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.

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**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.

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## Engagement with the sector

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

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**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.

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## 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 | s.73 - Irrelevant information | | | | | | |
| **Health care workers (private)** | AHPPC recommendation: by 15 Dec | ✓ 15 Dec | | | | | | | |
| **Residential aged care workers** | AHPPC recommendation: by 17 Sept | ✓ 15 Dec | | | | | | | |
| **Disability support workers** | AHPPC recommendation: by 31 Dec | ✓ 15 Dec | | | | | | | |
| **Aged care in-home and community aged care workers** | AHPPC recommendation: by 31 Dec | ✓ 15 Dec | | | | | | | |
| **Private provider facilities (GPs, pharmacies)** | AHPPC recommendation by 15 Dec | ✓ 15 Dec | | | | | | | |
| **Education and childcare workers** | Vaccination of staff encouraged by AHPPC | – | | | | | | | |
| **Correctional services and prison workers** | – | – | | | | | | | |
| **Quarantine facility workers** | Vaccination of staff encouraged by AHPPC | ✓ | | | | | | | |
| **Workers at airport setting** | – | – | | | | | | | |
| **Definition of fully vaccinated** | TGA: when required doses received | 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

s.73 - Irrelevant information

| 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**<br>*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)*<br>*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.**<br>- 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.<br>- Vaccination uptake among workers and people detained in these settings is typically low, with higher vaccine hesitancy than the general population[4]<br><br>**QLD**<br>- Uptake in Qld may be higher than in other jurisdictions, over 11,500 doses delivered at facilities to date.<br>- BYDC / Corrections Academy Training facility outbreak August 2020 was Qld's second largest outbreak at 49 cases.<br>s.73 - Irrelevant information |

s.73 - Irrelevant information

[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.

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

[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.

s.73 - Irrelevant information

**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.<br>• All health service employees who are employed to work in a hospital or other facility where clinical care or support is provided.<br>*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.*<br>• 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.<br>*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;<br>• Administration staff, including reception staff and management;<br>• Ancillary staff, including food preparation staff, cleaners, laundry staff, gardeners and maintenance staff;<br>• Lifestyle and social care staff, including for music and art therapy;<br>• Transport drivers of residents of a residential aged care facility;<br>• A volunteer engaged by a residential aged care facility to undertake duties at a residential aged care facility;<br>• 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<br>*Examples:*<br>*Public hospitals, public health clinics, ambulance services, patient transport services, and other health services*<br>*Private health facilities, such as private hospitals or day procedure centres, or specialist outpatient services*<br>*Residential aged care facilities*<br>*Shared disability accommodation services*<br>*Outreach services in other settings provided by the above facilities, including in-home healthcare services*<br>*Private provider facilities, such as general practitioners, private nurse offices and allied health consulting offices, pharmacies, optometrists, dental surgeries and private pathology centres*<br>*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*<br>*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*<br>*Education settings within a healthcare setting*<br>*Australian Red Cross Lifeblood collection centres*<br>*In home delivery of intensive disability support services*<br>*Aged care services funded by the Australian Government and delivered in the home*<br>*School-based healthcare, including in special schools*<br>*Healthcare services provided in other settings such as gyms* | A person who works, undertakes an educational placement, or volunteers in a healthcare setting, including:<br>• A person registered under the National Registration and Accreditation Scheme administered by the Australian Health Practitioner Regulation Agency (Ahpra)<br>• A person who is a self-regulated allied health professional as published on the Australian Government Department of Health website^<br>• 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<br>• 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.<br>*Examples:*<br>*A doctor who has consulting rooms at a private hospital, and their receptionist*<br>*A Visiting Medical Officer*<br>*Kitchen staff in a healthcare setting, including aged care or disability accommodation*<br>*Volunteers who assist visitors to a healthcare setting.*<br>*An employee of a company that supplies and services medical equipment under a contractual arrangement with a public hospital*<br>*An agency nurse engaged for relief work in a specialist outpatient service*<br>*Volunteers, including volunteers engaged by Health Consumers Queensland, providing face to face advice and support services across the health system in Queensland*<br>*Exercise physiologists providing healthcare services in a gym;*<br>*An employee of a community pharmacy*<br>*Chaplains visiting patients in a hospital or other healthcare setting*<br>*Teachers in a hospital or other healthcare setting*<br>*Hospital clowns*<br>*Florist or coffee shop employees in a healthcare setting*<br>*Support worker in supported independent living*<br>*NDIS funded psychologist or occupational therapist providing in home support for an NDIS participant's wellbeing (whether a registered or unregistered NDIS provider)*<br>*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 | s.73 - Irrelevant information | | | | | | | |
| ACT | | | | | | | | |
| VIC | | | | | | | | |
| SA | | | | | | | | |
| TAS | | | | | | | | |
| WA | | | | | | | | |
| NT | | | | | | | | |

[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.

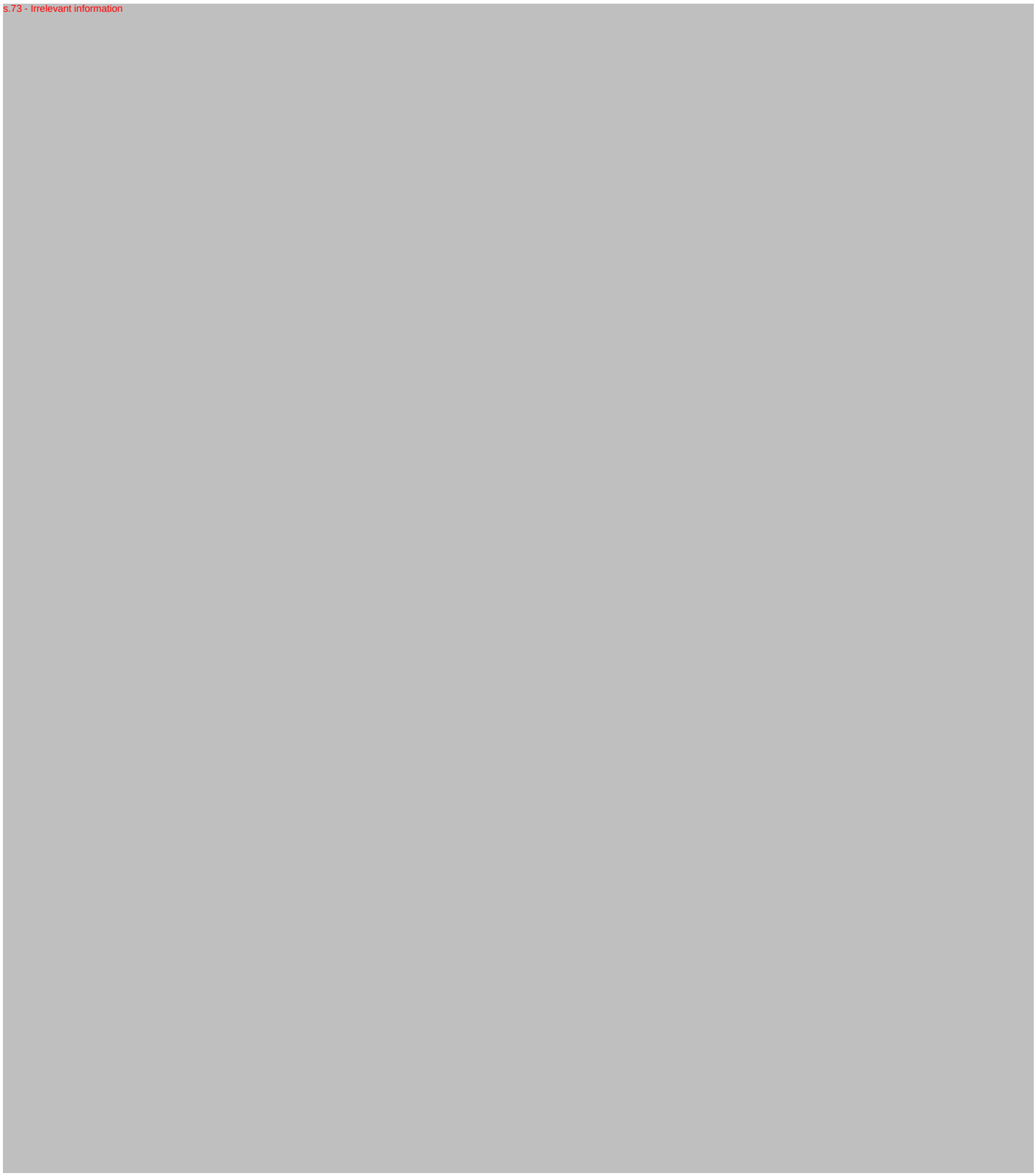
**National**

- 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.

s.73 - Irrelevant information

[redacted]

s.73 - Irrelevant information



**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**

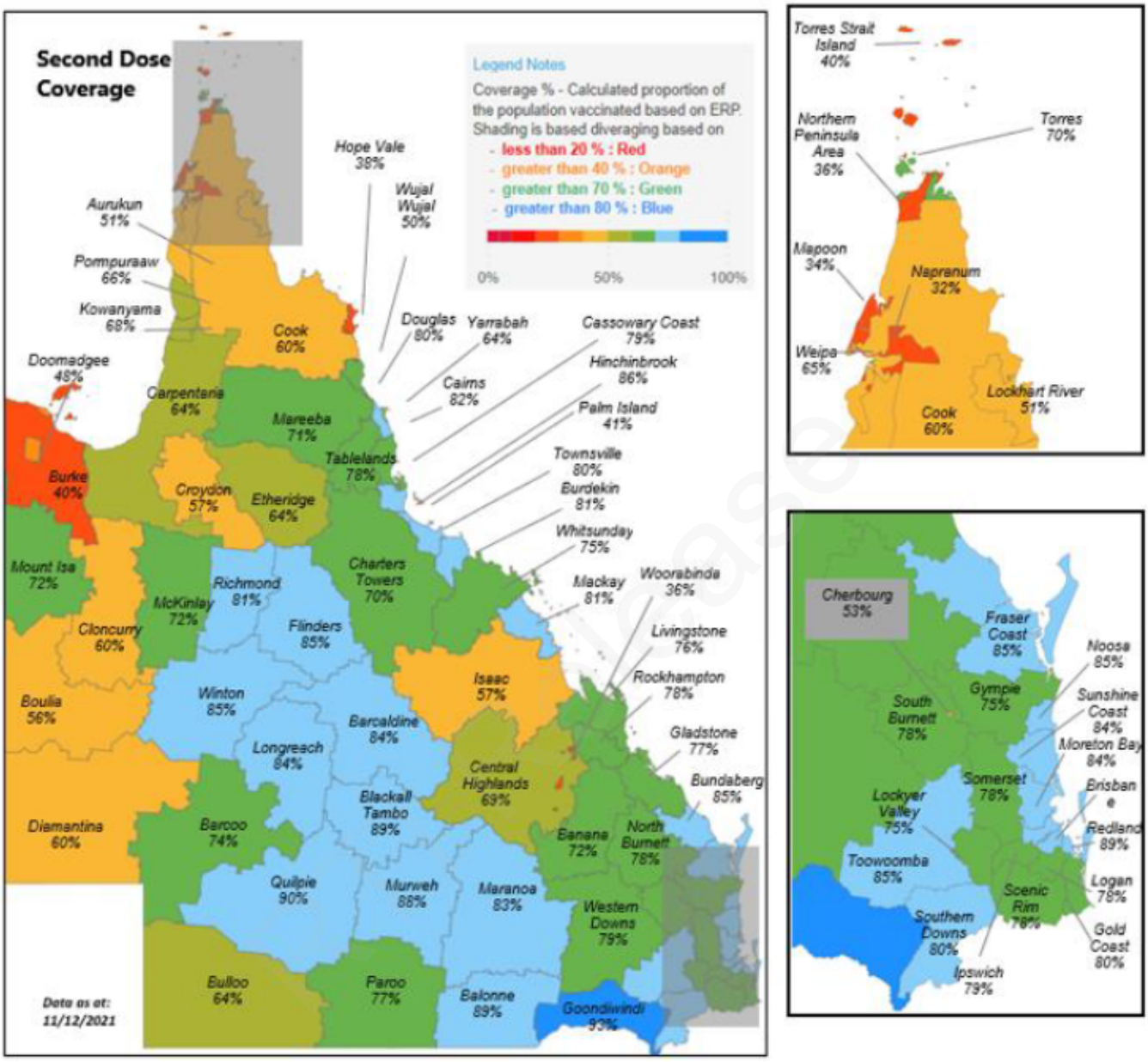
- Queensland's public health measures have been generally well-received and met with compliance. The community have so far been accepting and supportive of public health measures.
- There are ongoing concerns of 'pandemic fatigue' and associated non-compliance with public health measures nationally. 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.

**From:** DG correspondence
**To:** QAS.Correspondence; DDGCSD-CORRO
**Subject:** C-ECTF-22/2175 - brief approved by Dr John Wakefield, Director-General, Queensland Health
**Date:** Tuesday, 1 February 2022 8:54:00 AM
**Attachments:** DG BN - Policy QAS employees (other workers) vaccination COVID19.pdf
image001.png
image002.png
image003.png
image004.png
image005.png
image006.png

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Good morning

Please see attached brief approved by Dr John Wakefield, Director-General, Queensland Health, for your attention.

Kind Regards

Queensland Government

Ministerial & Executive Services Unit, Office of the Director-General | Queensland Health

E s.73 - Irrelevant information @health.qld.gov.au
W health.qld.gov.au

campaign image

Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

**SUBJECT: Approve a policy position requiring Queensland Ambulance Service employees (and honorary ambulance officers and work experience students/students undertaking clinical placements) identified as working in high-risk roles to be vaccinated against COVID-19**

| | |
|---|---|
| ☒ Approved<br>☐ Not approved<br>☐ Noted<br>☐ Further information required (see comments) | Signed s.73 - Irrelevant information Date 31/01/2022<br>Dr John Wakefield, Director-General, Queensland Health<br>Comments: |

**ACTION REQUIRED BY** 31 January 2022 to ensure the effective date of the policy can be met.

**RECOMMENDATION**
It is recommended the Director-General:

- **Approve** the policy position paper titled "COVID-19 Vaccination Requirements for Queensland Ambulance Service employees" which articulates the proposal to mandate COVID-19 vaccinations for all Queensland Ambulance Service employees (and honorary ambulance officers engaged under section 14 of the *Ambulance Service Act 1991* and work experience students/students undertaking clinical placements), engaged in 'at risk cohorts' (as defined in the paper) and the consider the human rights assessments in making this decision (Attachment 1).
- **Approve** a proposal to require these individuals to have received the first two doses of a COVID-19 vaccine by 27 February 2022.
- **Approve** the proposed Queensland Ambulance Service HR Policy that has been drafted to give effect to this recommendation (Attachment 2).
- **Note** the s.73 - Irrelevant information s.73 - Irrelevant information
- **Note** that on approval, the A/Commissioner QAS will repeal the QAS HR Procedure: COVID-19 Vaccine Requirements (the QAS HR Procedure).

