The *COVID-19 Vaccination Requirements for workers in a high-risk setting Direction* (Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the Public Health Act 2005.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the *COVID-19 Vaccination Requirements for workers in a high-risk setting Direction* is to reduce the impact of COVID-19 on individuals and the Queensland Health system by providing an operational framework for vaccination requirements for workers in identified high risk settings.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the Direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

Widespread COVID-19 transmission in high risk settings where there are high numbers of vulnerable people or where the nature of the setting increases the risk of transmission can significantly increase the risk of transmission within the setting and into the community, and has the potential for significant adverse effects for vulnerable patients and clients accessing high risk settings.

Mandatory vaccination can help reduce the risk of transmission and the impacts on those who access services at the high-risk setting.

The *COVID-19 Vaccination Requirements for workers in a high risk setting Direction (No.2)* (the Direction) revokes and replaces the *COVID-19 Vaccination Requirements for workers in a high risk setting Direction (No.1)* from time of publication.

The Direction has been amended to provide greater flexibility to meet surveillance testing requirements, including:

- replacing references to COVID-19 PCR test with references to COVID-19 test, which includes both COVID-19 PCR test and COVID-19 RAT;
- an updated definition for COVID-19 PCR test and a definition for COVID-19 RAT;
- amending daily testing requirements to require a test and negative test result before the next day of work after commencement of the direction, and every second day thereafter;
- simplifying the vaccination requirements as the date for the first and second dose has now passed;

- at the request of Queensland Corrective Services, including prisoner in the definition of vulnerable persons as they are included in an example in the Direction but may not currently meet the conditions in the definition;
- clarifying that the exemptions for participation in a COVID-19 clinical trial and medical contraindication do not apply to a student undertaking an education placement.

How the Direction Achieves the Purpose

Outlining the vaccination requirements for workers in high risk settings will help to reduce the impacts on individuals, particularly vulnerable individuals, with the anticipated spread of COVID-19 once Queensland borders open to other Australian States and Territories

The Direction achieves this by identifying settings considered by the Chief Health Officer to be high risk settings based on specified criteria and by providing COVID-19 vaccination requirements for those settings, and requiring proof of COVID-19 vaccination, or evidence of medical contraindication, for compliance with those requirements or for eligibility for an exemption. The Direction does not affect an employer's right to require COVID-19 vaccination of employees where their role requires it.*Human Rights Engaged*

The human rights engaged by the Direction are:

- Right to equality (section 15)
- Right to life (section 16)
- Consent to medical treatment (section 17)
- Freedom of movement (section 19)
- Freedom of thought, conscience, religion and belief (section 20)
- Freedom of expression (section 21)
- Peaceful assembly and freedom of association (section 22)
- Right of equal access to the public service (section 23)
- Right to privacy (section 25)
- Right to non-interference with family and protection of family (sections 25 and 26)
- Right of children to protection in their best interests (section 26)
- Cultural rights of Indigenous and non-Indigenous peoples (sections 27 and 28)
- Right to humane treatment when deprived of liberty (section 30)
- Right to education (section 36)
- Right to health services (section 37)

Right to equality (section 15): Every person has the right to recognition as a person before the law and the right to enjoy their human rights without discrimination. Every person is equal before the law and is entitled to equal protection of the law without discrimination. Every person is entitled to equal and effective protection against discrimination. Discrimination includes direct and indirect discrimination on the basis of a protected attribute under the *Anti-Discrimination Act 1991*, such as age, pregnancy, impairment or religious belief. Because the definition is inclusive, discrimination under the *Human Rights Act* also likely covers additional analogous grounds, which may include conscientious belief (however, it is considered that vaccination status or employment status in a particular industry will not be protected attributes as these are not immutable characteristics: *Miron v Trudel* [1995] 2 SCR 418, 496-7 [148]). The direction may result in people with protected attributes being treated differently (for example, a person with a genuine religious objection to vaccines may not be able to continue their employment working in a school or business in an airport precinct). But not all differential treatment amounts to direct or indirect discrimination.

However, it is considered that the direction does not directly or indirectly discriminate on the basis of any other protected or analogous attribute. A person with an impairment in the form of a medical contraindication will be treated by the direction in the same way as a person who is vaccinated (provided they are able to provide proof). Further, the policy

prevents people from entering and remaining in, working in or providing services in certain businesses because they are unvaccinated, not because they have one of those protected or analogous attributes. This means there is no direct discrimination on the basis of an impairment, pregnancy, religious belief or conscientious belief.

Broadly, indirect discrimination is an unreasonable requirement that applies to everyone but has a disproportionate impact on people with an attribute (such as a religious or conscientious objection to vaccines). Preventing unvaccinated people from entering and remaining in, working in or providing services in certain businesses may have a disproportionate impact on people who are pregnant or who have a religious or conscientious objection to vaccines. However, it is considered that the requirements under the direction are reasonable in light of the public health rationale. Because the requirement is reasonable, there is no indirect discrimination on the basis of an impairment, pregnancy, religious belief or conscientious belief.

Right to life (section 16): The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. This right is an absolute right. The Direction promotes the right to life by protecting the health, safety and wellbeing of people in Queensland, in particular vulnerable Queenslanders, by placing vaccination requirements on those who work in high risk settings. Prisoners are now also included in the definition of vulnerable persons, promoting the right to life.

On the other hand, as with any medical intervention, requiring a person to be vaccinated may come with a small risk of unintended consequences, some of which may be life threatening. Presently, in Australia, the Therapeutic Goods Administration has found that 9 deaths were linked to a COVID-19 vaccination (not necessarily caused by a COVID-19 vaccination) (of the more than 39 million doses that have been administered so far).[1]

Human rights cases in Europe have held that the possibility that a small number of fatalities may occur does not mean that the right to life is limited by a compulsory vaccination scheme (*Application X v United Kingdom* (1978) 14 Eur Comm HR 31, 32-3; *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 33). Arguably, the right to life is engaged (that is relevant), but not limited, by the proposed direction. As noted above, the right to life is promoted by the proposed direction.

- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c)): Section 17(c) of the Human Rights Act provides that a person must not be subject to medical treatment without the person's full, free and informed consent.

  Medical treatment for the purposes of section 17(c) includes administering a drug for the purpose of treatment or prevention of disease, even if the treatment benefits the person (*Kracke v Mental Health Review Board* (2009) 29 VAR 1, 123 [576]; *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647, 707 [158]-[160]). While the direction will prevent workers from entering a high risk setting for work if they are not vaccinated, the direction will not compel anyone to be vaccinated without their consent. Arguably, this means that the right in section 17(c) is not limited (*Kassam v Hazzard* [2021] NSWSC 1320, [55]-[70]). However, international human rights cases suggest the right may be limited in circumstances where a person is left with little practical choice but to receive the treatment (*GF v Minister of COVID-19 Response* [2021] NZHC 2526, [70]-[72]). It is possible that the proposed direction will leave people with little practical choice but to receive a vaccine, so that while consent is given, that consent may not be full and free for the purposes of section 17(c). If a COVID-19 PCR test is used, the results must be provided to the employer on a rolling basis when the results are received. Where a Rapid

[1] <https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-02-12-2021>.

Antigen Test is used, the test must be undertaken and a negative test result received before the worker starts the shift.

- Freedom of movement (section 19): Every person lawfully within Queensland has the right to move about freely within Queensland. The Direction limits the freedom of movement by restricting who may enter and work in high risk settings according to their vaccination status. While freedom of movement is limited, the restriction on movement is not so severe that the right to liberty in section 29 is also limited (*Loielo v Giles* (2020) 63 VR 1, 59 [218]). The Direction reduces the limitations on freedom of movement because with the increased options of testing people may now be able to return to the workforce sooner, with less limited physical and procedural barriers.

- Freedom of thought, conscience and religion (section 20) and freedom of expression (section 21): Section 20 of the *Human Rights Act* provides that a person has the right to freedom of thought, conscience, religion and belief. Some people have deeply held religious or conscientious objections to vaccines. For example, the Catholic Church has previously advised against using vaccine products that use cell lines derived from an aborted foetus (such as AstraZeneca), unless another vaccine (such as Pfizer) is not available.

  Freedom of religion in section 20 also encompasses a right not to be coerced or restrained in a way that limits the person's freedom to have or adopt a religion or belief (separate from the freedom to manifest their religion or belief). Similarly, freedom of expression in section 21 encompasses a right to hold an opinion without interference. At international law these are absolute rights (*Christian Youth Camps v Cobaw Community Health Service* (2014) 50 VR 256, 395 [537]). However, nothing in the proposed direction would coerce a person to believe a particular thing or not to hold a particular opinion. It would only limit a person's manifestation of that belief or opinion. Accordingly, those aspects of those rights are not limited by the proposed direction.

  Right to peaceful assembly and freedom of association (section 22): Freedom of assembly and association upholds the rights of individuals to gather together in order to exchange, give or receive information, to express views or to conduct a protest or demonstration for any peaceful purpose and to associate with each other. The freedom of association includes a right to form and join trade unions. The Direction may limit the rights to peaceful assembly and association through the vaccination requirements placed on workers in high risk settings. For example, people who are not vaccinated will not be able to associate through their work with like-minded people in high-risk settings, and unvaccinated union officials will not be able to visit union members in high-risk settings. The changes in the Direction reduce the limitations on the right to peaceful assembly. With the increased options of testing, more people may be able to associate through their work with like-minded people in high-risk settings.

- The right of access to the public service (section 23): Under section 23(2)(b) of the *Human Rights Act*, everyone has a right of equal access to the public service and public office. A risk of dismissal from the public service may engage this right (UN Human Rights Committee, *Communication No 203/1986*, 34th sess, UN Doc Supp No 40 (A/44/40) Appendix (4 November 1988) [4] ('*Hermoza v Peru*')). The effect of the proposed direction is that some public service employees may need to be vaccinated in order to be able to continue in their role, such as people working at schools and corrective services facilities, including youth detention centres.

- Right to property (section 24): Everyone has the right to own property and to not be arbitrarily deprived of that property. 'Property' encompasses all real and personal property

interests. One right in the bundle of rights which make up 'ownership' is the right to decide who to allow onto one's property. The proposed direction interferes with that right by stipulating that certain businesses which are high-risk settings cannot allow unvaccinated workers to enter and remain in, work in or provide services in the property owned or occupied by the business. 'Property' may also include the right to practise a profession (*Malik v United Kingdom* [2012] ECHR 438, [89]-[93]). The right to property will only be engaged where the relevant property interest is held by a natural person. Section 24(2) also only protects against deprivations of property which are 'arbitrary'. As arbitrary in this context means (among other things) disproportionate, it is convenient to consider whether the impact is arbitrary below when considering whether the impact is justified (following the approach in *Minogue v Thompson* [2021] VSC 56, [86], [140]).

- Right to privacy (section 25): There are a number of different aspects of the right to privacy that may be engaged.

  First, the proposed direction would require workers to share personal information, such as their vaccination status. Requiring a person to disclose personal information interferes with privacy (*DPP (Vic) v Kaba* (2014) 44 VR 526, 564 [132]). Arguably, the freedom to impart information under section 21(2) includes a freedom not to impart information (*Slaight Communications Inc v Davidson* [1989] 1 SCR 1038, 1080). However, a limit on this right would add no more to the interference with privacy.

  Second, the right to privacy includes a right to bodily integrity (*Pretty v United Kingdom* (2002) 35 EHRR 1, [61]; *PBU v Mental Health Tribunal* (2018) 56 VR 141, 179 [125]). This right will be limited by compulsory vaccination, whether as an involuntary treatment, or where there are repercussions for failing to vaccinate, such as an inability to access services (*Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [263]).

  Third, because the right to privacy encompasses an individual's right to establish and develop meaningful social relations (*Kracke v Mental Health Review Board (General)* (2009) 29 VAR 1, [619]-[620]), the right to privacy may also incorporate a right to work of some kind and in some circumstances (*ZZ v Secretary, Department of Justice* [2013] VSC 267, [72]-[95]). The direction may engage this right by interfering with the ability of people to make and maintain social and professional connections and may engage a person's right to work by requiring that they be fully vaccinated to work in certain businesses.

  The right to privacy in section 25(a) will only be limited if the interference with privacy is 'unlawful' or 'arbitrary'. As these raise questions that are addressed in considering whether any limit is justified, it is convenient to consider these questions at the next stage when considering justification (following the approach in *Minogue v Thompson* [2021] VSC 56, [86], [140]).

- Right to non-interference with family (section 25) and protection of families (section 26): Section 25(a) of the *Human Rights Act* protects a right not to have one's family unlawfully or arbitrarily interfered with. The proposed direction may interfere with a person's family, for example, by preventing an unvaccinated family member from working in the same school as their child, and the direction may also interfere with a parent's decision about their child's education and childcare arrangements. However, the direction makes clear that a worker is not prevented from using the services of the high-risk setting as a client or visitor, so any such impact is likely to be minimal if it arises at all. Again, whether the interference is lawful and non-arbitrary will be considered below when considering whether the interference is justified. The proposed direction may also limit the support available to

vulnerable children in education settings by requiring vaccination of workers who visit them within the education setting.

Section 26(1) of the *Human Rights Act* recognises that families are the fundamental group unit of society and are entitled to be protected by society and the State. That right is an 'institutional guarantee'. Compared to the individual protection of families in section 25(a), '[t]he true significance of [section 26(1)] lies not in the warding off of State interference but rather in the protected existence of the family' (Schabas, U*N International Covenant on Civil and Political Rights: Nowak's CCPR Commentary* (NP Engel, 3rd ed, 2019) 633-4 [1]-[2], 639 [12]). The proposed direction does not limit the right of families to be protected under section 26, because the proposed direction does not threaten the existence of the family as an institution of society.

- Best interests of the child (section 26): Under section 26(2) of the *Human Rights Act*, every child has the right, without discrimination, to the protection that is in their best interests as a child. The right recognises that special measures to protect children are necessary given their vulnerability due to age. The best interests of the child should be considered in all actions affecting a child, aimed at ensuring both the full and effective enjoyment of all the child's human rights and the holistic development of the child. 'The child's right to health … and his or her health condition are central in assessing the child's best interest.' In all decisions about a child's health, 'the views of the child must also be given due weight based on his or her age and maturity' (UN Committee on the Rights of the Children, *General comment No 14*, UN Doc CRC/C/GC/14 (29 May 2013) 9). The proposed direction seeks to safeguard the best interests of the child by requiring vaccination of those who work closely with children, and are in regular close proximity with them in education settings.

  The proposed direction protects the best interests of the child by preventing unvaccinated persons from entering or remaining in, working in or providing services in youth detention centres (with some exceptions), in order to prevent the risk of an outbreak amongst youths in the youth detention centre. However, by doing so, the direction may also limit other aspects of the right of children to protection in their best interests by, for example, preventing visits from support workers.

- Cultural rights – generally (section 27) and Cultural rights – Aboriginal peoples and Torres Strait Islander peoples (section 28): Section 27 of the *Human Rights Act* protects the rights of all people with particular cultural, religion, racial and linguistic backgrounds to enjoy their culture, declare and practise their religion, and use their language in community. It promotes the right to practise and maintain shared traditions and activities and recognises that enjoying one's culture is intertwined with the capacity to do so in connection with others from the same cultural background. Section 28 provides that Aboriginal and Torres Strait Islander peoples hold distinct cultural rights as Australia's first people and must not be denied the right, together with other members of their community, to live life as an Aboriginal or Torres Strait Islander person who is free to practise their culture.

  The proposed direction may limit cultural rights in a number of ways. For example, it requires workers who visit prisoners and students to be vaccinated. In some areas, there may be limited numbers of specialist workers available to effectively support vulnerable students and prisoners in a culturally appropriate way. Requiring them to be vaccinated may further reduce the available culturally appropriate support options.

- Right to humane treatment when deprived of liberty (section 30): Under section 30(1) of the *Human Rights Act*, any person deprived of liberty must be treated with humanity and

with respect for the inherent dignity of the human person. That right is relevant whenever prisoners are 'subjected to hardship or constraint other than the hardship or constraint that results from the deprivation of liberty'. The right is relevant to this direction because it may impact a prisoner's connection to family and the community through support workers with some exceptions to ensure continuity of care and support for mental health and wellbeing and for legal and advocacy support. A similar point applies to youth detention centres. However, whether the right is in fact 'limited' must take into account that 'although prisoners do not forgo their human rights, their enjoyment of many of the rights and freedoms enjoyed by other citizens will necessarily be compromised by the fact that they have been deprived of their liberty' (*Castles v Secretary, Department of Justice* (2010) 28 VR 141, 169 [108]-[110]; *Owen-D'Arcy v Chief Executive, Queensland Corrective Services* [2021] QSC 273, [239]). As the exceptions are designed to provide essential supports, it is considered that the right not to be subjected to cruel, inhuman or degrading treatment or punishment under section 17(b) is also not limited.Right to education (section 36): Every child has the right to have access to primary and secondary education appropriate to the child's needs. Every person has the right to have access, based on the person's abilities, to further vocational education and training that is equally assessable to all. The value underlying the right to education is empowerment: 'as an empowerment right, education is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities' (Committee on Economic, Social and Cultural Rights, *General Comment No 13: The right to education (article 13 of the Covenant)*, 21st sess, UN Doc E/C.12/1999/10 (8 December 1999) 1 [1]).

As the direction applies to schools and other education settings designated as high-risk settings, it may impact on the right to education of students attending those settings, by potentially reducing the availability of teachers and other persons providing support in the delivery of education. On the other hand, the right to education is strengthened by reducing the risk of education delivery being interrupted by an outbreak in those settings.

- Right to health services (section 37): Every person has the right to access health services without discrimination and must not be refused necessary emergency medical treatment. An objective of the proposed direction is to avoid a surge in hospitalisations once borders reopen. Preventing hospitals from being overwhelmed ensures access to health serves and thereby protects the right in section 37.

In summary, the proposed direction seeks to protect and promote the right to life, the right to protection in the best interests of the child and the right of access to education and health services (sections 16, 26, 36 and 37). On the other hand, the proposed direction limits or may limit the right not to receive medical treatment without full, free and informed consent (section 17(c)), freedom of movement (section 19), freedom of conscience and religion (section 20(1)), the freedom not to impart information (section 21(2)), freedom of peaceful assembly and association (section 22), the right of equal access to the public service (section 23), property rights (section 24), the right to privacy (which may include privacy of personal information, a right to bodily integrity and aspects of the right to work) (section 25(a)), the right to non-interference with family (section 25(a)), cultural rights of Indigenous and non-Indigenous peoples (sections 27 and 28) and the right to education (section 36).

Compatibility with Human Rights

The direction will be compatible with human rights if the limits it imposes are reasonable and justified.

A limit on a human right will be reasonable and justified if:

- it is imposed under law (section 13(1));
- after considering the nature of the human rights at stake (section 13(2)(a));
- it has a proper purpose (section 13(2)(b));
- it actually helps to achieve that purpose (section 13(2)(c));
- there is no less restrictive way of achieving that purpose (section 13(2)(d)); and,
- it strikes a fair balance between the need to achieve the purpose and the impact on human rights (section 13(2)(e), (f) and (g)).

Are the limits imposed 'under law'? (section 13(1))

The Chief Health Officer is authorised to give the proposed direction under section 362B of the *Public Health Act* if they reasonably believe the direction is necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The nature of the rights that would be limited (section 13(2)(a))

What is at stake, in human rights terms, is the ability of all people to take part in all aspects of community life. The direction implicates the ability of people to lead dignified lives, integrated in their community. Requiring people to choose between vaccination and a life integrated in their community, including their work, brings into play the principle that people are entitled to make decisions about their own lives and their own bodies, which is an aspect of their individual personality, dignity and autonomy (*Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 121-2 [569], 123 [577]). When it comes to people with genuine religious and conscientious objections, one of the values that underpins a pluralistic society like Queensland is 'accommodation of a wide variety of beliefs', including beliefs about health and vaccinations (*R v Oakes* [1986] 1 SCR 103, 136 [64]). Creating consequences for a person's employment also affects a person's dignity and autonomy through work. Those values at stake inform what it is that needs to be justified.

Proper purpose (section 13(2)(b))

The purpose of the proposed direction is to reduce the impact on individuals (particularly vulnerable people in high-risk settings) as well as the impact on the health system from spread of the COVID-19 within the broader community once Queensland borders open to other States and Territories. This can only be achieved by setting vaccination requirements for high risk settings in order to contain and prevent the spread of the virus.

The aim of protecting public health is a proper purpose. As noted above, protecting people in the community from the risk of COVID-19 promotes their human rights to life (section 16) and access to health services (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) article 12(2)(c). The purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the *Human Rights Act*).

Suitability (section 13(2)(c))

The limits on human rights will help to achieve the intended purposes. The available evidence to date is that vaccination against COVID-19 helps to reduce the risk of being infected and

transmitting the virus on to others (even if the vaccine is not 100 percent effective).[2] This means vaccinated workers in high risk settings will be less likely to be infected by other workers in their workplace. Further, they are less likely to transmit the virus on to others, particularly the vulnerable cohorts and community members in the high risk settings. If they do contract COVID-19, their symptoms will be less severe and less likely to result in hospitalisation reducing the flow on of critical impacts to vulnerable cohorts and the wider community.

Requiring people to provide proof of vaccination to their employer helps to provide an environment that limits the opportunities for transmission of COVID-19 and protects both vulnerable cohorts who are unable to be vaccinated, or are in an environment that has a higher risk of transmission due to limited freedom of movement and/or a large concentration of people with the potential for rapid transmission in the event of exposure to COVID-19.

The rational connection is not undermined by providing exceptions for people with a medical contraindication. Even with those exceptions, it is still the case that a greater proportion of workers in high-risk settings will be vaccinated.

The exemptions for participation in a COVID-19 clinical trial and medical contraindication do not apply to a student undertaking an education placement. This is because they are not yet a part of a critical workforce. Furthermore, participation in a COVID-19 clinical trial and medical contraindications are generally temporary, and therefore, they could defer their placement until such time as they are no longer participating in a trial or no longer have a medical contraindication.

Necessary (section 13(2)(d))

The following less restrictive alternatives were considered:

- applying the vaccination requirement to fewer settings;
- allowing a wider range of exemptions (such as a genuine religious objection);
- requiring settings to adopt a range of control measures such as social distancing, face masks and improving ventilation.

As to the first alternative of applying the direction to fewer venues, the Policy Rationale for the proposed direction explains that each of the categories of venues are included in the direction because they are high-risk. For example, prisons are included because the risks of COVID-19 to prisoners are higher. Prisoners typically have a lower health status and the enclosed environment of prisons gives rise to the risk of super-spreader events[3]. Education settings are included because there are large numbers of children who are unable to be vaccinated, studying and participating in sport and other activities in close proximity. Airports have large numbers of people travelling from hotspots and gathering in relatively small spaces as they onward travel.

Removing any of these categories of high-risk setting would not achieve the purpose of reducing the risks of COVID-19 transmission to the same extent as the direction in its current form.

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[2] Australian Technical Advisory Group on Immunisation (ATAGI), *Clinical guidance on use of COVID-19 vaccine in Australia in 2021 (v7.4)* (29 October 2021) 26-32.

[3]< https://www.aihw.gov.au/reports/australias-health/health-of-prisoners>, <https://nypost.com/2021/02/06/federal-executions-were-likely-covid-19-superspreader-events/>.

As to the second option of allowing a wider range of exemptions, any additional exemptions would come at greater risk of COVID-19 transmission. Accordingly, this option would not be as effective in achieving the public health objective. Further, assessing the genuineness of a person's religious or conscientious belief would be extremely difficult in each individual case and resource-intensive given the scope of the direction. Accordingly, this alternative option would also not be reasonably practicable.

The third option is to require the settings covered by the direction to implement an alternative suite of control measures, such as social distancing and face masks. However, these alternative control measures, alone or in combination, are unlikely to be equally as effective as a vaccination requirement. The Therapeutic Goods Administration advises that '[v]accination against COVID-19 is the most effective way to reduce deaths and severe illness from infection.'[4] Further, the precautionary principle applied by epidemiologists provides that, 'from a purely public health perspective, all reasonable and effective measures to mitigate th[e] risk should ideally be put in place', not merely some of those measures (*Palmer v Western Australia [No 4]* [2020] FCA 1221, [79]). In particular, vaccination and face masks are not mutually exclusive. It is true that face mask requirements have been relaxed in South East Queensland in advance of the borders reopening, but they may be reintroduced if necessary, alongside vaccination requirements. Further, it is not clear that face masks would necessarily be less restrictive of human rights. A requirement to be vaccinated may be more intrusive of human rights for an individual in the short-term (as it involves medical treatment). However, a requirement to wear a face mask would impact all people – whether vaccinated or not – on a day-to-day basis.

In considering whether the limits on human rights are the least restrictive means, it is relevant that a number of safeguards are built in.

- The direction includes safeguards on the collection of vaccination information, including only requiring evidence to be sighted and not retained and requiring that records be kept by the employer and not by others. This is reinforced by part 7A, division 6 of the *Public Health Act* which sets out safeguards for personal information collected, including protection against direct or derivative use of the information in criminal proceedings (thereby safeguarding the right not to testify against oneself in section 32(2)(k) of the *Human Rights Act*).
- There are exceptions to the requirement to provide proof of vaccination in emergency situations. The exceptions based on risk to physical safety promote the right to security of the person in section 29(1) of the *Human Rights Act*.
- The direction is also in effect for a temporary period. The vaccination requirements within the direction will be regularly reassessed by the Chief Health Officer, and in particular once the population reaches 90 per cent double vaccination, with the opportunity to open up the community and economy further to everyone regardless of vaccination status.

There is no less restrictive, equally effective and practicable way to reduce the risk of COVID-19 transmission in the community. Accordingly, the limits on human rights are necessary to achieve the direction's public health objective.

<u>Fair balance (section 13(2)(e), (f) and (g)</u>

[4] <https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-04-11-2021>.

The purpose of the Direction is to reduce the risk of COVID-19 spreading within vulnerable cohorts in high-risk settings and the community, as well as driving vaccination uptake. The benefits of achieving this purpose include reduced impacts on individuals and the health system as more COVID-19 circulates in the community. It also provides the opportunity to open up the Queensland community and economy further to everyone regardless of vaccination status. The benefit also translates to a reduced impact on the health care system by preventing the significant pressure on the health care system caused by the spread of COVID-19 in the community. Conversely, a failure to mitigate the risk of transmission would likely result in loss of life.

On the other side of the scales, these benefits come at the cost of deep and wide impacts on some people, especially people who are not vaccinated against COVID-19. Some people may be effectively locked out of their work. While incentivising vaccination protects public health, it may interfere with a person's autonomy to make decisions about their bodies and their own health, and it may effectively force people to go against their deeply-held conscientious or religious beliefs.

When considering the weight of the impact on human rights, it should be emphasised that human rights come with responsibilities (reflected in clause 4 of the preamble to the *Human Rights Act*). As human rights cases overseas have held, individuals have a 'shared responsibility' or 'social duty' to vaccinate against communicable diseases 'in order to protect the health of the whole society' (*Pl ÚS 16/14* (Constitutional Court of the Czech Republic, 27 January 2015) 17 [102]; *Acmanne v Belgium* (1984) 40 Eur Comm HR 251, 265; *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 35; *Solomakhin v Ukraine* [2012] ECHR 451, [36]; *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [279], [306] (majority), [2] (Judge Lemmens)). That is, people have a choice not to get vaccinated, but if they exercise that choice, they are putting the health, livelihoods and human rights of others in their community at risk. The right to exercise that choice carries less weight on the human rights side of the scales..

On balance, the importance of limiting the spread of COVID-19 within Queensland (taking into account the right to life) and reducing the impacts on individuals and the health system outweighs the impact on other human rights. Indeed, it is difficult to overstate the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading within Queensland.

COVID-19 Public Health Rationale
Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction
5 November 2021

DRAFT NOT GOVERNMENT POLICY

Overarching intent

The overarching intent of the *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction* (the Direction) is to protect the health of the community and workers in healthcare settings, and safeguard the delivery of health care by minimising the risk of COVID-19 transmission within healthcare settings and into the Queensland community. This Direction further mitigates the risk of COVID-19 exposure and transmission and builds on existing COVID-19 vaccine mandates for healthcare workers and workers in other related settings, like quarantine facilities.

The Direction sets out mandatory COVID-19 vaccination requirements for workers, students and volunteers in healthcare settings, and extends to any other person who works as a health professional, contractor, independent third party provider, other employee or volunteer, whether employed by the healthcare facility or performing the work under another arrangement. The Direction states that by 15 December 2021, these people must have received their second dose of a TGA approved COVID-19 vaccine to enter, work in, or provide services in a healthcare setting. The definition of healthcare setting is broad and includes private hospitals or day procedure centres, general practitioners, private nurse offices and allied health consulting offices, pharmacies, optometrists, dental surgeries and private pathology centres, in-home aged care or disability support services, not-for-profit health organisations providing public healthcare under a service agreement with any State or Commonwealth agency, including an Aboriginal and Torres Strait Islander Community Controlled Health Service and Non-Government Organisations delivering healthcare services.

The Direction complements existing mandatory vaccination requirements in other Queensland Public Health Directions. The proposed policy position aligns with the Australian Health Protection Principal Committee (AHPPC) statement from 1 October 2021 recommending mandatory COVID-19 vaccination for all workers in healthcare settings other than disability support services, as a condition of work. This Direction is deliberately broad and captures the principles of this and other relevant AHPPC statements (such as the statement from 9 July 2021 mandating vaccination among residential disability support workers[1]) as well as AHPPC positions currently under consideration in relation to vaccination for in-home aged care and disability workers. Many states and territories have already mandated vaccinations in the healthcare settings in this Direction, as outlined in Table 2 towards the end of this document.

The Direction recognises existing vaccination requirements for Queensland Health employees in healthcare settings and for students undertaking placements and does not extend the timeframes for these cohorts.

Consultation for this Direction occurred with relevant areas within Queensland Health, including Aged Care, Child Safety, Disability and Multicultural Health, and other Government agencies (i.e. Queensland Corrective Services). External stakeholders have also been consulted on the development of the Direction through the private health regulation unit and the Primary Care Network, and were supportive.

Broadening current COVID-19 vaccination mandates to workers across a wide range of healthcare settings enhances protection across Queensland's entire healthcare system and creates a uniform standard of protection for workers and the community.

[1] Australian Health Protection Principal Committee (AHPPC) statement on mandating vaccination among residential disability support workers (published 9 July 2021)

Background and rationale at 5 November 2021

Queensland's response to the COVID-19 pandemic has been very successful to date. Large scale outbreaks in Queensland have been prevented with a rapid and decisive public health response. The emergence of the Delta variant early this year and its rapid spread around the globe has changed the COVID-19 context. In addition to widespread outbreaks around the world, nationally almost every State and Territory in Australia has faced local transmission of the Delta variant. New South Wales (NSW) and Victoria (VIC) have experienced widespread and sustained outbreaks of COVID-19 since June. This experience, along with the limited likelihood of achieving true herd immunity even with high rates of vaccination, has provoked a shift from a 'suppression' to a 'living with COVID-19' approach to managing COVID-19.

Under *Queensland's COVID-19 Vaccine Plan To Unite Families* released on 18 October 2021, Queensland's border restrictions and quarantine requirements will be progressively adapted as the Queensland population aged 16 and over nears or meets vaccine coverage milestones of 70 per cent (19 November or earlier), 80 per cent (17 December or earlier) and 90 per cent (currently no fixed date).

As Queensland transitions to an environment where COVID-19 is endemic, it is inevitable that every Queenslander will eventually be exposed to COVID-19. Effective vaccines for COVID-19 that prevent severe illness and reduce transmission are now widely available and endorsed by regulatory authorities globally and including Australia's Therapeutic Goods Administration (TGA). Queensland Health is strongly encouraging and promoting COVID-19 vaccination state-wide. High vaccination coverage is essential to protect the community, the health system, and the economy.

Vaccine mandates are widely supported and becoming more common as a mechanism to protect cohorts and workplaces. Vaccination for workers has been mandated by a number of industries that are impacted by COVID-19 exposure, including airlines (like Qantas and Jetstar; cabin crew, pilots and airport workers by November 15 and all other employees by March 31 2022) and mining corporations like BHP (all workers and people entering BHP coal mines from January 2022). On 23 October 2021, Woolworths and Aldi announced that all staff across Australia will be required to be vaccinated for COVID-19 (applying from 31 March 2022 for Queensland).

High vaccination coverage among workers in settings with the potential for exposure to COVID-19, particularly those serving vulnerable cohorts, will be a key determinant of health outcomes for Queenslanders and the impact of COVID-19 on health care delivery across the State. Table 1 describes the current mandatory COVID-19 vaccination requirements for Queensland.

There are already COVID-19 vaccination requirements that apply to workers or students undertaking placements in several Directions, including the *Requirements for Quarantine Facility Workers Direction; Residential Aged Care Direction; Disability Accommodation Services Direction and Hospital Entry Direction* and *Designated COVID-19 Hospital Network Direction*. By 21 October 2021, all 51 Queensland Health Aged Care facilities, including multi-purpose facilities reported that 100 per cent of workers had commenced their program of vaccination with at least their first dose administered.

An enduring requirement for COVID-19 vaccination for Queensland Health staff who work in locations where care is provided to patients is in place via the *Health Employment Directive No.12/21 Employee COVID-19 vaccination requirements*. Queensland Health staff working at sites where care is provided to patients must be fully vaccinated by the end of October 2021. As at 30 October 2021, 95 per cent of staff had received at least their first dose of vaccination. Workers unable or unwilling to be vaccinated are being supported and will be redeployed to other workplaces across Queensland Health wherever possible.

Outside of Queensland Health, health care providers including private hospitals, private specialists, general practitioners and non-government providers have all expressed support for clarity on mandatory COVID-19 vaccination for the workforce. Vaccination against COVID-19 is particularly important in higher-risk settings to protect employees, vulnerable cohorts and the wider community from infection and transmission.

On 1 October 2021, National Cabinet noted AHPPC's recommendation for mandatory COVID-19 vaccination for all workers in healthcare settings as a condition of work. AHPPC recommended that all jurisdictions accept a

national definition of healthcare settings in their relevant legislation to ensure consistency, noting the variance across jurisdictions' regulatory mechanisms for healthcare settings. AHPPC propose a national definition of healthcare settings to ensure national consistency, including:

- Public health settings including public hospitals, public health clinics, ambulance services, patient transport services, and other health services managed by a jurisdiction.
- Private health facilities, such as private hospitals or day procedure centres, or specialist outpatient services.
- Private provider facilities, such as general practitioners, private nurse offices and consulting offices.
- Education settings that manage health care student placements, registration, and/or internships in clinical settings.

All jurisdictions have implemented vaccine mandates for workers in healthcare settings to varying degrees. The current mandates in place nationally are summarised in Table 2 below. All jurisdictions have introduced mandatory vaccination requirements for healthcare workers across the public and private health sectors. While the timeframes vary, all states and territories plan to mandate vaccinations for these sectors before the end of 2021. Vaccination mandates for other healthcare settings are in place in most jurisdictions; however, this is not yet completely uniform. For example, NSW and the Australian Capital Territory have not extended requirements to settings such as primary care and pharmacies; and South Australia and Tasmania do not currently mandate vaccinations for in-home aged care and disability workers. All jurisdictions apply the vaccination requirement to all workers within the captured healthcare setting, in accordance with the AHPPC recommendation.

The Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction will give effect to the AHPPC's recommendation for mandatory COVID-19 vaccination for all workers in healthcare settings as a condition of work. Although the current endorsed advice excludes disability support services, AHPPC has recommended that National Cabinet consider making vaccination mandatory for disability support workers. Mandating vaccination for workers in disability settings is particularly important. People with disability are more likely to have health comorbidities, leaving them particularly vulnerable to the worst impacts of COVID-19, including death. Ensuring that all staff who work with people who are affected by disability are vaccinated is an important protection for this vulnerable cohort.

The Direction will apply to workers in healthcare, including those in the National Registration and Accreditation Scheme, all self-regulated allied health professionals, qualified persons who provide a service or treatment that attracts or is eligible for a rebate from Medicare or a private health insurance organisation, and all other individuals who work in healthcare settings (other than excluded workers in healthcare and excluded healthcare settings).

The Direction also provides that a worker in healthcare must not enter, work in, or provide services in a healthcare setting unless the worker in healthcare complies with the COVID-19 vaccination requirements. The requirements do not apply to worker in healthcare who is entering a healthcare setting in a private capacity, for example as a visitor, or to receive care.

COVID-19 vaccination requirements in this Direction will protect the health of the community and workers across healthcare settings in Queensland. The definition of healthcare setting is deliberately broad—any setting or premises where health care is provided—and includes (but is not limited to) private hospitals or day procedure centres, general practitioners, private nurse offices and allied health consulting offices, pharmacies, optometrists, dental surgeries and private pathology centres, in-home aged care or disability support services, not-for-profit health organisations providing public healthcare under a service agreement with any State or Commonwealth agency, including an Aboriginal and Torres Strait Islander Community Controlled Health Service and Non-Government Organisations delivering healthcare services. Table 1 provides a summary of the settings and cohorts that are currently included in requirements under existing Directions, and those that will now be captured by this Direction.

The Direction recognises existing vaccination requirements for Queensland Health employees in healthcare settings and for students undertaking placements and does not extend the timeframes or override other requirements and exceptions for these cohorts.

The policy goes further than the AHPPC recommendation and the Direction also applies to a worker who provides health care regardless of the setting, which could include a physiotherapist at a gym, or a health worker at a correctional facility, for example. This reinforces the intent and the need for protection from COVID-19 in healthcare by applying the requirement uniquely to healthcare workers; it recognises the close physical contact inherent to the work, and the often vulnerable nature of clients as a factor independent of the setting.

Uniform vaccination coverage will protect staff and safeguard the delivery of health care by minimising the risk of COVID-19 transmission within the workforce as well as to and from patients and clients as COVID-19 becomes more widespread. Limiting transmission within a workplace via the protection of COVID-19 vaccination will also reduce the likelihood of workplace outbreaks and staff shortages.

It is recognised that in rare circumstances, a worker may be genuinely unable to be vaccinated due to a medical contraindication. Accordingly, and provided the contraindication is certified, the worker may continue to work in a healthcare setting where their work cannot be performed outside the setting. For their own and others' protection when at the healthcare setting, they will need to comply with PPE requirements consistent with PPE guidelines and any COVID safe plans for the setting, They must also produce a negative test result (via a PCR test, not including a self-test) before commencing each work shift. It should be noted that there are limited recognised medical contraindications for COVID-19 vaccination, and staff with a temporary contraindication will be expected to complete their vaccination following the exclusion period.

From time to time there may be exceptional circumstances that result in a critical workforce shortage, such as illness, high demand or another emergent event, and there may be an occasion where there is a shortage of vaccinated workers. In this event, and to allow for the continued and safe delivery of services, the Direction provides that an unvaccinated worker may be permitted to enter, work in or provide services in the setting, for a short period until vaccinated workers can be recruited. This would not be expected to take longer than three months, and is subject to strict standards, including a risk assessment by the person responsible for the healthcare setting and PPE use and a negative COVID-19 test before each work shift by the unvaccinated worker. It is expected that this option only be exercised in extreme and sustained circumstances, where the shortage means a direct impact on patient or client care or the effective operation of the healthcare setting. An example is a shortage of more than 10 per cent of staff for a sustained period of 7 days or more in a small healthcare setting, with the remaining skills mix and rostering unable to compensate for the shortage. Similarly, in an emergency where it is absolutely necessary, other unvaccinated workers, including contractors, may enter a healthcare setting to respond to an emergency, but must comply with PPE requirements.

Consultation for this Direction occurred with relevant areas within Queensland Health, including Aged Care, Child Safety, Disability and Multicultural Health, and other Government agencies (i.e. Queensland Corrective Services). External stakeholders have also been consulted on the development of the Direction through the private health regulation unit and the Primary Care Network and were supportive.

Public health considerations at 5 November 2021

Epidemiological situation

Queensland

- There were two overseas acquired cases detected in Queensland in the previous 24 hours.
- There has been recent community transmission in Goondiwindi that is related to cross-border travel to Moree, NSW. On 4 November, three locally acquired cases were reported and were connected to multiple potential super-spreader events. Three locally acquired cases in NSW, two with recent travel to Goondiwindi, have been associated with these events.

- Goondiwindi has one of highest vaccination rates in Queensland. Further, average testing rates over the past 7 days reached 3.8 tests per 1,000 people, which places Goondiwindi in the highest coverage testing bracket. Additional restrictions, particularly for vulnerable facilities, are being enacted for this region as a protective measure.
- Queensland is currently managing a total of 9 active cases, 7 of whom are in hospital.
- The total number of cases in Queensland stands at 2,094, 23 of which have been among First Nations Australians to date.
- There are a total of 4,494 people in quarantine: 1,398 people in home quarantine, 2,945 people in hotel quarantine and 151 in alternate quarantine.
- An average of 2,980 travel declaration applications are being received each day—with a total of 20,863 in the last 7 days—reflecting the number of people wishing to travel into Queensland from non-hotspot jurisdictions. Green travel declarations are granted automatically and represent nearly all travel declarations. Of the 1,089,704 travel declarations to date only 627 have been 'orange' (subject to quarantine due to being at an exposure site in a non-hotspot area).
- A daily average of 7,506 border pass applications are being made by people wishing to enter Queensland from a declared hotspot—with a total of 52,542 in the last 7 days. The number of people travelling into Queensland from a hotspot is lower than this figure and is limited by hotel quarantine availability, with some people able to quarantine at home with an exemption.

Vaccination

- As at end 4 November 2021, a total of 2,706,602 Queenslanders aged 16 and over have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 65.8 per cent of this cohort; 3,241,102 people – 78.8 per cent – have had at least one dose.

National

- As at 4 November 2021, in the 24 hours prior jurisdictions have reported 1,573 newly confirmed cases, 2 of which were overseas acquired cases, and 13 deaths.
- Australia has reported 79.1 per cent of the eligible population aged 16 years and over is fully vaccinated; 88.9 per cent have had at least one dose.
- NSW and VIC, with sustained and widespread outbreaks of the Delta variant since June-July had seen a reduction in daily new cases in recent weeks with a steady downward trajectory, but following wide-ranging lifting of restrictions and lockdown conditions, there are early indications that case numbers may be once again increasing. NSW has reported a rise in daily cases for the fifth day in a row and VIC cases are once again over 1,000 cases per day.
- The outbreak in the ACT since 12 August has been contained to fewer numbers overall but has persisted despite lockdown conditions. Daily case numbers in the ACT are now also reducing.
- Health system capacity in both NSW and VIC has been placed under significant strain by these outbreaks.
- From 1 November, quarantine requirements for Australians returning from overseas to NSW and VIC were lifted.
- The Northern Territory has responded quickly to a case of COVID-19 detected in the Katherine region on 4 November and has declared lockdown and lockout conditions for the affected area and greater Darwin. A second case has been reported as at 5 November. Under lockout conditions, fully vaccinated people will be required to wear a mask when outdoors, while unvaccinated people will be subject to full lockdown restrictions.

New South Wales

- NSW reported 249 new locally acquired COVID-19 cases and 3 deaths in the past 24 hours; there have been 70,437 locally acquired cases and 530 deaths reported since 16 June.
- 285 cases are admitted to hospital, with 61 people in intensive care (28 of whom require ventilation).
- NSW has reported 93.8 per cent of the State's eligible population aged 16 years and over has received at least one dose and 89.1 per cent are fully vaccinated.
- Restrictions that were due to be relaxed for fully vaccinated people on 1 December will be relaxed ahead of schedule to Monday 8 November. Restrictions for unvaccinated people will remain in place until 15 December or until the state reaches 95 per cent double dose vaccination.