**ISSUES**

1. The Director-General, Queensland Health Briefing Note of 7 September 2021 approved:
   1.1. the policy position of mandating vaccination against COVID-19 for all Queensland Health (QH) employees engaged to work in or enter a facility where care is provided to patients (the Queensland Health Policy Position paper) (Attachment 4 to Attachment 5); and
   1.2. a requirement for those employees to have received at least one dose of a COVID-19 vaccine by 30 September 2021, and the prescribed number of doses of a COVID-19 vaccine by 31 October 2021.
2. The Queensland Health Employment Directive No. 12/21: Employee COVID-19 Vaccination Requirements (HED) and the Employee COVID-19 Vaccination Requirements HR Policy (HR Policy) were released to give effect to the policy position and applied to all QH employees (excluding QAS employees).
3. Following the release of the HED and HR Policy, the A/Commissioner, QAS released the QAS HR Procedure: COVID-19 Vaccine Requirements (the QAS HR Procedure) as a Code of Practice pursuant to s41(1) of the *Ambulance Service Act 1991* to enact and implement the policy position that was approved by the DG.
4. On 30 September 2021, minor amendments were made to the HED and the QAS HR Procedure.
5. It has since come to light that specific considerations, including human rights considerations and risk assessments which were taken into account by the DG in approving the HED and HR Policy may not have been fully considered in the QAS context.
6. To ensure that the original and intended policy position remains applicable and appropriate in the QAS environment, and the applicable instruments align fully with Queensland Health and take into account, in a consistent manner, the human rights considerations and level of risk, it is proposed that the Director General consider and approve the QAS Policy position paper (Attachment 1) and the proposed QAS policy Employee COVID-19 vaccine requirements (Attachment 2).
7. The current QAS HR Procedure required QAS employees (and honorary ambulance officers engaged under section 14 of the *Ambulance Service Act 1991* and work experience students/students undertaking clinical placements) who are employed to work in high-risk areas to be fully vaccinated against COVID-19 by 31 October 2021 (the same timeframes as existed across Queensland Health).

8. The QAS Policy Position paper considers the risk associated with the work undertaken by the service to QAS employees, patients and the community.
9. Whilst QAS vaccination rates are high (95.2% double vaccination rate) the COVID-19 operating environment continues for QAS, and accordingly, the level of risk remains high.
10. The QAS Policy Position paper takes into account detailed consideration of the environmental and industrial rationale in support of the vaccine requirement which is set out in the Policy Position paper.
11. Detailed consideration has been given to the potential impact on human rights in the QAS Policy Position paper and it is recommended the Director General consider these impacts against the policy objective when making the decision to approve/not approve the proposed QAS policy.
12. Out of scope
13.
14.
15.
16. s.73 - Irrelevant information
17.

**BACKGROUND**

18. Taking into account consideration of the daily transmission events occurring in health facilities in all States, as well as other transmission events linked to Health Care Workers, there is a demonstrable level of risk associated with the work performed by QAS employees (and honorary ambulance officers engaged under section 14 of the *Ambulance Service Act 1991* and work experience students/students undertaking clinical placements).
19. Due to the highly transmissible and increasingly virulent nature of COVID-19, particularly the Omicron and Delta variants, increasing numbers of employers have announced policies requiring employee vaccination, including QANTAS, SPC and New South Wales, Tasmania and Western Australian Health departments.

**RESULTS OF CONSULTATION**

20. The QAS has undertaken consultation with the United Workers Union (UWU) and Together Queensland in respect of the proposed QAS HR Policy: Employee COVID-19 vaccine requirements who remain supportive of the approach.
21. The draft proposed QAS policy document was provided to both unions on Thursday 27/01/2022.
22. s.73 - Irrelevant information

**RESOURCE/FINANCIAL IMPLICATIONS**

23. There are no resource or financial implications associated with this brief.

**SENSITIVITIES/RISKS**

Out of scope

Out of scope

**ATTACHMENTS**

27. Attachment 1. Proposed QAS Policy Position paper
    Attachment 2. Proposed QAS HR Policy
    Attachment 3. s.73 - Irrelevant information
    Attachment 4. Queensland Health Policy Position paper
    Attachment 5. Queensland Health, Health Employment Directive 12/21 Employee COVID-19 Vaccination Requirements

| **Cleared by (Dir/Snr Dir)** | **Content verified by (DDG/CE)** |
|---|---|
| Name: Theresa Hodges<br>Position: Chief Human Resources Officer<br>Branch: Department of Health<br>Tel No: s.73 - Irrelevant information<br>Date Cleared: 27/01/2022 | Name: Craig Emery<br>Position: Commissioner<br>Division: Queensland Ambulance Service<br>Tel No: s.73 - Irrelevant information<br>Date Verified: 21/01/2022 |

# COVID-19 Vaccination Requirements for Queensland Ambulance Service (QAS) employees

Contents

## 1. Executive Summary

***What***
This paper proposes a decision be made to require mandatory vaccination against COVID-19 for all QAS employees, honorary ambulance officers engaged under section 14 of the *Ambulance Service Act 1991* and work experience students/students undertaking clinical placements (collectively referred to as QAS employees) within the at-risk cohorts as identified within the draft QAS HR Policy.

***Why***
This decision has been made based on the level of risk inherent to working in places where care is provided. Based on consideration of key criteria and the nature of the virus, these employees are at increased risk to either acquire or transmit COVID-19 either to fellow employees, to patients or the broader community, due to the nature of their work and the environment it is performed in.

***How***
Reasonable and lawful direction
In acknowledgement of the connection between the risks posed by the virus and the work performed by these employees, it is appropriate that a reasonable and lawful direction be given to require vaccination. This will be achieved through the introduction of QAS policy requiring existing and prospective employees working in or entering a health care facility or health care setting to be vaccinated against COVID-19.

Timeframes
Consistent with the levels of supply, as well as the inherent risk associated with the work of these QAS employees, it is recommended that:

- All QAS employees who work in or enter a site where care or support is provided to patients must receive two doses of COVID-19 vaccine by 20 February 2022 or a date as determined by the Chief Executive to enable persons to be able to reasonably comply;
- And to have provided evidence of that vaccination; and
- Further any booster shots required in accordance with ATAGI advice are required within the recommended timeframes.

Managing unvaccinated employees
The Policy will also provide a framework for those employees who may be unable to be vaccinated due to medical contraindication or for reasons of genuinely held religious beliefs. Employees electing to remain unvaccinated for other reasons will be supported to the extent reasonably practicable, however, where they remain unvaccinated, they will be considered refusing to follow a lawful direction.

Human rights impacts
In developing this proposal, consideration has been given to the human rights impacts through a human rights compatibility assessment. Taking into consideration the public health impacts, and the mechanisms proposed to support unvaccinated employees with medical contraindications or genuine religious beliefs, the proposal has been determined to be compatible with human rights.

## 2. Proposal

Queensland Health is mandating the requirement to be vaccinated against COVID-19 for QAS employees through a Policy.

The policy will require QAS employees who work in or enter sites where care is provided to patients or clients to be vaccinated against the virus. By requiring that these staff are vaccinated, QAS will be making every reasonable effort to minimise the risks of exposure and transmission of the virus to QAS employees, other health professionals, patients and the broader community.

This document sets out the environmental and industrial context in which this consideration is being made. It also provides an exemption framework for QAS employees who are unable to get vaccinated.

## 3. Background

The Queensland Ambulance Service (QAS) is established by the *Ambulance Service Act* 1991 and operates as a Statewide service as a Division within Queensland Health.

The QAS delivers pre-hospital ambulance response services, emergency and non-emergency pre-hospital patient care and transport services, inter-facility ambulance transport, casualty room services, planning and coordination of multi-casualty incidents and disasters, and confidential health assessment and information services.

The chief executive of Queensland Health is the employer of all persons employed within the QAS, under either the employment provisions contained in the *Ambulance Service Act* 1991 or the *Public Service Act* 2008 with the exception of honorary ambulance officers engaged by the QAS Commissioner under section 14 of the *Ambulance Service Act 1991*, however, are subject to the policies established by the Chief Executive in accordance with section 3E (2) (a) of the of the *Ambulance Service Act 1991*

As of 20 January 2022, the QAS employees a headcount of 5856 employees, 5572 of whom are double vaccinated (i.e. 95.2% of QAS employees have received two doses of an approved COVID-19 Vaccine).

## 4. The QAS Operating Environment

Under the QAS service delivery model, most operational employees of the QAS primarily operate on a 24/7 basis in an environment which is unpredictable in dynamic operational circumstances.

Officers providing direct patient care operate with a high degree of clinical autonomy where in field supervision is limited in most circumstances. This creates a risk that either unidentified or inadvertent exposure to individuals who are COVID-19 positive may occur.
Health care, treatment and transport generally occurs in the community, albeit that treatment may also occur in Queensland Health facilities including ambulance stations, aged care facilities or hospitals prior to, or during, patient transfer in hospital care.

In this regard, QAS employees deliver care to an 'unsegregated' patient cohort (i.e. at the time of treatment patients may not have been tested, or diagnosed as being either COVID-19 positive, or negative). This creates an additional unknown risk factor for both QAS employees and patients "in the field".

These circumstances present a unique risk profile, including:

- An increase in the potential exposure of QAS employees to COVID-19 arising from attendance and/or treatment of both known and unknown COVID positive patients; and
- An increase in the frequency of uncontrolled patient/employee, and employee/employee interactions across the operating environment.

## 5. Rationale

### *5.1 The impact of COVID-19 on Queensland Ambulance Service*

Leading public health bodies have identified the following groups at high risk of exposure:

- People who have travelled overseas;
- People who provide care to COVID-19 patients; and
- People who come in contact with persons at higher likelihood of having active infection (i.e. workers supporting border control, quarantine and isolation services).

Health and aged care workers have been identified as being of particularly high risk due to the nature of their work, which involves the provision of care to unwell persons as well as an inability to practice public health prevention measures due to this work (e.g. inability to physically distance). In fact, research indicates that patient-facing health and aged care workers are at three times the risk of contracting COVID-19 when compared with the general population.[1]

Healthcare and aged care facilities, have also been identified as being high risk settings where there is evidence of a risk of rapid spread and ongoing chains of transmission where an infectious case is introduced.[2] People who work or reside in these settings are at increased risk of infection as a result of the high population density, and other particular environmental conditions.[3]

Taking these factors into consideration, there is a high level of risk for all QAS employees working in facilities where care is provided due to both environmental factors, and the increased likelihood of exposure to an infected person. This is particularly so given the role of QAS operational staff entering people's home in response to emergency medical need.
These factors also pose risks to QAS patients, clients and people who access care, particularly as these people are often considered vulnerable individuals at increased risk of severe illness.

[1] U. Karlsson and C.J Fraenkel (2020) COVID-19 Risks to Healthcare workers and their families, *British Medical Journal,* 371.
[2] Above n 2, 12.
[3] Ibid.

Since the start of the pandemic, a number of Queensland Health including QAS employees have contracted the virus in the workplace, triggering outbreak response which included has previously included wide scale lockdowns to minimise the scale of outbreaks. As the pandemic has progressed, decisions have been taken to re-open state and international borders.

These circumstances potentially expose QAS patients and QAS employees to COVID-19, as well as the broader Queensland community. The likelihood of transmission within health settings is greater with non-vaccinated employees than with vaccinated employees.

Critically, in New South Wales, Victoria as well as other countries around the world there have been a large number of hospital outbreaks initiated by infected, non-vaccinated healthcare workers, resulting in the deaths of dozens of vulnerable in-patients who were admitted to hospital for other reasons but died as a result of hospital acquired COVID-19.

Additionally, and despite a focused effort on infection control through existing safety measures, QAS employees are contracting COVID-19. While the mechanism of transmission is unable to be ascertained, there is potential for this transmission to have occurred from patient to employee, or employee to employee.

## 6. Industrial Requirements

Both the research, and the experience of QAS over the past 18 months, conclusively indicate that there is an increased risk to QAS employees and patients from COVID-19 when compared with the general population. There is also evidence and experience of patients acquiring COVID-19 from healthcare workers, resulting in death and permanent disability from other jurisdictions.

This elevated risk level has particular bearing on the legislative obligation's incumbent on QAS employees to:

- follow reasonable and lawful directions of their employer;
- minimise risks to the health and safety of themselves, other employees, other persons, clients and patients in the workplace; and
- take reasonable precautions to minimise risks of infection.

In many ways, this elevated level of risk, coupled with the legislative obligations of employees and QAS's obligations to the community are analogous, or even exceeds those of Ozcare,[4] given that:

- there are particular positive legal obligations incumbent on both the organisation and staff; and
- that there is an elevated level of risk to patients or clients where a staff member works without being vaccinated as a result of the high-risk work environment; and
    - the mortality rates of COVID-19 are significantly higher than those of influenza.

In considering the very real and imminent risk posed by the virus to QAS employees, patients, clients and the community, it would appear inherently reasonable that QAS's workforce should be required to be vaccinated against

[4] *Ozcare v Glover* [2021] FWC 2989 [164].

COVID-19. This would align with QAS's legislative obligations, as well as the community expectations that healthcare workers and staff involved in healthcare delivery would make every effort to keep patients and the community safe.

## 7. Criteria

### *7.1 QAS employee cohorts*

QAS employees are broadly aligned to the following functional categories:

a. Ambulance Operatives (e.g. paramedics, patient transport officers, emergency medical dispatchers, officers in charge etc)

b. Frontline support officers (e.g. pharmacists, infection control nurses etc)

c. Corporate support officers (e.g. public servants)

d. honorary ambulance officers engaged under section 14 of the *Ambulance Service Act 1991* and work experience students/students undertaking clinical placements.

Ambulance Operatives include the following cohorts who provide or supervise direct patient treatment and/or transport in the community:

a. Paramedics

b. Patient Transport Officers

c. Other health professionals (e.g. doctors)

d. Frontline supervisors, managers and executives.

A further cohort of ambulance operatives include officers employed within the Operations Centre environment who, depending on role and location, may or may not have direct contact with the community and/or colleagues involved in direct patient care.

Additionally, the QAS employs public service employees in both corporate support and frontline support roles whose risk to contracting COVID-19 will depend on the nature of their work and location.

### *7.2 Risk Assessment for QAS*

Taking into consideration the highly virulent and transmissible nature of the virus, a risk assessment for different QAS employee cohorts is set out below using criteria established through case law:

| Criteria | Key criteria |
|---|---|
| 1. | Working in an area with suspect or confirmed COVID-19 patients or an area that a suspect or confirmed COVID-19 patient may enter<br>• Heightened risk of exposure to virus (e.g. transmission events in health facilities)<br>• Working with vulnerable, high risk or COVID-19 epidemiological vulnerable groups (i.e. severely ill patients, overseas arrivals)<br>• Community expectation of vaccination |

| | |
|---|---|
| 2. | Coming into direct or indirect contact with people who work in an area with suspect or confirmed COVID-19 patients or an area that a suspect or confirmed COVID-19 patient may enter<br>• Heightened risk of inadvertent exposure to virus (e.g. transmission event at Prince Charles Hospital)<br>• Working with or near vulnerable groups (i.e. unwell patients, overseas arrivals)<br>• Community expectation of vaccination |
| 3. | Unable to observe public health requirements (e.g. physical distancing, working in areas of high population density, rapid donning/doffing of PPE in emergent situations). This may include QAS employees attending to callouts where the status of the clients and environment is unknown (e.g. attending a call out in a highly and densely populated location such as night club, shopping centre or attending a persons home to provide care). |
| 4. | Potential to expose patients, clients, other staff or the broader community to the virus (e.g. occupying shared spaces such as lifts, cafeterias with people working with suspect or confirmed COVID-19 patients); or be exposed (knowingly and unknowingly) to other environments, clients, patients etc who may be COVID-19 positive. |

### *7.3 At risk cohorts*

Based on the key criteria, the following QAS employee groups have been identified as being at increased risk of the virus.

| Cohort | Who is included in this group? | Explanation |
|---|---|---|
| **Group 1** | All QAS employees in or required to attend a residential aged care facilities and residential aged care within multipurpose health services. | • Increased risk due to the vulnerability of aged care residents<br>• Subject to the existing COVID-19 vaccination requirements |
| **Group 2** | All QAS employees who are employed to work in or attend a public Hospital or other Queensland Health facility (including QAS facility) where clinical care or support is provided.<br><br>This includes 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 | • Reduce the risk level of exposure to employees and patients throughout the facility or health care setting.<br>• It also supports industrially compliant workforce management and maximises the available workforce that can undertake the |

| Cohort | Who is included in this group? | Explanation |
|---|---|---|
| | people with disability or any other location where QAS employees provide care or support to patients/clients/community.<br><br>This also includes public health officers/teams, emergency operations centre staff including employees working in Hospital Emergency Operation Centres and the Statewide Health Emergency Command Centre. | prescribed functions in the CHO Direction.<br>• Aligns with a growing community expectation that all QAS employees are vaccinated (irrespective of the nature of the work performed). |
| **Group 3** | All QAS employees who enter a public Hospital or other Queensland Health facility (including QAS facility) where clinical care or support is provided.<br><br>This includes 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 QAS employees provide care or support to patients/clients. | • Reduces the potential for transmission to patients or to the broader community as a result of environmental conditions in a health facility (i.e. inability to physically distance, emergent situations in a QAS health care service context). |

## 8. Application to QAS employees

### *8.1 Application of the proposal to prospective QAS employees*

An integral component of this proposal is that, moving forward, all new and/or prospective QAS employees within the proposed groups will be required to be vaccinated against COVID-19.

In recognition of the risk posed by the virus, particularly the Delta strain, the newly emerged Omicron strain and any future variants, new QAS employees will be required to have received two doses of an approved COVID-19 vaccine prior to commencement except under exceptional circumstances. Key considerations to support this are set out below:

- Establishing new/prospective QAS employees as a priority vaccination group to ensure they can be vaccinated prior to commencement.
- Updating role descriptions, job advertisements, graduate portal requirements and position descriptions, as well as the recruitment system.

### *8.2 Application of the proposal to existing QAS employees*

Vaccination uptake among existing QAS employees is high, with current data indicating 95.2 per cent of QAS's workforce having received the two doses.

Given the high levels of vaccination uptake among staff, and the high level of risk associated with the work performed by staff, there is a strong rationale in support of requiring staff to be vaccinated by the date set by the Director-General. This would also align with the expectation that 90 per cent of Queenslanders should be vaccinated by January 2022 by ensuring that QAS employees model this expectation.

Taking into consideration the COVID-19 environment, it is recommended that all QAS employees in these three high risk cohorts must:

- receive two doses of COVID-19 vaccine by the date set by the Director-General
- provide appropriate evidence of that vaccination
- receive any booster shots required in accordance with ATAGI advice are required within the recommended timeframes.

### *8.4 Management of unvaccinated QAS employees*

It is acknowledged that a QAS employee who is required to be vaccinated under the relevant policy may be unable to be vaccinated or elect not to, and the considerations for these QAS employees is detailed below.

Each QAS employee's circumstances will be considered on a case-by-case basis, however QAS's obligations to the employee are dependent on their reason for not meeting vaccination requirements.

### *8.5 QAS Employees unable to be vaccinated*

QAS employees may be unable to be vaccinated due to medical contraindication to the COVID-19 vaccine; or due to a genuinely held religious belief. It is anticipated this will be a small cohort of employees, and QAS has particular obligations to these cohorts arising from the *Human Rights Act 2019* (Qld) and the *Anti-discrimination Act 1999* (Qld).

Where this issue arises, the employee will be required to provide evidence substantiating these circumstances and the following process will be followed:

| Step | Step Details | Comment |
|---|---|---|
| 1. | Employee to provide evidence substantiating their circumstances | For employees with medical contraindication:<br>• This will be in the form of a letter from their treating specialist medical practitioner outlining the condition, whether it is temporary in nature (and if so) the duration.<br><br>For employees with genuinely held religious beliefs:<br>• This will be in the form of a letter certifying the employees deeply held religious belief and their affiliation/connection to the religious group from the religious official or leader. |
| 2. | Consideration of whether the employee is able to | It is acknowledged this arrangement is unlikely to be supported for the majority of QAS's |

| | | |
|---|---|---|
| | perform their role remotely or flexibly on a permanent basis | employees/workforce as a result of the levels of patient/client interaction inherent in the delivery of healthcare; and is heavily dependent on the nature of the work performed by the employee and their location. |
| 3. | Consideration of options for the employee to be temporarily redeployed | This option will be supported wherever possible however it is heavily dependent on the nature of the work performed by the employee and their location. |
| 4. | Consideration of any other reasonable adjustments the employer may be able to make | This may include, where appropriate/relevant, the provision of higher order additional PPE or ensuring the employee does not work during periods of increased risk (i.e. during periods of community transmission). Noting that PPE is a lower level control.<br><br>It may be appropriate for the employer to provide paid discretionary special leave pursuant to Directive 05/17 |
| 5. | Where these options have been exhausted the employee will be encouraged to access their own leave accruals | It may be appropriate for the employee to access sick, Long Service or Annual Leave as appropriate. |
| 6. | Where all other options have been exhausted, consideration will be given to an exit strategy for the employee. | This is because the employee is physically incapable of meeting the inherent requirements of the role. |

### *8.6 QAS employees electing not to be vaccinated for any other reason*

Feedback from internal and external consultation indicates that employees may decline to meet the vaccination requirements either due to reasons of conscientious objection or as a result of 'vaccine hesitancy.'

The proposed process for managing these QAS employees is set out below:

| Step | Step details | Comment |
|---|---|---|
| 1. | Conversation with the employee about their specific concerns in relation to the vaccine and to ascertain whether there is any additional information/support which could be provided. | A file note of the conversation should be made. |
| 2. | Additional education to address any concerns the employee may have and offering additional opportunities to be vaccinated as appropriate. | Hospital and Health Services have developed particular educational resources targeted to particular employee concerns (e.g. concerns of pregnant employees) and have |

| Step | Step details | Comment |
|---|---|---|
| | | implemented one-on-one discussions led by a respected clinician with staff to discuss their concerns in relation to the vaccine. |
| 3. | Consideration of whether the employee could perform their role remotely or through a permanent flexible work arrangement | It is acknowledged this arrangement is unlikely to be supported for the majority of QAS's workforce as a result of the levels of patient/client interaction inherent in the delivery of healthcare. |
| 4. | Consideration of whether the employee could be redeployed | This option will be supported wherever possible however it is heavily dependent on the nature of the work performed by the employee and their location. |
| 5. | Employee should be encouraged to access their own leave accruals | It may be appropriate for the employee to access sick, Long Service or Annual Leave as appropriate. |
| 6. | Employee to be placed on leave without pay | |
| 7. | Where all other options have been exhausted, consideration will be given to an exit strategy | This is because the employee remains unable to meet an inherent requirement of their role and has refused to follow a reasonable and lawful direction to be vaccinated. |

## 9. Human rights compatibility assessment

The Chief Executive of Queensland Health has authority to issue a lawful and reasonable direction to Queensland Ambulance Service (QAS) employees. When deciding whether to issue such a direction, the Chief Executive is required by s 58 of the *Human Rights Act 2019* to give proper consideration to human rights, and to ensure that any direction that is made is compatible with human rights.

### *9.1 Overview of the Direction*

While the proposed policy is intended to apply to all QAS employees but the mandatory vaccination direction would apply to identified at-risk cohorts. This mandatory vaccination direction requires QAS employees identified in at-risk cohorts to be vaccinated against COVID-19 unless they fall within an exemption. Exemptions are available for QAS employees who are unable to be vaccinated due to a medical contraindication, genuine religious objection, or because other circumstances apply. Further, to meet the vaccination requirements of the proposed lawful and reasonable direction, QAS employees are required to receive the prescribed subsequent dose/s of a COVID-19 vaccination (i.e. booster), as may be approved by the Australian Technical Advisory Group on Immunisation (ATAGI), within any recommended timeframe following the second dose.

The context of the direction is that a public health emergency was declared on 29 January 2020 for the whole of Queensland, under the *Public Health Act 2005*, due to the outbreak of COVID-19 and the health implications to Queensland. The risk presented by COVID-19 has increased with the emergency of variants, including the delta variant, and most recently, the omicron variant.

To effectively respond to the pandemic, the Chief Health Officer (CHO) has issued a number of public health directions under section 362B of the *Public Health Act*. Recently, the Chief Health Officer has issued directions, and may issue further directions, requiring certain people to be vaccinated against COVID-19 in order to enter certain places, including workers in a healthcare setting.

On 13 December 2021, the CHO eased border restrictions. From 17 December 2021, various restrictions on businesses were also eased. With the easing of restrictions and the emergence of the omicron variant, it is expected that COVID-19 will circulate in the Queensland community.

The QAS has important functions of providing ambulance services during rescue, providing transport for persons requiring attention at medical or health care facilities, and participating with other emergency services in counter-disaster planning. It is critical that QAS be able to continue to provide these essential services as safely as possible during the pandemic.

The *Work Health and Safety Act 2011* places a responsibility on the Chief Executive, so far as is reasonably practicable, to ensure the health and safety of QAS employees. That Act also requires the Chief Executive to ensure, so far as is reasonably practicable, the health and safety of other people with whom QAS employees interact when performing the functions of QAS.

### *9.2 Consideration of human rights*

Which human rights are relevant?

In considering whether human rights will be impacted by a decision to require vaccination for QAS employees, the Chief Executive is required to consider which rights will be:

- protected;
- promoted; and
- limited.

Human rights protected and promoted

The proposed direction would protect and promote the right to life under s 16 of the *Human Rights Act*. The right to life may require the state to 'take appropriate measures to address the general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity', including 'the prevalence of life-threatening diseases'.[5]

[5] UN Human Rights Committee, *General comment No. 36 – Article 6: right to life*, 124th sess, UN Doc CCPR/C/GC/36 (3 September 2019) 6 [26].

The virus that causes COVID-19 is highly virulent and can cause serious illness or death, particularly in vulnerable cohorts of the population with whom employees may be required to interact. Vaccination is shown to reduce the transmission and likelihood of serious illness or death from COVID-19. Ensuring employees are vaccinated as far as possible protects and promotes the right to life of the employees and the community.

Because vaccination of QAS employees will help to ensure that QAS can continue to provide essential services during the pandemic, the direction also promotes the right of access to health services under s 37 of the *Human Rights Act*. More broadly, vaccination also fulfills the right to the highest attainable standard of health under art 12(1) of the *International Covenant on Economic, Social and Cultural Rights*.[6]

Human rights limited

The Chief Executive has identified the following human rights that may potentially be limited by the proposed direction:

- The right to enjoy human rights without discrimination (s 15(2) of the *Human Rights Act*) and the right to non-discrimination (s 15(4) of the *Human Rights Act*) – Under s 15(2) of the *Human Rights Act*, employees have a right to enjoy their human rights without discrimination. Under s 15(4) of the *Human Rights Act*, employees have a right 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 pregnancy, impairment or religious belief. Because the definition is inclusive, discrimination under the *Human Rights Act* also likely covers additional analogous grounds,[7] which may include conscientious belief (though not vaccination status or employment status as a particular kind of employee, as these are not immutable characteristics). The direction may result in people with protected attributes being treated differently (for example, having their employment terminated). But not all differential treatment amounts to direct or indirect discrimination.

  It is considered that the direction does not directly or indirectly discriminate on any of those grounds. As to direct discrimination, the direction does not require people to vaccinate because they have one of those attributes. Broadly, indirect discrimination is an unreasonable requirement that applies to everyone but has a disproportionate impact on people with an attribute. A mandatory vaccination requirement could disproportionately impact people with a religious or conscientious belief. 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

6 Although this aspect of the right to health has not been translated to s 37 of the *Human Rights Act*, the right may nonetheless be taken into account: *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [2] (concurring judgment of Judge Lemmens); *ZD v Secretary, Department of Health and Human Services* [2017] VSC 806, [108] n 35; *PBU v Mental Health Tribunal* (2018) 56 VR 141, 167-8 [93]-[95].