Victoria

- Victoria reported 1,343 new locally acquired cases and 10 deaths in the last 24 hours; there have been 74,025 locally acquired cases and 345 deaths reported since 16 June.
- 634 cases are hospitalised with COVID-19, including 109 in intensive care (73 of whom require ventilation).
- 92.7 per cent of eligible Victorians aged 16 years and over have received at least one dose of a COVID-19 vaccine and 82.2 per cent are fully vaccinated.
- Once Victoria reaches 90 per cent full vaccine coverage, there will be no restrictions on gatherings, no density restrictions and masks will only be required in high risk indoor settings.

Australian Capital Territory

- ACT reported 6 new locally acquired cases in the past 24 hours. 1 death has been reported in the previous 24 hours; there have been 1,698 locally acquired cases and 11 deaths reported since 12 August.
- ACT is managing 3 cases in hospital, with 1 people in intensive care (1 of whom requires ventilation).
- The vaccination rate of the population over 12 years old is ~94 per cent.

Global

- As of 5 November 2021, more than 7 billion doses of COVID-19 vaccine have been administered globally (John Hopkins University).
- The cumulative number of confirmed cases reported globally is now over 248 million and the cumulative number of deaths is over 5 million.
- Globally, the numbers of weekly COVID-19 cases and deaths increased slightly during the past week, with over 3 million cases and over 50,000 new deaths, a 3% and 8% increase respectively. With the exception of the European region, which reported a 6% increase in new weekly cases as compared to the previous week, other regions reported declines or stable trends.
- New weekly deaths increased by 8% as compared with the previous week, with over 50,000 new fatalities. The observed rise in new weekly deaths has been mainly driven by the South-East Asia Region, which reported the largest increase (50%), followed by the European Region (12%) and the Western Pacific Region (10%)
- The highest numbers of new cases were reported from the United States of America (528 455 new cases; 7% increase), the United Kingdom (285 028 new cases; 14% decrease), the Russian Federation (272 147 new cases; 9% increase), Turkey (182 027 new cases; 8% decrease), and Ukraine (152 897 new cases; 14% increase).

Living with COVID-19

- The Queensland Government has launched a state-wide campaign to encourage Queenslanders to get vaccinated. There is a particular focus on encouraging increased uptake in regional and remote areas. Many of these areas currently have lower vaccination coverage than the State average.
- Vaccination efforts for the weekend of 30-31 October targeted Surf Life Saving clubs, theme parks and entertainment venues (3,399 total doses; 82.2% first doses).
- From Monday 1 November, Designated COVID-19 Hospitals in Queensland are offering booster COVID-19 vaccination doses for people who received their second dose at least six months ago.
- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.
- At 70% of Queensland's eligible population fully vaccinated (expected on 19 November), anyone who has been in a declared domestic hotspot in the previous 14 days can travel into Queensland provided they:
    - are fully vaccinated
    - arrive by air
    - have a negative COVID-19 test in the previous 72 hours
    - undertake home quarantine for 14 days, subject to meeting conditions.
- At 80% of Queensland's eligible population fully vaccinated (expected on 17 December):
    - travellers from an interstate hotspot can arrive by road or air, with no quarantine required but must be fully vaccinated and have a negative COVID-19 test in the previous 72 hours.
    - direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90% of Queensland's eligible population fully vaccinated, there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas.
    - Unvaccinated travellers will need to apply for a border pass, or enter within the international arrivals cap, and undertake quarantine.

Public Health System capacity

- Currently, Queensland Public Health Units are working to ensure the Queensland community is complying with public health controls. Another key focus for Queensland's Public Health Units is to ensure that those directed to undertake quarantine, including home quarantine, comply with all requirements, including the testing regime.
- Additional restrictions are imposed and lifted in response to evidence of community outbreaks to ensure the safety of Queenslanders, and more specifically our most vulnerable people in residential aged care facilities, hospitals, and disability accommodation services.
- While cases of COVID-19 in the Queensland community have been managed well to date, it is important to mitigate against widespread outbreaks. It is particularly important to quickly bring clusters under control with effective contact tracing and other protective measures to maintain the integrity of the health system to respond to non-COVID-19 related care.

Health Care System capacity

- Queensland will soon transition to the next phase of the COVID-19 response, which will involve wider circulation of COVID-19 in the Queensland community. Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts to hospital capacity and workforce. This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is critical. It is expected that with increased vaccine protection, the

number of people requiring hospitalisation and intensive care in the event of an outbreak are likely to remain within hospital and health system capacity.

- As Queensland's response to COVID-19 has evolved, expert advisory groups, particularly the COVID-19 Response Group (CRG) have further developed and refined Queensland Health's response plans. Particular consideration has been given to the impacts of the Delta variant and an increasing likelihood of a surge in cases as Queensland transitions to living with COVID-19.
- To support health system delivery in this new phase of COVID-19, Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met. This response includes expanding to hospitals and settings (such as homes) beyond the Designated COVID-19 Hospital Network, postponing elective surgeries, and leveraging private hospital capacity as required.
- The established Designated COVID Hospital Network can accommodate a moderate surge in cases, across both inpatient and at home care through Hospital in The Home (HITH) placements.
- Strategies are in place with private providers to minimise the interruption to urgent elective services should a wider community outbreak across Queensland impact on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.

Community acceptance and adherence

- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been accepting and supportive of public health measures.
- There are ongoing concerns of 'pandemic fatigue', particularly in vulnerable sections of the community, and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions is expected to reduce dramatically with increased vaccination coverage. Queensland, like other jurisdictions, is preparing to move into a new 'living with COVID-19' phase of the pandemic.
- With lengthy periods of restriction in some jurisdictions (i.e. NSW and VIC) a number of protests have been held in recent months, principally in east-coast states.
- The key issue in the medium-term is likely to be in relation to vaccine mandates, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates vary with local context. For example, VIC and NSW, managing widespread outbreaks and health systems at capacity have mandated vaccination across many industries and settings, including construction, education, and other authorised workforces including retail. In the context of very low case numbers and strict requirements throughout the pandemic, Western Australia has announced mandatory vaccine requirements across almost every sector, estimated to affect up to 75% of the population, with similar vaccine requirements also announced by the Northern Territory.

Wastewater monitoring

- To strengthen surveillance capabilities and increase confidence that transmission is not occurring, Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.
- COVID-19 fragments were detected in wastewater samples from Beenleigh for the week ending 31 October with some sites still to be tested.

Table 1. Summary of current, proposed and excluded settings for mandatory COVID-19 vaccination requirements

EXISTING REQUIREMENTS		
Setting	**Cohort/s**	**Direction/Directive**
Quarantine facilities	• All individuals working in identified quarantine facility such as quarantine hotels where people are completing mandatory quarantine	*Requirements for Quarantine Facility Workers Direction (No.4)*
Queensland Health facilities	• All health service employees in residential aged care facilities and residential aged care within a multipurpose health service. • All health service employees who are employed to work in a hospital or other facility where clinical care or support is provided. *This may include: both clinical and non-clinical employees; hospitals, quarantine facilities, vaccination clinics/hubs, fever clinics, dental clinics, outpatient services, prison health services, disability care services, including residential or sub-acute care for people with disability, or any other location where Queensland Health employees provide care or support to patients/clients; public health officers/teams, emergency operations centre staff including employees working in Hospital Emergency Operation Centres and Retrieval Services Queensland.* • All other health service employees who are employed in roles that require attendance at a hospital or other facility where clinical care or support is provided. *This may include: the requirement to attend hospitals, quarantine facilities, vaccination clinics/hubs, fever clinics, dental clinics, outpatient services, prison health services, disability care services, including residential or sub-acute care for people with disability, or any other location where health service employees provide care or support to patients/clients.*	*Health Employment Directive No.12/21 Employee COVID-19 vaccination requirements*.
Residential Aged Care Facilities	• Direct care workers, including nurses, personal care workers, allied health assistants; • Administration staff, including reception staff and management; • Ancillary staff, including food preparation staff, cleaners, laundry staff, gardeners and maintenance staff; • Lifestyle and social care staff, including for music and art therapy; • Transport drivers of residents of a residential aged care facility; • A volunteer engaged by a residential aged care facility to undertake duties at a residential aged care facility; • A medical practitioner and allied health professional, including paramedics and emergency services staff who regularly attends and provides care to residents of a residential aged care facility	*Residential Aged Care Direction (No.9)*

NEW		
Setting	**Cohort/s**	**Direction/Directive**
Any setting where health care is provided *Examples:* *Public hospitals, public health clinics, ambulance services, patient transport services, and other health services* *Private health facilities, such as private hospitals or day procedure centres, or specialist outpatient services* *Residential aged care facilities* *Shared disability accommodation services* *Outreach services in other settings provided by the above facilities, including in-home healthcare services* *Private provider facilities, such as general practitioners, private nurse offices and allied health consulting offices, pharmacies, optometrists, dental surgeries and private pathology centres* *Not for profit health organisations providing and/or commissioning public healthcare under a service agreement with any State or Commonwealth agency, including an Aboriginal and Torres Strait Islander Community Controlled Health Service* *Non-Government Organisations (NGO) delivering healthcare services, for example Alcohol and other Drugs residential rehabilitation and treatment services; hospital and other public healthcare services on a Hospital and Health Service campus e.g. integrated mental health Step-Up-Step-Down models* *Education settings within a healthcare setting* *Australian Red Cross Lifeblood collection centres* *In home delivery of intensive disability support services* *Aged care services funded by the Australian Government and delivered in the home* *School-based healthcare, including in special schools* *Healthcare services provided in other settings such as gyms*	A person who works, undertakes an educational placement, or volunteers in a healthcare setting, including: • A person registered under the National Registration and Accreditation Scheme administered by the Australian Health Practitioner Regulation Agency (Ahpra) • A person who is a self-regulated allied health professional as published on the Australian Government Department of Health website^ • A qualified person who meets the requirements defined in the *Private Health Insurance (Accreditation) Rules 2011* and who provides a service or treatment that attracts or is eligible for a rebate from Medicare or a private health insurance organisation; or • Any other person who works as a health professional, contractor, independent third-party provider, other employee or volunteer in a healthcare setting, whether employed by the healthcare setting or performing the work under another arrangement. *Examples:* *A doctor who has consulting rooms at a private hospital, and their receptionist* *A Visiting Medical Officer* *Kitchen staff in a healthcare setting, including aged care or disability accommodation* *Volunteers who assist visitors to a healthcare setting.* *An employee of a company that supplies and services medical equipment under a contractual arrangement with a public hospital* *An agency nurse engaged for relief work in a specialist outpatient service* *Volunteers, including volunteers engaged by Health Consumers Queensland, providing face to face advice and support services across the health system in Queensland* *Exercise physiologists providing healthcare services in a gym;* *An employee of a community pharmacy* *Chaplains visiting patients in a hospital or other healthcare setting* *Teachers in a hospital or other healthcare setting* *Hospital clowns* *Florist or coffee shop employees in a healthcare setting* *Support worker in supported independent living* *NDIS funded psychologist or occupational therapist providing in home support for an NDIS participant's wellbeing (whether a registered or unregistered NDIS provider)* *Non NDIS support person that provides in home assistance to a young person in residential aged care*	*Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction*

Table 2. COVID-19 vaccination mandates for health care workers nationally (as available on 4 November 2021)

	AHPPC recommendation for mandatory COVID-19 vaccination in health care					Under consideration by AHHPC	Other	Notes
	National definition of healthcare settings				Workers			
	Public health settings[1]	Private health facilities[2]	Private provider facilities[3]	Education settings related to healthcare[4]	All workers at the healthcare setting[5]	Workers providing in-home disability and/or aged care	Workers providing health care in other settings[6]	
National/Qld consistency	All	All	Most (6/8)	Most (6/8)	All	Most (6/8)	Half (4/8)	
QLD	✓	✓	✓	✓	✓	✓	✓	
NSW	✓ 2nd dose 30 Nov	✓ 2nd dose 30 Nov	-	-	✓ Until 95% vacc.	✓ 25 Oct/ 4 Dec	✓ Until 95% vacc.	Only health care workers Vaccination rules apply for a wide range of other businesses in NSW (some of which may operate in a healthcare setting such as a Hospital). In place until 95% population coverage, including hospitality venues, such as cafes, restaurants, or pubs, hairdressers, spas, nail salons, beauty salons, waxing salons, tanning salons, tattoo parlours or massage parlours, retail premises other than critical retail.
ACT	✓ 29 Oct/ 1 Dec	✓ 29 Oct/ 1 Dec	-	-	✓ 29 Oct/ 1 Dec	✓ 15 Nov/ 13 Dec	-	Vaccination mandate extends to any person who regularly provides goods or services at a health care setting either paid or voluntary This can include, but is not limited to: administrative staff, personal care workers, ancillary staff, a pastoral care worker or clergy, regular volunteers, people who provide lifestyle care and people who are employed or engaged by a third party who provide goods or services at the health care setting.
VIC	✓ 1st dose 29 Oct	✓ 1st dose 29 Oct	✓ 1st dose 29 Oct	✓ 1st dose 29 Oct	✓ 1st dose 29 Oct	✓ 1st dose 29 Oct	✓	Healthcare settings include businesses operating within health settings (e.g. workers at the café/restaurant/ newsagent/ florist within a hospital)
SA	✓ 1st dose 1 Nov	✓ 1st dose 1 Nov	✓ 1st dose 8 Nov	✓ 1st dose 8 Nov	✓ 1st dose 8 Nov	-	-	Requirements apply to all persons at the healthcare setting and who attend a healthcare setting in the course of their work or duties, including if their attendance is incidental such as delivery drivers or suppliers.
TAS	✓ 31 Oct	✓ 31 Oct	✓ 31 Oct	✓ 31 Oct	✓ 31 Oct	-	-	Non-health workers within these medical or health facilities must also be sufficiently vaccinated, such as security personnel, cleaners, maintenance, catering and administration staff.
WA	✓ 1 Oct/ 1 Nov	✓ 1 Oct/ 1 Nov	✓ 1 Nov/1 Dec	✓ 1 Dec/ 1 Jan	✓ 31 Dec/ 31 Jan	✓ 1 Dec/ 31 Dec	-	Mandatory vaccination by 31 January in place for a number of industries/occupations deemed critical to the ongoing delivery of critical services to the community (some of which may operate in a healthcare setting such as a Hospital), including shops, bakeries, cafes, maintenance/building services, etc.
NT	✓ 12 Nov/ 24 Dec	✓ 12 Nov/ 24 Dec	✓ 12 Nov/ 24 Dec	✓ 12 Nov/ 24 Dec	✓ 12 Nov/ 24 Dec	✓ 12 Nov/ 24 Dec	✓ 12 Nov/ 24 Dec	Worker (including people who work in customer-facing roles and people who work with vulnerable people) who is likely to come into contact with people who are at risk of severe illness from COVID; worker who is at an increased risk of contracting COVID or who works in a high risk setting where there is a known risk of transmission - including healthcare workers, essential infrastructure and logistics.

[1] including public hospitals, public health clinics, ambulance services, patient transport services, and other health services managed by a jurisdiction
[2] such as private hospitals or day procedure centres, or specialist outpatient services
[3] such as general practitioners, private nurse offices and consulting offices.
[4] that manage health care student placements, registration, and/or internships in clinical settings.
[5] Intended to capture all health professions, including those in the National Registration and Accreditation Scheme, all self-regulated allied health professions as published on the Australian Government Department of Health website, and all other individuals who work in these settings
[6] for example, physio in a gym; workers providing healthcare services in correction settings (Qld); Health services in other agencies or sectors (e.g. healthcare workers in corrections) (NSW)

Public Health Directions – Human Rights Assessment
Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction

Title	*Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction*
Date effective	3 November 2021

Background
The *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction* (Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction
The purpose of the Direction is to set out the COVID-19 vaccination requirements for workers in healthcare settings. The Direction applies broadly, to anyone who enters, works in, or provides services in healthcare settings, with limited exceptions, and complements existing mandatory vaccination requirements applying in other high risk settings. The Direction gives effect to the agreed Australian Health Protection Principal Committee (AHPPC) position recommending mandatory vaccination for workers in a range of private health care settings and complements existing mandatory vaccination requirements.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the Direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

Widespread COVID-19 transmission in health care settings can significantly impact the healthcare workforce due to a large number of exposed (or potentially exposed) workers, and has the potential for significant adverse effects for vulnerable patients and clients accessing healthcare settings. Staff may not be able to attend work because they are confirmed cases or close contacts and may be directed not to attend work because they have (or potentially have) had unprotected exposure to COVID-19.

The Queensland COVID-19 Vaccine Plan to Unite Families was recently released and outlines the opening of Queensland's borders, and changes to domestic and international quarantine requirements when 70%, 80% and 90% of the eligible Queensland population are fully vaccinated. Once entry and quarantine restrictions ease and there is increased movement of people from COVID-19 hotspots, the need for an available workforce within healthcare settings is expected to significantly increase. Protecting the public, staff and patients by mandating the vaccination of workers who enter, work in, or provide services in a healthcare setting is necessary.

Mandatory vaccination can help reduce the impact to health system capacity and reduce risk of exposure to staff whose duties take them into a healthcare setting, and to patients and clients at the healthcare setting.

The Direction will prohibit workers in healthcare from entering, working in, performing duties or providing services in a healthcare setting unless they meet the COVID-19 vaccination requirements for workers in a healthcare setting. There are limited exceptions and where these apply the unvaccinated worker must use PPE and provide a daily negative COVID-19 PCR test result before starting their shift.

How the Direction Achieves the Purpose

The Direction achieves this purpose through:

1. Establishing vaccination requirements for all workers in healthcare that enter, work in or provide services in a healthcare setting, with limited exceptions:
   - to be fully vaccinated by 16 December 2021 or by the date that has already been specified for the worker in another public health direction or Health Employment Directive (HED);
   - to provide evidence of complying with the COVID-19 vaccination requirements to their employer, where applicable and to the responsible person for the healthcare setting, as soon as reasonably practicable after each dose of the COVID-19 vaccine;
   - providing exceptions to the mandatory vaccination requirements where the worker is unable to be vaccinated due to a medical contraindication and the responsible person for the healthcare setting assesses the risk and allows the person to continue working with PPE and daily PCR testing; for an unvaccinated person to enter for an emergency response; and, to meet critical workforce shortages for a short period of up to, for example, 3 months to allow time to address the critical workforce shortage based on a risk assessment by the responsible person. PPE and daily testing requirements apply;
   - complements existing mandatory vaccination requirements for high risk and vulnerable settings, and recognises exemptions provided by the HED.

Human Rights Engaged

- Right to life (section 16): The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. Under international law, this right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights.

- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c)): Section 17(c) of the Human Rights Act provides that a person must not be subject to medical treatment without the person's full, free and informed consent. Administering a nasal swab test to check for the presence or absence of COVID-19 amounts to medical treatment. This right includes treatment of any kind, even if the treatment benefits the person (*Kracke v Mental Health Review Board* (2009 29 VAR 1, 123 [576]). This right is engaged as the direction limits the practical choice available to a worker in healthcare whether or not to agree to the treatment by preventing them from attending their workplace unless they meet the COVID-19 vaccination requirements by 16 December 2021, or the date specified in another public health direction or the HED for a cohort of workers. Limited exceptions apply where a person has a medical contraindication, to respond to a critical workforce shortage or for an emergency response for patients. A worker in healthcare who is unable to be vaccinated due to a recognised medical contraindication, evidenced by a medical certificate, should be deployed or work from an alternative location if possible. The person can continue to work in the healthcare setting if permitted by the responsible person for the healthcare setting, based on a risk assessment, and if they use PPE and provide a daily negative COVID-19 PCR test result before each shift. The COVID-19 PCR test also engages this human right. However, the Direction does not limit the holding of a belief or opinion about COVID-19 or testing or vaccination for COVID-19. The Direction also recognises WHO-COVAX endorsed

vaccinations that are provided to a person outside of Australia to be an acceptable form of vaccination. The requirement is for a limited period until the Direction is revoked or replaced, or the pandemic ends.

- Freedom of movement (section 19): Section 19 of the Human Rights Act provides that every person lawfully within Queensland has the right to move freely within Queensland, to enter and leave it and has the freedom to choose where to live. The right means that a person cannot be arbitrarily forced to remain in, or move to or from, a particular place. The right also includes the freedom to choose where to live, and freedom from physical and procedural barriers, like requiring permission before entering a public park or participating in a public demonstration in a public place. The right may be engaged where a public entity actively curtails a person's freedom of movement. The Direction may limit the right to freedom of movement by preventing workers in healthcare from working at a specified healthcare facility that is their usual place of work.

- Right to education (section 36): Section 36 of the Human Rights Act provides that every person has the right to have access, based on their abilities, to equally accessible further vocational education and training. The right to education is intended to be interpreted in line with the *Education (General Provisions) Act 2006* and to provide rights in relation to aspects of Queensland's responsibilities for education service delivery. Internationally, this right has been interpreted as requiring that education be accessible to all individuals without discrimination. The Direction does not provide any greater limitation on students for their placements than already exist within other public health directions.

- Freedom of thought and conscience (section 20) and freedom of expression (section 21): Section 20 of the Human Rights Act provides that a person has the right to freedom of thought, conscience, religion and belief. The right to hold a belief without interference is an absolute right however limits on how a person manifests their belief can be justified (*Christian Youth Camps v Cobaw Community Health Service* (2014) 50 VR 256, 395 [537]). Section 21 of the Human Rights Act provides that the right to freedom of expression includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be expressed in various ways, including in writing, through art, or orally. The Direction engages this right by requiring workers in healthcare who enter, work in or provide services at healthcare settings to be vaccinated. Workers in healthcare who have a conscientious objection to this requirement will not be permitted to enter, work in or provide services at a healthcare setting if they remain unvaccinated after 16 December 2021, other than for the short period allowed to respond to critical workforce shortages.

- Peaceful assembly and freedom of association (section 22): Section 22 of the Human Rights Act upholds the rights of individuals to gather in order to exchange, give or receive information, to express views or conduct a protest or demonstration. The Direction may limit the right to peaceful assembly as it restricts workers in healthcare from entering a healthcare setting, which in turn may prevent groups gathering together for a common purpose/interest.

- Privacy (section 25): The right to privacy in section 25 of the Human Rights Act is broadly construed. A person has the right to not have their privacy, family or home arbitrarily interfered with. The right encompasses an individual's rights to establish and develop meaningful social relations (*Kracke v Mental Health Review Board* (General) (2009 29 VAR 1, [619]-[620]). The right to privacy may also incorporate a right to work of some kind and in some circumstances (*ZZ v Secretary, Department of Justice* [2013] VSC 267, [72]-

[95] (Bell J)). The Direction may limit a person's right to privacy by making a worker in healthcare provide personal details about their vaccination status. The right to privacy also protects the freedom of a person not to be subjected to physical interference, including medical treatment, without consent (*PBU v Mental Health Tribunal* (2018) 56 VR 141, 180-1 [128]). Involuntary medical treatment has been held to amount to interference with the right to respect for personal life which includes a person's physical and psychological integrity (*Solomakhin v Ukraine* (European Court of Human Rights, Fifth Section, Application No 24429/03, 15 March 2012) [33]). The Direction engages this right by requiring workers in healthcare entering, working in or providing services in a healthcare setting to comply with the mandatory vaccination requirements by the relevant date, and by requiring daily COVID-19 PCR testing for unvaccinated workers who continue to enter, work in or provide services in a healthcare setting.

Compatibility with Human Rights

Proper purpose (section 13(2)(b))

The limits on the above human rights arise from:

1. Restricting who can enter a healthcare setting;
2. Requiring vaccination, notification of vaccination and record keeping in relation to workers in healthcare who work in a healthcare setting;
3. Requiring the use of PPE and daily COVID-19 PCR testing by unvaccinated workers in healthcare who are permitted to enter, work or provide services in a healthcare setting;
4. Providing a public health officer (public health) with discretion to issue additional directions to a worker in healthcare, their employer or the responsible person of a healthcare setting.

The purpose of these limitations is to reduce the risk of COVID-19 cases spreading to vulnerable people in healthcare settings and to ensure that there is an adequate health workforce available to respond to the expected increase in COVID-19 cases requiring hospitalisation following relaxation of border entry and quarantine restrictions. The Direction is in effect for a temporary period, and the restrictions on who may work, enter or provide services in a healthcare setting.

These purposes of protecting public health are proper purposes. Vaccines protect the community as a whole, by increasing the overall immunity in the community to reduce the spread of vaccine-preventable diseases. Protecting public health is clearly a legitimate objective (*Boffa v San Marino* (1998) 92 Eur Comm HR 27). Vaccines also protect vaccinated individuals by immunising them from the relevant disease.

Moreover, protecting people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

A purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

Reducing and containing the spread of COVID-19 within the community is achieved by the Direction. As COVID-19 is a communicable disease that may be easily transmitted between people and given the direct risk to the lives and health of others posed by a person who has

been diagnosed with COVID-19, this purpose can only be achieved by setting out vaccination requirements for workers in healthcare at healthcare settings.

The requirement for workers in healthcare to be vaccinated to work in a healthcare setting, and for unvaccinated workers in healthcare settings to wear PPE and to provide a daily negative COVID-19 PCR test result before starting each shift is targeted at managing the potential risk of transmission to patients, clients and other healthcare workers. Vaccination also protects individuals and the community, from the spread of COVID-19 and maintains an available workforce in healthcare settings.

Necessary (s 13(2)(d))

The purpose of the Direction cannot be achieved through any reasonably available and less restrictive means. COVID-19 is a communicable disease that may be easily transmitted between people. Social distancing has been proven to slow the transmission of COVID-19, particularly to vulnerable persons who may develop complications or otherwise require emergency or life-sustaining treatment. Vaccination achieves this purpose as it significantly reduces the adverse impacts of COVID-19 and may reduce transmission. This purpose is also achieved by setting out vaccination requirements for workers in healthcare at healthcare settings.

The limits on human rights are necessary given the immediate and direct risk to the lives and health of others posed by a person who has been diagnosed with COVID-19. There is no other way to address the risk of transmissibility from a COVID-19 positive person.

The delta variant is becoming the prevalent strain of COVID-19 globally, and there is evidence of community transmission in Queensland. With Border Restrictions relaxing in Queensland once milestone vaccination rates are achieved, it is necessary to take further measures through the vaccination of workers in healthcare who enter, work in, or provide services in a healthcare setting, to protect the community. This measure will provide an additional level of protection and will assist in minimising disruptions to the level of care provided in healthcare settings if community outbreaks occur. In addition, the Direction provides that WHO-COVAX endorsed vaccinations administered overseas are accepted where the employee was vaccinated overseas.

Workers in healthcare who provide services in a healthcare setting are a critical workforce, necessary to ensure continuity of care for our community. Requiring vaccination of this workforce protects both the worker and their patients or clients in the healthcare setting from experiencing adverse outcomes from COVID-19 transmission. Limited exceptions have been included to manage critical workforce impacts, respond to emergencies and recognise medical contraindications.

The requirements to wear appropriate PPE and undertake daily PCR COVID-19 tests before a shift is a necessary measure to manage the risk of transmission of COVID-19. It will also assist in reducing the ‘close contact’ between staff, visitors and residents and potential transmission of the virus.

Similarly, providing a public health officer the ability to issue additional directions to a worker in a healthcare setting, their employer and the responsible person for the healthcare setting will enable any localised issues in specific healthcare settings to be addressed rapidly. The power for public health officers to issue directions to specified healthcare facilities contains appropriate internal limitations. Directions can only be issued if the public health officer

considers it to be reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The right to privacy is subject to an internal limitation in that it applies only to interferences with privacy that are 'unlawful' or 'arbitrary'. This internal limitation may apply where the Direction authorises restrictions on movement pursuant to a lawful direction based on a reasonable belief that the restriction is necessary to assist in containing or responding to the spread of COVID-19 within the community.

Fair balance (section 13(2)(e), (f) and (g))

The purpose of the Direction is to reduce the spread of COVID-19 within the community and protect the most vulnerable people within the community.

The limitation on the right to freedom of movement may be justified for the purpose of preventing the spread of COVID-19 within healthcare settings in Queensland. The limitation on the right of freedom of movement and freedom of association does not deny people to enter, work in, or provide services in a healthcare setting, but sets out the COVID-19 vaccination requirements.

The requirement for workers in healthcare to be fully vaccinated in a healthcare setting provides an additional layer of protection for vulnerable members of our community..

However, the extent of the limitation on human rights is reduced by the following factors:

- there are exceptions to the requirement for mandatory vaccination for a worker in healthcare who enters, works in, or provides services in a healthcare setting. These exceptions balance the individual's rights, the need to maintain continuity of care and protection of the community from COVID-19 transmission
- overseas vaccination is recognised where the vaccination is WHO-COVAX endorsed.

Overall, the limitations on human rights are reasonable and demonstrably justifiable, as the Direction is only in force for a temporary period and will help contain the spread of COVID-19, thereby protecting the health and safety of the community. The health benefits to the broader community by implementing the Direction outweighs any potential limitation on the person's right to freedom of movement, freedom of association and protection of families.

COVID-19 Public Health Rationale
Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 2)

15 December 2021

DRAFT NOT GOVERNMENT POLICY

Overarching intent

The overarching intent of the *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (the Direction)* is to protect the health of the community and workers in healthcare settings and safeguard the delivery of health care.

The Direction sets out mandatory COVID-19 vaccination requirements for workers, students and volunteers in healthcare settings, and extends to any other person who works as a health professional, contractor, independent third party provider, other employee or volunteer, whether employed by the healthcare facility or performing the work under another arrangement. The Direction states that by 15 December 2021, these people must have received their second dose of a TGA approved COVID-19 vaccine to enter, work in, or provide services in a healthcare setting. The Direction also outlines the circumstances under which an unvaccinated worker may be permitted to enter and work in a healthcare setting.

The updated Direction addresses operational constraints noted by the healthcare sector since the introduction of the Direction, while continuing to provide the necessary protections for those in a healthcare setting.

The updated Direction provides for the exception from vaccination requirements where a healthcare worker is an active participant in a COVID-19 vaccine trial and where a worker enters for the purposes of law enforcement, clarifies the considerations and period of the critical workforce shortage exemption and defines services delivered solely by telehealth as out of scope for the purposes of the Direction. An update to the definition of the healthcare setting is also provided, with a part of a healthcare setting that is co-located excluded from the requirements of the Direction.

The updated Direction also makes technical amendments to make clear vaccination arrangements also apply to sole traders and outlines broad recording keeping requirements.

Background and considerations at 15 December 2021

Under *Queensland's COVID-19 Vaccine Plan To Unite Families* released on 18 October 2021, Queensland's border restrictions and quarantine requirements will be progressively adapted as the Queensland population reaches 70, 80 and 90 per cent vaccination coverage.

As Queensland transitions to an environment where COVID-19 is endemic, it is inevitable that every Queenslander will eventually be exposed to COVID-19. Effective vaccines for COVID-19 that prevent severe illness and reduce transmission are now widely available and endorsed by regulatory authorities globally and including Australia's Therapeutic Goods Administration (TGA). Queensland Health is strongly encouraging and promoting COVID-19 vaccination state-wide.

High vaccination coverage among workers in settings with the potential for exposure to COVID-19, particularly those serving vulnerable cohorts, will be a key determinant of health outcomes for Queenslanders and the impact of COVID-19 on health care delivery across the State.

Exceptions to vaccination requirements

The current Direction provides that if a worker cannot be vaccinated due to a certified medical contraindication, the worker may continue to work in a healthcare setting where their work cannot be

performed outside and following a risk assessment by the person engaging or employing the worker. To minimise the risk of COVID-19 transmission, the unvaccinated worker must comply with additional PPE requirements and produce a negative PCR test result before commencing each work shift.

Since the release of the Direction, consideration to exempt workers who are active participants in COVID-19 vaccine trials from vaccination requirements have been received. Similar considerations have been raised for Queensland Health employees, with exceptions provided for under the Health Employment Directive (HED) No. 12/21 - Employee COVID-19 vaccination requirements.

Participation in clinical trials is important to ensure the continued availability of safe and effective COVID-19 vaccines and forms an integral component in the transition from elimination to 'living with COVID-19'. To ensure that the current Direction does not create unnecessary barriers to the participation in such trials, and to remove any contradiction with exceptions provided under the HED, it is proposed to allow a healthcare worker participating in a COVID-19 vaccine trial to be exempt from vaccination requirements.

This exception only applies where the person engaging or employing the worker has assessed the risk to other staff, patients, clients and other persons in the healthcare setting and determines that the worker may continue to work in that setting. The worker must provide a medical certificate or letter from a medical practitioner to confirm active participation in the trial and that the worker has received at least one dose of the COVID-19 vaccine being trialled. The requirement for at least one dose of the trial vaccine is expected to provide a level of protection against COVID-19 and will assist to reduce the risk of transmission.

The COVID-19 vaccine trial exception ceases when the trial vaccine is recognised, approved or rejected for use in Australia by the TGA at which time mandatory vaccination requirements apply.

The updated Direction also provides for an exception from vaccination requirements for a worker entering for the purposes of law enforcement. In these circumstances, it may not be reasonable to collect proof of COVID-19 vaccination due to a risk to the safety of staff, patients and visitors. As such, a responsible person within the healthcare setting is permitted to allow a worker entering for the purposes of law enforcement to enter and remain in the setting without showing evidence of vaccination, or an exemption.

An exception is also provided for healthcare workers who are providing support to a patient, client or person with a disability, where the support is deemed necessary to provide health, wellbeing, legal or advocacy support to the person. This exception is for a maximum consecutive period of three months and allows for continuity of support until the healthcare worker is vaccinated or alternate care arrangements to be made. The person employing or engaging the worker must undertake an assessment of risk to others in the healthcare setting and if permitted to enter, work and remain in the healthcare setting, the worker is required to utilise appropriate PPE and undertake a COVID-19 PCR test within 24 hours prior to entry for a single visit or each day where services are provided on multiple consecutive days.

Telehealth services – out of scope

The use of telehealth has been critical in helping to protect health care professionals, their staff and patients from the unnecessary risk of COVID-19 infection throughout the pandemic.

A practitioner providing healthcare from any premise, even via telehealth where there are no other in-person services being provided, meet the definitions of the current Direction and therefore are required to be fully vaccinated to be able to enter, work in or provide services in a healthcare setting.

The Allied Health sector has raised concerns that the current provisions will prevent unvaccinated health practitioners, who only provide services via telehealth from a private residence or other facility where in-person services are not provided, to continue practicing beyond 15 December (i.e. the date by which all healthcare workers must be fully vaccinated to continue to enter or work in a healthcare setting).

The public health intent of the Direction is to minimise the risk of COVID-19 exposure / transmission within the healthcare setting. Although not stated explicitly, the mitigation of public health risk is focussed on in-

person healthcare provision. Services provided by telehealth, whether by a vaccinated or unvaccinated practitioner, from a location where no other in-person services are provided, avoids this risk as there is no physical contact / attendance.

It is therefore considered appropriate to define that a person solely providing healthcare services from their home or another location via telehealth, and who is not providing any in-person services, is considered out of scope for the purposes of the Direction.

Part of a healthcare setting that is not co-located - not subject to requirements

As noted above, the intent of the Direction is to minimise the risk of COVID-19 exposure / transmission within the healthcare setting. The definition of the healthcare setting has been updated to exclude a part of the healthcare setting that is not co-located where the area is not occupied by the users or workers of the healthcare setting; is physically separated from the occupied part of the healthcare setting and users or workers of the healthcare setting cannot gain access to the area; and has no shared points of access with users and workers of the healthcare setting. Under these requirements, the risk of COVID-19 transmission is substantially minimised as the users and workers of the healthcare setting are physically excluded from the area.

For example, part of a healthcare setting grounds are fenced off while construction of a new building is undertaken. While the construction work progresses, users and workers of the healthcare setting are not permitted to enter the construction site and the construction company has control of the site. The construction site is not co-located with the healthcare setting and is therefore not subject to the COVID-19 vaccination requirements that apply to the healthcare setting.

This update also brings into alignment the *COVID-19 Vaccination Requirements for Workers in a high risk setting Direction* provision, where a worker in a part of a high-risk setting that is not co-located is not subject to COVID-19 vaccination requirements.

Critical workforce shortages

From time to time there may be exceptional circumstances that result in a critical workforce shortage, such as illness, high demand or another emergent event, and there may be an occasion where there is a shortage of vaccinated workers. In this event, and to allow for the continued and safe delivery of services, the Direction provides that an unvaccinated worker may be permitted to enter, work in or provide services in the setting, for a short period until vaccinated workers can be recruited.

To provide clarity to the sector, the updated Direction outlines the extent of this provision is for a period of three months from 17 December 2021 or until the critical workforce issue can be resolved, whichever is shorter.

The intent of the Direction is that vaccination is critical to protect staff and patients in this high risk setting and it is expected that this option only be exercised in extreme and sustained circumstances, where the shortage means a direct impact on patient or client care or the effective operation of the healthcare setting.

To further provide guidance to the sector, considerations on whether a critical workforce shortage exists is also provided.

Public health considerations – 15 December 2021

Epidemiological situation

Queensland

- Queensland reported six new COVID-19 cases in the previous 24 hours, all locally acquired and linked to recent interstate travel. Affected locations include Wide Bay, Townsville, Goondiwindi, South Brisbane and Gold Coast. All six cases were fully vaccinated and one is a First Nations person.
- The total number of cases in Queensland stands at 2,188, including 29 First Nations people.
- Queensland is managing a total of 50 active cases, with 28 in hospital (nil in ICU), 8 in Hospital in the Home and 14 awaiting transfer. There are currently one active First Nations case in Queensland.
- Queensland has recorded three confirmed cases of the Omicron variant of COVID-19, one case reported on 6 December, detected in hotel quarantine in Cairns, the second case reported on 4 December, detected in Brisbane and third case detected on 12 December in hotel quarantine (international arrival from Nigeria). In addition, one case reported on 15 December is linked to Argyle House nightclub Omicron outbreak in Newcastle.
- From 13 December fully vaccinated arrivals from interstate hotspots are no longer required to quarantine and the need for home quarantine has decreased as a result. There are currently 1,016 people in home quarantine, 2,221 people in government hotel quarantine and 24 in alternate quarantine.
- As at 13 December 2021, a total of 3,373,810 Queenslanders aged 16 and over have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 82 per cent of this cohort; 3,644,371 people – 88.6 per cent – have had at least one dose.
- As at 13 December 2021, a total of 155,135 Queenslanders aged 12-15 years have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 57.43 per cent of this cohort; 180,884 people – 66.96 per cent – have had at least one dose.

Emergence of Omicron variant

- On 26 November, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern.
- The first known confirmed infection was from a specimen collected on 9 November 2021 and the variant was first reported to the WHO from South Africa on 24 November 2021.
- The variant has a large number of mutations (including 32 on the spike protein alone, compared to only nine on the Delta variant), and preliminary evidence is suggesting this variant may produce an increased risk of reinfection among people who have had COVID-19 previously.
- Omicron is being urgently investigated by researchers globally, with the WHO announcing it could take weeks for sufficient data and analysis to draw preliminary conclusions.
- There is currently insufficient information available to make conclusions on the transmissibility and disease severity of the variant. The effectiveness of available vaccines against the Omicron variant is also under investigation.
- The variant is detectable through current PCR testing.
- As at 14 December, there were around 9000 cases of the Omicron variant of concern reported by 75 countries globally, however, case numbers are expected to increase significantly. As at 15 December, over 120 Omicron cases have been confirmed in Australia.
- At this stage, the primary risk of Omicron incursion into Queensland is from other Australian jurisdictions with minimal quarantine requirements (Victoria, New South Wales) for international arrivals.
- On Saturday 27 November, the Commonwealth announced a range of new measures in response to the new variant. Anyone who is not an Australian citizen or their dependents and who has been in nine countries in Southern Africa in the past 14 days cannot travel to Australia. Australian citizens and their

dependents are required to go into supervised quarantine on arrival. The nine countries are South Africa, Namibia, Zimbabwe, Botswana, Losoto, Eswatini, The Seychelles, Malawi and Mozambique.

- Australia has also suspended flights from these countries and several jurisdictions have tightened travel restrictions.
- On 12 December, ATAGI recommended that, given the likelihood of ongoing transmission of both Omicron and Delta variants, booster vaccinations be administered in those 18 and over who completed their primary course of COVID-19 vaccination five or more months ago.
- On 13 December, ATAGI provisionally approved the Spikevax (Moderna) COVID-19 vaccine for use as a COVID-19 booster vaccine in people aged 18 years and over.

National

- As at 14 December, in the 24 hours prior, jurisdictions have reported 2,029 newly confirmed cases, including locally and internationally acquired. There are at least 16,467 active cases nationwide.
- As at 13 December, Australia has reported 89.5 per cent of the eligible population aged 16 years and over as fully vaccinated; 93.43 per cent has had at least one dose.
- As at 13 December, Australia has reported 70.32 per cent of the eligible population aged 12-15 years as fully vaccinated; 77.62 per cent has had at least one dose.
- On 10 December the Australian Government confirmed that Australia's COVID-19 vaccination program will be extended to all children aged 5 to 11 years from 10 January 2022, after the Australian Government accepted recommendations from the Australian Technical Advisory Group on Immunisation (ATAGI).
- NSW and Victoria, with sustained and widespread outbreaks of the Delta variant since June-July, were seeing a reduction in daily new cases in recent weeks with fluctuating numbers. However, case numbers have started to increase again in recent days. Noting wide-ranging lifting of restrictions and lockdown conditions, Queensland is monitoring case numbers in these jurisdictions as well as in the Australian Capital Territory (ACT) where daily positive cases have also been gradually falling since the start of the latest outbreak.
- Quarantine requirements for Australians returning from overseas to NSW, Victoria, ACT and South Australia had started to ease in November. However, following the emergence of the Omicron variant, these jurisdictions have re-introduced restrictions for arrivals from countries of concern.
- South Australia opened its borders to NSW, Victoria and the ACT on 23 November. Since then, there have been over 100 new cases.
- On 13 December, Western Australia announced plans to allow interstate and international arrivals to enter without quarantine from 5 February 2021 when the state is expected to reach 90 per cent vaccination coverage target.

New South Wales

- NSW reported 1360 new COVID-19 cases and one new death in the past 24 hours; there have been 82,000 locally acquired cases and 587 deaths reported since 16 June. A total of 110 cases of COVID-19 with the Omicron variant have been confirmed in NSW on 15 December, which is as significant increase from nine Omicron cases reported on 13 December
- NSW is currently managing 168 cases in hospital, with 21 people in ICU (nine requiring ventilation).
- As at 13 December, NSW has reported that 93.2 per cent of the eligible population aged 16 years and over is fully vaccinated and 94.8 per cent have received at least one dose.
- As at 13 December, NSW has reported that 77.76 per cent of the eligible population aged 12-15 years is fully vaccinated and 81.39 per cent have received at least one dose.
- NSW has recorded 85 cases of the Omicron COVID-19 variant.
- NSW had a range of movement and gathering restrictions in place for unvaccinated people, which are expected to be lifted on 15 December when NSW is expected to reach 95% vaccination coverage of its population aged 16 years and over.