7 *Miron v Trudel* [1995] 2 SCR 418, 496-7 [148]; *Quebec (Attorney-General) v A* [2013] 1 SCR 61, 144 [144].

impairment, pregnancy, religious belief or conscientious belief. The right to non-discrimination is therefore engaged (that is relevant) but not limited.

- The right to life (s 16 of the *Human Rights Act*) – As with any medical intervention, there is a risk (however small) of unintended side effects of the vaccination, 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 (of the more than 19 million doses that have been administered so far).[8] 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.[9] Arguably, the right to life is engaged (that is relevant), but not limited, by the proposed direction.

- The right not to be subjected to medical treatment without full, free and informed consent (s 17(c) of the *Human Rights Act*) – Medical treatment includes administering a drug for the purpose of treatment or prevention of disease.[10] The right is directed to treatment of any kind, 'even that which is beneficial to the individual'.[11] Under the proposed direction, QAS employees will not be able to be vaccinated without their consent. Arguably this means that the right in s 17(c) is not limited.[12] 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.[13] It is possible that the proposed direction will leave an employee with little practical choice but to receive a vaccine, so that while consent is given, that consent may not be full and free.

- Freedom of thought, conscience, religion and belief (s 20 of the *Human Rights Act*) – QAS employees may have a conscientious belief about vaccines. A conscientious belief for the purposes of s 20 of the *Human Rights Act* encompasses 'views based on strongly held moral ideas of right and wrong'.[14] However, in the context of vaccinations, case law in Europe suggests that there will need to be clear evidence of a deeply ingrained belief before freedom of conscience is engaged.[15] A person may also have a genuinely-held religious belief about vaccines.[16] Because the Standing Order does not include an

8 https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-09-12-2021.
9 *Application X v United Kingdom* (1978) 14 Eur Comm HR 31, 32-3; *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 33.
10 *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647, 707 [158]-[160].
11 *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 123 [576] (Bell J).
12 *Kassam v Hazzard* [2021] NSWSC 1320, [55]-[70]; *Larter v Hazzard [No 2]* [2021] NSWSC 1451, [99].
13 *New Health New Zealand Inc v South Taranaki District Council* [2018] 1 NZLR 948, 978 [99], 994-5 [172], 1011 [225]; *GF v Minister of COVID-19 Response* [2021] NZHC 2526, [70]-[72]; *Harding v Sutton* [2021] VSC 741, [161].
14 *Roach v Canada (Minister of State for Multiculturalism and Culture)* [1994] 2 FC 406, [25].
15 *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [323].
16 *BST Holding LLC v Occupational Safety and Health Administration, United States Department of Labor* (United States Court of Appeals Fifth Circuit, No 21-60845, 12 November 2021) 19 n 21.

exemption for conscientious or religious objections, the Standing Order limits the right in s 20.

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. Similarly, freedom of expression in section 21 encompasses a right to hold an opinion without interference. At international law these are absolute rights. However, nothing in the proposed Standing Order would coerce a person to believe a particular thing or not to hold a particular opinion. They would only limit a person's manifestation of that belief or opinion. Accordingly, those aspects of those rights are not limited by the proposed decisions.

- The right of access to the public service (s 23(2)(b) of the *Human Rights Act*) – Everyone has a right of equal access to the public service and public office. QAS is an administrative unit within the public service. Dismissal from the public service may engage this right.[17] A mandatory vaccination policy may have consequences for an employee's continued employment with QAS if they refuse to comply. Further, prospective QAS employees may be precluded from accessing the public service if they are not vaccinated. To the extent that the right to property (s 24) or the right to privacy (s 25) might protect aspects of a person's work,[18] any impacts on those rights would not add to the limit already imposed on s 23(2)(b).

- The right to privacy (s 25(a) of the *Human Rights Act*) – Section 25 provides that a person has the right not to have the person's privacy, family, home or correspondence unlawfully or arbitrarily interfered with. There are a number of different aspects of the right to privacy that may be engaged.

  First, the direction requires QAS employees to share personal information, such as their vaccination status. Requiring a person to disclose personal information interferes with privacy.[19] Arguably, the freedom to impart information under s 21(2) includes a freedom not to impart information.[20] However, a limit on this right would add no more to the interference with privacy.

- Second, the right to privacy may include a right to bodily integrity.[21] 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.[22]

- Third, because the right to privacy encompasses an individual's right to establish and develop meaningful social relations,[23] the right to privacy may also

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17 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*').

18 *Legal and General Assistance Ltd v Kirk* [2002] IRLR 124, [41] (property); *ZZ v Secretary, Department of Justice* [2013] VSC 267, [82]-[95] (privacy).

19 *DPP (Vic) v Kaba* (2014) 44 VR 526, 564 [132].

20 *Slaight Communications Inc v Davidson* [1989] 1 SCR 1038, 1080.

21 *Pretty v United Kingdom* (2002) 35 EHRR 1, [61]; *PBU v Mental Health Tribunal* (2018) 56 VR 141, 179 [125].

22 *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [263].

23 *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, [619]-[620].

incorporate a right to work of some kind and in some circumstances.[24] The direction may engage this right by interfering with the ability of QAS employees to continue their employment with QAS.

- 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 next.[25]

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

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

The Chief Executive is authorised to give lawful and reasonable directions to QAS employees under the common law and s 13 of the *Ambulance Service Act 1991*.[26]]

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

What is at stake is the recognition that people are entitled to make decisions about their own life and their own bodies, which is an aspect of their individual personality, dignity and autonomy.[27] Requiring a person to receive medical treatment (such as a vaccine) which they do not wish to receive is an affront to their dignity,[28] and the principle of personal inviolability.[29]

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',[30] including beliefs about health and vaccinations. Freedom of religious and conscientious belief 'is of the essence of a free society'.[31]

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24 *ZZ v Secretary, Department of Justice* [2013] VSC 267, [72]-[95].
25 As in *Minogue v Thompson* [2021] VSC 56, [86], [140].
26 *R v Darling Island Stevedoring & Lighterage Co Ltd; Ex parte Halliday* (1938) 60 CLR 601, 621-2 (Dixon J)
27 *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 121-2 [569], 123 [577].
28 *Jehovah's Witnesses of Moscow v Russia* (European Court of Human Rights, First Section, Application No 302/02, 10 June 2010) [135]-[136].
29 *PBU v Mental Health Tribunal* (2018) 56 VR 141, 180-1 [128].
30 *R v Oakes* [1986] 1 SCR 103, 136 [64].
31 *Haigh v Ryan* [2018] VSC 474, [48].

Creating consequences for a person's employment also affects a person's dignity and autonomy through work. For the public service in particular, it engages the values underlying secure tenure, such as independence.[32]

Those values at stake inform what it is that needs to be justified.

Do the limits have a proper purpose? (13(2)(b))

The purpose of mandatory vaccinations for QAS employees is to ensure the health and safety of employees in roles where they face a higher risk of contracting or transmitting COVID-19, as well as the health and safety of members of the community with whom QAS employees interact, particularly those who are vulnerable to contracting or transmitting COVID-19.

In particular, the purpose is to:

- minimise the risk of transmission to and from the members of the community with whom QAS employees interact; and
- minimise the risk of transmission of COVID-19 between employees, which threaten the ability of QAS to deliver crucial services.

Ultimately, the purpose of preventing transmission of COVID-19 to and from employees is to protect the right to life under s 16 of the *Human Rights Act*. Those are purposes which are consistent with the values of our free and democratic society.

A further purpose of the direction is to appropriately manage the workforce where current public health directions issued by the CHO require at least some QAS employees to be vaccinated against COVID-19. That purpose is also consistent with the values of our society.

Do the limits help to achieve the purpose? (s 13(2)(c))

Mandatory vaccinations will help to achieve the purpose of minimising the risk of COVID-19 transmission from and to employees, as well as the purpose of protecting the right to life.

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).[33] This means vaccinated employees will be less likely to be infected by members of community. Further, they are less likely to transmit the virus. If they do contract it, their symptoms will be less severe requiring less time away from work.

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32 Human Rights Committee, *General Comment No 25*, 57th sess, UN Doc CCPR/C/21/Rev.1/Add.7 (27 August 1996) 7 [23].

33 Australian Technical Advisory Group on Immunisation (ATAGI), *Clinical guidance on use of COVID-19 vaccine in Australia in 2021 (v7.4)* (29 October 2021) <https://www.health.gov.au/sites/default/files/documents/2021/10/covid-19-vaccination-atagi-clinical-guidance-on-covid-19-vaccine-in-australia-in-2021_0.docx>.

The AHPPC notes also that the Omicron variant is substantially more transmissible than Delta in populations with a high previous exposure to COVID-19 and/or high vaccination coverage. In this regard, the AHPPC has reiterated the need to ensure those who are partially vaccinated complete their courses and those who remain unvaccinated are encouraged to undergo vaccination. The AHPPC has agreed that booster doses will play an important role in reducing transmission and severity of the Omicron variant[34].

The rational connection is not undermined by providing exemptions for people with a medical contraindication or religious objection.[35] Even with those exemptions, it is still the case that a greater proportion of QAS employees will be vaccinated.

Are the limits necessary or are there other ways to achieve the purpose? (s 13(2)(d))

The following less restrictive alternatives have been considered:

- educating and allowing QAS employees to take up vaccination voluntarily;
- relying upon the high vaccination rates within QAS and the wider community for herd immunity;
- applying the direction to fewer categories of QAS employees;
- allowing wider categories of exemptions; and,
- implementing other control measures such as physical distancing, improving ventilation, encouraging good hygiene, wearing masks and rapid antigen testing.

It is not possible to exclude more employees from the scope of the policy or allow for any wider categories of exemptions (such as a medical contraindication or genuine religious objection) without undermining the purpose of reducing the risk of COVID-19 transmission. The direction is already tailored to confine the impacts on human rights to the extent strictly required, by:

- only applying the direction to officers who fall within the following risk profile:
  - They are working in an area with suspected or confirmed COVID-19 patients or an area that a COVID-19 patient may enter.
  - They are coming into direct or indirect contact with people who work in an area with COVID-19 patients or an area that a suspected or actual COVID-19 patient may enter.
  - They are unable to observe public health requirements (e.g. physical distancing, working in areas of high population density, rapid donning/doffing of personal protective equipment (PPE) in emergent situations).
  - They have the potential to expose patients, clients, other staff or the broader community to the virus (e.g. occupying shared spaces such as lifts, cafeterias, car parks, with people working with suspected or actual COVID-19 patients) or be exposed to (knowingly or unknowing) persons who may or suspected ti be COVID-19 positive.
- providing exemptions for employees with a medical contraindication, genuine religious objection or other exceptional circumstances.

[34] AHPPC statement on the Omicron public health implications and response options <https://www.health.gov.au/news/ahppc-statement-on-the-omicron-public-health-implications-and-response-options>

[35] *Taylor v Newfoundland and Labrador*, 2020 NLSC 125, [440]-[451]; *McCloy v New South Wales* (2015) 257 CLR 178, 251 [197].

QAS has already implemented a number of control measures (such as physical distancing). However, these alternative control measures, alone or in combination, are unlikely to be equally as effective as a vaccination requirement. The precautionary principle applied by epidemiologists provides that, 'from a purely public health perspective, all reasonable and effective measures to mitigate the risk should ideally be put in place',[36] not merely some of those measures.

Having regard for testing as an alternative to vaccination, the AHPPC notes that PCR testing capacity is finite and has been further constrained by the inability to pool samples given high positivity rates, the impact of high community transmission on staff infections and furlough periods, and supply chain constraints (e.g. for reagents)[37].

Further the QHPPC proposed that rapid antigen tests can be used for the following 3 purposes:

1. As a diagnostic test as an alternative to PCR for those at high risk of having COVID-19. In most circumstances in the current high-prevalence environment, a positive rapid antigen test should be accepted as a diagnosis of COVID-19.
2. To manage outbreaks.
3. To help early identification of cases in high-risk settings.

Further, earlier this year, a recent journal paper suggested that "the addition of routine asymptomatic surveillance to decrease transmission in healthcare facilities should not be pursued as a primary infection prevention strategy" (Shenoy & Weber, 2021).[38]

The ability to provide an exemption in other exceptional circumstances also avoids unintended harsh consequences. For example, depending on the surrounding circumstances, the exceptional circumstances exemption may apply where an employee technically falls within the scope of the policy, but they do not have regular contact with members of the public, or other high risk situations in their working role, and the risks of COVID-19 can be mitigated in other ways.

Overall, given the nature of the risk of the COVID-19 pandemic, a mandatory vaccination direction falls within the range of reasonable alternatives.[39] As there is no less restrictive way to ensure the health and safety of employees, patients and the community, to ensure the QAS can perform its statutory duties, and to protect

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[36] *Palmer v Western Australia [No 4]* [2020] FCA 1221, [79].

[37] A statement from the Australian Health Protection Principal Committee (AHPPC) on National Principles for Infection Prevention and Control in Quarantine <https://www.health.gov.au/news/ahppc-statement-on-rapid-antigen-testing-for-current-high-community-prevalence-environment>

[38] Shenoy, E. S., & Weber, D. J. (2021). Routine surveillance of asymptomatic healthcare personnel for severe acute respiratory coronavirus virus 2 (SARS-CoV-2): Not a prevention strategy. Infection Control & Hospital Epidemiology, 42(5), 592-597. doi:10.1017/ice.2020.1428

[39] *Sabet v Medical Practitioners Board (Vic)* (2008) 20 VR 414, 442 [188]; *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [273]-[280], [310].

the right to life, the limits on human rights are necessary to achieve the direction's purposes.

Do the limits strike a fair balance? (s 13(2)(e), (f) and (g))

Finally, do the limits strike a fair balance between the rights of the individual and the interests of the community?

The benefits of achieving the direction's purposes include:

- a reduced risk of employees suffering from COVID-19 and its effects, or acting as a vector for the spread of COVID-19;
- ensuring QAS can continue to provide critical services through the pandemic;
- an increase in the enjoyment of the right to life (s 16 of the *Human Rights Act*);
- an increase in the enjoyment of the right to the highest attainable standard of health (under article 12(1) of the *International Covenant on Economic, Social and Cultural Rights*);
- savings in indirect costs, such as loss of productivity and economic loss suffered as a result of employees contracting the virus and developing COVID-19; and
- possibly, broader benefits for the wider community, such as protecting people who cannot receive a vaccine for medical reasons through herd immunity, and enhancement of equality (which is protected in s 15 of the *Human Rights Act*), given that the burden of infectious diseases falls disproportionately on the disadvantaged.

The importance of the direction's purpose is only greater now that the State borders have reopened, the omicron variant has emerged, and community transmission has increased across the State. QAS employees are on the frontline of that risk. Experience interstate and overseas is that paramedics and ambulance officers are at increased risk of contracting and spreading COVID-19. To this end, and having regard for the impacts of the Omicron variant, the World Health Organisation recommends that "health care workers should also get a booster jab due to their high risk of exposure to the virus and the danger of spreading it to the vulnerable people they care for"[40].

On the other side of the scales, these benefits come at the cost of:

- exposing employees to the risks that are inherent with any vaccine, including suffering rare (though potentially serious) side effects;
- interfering with people's bodily integrity, and their autonomy to make decisions about their bodies and their own health; and,
- potentially forcing employees to go against their deeply-held conscientious or religious beliefs.

However, the extent of the harm to human rights is reduced by a number of factors. First, the harm to human rights is reduced by allowing exemptions for employees with a contraindication or religious objection.

[40] World Health Organisation – The Omicron Variant: Sorting Fact from Myth < https://www.euro.who.int/en/health-topics/health-emergencies/pages/news/news/2022/01/the-omicron-variant-sorting-fact-from-myth>

Second, QAS employees are already required to vaccinate in various situations under the following public health directions issued by the CHO, including:

- the Workers in a healthcare setting (COVID-19 Vaccination Requirements) Direction (No. 2);
- Residential Aged Care Direction (No. 12)
- the Hospital Entry Direction (No. 8).

This direction does not add a significant additional burden on human rights compared to the burden already imposed.

Finally, 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.'[41] That is, QAS employees 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.

Overall, the harm caused to human rights would be outweighed by the benefits of minimising the risk of COVID-19 transmission from and to employees, as well as the protection and promotion of the right to life.

### *9.4 Conclusion*

The proposed direction is compatible with human rights.

Because the justification of the limits on human rights depends on the circumstances that currently apply, the direction will be reviewed regularly to ensure that the limits imposed on human rights remain justified.

When making individual exemption decisions under the direction, the Chief Executive (or delegate) will need to separately consider human rights and act compatibly with human rights under s 58 of the *Human Rights Act 2019*. However, because comprehensive consideration has already been given to human rights in this compatibility assessment, the consideration given to human rights for each exemption decision will not need to be as detailed.[42]

[41] *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).

[42] *Minogue v Thompson* [2021] VSC 56, [61], [75], [78].

# Employee COVID-19 Vaccination Requirements

## Human Resources Policy

**Publication date:** January 2022

**Purpose:** To outline COVID-19 vaccination requirements for existing employees and prospective employees employed to work in the identified high risks groups designated in this policy.

**Application:** This policy applies to all existing and prospective employees working for the Queensland Ambulance Service (and honorary ambulance officers engaged under section 14 of the *Ambulance Service Act 1991* and work experience students/students undertaking clinical placements).

Health service employees, working in the Queensland Ambulance Service are covered by Health Employment Directive No. 12/21: Employee COVID-19 vaccination requirements.

**Delegation:** The 'delegate' is as listed in the Department of Health – Queensland Ambulance Service Human Resource (HR) Delegations Manual, as amended from time to time.

**Legislative or other authority:**

- *Ambulance Service Act 1991*
- Ambulance Service Regulation 2015
- *Anti-Discrimination Act 1991*
- *Disability Discrimination Act 1992*
- *Hospital and Health Boards Act 2011*
- *Human Rights Act 2019*
- *Industrial Relations Act 2016*
- *Information Privacy Act 2009*
- *Public Health Act 2005*
- *Public Records Act 2002*
- *Public Service Act 2008*
- *Work Health and Safety Act 2011*
- Health Employment Directive 12/21: Employee COVID-19 vaccination requirements

**Related policy or documents:**

- QAS HR Policy Statement – Recruitment and Selection
- QAS HR Procedure – Selection of Applicants

## Policy subject:



## 1 Risk management

The COVID-19 virus has been shown to disproportionately affect healthcare workers, including paramedics, and health support staff and poses a significant risk to Queensland Ambulance Service (QAS) patients, and the broader community.

In recognition of the risks posed by the virus, as well as workplace health and safety obligations incumbent upon both the organisation and employees, this policy requires QAS employees who are identified as being in high risk groups to be vaccinated against COVID-19.

Prospective and existing QAS employees subject to these requirements have been identified based on the following risk profile:

- They are working in an area with suspected or confirmed COVID-19 patients or an area that a COVID-19 patient may enter.
- They are coming into direct or indirect contact with people who work in an area with COVID-19 patients or an area that a suspected or actual COVID-19 patient may enter.
- They are unable to observe public health requirements (e.g. physical distancing, working in areas of high population density, rapid donning/doffing of personal protective equipment (PPE) in emergent situations).
- They have the potential to expose patients, clients, other staff or the broader community to the virus (e.g. occupying shared spaces such as lifts, cafeterias, vehicles, car parks, with people working with suspected or actual COVID-19 patients) or to be exposed to the virus due to the nature of their work.

## 2 Requirement for vaccination

In acknowledgment of the risks posed by the COVID-19 virus to the health and safety of QAS employees, patients and the broader community, clauses 3 and 4 of this Policy require that all existing and prospective employees who are or are to be employed to work in the cohorts as categorised in accordance with Table 1 (below), to be vaccinated as a condition of employment, subject to certain limited exemptions described in clause 5 of this Policy.

Any existing or prospective honorary ambulance officer engaged under section 14 of the *Ambulance Service Act 1991* or work experience students/students undertaking clinical placements) in a group identified in Table 1 below, is required to be vaccinated against COVID-19 and provide evidence of vaccination.

It should be noted that Table 1 (below) outlines the requirements for QAS employees.

| COVID-19 vaccination requirements for Queensland Ambulance Service employees | |
|---|---|
| **Group No.** | **Employee cohort** |
| **Group 1** | All QAS working in or providing services to residential aged care facilities and residential aged care within a multipurpose health service. |
| **Group 2** | All QAS employees who are employed to work in a hospital or other healthcare setting where clinical care or support is provided.<br>This may include:<br>• both clinical and non-clinical employees.<br>• ambulance stations, 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 QAS employees provide care or support to patients/clients.<br>• public health officers/teams, emergency operations centre staff including employees working in the Hospital Emergency Operation Centres and Retrieval Services Queensland. |
| **Group 3** | All other QAS employees who are employed in roles that require attendance at a hospital or other facility where clinical care or support is provided.<br>This may include:<br>• the requirement to attend ambulance stations, 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 QAS employees provide care or support to patients/clients. |

*Table 1: COVID-19 Vaccination requirements for Queensland Ambulance Service employees*

## 3 Existing employees

Existing employees currently undertaking work or moving into a role undertaking work listed in a cohort of Table 1, must:

- have received the first dose and second dose of a COVID-19 vaccine by 27 February 2022.

An existing employee must provide their line manager or other designated person:

a. evidence of vaccination confirming that the employee has received at least the first dose of a COVID-19 vaccine by no later than 7 days after receiving the vaccine.
b. evidence of vaccination confirming that the employee has received both doses of a COVID-19 vaccine by no later than 7 days after receiving the vaccine.

An existing employee must maintain vaccine protection. Therefore, an existing employee is required to receive the prescribed subsequent dose/s of a COVID-19 vaccination (i.e. booster), as may be approved by the Australian Technical Advisory Group on Immunisation (ATAGI), within any recommended timeframe following the second dose. Evidence of vaccination, confirming the employee has received prescribed subsequent dose/s of the vaccine, is to be provided to their line manager or other designated person within 7 days of receiving the vaccination.

An existing employee who is required to have received a first and second dose of a COVID-19 vaccination at an earlier date under a Chief Health Officer public health direction must be vaccinated by the dates specified in the public health direction.

The requirements of this clause 3 do not apply to existing employees who have been granted an exemption under clause 5 of this Policy.

## 4 Prospective/new employees

When offering a position to a prospective employee, the relevant advertising and engagement documentation must clearly state that engagement is subject to the person fully satisfying the COVID-19 vaccination requirements. Evidence of satisfying the vaccination requirements must be provided as part of the recruitment and on-boarding process to satisfy this requirement.

The requirements of this clause 4 do not apply to prospective employees who have been granted an exemption under clause 5 of this Policy.

## 5 Exemptions

Where an existing employee is unable to be vaccinated they are required to complete an exemption application form.

Exemptions will be considered in the following circumstances:

- Where an existing employee has a recognised medical contraindication;
- Where an existing employee has a genuinely held religious belief;
- Where another exceptional circumstance exists.

If an existing employee is granted an exemption, they do not have to comply with clause 3 or 4 of this Policy.

## 6 Reporting and record keeping

In accordance with clause 3 of this Policy evidence of COVID-19 vaccination must be provided to the employee's line manager or the person nominated in locally developed processes. Evidence of vaccination must also be submitted using the QAS COVID Vaccination MACH Form (located on the 'COVID-19' page of the QAS Portal).

A record will be kept of all COVID-19 vaccinations reported by an existing or prospective employee (for employees and prospective employees covered by this policy).

The record must be stored in a secure database that is accessible to authorised persons only and maintained in accordance with the *Information Privacy Act 2009* and the *Public Records Act 2002*.

Documentary evidence of exemptions, as well as risk assessments and risk management plans must be kept for all existing or prospective employees.

De-identified information about employee vaccination rates will be reported in accordance with relevant state or federal government requirements.

## Definitions:

| | |
|---|---|
| COVID-19 vaccine | Means a vaccine approved by the Therapeutic Goods Administration for use in Australia or endorsed by WHO-COVAX where the employee was vaccinated overseas. |
| Evidence of vaccination | A copy of the employee's immunisation history statement from the *Australian Immunisation Register.*<br><br>Where a person has been vaccinated overseas, a record of this must be provided. |
| Healthcare setting | Includes public hospitals, public health clinics, ambulance services, patient transport services, and other health services. |
| Queensland Health | Queensland Health includes:<br>• Hospital and Health Services established under the *Hospital and Health Boards Act 2011*<br>• The Department, comprising:<br>– Aboriginal and Torres Strait Islander Health Division<br>– Clinical Excellence Queensland<br>– Corporate Services Division<br>– COVID-19 Supply Chain Surety Division<br>– Healthcare Purchasing and System Performance Division<br>– Chief Health Officer and Prevention Division<br>– Office of the Director-General<br>– eHealth Queensland<br>– Queensland Ambulance Service. |

## History:

| | |
|---|---|
| January 2022 | • Policy:<br>– Developed to require employees of the Queensland Ambulance Service to be vaccinated against COVID-19 where they are employed in certain high risk cohorts. This policy supersedes and replaces the former QAS HR Procedure / Code of Practice – COVID-19 Vaccine Requirements. |

s.73 - Irrelevant information

s.73 - Irrelevant information

s.73 - Irrelevant information

s.73 - Irrelevant information

# Policy position:
# Mandatory vaccination for Queensland Health employees

**As at 6 September 2021**

# Contents

# Executive Summary

## *What*

This document sets out Queensland Health's policy position to mandate COVID-19 vaccination for staff employed to work at any facility where care is provided to patients and to staff where their roles requires them to attend to a facility as part of their job.

## *Why*

This decision has been made based on the level of risk inherent to employees working or entering these areas. Based on consideration of key criteria and the nature of the virus, these employees have been identified as at increased risk to either acquire or transmit COVID-19 either to fellow employees, to patients or the broader community, due to the nature of their work and the environment it is performed in.

## *How*

Reasonable and lawful direction

In acknowledgement of the connection between the risks posed by the virus and the work performed by these employees, it is appropriate that a reasonable and lawful direction be given to require vaccination. This will be achieved through the introduction of a Health Employment Directive (HED) which requires existing and prospective employees working in or entering a facility to be vaccinated against COVID-19.

Timeframes

Consistent with the levels of supply, as well as the inherent risk associated with the work of these Queensland Health employees, it is recommended that:

- All Queensland Health employees who work in or enter a site where care or support is provided to patients must receive one dose of a COVID-19 vaccine by 30 September 2021; and
- All Queensland Health employees who work in or enter a site where care or support is provided to patients must have received the prescribed number of doses of a COVID-19 vaccine by 31 October 2021.

Managing unvaccinated employees

The HED will also provide a framework for managing circumstances where an employee may be unvaccinated. The circumstances of these employees will be considered on a case-by-case basis with particular consideration given to Queensland Health's obligations to support those employees who may be unable to be vaccinated due to medical contraindication or for reasons of genuinely held religious beliefs. Employees electing to remain unvaccinated for other reasons will be supported to the extent reasonably

practicable however where they remain unvaccinated they will be considered refusing to fulfill an inherent requirement of their role.

Human rights impacts

In developing this proposal, consideration has been given to the human rights impacts and assessment has been developed. Taking into consideration the public health impacts, and the mechanisms proposed to support unvaccinated employees with medical contraindications or genuine religious beliefs, the proposal has been determined to be compatible with human rights.

# 1. Proposal

Queensland Health is mandating the requirement to be vaccinated against COVID-19 for employees through a Health Employment Directive (HED).

The HED will require employees who work in or enter sites where care is provided to patients or clients to be vaccinated against the virus. By requiring that these staff are vaccinated, Queensland Health will be making every reasonable effort to minimise the risks of exposure and transmission of the virus to staff, patients and the broader community.

This document sets out the environmental and industrial contexts in which this consideration is being made. It also provides an exemption framework for employees who are unable to get vaccinated.

# 2. Rationale

## 2.1 The impact of COVID-19 on Queensland Health

Leading public health bodies have identified the following groups at high risk of exposure:

- People who have travelled overseas;
- People who provide care to COVID-19 patients; and
- People who come in contact with persons at higher likelihood of having active infection (i.e. workers supporting border control, quarantine and isolation services).