Victoria

- Victoria has reported 1,405 new locally acquired cases and three deaths in the last 24 hours; there now have been 119,009 locally acquired cases and 617 deaths reported since 13 July.
- Victoria is managing 364 cases in hospital, including 80 active cases and 39 cleared cases in intensive care (44 of whom require ventilation).
- As at 13 December, Victoria has reported that 91.8 per cent of its eligible population aged 16 years and over is fully vaccinated and 93.6 per cent have received at least one dose.
- As at 13 December, Victoria has reported that 81.58 per cent of its eligible population aged 12-15 years is fully vaccinated and 87.71 per cent have received at least one dose.
- There are currently no restrictions in place for Victorians who are fully vaccinated.

Australian Capital Territory

- ACT has reported seven new locally acquired cases and nil new deaths in the last 24 hours; there have been 2,087 locally acquired cases and 12 deaths reported since 12 August.
- ACT is managing four cases in hospital, with one person in intensive care, who does not require ventilation.
- As at 13 December, ACT has reported that over 99 per cent of its eligible population aged 16 years and over is fully vaccinated.
- As at 13 December, ACT has reported that 96.63 per cent of its eligible population aged 12-15 years is fully vaccinated and >99 per cent have received at least one dose.

Northern Territory

- The NT has reported two new community cases in past 24 hours. The Katherine and Robinson River outbreak now totals 90cases since 15 November 2021.
- Kalkarindji, Daguragu, Timber Creek and Gilwi entered into a lockout on 14 December until 2pm on 17 December. Beswick community remains in lockout.
- As at 13 December, NT has reported that 81.48 per cent of its eligible population aged 16 years and over is fully vaccinated and 88.47 per cent have received at least one dose.
- As at 13 December, NT has reported that 61.60 per cent of its eligible population aged 12-15 years is fully vaccinated and 74.72 per cent have received at least one dose.

Global

- As at 15 December, there have been over 271 million confirmed COVID-19 cases, 5.32 million confirmed COVID-19 related deaths and 8.510 billion COVID-19 vaccine doses administered (Source: John Hopkins University).
- In the week to 5 December, weekly COVID-19 case incidence plateaued, with over 4 million confirmed new cases. However, new weekly deaths increased by ten per cent compared to the previous week, with over 52,500 new deaths reported (Source: WHO).
- In the week to 5 December, cases increased in two of the six WHO regions – America and Africa Regions. An increase in weekly deaths was reported in two of the six regions - by 49 per cent in the South-East Asia region and 38 per cent in the America region (Source: WHO).

Living with COVID-19

- The Queensland Government continues to progress its state-wide campaign to encourage Queenslanders to get vaccinated. There is a particular focus on encouraging increased uptake in regional and remote areas. Many of these areas currently have lower vaccination coverage than the Queensland average.
- Booster COVID-19 vaccines are now widely available to anyone who has had their second dose at least six months ago.

- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.
- From 13 December:
  - Fully vaccinated travellers from a domestic COVID-19 hotspot can arrive by road or air, with no quarantine required but must have had a negative COVID-19 test in the previous 72 hours and agree to get a further COVID-19 PCR test on day five of their stay in Queensland.
  - Fully vaccinated direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90% of Queensland's eligible population fully vaccinated, there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas.
  - Unvaccinated travellers will need to apply for a border pass, enter within the international arrivals cap, and undertake a period of quarantine.
- On 9 November 2021, the Queensland Government released its *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond*, which sets out measures variously applying to vaccinated and unvaccinated people aged 16 years and over. The associated Direction was published on 7 December and will come into effect on 17 December.
- Under the Plan, there will be no COVID-19 density restrictions on pubs, clubs, cafés, cinemas, theatres, music festivals and all staff and visitors must be fully vaccinated.

Public Health System capacity

- Currently, Queensland Public Health Units are working to ensure the Queensland community is complying with public health controls. Another key focus for Queensland's Public Health Units is to ensure that those directed to undertake quarantine, including home quarantine, comply with all requirements, including the testing regime.
- Additional restrictions are imposed and lifted in response to evidence of community outbreaks to ensure the safety of Queenslanders, and more specifically our most vulnerable people in residential aged care facilities, hospitals, and disability accommodation services.
- While cases of COVID-19 in the Queensland community have been managed well to date, it is important to mitigate against widespread outbreaks. It is particularly important to quickly bring clusters under control with effective contact tracing and other protective measures to maintain the integrity of the health system to respond to non-COVID-19 related care.

Health Care System capacity

- Queensland will soon transition to the next phase of the COVID-19 response, which will involve wider circulation of COVID-19 in the Queensland community. Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts on hospital capacity and workforce.
- This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is needed. It is expected that with increased vaccine protection, the number of people requiring hospitalisation and intensive care in the event of an outbreak are likely to remain within hospital and health system capacity.
- As Queensland's response to COVID-19 has evolved, expert advisory groups, particularly the COVID-19 Response Group (CRG) have further developed and refined Queensland Health's response plans. Particular consideration has been given to the impacts of the Delta variant and an increasing likelihood of a surge in cases as Queensland transitions to living with COVID-19.
- To support health system delivery in this new phase of COVID-19, Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met. This response includes expanding to hospitals and settings (such as homes) beyond the Designated COVID-19 Hospital Network, postponing elective surgeries, and leveraging private hospital capacity as required.

- The established Designated COVID Hospital Network can accommodate a moderate surge in cases, across both inpatient and at home care through Hospital in the Home (HITH) placements.
- Strategies are in place with private providers to minimise the interruption to urgent elective services should a wider community outbreak across Queensland impact on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.

Community acceptance and adherence

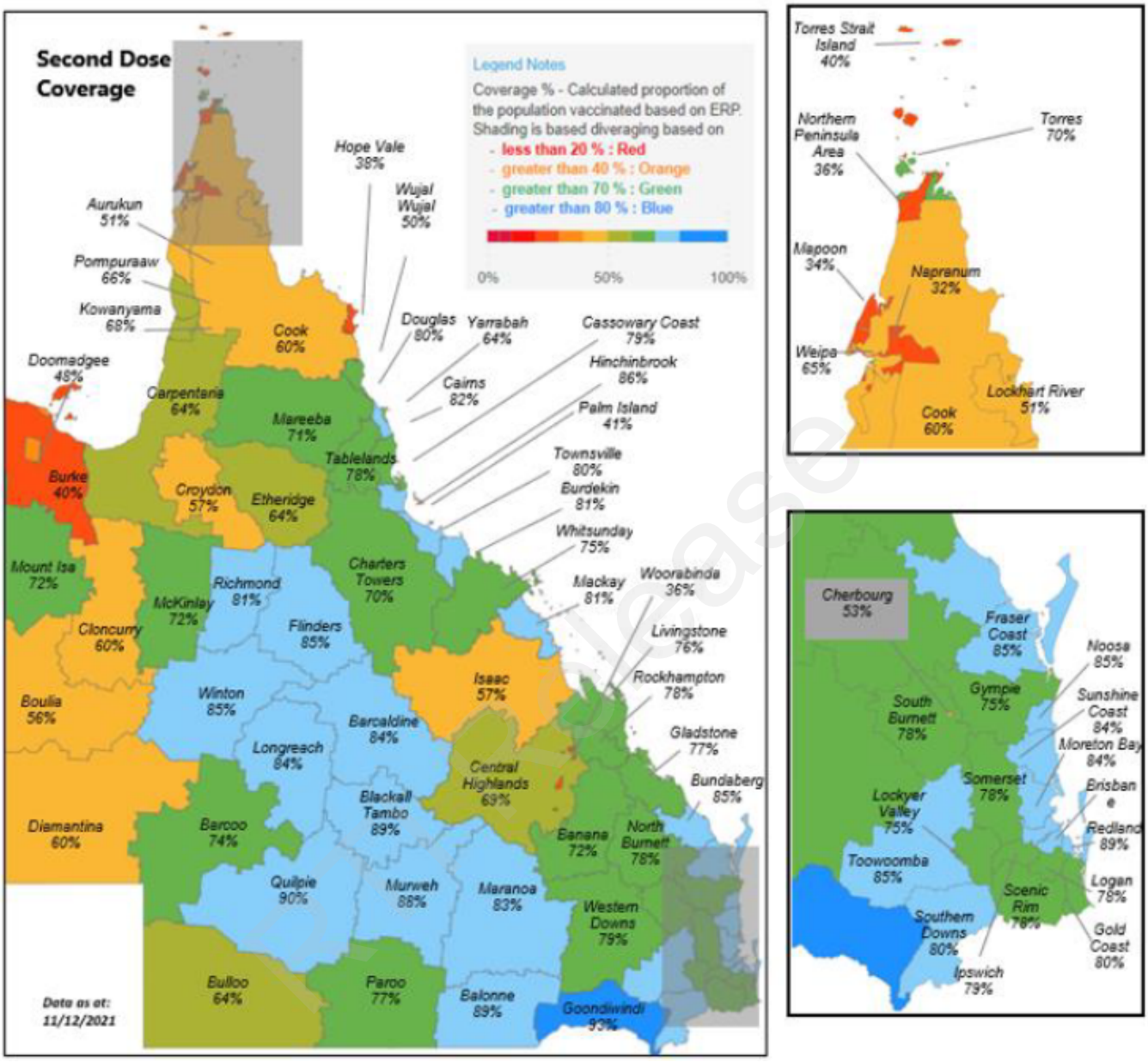
- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been accepting and supportive of public health measures.
- There are ongoing concerns of 'pandemic fatigue' and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions is expected to reduce dramatically with increased vaccination coverage. Queensland, like other jurisdictions, is preparing to move into a suppression phase, and towards a new 'living with COVID-19' phase of the pandemic.
- With lengthy periods of restriction in some jurisdictions (i.e. NSW and Victoria), as well as new vaccine-related mandates and public health and safety measures coming into effect, a number of protests have been held in recent months, principally in east-coast states.
- The key issue in the medium-term is likely to be in relation to vaccine mandates, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates vary with local context. For example, Victoria and NSW—managing widespread outbreaks and health systems at capacity —have mandated vaccination across many industries and settings, including construction, education, and other authorised workforces including retail. In the context of very low case numbers and strict requirements throughout the pandemic, Western Australia has announced mandatory vaccine requirements across almost every sector, estimated to affect up to 75% of the population, with similar vaccine requirements also announced by the Northern Territory.
- Queensland will also require vaccination for workers at high risk settings (schools, correctional facilities and airports) and for entry to a range of high-risk venues like hospitality and entertainment venues as part of baseline protections following reopening of borders to vaccinated travellers from declared hotspots from 13 December .

Wastewater monitoring

- To strengthen surveillance capabilities and increase confidence that transmission is not occurring, Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.
- There have been positive wastewater detections at the Merrimac, Coombabah, Pimpama and Capalaba wastewater treatment plants on 8 December 2021.

(As at 11 December 2021)

Local Government – Second Dose Coverage (16+)



Public Health Directions – Human Rights Assessment
Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 2)

Title	*Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 2)*
Date effective	16 December 2021

Background
The *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 2)* (Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction
The purpose of the Direction is to set out the COVID-19 vaccination requirements for workers in healthcare settings. The Direction applies broadly, to anyone who enters, works in, or provides services in healthcare settings, with limited exceptions.

The Direction complements existing mandatory vaccination requirements applying in other high risk settings and gives effect to the agreed Australian Health Protection Principal Committee (AHPPC) position recommending mandatory vaccination for workers in a range of private health care settings and complements existing mandatory vaccination requirements.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the Direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

Widespread COVID-19 transmission in health care settings can significantly impact the healthcare workforce due to a large number of exposed (or potentially exposed) workers and has the potential for significant adverse effects for vulnerable patients and clients accessing healthcare settings. Staff may not be able to attend work because they are confirmed cases or close contacts and may be directed not to attend work because they have (or potentially have) had unprotected exposure to COVID-19.

The Queensland COVID-19 Vaccine Plan to Unite Families was recently released and outlines the opening of Queensland's borders, and changes to domestic and international quarantine requirements when 70%, 80% and 90% of the eligible Queensland population are fully vaccinated. Once entry and quarantine restrictions ease and there is increased movement of people into Queensland from COVID-19 hotspots, the need for an available workforce within healthcare settings is expected to significantly increase. Protecting the public, staff and patients by mandating the vaccination of workers who enter, work in, or provide services in a healthcare setting is necessary.

Mandatory vaccination can help reduce the impact to health system capacity and reduce risk of exposure to staff whose duties take them into a healthcare setting, and to patients and clients at the healthcare setting.

The Direction will prohibit workers in healthcare from entering, working in, performing duties or providing services in a healthcare setting unless they meet the COVID-19 vaccination requirements for workers in a healthcare setting. There are limited exceptions and where these apply the unvaccinated worker must use PPE and undertake a COVID-19 PCR test result before starting their shift.

How the Direction Achieves the Purpose

Outlining the vaccination requirements for workers in healthcare settings will help reduce the impacts on individuals, particularly vulnerable healthcare consumers, with the with the anticipated spread of COVID-19 once Queensland borders open to other Australian States and Territories.

The Direction achieves this purpose through establishing vaccination requirements for all workers in healthcare that enter, work in or provide services in a healthcare setting, with limited exceptions:

- to be fully vaccinated by 15 December 2021 or by the date that has already been specified for the worker in another public health direction or Health Employment Directive (HED);
- to provide evidence of complying with the COVID-19 vaccination requirements to their employer, where applicable and to the responsible person for the healthcare setting, as soon as reasonably practicable after each dose of the COVID-19 vaccine;
- providing exceptions to the mandatory vaccination requirements where:
    - the worker is unable to be vaccinated due to a medical contraindication and the responsible person for the healthcare setting assesses the risk and allows the person to continue working with PPE and PCR testing prior to commencement of each shift; or
    - the worker is a participant in a COVID-19 vaccine trial and has received at least one active doses of the trialed COVID-19 vaccine; or
      an unvaccinated person is required to enter the healthcare setting for an emergency response; or
    - an unvaccinated support person is required to enter and remain at a healthcare setting to provide critical support to a patient, client or person with a disability, if the responsible person assesses the risk and allows the person to enter the facility subject to PPE and PCR testing requirements; or
    - to meet critical workforce shortages for a short period of up to 3 months to allow time to address the critical workforce shortage based on a risk assessment by the responsible person. PPE and pre-shift testing requirements apply or
    - a worker in healthcare is required to enter and remain at a healthcare setting in their personal or private capacity, provided they comply with all other public health directions applicable to entering a healthcare setting.

The Direction complements existing mandatory vaccination requirements for high risk and vulnerable settings, and recognises exemptions provided by the Queensland Health Health Employment Directive 12/21.

Human Rights Engaged

The human rights engaged by the Direction are:

- Right to life (section 16)
- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c))
- Freedom of movement (section 19)

- Right to education (section 36)
- Freedom of thought, conscience, religion, and belief (section 20)
- Freedom of expression (section 21)
- Peaceful assembly and freedom of association (section 22)
- Right to privacy (section 25)

- Right to life (section 16): The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. Under international law, this right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights. The Direction promotes the right to life by protecting the health, safety and wellbeing of vulnerable Queenslanders through placing vaccination requirements on workers entering and working at healthcare facilities.

- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c)): Section 17(c) of the Human Rights Act provides that a person must not be subject to medical treatment without the person's full, free and informed consent.

  Medical treatment for the purposes of section 17(c) includes administering a drug for the purposes of treatment or prevention of disease. Administering a nasal swab test to check for the presence or absence of COVID-19 also amounts to medical treatment. This right includes treatment of any kind, even if the treatment benefits the person (*Kracke v Mental Health Review Board* (2009 29 VAR 1, 123 [576]).

  This right is engaged as the direction limits the practical choice available to a worker in healthcare whether or not to agree to the treatment by preventing them from attending their workplace unless they meet the COVID-19 vaccination requirements by 15 December 2021, or the date specified in another public health direction or the HED for a cohort of workers. Limited exceptions apply where a person has a medical contraindication, where the person is a participant in a COVID-19 vaccine clinical trial and has received at least one active dose of the trial vaccine; to provide critical support needs to a patient, client or person with a disability; respond to a critical workforce shortage; for an emergency response for patients; or to enter in their personal or private capacity. A worker in healthcare who is unable to be vaccinated due to a recognised medical contraindication, evidenced by a medical certificate, should be deployed or work from an alternative location if possible. Unvaccinated persons person may continue to work in the healthcare setting due to medical contraindication, or to respond to a critical workforce shortage must be permitted to do so by the responsible person for the healthcare setting, based on a risk assessment, and use PPE and undertake a COVID-19 PCR test result prior to the commencement of each shift.

  The COVID-19 PCR test also engages this human right. However, the Direction does not limit the holding of a belief or opinion about COVID-19 or testing or vaccination for COVID-19. The Direction also recognises WHO-COVAX endorsed vaccinations that are provided to a person outside of Australia to be an acceptable form of vaccination. The requirement is for a limited period until the Direction is revoked or replaced, or the pandemic ends.

- Freedom of movement (section 19): Section 19 of the Human Rights Act provides that every person lawfully within Queensland has the right to move freely within Queensland, to enter and leave it and has the freedom to choose where to live. The right means that a person cannot be arbitrarily forced to remain in, or move to or from, a particular place. The right also includes the freedom to choose where to live, and freedom from physical and procedural barriers, like requiring permission before entering a public park or participating in a public demonstration in a public place. The right may be engaged where a public entity actively curtails a person's freedom of movement. The Direction may limit the right to

freedom of movement by preventing workers in healthcare from working at a specified healthcare facility that is their usual place of work.

- Right to education (section 36): Section 36 of the Human Rights Act provides that every person has the right to have access, based on their abilities, to equally accessible further vocational education and training. The right to education is intended to be interpreted in line with the *Education (General Provisions) Act 2006* and to provide rights in relation to aspects of Queensland's responsibilities for education service delivery. Internationally, this right has been interpreted as requiring that education be accessible to all individuals without discrimination. The Direction does not provide any greater limitation on students for their placements than already exist within other public health directions.

- Freedom of thought and conscience (section 20) and freedom of expression (section 21): Section 20 of the Human Rights Act provides that a person has the right to freedom of thought, conscience, religion and belief. The right to hold a belief without interference is an absolute right however limits on how a person manifests their belief can be justified (*Christian Youth Camps v Cobaw Community Health Service* (2014) 50 VR 256, 395 [537]). Section 21 of the Human Rights Act provides that the right to freedom of expression includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be expressed in various ways, including in writing, through art, or orally. The Direction engages this right by requiring workers in healthcare who enter, work in or provide services at healthcare settings to be vaccinated. Workers in healthcare who have a conscientious objection to this requirement will not be permitted to enter, work in or provide services at a healthcare setting if they remain unvaccinated after 15 December 2021, other than for the short period allowed to respond to critical workforce shortages, to enter to provide critical support to a patient, client or person with a disability or to enter in their private or personal capacity.

- Peaceful assembly and freedom of association (section 22): Section 22 of the Human Rights Act upholds the rights of individuals to gather in order to exchange, give or receive information, to express views or conduct a protest or demonstration. The Direction may limit the right to peaceful assembly as it restricts workers in healthcare from entering a healthcare setting, which in turn may prevent groups gathering together for a common purpose/interest.

- Privacy (section 25): The right to privacy in section 25 of the Human Rights Act is broadly construed. A person has the right to not have their privacy, family or home arbitrarily interfered with. The right encompasses an individual's rights to establish and develop meaningful social relations (*Kracke v Mental Health Review Board* (General) (2009 29 VAR 1, [619]-[620]).

  The right to privacy may also incorporate a right to work of some kind and in some circumstances (*ZZ v Secretary, Department of Justice* [2013] VSC 267, [72]-[95] (Bell J)). The Direction may limit a person's right to privacy by making a worker in healthcare provide personal details about their vaccination status to their employer or the responsible person of a healthcare facility.

  The right to privacy also protects the freedom of a person not to be subjected to physical interference, including medical treatment, without consent (*PBU v Mental Health Tribunal* (2018) 56 VR 141, 180-1 [128]). Involuntary medical treatment has been held to amount to interference with the right to respect for personal life which includes a person's physical and psychological integrity (*Solomakhin v Ukraine* (European Court of Human Rights, Fifth Section, Application No 24429/03, 15 March 2012) [33]). The Direction engages this right

by requiring workers in healthcare entering, working in or providing services in a healthcare setting to comply with the mandatory vaccination requirements by the relevant date, and by requiring daily COVID-19 PCR testing for unvaccinated workers who continue to enter, work in or provide services in a healthcare setting.

Compatibility with Human Rights

The direction will be compatible with human rights if the limits it imposes are reasonable and justified.

A limit on a human right will be reasonable and justified if:

- It is imposed under law (section 13(1));
- After considering the nature of the human rights at stake (section 13(2)(a));
- It actually helps to achieve that purpose (section 13(2)(b));
- There is no less restrictive way of achieving that purpose (section 13(2)(d)); and
- It strikes a fair balance between the need to achieve the purpose and the impact on human rights (section 13(2)€, (f) and (g)).

Are the limits imposed 'under law'? (section 13(1))

The Chief Health Officer is authorised to give the proposed direction under section 362B of the *Public Health Act* if they reasonably believe the direction is necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The nature of the rights that would be limited (section 13(2)(a))

The limits on the above human rights arise from:

1. Restricting who can enter a healthcare setting;
2. Requiring vaccination, notification of vaccination and record keeping in relation to workers in healthcare who work in a healthcare setting;
3. Requiring the use of PPE and pre-shift COVID-19 PCR testing by unvaccinated workers in healthcare who are permitted to enter, work or provide services in a healthcare setting;
4. Providing a public health officer (public health) with discretion to issue additional directions to a worker in healthcare, their employer or the responsible person of a healthcare setting.

Proper purpose (section 13(2)(b))

The purpose of these limitations is to reduce the risk of COVID-19 cases spreading to vulnerable people in healthcare settings and to ensure that there is an adequate health workforce available to respond to the expected increase in COVID-19 cases requiring hospitalisation following relaxation of border entry and quarantine restrictions. The Direction is in effect for a temporary period, and the restrictions on who may work, enter or provide services in a healthcare setting.

These purposes of protecting public health are proper purposes. Vaccines protect the community as a whole, by increasing the overall immunity in the community to reduce the spread of vaccine-preventable diseases. Protecting public health is clearly a legitimate objective (*Boffa v San Marino* (1998) 92 Eur Comm HR 27). Vaccines also protect vaccinated individuals by immunising them from the relevant disease.

Moreover, protecting people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

A purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

Reducing and containing the spread of COVID-19 within the community is achieved by the Direction. As COVID-19 is a communicable disease that may be easily transmitted between people and given the direct risk to the lives and health of others posed by a person who has been diagnosed with COVID-19, this purpose can only be achieved by setting out vaccination requirements for workers in healthcare at healthcare settings.

The requirement for workers in healthcare to be vaccinated to work in a healthcare setting, and for unvaccinated workers in healthcare settings to wear PPE and to provide undertake a COVID-19 PCR test before starting each shift is targeted at managing the potential risk of transmission to patients, clients and other healthcare workers. Vaccination also protects individuals and the community, from the spread of COVID-19 and maintains an available workforce in healthcare settings.

Necessary (s 13(2)(d))

The purpose of the Direction cannot be achieved through any reasonably available and less restrictive means. COVID-19 is a communicable disease demonstrated to be highly transmittable between people. Vaccination has been proven to slow the transmission of COVID-19, particularly to vulnerable persons who may develop complications or otherwise require emergency or life-sustaining treatment. Vaccination achieves this purpose as it significantly reduces the adverse impacts of COVID-19 and may reduce transmission. This purpose is also achieved by setting out vaccination requirements for workers in healthcare at healthcare settings.

The limits on human rights are necessary given the immediate and direct risk to the lives and health of others posed by a person who has been diagnosed with COVID-19. There is no other way to address the risk of transmissibility from a COVID-19 positive person.

The delta variant is becoming the prevalent strain of COVID-19 globally, and has been found in the community in Queensland. With Border Restrictions relaxing in Queensland from 13 December 2021, it is necessary to take further measures through the vaccination of workers in healthcare who enter, work in, or provide services in a healthcare setting, to protect the community, and particularly vulnerable cohorts. This measure will provide an additional level of protection and will assist in minimising disruptions to the level of care provided in healthcare settings if community outbreaks occur. In addition, the Direction provides that WHO-COVAX endorsed vaccinations administered overseas are accepted where the employee was vaccinated overseas.

Workers in healthcare who provide services in a healthcare setting are a critical workforce, necessary to ensure continuity of care for our community. Requiring vaccination of this

workforce protects both the worker and their patients or clients in the healthcare setting from experiencing adverse outcomes from COVID-19 transmission. Limited exceptions have been included to manage critical workforce impacts, respond to emergencies, recognise medical contraindications, recognise participation in a COVID-19 vaccine trial and enable critical support to be administered to disabled patients and clients.

The requirements to wear appropriate PPE and undertake PCR COVID-19 testing before a shift is a necessary measure to manage the risk of transmission of COVID-19. It will also assist in reducing the 'close contact' between staff, visitors and residents and potential transmission of the virus.

Similarly, providing a public health officer the ability to issue additional directions to a worker in a healthcare setting, their employer and the responsible person for the healthcare setting will enable any localised issues in specific healthcare settings to be addressed rapidly. The power for public health officers to issue directions to specified healthcare facilities contains appropriate internal limitations. Directions can only be issued if the public health officer considers it to be reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The right to privacy is subject to an internal limitation in that it applies only to interferences with privacy that are 'unlawful' or 'arbitrary'. This internal limitation may apply where the Direction authorises restrictions on movement pursuant to a lawful direction based on a reasonable belief that the restriction is necessary to assist in containing or responding to the spread of COVID-19 within the community.

Fair balance (section 13(2)(e), (f) and (g))

The purpose of the Direction is to reduce the spread of COVID-19 within the community and protect the most vulnerable people within the community.

The limitation on the right to freedom of movement may be justified for the purpose of preventing the spread of COVID-19 within healthcare settings in Queensland. The limitation on the right of freedom of movement and freedom of association does not deny people to enter, work in, or provide services in a healthcare setting, but sets out the COVID-19 vaccination requirements.

The requirement for workers in healthcare setting to be fully vaccinated provides an additional layer of protection for vulnerable members of our community.

However, the extent of the limitation on human rights is reduced by the following factors:

- there are exceptions to the requirement for mandatory vaccination for a worker in healthcare who enters, works in, or provides services in a healthcare setting. These exceptions balance the individual's rights, the need to maintain continuity of care and protection of the community from COVID-19 transmission
- overseas vaccination is recognised where the vaccination is WHO-COVAX endorsed.

Overall, the limitations on human rights are reasonable and demonstrably justifiable, as the Direction is only in force for a temporary period and will help contain the spread of COVID-19, thereby protecting the health and safety of the community. The health benefits to the broader community by implementing the Direction outweighs any potential limitation on the person's right to freedom of movement, freedom of association and protection of families.

Queensland Health

COVID-19 Public Health Summary
Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 3) and *COVID-19 Vaccination Requirements for Workers in a high-risk setting Direction (No.2)*

Summary of changes

Requirement	Type of change	Consistency	Rationale
Replaces references to COVID-19 PCR test with references to COVID-19 test, which includes both COVID-19 PCR test and COVID-19 RAT	Technical	Consistent with all other Public Health Directions	*Policy Rationale* for the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction*
Updated definition for COVID-19 PCR test and a definition for COVID-19 RAT	Technical	Consistent with all other Public Health Directions	*Policy Rationale* for the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction*
Requires unvaccinated workers to be tested and have a negative result a day prior to work and every second day thereafter (previously daily testing requirement)	Technical	Consistent with testing requirements for close contacts returning to work as critically essential workers	*Policy Rationale* for the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction*
Updates the vaccination requirements	Technical	-	The date for the first dose has now passed and the date for having received the prescribed number of doses will have passed by the publication of the direction
For high risk settings, at the request of Queensland Corrective Services, includes prisoner in the definition of vulnerable persons as they are included in an example in the Direction but may not currently meet the conditions in the definition	Technical	-	-
For workers in healthcare, clarifies that the exemption for participation in a clinical trial does not apply to a student undertaking an education placement	Technical	Consistent with existing policy applying to and mitigating risks posed by students undertaking education placements.	*Applies the same Policy Rationale as* for the other directions that regulate student placements in healthcare settings. Students do not receive an exemption from vaccination requirements to participate in COVID-19 clinical trials or for a medical contraindication.
For workers in healthcare, removes references to vaccination dates under other health or employment directions	Technical	-	All workers in healthcare are now required to be fully vaccinated irrespective of the instrument that applies

Public Health Directions – Human Rights Assessment
Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 3)

Title	*Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 3)*
Date effective	4 February 2022

Background
The *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 32)* (Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction
The purpose of the Direction is to set out the COVID-19 vaccination requirements for workers in healthcare settings. The Direction applies broadly, to anyone who enters, works in, or provides services in healthcare settings, with limited exceptions.

The Direction complements existing mandatory vaccination requirements applying in other high-risk settings and gives effect to the agreed Australian Health Protection Principal Committee (AHPPC) position recommending mandatory vaccination for workers in a range of private health care settings and complements existing mandatory vaccination requirements.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the Direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

Widespread COVID-19 transmission in health care settings can significantly impact the healthcare workforce due to a large number of exposed (or potentially exposed) workers and has the potential for significant adverse effects for vulnerable patients and clients accessing healthcare settings. Staff may not be able to attend work because they are confirmed cases or close contacts and may be directed not to attend work because they have (or potentially have) had unprotected exposure to COVID-19.

The Queensland COVID-19 Vaccine Plan to Unite Families outlines the opening of Queensland's borders, and changes to domestic and international quarantine requirements when 70%, 80% and 90% of the eligible Queensland population are fully vaccinated. With increased movement of people into Queensland from interstate and overseas, the need for an available workforce within healthcare settings has significantly increased. Protecting the public, staff and patients by mandating the vaccination of workers who enter, work in, or provide services in a healthcare setting is necessary.

Mandatory vaccination can help reduce the impact to the health system capacity and reduce risk of exposure to staff, patients and clients at the healthcare setting.

The Direction will prohibit workers in healthcare from entering, working in, performing duties or providing services in a healthcare setting unless they meet the COVID-19 vaccination requirements for workers in a healthcare setting. There are limited exceptions and where these apply the unvaccinated worker must use PPE and undertake a COVID-19 test result before starting their shift.

The *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No.3)* (the Direction) revokes and replaces the *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No.2)* from time of publication.

The Direction has been amended to provide greater flexibility to meet surveillance testing requirements, including:

- replacing references to COVID-19 PCR test with references to COVID-19 test, which includes both COVID-19 PCR test and COVID-19 RAT;
- an updated definition for COVID-19 PCR test and a definition for COVID-19 RAT;
- amending daily testing requirements to require a test and negative test result before the next day of work after commencement of the direction, and every second day thereafter;
- updating the vaccination requirements as the date for the first dose has now passed and the date for having received the prescribed number of doses will have passed by the publication of the direction;
- clarify that the exemptions for participation in a COVID-19 clinical trial and medical contraindication do not apply to a student undertaking an education placement;
- remove references to vaccination dates under other health or employment directions as all workers in healthcare are now required to be fully vaccinated irrespective of the instrument that applies.

How the Direction Achieves the Purpose

Outlining the vaccination requirements for workers in healthcare settings will help reduce the impacts on individuals, particularly vulnerable healthcare consumers, now that the COVID-19 case numbers are high in Queensland and are approaching the peak in South-east Queensland.

The Direction achieves this purpose through establishing vaccination requirements for all workers in healthcare that enter, work in or provide services in a healthcare setting, with limited exceptions:

- to be fully vaccinated
- to provide evidence of complying with the COVID-19 vaccination requirements to their employer, where applicable and to the responsible person for the healthcare setting, as soon as reasonably practicable after each dose of the COVID-19 vaccine;
- providing exceptions to the mandatory vaccination requirements where:
    - the worker is unable to be vaccinated due to a medical contraindication and the responsible person for the healthcare setting assesses the risk and allows the person to continue working with PPE and ~~PCR~~ COVID-19 testing prior to commencement of each shift; or
    - the worker is a participant in a COVID-19 vaccine trial and has received at least one active dose of the trialed COVID-19 vaccine; or
      an unvaccinated person is required to enter the healthcare setting for an emergency response; or
    - an unvaccinated support person is required to enter and remain at a healthcare setting to provide critical support to a patient, client or person with a disability, if

the responsible person assesses the risk and allows the person to enter the facility subject to PPE and COVID-19 testing requirements; or
- to meet critical workforce shortages for a short period of up to 3 months to allow time to address the critical workforce shortage based on a risk assessment by the responsible person. PPE and pre-shift testing requirements apply or
- a worker in healthcare is required to enter and remain at a healthcare setting in their personal or private capacity, provided they comply with all other public health directions applicable to entering a healthcare setting.

The Direction complements existing mandatory vaccination requirements for high risk and vulnerable settings, and recognises exemptions provided by the Queensland Health Employment Directive 12/21.

Human Rights Engaged

The human rights engaged by the Direction are:
- Right to life (section 16)
- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c))
- Freedom of movement (section 19)
- Right to education (section 36)
- Freedom of thought, conscience, religion, and belief (section 20)
- Freedom of expression (section 21)
- Peaceful assembly and freedom of association (section 22)
- Right to privacy (section 25)

- Right to life (section 16): The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. Under international law, this right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights. The Direction promotes the right to life by protecting the health, safety and wellbeing of vulnerable Queenslanders through placing vaccination requirements on workers entering and working at healthcare facilities.

- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c)): Section 17(c) of the Human Rights Act provides that a person must not be subject to medical treatment without the person's full, free and informed consent.

  Medical treatment for the purposes of section 17(c) includes administering a drug for the purposes of treatment or prevention of disease. Administering a nasal swab test to check for the presence or absence of COVID-19 also amounts to medical treatment. This right includes treatment of any kind, even if the treatment benefits the person (*Kracke v Mental Health Review Board* (2009 29 VAR 1, 123 [576]).

  This right is engaged as the direction limits the practical choice available to a worker in healthcare whether or not to agree to the treatment by preventing them from attending their workplace unless they meet the COVID-19 vaccination requirements or the date specified in another public health direction or the HED for a cohort of workers. Limited exceptions apply where a person has a medical contraindication, where the person is a participant in a COVID-19 vaccine clinical trial and has received at least one active dose of the trial vaccine; to provide critical support needs to a patient, client or person with a disability; respond to a critical workforce shortage; for an emergency response for patients; or to enter in their personal or private capacity. A worker in healthcare who is unable to be vaccinated due to a recognised medical contraindication, evidenced by a medical certificate, should be deployed or work from an alternative location if possible. Unvaccinated persons may continue to work in the healthcare setting due to medical

contraindication, or to respond to a critical workforce shortage must be permitted to do so by the responsible person for the healthcare setting, based on a risk assessment, and use PPE and undertake a COVID-19 test prior to the commencement of each shift. If a COVID-19 PCR test is used, the results must be provided to the employer on a rolling basis when the results are received. Where a Rapid Antigen Test is used, the test must be undertaken and a negative test result received before the worker starts the shift.

The COVID-19 test engages this human right. However, the Direction does not limit the holding of a belief or opinion about COVID-19 or testing or vaccination for COVID-19.

- Freedom of movement (section 19): Section 19 of the Human Rights Act provides that every person lawfully within Queensland has the right to move freely within Queensland, to enter and leave it and has the freedom to choose where to live. The right means that a person cannot be arbitrarily forced to remain in, or move to or from, a particular place. The right also includes the freedom to choose where to live, and freedom from physical and procedural barriers, like requiring permission before entering a public park or participating in a public demonstration in a public place. The right may be engaged where a public entity actively curtails a person's freedom of movement. The Direction may limit the right to freedom of movement by preventing workers in healthcare from working at a specified healthcare facility that is their usual place of work. The Direction eases the limit for freedom of movement because the increased options of testing means that people may be able to return to the workforce sooner, and there are less physical and procedural barriers associated with PCR tests.

- Right to education (section 36): Section 36 of the Human Rights Act provides that every person has the right to have access, based on their abilities, to equally accessible further vocational education and training. The right to education is intended to be interpreted in line with the *Education (General Provisions) Act 2006* and to provide rights in relation to aspects of Queensland's responsibilities for education service delivery. Internationally, this right has been interpreted as requiring that education be accessible to all individuals without discrimination. The Direction does not provide any greater limitation on students for their placements than already exist within other public health directions.

- Freedom of thought and conscience (section 20) and freedom of expression (section 21): Section 20 of the Human Rights Act provides that a person has the right to freedom of thought, conscience, religion and belief. The right to hold a belief without interference is an absolute right however limits on how a person manifests their belief can be justified (*Christian Youth Camps v Cobaw Community Health Service* (2014) 50 VR 256, 395 [537]). Section 21 of the Human Rights Act provides that the right to freedom of expression includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be expressed in various ways, including in writing, through art, or orally. The Direction engages this right by requiring workers in healthcare who enter, work in or provide services at healthcare settings to be vaccinated. Workers in healthcare who have a conscientious objection to this requirement will not be permitted to enter, work in or provide services at a healthcare setting if they remain unvaccinated, other than for the short period allowed to respond to critical workforce shortages, to enter to provide critical support to a patient, client or person with a disability or to enter in their private or personal capacity.

- Peaceful assembly and freedom of association (section 22): Section 22 of the Human Rights Act upholds the rights of individuals to gather in order to exchange, give or receive information, to express views or conduct a protest or demonstration. The Direction may limit the right to peaceful assembly as it restricts workers in healthcare from entering a healthcare setting, which in turn may prevent groups gathering together for a common

purpose/interest. The changes in the Direction reduces the limitation by increasing the testing options more people may be able to enter the healthcare setting, which in turn may allow groups gathering together for a common purpose/interest.

- Privacy (section 25): The right to privacy in section 25 of the Human Rights Act is broadly construed. A person has the right to not have their privacy, family or home arbitrarily interfered with. The right encompasses an individual's rights to establish and develop meaningful social relations (*Kracke v Mental Health Review Board* (General) (2009 29 VAR 1, [619]-[620]).

  The right to privacy may also incorporate a right to work of some kind and in some circumstances (*ZZ v Secretary, Department of Justice* [2013] VSC 267, [72]-[95] (Bell J)). The Direction may limit a person's right to privacy by making a worker in healthcare provide personal details about their vaccination status to their employer or the responsible person of a healthcare facility.

The right to privacy also protects the freedom of a person not to be subjected to physical interference, including medical treatment, without consent (*PBU v Mental Health Tribunal* (2018) 56 VR 141, 180-1 [128]). Involuntary medical treatment has been held to amount to interference with the right to respect for personal life which includes a person's physical and psychological integrity (*Solomakhin v Ukraine* (European Court of Human Rights, Fifth Section, Application No 24429/03, 15 March 2012) [33]). The Direction engages this right by requiring all workers in healthcare entering, working in or providing services to be fully vaccinated irrespective of the instrument that applies and by requiring daily COVID-19 testing for unvaccinated workers who continue to enter, work in or provide services in a healthcare setting.

Compatibility with Human Rights

The direction will be compatible with human rights if the limits it imposes are reasonable and justified.

A limit on a human right will be reasonable and justified if:
- It is imposed under law (section 13(1));
- After considering the nature of the human rights at stake (section 13(2)(a));
- It actually helps to achieve that purpose (section 13(2)(b));
- There is no less restrictive way of achieving that purpose (section 13(2)(d)); and
- It strikes a fair balance between the need to achieve the purpose and the impact on human rights (section 13(2)€, (f) and (g)).

Are the limits imposed 'under law'? (section 13(1))

The Chief Health Officer is authorised to give the proposed direction under section 362B of the *Public Health Act* if they reasonably believe the direction is necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The nature of the rights that would be limited (section 13(2)(a))

The limits on the above human rights arise from:
1. Restricting who can enter a healthcare setting;
2. Requiring vaccination, notification of vaccination and record keeping in relation to workers in healthcare who work in a healthcare setting;

3. Requiring the use of PPE and pre-shift COVID-19 testing by unvaccinated workers in healthcare who are permitted to enter, work or provide services in a healthcare setting;
4. Providing a public health officer (public health) with discretion to issue additional directions to a worker in healthcare, their employer or the responsible person of a healthcare setting.

Proper purpose (section 13(2)(b))

The purpose of these limitations is to reduce the risk of COVID-19 cases spreading to vulnerable people in healthcare settings and to ensure that there is an adequate health workforce available to respond to the expected increase in COVID-19 cases requiring hospitalisation following relaxation of border entry and quarantine restrictions. The Direction is in effect for a temporary period, and the restrictions on who may work, enter or provide services in a healthcare setting.

These purposes of protecting public health are proper purposes. Vaccines protect the community as a whole, by increasing the overall immunity in the community to reduce the spread of vaccine-preventable diseases. Protecting public health is clearly a legitimate objective (*Boffa v San Marino* (1998) 92 Eur Comm HR 27). Vaccines also protect vaccinated individuals by immunising them from the relevant disease.

Moreover, protecting people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

A purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

Reducing and containing the spread of COVID-19 within the community is achieved by the Direction. As COVID-19 is a communicable disease that may be easily transmitted between people and given the direct risk to the lives and health of others posed by a person who has been diagnosed with COVID-19, this purpose can only be achieved by setting out vaccination requirements for workers in healthcare at healthcare settings.

The requirement for workers in healthcare to be vaccinated to work in a healthcare setting, and for unvaccinated workers in healthcare settings to wear PPE and to provide undertake a COVID-19 test before starting each shift is targeted at managing the potential risk of transmission to patients, clients and other healthcare workers. Vaccination also protects individuals and the community, from the spread of COVID-19 and maintains an available workforce in healthcare settings.

Necessary (s 13(2)(d))

The purpose of the Direction cannot be achieved through any reasonably available and less restrictive means. COVID-19 is a communicable disease demonstrated to be highly transmittable between people. Vaccination has been proven to slow the transmission of COVID-19, particularly to vulnerable persons who may develop complications or otherwise require emergency or life-sustaining treatment. Vaccination achieves this purpose as it

significantly reduces the adverse impacts of COVID-19 and may reduce transmission. This purpose is also achieved by setting out vaccination requirements for workers in healthcare at healthcare settings.

The limits on human rights are necessary given the immediate and direct risk to the lives and health of others posed by a person who has been diagnosed with COVID-19. There is no other way to address the risk of transmissibility from a COVID-19 positive person.

Workers in healthcare who provide services in a healthcare setting are a critical workforce, necessary to ensure continuity of care for our community. Requiring vaccination of this workforce protects both the worker and their patients or clients in the healthcare setting from experiencing adverse outcomes from COVID-19 transmission. Limited exceptions have been included to manage critical workforce impacts, respond to emergencies, recognise medical contraindications, recognise participation in a COVID-19 vaccine trial and enable critical support to be administered to disabled patients and clients.

The exemptions for participation in a COVID-19 clinical trial and medical contraindication do not apply to a student undertaking an education placement. This is because they are not yet a part of a critical workforce. Furthermore, participation in a COVID-19 clinical trial and medical contraindications are generally temporary, and therefore, they could defer their placement until such time as they are no longer participating in a trial or no longer have a medical contraindication.

The requirements to wear appropriate PPE and undertake COVID-19 testing before a shift is a necessary measure to manage the risk of transmission of COVID-19. It will also assist in reducing the 'close contact' between staff, visitors and residents and potential transmission of the virus.