Health and aged care workers have been identified as being of particularly high risk due to the nature of their work which involves the provision of care to unwell persons as well as an inability to practice public health prevention measures due to this work (e.g. inability to physically distance). In fact, research indicates that patient-facing health and aged care workers are at three times the risk of contracting COVID-19 when compared with the general population.[1]

Healthcare and aged care facilities, have also been identified as being high risk settings where there is evidence of a risk of rapid spread and ongoing chains of transmission where an infectious case is introduced.[2] People who work or reside in these settings are

[1] U. Karlsson and C.J Fraenkel (2020) COVID-19 Risks to Healthcare workers and their families, *British Medical Journal,* 371.
[22] Above n 2, 12.

at increased risk of infection as a result of the high population density, and other particular environmental conditions.[3]

Taking these factors into consideration, there is a high level of risk for all Queensland Health employees working in facilities where care is provided due to both environmental factors, and the increased likelihood of exposure to an infected person.

These factors also pose risks to Queensland Health patients, clients and people who access care through Queensland Health providers, particularly as these people are often considered vulnerable individuals at increased risk of severe illness.

Since the start of the pandemic, a number of Queensland Health employees have contracted the virus in the workplace, triggering outbreak response which included wide scale lockdowns to minimise the scale of outbreaks. These transmission events potentially expose Queensland Health's patients and staff to COVID-19, as well as the broader Queensland community. The likelihood of transmission within health settings is greater with non-vaccinated employees than with vaccinated employees.

Critically, in New South Wales, Victoria as well as other countries around the world there have been a large number of hospital outbreaks initiated by infected, non-vaccinated healthcare workers, resulting in the deaths of dozens of vulnerable inpatients who were admitted to hospital for other reasons but died as a result of hospital acquired COVID-19.

## 3. Industrial Requirements

Both the research, and the experience of Queensland Health over the past 18 months, conclusively indicate that there is an increased risk to Queensland Health employees and patients from COVID-19 when compared with the general population. There is also evidence and experience of patients acquiring COVID-19 from healthcare workers, resulting in death and permanent disability from other jurisdictions.

This elevated risk level has particular bearing on the legislative obligations incumbent on Queensland Health employees to:

- Follow reasonable and lawful directions of their employer; and
- Minimise risks to the health and safety of themselves, other employees and patients in the workplace; and
- Take reasonable precautions to minimise risks of infection.

In many ways, this elevated level of risk, coupled with the legislative obligations of employees and Queensland Health's obligations to the community are analogous, or even exceeds those of Ozcare,[4] given that;

- there are particular positive legal obligations incumbent on both the organisation and staff; and
- that there is an elevated level of risk to patients or clients where a staff member works without being vaccinated as a result of the high-risk work environment; and
- the mortality rates of COVID-19 are significantly higher than those of influenza.

[3] Ibid.
[4] *Ozcare v Glover* [2021] FWC 2989 [164].

In considering the very real and imminent risk posed by the virus to Queensland Health employees, patients, clients and the community, it would appear inherently reasonable that Queensland Health's workforce should be required to be vaccinated against COVID-19. This would align with Queensland Health's legislative obligations, as well as the community expectations that healthcare workers and staff involved in healthcare delivery would make every effort to keep patients and the community safe.

# 4. Criteria

## 6.1. Risk Assessment for Queensland Health employees and contractors

Taking into consideration the highly virulent and transmissible nature of the virus, a risk assessment for different Queensland Health employee cohorts is set out below using criteria established through case law:

| Criteria No. | Key criteria |
|---|---|
| 1. | Working in an area with suspect or confirmed COVID-19 patients or an area that a suspect or confirmed COVID-19 patient may enter<br>• Heightened risk of exposure to virus (e.g. transmission events in health facilities)<br>• Working with vulnerable, high risk or COVID-19 epidemiological vulnerable groups (i.e. severely ill patients, overseas arrivals)<br>• Community expectation of vaccination |
| 2. | Coming into direct or indirect contact with people who work in an area with suspect or confirmed COVID-19 patients or an area that a suspect or confirmed COVID-19 patient may enter<br>• Heightened risk of inadvertent exposure to virus (e.g. transmission event at Prince Charles Hospital)<br>• Working with or near vulnerable groups (i.e. unwell patients, overseas arrivals)<br>• Community expectation of vaccination |
| 3. | Unable to observe public health requirements (e.g. physical distancing, working in areas of high population density, rapid donning/doffing of PPE in emergent situations) |
| 4. | Potential to expose patients, clients, other staff or the broader community to the virus (e.g. occupying shared spaces such as lifts, cafeterias with people working with suspect or confirmed COVID-19 patients) |

## 4.2. At risk cohorts

Based on the key criteria, the following groups have been identified as being at increased risk of the virus

| Cohort | Who is included in this group? | Explanation |
|---|---|---|
| **Group 1** | All Queensland Health employees in residential aged care facilities and residential aged care within multipurpose health services. | • Increased risk due to the vulnerability of aged care residents<br>• Subject to the existing COVID-19 vaccination requirements |
| **Group 2** | All Queensland Health employees who are employed to work in a public Hospital or other Queensland Health facility where clinical care or support is provided.<br>This includes 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. This also includes public health officers/teams, emergency operations centre staff including employees working in Hospital Emergency Operation Centres and the Statewide Health Emergency Command Centre.<br>This group has been categorised into three sub-groups with different timeframes to be vaccinated (refer next section for details). An in-depth risk profile for this group is set out in Appendix 5. | • Reduce the risk level of exposure to employees and patients throughout the facility.<br>• It also supports industrially compliant workforce management and maximises the available workforce that can undertake the prescribed functions in the CHO Direction.<br>• Aligns with a growing community expectation that all Queensland Health employees are vaccinated (irrespective of the nature of the work performed). |
| **Group 3** | All Queensland Health employees who enter a public Hospital or other Queensland Health facility where clinical care or support is provided.<br>This includes 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 | • Reduces the potential for transmission to patients or to the broader community as a result of environmental conditions in a health facility (i.e. inability to |

| | | |
|---|---|---|
| | care or support to patients/clients. The scope of this group will be determined based on individualised risk assessments and the availability of viable alternative options. | physically distance, emergent situations in a HHS). |

# 5. Application to Queensland Health employees

## 5.1. Application of the proposal to prospective employees

An integral component of this proposal is that, moving forward, all new/prospective employees within the proposed groups will be required to be vaccinated against COVID-19.

In recognition of the risk posed by the virus, particularly the Delta strain, new employees will be required to have received two doses of an approved COVID-19 vaccine. Key considerations to support this are set out below:

- Establishing new/prospective Queensland Health employees as a priority vaccination group to ensure they can be vaccinated prior to commencement.
- Updating role descriptions, job advertisements, graduate portal requirements and position descriptions, as well as the recruitment system.

## 5.2. Application of the proposal to existing employees

Vaccination uptake among existing Queensland Health employees is high with current data indicating 78.8 per cent of Queensland Health's workforce having received at least one dose of a COVID-19 vaccine, and 70.3 per cent of Queensland Health's workforce having received the full course.

Initially, only Queensland Health employees who work in or enter the COVID-19 ward or provide occasional or intermittent care to a COVID-19 patient have been required to be vaccinated consistent with the public health direction requirements. More recently, employees in Residential Aged Care Facilities have been required to be vaccinated, consistent with the requirements of the Queensland Health Residential Aged Care Facilities (COVID-19 Vaccination) Direction.

Given the high levels of vaccination uptake among staff, as well as the growing supply levels, and the high level of risk associated with the work performed by staff, there is a strong rationale in support of requiring staff to be vaccinated by late September 2021. This would also align with the expectation that 80 per cent of Queenslanders should be vaccinated by November 2021 by ensuring that Queensland Health employees model this expectation.

### 5.2.1. Timeframes

Taking into consideration current availability of the COVID-19 vaccine, it is recommended that all employees in these three high risk cohorts must:

- Have received at least the first dose of a COVID-19 vaccine by 30 September 2021; and
- Have received the prescribed number of doses of a COVID-19 vaccine by 31 October 2021.

### 5.2.2. Management of unvaccinated employees

It is acknowledged that a Queensland Health employee may be unable to be vaccinated or elect not to, and the considerations for these employees is detailed below.

Each employee's circumstances will be considered on a case-by-case basis, however Queensland Health's obligations to the employee are dependent on their reason for not meeting vaccination requirements.

#### 5.2.2.1. Employees unable to be vaccinated

Employees may be unable to be vaccinated due to medical contraindication to the COVID-19 vaccine; or due to a genuinely held religious belief. It is anticipated this will be a small cohort of employees, and Queensland Health has particular obligations to these cohorts arising from the *Human Rights Act 2019* (Qld) and the *Anti-discrimination Act 1999* (Qld).

Where this issue arises, the employee will be required to provide evidence substantiating these circumstances and the following process will be followed:

| Step No. | Step Details | Comment |
|---|---|---|
| 1. | Employee to provide evidence substantiating their circumstances | For employees with medical contraindication:<br>• This will be in the form of a letter from their treating specialist medical practitioner outlining the condition, whether it is temporary in nature (and if so) the duration.<br>For employees with genuinely held religious beliefs:<br>• This will be in the form of a letter certifying the employee's deeply held religious belief and their affiliation/connection to the religious group from the religious official or leader. |
| 2. | Consideration of whether the employee is able to perform their role remotely or flexibly on a permanent basis | It is acknowledged this arrangement is unlikely to be supported for the majority of Queensland Health's workforce as a result of the levels of patient/client interaction inherent in the delivery of healthcare. |
| 3. | Consideration of options for the employee to be temporarily redeployed | This option will be supported wherever possible however it is heavily dependent on the nature of the work performed by the employee and their location. |
| 4. | Consideration of any other reasonable adjustments the employer may be able to make | This may include the provision of additional PPE or ensuring the employee does not work |

| | | |
|---|---|---|
| | | during periods of increased risk (i.e. during periods of community transmission).<br>It may be appropriate for the employer to provide paid discretionary special leave pursuant to Directive 05/17 |
| 5. | Where these options have been exhausted the employee will be encouraged to access their own leave accruals | It may be appropriate for the employee to access sick, Long Service or Annual Leave as appropriate. |
| 6. | Where all other options have been exhausted, consideration will be given to an exit strategy for the employee. | This is because the employee is physically incapable of meeting the inherent requirements of the role. |

#### 5.2.2.2. Employees electing not to be vaccinated for any other reason

Feedback from internal and external consultation indicates that employees may decline to meet the vaccination requirements either due to reasons of conscientious objection or as a result of 'vaccine hesitancy.'

The proposed process for managing these employees is set out below:

| Step No. | Step details | Comment |
|---|---|---|
| 1. | Conversation with the employee about their specific concerns in relation to the vaccine and to ascertain whether there is any additional information/support which could be provided. | |
| 2. | Additional education to address any concerns the employee may have and offering additional opportunities to be vaccinated as appropriate. | Hospital and Health Services have developed particular educational resources targeted to particular employee concerns (e.g. concerns of pregnant employees) and have implemented one-on-one discussions led by a respected clinician with staff to discuss their concerns in relation to the vaccine. |
| 3. | Consideration of whether the employee could perform their role remotely or through a permanent flexible work arrangement | It is acknowledged this arrangement is unlikely to be supported for the majority of Queensland Health's workforce as a result of the levels of patient/client interaction inherent in the delivery of healthcare. |

| | | |
|---|---|---|
| 4. | Consideration of whether the employee could be redeployed | This option will be supported wherever possible however it is heavily dependent on the nature of the work performed by the employee and their location. |
| 5. | Employee should be encouraged to access their own leave accruals | It may be appropriate for the employee to access sick, Long Service or Annual Leave as appropriate. |
| 6. | Employee to be placed on leave without pay | |
| 7. | Where all other options have been exhausted, consideration will be given to an exit strategy | This is because the employee remains unable to meet an inherent requirement of their role and has refused to follow a reasonable and lawful direction to be vaccinated. |

# 6. Human Rights Assessment

## 6.1. Queensland Health's obligations

Queensland Health's obligations under the *Human Rights Act 2019* (Qld) are two-fold and can be summarised as follows:

- to give consideration to human rights when making decisions; and
- to act and make decisions compatible with human rights law.[5]

## 6.2. Consideration of human rights

### 6.2.1. What human rights will be impacted?

In considering whether human rights will be impacted by a decision to mandate vaccination for Queensland Health employees, Queensland Health is required to consider which rights will be:

- protected;
- promoted; and
- limited.

### 6.2.2. Human rights promoted and protected

The proposed policy would protect and promote the right to life under s 16 of the *Human Rights Act*. The right to life may require the state to 'take appropriate measures to address the general conditions in society that may give rise to direct threats to life or prevent individuals from enjoying their right to life with dignity', including 'the prevalence of life-threatening diseases'.[6]

The virus that causes COVID-19 is highly virulent and can cause serious illness or death, particularly in vulnerable cohorts of the population with whom Queensland Health workers regularly interact. Vaccination is shown to reduce the transmission and likelihood of serious illness or death from COVID-19. Ensuring all workers are vaccinated as far as possible protects and promotes the right to life of Queensland Health workers and the community.

Vaccination also fulfills the right to the highest attainable standard of health under art 12(1) of the International Covenant on Economic, Social and Cultural Rights.[7]

### 6.2.3. Human rights limited

Queensland Health has identified the following human rights that may potentially be limited by the proposed policy:

- The right to enjoy human rights without discrimination (s 15(2) of the *Human Rights Act*) – Under s 15(2) of the *Human Rights Act*, Queensland health employees have a right to enjoy their human rights without discrimination. As will be seen

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5 *Human Rights Act 2019*, s 58.

6 UN Human Rights Committee, *General comment No. 36 – Article 6: right to life*, 124th sess, UN Doc CCPR/C/GC/36 (3 September 2019) 6 [26].

7 Although this aspect of the right to health has not been translated to s 37 of the *Human Rights Act*, the right may nonetheless be taken into account: *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [2] (concurring judgment of Judge Lemmens); *ZD v Secretary, Department of Health and Human Services* [2017] VSC 806, [108] n 35; *PBU v Mental Health Tribunal* (2018) 56 VR 141, 167-8 [93]-[95].

below, discrimination may include discrimination on the basis of conscientious belief. The policy distinguishes between people with a religious objection and people with a conscientious objection (by prioritising redeployment options for the former). This involves providing discriminatory enjoyment of the freedom of thought, conscience, religion and belief in s 20 of the *Human Rights Act*.

- The right to non-discrimination (s 15(4) of the *Human Rights Act*) – Under s 15(4) of the *Human Rights Act*, Queensland Health employees have a right to equal and effective protection against discrimination.[8] Discrimination includes direct and indirect discrimination on the basis of a protected attribute under the *Anti-Discrimination Act 1991*, such as pregnancy, impairment or religious belief. Because the definition is inclusive, discrimination under the *Human Rights Act* also likely covers additional analogous grounds,[9] which may include conscientious belief (though not vaccination status as it is not an immutable characteristic). The policy may result in people with these attributes being treated differently (for example, being redeployed or having their employment terminated). However, the policy does not directly or indirectly discriminate on any of those grounds. As to direct discrimination, the policy does not require people to vaccinate because they have one of those attributes. Broadly, indirect discrimination is an unreasonable requirement that applies to everyone but has a disproportionate impact on people with an attribute. However, the requirements under the policy (such as to be vaccinated or be redeployed) are unlikely to be unreasonable. The right to non-discrimination is therefore engaged (that is relevant), but it is unlikely to be limited.
- The right to life (s 16 of the *Human Rights Act*) – As with any medical intervention, there is a risk (however small) of unintended side effects of the vaccination, some of which may be life-threatening. Presently, in Australia, the Therapeutic Goods Administration has found that 7 deaths were linked to a COVID-19 vaccination (of the 15.3 million doses that have been administered so far).[10] 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.[11] Arguably, the right to life is engaged (that is relevant), but not limited, by the proposed policy.
- The right not to be subjected to medical treatment without full, free and informed consent (s 17(c) of the *Human Rights Act*) – Medical treatment includes administering a drug for the purpose of treatment or prevention of disease.[12] The right may be limited in circumstances where a person is left with little practical

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8 Other rights in s 15 are not relevant. For example, the right to equality before the law in s 15(3) is a right to non-arbitrary application of the law, and the right to equal protection of the law without discrimination in s 15(3) is directed to the legislature and the content of laws.

9 *Miron v Trudel* [1995] 2 SCR 418, 496-7 [148]; *Quebec (Attorney-General) v A* [2013] 1 SCR 61, 144 [144].

10 <https://www.tga.gov.au/periodic/covid-19-vaccine-weekly-safety-report-19-08-2021>.

11 *Application X v United Kingdom* (1978) 14 Eur Comm HR 31, 32-3; *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 33.

12 *De Bruyn v Victorian Institute of Forensic Mental Health* (2016) 48 VR 647, 707 [158]-[160].

choice but to receive the treatment.[13] Under the proposed policy, it is possible that the limited circumstances for redeployment or other impacts on employment may leave an employee with little practical choice but to receive a vaccine.

- Freedom of conscience and religion (s 20 of the *Human Rights Act*) – The proposed policy will treat people with a religious or conscientious objection on a case-by-case basis. However, the policy will prioritise redeployment options for people with a religious objection (or a contraindication) over those with a conscientious objection. In either case, there may still be consequences for a person with such an objection. This means that the freedom of conscience and religion will be limited. A conscientious belief for the purposes of s 20 of the *Human Rights Act* encompasses 'views based on strongly held moral ideas of right and wrong'.[14] In the context of vaccinations, case law in Europe suggests that there will need to be clear evidence of a deeply ingrained belief before freedom of conscience is engaged.[15] A person may also have a genuinely-held religious belief about vaccines. For example, the Catholic Church advises 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.[16]
- The right of access to the public service (s 23(2)(b) of the *Human Rights Act*) – Everyone has a right of equal access to the public service and public office. Queensland Health employees likely form part of the public service or hold public office for the purposes of s 23 of the *Human Rights Act*. This right may be limited where there are consequences for a person's continued employment with the public service.[17] The policy limits this right because there may be consequences for a Queensland Health employee's continued employment if they are unable or refuse to be vaccinated or redeployed. To the extent that the right to property (s 24) or the right to privacy (s 25) might protect aspects of a person's work,[18] any impacts on those rights would not add to the limit already imposed on s 23(2)(b).
- The right to privacy (s 25(a) of the *Human Rights Act*) – The right to privacy includes a right to bodily integrity.[19] This right will be limited by compulsory vaccination, whether as an involuntary treatment,[20] or where there are repercussions for failing

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13 *New Health New Zealand Inc v South Taranaki District Council* [2018] 1 NZLR 948, 978 [99], 994-5 [172], 1011 [225].

14 *Roach v Canada (Minister of State for Multiculturalism and Culture)* [1994] 2 FC 406, [25].

15 *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [323].

16 <https://www.vatican.va/roman_curia/congregations/cfaith/documents/rc_con_cfaith_doc_20201221_nota-vaccini-anticovid_en.html>; <https://adelaide.catholic.org.au/__files/f/55450/FAQs%20and%20Guidance%20on%20COVID-19%20Vaccination.pdf>.

17 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*').

18 *Legal and General Assistance Ltd v Kirk* [2002] IRLR 124, [41] (property); *ZZ v Secretary, Department of Justice* [2013] VSC 267, [82]-[95] (privacy).

19 *Pretty v United Kingdom* (2002) 35 EHRR 1, [61]; *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 126 [599]; *PBU v Mental Health Tribunal* (2018) 56 VR 141, 179 [125].

20 *Solomakhin v Ukraine* [2012] ECHR 451, [33].

to vaccinate.[21] The right to privacy in s 25(a) of the *Human Rights Act* 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 next.[22]

## 6.3. Compatibility with human rights

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

### 6.3.1. Are the limits imposed 'under law'? (s 13(1))

The Director-General has the legal ability to make a decision to make vaccination a condition of employment for Queensland Health employees pursuant to s 51A of the *Hospital and Health Boards Act 2011* (Qld).

The *Anti-Discrimination Act 1991* provides limited exceptions to the requirements not to discriminate against individuals or groups. These include an ability to do an act reasonably necessary to protect public health,[23] and an act reasonably necessary to protect the health and safety of people at a place of work.[24]

### 6.3.2. The nature of the rights that would be limited (s 13(2)(a))

What is at stake is the recognition that people are entitled to make decisions about their own life and their own bodies, which is an aspect of their individual personality, dignity and autonomy.[25] Requiring a person to receive medical treatment – such as a vaccine – which they do not wish to receive is an affront to their dignity,[26] and the principle of personal inviolability.[27]

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',[28] including beliefs about health and vaccinations. Freedom of religious and conscientious belief 'is of the essence of a free society'.[29]

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21 *Boffa v San Marino* (1998) 92 Eur Comm HR 27, 34; *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [263].
22 *Minogue v Thompson* [2021] VSC 56, [86], [140].
23 *Anti Discrimination Act 1991* (Qld) s 107.
24 Ibid s 108.
25 *Re Kracke and Mental Health Review Board* (2009) 29 VAR 1, 121-2 [569], 123 [577].
26 *Jehovah's Witnesses of Moscow v Russia* (European Court of Human Rights, First Section, Application No 302/02, 10 June 2010) [135]-[136].
27 *PBU v Mental Health Tribunal* (2018) 56 VR 141, 180-1 [128].
28 *R v Oakes* [1986] 1 SCR 103, 136 [64].
29 *Haigh v Ryan* [2018] VSC 474, [48].

Creating consequences for a person's employment also affects a person's dignity and autonomy through work. For the public service in particular, it engages the values underlying secure tenure, such as independence.[30]

Those values at stake inform what it is that needs to be justified.

#### 6.3.3. Do the limits have a proper purpose? (13(2)(b))

The purpose of mandatory vaccinations for Queensland Health employees is to ensure the readiness of the health system in responding to a pandemic, as well as to protect the right to life of both the employees and the community they serve. Evidence indicates rates of infection and transmission of COVID-19 among healthcare workers are substantially higher due to the nature of the work performed and the environmental context. The risk the virus poses to vulnerable groups such as the elderly and patients with comorbidities is also significantly higher than the general population.

The policy also aligns with a growing expectation among the community that all Queensland Health employees are vaccinated against COVID-19 to ensure that patients and the broader community are kept safe from the virus. All of these purposes are legitimate and consistent with the values of our free and democratic society.

#### 6.3.4. Do the limits help to achieve the purpose? (s 13(2)(c))

Mandatory vaccinations will help to achieve the purpose of ensuring the readiness of the health system to respond to a pandemic as well as the purpose of protecting the right to life. The available evidence to date is that vaccination against COVID-19 helps to reduce the risk of being infected (at least with symptoms) and transmitting the virus on to others (even if the vaccine is not 100 percent effective).[31] This means vaccinated Queensland Health employees will be less likely to be infected by members of community. Further, they are less likely to transmit the virus, and if they do contract it, their symptoms will be less severe requiring less time away from work.

The rational connection is not undermined by dealing with certain employees on a case-by-case basis, such as those with a contraindication or religious objection.[32] Even if the policy allows for the possibility of accommodating some employees who cannot be vaccinated, it is still the case that a greater proportion of employees will be vaccinated.

#### 6.3.5. Are the limits necessary or are there other ways to achieve the purpose? (s 13(2)(d))

Given the nature of the COVID-19, a mandatory vaccination policy likely falls within the range of reasonable alternatives.[33] In any event, the main alternative of allowing employees to take up vaccinations voluntarily has not been as effective to date in ensuring that a sufficient proportion of employees are vaccinated. Further, the policy confines the impacts on employees only to the extent required to achieve the purpose. It

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30 Human Rights Committee, *General Comment No 25*, 57th sess, UN Doc CCPR/C/21/Rev.1/Add.7 (27 August 1996) 7 [23].

31 Australian Technical Advisory Group on Immunisation (ATAGI), *Clinical guidance on use of COVID-19 vaccine in Australia in 2021 (v6.0)* (30 July 2021) 22-4.

32 *Taylor v Newfoundland and Labrador*, 2020 NLSC 125, [440]-[451]; *McCloy v New South Wales* (2015) 257 CLR 178, 251 [197].

33 *Sabet v Medical Practitioners Board (Vic)* (2008) 20 VR 414, 442 [188]; *Vavřička v The Czech Republic* (European Court of Human Rights, Grand Chamber, Applications nos. 47621/13 and 5 others, 8 April 2021) [273]-[280], [310].

does this by providing individual arrangements determined on a case-by-case basis for Queensland Health employees who have a contraindication or religious objection.

Consideration was given to also treating people with a conscientious objection or vaccine hesitancy on the same basis as those with a contraindication or religious objection. However, this would significantly undermine the policy's objective. The policy would not be mandatory if exemptions were allowed for people who do not wish to be vaccinated or who believe they should not be.

To support the transparency of arrangements for Queensland Health employees who will be impacted, the proposed policy position will be subject to consultation with Queensland Health's industrial partners who represent employees, as well as internal stakeholders. To further support those employees who may be impacted by the proposal, a framework process to support the management of unvaccinated employees will be developed and agreed with the unions.

As there is no less restrictive way to prepare the health system and to protect life, the limits on human rights are necessary to achieve those purposes.

#### 6.3.6. Do the limits strike a fair balance? (s 13(2)(e), (f) and (g))

Finally, do the limits strike a fair balance between the rights of the individual and the interests of the community?

The benefits of achieving the policy's purposes include:

- a reduced risk of frontline employees suffering from COVID-19 and its effects, or acting as a vector for the spread of COVID-19;
- ensuring the readiness of the health system to respond to a pandemic, promoting overall health outcomes for the community;
- an increase in the enjoyment of the right to life (s 16 of the *Human Rights Act*);
- an increase in the enjoyment of the right to the highest attainable standard of health (under article 12(1) of the International Covenant on Economic, Social and Cultural Rights);
- significant savings in health care costs and indirect costs, such as loss of productivity and economic loss suffered as a result of employees contracting the virus and developing COVID-19.
- possibly, broader benefits for the wider community, such as protecting people who cannot receive a vaccine for medical reasons through herd immunity, and enhancement of equality (which is protected in s 15 of the *Human Rights Act*), given that the burden of infectious diseases falls disproportionately on the disadvantaged.

On the other side of the scales, these benefits come at the cost of:

- exposing individuals to the risks that are inherent with any vaccine, including suffering rare (though potentially serious) side effects;
- interfering with people's bodily integrity, and their autonomy to make decisions about their bodies and their own health; and,
- potentially forcing employees to go against their deeply-held conscientious or religious beliefs.

However, the extent of the harm to human rights is greatly reduced by the tailored approach to respond to employees with a contraindication or religious (and, so far as possible, employees with a conscientious objection or vaccine hesitancy). The health risk to the individual presented by vaccines is overwhelmingly outweighed by the health risk of COVID-19 to all of us. 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.'[34]

Overall, the harm caused to human rights would be outweighed by the benefits of ensuring the readiness of the health system to respond to a pandemic, as well as the protection and promotion of the right to life.

### 6.4. Outcome

The proposed mandatory vaccination policy would be compatible with human rights, including as it applies to each of the following categories of people:

- employees who refuse vaccination on grounds of a religious objection;
- employees who refuse vaccination on grounds of a conscientious objection;
- employees who want to 'wait' or are 'hesitant' to get the vaccine;
- employees who have a permanent medical contraindication to the COVID-19 vaccine (i.e. history of anaphylaxis);
- employees who have a temporary medical contraindication to the COVID-19 vaccine (i.e. employees who may be on immunosuppressive therapy); and,
- employees who refuse vaccination due to pregnancy (note: not a recognised medical contraindication, and in fact pregnant women are strongly recommended to receive the vaccine).

While alternative options (such as redeployment) will be prioritised for people with a contraindication or a religious objection, each of the above cohorts will be dealt with on a case-by-case basis, allowing for some flexibility in the individual circumstances of the employee.

Importantly, a public entity dealing with a person on a case-by-case basis will also need to separately consider human rights and act compatibly with human rights under s 58 of the *Human Rights Act 2019*. The public entity's consideration of an employee's human rights in a particular case will not need to be as detailed because comprehensive consideration has already been given to human rights in this compatibility assessment.[35]

[34] *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).