Similarly, providing a public health officer the ability to issue additional directions to a worker in a healthcare setting, their employer and the responsible person for the healthcare setting will enable any localised issues in specific healthcare settings to be addressed rapidly. The power for public health officers to issue directions to specified healthcare facilities contains appropriate internal limitations. Directions can only be issued if the public health officer considers it to be reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The right to privacy is subject to an internal limitation in that it applies only to interferences with privacy that are 'unlawful' or 'arbitrary'. This internal limitation may apply where the Direction authorises restrictions on movement pursuant to a lawful direction based on a reasonable belief that the restriction is necessary to assist in containing or responding to the spread of COVID-19 within the community.

Fair balance (section 13(2)(e), (f) and (g))

The purpose of the Direction is to reduce the spread of COVID-19 within the community and protect the most vulnerable people within the community.

The limitation on the right to freedom of movement may be justified for the purpose of preventing the spread of COVID-19 within healthcare settings in Queensland. The limitation on the right of freedom of movement and freedom of association does not deny people to enter, work in, or provide services in a healthcare setting, but sets out the COVID-19

vaccination requirements. With increased options for undertaking testing, the limitations on the right to freedom of movement and freedom of association are reduced.

The requirement for workers in healthcare setting to be fully vaccinated provides an additional layer of protection for vulnerable members of our community.

However, the extent of the limitation on human rights is reduced by the following factors:

- there are exceptions to the requirement for mandatory vaccination for a worker in healthcare who enters, works in, or provides services in a healthcare setting. These exceptions balance the individual's rights, the need to maintain continuity of care and protection of the community from COVID-19 transmission
- overseas vaccination is recognised where the vaccination is WHO-COVAX endorsed.

Overall, the limitations on human rights are reasonable and demonstrably justifiable, as the Direction is only in force for a temporary period and will help contain the spread of COVID-19, thereby protecting the health and safety of the community. The health benefits to the broader community by implementing the Direction outweighs any potential limitation on the person's right to freedom of movement, freedom of association and protection of families.

COVID-19 Public Health Rationale Staff and Visitors in Healthcare Settings

8 March 2022

DRAFT NOT GOVERNMENT POLICY

Summary

This Policy Rationale describes adjustments to the settings for visitors and staff at vulnerable settings, including hospitals, residential aged care facilities and disability accommodation services, across the following four Directions.

- *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction*
- *Residential Aged Care Visitor Direction* (previously the Residential Aged Care Direction)
- *Disability Accommodation Services Visitor Direction* (previously the Disability Accommodation Services Direction)
- *Hospital Visitor Entry Direction* (previously the Hospital Entry Direction)

This document also describes the revocation of the *Queensland COVID-19 Restricted Areas Direction.*

The overarching intent of the Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No.4) is to protect workers in healthcare settings, protect the health of the community and to safeguard the delivery of healthcare services during the COVID-19 pandemic. The Direction establishes entry and mandatory COVID-19 vaccination requirements for workers, students and volunteers in healthcare settings. The Direction also places an obligation on the employer to ensure compliance with vaccination requirements.

The overarching intent of *the Residential Aged Care Visitor Direction, Disability Accommodation Services Visitor Direction and Hospital Entry Visitor Direction are* to minimise the impact of COVID-19 in vulnerable settings and ensure patient health and wellbeing by setting entry requirements and visitor limits appropriate to the current epidemiological situation in Queensland.

In this iteration of the Directions, requirements for staff in healthcare and vulnerable settings have been consolidated into the *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction*. Similarly, entry and vaccination requirements for hospital workers will be removed from the current Direction and consolidated into the Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction, removing any duplication of requirements. A new requirement has been introduced to require staff, volunteers and students of residential aged care facilities to be up to date with COVID-19 vaccination, in line with expert advice and national agreement.

Requirements for visitors, volunteers and students to vulnerable facilities continue to be reflected in the *Residential Aged Care Visitor Direction, Disability Accommodation Services Visitor Direction* and *Hospital Entry Visitor Direction.* The Directions have been updated to simplify and limit restrictions to visitors, students and certain volunteers, as distinct from workers. A provision for an additional support person for women attending antenatal or postnatal appointments is also described.

The updated Directions also provide for technical amendments to align post-quarantine and isolation requirements with the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction* and to remove references to restricted and non-restricted in accordance with the revocation of the *Queensland COVID-19 Restricted Areas Direction.* Further, the updated *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction* makes a minor policy shift to require testing every second day for critical support workers, instead of every day, to align with infection prevention and control advice and requirements for other critical workers.

Background and considerations as at 8 March 2022

Queensland is experiencing widespread community transmission of COVID-19, predominately of the Omicron variant. Fortunately, this rate of transmission is occurring within a highly vaccinated population (92.9 per cent single dose, 91.1 per cent double dose and 62.2 per cent of the eligible population have received a booster dose as at 6 March 2022). Among children, vaccination coverage is 89.8 per cent of 12 years+ having received two doses and 42.7 per cent of 5-11 year olds receiving at least one vaccination dose. Although Omicron is immune evasive and more transmissible than previous variants, the evidence is that vaccination continues to provide protection against severe disease.

Modelling for the Omicron wave indicated that between 3,000 and 5,000 hospital inpatients and between 300 to 450 ICU inpatients could be expected at the peak. Actual hospitalisation and ICU rates were well below these numbers, reaching 928 in hospital and 54 in ICU at what was likely the peak of this wave in late January. Overall hospitalisations are a key indicator of the impact of COVID-19. New hospitalisations remain stable and overall, the number of people in hospital continues to reduce; 267 people are in hospital with COVID-19 on 7 March. A statewide staged restart of elective surgery across Queensland public hospitals is beginning, with the initial focus on the most urgent matters.

As at 7 March, there are 30,557 active cases in Queensland. Although it is likely the true number of cases in the community is higher, the number of known cases has remained relatively stable over the past week and it is apparent that the peak of the first Omicron wave seen over January 2022 has passed.

The number and distribution of case numbers and deaths in Queensland demonstrate that those who are most vulnerable to COVID-19 are:

- older and more vulnerable members of the community
- those who are unvaccinated or have not received a booster dose
- and those with other contributing or underlying health conditions.

There have been 593 deaths in Queensland since the beginning of the pandemic with 312 deaths occurring in aged are residents.

In line with Queensland's COVID-19 Vaccine Plan to Unite Families (the Vaccine Plan), and the National Plan to transition Australia's National COVID-19 Response, Queensland has been gradually easing restrictions. This approach, at this point in the pandemic and with high vaccination coverage, is consistent with the adjustment of measures nationally and globally according to local context.

Since late 2021, Queensland's borders have reopened to domestic and overseas arrivals and quarantine is no longer required for vaccinated persons. On 4 March 2022, Queensland further eased restrictions in relation to density, most indoor mask wearing and private gatherings, with vaccination rules to remaining in place at high-risk settings, including in vulnerable settings.

Isolation and close contact quarantine, mask wearing in limited settings, workforce vaccine mandates, and vaccine requirements for entry to high-risk venues and settings are the primary remaining public health measures in place to temper community transmission of COVID-19.

This approach to easing restrictions is in line with other jurisdictions and globally. Up to date vaccination against COVID-19 continues to be encouraged as Queensland moves toward a model of managing a degree of ongoing COVID-19 transmission in the community and the potential for future waves and variants.

Queensland's public health response remains flexible and adaptable to the circumstances. The intent of public health directions is to ensure necessary protection of public health and health system capacity. While many remaining restrictions will be lifted on 4 March, the protection of vulnerable populations continues to be central to Queensland's ongoing public health response.

Visitor requirements

Defining a visitor, volunteer, and student

Visitors are critical in supporting wellbeing and social connectedness for patients and residents in a vulnerable setting and it is important that this support continues in a sustainable and safe way. The current Hospital Visitor Entry, Residential Aged Care and Disability Accommodation Services Directions vary in the definition of visitor. To streamline and simplify requirements for visitors to healthcare and vulnerable settings, a universal definition of visitor has been specified in the updated Directions.

Broadly, a visitor excludes a patient; an employee or a person who is engaged by the hospital (whether paid or not); a contractor; a student; and emergency services staff. Additional provisions for an unvaccinated person, a diagnosed person and close contact to attend a hospital setting in specified conditions, including for end of life, and beginning of life events, are provided.

For clarity, the updated Directions define a volunteer as a person who enters the hospital to provide products or services on a voluntary basis, as part of their role with an organisation other than the hospital. A person engaged directly by the hospital for unpaid services is not considered a volunteer and therefore not subject to restrictions imposed on a volunteer under this Direction. They would however be subject to the requirements of the Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction.

The Directions have been updated to specify that students undertaking placement at a residential aged care facility in connection with an enrolled course of study must have an up to date vaccination to enter the facility. This requirement aligns with that being introduced for staff and volunteers employed directly by the aged care facility, with the rationale described further below. Rather than consolidating these provisions to the Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction, provisions for students have been retained in the individual Directions for settings to assist with ease of understanding and compliance for the sector.

On 20 January 2022, tighter visitor restrictions were put in place for public and private hospitals across Queensland to ensure the ongoing safety of patients and staff. Two fully vaccinated visitors per patient are allowed in most instances, with some exceptions in the most high-risk areas of a hospital including the emergency department and neonatal intensive care units. This followed feedback from Hospital and Health Services (HHSs) that the ability to implement good infection control practices and social distancing without a cap on visitors was challenging and presented an increased risk in transmission at a time of widespread community transmission. For example, a person might present sick to an emergency department with two or three family members and if either the patient or the family members had any COVID-19 symptoms, this would create challenges. Similarly, a family of five might want to visit someone on a ward making social distancing from other patients or visitors on the ward difficult to manage. A similar approach was taken by most other states and territories. Visitor requirements were not changed for residential aged care facilities and disability accommodation services during this time.

It is not proposed to vary visitor entry or vaccination requirements or visitor limits at this time during ongoing COVID-19 transmission in the community, noting these measures seek to minimise the risk of introducing COVID-19 into the hospital setting. Additional safeguards also remain in place, such as requiring a visitor or volunteer who is permitted to enter the hospital to comply with face mask requirements, any additional personal protective equipment (PPE) requirements or any other restrictions implemented by the operator of the hospital. Visitors, volunteers and students are also required to provide contact information to support rapid and targeted contact tracing if required, which is important for local management of any outbreaks at these vulnerable settings.

Requirements for visitors who are a diagnosed case or close contact will be updated to align with post-isolation and quarantine requirements as outlined in the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction.* In these cases, a diagnosed person or close contact must not for 7 days after isolation or quarantine, enter and remain in a vulnerable and high risk setting other than for specific conditions. The intent of this policy is to ensure that despite a person completing the minimum

required period of isolation and quarantine, they do not enter a vulnerable facility within the critical 14-day period after infection or exposure, where transmission could still occur.

The updated Direction notes that an international arrival is not permitted to enter or remain at a hospital within 14 days of their arrival in Australia, regardless if they no longer have to isolate or quarantine. This provision provides protection against the current and future risk of COVID-19 importation from overseas into the hospital environment, particularly in the current context of ongoing COVID-19 transmission globally and likely emergence of new variants in the future. This exclusion period ensures that, despite no quarantine period being required for international arrivals, they do not enter a vulnerable facility with a potential infection during the critical 14-day period after their arrival.

The operator of the hospital has an obligation to make reasonable efforts to ensure that a visitor, volunteer or student does not enter or remain within a hospital or vulnerable facility if the person is prohibited from doing so under the Directions. To ensure the consistency of applying visitor limits, the updated Direction will clarify that the operator of a hospital or vulnerable facility must not unreasonably limit visitor numbers beyond what is required by the Direction. Additional restrictions however may be applied in response to a particular emergency or local outbreak within the hospital, with consideration of the least restrictive option to address the situation.

Support persons for antenatal and postnatal appointments

The updated Hospital Visitor Entry Direction includes an amendment that specifies women are permitted to be accompanied by partner or one support person for antenatal and postnatal appointments. A second support person may be permitted in exceptional circumstances and must be arranged with the clinic prior to the appointment. This amendment has been made in recognition of the important emotional and mental wellbeing a support person plays during these appointments.

A diagnosed person may not accompany a woman for antenatal and postnatal appointments, as this poses a high risk of onward transmission to staff and vulnerable cohorts, including pregnant women or newborns. This would directly impact the wellbeing of these cohorts and the possibility of exposure in this way could deter mothers against attending antenatal and postnatal appointments and lead to avoidable complications.

Right to entry for support persons in a birthing suite, irrespective of their COVID-19 status, is maintained. Where a support person is diagnosed with COVID-19 at the time of the birth, the person must comply with the requirements of the facility, and the hospital may take additional precautions to limit the risk of transmission. This in recognition of the critical emotional, physical and mental wellbeing role a support person plays in birthing events.

Staff requirements

Consolidating requirements for workers

For clarity, entry and vaccination requirements for hospital workers will be removed from the current Direction and consolidated into the Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction. Similarly, entry and vaccination requirements for staff will also be removed from the Aged Care Direction and Disability Accommodation Direction and consolidated into this Direction.

There is no proposal with this to change the requirements for a worker in healthcare who enters, works in or performs services in a healthcare setting. Rather, the intent is to streamline healthcare worker requirements into a single Direction.

The Directions relating to health care and vulnerable facilities are in place to minimise COVID-19 transmission among healthcare workers and settings, provide protection for highly at-risk workers, vulnerable patients and residents against both infection and serious disease, avoiding preventable deaths, and to support the sustainability of the healthcare workforce and services. Protection from COVID-19 through vaccination in vulnerable settings is a key determinant of the impact of COVID-19 on workers, patients and residents.

The Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction aligns with AHPPC statements regarding mandatory vaccination for all workers in healthcare settings (1 October 2021), residential disability support workers (9 July 2021) and residential aged care workers (29 June 2021). The requirements also complement mandatory vaccination requirements in other Public Health Directions, including the *Queensland Health Employment Directive No. 12/21 - Employee COVID-19 vaccination requirements.*

Vaccination remains the best protection against infection with or severe illness from COVID-19. Despite the high transmissibility and immune evasion of Omicron, vaccination continues to offer protection against infection particularly when the schedule is up-to-date. Vaccination and booster doses continue to be encouraged as Queensland manages a degree of ongoing COVID-19 transmission in the community and the potential for future waves and variants.

Uninfected individuals cannot transmit COVID-19; therefore, high rates of vaccination also provide some protection against transmission. Omicron is immune evasive and more transmissible than previous variants and the evidence is that vaccination remains the best protection against severe disease, particularly when the schedule is up to date.

Testing requirements for critical support needs workers

From time to time there may be exceptional circumstances that result in a critical workforce shortage, such as illness, high demand or another emergent event, and there may be an occasion where there is a shortage of vaccinated workers. In this event, and to allow for the continued and safe delivery of services, the Direction provides that an unvaccinated worker may be permitted to enter, work in or provide services in the setting, for a short period until vaccinated workers can be recruited.

It is important that critical support workers who must enter a vulnerable facility for the health and wellbeing of residents, despite not meeting vaccination requirements, comply with additional testing requirements to mitigate the risk to residents.

Testing requirements have been revised to every other day instead of every day to aligns with infection prevention and control advice that this is an appropriate testing integral for asymptomatic individuals to mitigate risk. Testing every second day also aligns with requirements for other critical working cohorts including Critically Essential Workers. Provisions for symptomatic workers and visitors are outlined in their respective Directions.

Vaccination requirements for staff working in Residential Aged Care Facilities

The number and distribution of case numbers and deaths throughout the pandemic, and those in Queensland, demonstrate that those who are most vulnerable to COVID-19 are older, unvaccinated, or have other contributing or underlying health conditions.

As at 10 February 2022, ATAGI's advice is that three doses of a COVID-19 vaccine are required to be up to date to protect against both infection and severe disease from COVID-19 and particularly, the Omicron variant. In a statement published on 15 February 2022, AHPPC has recommended to National Cabinet that the residential aged care workforce receive a third (booster) COVID-19 vaccine dose as a condition of working in a residential aged care facility to protect against both infection and disease. This recommendation has been agreed to by National Cabinet.

In the statement, AHPPC advises that there is a potential effect of vaccination in reducing onward transmission from infected individuals who are vaccinated, although data on this are not yet available for Omicron. Individuals who become infected despite vaccination (break-through infection) are at reduced risk of transmitting due to a generally lower viral load and shortened duration of shedding. Several studies of household transmission have provided evidence of reduced risk of transmission from vaccinated cases compared to unvaccinated cases, with boosted individuals at the lowest risk of transmitting.

It is anticipated that up to date vaccination of residential aged care workers will reduce the risk of transmission to residents and co-workers and help to protect workers, their families and the community from the impacts of COVID-19. AHPPC notes that:

- residential aged care settings are a very high-risk transmission setting for COVID-19
- residents are among the most vulnerable to severe outcomes of COVID-19
- current high rates of community transmission of the Omicron variant increases the risk of exposure to care recipients in residential aged care settings.

For this reason and in accordance with the agreed approach, this iteration of the Direction updates the requirement for residential aged care workers' vaccination to be 'up to date', meaning that from 31 March 2022 workers must have received the third (booster) dose of COVID-19 vaccine from 3 up to a maximum of 6 months after being fully vaccinated as a condition of working in a residential aged care facility. Ensuring that workers remain up to date in their vaccination schedule will provide optimal protection against infection and disease from COVID-19 and the drafting of the provision accommodates, and makes explicit the requirement to comply with, any further updates to the schedule as the pandemic continues.

The aged care workforce is the first cohort of workers for whom the vaccination schedule will be redefined as needing to be 'up to date', meaning at this time that a third COVID-19 vaccination dose will be required. This is consistent with this being the setting providing direct care to the most vulnerable to COVID-19 and is consistent with the priority given to this cohort during the initial vaccine rollout and implementation of workforce vaccine mandates. As at 2 March, 100.0 per cent of aged care workers in Queensland were fully vaccinated and as at 7 March, Queensland Health Residential Aged Care Facilities have reported 70.26% of staff have received a booster.

Going forward, consideration will be given to broadening this requirement to other cohorts of workers, including those working in the disability sector, and embedding it in requirements for healthcare workers.

All States and Territories have implemented vaccination mandates for health and aged care workers and up to date vaccination requirements have now been adopted almost uniformly (refer to Table 1 – jurisdictional comparison).

Table 1. Jurisdictional comparison – workforce vaccination requirements (8 March 2022)

Public health measure	QLD	NSW	VIC	ACT	SA	WA	NT	TAS
Vaccination requirements								
Workers in health settings	✓	✓	✓	✓	✓	✓	✓	✓
Workers in aged care and disability	✓	✓ [discretional]	✓	✓	✓	✓	✓	✓
Workers in aged care – 'up to date' required		✓	✓		✓	✓	✓	✓

Removal of restricted and non-restricted requirements

Under Queensland's COVID-19 Restricted Areas Direction, Local Government Areas (LGAs) with elevated COVID-19 transmission risk have been in the past declared as a restricted area for the purpose of increasing protections for vulnerable populations. The declaration of LGAs as restricted areas activated additional protective provisions in the Residential Aged Care, Hospital Entry and Disability Accommodation Services Directions.

Under an automatic increase to a "moderate" risk category under the *Personal protective equipment in healthcare delivery guidelines* all health and care settings in LGA's declared as a restricted area also escalated the use of PPE, including hospitals, residential aged care and residential disability care facilities, prison health services, youth detention health services, community health care settings (including general practice, dentistry and home care settings) and Queensland Health Vaccination Clinics.

The Direction was applied repeatedly during the elimination and suppression phases of Queensland's COVID-19 response. A similar approach was taken by most other states and territories. During periods

of elevated COVID-19 risk, the declaring of LGAs as a restricted area (and consequential activation of restrictions across vulnerable facilities) was often coupled with targeted and time-limited restrictions on movement and gathering, requirements for mandatory mask wearing and restrictions on businesses, activities and undertakings enacted through the now revoked *Restrictions for Impacted Areas Direction.*

Implementation of these provisions enabled rapid ring-fencing of community transmission events and played an important role in preventing the spread of the Delta variant in Queensland in the context of constrained vaccine supply and minimal vaccination coverage. It allowed the public hospital and health system to continue to deliver care to existing patients unimpeded by COVID-19 outbreaks.

During elimination, significant effort and resources were directed at all community cases and outbreaks, with the goal of completely removing COVID-19 from the community. There was a higher likelihood of uncontrolled spread in context of lower levels of immune protection (due to vaccination or past illness) in the community. Implementation of societal restrictions (i.e., restrictions on the movement and gathering of people and business and activity, including lockdowns) alongside contact tracing to manage COVID-19 incidents were central to the response.

The COVID-19 context in Queensland has changed. Following the emergence of the Omicron variant, COVID-19 is now circulating widely in the community and Queensland's public health response has shifted. Elimination or suppression of the virus is no longer possible, and Queensland can expect to see some degree of COVID-19 transmission for the foreseeable future. As such, Queensland's public health response is transitioning to managing waves of infection as they arise, as well as any developments from emerging variants or new evidence / updated advice for COVID-19 protections.

Beyond the easing of restrictions on 4 March 2022, public health measures including vaccination mandates in high-risk settings, isolation and close contact quarantine, protections for vulnerable settings and indoor mask wearing in high-risk environments will remain. Together with vaccination, which we know to be effective at preventing serious disease and hospitalisation, these measures seek to protect the most vulnerable and the capacity of Queensland's health and hospital system.

The declaration of restricted areas is no longer consistent with Queensland's COVID-19 response and it is appropriate at this time that the *Queensland COVID-19 Restricted Areas Direction* be revoked. The revocation of this Direction will not increase risk to vulnerable cohorts or the community.

With the revocation of this Direction, references to restricted and non-restricted will be removed from the Public Health Directions related to vulnerable facilities. To ensure the continued protection of vulnerable cohorts, public health measures relating to entry and vaccination requirements for workers and visitors across vulnerable facilities will remain in place.

As the pandemic continues the responsibility for COVID-19 risk mitigation is increasingly being managed by the responsible sector in partnership with Queensland Health, rather than via public health direction alone.

Should further developments, such as the emergence of additional variants or other unforeseen risks reduce the protections afforded by the current approach, additional targeted measures can be quickly put in place through a Public Health Direction if needed.

Summary of amendments

Amendment	Type and description		Rationale
Requirements for visitors, volunteers, and students			
Provide that the requirements of the Direction apply to a visitor, volunteer or student as distinct from a worker.	Technical	Simplify and streamline visitor and worker requirements.	The requirements for workers will be removed and consolidated into the *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction.* Visitors, volunteers and students continue to be required to meet entry, vaccination and visitor limit requirements (as per current Directions). Provisions for students have been retained in the individual Directions for settings to assist with ease of understanding and compliance for the sector. Requirements for volunteers and students at aged care facilities have been updated as per the *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction.*
Provide entry requirements for visitors and additional requirements set by the operator of the hospital in limited circumstances.	Policy	Ensure consistency and least restrictive application of visitor limits across hospitals and vulnerable facilities. Aligns with the revocation of *Queensland COVID-19 Restricted Areas Direction.*	Visitors are critical in supporting the wellbeing of patients in hospital and providing family and social connectedness. The current Direction provides for visitor limits per setting within the hospital in the context of widespread community transmission throughout Queensland. Following reports that some hospitals are applying more restrictive visitor limits, the updated Direction clarifies that the current limits are considered reasonably necessary and that more restrictive limits should only be applied when responding to a local emergency or outbreak – any additional restrictions should be the least restrictive required to respond to the situation. Further, clarification that visitor limits apply at a particular time (i.e. there can be multiple visitors attend during a single visitor session as long as maximum visitor limits at any time are not exceeded) is provided. Further, the revocation of the *Queensland COVID-19 Restricted Areas Direction* removes a higher order lever to rapidly impose additional restrictions. If the epidemiological situation evolves and additional restrictions are necessary, this inclusion makes the allowance for immediate action explicit.
Provide that women are permitted to be accompanied by partner or one support person for antenatal appointments	Policy	Consistent with the intent to have proportionate measures that match current risk levels	The updated Hospital Visitor Entry Direction includes an amendment that specifies women are permitted to be accompanied by partner or one support person for antenatal and postnatal appointments. A second support person may be permitted in exceptional circumstances and must be arranged with the clinic prior to the appointment. This amendment has been made in recognition of the important emotional and mental wellbeing a support person plays during these appointments. A diagnosed

Amendment	Type and description		Rationale
			person may not accompany a woman for antenatal and postnatal appointments, as it is highly likely onward transmission will occur to vulnerable cohorts, including pregnant women or newborns. Such provision directly impacts the wellbeing of these cohorts and may deter mothers against attending antenatal and postnatal appointments and lead to avoidable complications.
Distinguish between volunteers who volunteer under a hospital's program and those who volunteer through a different organisation.	Technical	Consistent with the *Workers in Healthcare Setting (COVID-19 Vaccination Requirements) Direction (No. 4).*	To remove any doubt, the updated Directions specify that a volunteer directly engaged by a hospital or vulnerable facility must comply with staff vaccination requirements as per the *Workers in Healthcare Setting (COVID-19 Vaccination Requirements) Direction (No. 4).* This is to ensure consistency across Volunteers through a different organisation that has arranged with a hospital are subject to the same vaccination requirements as visitors.
Provide that an international arrival must not enter or remain in a hospital within 14 days of their arrival in Australia.	Technical	Consistent with the requirements of the *Quarantine for International Arrivals Direction.*	Consistency across Directions allows for increased clarity and simplification for audience comprehension. The intent of this policy is to ensure that, despite no quarantine period being required for international arrivals, they do not enter a vulnerable facility with a potential infection during the critical 14-day period after their arrival.
Provide that a visitor who is a diagnosed person or close contact must not for 7 days after isolation or quarantine, enter and remain in a hospital other than for specific conditions.	Technical	Consistent with the requirements of *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction.*	Consistency across Directions allows for increased clarity and simplification for audience comprehension. The intent of this policy is to ensure that despite a person completing the minimum required period of isolation and quarantine, they do not enter a vulnerable facility within the critical 14-day period after infection or exposure, where transmission could still occur.
Requirements for staff			
Introduce and define requirement for Residential Aged Care Workers to be 'up to date' with COVID-19 vaccination.	Policy	In accordance with expert advice and national agreement.	Queensland's public health response is adapting, with widespread and sustained COVID-19 transmission. There remains a need to protect the most vulnerable from the risks posed by COVID-19. Vaccination requirements for workers entering healthcare settings, including residential aged care and disability accommodation services, remain in place. Updating the vaccination requirement for aged care workers from being 'fully vaccinated' to being 'up to date' in their vaccination schedule and having a third 'booster' dose of COVID-9 vaccine within a specified time period is in accordance with ATAGI advice, AHPPC recommendation and agreement at National Cabinet,

Amendment	Type and description		Rationale
			and will protect vulnerable residents at significant risk of severe disease and death from COVID-19 and support the aged care workforce and service sustainability. Defining the vaccination standard as 'up to date' and making explicit that booster doses must continue to be received within the recommended dosing interval accommodates any further changes to the recommended schedule and makes explicit the requirement to comply with any further updates to the schedule as the pandemic continues. This ensures that this critical workforce and by extension the vulnerable people in their care are afforded the maximum level of protection against infection and transmission going forward.
Inclusion of worker and other requirements previously in *Residential Aged Care Direction* and *Disability Accommodation Services Direction* including co-location, workforce management and personal protective equipment	Technical	Simplify and streamline visitor and worker requirements.	The intent of consolidating worker requirements from the *Hospital Visitor Entry Direction, Residential Aged Care Direction* and *Disability Accommodation Services Direction* into the *Workers in a healthcare setting (COVID-19 Vaccination Requirements)* is to streamline and simplify with a single Direction outlining common requirements for workers across all healthcare settings, including hospitals, residential aged care and disability accommodation services.
Refine definitions, including facility and up to date vaccination	Technical	Definitions updated and refined to reflect the additional requirements	To provide clarity as to Queensland's definition of an 'up to date' in their vaccination schedule.
Amend the critical support needs provision to reflect testing of a worker every second day instead of every day	Policy	Aligns with requirements for Critically Essential Workers under the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction (No. 5).*	It is important that critical support workers who must enter a vulnerable facility for the health and wellbeing of residents, who do not meet vaccination requirements do not pose an additional risk, and they must currently comply with additional testing requirements to mitigate the risk to residents. Testing requirements have been revised to every other day instead of every day. This is consistent with infection prevention and control advice is that as an appropriate interval between testing to mitigate risk, particularly where the person is not a close contact, and is a less restrictive option than daily testing. It also aligns with requirements for other critical cohorts including Critically Essential Workers who are leaving quarantine to attend the workplace. Where a person is symptomatic, they must isolate and be tested immediately and may not attend the facility.

Amendment	Type and description		Rationale
Other			
Removal of any reference to 'restricted areas'	Policy	Consistent with the revocation of *Queensland COVID-19 Restricted Areas Direction*	Queensland's public health response has shifted from elimination to suppression towards living with COVID-19. Restricted Areas were introduced at a time when elimination was a critical element of our response. However, with ongoing community COVID-19 transmission and a shift in the public health response, management of the virus at an LGA level is no longer appropriate. This is evidenced though this Direction not being leveraged during the recent Omicron wave. Therefore, it is appropriate the *Queensland COVID-19 Restricted Areas Direction* be revoked at this time, with additional protective measures still in place for the affected facilities.
Aligning the *Residential Aged Care* and *Disability Accommodation Services Directions* in terms of consistency and layout	Technical	-	Consistency across Directions allows for increased clarity and simplification for audience comprehension.
Removal of reference to *Movement and Gathering Direction*	Technical	Aligns with the revocation of *Movement and Gathering Direction*	This Direction was revoked as part of a raft of eased restrictions that came into effect on 4 March 2022, including removal of restrictions on gatherings in private homes.
Removal of any worker's obligations and placing these requirements within the *Worker's in a Healthcare setting Direction*	Technical	Simplify and streamline visitor and worker requirements.	To streamline requirements for healthcare workers, requirements for staff in vulnerable facilities will be specified in the *Workers in a Healthcare Setting Direction.*
Removal of concepts such as co-location and emergency entry	Technical	Aligns with the revocation of *Queensland COVID-19 Restricted Areas Direction.*	Requirements for co-location and emergency entry referred to staff from Restricted Areas. As this concept has now been removed, so has have these provisions. Where applicable, they will be reflected in the Workers *in a Healthcare Setting Direction.*

Public Health Directions – Human Rights Assessment
Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 4)

Title	*Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 4)*
Date effective	8 March 2022

Background

The *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 4)* (Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the Direction is to set out the COVID-19 vaccination requirements and related obligations for workers, their employers and responsible persons in healthcare settings, as a means of containing and responding to the spread of COVID-19, particularly within a higher-risk or vulnerable setting. The Direction applies broadly, to anyone who enters, works in, or provides services in healthcare settings, with limited exceptions.

The Direction gives effect to the agreed Australian Health Protection Principal Committee (AHPPC) position recommending mandatory vaccination for workers in a range of public and private health care settings and complements existing mandatory vaccination requirements.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the Direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

Widespread COVID-19 transmission in health care settings can significantly impact the healthcare workforce due to a large number of exposed (or potentially exposed) workers and has the potential for significant adverse effects for vulnerable patients and clients accessing healthcare settings. Staff may not be able to attend work because they are confirmed cases or close contacts and may be directed not to attend work because they have (or potentially have) had unprotected exposure to COVID-19.

The Queensland COVID-19 Vaccine Plan to Unite Families outlined the opening of Queensland's borders, and changes to domestic and international quarantine requirements when 70%, 80% and 90% of the eligible Queensland population were fully vaccinated. With increased movement of people into Queensland from interstate and overseas, the need for an available workforce within healthcare settings significantly increased. Protecting the public, staff and patients by mandating the vaccination of workers who enter, work in, or provide services in a healthcare setting is necessary.

Mandatory vaccination can help reduce the impact to the health system capacity and reduce risk of exposure to staff, patients and clients at the healthcare setting.
The Direction will prohibit workers in healthcare from entering, working in, performing duties or providing services in a healthcare setting unless they meet the mandatory COVID-19 vaccination requirements. There are limited exceptions and where these apply the unvaccinated worker must use PPE and undertake a COVID-19 test result before starting their shift.

The *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No.4)* (the Direction) revokes and replaces the *Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No3)* from time of publication.

The Direction has been amended to include:

- Workers' vaccination requirements for residential aged care workers;
- Co-location requirements in relation to a healthcare setting;
- Workforce management and personal protective equipment requirements for residential aged care and shared disability accommodation services; and
- Updates to definitions.

As a result of the changes, vaccination requirements for workers in healthcare settings, including hospitals, residential aged care and disability accommodation services, are now consolidated into one direction. Requirements for visitors, students undertaking placements at hospital, residential aged care facility or a disability accommodation service, and volunteers engaged by a third party organisation remain in separate visitor entry directions for each setting.

How the Direction Achieves the Purpose

Outlining the vaccination requirements for workers in healthcare settings will help reduce the impacts on individuals, particularly vulnerable healthcare consumers.

The Direction achieves this purpose through establishing vaccination requirements for all workers in healthcare that enter, work in or provide services in a healthcare setting including:

- must be fully vaccinated;
- for residential aged care workers, this includes being 'up-to-date' with their vaccinations. This means that workers' will need to have received their two vaccinations plus their booster shot;
- providing evidence of complying with the COVID-19 vaccination requirements to their employer, where applicable and to the responsible person for the healthcare setting;
- providing exceptions to the mandatory vaccination requirements where:
    - the worker is unable to be vaccinated due to a medical contraindication and the responsible person for the healthcare setting assesses the risk and allows the person to continue working with PPE and COVID-19 testing prior to commencement of each shift; or
    - the worker is a participant in a COVID-19 vaccine trial; or
      an unvaccinated person is required to enter the healthcare setting for an emergency response; or
    - an unvaccinated support person is required to enter and remain at a healthcare setting to provide critical support to a patient, client or person with a disability, if the responsible person assesses the risk and allows the person to enter the facility subject to PPE and COVID-19 testing requirements; or

- to meet critical workforce shortages for a short period of up to 3 months to allow time to address the critical workforce shortage based on a risk assessment by the responsible person. PPE and pre-shift testing requirements apply or
- a worker in healthcare is required to enter and remain at a healthcare setting in their personal or private capacity, provided they comply with all other public health directions applicable to entering a healthcare setting.

The Direction recognises exemptions provided by the Queensland Health Employment Directive 12/21. Only limited exceptions to the vaccination requirements are provided.

Human Rights Engaged

The human rights engaged by the Direction are:

- Right to life (section 16)
- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c))
- Freedom of movement (section 19)
- Freedom of thought, conscience, religion, and belief (section 20)
- Freedom of expression (section 21)
- Peaceful assembly and freedom of association (section 22)
- Right to privacy (section 25)
- Right to education (section 36)

- Right to life (section 16): The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a public health emergency. Under international law, this right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights. The Direction promotes the right to life by protecting the health, safety and wellbeing of vulnerable Queenslanders through placing vaccination requirements on workers entering and working in a healthcare setting.

- Right not to be subjected to medical treatment without full, free and informed consent (section 17(c)): Section 17(c) of the Human Rights Act provides that a person must not be subject to medical treatment without the person's full, free and informed consent.

  Medical treatment for the purposes of section 17(c) includes administering a drug for the purposes of treatment or prevention of disease. Administering a nasal swab test to check for the presence or absence of COVID-19 also amounts to medical treatment. This right includes treatment of any kind, even if the treatment benefits the person (*Kracke v Mental Health Review Board* (2009 29 VAR 1, 123 [576]).

  This right is engaged as the direction limits the practical choice available to a worker in healthcare whether or not to agree to the treatment by preventing them from attending their workplace unless they meet the COVID-19 vaccination requirements or the Health Employment Directive 12/21 (HED) for a cohort of workers. Limited exceptions apply where a person has a medical contraindication, where the person is a participant in a COVID-19 vaccine clinical trial; to provide critical support needs to a patient, client or person with a disability; respond to a critical workforce shortage; for an emergency response for patients; or to enter in their personal or private capacity; or for purposes of law enforcement. A worker in healthcare who is unable to be vaccinated due to a recognised medical contraindication, evidenced by a medical certificate, should be deployed or work from an alternative location if possible. Unvaccinated persons who are continuing to work in the healthcare setting due to medical contraindication, or to respond to a critical workforce shortage must be permitted to do so by the responsible person for the healthcare setting, based on a risk assessment. The person must use PPE and undertake a COVID-19 test prior to the commencement of each shift. If a COVID-19 PCR

test is used, the results must be provided to the employer on a rolling basis when the results are received. Where a Rapid Antigen Test is used, the test must be undertaken and a negative test result received before the worker starts the shift.

The COVID-19 test engages this human right. However, the Direction does not limit the holding of a belief or opinion about COVID-19 or testing or vaccination for COVID-19.

- Freedom of movement (section 19): Section 19 of the Human Rights Act provides that every person lawfully within Queensland has the right to move freely within Queensland, to enter and leave it and has the freedom to choose where to live. The right means that a person cannot be arbitrarily forced to remain in, or move to or from, a particular place. The right also includes the freedom to choose where to live, and freedom from physical and procedural barriers, like requiring permission before entering a public park or participating in a public demonstration in a public place. The right may be engaged where a public entity actively curtails a person's freedom of movement. The Direction may limit the right to freedom of movement by preventing workers in healthcare from working at a specified healthcare facility that is their usual place of work. The amendments to the direction place stricter obligations on workers in a residential aged care facility, and requires them to receive a booster shot to be considered 'up-to-date' with their vaccination. Workers in residential aged care facilities who do not receive this booster shot within the appropriate timeframe will be unable to work in an aged care facility. Therefore, their freedom of movement is restricted by not allowing them to attend their workplace.

- Whilst the direction enforces this stricter obligation the direction also eases the limit for freedom of movement for those who are subject to surveillance testing requirements because the testing options now allow for RAT which has less physical and procedural barriers associated with PCR tests.

- Freedom of thought and conscience (section 20) and freedom of expression (section 21): Section 20 of the Human Rights Act provides that a person has the right to freedom of thought, conscience, religion and belief. The right to hold a belief without interference is an absolute right however limits on how a person manifests their belief can be justified (*Christian Youth Camps v Cobaw Community Health Service* (2014) 50 VR 256, 395 [537]). Section 21 of the Human Rights Act provides that the right to freedom of expression includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be expressed in various ways, including in writing, through art, or orally. The Direction engages this right by requiring workers in healthcare who enter, work in or provide services at healthcare settings to be vaccinated. Workers in healthcare who have a conscientious objection to this requirement will not be permitted to enter, work in or provide services at a healthcare setting if they choose to remain unvaccinated. An exception applies for a medical contraindication; or where the person is a participant in a COVID-19 vaccine clinical trial; or to provide critical support to a patient, client or person with a disability; or for the short period allowed to respond to critical workforce shortages; or to enter in their private or personal capacity; or to enter for the purposes of law enforcement.

- Peaceful assembly and freedom of association (section 22): Section 22 of the Human Rights Act upholds the rights of individuals to gather in order to exchange, give or receive information, to express views or conduct a protest or demonstration. The Direction may limit the right to peaceful assembly as it restricts workers in healthcare from entering a healthcare setting, which in turn may prevent groups gathering together for a common purpose/interest. The Direction reduces this limitation by providing testing options allowing healthcare workers to enter a healthcare setting once a negative test result is returned, which in turn may allow groups to gather together sooner, for a common purpose/interest.

- Privacy (section 25): The right to privacy in section 25 of the Human Rights Act is broadly construed. A person has the right to not have their privacy, family or home arbitrarily interfered with. The right encompasses an individual's rights to establish and develop meaningful social relations (*Kracke v Mental Health Review Board* (General) (2009 29 VAR 1, [619]-[620]).

  The right to privacy may also incorporate a right to work of some kind and in some circumstances (*ZZ v Secretary, Department of Justice* [2013] VSC 267, [72]-[95] (Bell J)). The Direction may limit a person's right to privacy by making a worker in healthcare provide personal details about their vaccination status to their employer or the responsible person of a healthcare facility.

  The right to privacy also protects the freedom of a person not to be subjected to physical interference, including medical treatment, without consent (*PBU v Mental Health Tribunal* (2018) 56 VR 141, 180-1 [128]). Involuntary medical treatment has been held to amount to interference with the right to respect for personal life which includes a person's physical and psychological integrity (*Solomakhin v Ukraine* (European Court of Human Rights, Fifth Section, Application No 24429/03, 15 March 2012) [33]). The Direction engages this right by requiring all workers in healthcare entering, working in or providing services to be fully vaccinated irrespective of the instrument that applies and by requiring regular COVID-19 testing for unvaccinated workers who continue to enter, work in or provide services in a healthcare setting. The right is further engaged by the Direction for workers in residential aged care, who will now be required to keep their vaccination status up to date with booster doses.

- Right to education (section 36): Section 36 of the Human Rights Act provides that every person has the right to have access, based on their abilities, to equally accessible further vocational education and training. The right to education is intended to be interpreted in line with the *Education (General Provisions) Act 2006* and to provide rights in relation to aspects of Queensland's responsibilities for education service delivery. Internationally, this right has been interpreted as requiring that education be accessible to all individuals without discrimination. The Direction does not provide any greater limitation on students for their placements than already exist within other public health directions.

Compatibility with Human Rights

The direction will be compatible with human rights if the limits it imposes are reasonable and justified.

A limit on a human right will be reasonable and justified if:
- It is imposed under law (section 13(1));
- After considering the nature of the human rights at stake (section 13(2)(a));
- It actually helps to achieve that purpose (section 13(2)(b));
- There is no less restrictive way of achieving that purpose (section 13(2)(d)); and
- It strikes a fair balance between the need to achieve the purpose and the impact on human rights (section 13(2)(e), (f) and (g)).

Are the limits imposed 'under law'? (section 13(1))

The Chief Health Officer is authorised to give the proposed direction under section 362B of the *Public Health Act* if they reasonably believe the direction is necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The nature of the rights that would be limited (section 13(2)(a))

The limits on the above human rights arise from:

1. Restricting who can enter a healthcare setting;
2. Requiring vaccination, including a booster dose for residential aged care workers, notification of vaccination and record keeping in relation to workers in healthcare who work in a healthcare setting;
3. Requiring the use of PPE and pre-shift COVID-19 testing by unvaccinated workers in healthcare who are permitted to enter, work or provide services in a healthcare setting;
4. Providing a public health officer (public health) with discretion to issue additional directions to a worker in healthcare, their employer or the responsible person of a healthcare setting.

Proper purpose (section 13(2)(b))

The purpose of these limitations is to reduce the risk of COVID-19 cases spreading to vulnerable people in healthcare settings and to ensure that there is an adequate health workforce available to respond to the expected increase in COVID-19 cases requiring hospitalisation following relaxation of border entry and quarantine restrictions. The Direction is in effect for a temporary period, and the restrictions on who may work, enter or provide services in a healthcare setting.

These purposes of protecting public health are proper purposes. Vaccines protect the community as a whole, by increasing the overall immunity in the community to reduce the spread of vaccine-preventable diseases. Protecting public health is clearly a legitimate objective (*Boffa v San Marino* (1998) 92 Eur Comm HR 27). Vaccines also protect vaccinated individuals by immunising them from the relevant disease.

Moreover, protecting people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

A purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

Reducing and containing the spread of COVID-19 within the community is achieved by the Direction. As COVID-19 is a communicable disease that may be easily transmitted between people and given the direct risk to the lives and health of others posed by a person who has been diagnosed with COVID-19, this purpose can only be achieved by setting out vaccination requirements for workers in healthcare at healthcare settings.

The requirement for workers in healthcare to be vaccinated to work in a healthcare setting, and for unvaccinated workers in healthcare settings to wear PPE and to undertake a COVID-19 test before starting each shift is targeted at managing the potential risk of transmission to

patients, clients and other healthcare workers. Vaccination also protects individuals and the community, from the spread of COVID-19 and maintains an available workforce in healthcare settings. Where required, booster doses ensure that a person's immunity through vaccination is maintained to reduce adverse outcomes from infection, reduce transmission and reduce the likelihood of catching COVID-19.

Necessary (s 13(2)(d))

The purpose of the Direction cannot be achieved through any reasonably available and less restrictive means. COVID-19 is a communicable disease demonstrated to be highly transmittable between people. Vaccination has been proven to slow the transmission of COVID-19, particularly to vulnerable persons who may develop complications or otherwise require emergency or life-sustaining treatment. Vaccination achieves this purpose as it significantly reduces the adverse impacts of COVID-19 and may reduce transmission. This purpose is also achieved by setting out vaccination requirements for workers in healthcare at healthcare settings.

The limits on human rights are necessary given the immediate and direct risk to the lives and health of others posed by a person who has been diagnosed with COVID-19. There is no other way to address the risk of transmissibility from a COVID-19 positive person.

Workers in healthcare who provide services in a healthcare setting are a critical workforce, necessary to ensure continuity of care for our community. Requiring vaccination of this workforce protects both the worker and their patients or clients in the healthcare setting from experiencing adverse outcomes from COVID-19 transmission. Limited exceptions have been included to manage critical workforce impacts, respond to emergencies, recognise medical contraindications, recognise participation in a COVID-19 vaccine trial and enable critical support to be administered to disabled patients and clients.

The exemptions for participation in a COVID-19 clinical trial and medical contraindication do not apply to a student undertaking an education placement. This is because they are not yet a part of a critical workforce. Furthermore, participation in a COVID-19 clinical trial and medical contraindications are generally temporary, and therefore, they could defer their placement until such time as they are no longer participating in a trial or no longer have a medical contraindication.

The requirements to wear appropriate PPE and undertake COVID-19 testing before a shift is a necessary measure to manage the risk of transmission of COVID-19. It will also assist in reducing the 'close contact' between staff, visitors and residents and potential transmission of the virus.

Similarly, providing a public health officer the ability to issue additional directions to a worker in a healthcare setting, their employer and the responsible person for the healthcare setting will enable any localised issues in specific healthcare settings to be addressed rapidly. The power for public health officers to issue directions to specified healthcare facilities contains appropriate internal limitations. Directions can only be issued if the public health officer considers it to be reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community.

The right to privacy is subject to an internal limitation in that it applies only to interferences with privacy that are 'unlawful' or 'arbitrary'. This internal limitation may apply where the

Direction authorises restrictions on movement pursuant to a lawful direction based on a reasonable belief that the restriction is necessary to assist in containing or responding to the spread of COVID-19 within the community.

Fair balance (section 13(2)(e), (f) and (g))

The purpose of the Direction is to reduce the spread of COVID-19 within the community and protect the most vulnerable people within the community.

The emergence of the Omicron variant has accelerated the anticipated shift in Queensland's public health response from elimination, to active suppression during the first wave and now a move into a phase of managing ongoing but temporarily stable transmission of COVID-19. This has resulted relaxation of restrictions in some settings, while restrictions have been retained for higher-risk settings where there is greater risk of transmission or adverse outcomes.

The limitation on the right to freedom of movement may be justified for the purpose of preventing the spread of COVID-19 within healthcare settings in Queensland. The limitation on the right of freedom of movement and freedom of association does not deny people to enter, work in, or provide services in a healthcare setting, but sets out the COVID-19 vaccination requirements. With requirements for unvaccinated healthcare workers to undertake regular testing prior to their shift as an alternative to excluding them from the workplace entirely, the limitations on the right to freedom of movement and freedom of association are reduced, balancing the rights of the healthcare worker with the need to maintain continuity of care and protection of the community from COVID-19 transmission.

The requirement for workers in healthcare setting to be fully vaccinated provides an additional layer of protection for vulnerable members of our community.

With widespread community transmission there is an increase in the likelihood of COVID-19 being transmitted into our healthcare settings; this risk must be addressed through limiting the number of opportunities for this to occur. There is already an increased risk that staff may transmit COVID-19 as they move in and out of healthcare settings on a daily basis. However, the measures in the direction are considered to provide a fair balance between individual rights and the public health risk, particularly given the need to maintain worker presence in the healthcare setting to ensure continuity of patient and resident care.

The impact on some human rights will be large. However, the importance of limiting the spread of COVID-19 into Queensland (taking into account the right to life) and reducing the impacts on individuals and the health system outweighs the impact on other human rights. Indeed, it is difficult to overstate the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading further into the health system.

However, the extent of the limitation on human rights is also reduced by the following factors:

- there are exceptions to the requirement for mandatory vaccination for a worker in healthcare who enters, works in, or provides services in a healthcare setting. These exceptions balance the individual's rights, the need to maintain continuity of care and protection of the community from COVID-19 transmission
- overseas vaccination is recognised where the vaccination is WHO-COVAX endorsed.

Overall, the limitations on human rights are reasonable and demonstrably justifiable, as the Direction is only in force for a temporary period for the duration of the pandemic or until

revoked as no longer reasonably necessary to respond to COVID-19, and will help contain the spread of COVID-19, thereby protecting the health and safety of the community. The health benefits to the broader community by implementing the Direction outweighs any potential limitation on the person's right to freedom of movement, freedom of association and protection of families.

Queensland Health

COVID-19 Public Health Rationale

Protecting Queenslanders as We Plan to Unite Families at 90%
- domestic travel arrangements

14 January 2022

DRAFT NOT GOVERNMENT POLICY

Summary

This document should be read in conjunction with the Protecting Queenslanders as We Plan to Unite Families at 80 % - domestic and international arrivals travel arrangements rationale.

Queensland's response to COVID-19 to date has successfully balanced the need to provide maximum protection to Queenslanders and the capacity of the Queensland health system and minimising social and economic disruption according to the level of risk at any point in time.

Queensland's COVID-19 Vaccine Plan to Unite Families – A Plan for Queensland's Borders (the Vaccine Plan), announced on 18 October 2021, works within this same principle. There are now highly effective and safe vaccines for COVID-19 and as Queensland reaches target vaccination coverage thresholds across its eligible population, the risk to the community and the health system is significantly reduced.

New home quarantine arrangements commenced on 15 November 2021 for fully vaccinated domestic arrivals entering Queensland from a COVID-19 hotspot. These new arrangements provided greater certainty about when these travellers can enter Queensland and more flexible provisions on mandatory quarantine that minimise the social, emotional and financial impacts of border restrictions on individuals.

The easing of border restrictions and quarantine requirements at the 80 per cent fully vaccinated milestone commenced on 13 December 2021 and removed quarantine requirements for all fully vaccinated travellers entering Queensland from COVID-19 hotspots and provides for fully vaccinated international travellers to home quarantine. These further relaxations provided a significant boost to consumer demand and workforce supply to the most impacted industries and greater certainty and improved conditions to the social and emotional wellbeing of eligible travellers seeking to enter Queensland.

At 90 per cent fully vaccinated, consistent with Australia's national transition to 'living with COVID' and as outlined in the Queensland Vaccine Plan to Unite Families, further changes to border restrictions are proposed.

Initially, all border restrictions were planned to commence when Queensland reached 90 per cent fully vaccinated. However, on 13 January 2022 the Premier announced changes for domestic travellers would commence from 1am 15 January 2022.

In the context of Queensland experiencing widespread community transmission, Queensland's fully vaccinated rate of over 88 per cent and the probability that anyone travelling domestically could have COVID-19, it is considered that the risk of COVID-19 incursion from cross border movement has lowered. Given this reduced risk, and the required regulatory and compliance overlay to enforce requirements, commencing domestic traveller changes earlier than planned is considered appropriate.

Changes to international traveller arrangements will come into effect following Queensland reaching 90 per cent fully vaccinated, projected to occur later this month.

From 1am 15 January 2022, there will be no requirements for domestic travellers entering Queensland, regardless of vaccination status. Queensland's Public Health and Social Measures will continue to apply beyond Queensland reaching 90 per cent fully vaccinated. These measures restrict who can access high-risk settings to ensure that only fully vaccinated people are entering those settings where the potential for COVID-19 transmission is greater and will continue to be an important strategy for limiting community spread.

To give effect to the proposed changes for domestic travellers, a number of Chief Health Officer Public Health Directions (Directions) and Protocols that set out entry and quarantine requirements for domestic travellers to

Queensland will be revoked, while others require amendment. Of note is the revocation of the *Border Restrictions Direction (No. 60)*. An overview of the required changes is provided in Table 1.

Existing Class Exemptions providing exemption to domestic traveller requirements will cease to have effect upon the revocation of the relevant Direction or Protocol, and therefore are not required to be revoked formally.

Revocation of the *Border Restrictions Direction (No.60)* will also provide for the early release of domestic travellers and others in home quarantine from 1am 15 January 2022 when quarantine is no longer required.

Amendments to the *Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction (No. 3)* will be progressed separately as the required updates extend beyond domestic traveller requirements.

This rationale outlines the changes to domestic traveller requirements commencing from 15 January 2021. Changes to international traveller requirements will be progressed separately.

Background and rationale at 14 January 2022

In line with Queensland's COVID-19 Vaccine Plan to Unite Families (the Vaccine Plan to Unite Families), Queensland has been gradually easing its border restrictions for interstate and overseas arrivals from November 2021 as certain vaccination milestones have been achieved. This reopening has coincided with the emergence of the Omicron variant of concern (Omicron) and prompted a significant shift in the epidemiological situation in Queensland in recent weeks with widespread community transmission.

Queensland has reported over 175,000 cases since the reopening of Queensland's domestic and international borders on 13 December last year. 119,777 of these cases have been reported in the last week. As at 14 January 2022, 23,630 new cases were reported in the previous 24 hours, including 10,182 positive rapid antigen test results.

While Queensland is experiencing widespread community transmission, this is occurring within a highly vaccinated population (91.41 per cent single dose, 88.35 per double dose as at 12 January 2021).

Although preliminary evidence on Omicron suggests that the risk of severe outcomes at the population level is lower than posed by the Delta variant of concern, due to its high rate of transmissibility, Omicron has spread among the Queensland community at a pace that was not foreseen during previous Delta focused planning. This pace of spread is also being experienced nationally and globally.

The World Health Organization (WHO) continues to reinforce the primary role of vaccines in fighting COVID-19 however, notes that to protect health system capacity and prevent uncontrolled spread, there will be a need to continue with additional protections such as wearing of masks, physical distancing, hand hygiene and ventilation for some time to come, and especially in the face of Omicron.

It is apparent that Omicron infects even people who are vaccinated. Early evidence suggests that even if Omicron is milder and that vaccinations continue to help prevent severe disease, with the current rate of growth, the increase in hospital admissions has the potential to be extreme and could exceed health system capacity.

Queensland Health has been undertaking scenario planning since 2020 for a COVID-19 outbreak of the magnitude that Queensland is expected to experience in the coming weeks and have mechanisms in place that are constantly revised and fine-tuned as circumstances change to respond to imminent threats and ensure the health of Queenslanders.

On 13 January 2022, National Cabinet met to discuss the response to COVID-19 and the Omicron variant, and reaffirmed the National Plan to Transition Australia's National COVID-19 Response and continue work to suppress the virus under Phase C of the National Plan - seeking to minimise serious illness, hospitalisation and fatalities as a result of COVID-19 with baseline restrictions.

In line with National Cabinet's position, Queensland will continue to ease border restrictions as outlined in the Queensland Vaccine Plan to Unite Families.

Domestic travel arrangements at 80 per cent fully vaccinated

Restrictions around international and interstate borders, including quarantine requirements, have been critical to Queensland's success to date in avoiding widespread community transmission and providing access to vaccines.

However, these protective measures have had an extensive impact on individuals and critical sectors of the Queensland economy, such as the tourism, hospitality, international students, and agricultural industries. The social and economic pressures this has created on Queensland's communities cannot be sustained indefinitely without placing a significant burden on the health and wellbeing of individuals and the economic sustainability of entire communities.

The *Border Restrictions Direction (No.60)* and supporting instruments provide the parameters for the arrival of eligible domestic travellers, and the conditions required to be met while undertaking quarantine when required to do so, to ensure they enter the community in a safe way.

Currently, anyone arriving from a COVID-19 hotspot who is fully vaccinated and has a negative COVID-19 test in the 72 hours prior to arrival in Queensland can enter Queensland without the need to quarantine. Unvaccinated travellers must meet requirements for entry and are required to undertake hotel quarantine for a period of 14 days.

Additional provisions have been made for Border Zone communities to enable a balanced approach between minimising the risk of virus incursion from these communities, while providing greater flexibility for New South Wales Border Zone residents and Queensland Border Zone residents with work, family and social ties in these areas to resume their normal lives.

The *Border Restrictions Direction* also operates in conjunction with a number of industry-specific protocols that outline operational requirements for people providing essential services, such as for maritime crew, disaster management workers and freight operators. This approach has supported Queensland's pandemic response key principle of ensuring maximum protection against the risk of widespread outbreaks, while minimising social and economic disruption.

The Border Restrictions Direction also makes provision for specialist and essential workers to support the continuity of services.

A range of Class Exemptions have also been approved by the Chief Health Officer, exempting specific industries / businesses from the requirements of the *Border Restrictions Direction* to continue business operations in a COVID safe manner.

Changes to domestic travel arrangements from 15 January 2021 (prior to 90 per cent fully vaccinated)

Earlier versions of the approved Queensland Vaccine Plan to Unite Families noted that at 90 per cent fully vaccinated, unvaccinated domestic travellers would be subject to requirements for entry and required to undertake a period of quarantine.

Border restrictions were imposed when there were low levels of community transmission, meaning unvaccinated arrivals were more likely to bring COVID-19 into Queensland and require healthcare, therefore placing a burden on Queensland's health system.

As school holidays come to an end, movement into Queensland for recreational purposes such as holidaying or visiting family will considerably decrease and most cross-border movement will be returning-Queenslanders. As a result, the risk of these unvaccinated arrivals meaningfully impacting the health system is low.

Given the shift in risk, all entry requirements will be removed for domestic travellers entering Queensland, regardless of vaccination status, from 1am 15 January 2022. This means anyone arriving from another Australian State or Territory who has not been overseas in the previous 14 days can enter Queensland without being tested, completing a border pass, or entering quarantine.

This change also reduces regulatory and compliance overlay burden, freeing up critical resources to enhance the capacity of the health system to manage positive cases, allow police to return to policing, and permits health staff involved in border compliance (e.g. hotel quarantine, exemptions) to be redirected to other parts of the COVID-19 response.

To demonstrate the extent and level of activity in relation to current entry requirements (domestic and international), as at 14 January 2022:

- 5,544 people are subject to a quarantine direction (3,646 in home quarantine, 1,713 in government hotel quarantine and 185 in alternate quarantine)
- Over 1.3 million travel declarations since 17 June 2021, with 14,310 received in the last 7 days
- Over 2.7 million border passes since 17 June 2021, with 258,406 requested in the last 7 days.

As noted above, existing Public Health and Social Measures (PHSM) will continue and as such unvaccinated arrivals will not be permitted to enter high-risk settings, mitigating the risks of becoming infected or infecting others. This also reflects that it will be more important to manage what people do and where they go when in Queensland, rather than where they arrive from.

Changed domestic traveller requirements will bring Queensland in line with the approach taken by New South Wales, Victoria, Australian Capital Territory and South Australia (refer to Table 2 for jurisdictional comparison).

Early release of domestic travellers from quarantine

From 1am 15 January 2022, quarantine is no longer required for domestic travellers.

To ensure the least restrictive approach to people's movement, it is proposed that a domestic traveller or a person who is required to quarantine under the *Home Quarantine for Household Members of a Domestic Traveller from a COVID-19 hotspot Direction*, is released from quarantine, potentially before their quarantine period has finished.

Quarantine persons have been released early on previous occasions for the same reason without any incidents to date. In this context, the benefit of maximising movement of low risk cohorts outweighs the potential risk to the community.

The relevant Public Health Unit will manage the release of these individuals, and where the individual is in hotel quarantine, their departure will be scheduled to not compromise infection control process.

Revocation / amendment of Chief Health Officer Public Health Directions and Protocols

As noted above, to give effect to changes for domestic travellers at 90 per cent fully vaccinated, the following Chief Health Officer Public Health Directions (Directions) and Protocols that set out entry and quarantine requirements for domestic travellers to Queensland will be revoked:

- *Border Restrictions Direction (No.60)*
- *Queensland Travel Declaration Direction*
- *Interstate Areas of Concern (Vulnerable Facilities) Direction*
- *Interstate Places of Concern (Stay at Home in Queensland) Direction*
- *Declared Interstate Places of Concern Direction*
- *COVID-19 Hotspots and Border Zone Declaration*
- *Operational Protocol for the Movement of Freight*
- *Disaster Management Protocol.*

The following Directions and Protocol will also require minor amendment to remove linkages / references to the Directions or Protocols to be revoked:

- *Quarantine for International Arrivals Direction*
- *Residential Aged Care Direction, Disability Accommodation Services Direction and Hospital Entry Direction*

- *Home Quarantine for Household Members of an Overseas Traveller Direction*
- *Use of Technology to Support Home Quarantine Direction*
- *Mandatory Face Masks Direction*
- *Maritime Protocol*.

Table 1 provides an overview of each Direction, the intent and the required amendment / action.

Consultation

The Queensland Police Service has been consulted and support the removal of entry requirements for domestic travellers from 1am 15 January 2022.

Table 1: Chief Health Officer Public Health Directions and Protocols – to be revoked or amended

Title	Intent	Action required
Border Restrictions Direction (No. 60)	To reduce the risk of COVID-19 transmission into Queensland by specifying the circumstances under which people may enter Queensland from domestic COVID-19 hotspots, the quarantine and associated requirements they must comply with once in Queensland and the circumstances in which people might be exempt from quarantine.	To be revoked.
COVID-19 Hotspots and Border Zone Declaration	To reduce the risk of COVID-19 transmission into Queensland by declaring specific interstate areas with increases risk and case numbers as COVID-19 hotspots. Border zone declarations (restricted and unrestricted) provide a mechanism to allow day to day activities to continue in NSW-Queensland communities (that are in declared hotspots), under certain conditions.	To be revoked.
Queensland Travel Declaration Direction (No. 6)	To collect traveller information and enable a scalable response when an event occurs in another jurisdiction, such as requiring quarantine for affected travellers and undertaking targeted messaging to support contact tracing.	To be revoked.
Declared Interstate Places of Concern Direction (No. 3)	To identify Interstate Places of Concern for the *Public Health Direction – Interstate Places of Concern (Stay at Home in Queensland) Direction* or its successors. A person who had been in a place of concern since the start date identified for the place of concern was required to follow the quarantine (stay at home requirements) in the Interstate Places of Concern Direction until 14 days passed since they were in the place of concern.	To be revoked.
Interstate Places of Concern (Stay at Home in Queensland) Direction (No. 5)	To specify and mandate requirements for persons already in Queensland from a geographic region determined to be a place of concern, typically via declaration of lockdown or other increased restrictions by that jurisdiction, due to community transmission of COVID-19, and applying these from a specified retrospective date.	To be revoked.
Interstate Areas of Concern (Vulnerable Facilities) Direction (No. 2)	To identify interstate areas of concern for the *Aged Care Direction*, the *Disability Accommodation Services Direction*, and the *Hospital Visitors Direction* and preventing people who had been in an interstate area of concern from entering vulnerable facilities.	To be revoked.
Quarantine and COVID-19 Testing for International Air Crew Direction	To specify quarantine and testing requirements for air crew entering Queensland, to continue to reduce the risk of COVID-19 transmission in the community from arrivals entering Queensland.	To be amended – remove references to COVID-19 hotspot and Queensland Border Declaration Pass
Quarantine for International Arrivals Direction (No. 18)	To specify quarantine requirements for persons entering Queensland from overseas and to continue to reduce the risk of COVID-19 transmission in the community from overseas arrivals entering Queensland, while providing appropriate flexibility for certain cohorts to ensure their wellbeing is not unnecessarily impacted by quarantine requirements.	To be amended – remove references to COVID-19 hotspot and Queensland Border Declaration Pass

Title	Intent	Action required
Disability Accommodation Services Direction (No. 26)	To minimise the risk of COVID-19 transmission to disability accommodation services residents while differentiating the risk between those who have been in COVID-19 hotspot and those who have only been in Border Zones prior to entering Queensland and provide for greater access for disability accommodation service residents to engage with the community.	To be amended - refers to definition of Border Zone with BRD. However, reference to this definition should be deleted in its entirety Other changes required to remove rules relating to travellers from a COVID-19 hotspot or interstate exposure venue.
Hospital Entry Direction (No. 7)	To minimise the risk of COVID-19 transmission at hospitals and ensure patient health and wellbeing by setting certain conditions for visitors.	To be amended - Border Restrictions Direction found within document and also referred to in definitions. Border Zone has the same meaning as in BRD - Reference to this definition should be deleted. Other changes required to remove rules relating to travellers from a COVID-19 hotspot or interstate exposure venue.
Residential Aged Care Direction (No. 11)	To minimise the risk of COVID-19 transmission to residential aged care facilities residents, ensure resident health and wellbeing and prescribe workforce and surge planning, personal protective equipment and administrative matters.	To be amended - refers to transit exceptions in paragraph 6 of BRD as well as border zone definition in BRD. Other changes required to remove rules relating to travellers from a COVID-19 hotspot or interstate exposure venue.
Home Quarantine for Household Members of an Overseas Traveller Direction	To establish a requirement to home quarantine and the quarantine conditions for a household member of an overseas traveller completing home quarantine at a nominated residential quarantine premises.	To be amended - BRD mentioned in 'Essential Worker' definition – additional definitions need to be added
Use of Technology to Support Home Quarantine Direction (No.2)	To prevent the spread of COVID-19 and support compliance checks in home quarantine by requiring these people to activate data and precise geo-location services on their mobile phones and comply with text message requests by responding within a given timeframe.	To be amended - BRD mentioned twice – para 5 example 2 and definition of 'nominated residential quarantine premises'
Mandatory Face Masks Direction (No. 2)	To set mask wearing requirements in specific settings and geographical areas to minimised transmission risks during outbreaks in Queensland.	To be amended - BRD mentioned once in example under 'Emergency Officer (public health) definition

Table 2: Jurisdictional comparison of domestic border restrictions (as at 13 January 2022)

	QLD	NSW	VIC	ACT	NT	TAS	SA	WA
Domestic Arrivals								
Testing	Nil	Nil	Nil	Nil	RAT within 2 hours of arrival, on day 3 and on day 6 (provided at the airport).	RAT within 24 hours of arrival or PCR 72 hours prior to arrival.	Nil	Yes - Within 24 hours and on day 12.
Quarantine	Nil	Nil	Nil	Nil	Vaccinated – Nil. Cannot enter high-risk settings for 14 days. Unvaccinated – 14 day hotel quarantine.	Vaccinated – Nil Unvaccinated – 5 to 14 days hotel quarantine.	Nil	14 day hotel quarantine
Border Pass	Not required	Not required	Not required	Not required	Required	Nil	Not required	Required

Policy Rationale – Public Health Face Mask Requirement (all of Queensland) Direction

DRAFT NOT GOVERNMENT POLICY

Summary

Recently, many jurisdictions in Australia and around the world, including Queensland, have shifted from an elimination to a 'suppression' approach to COVID-19. Eventually, COVID-19 will become endemic, and the approach will more towards 'living with COVID-19'.

On 26 November 2021, WHO designated "Omicron" (B.1.1.529) as a new variant of concern. Omicron has now been detected in almost every State and Territory in Australia (excl. WA and TAS). COVID-19 case numbers are doubling every 2-3 days in NSW and are now reaching record highs daily.

On 13 December 2021, Queensland removed quarantine requirements for fully vaccinated travellers entering Queensland from COVID-19 hotspots. Fully vaccinated international travellers may also home quarantine, provided conditions can be met.

Queensland has now reported 62 new cases between 13 and 17 December. At least 36 of these cases involved interstate travel, including some with exposure at venues with known Omicron transmission, and most cases have been infectious in the community. Exposure sites and case locations extend across the State, including South East Queensland as well as Goondiwindi, Cairns and Townsville.

There is an increased potential for outbreaks across Queensland. For this reason, and as a first step, mask wearing requirements in some settings will be reintroduced across Queensland in this iteration of the *Face Mask Restrictions for Impacted Areas (all of Queensland) Direction*. This will serve as an early baseline protective measure to slow the potential for spread. Indoor retail environments are a current area of focus, with concern about high numbers of people in these environments ahead of Christmas. Vulnerable settings are also in scope to, as has been the case throughout the pandemic, to protect vulnerable people and staff in those areas to support continuity of service delivery.

Queenslanders are being strongly encouraged to wear a mask in all other settings, particularly indoors, when physical distancing is not possible or where people mingle for extended periods.

Background and policy rationale as at 17 December 2021

Queensland is gradually shifting from a state-wide emergency response focused on eliminating COVID-19 into a 'living with COVID-19' future. While COVID-19 still has the potential to spread widely through the community, there remains a need for targeted public health measures.

On 26 November 2021, the World Health Organization (WHO) designated "Omicron" (B.1.1.529) as a new variant of concern. Omicron has since been sequenced in 60 countries (5,286 sequenced cases) and reported in an additional 25 countries (21,146 confirmed cases). Omicron is expected to become the dominant strain in many European countries and the UK within weeks.

Omicron has now been detected in almost every State and Territory in Australia (excluding Western Australia and Tasmania).

Evidence about the transmissibility, severity and immune evasion of this variant is accumulating. While it is too early to determine if Omicron produces more severe disease, it is becoming evident that it is highly

transmissible and can evade both naturally acquired and vaccine induced immunity. Early evidence suggests that even if Omicron is milder, the increase in hospital admissions will be exponential, with the potential to quickly overwhelm the health system.

After a period of stabilisation following the Delta outbreak (June 2021) in New South Wales (NSW), COVID-19 case numbers are now doubling every 2-3 days in NSW and reaching record levels daily (2,213 on 17 December; see Figure 1). Much of the recent increase been attributed to Omicron by the NSW Chief Health Officer. More broadly, Australian COVID-19-related hospitalisations are also beginning to increase (see Figure 2) with case numbers increasing in every jurisdiction.

The WHO continues to reinforce the primary role of vaccines in fighting COVID-19 however, notes there will be a need to continue with additional protections such as wearing of masks, psychical distancing, hand hygiene and ventilation for some time to come, and especially in the face of Omicron. The WHO also reinforces the importance of booster programs.

Queensland is currently protected primarily by vaccine-derived immunity. As at 17 December, 83 per cent of Queensland's eligible population over 16 years has had two doses of COVID-19 vaccine.

In line with ATAGI advice, Queenslanders aged 18 and over who completed their primary course of COVID-19 vaccination five or more months are eligible and being encouraged to receive their booster. Booster vaccinations are readily available in Queensland. Approximately 12 per cent of Queenslanders are currently eligible, at five months after their second dose This will increase to one-third of Queenslanders over 16 years of age by end-January 2022.

Overall, Queensland has high overall recent vaccination coverage, a number of protective vaccine mandates and pre-travel testing requirements.

Current COVID-19 context in Queensland

In the last seven days, there have been 244,742 border passes granted for travel from declared hotspots. It is reasonable to assume that the vast majority of these have been granted to vaccinated travellers who have entered Queensland freely, without requirements to quarantine.

Following the opening of borders to interstate arrivals on 13 December, there has been an increase in COVID-19 case numbers. Queensland has reported 62 new cases between 13 and 17 December. At least 36 of these cases involved interstate travel and most cases have been infectious in the community. The cases are being detected in many regions of Queensland, including Brisbane, Wide Bay, Townsville, Cairns Sunshine Coast, Gold Coast and West Moreton. There are now around 150 exposure sites identified in these locations, which include around 25 locations identified for close contacts, such as flights, gyms, restaurants/cafes and beauty salons. Queensland is now reporting locally acquired cases with interstate travel on a daily basis and is beginning to see unlinked locally-acquired cases, likely as a result of contact with COVID-positive travellers from interstate.

Currently, the overall number of confirmed cases of Omicron in Queensland is still in the minority of cases (five), but this is unlikely to continue. Omicron has been described as the most significant threat of the pandemic to date. The projected transmission rates for Omicron mean that timely interventions are more important than ever. Some current cases in Queensland have been exposed at interstate exposure venues with known Omicron transmission, and are anticipated to be confirmed as Omicron cases.

Queensland is at the beginning of the summer school holiday period, where students are not in class, many leisure activities are outdoors, and workers also take time off work—this may work as a protective factor but it alone will not be enough to reduce transmission. Familiar, easy to implement public health and social measures (PHSM) such as mask wearing, and avoidance of crowded spaces, will help to slow the transmission of the virus. Encouraging outdoor entertaining, outdoor dining and avoidance of crowded spaces will also help to limit transmission.

Mask wearing is a high-impact, low-effort public health measure to prevent the spread of COVID-19. Many published scientific studies have demonstrated that masks help to prevent COVID-19 transmission.

A recent systematic review and meta-analysis of 72 studies found that mask-wearing was the single most effective public health measure at tackling COVID-19, reducing the incidence of the disease by up to 53 per cent.[1]

An earlier systematic review of 172 studies on COVID-19, and other serious respiratory illnesses (SARS and MERS) published in the Lancet in June 2020 confirmed that wearing face masks protects both health-care workers and the general public against infection by these coronaviruses.[2] Protective measures to limit airborne spread are even more important in the context of more highly transmissible variants, transmitting even in the context of fleeting contact.

To support compliance and baseline protective measures, in the current context of increasing case number across the State and the emerging risk of Omicron to the community, mask wearing will be mandated in some settings across Queensland.

The intent of introducing mandatory mask wearing is to protect vulnerable populations and the unvaccinated, by slowing the spread of COVID-19. This, coupled with ongoing messaging about physical distancing and hand hygiene, will enable the community to limit their exposure to and transmission of any respiratory droplets or aerosolised virus when leaving the home and around other people.

As at 16 December the requirements for mask wearing across states and territories vary, with all requiring the wearing of masks in some settings. All jurisdictions require wearing of masks at airports, many require it in healthcare and vulnerable settings (Victoria, ACT, South Australia and Tasmania) and on public transport (NSW, Victoria, ACT and South Australia). Some states require masks in retail type setting, including Victoria (except hairdressing and beauty salons) and South Australia (defined as indoor public places). Mask wearing is also mandated at schools in Victoria (primary school only) and South Australia. Table 1 provides an overview of mask wearing requirements by jurisdictions.

In Queensland, mask wearing will be mandatory while waiting for or when on public transport, at airports (existing requirement), in taxis and rideshare vehicles and indoors at retail centres (e.g. shopping centres, retail outlets).

These settings have been identified as a first step for additional protections. These are indoor or enclosed places that service a range of people from a wide geographic area, including vulnerable cohorts. Unvaccinated people can also attend these settings, with substantially increased patronage during the holiday season. For additional protection of vulnerable populations, masks must also be worn when entering a hospital, other healthcare settings (e.g. GPs, dentists, etc). residential aged care facility, disability accommodation facility, corrective services facilities or detention centres.

Consistent with other iterations and public health advice, this requirement does not apply to children under the age of 12, or anyone affected by health or other medical conditions. Masks will not be required in workplaces. With the Christmas period, it is expected that many workplaces will be less busy than usual and physical distancing will be easier to achieve.

[1] Effectiveness of public health measures in reducing the incidence of covid-19, SARS-CoV-2 transmission, and covid-19 mortality: systematic review and meta-analysis, The British Medical Journal, Published 18 November 2021 (https://www.bmj.com/content/375/bmj-2021-068302)

[2] The Lancet Respiratory Medicine, Physical distancing, face masks, and eye- protection to prevent person-to-person transmission of SARS-COV-2 and CVOVID-19: a systematic review and meta-analysis , The Lancet Respiratory Medicine, 2020 (https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31142-9/fulltext)

The festive season brings with it increased entertaining and intergenerational mixing, including with people from states where daily case numbers are high. Mask wearing is being strongly encouraged in all other settings, particularly indoors, and where physical distancing is not possible.

Table 1 – Mask requirements in states and territories (as at 16 December 2021)

	Retail setting	Public transport	Airports	Healthcare setting/ hospitals	Other settings
QLD	✓	✓	✓	✓	Masks strongly encouraged in all other indoor settings
NSW		✓	✓		For indoors front-of-house hospitality staff who are not fully vaccinated
VIC	✓ (except hairdressing and beauty salons)	✓	✓	✓	• Indoors only at primary schools for staff, visitors and for students in grades 3-6 • Workers serving the public at hospitality venues • Workers in high-risk settings (prisons and other detention facilities) • Workers in an abattoir, meat, seafood and poultry processing sites • All persons in indoor areas of a court which are open to the public or used by jurors • Workers in resident-facing roles and visitors, while indoors at care facilities
ACT		✓	✓	✓	• High risk facilities, including, RACF, correction and detention facilities, residential accommodation facilities that support people who require frequent, close personal care and who are vulnerable to disease • In all indoor spaces at a school, early childhood education and care, noting that only children in years 7-12 are required to wear a face mask while in an indoor space at school. Children in years 3-6 encouraged to wear a mask when indoors at school
SA	✓	✓	✓	✓	Mandatory • Personal care • High risk settings • Indoor public places Strongly recommended • Indoor workplaces • Adult learning environments Optional • Childhood education services
NT			✓		
WA			✓		Transporting a person subject to a quarantine direction (e.g. in a personal vehicle, private car, hired car, ride-share vehicle or taxi)
TAS			✓	✓	Masks at events – required to be worn at events with more than 1000 people, regardless of whether the event is seated or unseated, indoors or outdoors. Masks in aged care settings

Public health considerations – 17 December 2021

Epidemiological situation

Queensland

- Queensland reported 20 new COVID-19 cases in the previous 24 hours, with 14 infectious in the community and two under investigation.
- The total number of cases in Queensland stands at 2,227.
- Queensland is managing a total of 84 active cases, with 42 in hospital (nil in ICU), 12 in Hospital in the Home and 28 awaiting transfer. There are currently one active First Nations cases in Queensland.
- There are currently 4,613 people in quarantine: 1,978 people in home quarantine (including 205 from interstate hotspots), 2,500 people in government hotel quarantine and 135 in alternate quarantine.
- As at 15 December, a total of 3,416,401 Queenslanders aged 16 and over have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 83.07 per cent of this cohort; 3,661,544 people – 89.03 per cent – have had at least one dose.

Emergence of Omicron variant

- On 26 November, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern.
- Omicron has been sequenced in 60 countries (5,286 sequenced cases) and reported in an additional 25 countries (21,146 confirmed cases) with confirmation via epidemiological link and sequencing.
- While the evidence regarding severity is not yet clear, the evidence regarding transmissibility and immune evasion means that even if severity was somewhat reduced there is the real potential for health and hospital systems to become overwhelmed and for many more people to end up with serious outcomes.
- Public health and social measures (PHSM) along with vaccinations (including third doses) will help to control the spread and may reduce the severity thereby delaying and reducing the impact on health systems.
- Omicron has now been detected in almost every State and Territory in Australia (except. WA and TAS).
- Cases are rising steeply in the UK and South Africa and hospitalisations in South Africa are also beginning to increase.
- On 12 December, ATAGI recommended that, given the likelihood of ongoing transmission of both Omicron and Delta variants, booster vaccinations be administered in those 18 and over who completed their primary course of COVID-19 vaccination five or more months ago.

National

- On 17 December, in the 24 hours prior, jurisdictions have reported 3,423 newly confirmed cases, including locally and internationally acquired.
- As at 17 December, Australia has reported 90.1 per cent of the eligible population aged 16 years and over as fully vaccinated; 93.7 per cent has had at least one dose.
- On 10 December the Australian Government confirmed that Australia's COVID-19 vaccination program will be extended to all children aged 5 to 11 years from 10 January 2022, after the Australian Government accepted recommendations from the Australian Technical Advisory Group on Immunisation (ATAGI).
- Quarantine requirements for Australians returning from overseas to NSW, Victoria, ACT and South Australia had started to ease in November. However, following the emergence of the Omicron variant, some jurisdictions have re-introduced restrictions for arrivals from countries of concern.
- On 13 December, Western Australia announced plans to allow interstate and international arrivals to enter without quarantine from 5 February 2021 when the state is expected to reach 90 per cent vaccination coverage.

New South Wales

- NSW reported 2,213 new COVID-19 cases, and one new death in the past 24 hours; there have been 86,510 locally acquired cases and 588 deaths reported since 16 June.
- NSW is currently managing 192 cases in hospital, with 26 people in ICU (eight requiring ventilation).
- As at 16 December, NSW has reported that 93.3 per cent of the eligible population aged 16 years and over is fully vaccinated and 94.8 per cent have received at least one dose.
- NSW has now recorded 185 cases of the Omicron variant.

Victoria

- Victoria has reported 1,503 new locally acquired cases and nine deaths in the last 24 hours; there have been approximately 122,125 locally acquired cases and 633 deaths reported in the current outbreak.
- Victoria is managing 386 cases in hospital, including 82 active cases and 36 cleared cases in intensive care (45 of whom require ventilation).
- Victoria has recorded over 30 cases of the Omicron variant.
- As at 16 December, Victoria has reported that 92.3 per cent of its eligible population aged 16 years and over is fully vaccinated and 94.3 per cent have received at least one dose.
- There are currently no restrictions in place for Victorians who are fully vaccinated.

Australian Capital Territory

- ACT has reported 20 new locally acquired cases and nil new deaths in the last 24 hours; there have been 2,118 locally acquired cases and 12 deaths reported since 12 August.
- ACT is managing four cases in hospital, with none in intensive care.
- ACT has reported that >98.3 per cent of its population aged 12 years and over is fully vaccinated.

Northern Territory

- The NT has reported one new case in past 24 hours.
- The NT has reported two cases of the Omicron variant.
- There have been 94 locally acquired cases as part of the Katherine and Robinson River outbreak since 15 November.

South Australia

- 25 cases were reported on 15 December, the highest daily total since April 2020.
- Two cases are currently in hospital, nil in ICU.
- Vaccine rates of the SA population 12 years and over – 91.1 per cent for first dose and 84 per cent second dose.
- SA has recorded two cases of the Omicron COVID-19 variant as at 13 December.

Global

- As at 17 December, there have been over 272.86 million confirmed COVID-19 cases, 5.34 million confirmed COVID-19 related deaths and over 8.588 billion COVID-19 vaccine doses administered (Source: John Hopkins University).
- In the week to 12 December, globally the weekly incidence of both cases and deaths has declined, with decreases of 5 per cent and 10 per cent respectively, as compared to the previous week. Nonetheless, this still corresponded to over 4 million new confirmed cases and just under 47 000 new deaths and the African Region reported a 111 per cent in new cases last week followed by and the Western Pacific Region which reported an increase of 7per cent. The Region of the Americas and South-East Asia Region both reported decreases of 10 per cent and the European Region reported a 7 per cent decrease. (Source: WHO).

Living with COVID-19

- The Queensland Government continues to progress its state-wide campaign to encourage Queenslanders to get vaccinated. There is a particular focus on encouraging increased uptake in regional and remote areas. Many of these areas currently have lower vaccination coverage than the Queensland average.
- Booster COVID-19 vaccines are now widely available to anyone who has had their second dose at least six months ago.
- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.
- From 13 December:
  - Fully vaccinated travellers from a domestic COVID-19 hotspot can arrive by road or air, with no quarantine required but must have had a negative COVID-19 test in the previous 72 hours and agree to get a further COVID-19 PCR test on day five of their stay in Queensland.
  - Fully vaccinated direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90 per cent of Queensland's eligible population fully vaccinated, there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas.
  - Unvaccinated travellers will need to apply for a border pass, enter within the international arrivals cap, and undertake a period of quarantine.
- On 9 November 2021, the Queensland Government released its *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond*, which sets out measures variously applying to vaccinated and unvaccinated people aged 16 years and over. The associated Direction was published on 7 December and has come into effect from 17 December.
- Under the Plan, all staff and visitors at hospitality and entertainment venues, including pubs, clubs, cafés, cinemas, theatres and music festivals must be fully vaccinated, and there will be no COVID-19 density restrictions at these venues.

Public Health System capacity

- Currently, Queensland Public Health Units are working to ensure the Queensland community is complying with public health controls. Another key focus for Queensland's Public Health Units is to ensure that those directed to undertake quarantine, comply with all requirements, including the testing regime.
- Additional restrictions are imposed and lifted in response to evidence of community outbreaks to ensure the safety of Queenslanders, and more specifically our most vulnerable people in residential aged care facilities, hospitals, and disability accommodation services.
- While cases of COVID-19 in the Queensland community have been managed well to date, it is important to mitigate against widespread outbreaks. It remains important to quickly bring clusters under control with effective contact tracing and other protective measures to maintain the integrity of the health system to respond to non-COVID-19 related care.

Health Care System capacity

- Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts on hospital capacity and workforce.
- This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is needed. It is expected that with increased vaccine protection, the number of people requiring hospitalisation and intensive care in the event of an outbreak are likely to remain within hospital and health system capacity.

- To support health system delivery in this new phase of COVID-19, Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met.
- Strategies are in place with private providers to minimise the interruption to urgent elective services should a wider community outbreak across Queensland impact on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.
- Notably, Queensland's planned COVID-19 response has been modelled on the Delta variant of concern. Evidence to date is suggesting that Omicron evades immunity more successfully and transmits more easily. This means that with Omicron the projected cases are likely to increase more rapidly and peak much higher than was anticipated under a dominant Delta scenario. Updated modelling will need to be considered when data becomes available.

Community acceptance and adherence

- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been accepting and supportive of public health measures. There are significant public and industry expectations of a 'return to normal' after reaching vaccination targets and borders opening.
- There are ongoing concerns of 'pandemic fatigue' and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions is expected to reduce dramatically with increased vaccination coverage. Queensland, like other jurisdictions, is preparing to move into a suppression phase, and towards a new 'living with COVID-19' phase of the pandemic.
- With lengthy periods of restriction in some jurisdictions (i.e. NSW and Victoria), as well as new vaccine-related mandates and public health and safety measures coming into effect, protests have been held in recent months, principally in east-coast states.
- The key issue in the medium-term is likely to be in relation to vaccine mandates, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates vary with local context. For example, Victoria and NSW—managing widespread outbreaks and health systems at capacity—mandated vaccination across many industries and settings, including construction, education, and other authorised workforces including retail. However, as vaccination coverage continues to increase there has now been a gradual lifting of these restrictions.
- In the context of very low case numbers and strict requirements throughout the pandemic, Western Australia has announced mandatory vaccine requirements across almost every sector, estimated to affect up to 75% of the population, with similar vaccine requirements also announced by the Northern Territory.
- Queensland also requires vaccination for workers at high risk settings (schools, correctional facilities and airports) and for entry to a range of high-risk venues like hospitality and entertainment venues as part of baseline protections.

Wastewater monitoring

- To strengthen surveillance capabilities and increase confidence that transmission is not occurring, Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.
- There have been positive wastewater detections from the Cairns North, Luggage Point, Capalaba, Pimpama, Coombabah, Merrimac and Goondiwini wastewater treatment plant during week ending

12 December 2021. On 15 December, there were positive detections also at Elanora, Noosa, Murrumba Downs and Loganholme wastewater treatment plants.

Figure 1. NSW daily case numbers and Reff

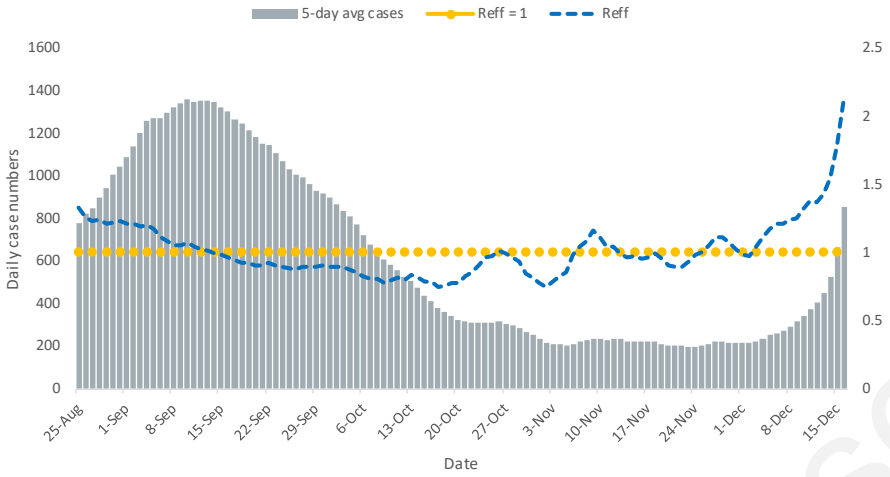
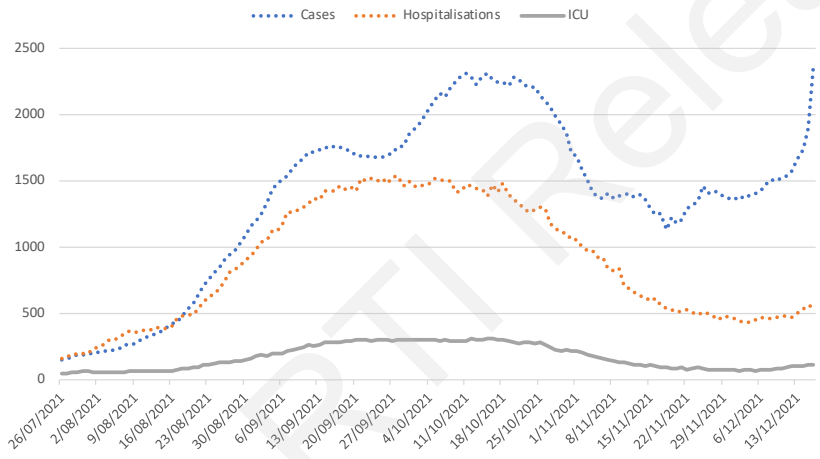


Figure 2. Australia COVID-19 cases, hospitalisations, and ICU admissions



Public Health Directions – Human Rights Assessment
Public Health Face Masks Requirements Direction

Title	Public Health Face Masks Requirements Direction
Date effective	17 December 2021

Background

The *Public Health Face Masks Requirements Direction* (the Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the Direction is to mitigate the risk of transmission of COVID-19 in high risk environments to the Queensland community, and to ensure the safety of people who are frequenting high risk environments through a requirement to wear masks. In addition to high risk environments covered by the *Mandatory Face Masks Direction (No.2),* high risk environments have been identified as public transport and transport waiting areeas, indoor retail and vulnerable settings including residential aged care, shared disability accommodation, hospitals, prisons and youth justice detention centres.

The Direction takes the least restrictive approach necessary by only requiring face masks to be worn in limited identified settings, including indoors in vulnerable settings and in retail shops, and on public transport and in associated passenger waiting areas.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

How the Direction achieves the purpose

The Direction requires a person to wear a mask in the following high-risk environments anywhere in Queensland:

- an indoor space that is a retail shop
- A residential aged care facility, shared disability accommodation service, a corrective services facility or detention centre
- On public transport and in waiting areas for public transport
- In a commercial passenger vehicle or waiting area

The Direction provides for a number of lawful excuses for wearing a mask in the following circumstances:

- for children under 12
- a person eating, drinking or taking medicine

- where visibility of the mouth is essential – for example, a person communicating to someone who is deaf or hard of hearing, a teacher
- a person with a particular medical condition or disability that may be made worse by wearing a mask – for example, a person who has breathing difficulties, a serious skin condition on their face, a mental health condition or psychological impacts from experienced trauma
- a person undergoing medical treatment – for example, a person receiving first aid
- if a person is asked to remove a face mask to ascertain identity
- if wearing a mask creates a risk to a person's health and safety
- for emergencies or if required under a law
- in any circumstances where it is not safe to wear a face mask.

If a person removes their face mask under any of the lawful excuses, they must put it back on as soon as practicable.

The Chief Health Officer may grant a person an exemption from all or part of the Direction on the basis of exceptional circumstances.

Human rights engaged

The human rights engaged by the Direction are:

- Right to life (section 16)
- Freedom of expression (section 21)
- Privacy (section 25)
- Right to equality and non-discrimination (section 15)

The right to life is protected under section 16 of the Human Rights Act. The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. This right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights. By requiring people to wear masks in high risk environments in Queensland, the Direction promotes the right to life by protecting the health, safety and wellbeing of people in the Queensland, by reducing the risk of the spread of COVID-19 into and throughout Queensland.

Limitations

Section 21 of the Human Rights Act provides that the right to freedom of expression includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be expressed in various ways, including in writing, through art, or orally. The Direction limits this right by restricting how a person may express themselves orally or through the garments they wear by requiring them to wear a certain type of face mask in high risks environments in Queensland. A person may still make or purchase a cloth mask of their choosing and is permitted to remove the mask in certain circumstances such as when making announcements, or teaching.

The right to privacy also includes a right to bodily integrity (see *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 126 599] and 'personal inviolability' in the sense of 'the freedom of all persons not to be subjected to physical or psychological interference, including medical treatment, without consent.' *See PBU v Mental Health Tribunal* (2018 56 VAR 141, 180-1 [128]. It is arguable that the Direction engages this aspect of the right through the requirement for a person to wear a face mask or potentially be fined. However, the extent of the impact on human rights is reduced by the fact that there a number of lawful excuses for removing a face mask in certain situations such as to eat, drink, consume medicine or receive medical treatment.

Right to equality and non-discrimination (section 15): The right to equality and non-discrimination protects people from discrimination on the basis of certain attributes such as disability or race. The requirements to wear face masks in high risk environments discriminates against people with a disability. For example, masks may make it harder for people with hearing loss to lip read and communicate. The definition of 'discrimination' under the *Human Rights Act* is inclusive. Discrimination may include discrimination on the basis certain attributes such as disability or race, as it does with respect to the right to equality under the Canadian Charter, which also contains an inclusive definition of discrimination: *R v Turpin* [1989] 1 SCR 1296. However, the extent of the impact on human rights is reduced by the fact that there a number of lawful excuses for removing a face mask such as to communicate with a person who is deaf or hard of hearing and visibility of the mouth is essential for communication. A person is not required to carry or wear a mask in high risk environments if they have a physical or mental health illness or condition, or disability, which makes wearing a face mask unsuitable.

Compatibility with Human Rights

Proper purpose (section 13(2)(b))

The purpose of the Direction is to reduce the spread of COVID-19 from high risk environments to the Queensland community.

Requiring certain people in high risk environments to wear a mask is to confine potential outbreaks. The Direction is in effect for a temporary period, and the restrictions as applying to a person only apply in particular environments. It is unlikely a person would be required to wear a mask for a long period of time under any of the requirements in the Direction. A person can remove their mask when in an outside area of retail shops, outdoors and in many settings. Ultimately, the purpose of wearing masks is to limit the opportunity for transmission of COVID-19 from high risk environments to the Queensland community.

The aim of protecting public health is a proper purpose. Protecting people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

The purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

The limits on human rights will help to achieve the intended purpose of protecting public health by limiting the opportunities for transmission of COVID-19 in high risk environments.

The mask wearing requirements and the exceptions to mask wearing requirements have been tailored to the needs of different cohorts. For example, a person visiting at a residential aged care facility can remove the mask to eat and drink while visiting a resident.

This approach ensures the Direction is suitably tailored to address the public health risks associated with COVID-19 while acknowledging there may be individual circumstances that need to be managed appropriately.

Necessary (s 13(2)(d))

The limits on human rights are necessary to achieve the purpose. There is no other way to address the risk of COVID-19 spreading into Queensland from overseas or interstate which would be (a) reasonably available (that is, as practicable), and (b) less restrictive of human rights.

In particular:

- Requiring face masks in all indoor settings and outdoor areas would be more restrictive of human rights.
- Relying on other measures such as contact tracing would not be as effective in achieving the purpose of limiting the spread of COVID-19 into Queensland, given the possibility that people in high risk environments such as on public transport or travelling in vehicles transporting people who may be asymptomatic or presymptomatic. In addition, one person could have a substantial number of contacts that need to be traced. For example, a single positive case in a busy shopping centre could have hundreds of contacts requiring investigation. This can be an onerous task given there are a limited number of contact tracing officers available.

Fair balance (section 13(2)(e), (f) and (g)

Given the risk posed by high risk environments based on the people who frequent these environments, including people who may have been in a COVID-19 hotspot or overseas in the last 14 days, the purpose of the Direction can only be reasonably achieved by requiring people to wear masks in these environments unless certain exceptions apply.

Many of the limits on human rights are incidental. For example, although the requirement to wear a face mask limits the right to equality and non-discrimination, people are able to remove their mask to communicate with a person with a disability.

The extent of the limitation on human rights is further reduced in other ways. The Direction is in effect for a temporary period, and the restrictions that apply to a person should in most circumstances only require a person to wear a mask for a short period of time.

The requirements of the Direction are proportionate and necessary to the unprecedented threat to public health, including the pressing need for physical distancing requirements. The Direction does not: limit the right to hold a religious belief; target any religious or cultural groups; or restrict people from engaging in their cultural or religious practices.

The limits on human rights by requiring a person to wear a mask in high risk environments or be subject to a fine are justifiable. Requiring a person to wear a mask is aimed at addressing the risk presented by COVID-19 and will assist in addressing that risk. For example, a person in any of these settings may potentially be asymptomatic and there will be no means of preventing transmission of COVID-19 to other people without the use of a face mask. The person could potentially infect people in the wider community while on public transport or in shopping centres. Tackling such a scenario would require resources for contact tracing (one person could have up to 200 contacts) and may divert resources from other critical areas. The need to address the risk of a potential outbreak or community transmission of COVID-19 in Queensland, outweighs the impact on human rights.

The Direction provides a broad exemption power enabling the Chief Health Officer to grant an exemption to any of its requirements based on exceptional circumstances. This broad power was included to protect against unintended consequences of the Direction, and to acknowledge that there may be circumstances where requiring a person to wear a mask may not be reasonable or appropriate.

There will be some impact on human rights, in particular, the right to equality for people with disabilities. However, the importance of limiting the spread of COVID-19 into Queensland (taking into account the right to life) outweighs the impact on other human rights. Indeed, it is difficult to overstate

the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading into Queensland.

Public Health Directions – Human Rights Assessment
Public Health Face Masks Requirements Direction (No.2)

Title	Public Health Face Masks Requirements Direction (No.2)
Date effective	19 December 2021

Background

The *Public Health Face Masks Requirements Direction (No.2)* (the Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the Direction is to mitigate the risk of transmission of COVID-19 in high risk environments to the Queensland community, and to ensure the safety of people who are frequenting high risk environments through a requirement to wear masks. In addition to high risk environments covered by the *Mandatory Face Masks Direction (No.2),* high risk environments have been identified as public transport and transport waiting areeas, indoor retail and vulnerable settings including residential aged care, shared disability accommodation, hospitals, prisons and youth justice detention centres.

The Direction takes the least restrictive approach necessary by only requiring face masks to be worn in limited identified settings, including indoors in vulnerable settings and in retail shops, and on public transport and in associated passenger waiting areas. In addition, exceptions are provided, including for emergencies and to ensure people can receive retail services that cannot reasonably be received or provided while wearing a face mask.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

The amendment to the Direction is a technical clarification that a face mask does not need to be worn while a person is having a photo taken as part of a retail service received at a retail shop. This means that Santa and people having a photo with Santa, or having a family or passport photo do not need to wear a mask while the photo is being taken.

How the Direction achieves the purpose

The Direction requires a person to wear a mask in the following high-risk environments anywhere in Queensland:

- an indoor space that is a retail shop
- A residential aged care facility, shared disability accommodation service, a corrective services facility or detention centre, a hospital or healthcare facility

- On public transport and in waiting areas for public transport
- In a commercial passenger vehicle or waiting area

The Direction provides for a number of lawful excuses for wearing a mask in the following circumstances:

- for children under 12
- a person eating, drinking or taking medicine
- where visibility of the mouth is essential – for example, a person communicating to someone who is deaf or hard of hearing, a teacher
- a person with a particular medical condition or disability that may be made worse by wearing a mask – for example, a person who has breathing difficulties, a serious skin condition on their face, a mental health condition or psychological impacts from experienced trauma
- a person undergoing medical treatment – for example, a person receiving first aid
- providing or receiving a service from a ***business, activity or undertaking*** which is permitted to operate under, and is operating in accordance with, the *Public Health and Social Measures linked to vaccination Direction (No.2)* or its successor, to the extent that it is not reasonably practicable to provide or receive that service wearing a ***face mask***
- providing or receiving a service that requires or relates to being in a photograph taken at a ***retail shop*** or within a ***retail shop***, while the photograph of the person is being taken
- if a person is asked to remove a face mask to ascertain identity
- if wearing a mask creates a risk to a person's health and safety
- for emergencies or if required under a law
- in any circumstances where it is not safe to wear a face mask.

If a person removes their face mask under any of the lawful excuses, they must put it back on as soon as practicable.

The Chief Health Officer may grant a person an exemption from all or part of the Direction on the basis of exceptional circumstances.

Human rights engaged

The human rights engaged by the Direction are:

- Right to life (section 16)
- Freedom of expression (section 21)
- Privacy (section 25)
- Right to equality and non-discrimination (section 15)

The right to life is protected under section 16 of the Human Rights Act. The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. This right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights. By requiring people to wear masks in high risk environments in Queensland, the Direction promotes the right to life by protecting the health, safety and wellbeing of people in the Queensland, by reducing the risk of the spread of COVID-19 into and throughout Queensland.

Limitations

Section 21 of the Human Rights Act provides that the right to freedom of expression includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be

expressed in various ways, including in writing, through art, or orally. The Direction limits this right by restricting how a person may express themselves orally or through the garments they wear by requiring them to wear a certain type of face mask in high risks environments in Queensland. A person may still make or purchase a cloth mask of their choosing and is permitted to remove the mask in certain circumstances such as when making announcements, or teaching.

The right to privacy also includes a right to bodily integrity (see *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 126 599] and 'personal inviolability' in the sense of 'the freedom of all persons not to be subjected to physical or psychological interference, including medical treatment, without consent.' *See PBU v Mental Health Tribunal* (2018 56 VAR 141, 180-1 [128]. It is arguable that the Direction engages this aspect of the right through the requirement for a person to wear a face mask or potentially be fined. However, the extent of the impact on human rights is reduced by the fact that there a number of lawful excuses for removing a face mask in certain situations such as to eat, drink, consume medicine or receive medical treatment.

Right to equality and non-discrimination (section 15): The right to equality and non-discrimination protects people from discrimination on the basis of certain attributes such as disability or race. The requirements to wear face masks in high risk environments discriminates against people with a disability. For example, masks may make it harder for people with hearing loss to lip read and communicate. The definition of 'discrimination' under the *Human Rights Act* is inclusive. Discrimination may include discrimination on the basis certain attributes such as disability or race, as it does with respect to the right to equality under the Canadian Charter, which also contains an inclusive definition of discrimination: *R v Turpin* [1989] 1 SCR 1296. However, the extent of the impact on human rights is reduced by the fact that there a number of lawful excuses for removing a face mask such as to communicate with a person who is deaf or hard of hearing and visibility of the mouth is essential for communication. A person is not required to carry or wear a mask in high risk environments if they have a physical or mental health illness or condition, or disability, which makes wearing a face mask unsuitable.

Compatibility with Human Rights

Proper purpose (section 13(2)(b))

The purpose of the Direction is to reduce the spread of COVID-19 from high risk environments to the Queensland community.

Requiring certain people in high risk environments to wear a mask is to confine potential outbreaks. The Direction is in effect for a temporary period, and the restrictions as applying to a person only apply in particular environments. It is unlikely a person would be required to wear a mask for a long period of time under any of the requirements in the Direction. A person can remove their mask when in an outside area of retail shops, outdoors and in many settings. Ultimately, the purpose of wearing masks is to limit the opportunity for transmission of COVID-19 from high risk environments to the Queensland community.

The aim of protecting public health is a proper purpose. Protecting people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

The purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

The limits on human rights will help to achieve the intended purpose of protecting public health by limiting the opportunities for transmission of COVID-19 in high risk environments.

The mask wearing requirements and the exceptions to mask wearing requirements have been tailored to the needs of different cohorts. For example, a person visiting at a residential aged care facility can remove the mask to eat and drink while visiting a resident.

This approach ensures the Direction is suitably tailored to address the public health risks associated with COVID-19 while acknowledging there may be individual circumstances that need to be managed appropriately.

Necessary (s 13(2)(d))

The limits on human rights are necessary to achieve the purpose. There is no other way to address the risk of COVID-19 spreading into Queensland from overseas or interstate which would be (a) reasonably available (that is, as practicable), and (b) less restrictive of human rights.

In particular:

- Requiring face masks in all indoor settings and outdoor areas would be more restrictive of human rights.
- Relying on other measures such as contact tracing would not be as effective in achieving the purpose of limiting the spread of COVID-19 into Queensland, given the possibility that people in high risk environments such as on public transport or travelling in vehicles transporting people who may be asymptomatic or presymptomatic. In addition, one person could have a substantial number of contacts that need to be traced. For example, a single positive case in a busy shopping centre could have hundreds of contacts requiring investigation. This can be an onerous task given there are a limited number of contact tracing officers available.

Fair balance (section 13(2)(e), (f) and (g)

Given the risk posed by high risk environments based on the people who frequent these environments, including people who may have been in a COVID-19 hotspot or overseas in the last 14 days, the purpose of the Direction can only be reasonably achieved by requiring people to wear masks in these environments unless certain exceptions apply.

Many of the limits on human rights are incidental. For example, although the requirement to wear a face mask limits the right to equality and non-discrimination, people are able to remove their mask to communicate with a person with a disability.

The extent of the limitation on human rights is further reduced in other ways. The Direction is in effect for a temporary period, and the restrictions that apply to a person should in most circumstances only require a person to wear a mask for a short period of time.

The requirements of the Direction are proportionate and necessary to the unprecedented threat to public health, including the pressing need for physical distancing requirements. The Direction does not: limit the right to hold a religious belief; target any religious or cultural groups; or restrict people from engaging in their cultural or religious practices.

The limits on human rights by requiring a person to wear a mask in high risk environments or be subject to a fine are justifiable. Requiring a person to wear a mask is aimed at addressing the risk presented by COVID-19 and will assist in addressing that risk. For example, a person in any of these settings may potentially be asymptomatic and there will be no means of preventing transmission of COVID-19 to other people without the use of a face mask. The person could potentially infect people in the wider community while on public transport or in shopping centres. Tackling such a scenario

would require resources for contact tracing (one person could have up to 200 contacts) and may divert resources from other critical areas. The need to address the risk of a potential outbreak or community transmission of COVID-19 in Queensland, outweighs the impact on human rights.

The Direction provides a broad exemption power enabling the Chief Health Officer to grant an exemption to any of its requirements based on exceptional circumstances. This broad power was included to protect against unintended consequences of the Direction, and to acknowledge that there may be circumstances where requiring a person to wear a mask may not be reasonable or appropriate.

There will be some impact on human rights, in particular, the right to equality for people with disabilities. However, the importance of limiting the spread of COVID-19 into Queensland (taking into account the right to life) outweighs the impact on other human rights. Indeed, it is difficult to overstate the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading into Queensland.

COVID-19 Public Health Policy Rationale – Public Health Face Mask Requirements Direction

22 December 2021

DRAFT NOT GOVERNMENT POLICY

This policy rationale should be read in conjunction with the Policy Rationale for the previous iteration of this Direction (17 December 2021) as the rationale and evidence base for mask wearing, and the current broader public health considerations, remain unchanged.

Summary and rationale as at 22 December 2021

On 13 December 2021, Queensland removed quarantine requirements for fully vaccinated travellers entering Queensland from COVID-19 hotspots. COVID-19 has now seeded widely in Queensland and COVID-19 case numbers are doubling approximately every two days, increasingly driven by the Omicron variant. Exposure sites and case locations extend throughout the State.

On 17 December as a first step to prevent additional transmission, mask wearing requirements were reintroduced across Queensland in some settings where vaccinated and unvaccinated people gather in close proximity. Currently, masks are required at retail settings, including supermarkets and shops, on public transport and ride shares and at vulnerable settings.

Since then, case numbers have continued to increase rapidly, with exponential growth. On 17 December, there were 20 cases newly reported and a total of 84 active cases, as at 22 December, there are 186 newly reported cases and a total of 447 cases. This is significant. If growth continues at this rate, up to 5,000 cases per day can be expected by 31 December.

It is apparent that Omicron is able to infect even people who are vaccinated. Early evidence suggests that even if Omicron is milder and that vaccinations continue to help prevent severe disease, with the current rate of growth, the increase in hospital admissions will be exponential, with the potential to exceed health system capacity.

This iteration of the Direction will extend mask wearing requirements as an additional protective measure to further identified indoor settings that have increased transmission risk, as follows.

Hospitality venues

Hospitality venues, like cafes and restaurants, are settings with high public attendance and high turnover. They are higher risk due to the nature of the setting (e.g. alcohol consumption, density, dancing), and attract a number of geographically and demographically diverse people, where COVID-19 exposure and transmission could lead to a widespread outbreak. It is for this reason that from 17 December, all staff and patrons are required to be vaccinated. This provides a baseline level of protection against community transmission. It is also likely that a meaningful proportion of patrons will be children under the age of 16 years, for whom a COVID-19 vaccine is currently not available. Ensuring uniform vaccination coverage among the adults in the identified settings is protecting children and reducing the risk of widespread outbreaks should a positive case attend the venue.

Mask wearing is a high-impact, low-effort public health measure to prevent the spread of COVID-19 (see previous Policy Rationale for this Direction for a more complete overview).

Staff in hospitality venues interact with a large number of visitors and patrons throughout their shift. Mask wearing for this cohort increases protection for staff (and support workforce continuity) and for the public.

Patrons and visitors at cafes and restaurants are primarily seated, eating and drinking with little movement through the venue.

Indoor cinemas and theatres

These indoor venues offer seated and ticketed entertainment, and all patrons and staff must be vaccinated to attend. The fact that patrons remain seated is protective, as is vaccination, however, events occur over a period of hours in an enclosed place, and in the case of a theatre, shouting and cheering is to be expected. Additionally, with set times for performances, crowds will often form at entrances and exits at these venues, as well as at bathroom facilities.

All of these factors increase the risk of transmission in the current context. For this reason, masks will be required for staff and patrons when inside the venue, except while eating and drinking, consistent with previous settings at places with food.

Consistent with other iterations and public health advice, this requirement does not apply to children under the age of 12, or anyone affected by health or other medical conditions. Masks will not be required in workplaces. With the Christmas period, it is expected that many workplaces will be less busy than usual and physical distancing will be easier to achieve.

The festive season brings with it increased entertaining and intergenerational mixing, including with people from states where daily case numbers are high. Mask wearing is being strongly encouraged in all other settings, particularly indoors, and where physical distancing is not possible.

Nationally, mask wearing requirements vary, but all jurisdictions are implementing this measure to some extent, with a focus on indoor areas. Table 1 at the end of this document summarises the current settings. South Australia, the Australian Capital Territory and Tasmania have stricter mask wearing requirements. Queensland's settings are most similar to these jurisdictions. Western Australia and Tasmania have the least restrictive requirements overall. New South Wales and Victoria's settings vary and may be subject to change with current transmission rates and case growth.

Public health considerations – 22 December 2021

Epidemiological situation

Queensland

- Queensland reported 186 new COVID-19 cases in the previous 24 hours, which is the largest number of daily cases recorded in Queensland.
- 80 of the 447 active cases in Queensland are confirmed as the Omicron variant.
- Queensland is managing a total of 447 active cases, with 80 in hospital (1 in ICU), 112 in Hospital in the Home and 255 awaiting transfer or new cases. There are currently four active First Nations cases in Queensland.
- As at 22 December, there are 5,615 people in quarantine: 2,896 people in home quarantine, 2,572 people in government hotel quarantine and 147 in alternate quarantine.
- As at 20 December, a total of 3,497,833 Queenslanders aged 16 and over have been vaccinated with two doses of a COVID-19 vaccine, which amounts to 85.05 per cent of this cohort; 3,698,968 people – 89.94 per cent – have had at least one dose.

Emergence of Omicron variant

- On 26 November, the World Health Organization (WHO) classified a new variant, the Omicron or B.1.1.529 variant as a variant of concern.

- On 18 December, the WHO stated that Omicron had been detected in 89 countries and was spreading rapidly, including in places with high levels of population immunity.
- While the evidence regarding severity is not yet clear, the evidence regarding transmissibility and immune evasion means that even if severity was somewhat reduced there is the real potential for health and hospital systems to become overwhelmed and for many more people to end up with serious outcomes.
- Public health and social measures (PHSM) along with vaccinations (including third doses) will help to control the spread and may reduce the severity thereby delaying and reducing the impact on health systems.
- Omicron has now been detected in almost every State and Territory in Australia.
- On 12 December, ATAGI recommended that, given the likelihood of ongoing transmission of both Omicron and Delta variants, booster vaccinations be administered in those 18 and over who completed their primary course of COVID-19 vaccination five or more months ago.

National

- On 21 December, in the 24 hours prior, jurisdictions have reported 4,575 newly confirmed cases, including locally and internationally acquired and cases under investigation.
- As at 21 December, 850 people are currently hospitalised.
- As at 20 December, Australia has reported 90.9 per cent of the eligible population aged 16 years and over as fully vaccinated; 93.9 per cent has had at least one dose.
- On 10 December the Australian Government confirmed that Australia's COVID-19 vaccination program will be extended to all children aged 5 to 11 years from 10 January 2022, after the Australian Government accepted recommendations from the Australian Technical Advisory Group on Immunisation (ATAGI).

New South Wales

- On 22 December, NSW reported 3,057 new COVID-19 cases and two deaths.
- NSW is currently managing 284 cases in hospital, with 39 people in ICU (11 requiring ventilation).
- As at 22 December, NSW has reported that 93.4 per cent of the eligible population aged 16 years and over is fully vaccinated and 94.9 per cent have received at least one dose.

Victoria

- On 22 December, Victoria has reported 1,245 new locally acquired cases, six deaths, in the last 24 hours.
- Victoria is managing 392 cases in hospital, including 73 active cases in intensive care, 43 of those on a ventilator.
- Victoria has 94.4 per cent first dose coverage and 92.9 per cent fully vaccinated coverage among its eligible population.

Australian Capital Territory

- On 22 December, ACT has reported 16 new locally acquired cases and nil new deaths in the last 24 hours.
- ACT is managing 3 cases in hospital and none in intensive care.
- ACT has reported that 98.4 per cent of its population aged 12 years and over is fully vaccinated.

Northern Territory

- On 22 December, the NT has reported 14 new cases in past 24 hours.
- NT has 95.0 per cent first dose and 95.0 per cent second dose coverage among its 16 and over population.

South Australia

- On 22 December, SA reported 154 new cases.
- Five cases are currently in hospital, nil in ICU.

- SA has 91.8 per cent first dose and 86.3 per cent second dose coverage among its 16 and over population.

Global

- As at 22 December, there have been over 276.16 million confirmed COVID-19 cases, 5.36 million confirmed COVID-19 related deaths and over 8.764 billion COVID-19 vaccine doses administered (Source: Johns Hopkins University).
- In the week to 13 December, globally the weekly incidence of cases has increased 0.76 per cent and deaths has declined 8.4 per cent, as compared to the previous week. Nonetheless, this still corresponded to over 4 million new confirmed cases and just under 45 000 new deaths and the African Region reported a 52.69 per cent in new cases last week followed by and the Western Pacific Region which reported an increase of 11.8 per cent. The Region of the Americas and South-East Asia Region both reported decreases of over 10 per cent and the European Region reported a 1.62 per cent increase. (Source: WHO).

Queensland's COVID plans

- Booster COVID-19 vaccines are now widely available to anyone who has had their second dose at least five months ago.
- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.
- From 13 December:
  - Fully vaccinated travellers from a domestic COVID-19 hotspot can arrive by road or air, with no quarantine required but must have had a negative COVID-19 test in the previous 72 hours and agree to get a further COVID-19 PCR test on day five of their stay in Queensland.
  - Fully vaccinated direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90 per cent of Queensland's eligible population fully vaccinated, there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas.
  - Unvaccinated travellers will need to apply for a border pass, enter within the international arrivals cap, and undertake a period of quarantine.
- On 9 November 2021, the Queensland Government released its *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond*, which sets out measures variously applying to vaccinated and unvaccinated people aged 16 years and over. The associated Direction was published on 7 December and has come into effect from 17 December.
- Under the Plan, all staff and visitors at hospitality and entertainment venues, including pubs, clubs, cafés, cinemas, theatres and music festivals must be fully vaccinated, and there are no COVID-19 density restrictions at these venues.

Public Health System capacity

- Currently, Queensland Public Health Units are working to contact positive cases and support contact tracing efforts. The growth in cases is a significant and contact tracing capacity is under increasing pressure.
- Contact tracers are triaging and moving through highest risk cohorts, focusing on contacting positive cases and their immediate contacts only. As at 22 December, Queensland Health has ceased publishing low risk exposure sites and will cease publicly reporting exposed flights or airports due to the volume of these indicated.
- Where people cannot be contacted directly for a close contact site, a public health alert is issued and these exposure sites are being listed online.

Health Care System capacity

- Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts on hospital capacity and workforce.
- This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is needed. It is expected that with increased vaccine protection and with continuing public health and social measures, including mask wearing, the number of people requiring hospitalisation and intensive care are likely to remain within hospital and health system capacity.
- To support health system delivery in this new phase of COVID-19, Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met.
- Strategies are in place with private providers to minimise the interruption to urgent elective services in the event of impacts on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.
- Notably, Queensland's planned COVID-19 response has been modelled on the Delta variant of concern. Evidence to date is suggesting that Omicron evades immunity more successfully and transmits more easily. This means that with Omicron the projected cases are likely to increase more rapidly and peak much higher than was anticipated under a dominant Delta scenario. Updated modelling will need to be considered when data becomes available.
- With the growth in cases in Queensland, hospitals are beginning to see cases and where appropriate people are now being managed in 'virtual wards' (total capacity of 500 places).
- Queensland's existing quarantine hotel network is also providing isolation services for COVID-well patients who do not have a suitable place to isolate while infectious. This is assisting with ensuring that hospital capacity is maintained for COVID-19 patients that require hospital care, including virtual care such as Hospital in the Home.

Community acceptance and adherence

- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been accepting and supportive of public health measures. There are significant public and industry expectations of a 'return to normal' after reaching vaccination targets and borders opening.
- There are ongoing concerns of 'pandemic fatigue' and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions has been reduced dramatically with increased vaccination coverage.
- With lengthy periods of restriction in some jurisdictions (i.e. NSW and Victoria), as well as new vaccine-related mandates and public health and safety measures coming into effect, protests have been held in recent months, principally in east-coast states.
- The key issue in the medium-term is likely to be in relation to vaccine mandates, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates vary with local context. For example, Victoria and NSW—managing widespread outbreaks and health systems at capacity—mandated vaccination across many industries and settings, including construction, education, and other authorised workforces including retail. However, as vaccination coverage continues to increase there has now been a gradual lifting of these restrictions.

- Queensland requires vaccination for workers at high risk settings (schools, correctional facilities and airports) and for entry to a range of high-risk venues like hospitality and entertainment venues as part of baseline protections.

Wastewater monitoring

- Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.
- In the week ending 12 December, there were positive detections at Cairns, Luggage Point, Capalaba, Pimpama, Coombabah, Merrimac, and Goondiwindi.
- In the week ending 19 December there were detections at Noosa, Murrumba Downs, Luggage Point upstream locations, Wynnum, Oxley Creek upstream, Loganholme and Loganholme upstream locations, Coombabah, Merrimac, Elanora, and Beenleigh upstream, noting that not all locations were tested yet.

Table 1 – Mask requirements in states and territories (as at 22 December 2021)

	Retail setting	Public transport	Airports	Healthcare setting/ hospitals	Hospitality	Indoor cinemas/ theatres	Other settings
QLD	✓	✓	✓	✓	✓ (staff only)	✓	Masks strongly encouraged in all other indoor settings
NSW		✓	✓		Unvacc. public facing staff		• If visiting aged care facility or disability home, there may be rules that apply
VIC	✓ (except hairdressing and beauty salons)	✓	✓	✓	Public facing staff		• Indoors only at primary schools for staff, visitors and for students in grades 3-6 • Workers in high-risk settings (prisons and other detention facilities) • Workers in an abattoir, meat, seafood and poultry processing sites • All persons in indoor areas of a court which are open to the public or used by jurors • After being tested for COVID-19; diagnosed or close contact
ACT	✓	✓	✓	✓	✓	✓	• Mandatory face mask for all indoor settings (other than residence) from 21 Dec 21
SA	✓	✓	✓	✓	✓	✓	Mandatory: • Health care services • Passenger transport • High risk settings • Airports and airplanes • Personal care • Indoor public places • In quarantine Strongly recommended: • Indoor workplaces • Adult learning environments Optional • Childhood education services
NT			✓				
WA			✓				
TAS	✓	✓	✓	✓	✓	✓	Everyone aged 12 and over when in public indoor settings (from 21 Dec 21); Mandatory: • Indoor workplaces • Education settings • Indoor Businesses and shops (supermarkets, restaurants, pubs) • Banks, pharmacies • Public transport *Not required outdoors (unless large event) or at home

Public Health Directions – Human Rights Assessment
Public Health Face Masks Requirements Direction (No.3)

Title	Public Health Face Masks Requirements Direction (No.3)
Date effective	22 December 2021

Background

The *Public Health Face Masks Requirements Direction (No.3)* (the Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the Direction is to mitigate the risk of transmission of COVID-19 in high risk environments to the Queensland community, and to ensure the safety of people who are frequenting high risk environments through a requirement to wear masks. In addition to high risk environments covered by the *Mandatory Face Masks Direction (No.3),* high risk environments have been identified as public transport and transport waiting areeas, indoor retail and vulnerable settings including residential aged care, shared disability accommodation, hospitals, prisons and youth justice detention centres.

The Direction takes the least restrictive approach necessary by only requiring face masks to be worn in limited identified settings, including indoors in vulnerable settings and in retail shops, in indoor cinemas and theatres, for staff in hospitality venues, and on public transport and in associated passenger waiting areas. In addition, exceptions are provided, including for emergencies and to ensure people can receive retail services that cannot reasonably be received or provided while wearing a face mask.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

The amendments to the Direction include additional indoor settings where there is increased risk of transmission due to the large numbers of people congregated in enclosed spaces.

How the Direction achieves the purpose

The Direction requires a person to wear a mask in the following high-risk environments anywhere in Queensland:

- an indoor space that is a retail shop
- a staff member working at a hospitality venue
- a patron, staff member or other person in an indoor cinema or theatre, when entering, exiting and seated

- a residential aged care facility, shared disability accommodation service, a corrective services facility or detention centre, a hospital or healthcare facility
- on public transport and in waiting areas for public transport
- in a commercial passenger vehicle or waiting area

The Direction provides for a number of lawful excuses for wearing a mask in the following circumstances:

- for children under 12
- a person eating, drinking or taking medicine
- where visibility of the mouth is essential – for example, a person communicating to someone who is deaf or hard of hearing, a teacher
- a person with a particular medical condition or disability that may be made worse by wearing a mask – for example, a person who has breathing difficulties, a serious skin condition on their face, a mental health condition or psychological impacts from experienced trauma
- a person undergoing medical treatment – for example, a person receiving first aid
- providing or receiving a service from a ***business, activity or undertaking*** which is permitted to operate under, and is operating in accordance with, the *Public Health and Social Measures linked to vaccination Direction* or its successor, to the extent that it is not reasonably practicable to provide or receive that service wearing a ***face mask***
- providing or receiving a service that requires or relates to being in a photograph taken at a ***retail shop*** or within a ***retail shop***, while the photograph of the person is being taken
- if a person is asked to remove a face mask to ascertain identity
- if wearing a mask creates a risk to a person's health and safety
- for emergencies or if required under a law
- in any circumstances where it is not safe to wear a face mask.

If a person removes their face mask under any of the lawful excuses, they must put it back on as soon as practicable.

The Chief Health Officer may grant a person an exemption from all or part of the Direction on the basis of exceptional circumstances.

Human rights engaged

The human rights engaged by the Direction are:

- Right to life (section 16)
- Freedom of expression (section 21)
- Privacy (section 25)
- Right to equality and non-discrimination (section 15)

The right to life is protected under section 16 of the Human Rights Act. The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. This right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights. By requiring people to wear masks in high risk environments in Queensland, the Direction promotes the right to life by protecting the health, safety and wellbeing of people in the Queensland, by reducing the risk of the spread of COVID-19 into and throughout Queensland.

Limitations

Section 21 of the Human Rights Act provides that the right to freedom of expression includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be expressed in various ways, including in writing, through art, or orally. The Direction limits this right by restricting how a person may express themselves orally or through the garments they wear by requiring them to wear a certain type of face mask in high risks environments in Queensland. A person may still make or purchase a cloth mask of their choosing and is permitted to remove the mask in certain circumstances such as when making announcements, or teaching.

The right to privacy also includes a right to bodily integrity (see *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 126 599] and 'personal inviolability' in the sense of 'the freedom of all persons not to be subjected to physical or psychological interference, including medical treatment, without consent.' *See PBU v Mental Health Tribunal* (2018 56 VAR 141, 180-1 [128]. It is arguable that the Direction engages this aspect of the right through the requirement for a person to wear a face mask or potentially be fined. However, the extent of the impact on human rights is reduced by the fact that there a number of lawful excuses for removing a face mask in certain situations such as to eat, drink, consume medicine or receive medical treatment.

Right to equality and non-discrimination (section 15): The right to equality and non-discrimination protects people from discrimination on the basis of certain attributes such as disability or race. The requirements to wear face masks in high risk environments discriminates against people with a disability. For example, masks may make it harder for people with hearing loss to lip read and communicate. The definition of 'discrimination' under the *Human Rights Act* is inclusive. Discrimination may include discrimination on the basis certain attributes such as disability or race, as it does with respect to the right to equality under the Canadian Charter, which also contains an inclusive definition of discrimination: *R v Turpin* [1989] 1 SCR 1296. However, the extent of the impact on human rights is reduced by the fact that there a number of lawful excuses for removing a face mask such as to communicate with a person who is deaf or hard of hearing and visibility of the mouth is essential for communication. A person is not required to carry or wear a mask in high risk environments if they have a physical or mental health illness or condition, or disability, which makes wearing a face mask unsuitable.

Compatibility with Human Rights

Proper purpose (section 13(2)(b))

The purpose of the Direction is to reduce the spread of COVID-19 from high risk environments to the Queensland community.

Requiring certain people in high risk environments to wear a mask is to confine potential outbreaks. The Direction is in effect for a temporary period, and the restrictions as applying to a person only apply in particular environments. It is unlikely a person would be required to wear a mask for a long period of time under any of the requirements in the Direction. A person can remove their mask when in an outside area of retail shops, outdoors and in many settings. Ultimately, the purpose of wearing masks is to limit the opportunity for transmission of COVID-19 from high risk environments to the Queensland community.

The aim of protecting public health is a proper purpose. Protecting people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

The purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

The limits on human rights will help to achieve the intended purpose of protecting public health by limiting the opportunities for transmission of COVID-19 in high risk environments.

The mask wearing requirements and the exceptions to mask wearing requirements have been tailored to the needs of different cohorts. For example, a person visiting at a residential aged care facility can remove the mask to eat and drink while visiting a resident, only staff at hospitality venues must wear a mask as they are moving around while patrons remain seated.

This approach ensures the Direction is suitably tailored to address the public health risks associated with COVID-19 while acknowledging there may be individual circumstances that need to be managed appropriately.

Necessary (s 13(2)(d))

The limits on human rights are necessary to achieve the purpose. There is no other way to address the risk of COVID-19 spreading into Queensland from overseas or interstate which would be (a) reasonably available (that is, as practicable), and (b) less restrictive of human rights.

In particular:

- Requiring face masks in all indoor settings and outdoor areas would be more restrictive of human rights.
- Relying on other measures such as contact tracing would not be as effective in achieving the purpose of limiting the spread of COVID-19 into Queensland, given the possibility that people in high risk environments such as on public transport or travelling in vehicles transporting people who may be asymptomatic or presymptomatic. In addition, one person could have a substantial number of contacts that need to be traced. For example, a single positive case in a busy shopping centre could have hundreds of contacts requiring investigation. This can be an onerous task given there are a limited number of contact tracing officers available.

Fair balance (section 13(2)(e), (f) and (g)

Given the risk posed by high risk environments based on the people who frequent these environments, including people who may have been in a COVID-19 hotspot or overseas in the last 14 days, the purpose of the Direction can only be reasonably achieved by requiring people to wear masks in these environments unless certain exceptions apply.

Many of the limits on human rights are incidental. For example, although the requirement to wear a face mask limits the right to equality and non-discrimination, people are able to remove their mask to communicate with a person with a disability.

The extent of the limitation on human rights is further reduced in other ways. The Direction is in effect for a temporary period, and the restrictions that apply to a person should in most circumstances only require a person to wear a mask for a short period of time.

The requirements of the Direction are proportionate and necessary to the unprecedented threat to public health, including the pressing need for physical distancing requirements. The Direction does not: limit the right to hold a religious belief; target any religious or cultural groups; or restrict people from engaging in their cultural or religious practices.

The limits on human rights by requiring a person to wear a mask in high risk environments or be subject to a fine are justifiable. Requiring a person to wear a mask is aimed at addressing the risk presented by COVID-19 and will assist in addressing that risk. For example, a person in any of these settings may potentially be asymptomatic and there will be no means of preventing transmission of COVID-19 to other people without the use of a face mask. The person could potentially infect people in the wider community while on public transport or in shopping centres. Tackling such a scenario would require resources for contact tracing (one person could have up to 200 contacts) and may divert resources from other critical areas. The need to address the risk of a potential outbreak or community transmission of COVID-19 in Queensland, outweighs the impact on human rights.

The Direction provides a broad exemption power enabling the Chief Health Officer to grant an exemption to any of its requirements based on exceptional circumstances. This broad power was included to protect against unintended consequences of the Direction, and to acknowledge that there may be circumstances where requiring a person to wear a mask may not be reasonable or appropriate.

There will be some impact on human rights, in particular, the right to equality for people with disabilities. However, the importance of limiting the spread of COVID-19 into Queensland (taking into account the right to life) outweighs the impact on other human rights. Indeed, it is difficult to overstate the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading into Queensland.

COVID-19 Public Health Policy Rationale – Public Health Face Mask Requirements Direction

1 January 2022

DRAFT NOT GOVERNMENT POLICY

Summary

COVID-19 has now seeded widely in Queensland and COVID-19 case numbers are doubling every two days, driven by the Omicron variant. Exposure sites and case locations extend throughout the State. Case numbers are increasing rapidly, maintaining exponential growth. On 1 January, there have been 2,266 cases reported in the last 24 hours, with a total of 13,947 cases since 13 December when Queensland removed quarantine requirements for fully vaccinated travellers entering Queensland from COVID-19 hotspots.

It is apparent that Omicron infects even people who are vaccinated. Early evidence suggests that even if Omicron is milder and that vaccinations continue to help prevent severe disease, with the current rate of growth, the increase in hospital admissions has the potential to be extreme and could exceed health system capacity.

The projected transmission rates for Omicron mean that timely interventions are more important than ever. Familiar, easy to implement public health and social measures (PHSM) such as mask wearing and avoidance of crowded and indoor spaces, will help to slow the transmission of the virus. Mask-wearing is a high-impact, low-effort public health measure to prevent the spread of COVID-19.

Mask wearing in some indoor places was reintroduced in Queensland on 17 December and extended to further settings on 22 December. This iteration of the Direction extends mask wearing requirements further to incorporate all indoor public places and workplaces, consistent with settings that have been applied previously during active outbreaks.

Background and policy rationale as at 1 January 2022

The World Health Organization (WHO) continues to reinforce the primary role of vaccines in fighting COVID-19 however, notes that to protect health system capacity and prevent uncontrolled spread, there will be a need to continue with additional protections such as wearing of masks, physical distancing, hand hygiene and ventilation for some time to come, and especially in the face of Omicron.

Mask wearing is a widely adopted and accepted measure to slow the spread of COVID-19 and performs a baseline protective function to reduce COVID-19 transmission. Evidence supports the benefits of cloth face masks for both source control (to protect others) and protection of the wearer. Multilayer cloth masks or nonmedical disposable masks for community use are widely recommended. It has long been agreed that face mask use is most important in indoor spaces and outdoors when physical distancing cannot be maintained. Many published scientific studies have demonstrated that masks help to prevent COVID-19 transmission.

A recent systematic review and meta-analysis of 72 studies found that mask-wearing was the single most effective public health measure for COVID-19, reducing the incidence of the disease by up to 53 per cent.[1] Protective measures to limit airborne spread are even more important in the context of more highly transmissible variants, transmitting even in the context of fleeting contact.

[1] Effectiveness of public health measures in reducing the incidence of covid-19, SARS-CoV-2 transmission, and covid-19 mortality: systematic review and meta-analysis, The British Medical Journal, Published 18 November 2021 (https://www.bmj.com/content/375/bmj-2021-068302)

On 17 December as a first step to slow COVID-19 transmission in Queensland, mask wearing requirements were reintroduced in some settings where vaccinated and unvaccinated people gather in close proximity. Masks were required while waiting for or when on public transport, at airports (existing requirement), in taxis and rideshare vehicles, indoors at retail centres (e.g. shopping centres, retail outlets) and at vulnerable settings. On 22 December, mask wearing requirements were extended to visitors and staff at indoor theatres and cinemas, and for staff at hospitality venues.

COVID-19 has seeded along the entirety of the Queensland coast, and is spreading inland (see Figure 1). While hospitalisation rates remain low overall, the rate of growth in cases has the potential to result in a high number of hospitalisations, particularly among the vulnerable and unvaccinated. Notably, in some of the most vulnerable regional areas where COVID-19 is now beginning to spread, vaccination coverage remains below the State average. For example, cases are growing rapidly in Cherbourg – there are 25 cases reported in Cherbourg with another 13 cases linked to the Cherbourg community in Murgon, Kingaroy and surrounding communities. Cherbourg has around 68 per cent first dose and 57 per cent two dose vaccination coverage compared to the State figures of 90.67 per cent first dose and 86.60 per cent second dose vaccination coverage among the eligible population (over 16 years).

In the current context of increasing case numbers across the State and consistent with settings applied previously during periods of increased risk and community transmission, mask wearing will be mandated in additional settings across Queensland and will now be required in all indoor public places and in workplaces, except where it is unsafe to wear a mask, or when seated (such as when eating and drinking) at a hospitality venue.

These settings bring Queensland into line with mask-wearing measures in place in all other Australian jurisdictions, with the exception of South Australia, which has mask wearing requirements for high risk settings only (not including workplaces) with a range of additional density restrictions, and restrictions on activities (e.g. no singing or dancing) in place. Changes to mandatory mask settings for Queensland are summarised below.

<table>
<tr><th>Current</th><th>From 1 January 2022</th></tr>
<tr><td>Retail settings</td><td rowspan="2">Staff, patrons, and visitors at all <u>indoor public places</u> (including pubs, clubs and restaurants, gyms, hairdressers, libraries, galleries, indoor stadiums)</td></tr>
<tr><td>Indoor cinemas and theatres</td></tr>
<tr><td rowspan="2">Staff at hospitality venues</td><td>All <u>workplaces</u>, except where alone or unsafe</td></tr>
<tr><td colspan="2">Airports and flights</td></tr>
<tr><td colspan="2">Public transport</td></tr>
<tr><td colspan="2">Healthcare and vulnerable settings</td></tr>
</table>

As per existing and previous settings, mask-wearing requirements do not apply to children under the age of 12 years, anyone affected by health or other medical conditions or who are hard of hearing. Masks will also not be required when travelling alone or with members of the household (or social circle) in a vehicle, while seated (such as while eating or drinking), or when in the workplace when alone or alone in a meeting room with the door closed.

Allowing for masks to be removed when seated indoors at higher-risk environments such as cafes and restaurants is a logical concession to this protective measure, as people are typically consuming food and drink at these environments and seated with people from the same household or social circle with frequent contact across a range of settings. Eating, talking and socialising in loud environments is known to create a higher risk of transmission however, and over time there may need to be additional measures, such as density restrictions imposed at these places to support increased distancing. People are encouraged to consider dining

outdoors wherever possible and venues should consider opening doors and windows to maximise airflow and ventilation.

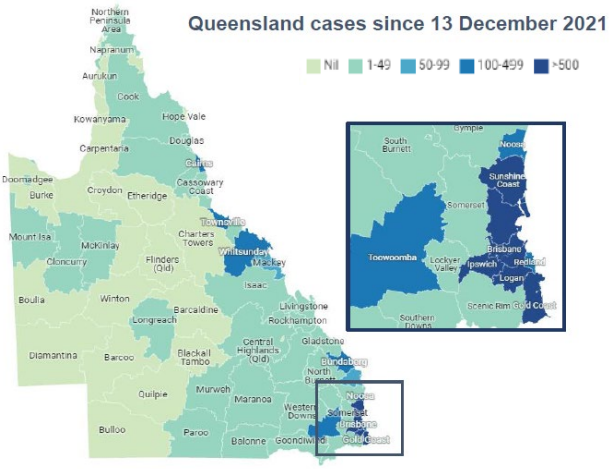
For consistency, in office environments, people at their workstation (sitting or standing) when physically distanced are also permitted to remove their mask, although they would be required to wear their mask while moving around the office, where they may come into contact with more people. Notwithstanding this concession, people should be strongly encouraged to consistently wear a mask (unless unsafe or exempt for another reason) while at work. With the updated and very targeted definition of close contact from 31 December capturing only household contacts with extended exposure, it is reasonably foreseeable that undetected COVID-19 transmission will occur in workplaces, particularly in enclosed environments where people are working together and talking in relative proximity for extended periods. Ventilation of buildings, particularly enclosed office buildings, is not regulated to a standard that will reliably reduce the risk of transmission. Mask wearing provides additional protection in this environment, even with physical distancing. People are also being strongly encouraged to work from home wherever possible, to maximise physical distancing at the workplace, reduce the scale of potential exposure, and protect against wider outbreaks that could also significantly impact on business continuity.

Like previous occasions, it is not expected that people wear masks in their own homes. However, there are occasions where mask wearing is strongly encouraged, such as when visiting with vulnerable loved ones indoors, and where thorough ventilation and distancing are not possible. Where a tradesperson attends a home and is working in proximity to other people, it would be expected that they would wear a mask – the home would be considered their workplace.

For those parts of Queensland with repeated experience of outbreaks and increased public health measures, the community has shown a high level of compliance. Community acceptance and familiarity with mask-wearing has progressed considerably during the pandemic and mask mandates have been employed at various times, not just for the immediate infection prevention benefits but as a valuable reminder to practise physical distancing and exercise increased vigilance during key risk periods.

For parts of the State that have had very little or no exposure to COVID-19 to date, the increased requirements may be met with some resistance or take some time to become habituated. As noted previously, COVID-19 has now seeded across the State and is increasingly moving into regional and remote areas (see Figure 1 below). This is why requirements will apply uniformly across the State and the mandate will be widely enforced, particularly in more vulnerable areas. As on previous occasions, it is expected that an educative and supportive approach will be taken in the first instance, but fines will apply for active non-compliance.

Figure 1. Heatmap of COVID-19 cases across Queensland (as at 1 January 2022)



Public health considerations – 1 January 2022

Epidemiological situation

Queensland

- Queensland reported 2,266 new COVID-19 cases in the previous 24 hours.
- The total number of active cases in Queensland is 13,959, with 150 people in hospital (1 person in ICU) and 2,498 receiving care in the home.
- As at 31 December, Queensland is at 90.67 per cent first dose and 86.60 per cent second dose vaccination coverage among its eligible population (over 16 years).

National

- In the 24 hours to 9pm on 29 December, 18,242 cases were reported in Australia. There are approximately 93,930 active cases and 1,314 people with COVID-19 are currently hospitalised.
- On 30 December, NSW reported 12,226 cases and one death, and Victoria recorded 5,137 cases and 13 deaths.
- As at 28 December, Australia has reported 91.2 per cent of the eligible population aged 16 years and over as fully vaccinated; 94.2 per cent has had at least one dose.
- On 10 December the Australian Government confirmed that Australia's COVID-19 vaccination program will be extended to all children aged 5 to 11 years from 10 January 2022, after the Australian Government accepted recommendations from the Australian Technical Advisory Group on Immunisation (ATAGI).

Queensland's COVID plans and settings

- Booster COVID-19 vaccines are now widely available to anyone who has had their second dose at least four months ago.
- On 18 October 2021, Queensland released the COVID-19 Vaccine Plan to Unite Families. Under this plan, changes to border restrictions and quarantine requirements at increasing levels of state-wide vaccination coverage are described.
- From 13 December:
  - Fully vaccinated travellers from a domestic COVID-19 hotspot can arrive by road or air, with no quarantine required but must have had a negative COVID-19 test in the previous 72 hours and agree to get a further COVID-19 PCR test on day five of their stay in Queensland.
  - Fully vaccinated direct international arrivals can undertake home quarantine subject to conditions set by Queensland Health, provided they are fully vaccinated and have a negative COVID-19 test in previous 72 hours.
- At 90 per cent of Queensland's eligible population fully vaccinated, there will be no entry restrictions or quarantine for vaccinated arrivals from interstate or overseas.
  - Unvaccinated travellers will need to apply for a border pass, enter within the international arrivals cap, and undertake a period of quarantine.
- On 9 November 2021, the Queensland Government released its *Public Health and Social Measures linked to Vaccination Status: A Plan for 80% and Beyond*, which sets out measures variously applying to vaccinated and unvaccinated people aged 16 years and over. The associated Direction was published on 7 December and has come into effect from 17 December.
- Under the Plan, all staff and visitors at hospitality and entertainment venues, including pubs, clubs, cafés, cinemas, theatres and music festivals must be fully vaccinated, with no COVID-19 density restrictions at these venues.
- Mask wearing is currently mandated across the State at all retail settings, and at cinemas and theatres, and for staff at hospitality settings.

Public Health System capacity

- Currently, Queensland Public Health Units are working to contact positive cases and support contact tracing efforts. The growth in cases is a significant and contact tracing capacity is under increasing pressure.
- Contact tracers are triaging and moving through highest risk cohorts, focusing on contacting positive cases and their immediate contacts only. As at 22 December, Queensland Health has ceased publishing low risk exposure sites and will cease publicly reporting exposed flights or airports due to the volume of these indicated.
- Where people cannot be contacted directly for a close contact site, a public health alert is issued, and these exposure sites are being listed online.

Health Care System capacity

- Queensland Health has considered a range of epidemiological modelling, including scenario-based impacts on hospital capacity and workforce.
- This modelling, and lessons from the recent NSW and Victorian outbreaks, have identified that a flexible and high capacity health system delivery model is needed. It is expected that with increased vaccine protection and with continuing public health and social measures, including mask wearing, the number of people requiring hospitalisation and intensive care are likely to remain within hospital and health system capacity.
- To support health system delivery in this new phase of COVID-19, Queensland Health is operating a tiered health system response to activate additional capacity when triggers associated with increasing case numbers are met.
- Strategies are in place with private providers to minimise the interruption to urgent elective services in the event of impacts on hospital and health service delivery. Strong partnerships with major private providers will assist public hospital systems to respond to a COVID-19 surge.
- Notably, Queensland's planned COVID-19 response has been modelled on the Delta variant of concern. Evidence to date is suggesting that Omicron evades immunity more successfully and transmits more easily. This means that with Omicron the projected cases are likely to increase more rapidly and peak much higher than was anticipated under a dominant Delta scenario. Updated modelling will need to be considered when data becomes available.
- With the growth in cases in Queensland, hospitals are beginning to see cases and where appropriate people are now being managed in 'virtual wards' (capacity of 500 places).
- Queensland's existing quarantine hotel network is also providing isolation services for COVID-well patients who do not have a suitable place to isolate while infectious. This is assisting with ensuring that hospital capacity is maintained for COVID-19 patients that require hospital care, including virtual care such as Hospital in the Home.

Community acceptance and adherence

- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been accepting and supportive of public health measures. There are significant public and industry expectations of a 'return to normal' after reaching vaccination targets and borders opening.
- There are ongoing concerns of 'pandemic fatigue' and associated non-compliance with public health measures nationally. However, the need for lockdowns or widespread restrictions has been reduced dramatically with increased vaccination coverage.
- With lengthy periods of restriction in some jurisdictions (i.e. NSW and Victoria), as well as new vaccine-related mandates and public health and safety measures coming into effect, protests have been held in recent months, principally in east-coast states.

- The key issue in the medium-term is likely to be in relation to vaccine mandates, and the complexities of differing freedoms for vaccinated and unvaccinated people. State and territory mandates vary with local context. For example, Victoria and NSW—managing widespread outbreaks and health systems at capacity—mandated vaccination across many industries and settings, including construction, education, and other authorised workforces including retail. However, as vaccination coverage continues to increase there has now been a gradual lifting of these restrictions.
- Queensland requires vaccination for workers at high risk settings (schools, correctional facilities and airports) and for entry to a range of high-risk venues like hospitality and entertainment venues as part of baseline protections.

Wastewater monitoring

- Queensland conducts a surveillance program to detect traces of coronavirus in wastewater in 19 communities across the state.
- Wastewater monitoring systems detect viral fragments and can help experts determine where in the state there might be people with a current or recent COVID-19 infection. The system has significant value in its potential to serve as an early warning system for potentially undetected cases. It cannot pinpoint the exact source of the viral fragments.
- In the week ending 26 December there were detections at numerous sites, including major wastewater locations in Brisbane, the Gold Coast, Sunshine Coast, Toowoomba, Cairns, Logan, Warwick and Goondiwindi.

Public Health Directions – Human Rights Assessment
Public Health Face Masks Requirements Direction (No.4)

Title	Public Health Face Masks Requirements Direction (No.4)
Date effective	31 December 2021

Background

The *Public Health Face Masks Requirements Direction (No.4)* (the Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Bill 2020. This Bill amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the Direction is to mitigate the risk of transmission of COVID-19 to the Queensland community, and to ensure the safety of people who are indoors at a venue outside their home through a requirement to wear a face mask. In addition to high risk environments covered by the *Mandatory Face Masks Direction (No.3),* other high risk settings where masks are already required include public transport and transport waiting areas, indoor retail and vulnerable settings including residential aged care, shared disability accommodation, hospitals, prisons and youth justice detention centres. Masks will also be required in workplaces, pubs, clubs and cafes (except when seated), indoor stadiums and sports arenas (except when seated), libraries, hairdressers and nail salons and waiting rooms at medical centres.

The Direction takes the least restrictive approach necessary by providing exceptions, including for emergencies and to ensure people can receive retail services that cannot reasonably be received or provided while wearing a face mask.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the direction, and form part of the purpose of the Direction. As the below human rights analysis draws on the information contained in the Policy Rationale, they should be read together.

The amendments to the Direction include additional indoor settings where there is increased risk of transmission due to the large numbers of people congregated in enclosed spaces.

How the Direction achieves the purpose

The Direction requires a person to wear a mask in the following indoor settings and high-risk environments anywhere in Queensland including:

- Workplaces
- Pubs, clubs and cafes (except when seated)
- Indoor stadiums and sports arenas (except when seated)
- Libraries
- Hairdressers and nail salons

- Waiting rooms at a medical centre
- retail shops and shopping centres
- a staff member working at a hospitality venue
- a patron, staff member or other person in an indoor cinema or theatre, when entering, exiting and seated
- a residential aged care facility, shared disability accommodation service, a corrective services facility or detention centre, a hospital or healthcare facility
- on public transport and in waiting areas for public transport
- in a commercial passenger vehicle or waiting area

The Direction provides for a number of lawful excuses for wearing a mask in the following circumstances:

- for children under 12
- a person eating, drinking or taking medicine
- where visibility of the mouth is essential – for example, a person communicating to someone who is deaf or hard of hearing, a teacher
- a person with a particular medical condition or disability that may be made worse by wearing a mask – for example, a person who has breathing difficulties, a serious skin condition on their face, a mental health condition or psychological impacts from experienced trauma
- a person undergoing medical treatment – for example, a person receiving first aid
- providing or receiving a service from a ***business, activity or undertaking*** which is permitted to operate under, and is operating in accordance with, the *Public Health and Social Measures linked to vaccination Direction* or its successor, to the extent that it is not reasonably practicable to provide or receive that service wearing a ***face mask***
- providing or receiving a service that requires or relates to being in a photograph taken at a ***retail shop*** or within a ***retail shop***, while the photograph of the person is being taken
- if a person is asked to remove a face mask to ascertain identity
- if wearing a mask creates a risk to a person's health and safety
- for emergencies or if required under a law
- in any circumstances where it is not safe to wear a face mask.

If a person removes their face mask under any of the lawful excuses, they must put it back on as soon as practicable.

The Chief Health Officer may grant a person an exemption from all or part of the Direction on the basis of exceptional circumstances.

Human rights engaged

The human rights engaged by the Direction are:

- Right to life (section 16)
- Freedom of expression (section 21)
- Privacy (section 25)
- Right to equality and non-discrimination (section 15)

The right to life is protected under section 16 of the Human Rights Act. The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. This right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights. By requiring people to wear masks in high risk environments in Queensland, the Direction promotes the right to life by protecting the health, safety and wellbeing of

people in the Queensland, by reducing the risk of the spread of COVID-19 into and throughout Queensland.

Limitations

Section 21 of the Human Rights Act provides that the right to freedom of expression includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be expressed in various ways, including in writing, through art, or orally. The Direction limits this right by restricting how a person may express themselves orally or through the garments they wear by requiring them to wear a certain type of face mask in high risks environments in Queensland. A person may still make or purchase a cloth mask of their choosing and is permitted to remove the mask in certain circumstances such as when making announcements, or teaching.

The right to privacy also includes a right to bodily integrity (see *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 126 599] and 'personal inviolability' in the sense of 'the freedom of all persons not to be subjected to physical or psychological interference, including medical treatment, without consent.' *See PBU v Mental Health Tribunal* (2018 56 VAR 141, 180-1 [128]. It is arguable that the Direction engages this aspect of the right through the requirement for a person to wear a face mask or potentially be fined. However, the extent of the impact on human rights is reduced by the fact that there a number of lawful excuses for removing a face mask in certain situations such as to eat, drink, consume medicine or receive medical treatment.

Right to equality and non-discrimination (section 15): The right to equality and non-discrimination protects people from discrimination on the basis of certain attributes such as disability or race. The requirements to wear face masks in high risk environments discriminates against people with a disability. For example, masks may make it harder for people with hearing loss to lip read and communicate. The definition of 'discrimination' under the *Human Rights Act* is inclusive. Discrimination may include discrimination on the basis certain attributes such as disability or race, as it does with respect to the right to equality under the Canadian Charter, which also contains an inclusive definition of discrimination: *R v Turpin* [1989] 1 SCR 1296. However, the extent of the impact on human rights is reduced by the fact that there a number of lawful excuses for removing a face mask such as to communicate with a person who is deaf or hard of hearing and visibility of the mouth is essential for communication. A person is not required to carry or wear a mask in high risk environments if they have a physical or mental health illness or condition, or disability, which makes wearing a face mask unsuitable.

Compatibility with Human Rights

Proper purpose (section 13(2)(b))

The purpose of the Direction is to reduce the spread of COVID-19 in indoor settings and high risk environments.

Requiring people in indoor settings and high risk environments to wear a mask is to confine potential outbreaks. The Direction is in effect for a temporary period, and the restrictions as applying to a person only apply in particular environments. It is unlikely a person would be required to wear a mask for a long period of time under any of the requirements in the Direction. A person can remove their mask when in an outside area of retail shops, outdoors and in many settings. Ultimately, the purpose of wearing masks is to limit the opportunity for transmission of COVID-19 from indoor settings and high risk environments to the Queensland community.

The aim of protecting public health is a proper purpose. Protecting people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At

international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

The purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

The limits on human rights will help to achieve the intended purpose of protecting public health by limiting the opportunities for transmission of COVID-19 in high risk environments.

The mask wearing requirements and the exceptions to mask wearing requirements have been tailored to the needs of different cohorts. For example, a person visiting at a residential aged care facility can remove the mask to eat and drink while visiting a resident.

This approach ensures the Direction is suitably tailored to address the public health risks associated with COVID-19 while acknowledging there may be individual circumstances that need to be managed appropriately.

Necessary (s 13(2)(d))

The limits on human rights are necessary to achieve the purpose. There is no other way to address the risk of COVID-19 spreading into Queensland from overseas or interstate which would be (a) reasonably available (that is, as practicable), and (b) less restrictive of human rights.

In particular:

- Requiring face masks in all outdoor areas would be more restrictive of human rights.
- Relying on other measures such as contact tracing would not be as effective in achieving the purpose of limiting the spread of COVID-19 into Queensland, given the high case numbers and possibility that people in indoor settings and high risk environments such as on public transport or travelling in vehicles transporting people who may be asymptomatic or pre-symptomatic. In addition, one person could have a substantial number of contacts that need to be traced. For example, a single positive case in a busy shopping centre could have hundreds of contacts requiring investigation. This can be an onerous task given there are a limited number of contact tracing officers available.

Fair balance (section 13(2)(e), (f) and (g)

Given the risk posed by indoor settings and high risk environments based on the people who frequent these environments, including people who may have been in a COVID-19 hotspot or overseas in the last 14 days, the purpose of the Direction can only be reasonably achieved by requiring people to wear masks in these environments unless certain exceptions apply.

Many of the limits on human rights are incidental. For example, although the requirement to wear a face mask limits the right to equality and non-discrimination, people are able to remove their mask to communicate with a person with a disability.

The extent of the limitation on human rights is further reduced in other ways. The Direction is in effect for a temporary period, and the restrictions that apply to a person should in most circumstances only require a person to wear a mask for a short period of time.

The requirements of the Direction are proportionate and necessary to the unprecedented threat to public health, including the pressing need for physical distancing requirements. The Direction does

not: limit the right to hold a religious belief; target any religious or cultural groups; or restrict people from engaging in their cultural or religious practices.

The limits on human rights by requiring a person to wear a mask in high risk environments or be subject to a fine are justifiable. Requiring a person to wear a mask is aimed at addressing the risk presented by COVID-19 and will assist in addressing that risk. For example, a person in any of these settings may potentially be asymptomatic and there will be no means of preventing transmission of COVID-19 to other people without the use of a face mask. The person could potentially infect people in the wider community while on public transport or in shopping centres. Tackling such a scenario would require resources for contact tracing (one person could have up to 200 contacts) and may divert resources from other critical areas. The need to address the risk of a potential outbreak or community transmission of COVID-19 in Queensland, outweighs the impact on human rights.

The Direction provides a broad exemption power enabling the Chief Health Officer to grant an exemption to any of its requirements based on exceptional circumstances. This broad power was included to protect against unintended consequences of the Direction, and to acknowledge that there may be circumstances where requiring a person to wear a mask may not be reasonable or appropriate.

There will be some impact on human rights, in particular, the right to equality for people with disabilities. However, the importance of limiting the spread of COVID-19 into Queensland (taking into account the right to life) outweighs the impact on other human rights. Indeed, it is difficult to overstate the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading into Queensland.

COVID-19 Public Health Rationale
Easing mask wearing, density and gathering restrictions for Queensland
4 March 2022

DRAFT NOT GOVERNMENT POLICY

Summary

This Policy Rationale describes the planned changes to public health protections announced by the Premier on 22 February 2022, to commence on 4 March 2022, coinciding with the plateau of the first wave of Omicron in Queensland. The changes that are described in this Policy Rationale impact on the *Movement and Gathering Direction*, the *Public Health and Social Measures linked to vaccination status Direction* and the *Public Health Face Mask Requirement Direction.*

The changes encompass the removal of all density restrictions, including at homes and at community and publicly accessible venues, and the easing of mask wearing requirements in most settings. These measures applied at a population level have high merit during periods of accelerating case numbers and transmission where slowing transmission is the priority, however in the current context of stable case numbers, it is appropriate to ease these restrictions.

It is safest and most practical to first remove those measures that can be quickly and easily reinstated, should the context shift rapidly. Relaxing measures that impact the entire population, like mask-wearing in most places, and density restrictions and caps at homes and community-accessible venues as soon as it is safe to do so from a public health risk perspective also preserves community confidence and limits fatigue or issues of sustained compliance.

The proof of vaccination requirement at identified high-risk, high-transmission venues, settings, and activities will be one of the last remaining baseline protections in place at a community level. These requirements continue to protect public health and health system capacity, particularly while the epidemiological context is monitored over the coming weeks, and they an important role in tempering severe outcomes from ongoing transmission across the State. It is for this reason these requirements remain in place at this time. Broader consideration is being given to the most effective and appropriate response to COVID-19 going forward, in the context of ongoing and likely fluctuating COVID-19 transmission, community and health system burden.

Mask wearing will continue to apply at settings that are higher-risk due to the cohorts receiving care or who are housed there, including across vulnerable facilities, at general practitioners and other settings where healthcare is being provided. Masks will also remain at settings where people are in particularly close proximity in a small, enclosed space for a period of time, including on domestic flights in Queensland (and airports), and on public transport.

The changes to attendance caps and density restrictions at homes and publicly accessible places, like places of worship and community halls, mean that private and community gatherings may now take place without restrictions, regardless of vaccination status. Wedding ceremonies and receptions are currently limited to 20 people where unvaccinated people are in attendance, regardless of the venue or setting. With the removal of these restrictions, it is appropriate that weddings, regardless of vaccination status, also be released from restrictions at these venues and more broadly, outdoors. The COVID-19 risk posed by a wedding ceremony or reception with unvaccinated persons in attendance, outdoors or at a place not otherwise subject to restrictions is no greater than the risks or potential impact of a similarly attended church service, a community dance at a hall, or a large birthday party at a park.

Additional minor amendments for mask wearing, arising from emerging needs of disaster recovery workers during recent severe weather events, and for proof of vaccination requirements for school-based activities and excursions to ensure equitable access for students, are also described in this Policy Rationale.

There will be no changes to the protections in place at vulnerable facilities, including mask wearing. Public health measures at these settings remain critical to prevent COVID-19 exposure and transmission to the cohorts most vulnerable to the impacts of COVID-19.

Background and rationale as at 4 March 2022

Current epidemiological situation

Following the reopening of Queensland's border in December 2021 and coinciding with the emergence of the Omicron variant in Australia, Queensland has experienced a significant COVID-19 wave, predominantly of the Omicron variant, which has seen 11% of the population infected (confirmed cases only, the true figure is likely to be much higher), more than 500 deaths in three months, compared to a total of 7 deaths in the previous 20 months.

Queensland is for the first time, experiencing widespread and sustained community transmission of COVID-19. Omicron has spread through the Queensland community at a much greater rate than calculated in previous Delta-focused planning. This rate of spread is also being experienced nationally and globally. There have been different patterns of transmission across Queensland, with the South-East corner reporting the majority of cases during this wave. However, as Omicron continues to transmit throughout Queensland, more cases will occur in regional areas.

Although Omicron is immune evasive and extremely transmissible, preliminary evidence on Omicron suggests that the risk of severe outcomes at the population level is lower than that posed by the Delta variant. It is apparent however that due to its high rate of transmissibility that the impact of this variant can still be substantial. The evidence to date is that vaccination continues to provide strong protection against severe disease with Omicron and up to date vaccination is the best way to protect against infection and transmission.

Fortunately, the recent very high rates of transmission in Queensland occurred against a backdrop of a highly vaccinated population. Across the eligible adult population, more than nine in 10 Queenslanders have now received two doses of COVID-19 vaccine (92.9 per cent single dose, 91.0 per cent double dose) and close to two in three of those eligible (62.1 per cent) have received a third 'booster' dose as at 2 March. Among children, vaccination coverage of two doses is over 70.8 per cent for young adults (aged 12-16) and is at 42.7 per cent first dose for recently eligible 5-11 year olds.

It is likely that the protection of widespread vaccination contributed to a lower rate of morbidity and mortality, and less pressure on health services than anticipated, despite the accumulation of well over 580,000 confirmed cases in three months and many thousands more in cases not reported.

Modelling for the Omicron wave indicated that between 3,000 and 5,000 hospital inpatients and between 300 to 450 ICU inpatients could be expected at the peak. There is surge capacity in Queensland's acute care system, and ICU capacity can be scaled up to 570 beds if needed (up to 800 with private ICU beds included). Like other jurisdictions and in anticipation of the peak of the Omicron wave, Queensland postponed all non-urgent public elective surgeries (category 3 and non-urgent category 2) in early January until 1 March. Elective surgery for private patients continued to occur in private hospitals throughout Queensland with some private hospitals providing elective surgery for public patients. Actual hospitalisations and ICU admissions were well below those modelled, reaching 821 people in hospital and 33 people in ICU at what was the peak of this wave on 31 January.

Evidence shows that there is an increased likelihood of hospitalisation from COVID-19 for people who are not vaccinated and that the likelihood of being hospitalised increases with age. According to Queensland Health data, people who were unvaccinated were 5.4 times more likely to be admitted to the ICU compared to people who have had two or more doses of a COVID-19 vaccine. For people aged 60 years or more, those who were unvaccinated were 5 times more likely to die than those cases who had been partially vaccinated (that is people who had started their vaccination program but were not up to date) and were 15 times more likely to die than those cases who were fully vaccinated (that is people with COVID-19 who had received two doses and were not yet due for their 3rd or people who had received 3 doses).

Older age and comorbidities remain the biggest risk factor for severe outcomes from infection with COVID-19. The number and distribution of case numbers and deaths since December, and throughout the pandemic, demonstrate that those who are most vulnerable to COVID-19 are older and more vulnerable members of the

community, those who are unvaccinated or have not received a booster dose and those with other contributing or underlying health conditions. Of the 577 deaths in Queensland, 305 have occurred in aged are residents.

As at 4 March, there are 30,377 active cases in Queensland. Although it is likely the true number of active and new cases in the community is higher, the number of daily confirmed cases has remained relatively stable over the past two weeks (averaging approximately 4,700 per day). Although daily cases remain in the thousands, indications are that the first wave of COVID-19 in Queensland has passed. Overall hospitalisations are a key indicator of the impact of COVID-19. New hospitalisations remain stable, and overall the number of people in hospital continues to reduce; 284 people are in hospital with COVID-19 on 4 March. A statewide staged restart of elective surgery across Queensland public hospitals is beginning, with the initial focus on the most urgent matters.

The emergence of the Omicron variant has accelerated the anticipated shift in Queensland's public health response from elimination, to suppression during the first wave from December 2021 to February 2022 and now a move into a phase of managing ongoing but temporarily stable transmission of COVID-19, with a view to preparing for future waves, additional variants, and potentially a parallel influenza outbreak in 2022.

Queensland, in line with both Queensland and National Plans has been gradually easing restrictions that were designed for the elimination phase of the pandemic. This approach is consistent with other jurisdictions both here in Australia and globally. In the context of a flattening curve in confirmed COVID-19 cases and new hospitalisations, and despite ongoing transmission, the need for higher-level public health protections against exponential growth in cases has eased. Table 1 provides a high-level summary of the current public health measures in place, with the changes described in this Policy Rationale highlighted in green.

Table 1. Summary of current and proposed public health measures as they apply to relevant settings

Measure and setting	Current	Proposed
Masks		
All indoors, including workplaces	✓	-
Vulnerable facilities and healthcare settings	✓	✓
Airports and flights	✓	✓
Public transport, taxis, rideshare and shuttles	✓	✓
Density restrictions (1 per 2 sqm)		
Community facilities	✓	-
Food courts	✓	-
Indoor play centres	✓	-
Funerals	✓	-
Places of worship, churches	✓	-
Hospitality and entertainment venues*	✓	- *(cap retained)*
Vaccination requirements		
Hospitality and entertainment venues	✓	✓
Amusement parks and zoos	✓	✓
Government owned galleries, libraries, museums	✓	✓
Stadiums above 5,000 attendees	✓	✓
Stadiums below 5,000 attendees	-	-
Festivals and shows (including showgrounds)	✓	✓
Outdoor community events	-	-
Caps on numbers		
Private gatherings at homes and non-residences	✓ (100)	-
Wedding ceremonies and receptions with unvaccinated attendees	✓ (20)	*No restrictions except when private hire at a venue with vaccination requirements, then capped at 20*

**Applying to private hire where unvaccinated people attend, 1 per 4 sqm, with cap of 20 people.*

Mask wearing

Mask wearing is a high impact and low impost public health measure that slows transmission during active outbreaks of COVID-19 and is especially important as a timely measure during accelerating growth in cases. Mask wearing is a high value, baseline protective public health measure that has been applied repeatedly within and across all of Queensland, and within and across a range of settings as needed.

Evidence supports the benefits of cloth face masks for both source control (to protect others) and protection of the wearer. Multilayer cloth masks or nonmedical disposable masks for community use are widely recommended. It has long been agreed that face mask use is most important in indoor spaces and outdoors when physical distancing cannot be maintained. A recent systematic review and meta-analysis of 72 studies found that mask-wearing was the single most effective public health measure for COVID-19, reducing the incidence of the disease by up to 53 per cent.[1] Protective measures to limit airborne spread are even more important in the context of more highly transmissible variants, transmitting even in the context of fleeting contact. Mask wearing is most impactful during periods of high community transmission.

Most recently, on 17 December as a first step with growing COVID-19 transmission in Queensland, mask wearing requirements were reintroduced in some settings where vaccinated and unvaccinated people gather in close proximity. Masks were required while waiting for or when on public transport, at airports (existing requirement), in taxis and rideshare vehicles, indoors at retail centres (e.g. shopping centres, retail outlets) and at vulnerable settings. On 22 December as exponential case growth became apparent, mask wearing requirements were extended to visitors and staff at indoor theatres and cinemas, and for staff at hospitality venues. Over the Christmas period, movement was naturally slowed and no further adjustments were made, but on 2 January 2022, mask wearing requirements were extended further to incorporate all indoor public places and workplaces. These settings were adopted in the context of rapidly increasing case numbers and have remained in place throughout the peak of this first wave of Omicron.

It is safest and most practical to first remove those measures that can be quickly and easily reinstated, should the risk profile shift rapidly, such as with an accelerating increase in cases or a new variant. Relaxing protective measures, especially those that impact the entire population, during periods of reduced overall risk is critical, even if the relaxation is only temporary. It also preserves community confidence and limits fatigue or issues of sustained compliance. There is an argument that prolonged mask wearing could habituate the behaviour, and indeed there are benefits in mask-wearing for the protection against other transmissible viruses like influenza, and mask wearing is always strongly encouraged when people are in close proximity or if they feel vulnerable.

However, in the current epidemiological context of COVID-19 and consistent with the intended application and duration of public health directions, it is appropriate at this time that mask wearing requirements be eased in certain settings. Mask settings will return to baseline settings and will no longer be required in indoor places or workplaces. Mask wearing at schools, in accordance with the Department of Education's (DoE) Back to School plan, will also be lifted.

Mask wearing requirements will continue to apply to settings that are higher-risk due to the cohorts receiving care or who are housed there, or at settings where people are in particularly close proximity in a small, enclosed space for a period of time. This includes healthcare settings where face-to-face services are provided to patients (including general practitioners and pharmacies), clients and others accessing healthcare, residential aged care facilities, shared disability accommodation services, hospitals, corrective services facilities, or detention centres; on, or waiting for, public transport; in, or waiting for, a taxi, ride share or commercial shuttle. Mask wearing is also required where a person has COVID-19 symptoms or where a person has been tested for COVID-19 and is awaiting results.

These settings will mean masks are not mandated for the majority of day-to-day activities of the entire Queensland population. It is expected that the risk of exposure to and transmission of COVID-19 may be

[1] Effectiveness of public health measures in reducing the incidence of covid-19, SARS-CoV-2 transmission, and covid-19 mortality: systematic review and meta-analysis, The British Medical Journal, Published 18 November 2021 (https://www.bmj.com/content/375/bmj-2021-068302)

slightly increased with the removal of masks indoors, particularly in areas that are experiencing ongoing transmission, however, the most vulnerable members of the population will continue to be protected.

A recent severe weather event in Queensland, with major flooding and significant disaster recovery efforts. To facilitate and accommodate these specific activities, an exemption to mask wearing has been included as a minor amendment, for future application of the Direction, in addition to existing exemptions for eating or drinking, and medical conditions. This will exempt a person who is assisting in or undertaking as disaster recovery or clean-up activity at a vulnerable facility or healthcare service from wearing a mask under the Direction. For example, a person cleaning mud and flood debris as part of disaster recovery work in a healthcare setting may remove their face mask while undertaking that activity. Mask wearing requirements for disaster recovery workers and critically essential workers who are permitted to leave quarantine to attend the premises will remain in place.

The community continues to be strongly encouraged to wear a mask if they feel at risk and messaging is strongly promoting the ongoing purpose and value of mask wearing. The Queensland public are familiar and highly compliant with this measure and it can be quickly reintroduced as needed.

Density and gathering restrictions

Physical distancing and gathering restrictions are among the easiest and most effective ways to reduce the risk of transmission and rate of spread of COVID-19. COVID-19 spreads from person to person, and these measures directly limit the number of people who may come into in close contact with a confirmed case of COVID-19. Anywhere that groups of people spend extended periods together, where they are indoors, engaged in loud conversation or in proximity to one another and around other groups are known to be higher risk environments for transmission of COVID-19. Households are among the highest transmission environments for COVID-19. Measures which limit people gathering are supported by evidence as having a considerable influence on reducing the spread of COVID-19.

Community venues and public settings

With the introduction of public health and social measures linked to vaccination status, a number of venues and settings were excluded from proof of vaccination requirements for staff and visitors, on the basis that they were places where unrestricted access was essential, including retail and essential services, universities, community facilities, places of worship, beauty services, gyms and health clubs and auction houses and inspections. Funerals held indoors were also restricted. To retain a degree of protection, density restrictions at some places were maintained, and settings were limited by a 1 person per 2 square metre density restriction for indoor spaces open to or used by visitors, or in the case of indoor funerals, also capped at a maximum of 200 attendees or to ticketed capacity. This limited, to varying degrees, the number of people able to access these venues, places and activities. The intent was to minimise the rate and scale of transmission while both vaccinated and unvaccinated people accessed these places, while retaining access to these places essential for community functioning and wellbeing.

Since these measures were put in place, COVID-19 has become widespread, and the epidemiological context and approach to managing COVID-19, particularly while Omicron is dominant, has changed, as described above. Table 2 at the end of this document outlines the risk profile of the settings currently captured by density restrictions and it is evident that the COVID-19 risk, both in terms of transmission and wider community impact is uniformly low at these places. In the context of taking the least restrictive approach according to the context, it is considered appropriate at this time to relax density restrictions at these specific settings, venues and for funerals held indoors.

The exception is for funerals, which have long been recognised as posing higher risks due to the nature of the event and sometimes wide travel involved. Funerals are an important ritual which sometimes occur at short notice and often under difficult circumstances. The small additional risk of removing all restrictions for these important events is considered appropriate in the wider context and with additional relaxations for other events.

Removing the remaining density restrictions at these settings is not expected to significantly increase crowding. These are settings that continue to be subject to enduring safety and accessibility standards, and

that are typically self-limiting in maximum capacity (such as a university lecture theatre, or a church). Many of these places have been operating in accordance with a COVID Safe checklist for some time, and COVID safe practises have become familiar and embedded. Removing the restrictions means that private and community gatherings may once again take place without restrictions and that they will occur without the protection of mask wearing, with this measure being relaxed at the same time. It is not expected that removing this measure at this time in these settings will lead to a significant growth in cases.

Caps on private gatherings

The overarching intent of the *Movement and Gathering Direction* is to reduce the risk of COVID-19 transmission in the community by specifying the conditions under which people can gather at homes and non-residences while practicing physical distancing, where the activity is not controlled by a business, facility or service. This Direction had significant utility during the elimination phase of the pandemic response, and gatherings at homes were limited from 2 to 50 people at a time at varying stages, applied in a staggered way and allowing for gradual easing, as well as snap reductions. Currently, household gatherings are limited to 100 people gathering privately at a residence or non-residence. This setting has been in place at this level since 21 September 2021.

COVID-19 is now widespread and established. A shift away from contact tracing has meant that notifying individuals of potential community exposure is no longer occurring. The threshold for close contact quarantine has also changed, in accordance with the nationally agreed approach, to capture only household members, or people who were at an accommodation setting for 4 or more hours.

Self-testing for COVID-19 with rapid antigen testing kits has also become widely accepted and available. This means that persons attending a gathering at a home where it transpires than an attendee has COVID-19 are in an empowered position to manage their risk. Further, this information is more likely to be shared than through a public venue with no current means of advising of a positive case in attendance.

Within these conditions, an upper limit of 100 people gathering at a private household has limited individual utility in preventing transmission of COVID-19. It is also likely that this upper limit already captures most private gatherings occurring at residences. Indoor areas will have a natural capacity, with large events often occurring in outdoor spaces.

Public health directions should only remain in place for as long as they are reasonably necessary to respond to or contain the impact of COVID-19. For this reason and in the context described above, revocation of the Movement and Gathering Direction is considered appropriate at this time. This will remove the household gathering cap of 100 people, and the remaining requirements in the Direction that people at a private residence encourage physical distancing and not receive visitors as a close contact or a person with COVID-19 (a provision captured in the *Isolation of Diagnosed Cases and Management of Close Contacts Direction*). This change is not expected to have a meaningful impact on COVID-19 transmission or the health system. Allowing for gatherings to occur at homes without limit is also consistent with the easing of restrictions on gatherings in community settings and unrestricted gatherings in public places.

Weddings

Due to the nature of weddings as higher-risk activities, involving higher risk activities such as kissing, hugging, and dancing, and with guests travelling long distances, weddings have long been subject to higher levels of restriction than other activities. This restriction was particularly important when larger gatherings of all types were restricted, before vaccination was available, and later when limits were in place for larger gatherings of vaccinated and unvaccinated people.

Under current rules wedding ceremonies and receptions with more than 20 people in attendance are capped at 20 people if unvaccinated people are in attendance. This has been intended to limit the size of a high-risk gathering with the potential for rapid spread of COVID-19, during a time where vaccination status was a key protective factor against transmission. It has meant that weddings have for some time been among the most restricted gathering types across all settings, whether held indoors or outdoors.

The changes to attendance caps and density restrictions at homes and publicly accessible places, like places of worship and community halls, mean that private and community gatherings may now take place without restrictions, and without regard to vaccination status. With the removal of these restrictions, it is appropriate that weddings, regardless of vaccination status, also be permitted to take place at these venues and outdoors, without restriction on the number of attendees. At this stage of the pandemic, the COVID-19 risk posed by a wedding ceremony or reception with unvaccinated persons in attendance, outdoors or at a place not otherwise subject to restrictions is no greater than the risks or potential impact of a similarly attended church service, a community dance at a hall, or a large birthday party at a park. Where a wedding ceremony or reception with unvaccinated people is to take place at a venue still subject to additional vaccination requirements, a cap of 20 people will continue to apply, like the cap for private hire of these venues for other purposes where unvaccinated people will attend. An additional relaxation in density requirements for private hire of high-risk venues where unvaccinated people may attend will mean that these activities may take place with up to 20 people (as per the existing cap) regardless of the size of the space. It is appropriate that activities taking place at a high-risk private hire venue where vaccination requirements continue to apply, and where unvaccinated people may be in attendance (theoretically, up to 20 people at a time) that this be kept to a small number, both for the protection of staff and other patrons of the venue, but also to limit the scale and severe outcomes should a COVID-19 super-spreader event occur.

Proof of vaccination at high-risk, high transmission environments

The *Public Health and Social Measures linked to vaccination status Direction* (PHSM Direction) commenced on 17 December 2021 and was developed to directly address the risks posed by COVID-19, and in particular the Delta variant, at a time where the evidence indicated that vaccination was highly protective against transmission, symptomatic mild as well as severe disease and death due to COVID-19. It established vaccination requirements for owners, operators, visitors and staff entering and remaining in certain businesses, activities and undertakings. Businesses were selected on the basis of transmission risk, and essential services were excluded.

With the emergence of the Omicron variant, it has become apparent that the utility of vaccination against transmission is reduced, that vaccinated people are regularly experiencing 'breakthrough' infections, and that the impact of waning immunity could be significant. This has raised a number of questions about the ongoing application of these measures, particularly where transmission is occurring among both vaccinated and unvaccinated people, and with evidence that transmission continues to occur in these settings despite vaccination requirements.

These developments mean that rather than becoming obsolete, only the effect of the PHSM Direction has changed. The PHSM Direction was initially a tool to primarily prevent transmission in high-transmission environments (elimination and suppression). In this context, while there may be reduced protection against transmission, vaccination contributes meaningfully to a protective tempering of the overall severity of COVID-19 outcomes, and by direct extension, health system capacity (management of widespread COVID-19), in these settings in the context of a highly transmissible variant. A degree of protection against COVID-19 transmission and infection also remains, particularly where people are up to date with their COVID-19 vaccinations.

Each of the categories of venues have been included in the PHSM Direction because they are high-risk for widespread and rapid transmission (reflected in Table 2 at the end of this document). Hospitality and entertainment venues are included because they are sites where large numbers of people from many households and areas across a region attend at the same time in largely enclosed places, and in close proximity for prolonged periods of time. Theme parks, tourist settings and major shows and festivals are included because they have high patron numbers, and often attract people from diverse geographical areas who gather and then return to their communities, giving rise to risks of widespread seeding.

The emergence of the Omicron variant has necessitated a rapid shift from elimination, to active suppression during the first wave and now a move into a phase of managing ongoing but temporarily stable transmission. The need for higher level protections against accelerated growth in cases has eased, resulting in the current changes to the Direction. At this time, it is safest to remove those measures that can be quickly and easily

reinstated, should the context shift rapidly. Removing the vaccination requirement as this point would remove the last remaining baseline protection in place at a community level that is tempering the severity of outcomes from COVID-19 infection at places where transmission is known to occur at higher rates. Removing these requirements, which right now set a baseline expectation and standard for coverage, without careful consideration could also risk a longer-term backslide of COVID-19 immunity at a population level and this could put Queenslanders at increased risk of moderate to severe illness from COVID-19. Although uptake of third doses is progressing at a reasonable rate, it is not yet known if this will hit a ceiling, and what impact that and subsequent waning immunity may have.

According to the analysis in Table 2, each of the settings for which the requirement remains presents at least a moderate level risk overall, not only of transmission but of the risk posed by transmission at the setting to the community more broadly. It is reasonably necessary to retain vaccination requirements at these settings in their current form in the interim while the impact of removing other protections is assessed.

The issue of waning immunity remains, and it is not being proposed at this time to change vaccination requirements at these settings to include the third 'booster' dose of COVID-19 vaccination. This will be considered in the context of the broader viability of longer-term maintenance of this setting. There are issues of equity (for example, international travellers who may only have had a single-dose vaccine) and the opportunity to explore other means to maintain population level immunity and protect against severe outcomes that may be less restrictive. This is discussed further below.

Proof of vaccination for school students

It is currently not explicitly stated in the Direction that students over the age of 16 years in a school group are exempt from the mandatory proof of vaccination requirement. A person is not required to give their contact information, proof of vaccination or evidence of medical contraindication if they are under the age of 16 years, or in primary or secondary school and part of a group attending an activity organised by a school, however it not currently explicitly specified that this applies to all students, regardless of age. DoE has requested a clarifying change to the Direction to make this intent more explicit.

It is intended that any school students travelling in groups for school-based excursions and activities are not subject to proof of vaccination requirements at public venues that otherwise have proof of vaccination requirements in place. This is consistent with not imposing any mandate on vaccination for students for any part of their schooling or school-related activities. The public health risk of this option is outweighed by the potential issues of inequity if a proof of vaccination requirement is applied based on age. There is not a compelling public health justification to require a subset of the cohort attending a public place as part of a school group to provide proof of vaccination, and therefore to be vaccinated, on the basis of their age alone. There are less restrictive options available for schools to manage the risk of transmission among students not showing symptoms of COVID-19, that would apply across the whole group, including the measures available to them in DoE guidance for schools relating to COVID-19 (e.g. the Back to School Plan).

To be clear, consistent with requirements for the public, where a person who is also a student attends a public place in a private capacity (such as a family outing on a weekend), relevant proof of vaccination requirements apply from 16 years of age. Further, where a student or group of students undertakes a visit (e.g. an excursion) to a high-risk vulnerable setting (e.g. aged care facility) as part of schooling they would be considered a visitor and any CHO Direction requirements that apply to visitors, including vaccination, must continue to apply. At this stage of the pandemic, the public health risk for vulnerable cohorts at these settings supersedes the inequity that may be imposed by the requirements. This technical issue is addressed in the current iteration of the PHSM Direction.

Jurisdictional comparison of relevant measures and settings

An analysis of Australian state and territory public health measures (see Table 3), including gathering and density restrictions, mask wearing, and vaccination requirements for workers and visitors, across a range of settings indicates that jurisdictions that are currently seeing the end of the peak, or have already seen the peak, of widespread community transmission (NSW, ACT and NT) have removed their gathering and density restrictions for visitors to the home, outdoor gatherings and events, indoor organised events, hospitality

settings (cafes, restaurants, food courts), gyms and indoor recreation facilities, and licensed venues (bars, nightclubs, casinos).

While Victoria has also removed most gathering and density restrictions, they have retained density limits in hospitality settings where there is still a high likelihood of transmission such as cafes, restaurants, food courts, and licensed areas such as bars and nightclubs.

SA, WA and Tas still have gathering and density restrictions for visitors to the home, outdoor gatherings and events, indoor organised events, hospitality settings (cafes, restaurants, food courts), gyms and indoor recreation facilities, and licensed venues (bars, nightclubs, casinos). SA have taken the approach of determining density limits for indoor organised events, hospitality settings and licensed venues by considering whether the setting is seated (3/4 limit) or standing (1/2 limit), and the risk associated with movement of people within the setting. SA have also retained limits on visitors to the home, currently capped at 50, including residents.

With regard to vaccination requirements, all states and territories are consistent in requiring workers in health settings, aged care and disability and high-risk settings to be fully vaccinated. This consistent with recommendations from AHPPC and agreement on a national approach to vaccination in these settings at National Cabinet. Visitors to health settings, aged care and disability, and other high-risk settings in Qld, SA and WA are all required to be fully vaccinated. NT and Tas have retained some of these requirements, with Tas requiring visitors to be fully vaccinated to visit a hospital and NT allowing hospitals to determine their visitor restrictions. Tas and ACT are allowing unvaccinated visitors to aged care settings, with Vic allowing unvaccinated visitors, but restricting them from entering any common areas.

NSW, SA, WA, NT (from 7 March) and Tas require transport workers to be fully vaccinated. This includes bus drivers, taxi and rideshare drivers, train and tram drivers.

Qld, Victoria, WA and NT require hospitality workers to be fully vaccinated, while NSW, ACT, SA and Tas do not have such requirements in place. Qld, Vic and WA require all visitors and patrons to hospitality venues (cafes, restaurants), licensed venues (bars, nightclubs, casinos), music festivals and organised events, to be fully vaccinated.

Vic and WA have retained requirements for visitors and patrons to retail shopping settings (excluding essential retail), and personal services (hairdressers, spas, beauty salons) to be fully vaccinated.

ACT and SA are the only two jurisdictions to remove vaccination requirements for visitors and patrons across all hospitality, licensed venues and retail shopping settings. NSW has taken a similar approach to removing all vaccination requirements from hospitality venues, licensed venues and retail shopping settings, but have retained vaccination requirements for nightclubs and indoor music festivals with over 1,000 attendees.

The future of the public health response to COVID-19

The pandemic is not over. Additional variants may emerge, and while there is global inequity in vaccination access and coverage, the likelihood that Omicron will not be the last variant is high. While Omicron appears to be less severe than Delta, there remain many unknowns. There is nothing to suggest that a future variant will be less severe. The long-term impacts of COVID-19 infection, even for mild illness or a breakthrough infection in a vaccinated person, are not yet fully understood. The ongoing community and health system burden of sustained COVID-19 transmission, along with the potentially cumulative and growing burden that 'long-COVID' may impose will require additional resources and planning.

Vaccination remains the best defence against moderate to severe illness from COVID-19. Up-to-date vaccination and mask-wearing when physical distancing cannot be observed continues to be strongly recommended. From a messaging perspective, there is not yet a 'complete schedule' of COVID-19 vaccination that is proven to provide sufficient and lasting protection against symptomatic, moderate, or severe disease across all known and future variants. This means that the messaging needs to adapt, from describing vaccination as having reached 'an acceptable threshold' (e.g. 90% coverage; 'fully vaccinated') to describing the COVID-19 vaccination rollout as ongoing. The rate and extent of waning immunity both from vaccines and immunity acquired through infection is still largely unknown. As at 10 February 2022, ATAGI's advice is that three doses of a COVID-19 vaccine are required to be up to date to protect against both infection and severe

disease from COVID-19 and particularly, the Omicron variant. It is likely additional doses will be needed and ATAGI has already approved a fourth dose for severely immunocompromised people.

Mandated third 'booster' doses for the residential aged care workforce to optimise protection against infection and transmission, and by extension, protect the very vulnerable, have already been agreed to nationally and will shortly be introduced in Queensland. It is anticipated that up to date vaccination of residential aged care workers will reduce the risk of transmission to residents and co-workers and help to protect workers, their families and the community from the impacts of COVID-19.

Whether vaccine mandates for staff and visitors at public places remain as a baseline protective measure, particularly as case numbers stabilise and potentially drop further, will be a matter for consideration in the coming weeks. There will come a time where the additional cases, and preventable severe disease, due to unvaccinated people attending higher risk venues will be considered reasonably manageable within health system capacity and at that point it is possible the measure will no longer have sufficient protective utility at a population level. Over time, as the population is repeatedly exposed to COVID-19, virus acquired immunity will also increase, and this also needs to be factored in.

In the current context, with South East Queensland experiencing protracted community- and system-wide impacts of severe weather over the past week (essentially serving as a 'shadow lockdown' of the south-east), and with the potential for a significant influenza wave in the coming winter, the importance of maintaining protective measures to mitigate the ongoing, parallel impacts of COVID-19 must not be underestimated.

Table 1. COVID-19 transmission risk factors and rationale for relaxation of selected public health measures

Setting	Key risk factors				Proposed	Rationale
	Transmission risk			Risk beyond setting		
	Gathering type and proximity	*Ventilation and air flow*	*Exposure*	*Wider community and health system impact*		
Hospitality *Includes cafés, restaurants, pubs, clubs, RSL clubs, taverns, function centres, bars, wineries, distilleries and microbreweries, but not including food courts*					**High risk**	In settings with a higher risk of transmission, vaccination continues to be important for individual health and protecting the public health system. Unvaccinated people are more vulnerable to infection with and severe disease from COVID-19 and can place an additional and preventable burden on the public health system. To temper the severity of COVID-19, vaccination continues to be required for entry to or employment at the highest-risk environments for COVID-19 transmission. This measure is particularly important particularly when the risk of COVID-19 infection in the community is high. The retained cap on gatherings with private hire at these venues when unvaccinated people attend limits potential severity of COVID-19 transmission at a gathering in a high-risk setting, and also protects staff at the venue from exposure.
	Gathering sizes limited, most cohorts seated; but engaged in high transmission risk activities – talking, eating and drinking	*Indoor venue*	*Moderate length of stay for patrons, frequent and long stay for staff*	*Increased likelihood of super-spreader event*	Minor change Density limit removed but gathering limits (20 people) remain for unvaccinated private hire. Vaccination requirements remain for staff and visitors, and for private hire over 20 people.	
Indoor entertainment venues *Includes gambling venues, nightclubs, indoor live music venues, convention and entertainment centres, adult entertainment venues.*						
	Gathering sizes small to moderate, cohorts consistently mingling; high risk activities singing and dancing	*Indoor venue*	*Moderate length of stay for patrons, frequent and long stay for staff*	*Increased likelihood of super-spreader event*		
Vulnerable settings *Includes hospitals, residential aged care facilities, disability accommodation services, youth detention centres, and prison visiting areas.*					**High risk**	Queensland now has widespread and sustained COVID-19 transmission. It is arguably more important than ever to protect the most vulnerable from the risks posed by COVID-19. COVID-19 transmission in vulnerable settings has profound impacts. Severe illness and death is more likely within these cohorts and an outbreak would result in significant avoidable pressures on the health system.
	Gathering sizes limited, but highly vulnerable cohorts	*Indoor venue*	*Moderate - long and perpetual length of stay*	*Residents highly vulnerable, with severe outcomes*	No change Vaccination requirements remain.	
Stadiums below 5,000 attendees *Indoor and outdoor*					**Lower risk**	Stadiums with fewer than 5,000 attendees present a lower risk and consequence of COVID-19 transmission. Events at stadiums are typically seated, with difficulties in maintaining physical distancing primarily at entry and exit points. Smaller events and stadiums are likely to be for local events and therefore draw local crowds. In the event of an outbreak, it is unlikely COVID-19 would transmit across a large geographical area. Indoor stadiums are typically well ventilated, with high or open ceilings and a lower occupant density where bleachers account for a small section of the overall space. Outdoor venues are well ventilated.
	Gathering size local, small to moderate; individual exposure limited - typically seated, cohorts proximal at entry/exit	*Indoor venues typically well ventilated* *Outdoor venues well ventilated*	*Moderate length of stay for patrons, frequent and long stay for staff*	*Could result in exposure across a moderate number of people*	No change No density or vaccination requirements.	
Stadiums above 5,000 attendees *Indoor and outdoor*					**Moderate risk**	Stadiums with more than 5,000 attendees present a moderate risk and consequence of COVID-19 transmission. Events at stadiums are typically seated, with physical distancing and cohort mingling only occurring at entry and exit points. Events with more than 5,000 patrons are more likely to draw crowds from a large geographical area (e.g., attendees from across Australia). Larger events increase the risk of transmission and impact of a super spreader event and may compromise health systems across Queensland.
	Gathering size large, widespread geographically, individual exposure limited - typically seated, cohorts	*Indoor venues typically well ventilated* *Outdoor venues well ventilated*	*Moderate length of stay for patrons, frequent and long stay for staff*	*Could result in exposure across a large, dispersed number of people*	No change Vaccination requirements remain.	
Amusement parks					**Moderate risk**	Gatherings at amusement parks are typically moderate in size, with most contact between patrons being transient, however there are several waiting areas where physical distancing is difficult to maintain (e.g., waiting lines). Shows and events within parks are typically seated. Indoor areas are typically inadequately ventilated to reduce transmission and physical distancing can be difficult to maintain. Patrons typically gather for half or full days with these venues being popular destinations for people on holidays. The risk of transmission and impact of a super spreader event, with a geographically dispersed population, may compromise health systems across Queensland.
	Gathering sizes moderate, cohorts consistently mingling	*Mingling in indoor venues* *Outdoor venues well ventilated*	*Moderate length of stay for patrons, frequent and long stay for staff*	*Could result in exposure across a large, dispersed number of people*	No change Vaccination requirements remain.	
Government owned galleries, museums and libraries					**Moderate risk**	Gatherings at government owned galleries, museums and libraries are typically small to moderate in size, with most contact between patrons being transient. There may be areas where physical distancing is difficult to maintain, and length of stay is typically moderate which increases exposure. Venues also attract a higher proportion of vulnerable cohorts.
	Gathering sizes small – moderate, cohorts consistently mingling	*Indoors. mingling in indoor venues, large spaces*	*Moderate length of stay for patrons, frequent and long stay for staff*	*Unlikely to produce a super spreader event*	No change Vaccination requirements remain.	
Food courts					**Lower risk**	Gatherings in food courts are typically transient, with most places offering take-away and a communal eating area. Indoor food courts are typically in larger spaces and outdoor venues are well ventilated. This setting is unlikely to result in a super spreader event. Density restrictions are an effective policy lever that can be easily reinstated if required. Easing density restrictions will allow businesses to operate at full capacity, improve public confidence in the COVID-19 response and mitigate pandemic fatigue.
	Gathering sizes limited, most cohorts seated; but engaged in high transmission risk activities – talking, eating and drinking	*Indoor area typically larger spaces* *Outdoor venues well ventilated*	*Short and transient stay of patrons*	*Unlikely to produce a super spreader event*	Remove restrictions No density restrictions.	

Setting	Key risk factors				Proposed	Rationale
	Transmission risk			Risk beyond setting		
	Gathering type and proximity	*Ventilation and air flow*	*Exposure*	*Wider community and health system impact*		
Indoor play centres	*Gathering sizes small – moderate, cohorts consistently mingling*	*Indoor venues must operate with a COVID Safe checklist*	*Moderate length of stay for patrons, frequent and long stay for staff*	*Cohort is of low risk of severe disease.*	**Lower risk** Remove restrictions No density restrictions.	Indoor play centres typically involve long periods of minimal physical distancing, particularly amongst young children. Despite this increase in risk of transmission, COVID-19 has a lower severity in children, meaning the consequence and impact of COVID-19 transmission is lower. This risk is further lowered to children aged 5 to 18 who are vaccinated. Density restrictions are an effective policy lever that can be easily reinstated if required. Easing density restrictions will allow businesses to operate at full capacity, improve public confidence in the COVID-19 response and mitigate pandemic fatigue.
Community facilities	*Gathering sizes small – moderate, cohorts consistently mingling*	*Indoor spaces moderately ventilated.*	*Short - moderate length of stay*	*Unlikely to produce a super spreader event*	**Lower risk** Remove restrictions No density restrictions.	Events at community facilities are typically short to moderate in length. Community facilities are typically hired for functions and meetings for local clubs and community groups, which can adequately accommodate physical distancing. These gatherings typically involve known cohorts from community, meaning the likelihood and consequence of COVID-19 transmission is low. Density restrictions are an effective policy lever that can be easily reinstated if required. Easing density restrictions will allow businesses to operate at full capacity, improve public confidence in the COVID-19 response and mitigate pandemic fatigue.
Other religious and civil services, churches and places of worship	*Gathering size local, small to moderate; individual exposure limited - typically seated, cohorts proximal at entry/exit*	*Indoor spaces moderately ventilated*	*Short - moderate length of stay*	*Unlikely to produce a super spreader event*	**Lower risk** Remove restrictions No density restrictions.	Other religious and civil services, churches and places of worship are usually small to moderate in size. These gatherings typically involve known cohorts from community, meaning the likelihood and consequence of COVID-19 transmission is low. Density restrictions are an effective policy lever that can be easily reinstated if required. Easing density restrictions will allow businesses to operate at full capacity, improve public confidence in the COVID-19 response and mitigate pandemic fatigue.
Funerals	*Gathering sizes small – moderate, cohorts consistently mingling*	*Mingling in indoor venues* *Outdoor venues well ventilated*	*Short - moderate length of stay*	*Could result in exposure across a moderate, dispersed number of people*	**Moderate risk** Remove restrictions No density restrictions.	Funerals typically involve small to moderate crowds who are known to one another. Attendees mingle and have close contact, and physical distancing is likely not maintained. Other higher risk activities, such as eating and drinking, may also occur. Attendees at funerals may have a geographically dispersed population and a transmission event may compromise health systems across Queensland. Despite being of moderate risk, restrictions for funerals will be lifted at this time. This is in recognition that funerals are also an important ritual across all cultures which sometimes occur at short notice and often under difficult circumstances, therefore making it hard to ensure all attendees are vaccinated. Density restrictions are an effective policy lever that can be easily reinstated if required. Easing density restrictions will allow businesses to operate at full capacity, improve public confidence in the COVID-19 response and mitigate pandemic fatigue.
Outdoor community events and markets	*Gathering size local, small to moderate; individual exposure limited - typically seated, cohorts proximal at entry/exit*	*Outdoor venues well ventilated*	*Short - moderate length of stay*	*Unlikely to produce a super spreader event*	**Lower risk** No change No restrictions apply	Outdoor community events and markets are well ventilated with patrons having a short to moderate length of stay. The risk of significant transmission in an completely outdoor environment with people distanced and moving freely, is very low.
Private gatherings at homes or non-residences (limited to 100)	*Gathering sizes small – moderate, known cohorts with consistent mingling*	*Indoor spaces moderately ventilated.* *Outdoor spaces well ventilated.*	*Short - moderate length of stay* *Typically, event is time-limited*	*Could result in exposure across a moderate number of people*	**Lower risk** Remove restrictions No limit on attendees.	Private gatherings at home or non-residences are typically small to moderate in size with cohorts known to one another and mingling regularly. Indoor spaces are moderately ventilated and outdoor spaces are well ventilated. The current cap of 100 likely exceeds the majority of gatherings that would typically take place. The removal of the cap would likely only permit time-limited and occasional major events. Indoor areas will have a natural capacity, with large events often occurring in outdoor spaces. This change is not expected to have a considerable impact on transmission or the health system.

Table 3. Jurisdictional summary – public health measures (as available on 3 March 2022)

Public health measure		QLD (proposed)	NSW	VIC	ACT	SA	WA	NT	TAS
Gathering and density restrictions									
Visitors at home	Gathering limit	-	-	-	-	[50 incl residents]	[10 people]	-	[up to 100 people]
	Density limit	-	-	-	-	-	-	-	-
Outdoor gatherings/events	Gathering limit	-	-	-	-	✓	Private - 50 people Public - 500 people	-	✓
	Density limit	-	-	-	-	-	[1 person per 2 m2]	-	[1 person per 2 m2]
Indoor events	Gathering limit	-	-	-	-	-	150 for weddings, funerals, worship	-	Up to 250
	Density limit	-	-	-	-	[1/2 for standing, ¾ for seated]	[1 person per 2 m2]	-	[1 person per 2 m2]
Hospitality (cafes, restaurants)	Gathering limit	*Cap of 20 retained for unvacc private hire*	-	-	-	-	150 patrons, seated	-	[up 250 indoors, 500 outdoors]
	Density limit	-	-	[1 person per 2 m2]	-	[1/2 for standing, ¾ for seated]	[1 person per 2 m2]	-	[1 person per 2 m2]
Food courts	Gathering limit	-	-	-	-	-		-	[up 250 indoors, 500 outdoors]
	Density limit	-	-	[1 person per 2 m2]	-	[1/2 for standing, ¾ for seated]	[1 person per 2 m2]	-	[1 person per 2 m2]
Gyms and indoor recreation facilities	Gathering limit	-	-	-	-	-	150 patrons	-	-
	Density limit	-	-	-	-	[1/2 for standing]	[1 person per 2 m2]	-	[1 person per 2 m2]
Licensed venues (bars, nightclubs, casinos)	Gathering limit	*Cap of 20 retained for unvacc private hire*	-	-	-	-	150 patrons, seated	-	[up 250 indoors, 500 outdoors]
	Density limit	-	-	[1 person per m2]	-	[1/2 for standing, ¾ for seated]	[1 person per 2 m2]	-	[1 person per 2 m2]
Mask wearing									
Vulnerable settings		✓*	✓	✓	✓	✓	✓	✓	✓
At airports and on flights		✓	✓	✓	✓	✓	✓	✓	✓
Workplaces		-	-	[in specified workplaces]	- [businesses and workplaces to consider]	-	✓	-	✓
Indoors		-	-	[only in specified limited settings]	[only in schools and ECEC/OSHC]	[except private functions less than 150 people, and private activities 50-150 people]	✓	- [from 7 Mar removed form most indoor settings]	✓
Outdoors		-	-	- [unless cannot physically distance]	-	-	[stadiums]	-	- [except events 1000+ people]
Public transport, taxis and rideshare		✓	[includes waiting areas e.g. bus stop, train station]	✓	✓	✓	✓	- [from 7 Mar]	✓
Libraries, museums and galleries		-	-	-	-	-	✓	- [from 7 Mar]	✓
Retail, shopping and personal services (e.g. hairdressers, spas, nail salons, beauty salons, waxing salons, tanning salons, tattoo and massage parlours)		-	-	✓	-	✓	✓	- [from 7 Mar]	✓
Vaccination requirements									
Workforce									
Workers in health settings		✓	✓	✓	✓	✓	✓	✓	✓
Workers in aged care and disability		✓	✓	✓	✓	✓	✓	✓	✓
Workers in other high-risk setting (e.g schools, corrective facilities, airports, quarantine facility)		✓	✓	✓	✓	✓	✓	✓	✓
Workers in hospitality, licensed venues		✓	-	✓		-	✓	✓	-
Transport workers			✓			✓	✓		-
General public									
Visitors to health settings		✓		✓	-	✓	✓	- [subject to hospital visitor restrictions]	✓
Visitors to aged care and disability		✓	✓	- [unvaccinated visitors not allowed in common areas]	-	✓	✓	-	✓
Visitors and patrons in other high-risk settings (e.g prisons, correctional facilities)		✓	-	✓	-	✓	✓	✓	-
Patrons of hospitality venues (cafes, restaurants)		✓	-	✓	-	-	✓	✓ [with liquor licence]	- [vaccination mandates for hospitality patrons removed form 26 Feb]
Patrons of licensed venues (bars, nightclubs, casinos)		✓	-	✓	-	-	✓	✓	-
Attendees at music festivals, organised events		✓	[nightclubs, indoor music festival - over 1,000 people]	✓		-	✓	[ticketed events 500+ people in urban and 100+ non-urban centres	✓
Retail, shopping and personal services (e.g. hairdressers, spas, nail salons, beauty salons, waxing salons, tanning salons, tattoo and massage parlours)		-	-	✓	-	-	✓	-	-

*Healthcare settings providing face to face services or care also included in Qld, but the jurisdictional analysis does not go to this level of detail

Public Health Directions – Human Rights Assessment
Public Health Face Masks Requirements Direction (No.5)

Title	Public Health Face Masks Requirements Direction (No.5)
Date effective	4 March 2022

Background

The *Public Health Face Masks Requirements Direction (No.5)* (Direction) is issued by the Chief Health Officer pursuant to the powers under section 362B of the *Public Health Act 2005*.

This analysis should be read in conjunction with the Human Rights Statement of Compatibility prepared in accordance with section 38 of the *Human Rights Act 2019* with respect to the Public Health and Other Legislation (Public Health Emergency) Amendment Act 2020. This Act amended the *Public Health Act 2005* to enable the Chief Health Officer to issue directions that are reasonably necessary to assist in containing or responding to the spread of COVID-19.

Purpose of the Direction

The purpose of the Direction is to mitigate the risk of transmission of COVID-19 to the Queensland community through a requirement to wear a face mask. In the previous iteration of the direction, this requirement applied to all Queenslanders, however, with the changing epidemiological landscape it is now only necessary to mitigate the risk of transmission of COVID-19 in vulnerable and high-risk settings such as residential aged care facilities, shared disability accommodation services, hospitals and other healthcare facilities and settings, corrective services facilities, detention centres. Some other large settings have also been identified for inclusion in the Direction due to the intermingling of large numbers of people in more confined spaces and the risk to themselves and others from the spread of COVID-19, which can be mitigated through the wearing of a mask. Other settings include in or at public transport, including commercial passenger transport.

In preparing the Direction, risks to the health and safety of Queenslanders were identified and the current epidemiological situation, both in and beyond Queensland, were considered. The risks and epidemiological situation are more fully set out in the Policy Rationale that informed the Direction, and form part of the purpose of the Direction. The human rights analysis below draws on information contained in the Policy Rationale; they therefore should be read together.

The Direction takes the least restrictive approach necessary by providing exceptions, including for emergencies, when consuming food, drink or medicine, and to ensure people can receive medical care and treatment that cannot reasonably be received or provided while wearing a face mask.

How the Direction achieves the purpose

The Direction removes the mask mandates in all settings currently required in the *Public Health Face Masks Requirements Direction (No.4)*, except for when a person:

- is on, or at, public transport infrastructure
- is in a commercial passenger vehicle, or waiting for a commercial passenger vehicle in a designated outdoor space that is not a residence
- is in an indoor space that is, or is part of a:
  - residential aged care facility
  - shared disability accommodation service
  - hospital or a healthcare setting where face-to-face services are provided

  - corrective services facility
  - detention centre
- has a temperature or any COVID-19 symptoms, while they are outside their home
- is awaiting results of a COVID-19 PCR test, while they are outside their home (except where the test is for a routine surveillance requirements)
- required to wear a mask under any other public health direction; or
- directed to do so by an emergency officer (public health).

The requirement to wear a face mask does not apply to:

- an infant or child under 12 years; or
- a person who has a physical or mental health illness or condition, or disability, which makes wearing a face mask unsuitable.

A person may be exempt from wearing a face mask in the following circumstances:

- communicating with a person who is deaf or hard of hearing and visibility of the mouth is essential for communication
- the nature of a person's work or education means that clear enunciation or visibility of the mouth is essential
- when consuming food, drink or medicine
- while undergoing medical care or treatment which requires no face mask to be worn
- for a person's identity to be ascertained
- if wearing a face mask would create any other serious risk to that person's life or health and safety, including if determined through work Occupational Health and Safety guidelines
- in the event of an emergency
- if required or authorised by law
- if continuing to wear the mask is not safe in the immediate circumstances.

The following exemptions apply in specific settings:

- a person who is working on, or operating, public transport may remove their mask where there are no passengers on board or where they are in an area that passengers cannot access
- a person who is the driver of a taxi, rideshare or commercial shuttle may remove their face mask if they are the only person in the commercial passenger vehicle
- a resident at a residential aged care facility or shared disability accommodation, an in patient in a hospital, a prisoner in a corrective services facility or detention centre, or a person who is receiving face-to-face healthcare in their own home
- an employee working at one of these facilities or services, while they are in a space where no face-to-face services are provided and where they can socially distance from other employees
- a person who is assisting or undertaking disaster recovery or clean-up activity.

The above exemptions do not need to be applied for under the Direction and can be determined by the individual, which provides them with greater autonomy over their personal circumstances and limits their need to seek permission from Government to utilise an exemption if they meet the criteria.

A person who is a close contact but who is permitted to return to work to perform a critically essential role is subject to all other requirements of the Isolation for Diagnosed Cases of COVID-19 and Management of Close Contacts Direction (No. 5) or its successors, including any face mask requirements.

If a person who is otherwise required to wear a face mask removes it in accordance with any of the allowed circumstances, they must put their face mask back on as soon as practicable.

The Chief Health Officer, Deputy Chief Health Officer or a delegate may grant a person or class of persons an exemption from all or part of the Direction on the basis of extreme exceptional circumstances.

Human rights engaged

The human rights engaged by the Direction are:

- Right to equality and non-discrimination (section 15)
- Right to life (section 16)
- Freedom of movement (section 19)
- Freedom of expression (section 21)
- Privacy (section 25)
- Cultural rights (section 27)

Right to equality and non-discrimination (section 15): The right to equality and non-discrimination protects people from discrimination on the basis of certain attributes, such as disability or race. The requirement to wear face masks in high-risk or vulnerable settings discriminates against people with a disability. For example, masks may make it harder for people with hearing loss to lip read and communicate. The definition of 'discrimination' under the *Human Rights Act* is inclusive of the right to equality, in accordance with the definition of discrimination in the Canadian Charter, which also contains an inclusive definition of discrimination: *R v Turpin* [1989] 1 SCR 1296. However, the extent of the impact on human rights is reduced by the fact that there are a number of lawful excuses for removing a face mask, such as to communicate with a person who is deaf or hard of hearing and visibility of the mouth is essential for communication. A person is not required to carry or wear a mask in high-risk or vulnerable settings if they have a physical or mental health illness or condition, or disability, which makes wearing a face mask unsuitable.

The **right to life** is protected under section 16 of the *Human Rights Act*. The right to life places a positive obligation on the State to take all necessary steps to protect the lives of individuals in a health emergency. This right is an absolute right which must be realised and outweighs the potential impacts on any one individual's rights. By requiring people to wear masks in high-risk and vulnerable settings in Queensland, the Direction promotes the right to life by protecting the health, safety and wellbeing of the most vulnerable people in the Queensland community. Masks are part of a series of public health mitigations that assist in reducing the potential spread of COVID-19 to vulnerable populations in high-risk and vulnerable settings.

Limitations

Freedom of movement (section 19)

- Section 19 of the *Human Rights Act* provides that every person lawfully within Queensland has the right to move freely within Queensland, to enter and leave it and has the freedom to choose where to live. The right means that a person cannot be arbitrarily forced to remain in, or move to or from, a particular place. The right also includes the freedom to choose where to live, and freedom from physical and procedural barriers, like requiring permission before entering a public

park or participating in a public demonstration in a public place. The right may be engaged where a public entity actively curtails a person's freedom of movement.

This may limit the right to freedom of movement by requiring a person to cover their nose and mouth at all times when the person is in specific settings such as waiting for public transport or on public transport.

Further, the Direction requires a person to wear a face mask when they are:

- in a commercial passenger vehicle, or waiting for a commercial passenger vehicle in a designated outdoor space that is not a residence
- in an indoor space that is, or is part of, a:
    - ***residential aged care facility***; or
    - ***shared disability accommodation service***; or
    - ***hospital*** or a ***healthcare setting*** where ***face-to-face services*** are provided to patients, clients and others accessing ***healthcare***; or
    - ***corrective services facility***; or a
    - ***detention centre***; or
    - outside their ***personal place of residence*** or ***temporary accommodation*** on a permanent or temporary basis if the person has a temperature equal to or higher than 37.5 degrees or has any symptoms consistent with COVID-19; or
- outside their personal place of residence or temporary accommodation on a permanent or temporary basis
- if the person has undertaken a COVID-19 PCR test and has not yet received the results of that test, unless the test is part of surveillance testing requirement
- is required to do so in accordance with any other Public Health Directions in effect under section 362B of the *Public Health Act 2005*
- is directed to do so by an ***emergency officer (public health)***.

The limits on the freedom of movement are tempered by the range of exemptions to the face mask requirement.

Section 21 of the Human Rights Act provides that the **right to freedom of expression** includes the freedom to seek, receive and impart information and ideas of all kinds. It protects almost all kinds of expression, providing it conveys or attempts to convey a meaning. Ideas and opinions can be expressed in various ways, including in writing, through art, or orally. The Direction limits this right by restricting how a person may express themselves orally or through the garments they wear by requiring them to wear a certain type of face mask in high-risk and vulnerable environments in Queensland. A person may still make or purchase a cloth mask of their choosing and is permitted to remove the mask in certain circumstances such as when making announcements, or teaching.

The **right to privacy** also includes a right to bodily integrity (see *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 126 599] and 'personal inviolability' in the sense of 'the freedom of all persons not to be subjected to physical or psychological interference, including medical treatment, without consent.' *See PBU v Mental Health Tribunal* (2018 56 VAR 141, 180-1 [128]. It is arguable that the Direction engages this aspect of the right through the requirement for a person to wear a face mask or potentially be fined. However, the extent of the impact on human rights is reduced by the fact that there are a number of lawful excuses for removing a face mask in certain situations such as to consume food, drink or medicine or receive medical or personal treatment to the extent that such care or treatment requires that no face mask be worn. This right may also be engaged by providing exemptions that a person could be questioned for utilising and thereby has to disclose personal information. However, it is considered that the balance of human rights in allowing people to make their own choice as to whether they fit into an exemption category, rather than needing to seek an exemption from Government, is the less restrictive choice.

Section 27 of the Human Rights Act states that all people with particular cultural, religion, racial and linguistic backgrounds have a right to enjoy their culture, declare and practice their religion and use their language in community with other people of that background. This promotes the practise and maintenance of shared traditions and activities. The Direction may limit cultural rights under section 27 for residents of residential aged care facilities who may ordinarily share their culture with their loved ones who visit but are limited from doing so due to the requirement of visitors to a residential aged care facility to wear a face mask, however they can still meet and practise aspects of their culture, religion and tradition, albeit while the visitors are wearing a face mask unless another exemption (such as consuming food or drink) applies.

Compatibility with Human Rights

Proper purpose (section 13(2)(b))

The purpose of the Direction is to reduce the spread of COVID-19 in specified high-risk and vulnerable settings.

Requiring people in specified high-risk and vulnerable settings to wear a mask is to confine potential outbreaks in settings where there may be people with increased vulnerabilities, and/or in settings where it is difficult or not practicable to maintain social distancing. The Direction is in effect for a temporary period, and the restrictions as applying to a person only apply in particular environments.

Ultimately, the purpose of wearing masks is to limit the opportunity for transmission of COVID-19 in high-risk and vulnerable settings, so as to protect the vulnerable in the Queensland community while managing ongoing but temporarily stable transmission of COVID-19 within Queensland's broader population in Queensland.

The aim of protecting public health is a proper purpose. Protecting vulnerable people in the community from the risk of COVID-19 also promotes their human rights to life (section 16) and health (section 37). At international law, the right to health includes '[t]he prevention, treatment and control of epidemic, endemic, … and other diseases': *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(2)(c).

The purpose of protecting and promoting human rights is necessarily consistent with a society 'based on human dignity, equality and freedom' (section 13(2)(b) of the Human Rights Act).

Suitability (section 13(2)(c))

The limits on human rights will help to achieve the intended purpose of protecting public health by limiting the opportunities for transmission of COVID-19 in high-risk and vulnerable settings. Following Queensland's achievement of a satisfactory level of vaccination rates and the subsequent lifting of some restrictions, the mask restrictions have been adjusted so that they remain suitable and reflect the improved public health conditions. Masks are no longer required at work (outside of specified settings retained in this and other public health directions), pubs, clubs or cafes, indoor stadiums, sports arenas, libraries and other less risk prone settings.

The mask wearing requirements and the exceptions to mask wearing requirements have been tailored to meet the needs of different cohorts. For example, a person visiting a residential aged care facility can remove the mask to eat and drink while visiting a resident.

This approach ensures the Direction is suitably tailored to address the public health risks associated with COVID-19 while acknowledging there may be individual circumstances that need to be managed appropriately.

Necessary (s 13(2)(d))

The limits on human rights are necessary to achieve the purpose. There is no other way to manage the ongoing but temporarily stable transmission of COVID-19 in Queensland which would be (a) reasonably available (that is, as practicable), and (b) less restrictive of human rights.

In particular:

- Requiring face masks in all outdoor areas would be more restrictive of human rights.
- Relying on other measures such as contact tracing would not be as effective in achieving the purpose of limiting the spread of COVID-19 in vulnerable populations. There is an inherent delay in contact tracing that could put vulnerable populations at risk while the tracing is being completed. Also, managing close contacts in high-risk or vulnerable settings is particularly challenging given the layout and operation of those settings. For example, safely isolating close contacts in a correctional centre could be particularly problematic especially if there were significant number of contacts.

The types of places where masks are required to be worn have been reduced to reflect current public conditions. This is to ensure the measure is applied only in high-risk setting and vulnerable settings where it is necessary.

Fair balance (section 13(2)(e), (f) and (g)

Given the risk posed in these high-risk and vulnerable settings where people who frequent these settings are generally more mobile in the community, the purpose of the Direction can only be reasonably achieved by requiring people to wear masks in these environments unless certain exceptions apply.

Many of the limits on human rights are incidental. For example, although the requirement to wear a face mask limits the right to equality and non-discrimination, people are able to remove their mask to communicate with a person with a disability.

The extent of the limitation on human rights is further reduced in other ways. The Direction is in effect for a temporary period, and the restrictions that apply to a person should in most circumstances only require a person to wear a mask for a short period of time.

The requirements of the Direction are proportionate and necessary to the reduce the spread in specific high risk and vulnerable settings. The Direction does not limit the right to hold a religious belief; target any religious or cultural groups directly but indirectly restricts people from engaging in their cultural or religious practices by requiring the shaving of facial hair in order to comply with mask wearing requirements in healthcare settings.

Any limitations on human rights imposed by requiring a person to wear a mask in high-risk or vulnerable settings or be subject to a fine are justifiable. Requiring a person to wear a mask is aimed at addressing the risk presented by COVID-19 and will assist in addressing that risk. For example, a person in any of these settings may potentially be asymptomatic and by wearing a face mask the chances of COVID-19 transmission can be reduced. Also, a person could potentially infect people in the wider community while on public transport. Tackling such a scenario would require resources for contact tracing (one person could have up to 200 contacts) and may divert resources from other critical areas. The need to address the risk to vulnerable and high-risk populations from the impact of the spread of COVID-19, and the flow on consequences for the Queensland health system outweighs the impact on human rights.

The Direction provides a broad exemption power enabling the Chief Health Officer to grant an exemption to any of its requirements based on exceptional circumstances. This broad power was

included to protect against unintended consequences of the Direction, and to acknowledge that there may be circumstances where requiring a person to wear a mask may not be reasonable or appropriate.

There will be some impact on human rights, in particular, the right to equality for people with disabilities. However, the importance of limiting the transmission of COVID-19 into high-risk and vulnerable populations (taking into account the right to life) outweighs the impact on other human rights. Indeed, it is difficult to overstate the importance to society of addressing the risk posed by a pandemic. Ultimately, the Direction strikes a fair balance between the human rights it limits and the need to reduce the risk of COVID-19 spreading uncontrolled into high-risk and vulnerable populations.