[35] *Minogue v Thompson* [2021] VSC 56, [61], [75], [78] (Richards J).

# 7. Appendices

## Appendix 1: Background on COVID-19

COVID-19 is an infectious respiratory disease caused by a newly discovered (novel) coronavirus (SARS-COV-2).[36]

The virus is transmitted through respiratory droplets, smaller particles (aerosols), direct physical contact with an infected individual, and indirectly through contaminated objects and surfaces. Those who have been in close contact with a person with the illness are at highest risk.[37]

The virus affects different people in different ways, and some people may be asymptomatic. In the majority of cases, an infected person will experience mild to moderate respiratory illness and recover without requiring hospitalisation.[38] When severe illness is present however, medical intervention including ventilation may be required and the illness may result in death particularly for the elderly and those with comorbidities.[39]

To date there have been over 200,000,000 cases of COVID-19 worldwide, and over 4,000,000 deaths globally.

Like all viruses, COVID-19 is changing over time. Some of these changes have affected the transmissibility and severity of the disease, as well as the performance of vaccines, therapeutic medicines, diagnostic tools and public health measures.[40]

The emergence and prevalence of new variants of COVID-19 such as the Delta variant is of particular concern. The Delta variant was first identified in India in December and reported in Australia in March 2021. It is currently the predominant strain worldwide and has been shown to be more contagious than previous variants and patients infected with the Delta variant are more likely to require hospital care than previous variants.

In Queensland, a range of controls have been utilised to minimise the impact of COVID-19 including:

- Telehealth;
- Border restrictions;
- The use of negative pressure rooms and physical barriers;
- Quarantine and physical distancing;
- The use of Personal Protective Equipment; and
- Staff vaccination program.

The use of border restrictions and quarantine requirements on non-infected employees (as a precautionary/preventative measure) have been demonstrated to impact healthcare service delivery, leading to severe service disruptions and the non-delivery of routine care.

[36] World Health Organisation (2019).
[37] Communicable Diseases Network Australia (2019) *Coronavirus disease 2019 (COVID-19); CDNA National Guidelines for Public Health Units,* 8.
[38] Ibid, 10.
[39] Above n 2, 12.
[40] Above n 1.

## Appendix 2: COVID-19 Vaccination

Australia's COVID-19 vaccination program commenced on 22 February 2021.[41] At present, the Therapeutic Goods Administration (TGA) has approved the following vaccines for use:

- AstraZeneca ChAdOx1-2 vaccine (known as the 'Oxford' Astra-Zeneca); and
- Pfizer Australia – COMIRNATY BNT162b2 (mRNA) vaccine.[42]

The TGA has also provisionally approved Moderna's mRNA vaccine on 9 August 2021.

No vaccine is 100% effective, however the use of these vaccines has been proven to reduce the risk of serious illness and death, as well as likely decrease the infectious period and is our strongest defence against the virus.[43]

Data around the vaccine's ability to manage the Delta variant is evolving, however it indicates that vaccinated people are less likely to become severely unwell and are infectious for a shorter period. Unvaccinated people are at the greatest risk from COVID-19, and the Delta variant in particular, due to their increased likelihood of contracting the virus, and the significant associated likelihood of transmission.

Queensland Health employees are considered a priority group for vaccination against COVID-19 and have been strongly encouraged to receive the vaccine. Recently, the Director-General outlined a target for 95% of Queensland Health employees to receive the vaccine.

Consistent with this target, there are currently a number of public health directions which apply to Queensland Health employees who require vaccination against COVID-19 in order to work in particular areas which have been identified as high risk. These directions have been made pursuant to the emergency powers of the Chief Health Officer under the *Public Health Act 2005,* and as such, will no longer have legal effect once the public health emergency declaration ceases.

Taking into consideration that some employees may be unable to receive the vaccine on medical grounds, the public health directions require employees in this circumstance who have provided evidence of a medical contraindication to be redeployed in the first instance and managed by an appropriate risk management framework.

An indeterminate number of employees decline to receive the vaccine for alternative reasons (e.g. conscientious objection) and these employees are encouraged to engage with clinical educators around the vaccine but maybe deployed if possible until such time as they can be vaccinated.

[41] Above n 2, 11.
[42] Ibid.
[43] *Doherty Institute Modelling Report for National Cabinet* (revised 10 August 2021) https://www.health.gov.au/resources/publications/doherty-institute-modelling-report-to-advise-on-the-national-plan-to-transition-australias-national-covid-response

## Appendix 3: Queensland Health's industrial framework

Queensland Health is governed by a series of legislative and industrial instruments, none of which currently provide for mandatory vaccination against COVID-19.

Nevertheless, Queensland Health employees have particular obligations under legislation to minimise risks to the health and safety of themselves, other employees and patients, as well as to follow the reasonable and lawful directions of their employer. In considering these legislative obligations in the context of recent decisions by the Fair Work Commission, which supported mandatory vaccination where the employer was able to demonstrate an increased level of risk, there would appear to be sufficient basis to support mandatory vaccination of staff.

*Obligation of employees to comply with reasonable and lawful direction*

Queensland Health employees have a duty to comply with reasonable and lawful directions issued by their employer, and any failure to do so may be considered misconduct where they do not have a reasonable excuse.[44]

Firstly, in order for a direction to be *'lawful'* it does not depend upon the existence of a discernible, positive rule of law supporting the direction. A direction will be lawful to the extent that it falls within the scope of the contract of service and involves no illegality.[45]

Secondly, for a direction to be '*reasonable*' the employer does not need to demonstrate that the relevant direction was the preferable or most appropriate course of action or in the best interests of the parties.[46] Instead, what is reasonable will be a question of fact, and there may be a number of matters to take into consideration including the nature of the employment, the accepted custom and practice of the industry, as well as terms of legislation and any applicable instruments.[47]

*Obligations under the Work Health and Safety Act 2011*

Pursuant to the *Work Health and Safety Act 2011*, the Department of Health, as a person conducting a business or undertaking, has a number of obligations including:

- A duty to ensure so far as reasonably practicable the health and safety of workers engaged, or caused to be engaged by the person, while at work; and
- A duty to ensure so far as reasonably practicable, that the health and safety of other persons is not put at risk from work carried out as part of the business or undertaking.

'*Reasonably practicable*' in relation to a duty to ensure health and safety is defined as 'that which is, or was at a particular time, reasonably able to be done in relation to ensuring health and safety, taking into account and weighing up all relevant matters.'[48]

In addition to the duties of care incumbent on Department of Health, Queensland Health employees have the following obligations at work:

- An employee must take reasonable care for his or her own safety; and

[44] *Public Service Act 2008* (Qld) s 187(1)(d).
[45] Grant v BHP Coal Pty Ltd (No 2) [2015] FCA 1374.
[46] *Briggs v AWH* [2013] FWCFB 3316.
[47] *CFMEU v Glencore Mt Owen Pty Ltd* [2015] FWC 7752.
[48] Ibid s 19.

- An employee must take reasonable care to ensure that their acts or omissions do not affect the health and safety of others; and
- An employee must comply, so far as they are reasonably able, with any reasonable instruction that is given by the Director-General to allow the Director-General to comply with this Act; and
- An employee must co-operate with any reasonable policy or procedure of the Director-General relating to health or safety at the workplace that has been notified to workers.[49]

*Obligations of employees under the Public Health Act 2005*

Obligations also apply to Queensland Health employees under the *Public Health Act 2005* which provides that:

- *A person involved in the provision of a declared health service must take reasonable precautions and care to minimise the risk of infection to other persons.*[50]



[49] Ibid s 28.
[50] *Public Health Act 2005* (Qld) s 151.

## Appendix 4: Key cases concerning mandatory vaccination

Recent consideration of mandatory vaccination by the Fair Work Commission indicates that such arrangements will be considered on a case-by-case basis. Notably however there is an increasing body of case law that would support mandatory vaccination in sectors where there is an increased level of risk as this would support the employer making a reasonable and lawful direction for employees to be vaccinated.

*Test case: Barber v Goodstart Early Learning*

In this case it was considered appropriate that the employer implemented a mandatory flu vaccination program on the basis that its business was a high-risk workplace.[51] This high risk status was determined based on close contact between its employees and children, many of whom may have had poor hygiene standards, and may be unvaccinated against infectious diseases. The Commission applauded Goodstart's approach to implementing the mandatory vaccination program which involved early and open engagement with staff prior to the implementation, multiple opportunities for the employee to provide medical evidence, the ability for her to access leave.

*Test case: Glover v Ozcare*

Of particular relevance is the recent decision of the Fair Work Commission in *Glover v Ozcare.* This case concerned a support care worker who had been dismissed for failing to comply with Ozcare's new policy requiring all staff in client facing roles to be vaccinated against influenza. The Commission ultimately determined that this requirement to be vaccinated was lawful and reasonable in the circumstances.

In an early decision on jurisdictional grounds in the matter, the Commission had provided the following as guidance:

- *It is not inconceivable that come November 2021, employers of men engaged to play the role of Santa Clause in shopping centres, having photos taken around young children, may be required by their employer to be vaccinated at least against influenza, and if a vaccination for COVID-19 is available, that too.*
- *The employer in those scenarios, where they are not mandated to provide physical distancing, may decide at their election that vaccinations of their employees are now an inherent requirement of the job. It may be that a court or tribunal is tasked with determining whether the employer's direction is lawful and reasonable, however in the court of public opinion, it may not be an unreasonable requirement. It may, in fact, be an expectation of a large proportion of the community.*[52]

In the determinative matter itself, the Commission accepted Ozcare's evidence of the lawful and reasonableness of the direction that all staff be vaccinated based on the level of risk associated with the work performed by the employees, as well as their particular obligations under the *Workplace Health and Safety Act 2011* to ensure the safety of staff, clients and the broader community.

The Commission noted that it would be reasonably foreseeable that were a client die from transmission of the flu by a staff member, Ozcare would be required to meet their

[51] *Barber v Goodstart Early Learning* [2021] FWC 2156.
[52] *Glover v Ozcare* [2021] FWC 231.

particular legal obligations and demonstrate that appropriate preventative measures had been taken, and mandatory vaccination would be evidence of that.

Ultimately, the Commission considered Ms Glover's rights to decline vaccination because of her belief that she may suffer an anaphylactic reaction to be overborne by the rights of her employer, and their obligations to their clients.

## Appendix 5: In depth profile of Group 2

| Group | Sub-group | Assessment against criteria |
|---|---|---|
| **Group 2:**<br>All Queensland Health employees who are employed to work in a public Hospital or other Queensland Health facility where clinical care or support is provided to patients or clients.<br>This includes all staff working in 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. | **Sub-group A:**<br>Employees coming into direct contact with diagnosed COVID-19 patients, or quarantined international arrivals.<br>Employees entering areas with diagnosed COVID-19 patients, or quarantined international arrivals.<br>Employees providing care or transporting diagnosed COVID-19 patients, or quarantined international arrivals. | ✓ **Criteria 1:** Employees in this group work in an area with COVID-19 patients or an area that a COVID-19 patient may enter.<br>✓ **Criteria 2:** Employees in this group come into direct or indirect contact with people who work in an area with COVID-19 patients or an area that a COVID-19 patient may enter.<br>✓ **Criteria 3:** Employees in this group may be unable to meet public health requirements<br>✓ **Criteria 4:** Employees in this group have the potential to expose patients, clients, other staff or the broader community to the virus.<br>**Explanation**<br>• These employees are already required to have the vaccine consistent with the public health direction.<br>• They are required to come into close contact with diagnosed COVID-19 patients by virtue of the work they perform.<br>• They are our first line of defence against the transmission of COVID to patients, other staff in the hospital and the community more broadly. |
| | **Sub-group B:**<br>All staff that work in a hospital with a COVID-19 ward.<br>This would include clinical staff not involved in the provision of care to patients with COVID-19 as well as non-clinical support staff including kitchen staff, security officers, administration | ✓ **Criteria 2:** Employees in this group come into direct or indirect contact with people who work in an area with COVID-19 patients or an area that a COVID-19 patient may enter.<br>✓ **Criteria 3:** Employees in this group may be unable to meet public health requirements (e.g. physical distancing, working in areas of high population density)<br>✓ **Criteria 4:** Employees in this group have the potential to expose patients, clients, other staff or the broader community to the virus. |

| | | |
|---|---|---|
| | officers, building and maintenance officers, IT staff. | **Explanation**<br>• There are significant risks to this cohort by virtue of the fact that they work at the same site as COVID patients and employees who work with COVID patients. Transmission events are not limited to COVID wards and may occur anywhere on hospital grounds.<br>• By requiring this cohort of employees to be vaccinated Queensland Health would remove the risk of a staff member inadvertently being exposed to COVID-19 and prevent further chains of transmission. |
| | **Sub-group C:**<br>All remaining Queensland Health employees in group 2 – This includes all other Queensland Health employees employed in a public Hospital (Hospitals without a COVID-19 ward) or other Queensland Health facility where clinical care or support is provided to patients or clients. This includes clinical and non-clinical roles.<br>This also includes public health officers/teams, emergency operations centre staff including employees working in Hospital Emergency Operation Centres and the Statewide Health Emergency Command Centre. | ✓ **Criteria 2:** Employees in this group come into direct or indirect contact with people who work in an area with COVID-19 patients or an area that a COVID-19 patient may enter.<br>✓ **Criteria 3:** Employees in this group may be unable to meet public health requirements (e.g. physical distancing, working in areas of high population density)<br>✓ **Criteria 4:** Employees in this group have the potential to expose patients, clients, other staff or the broader community to the virus.<br>**Explanation**<br>• There are significant risks to this cohort by virtue of the fact that they work at the same site as COVID patients and employees who work with COVID patients. Transmission events are not limited to COVID wards and may occur anywhere on hospital grounds.<br>• By requiring this cohort of employees to be vaccinated Queensland Health would remove the risk of a staff member inadvertently being exposed to COVID-19 and prevent further chains of transmission. |

# Health Employment Directive No. 12/21

*Effective date:*
*11 September 2021*

*Supersedes:*
*n/a*

## Employee COVID-19 vaccination requirements

### 1. Compliance

Compliance with this Health Employment Directive (HED) is mandatory.

### 2. Purpose

To outline COVID-19 vaccination requirements for existing employees and prospective employees employed to work in the identified high risks groups designated in this directive.

### 3. Legislative Provisions

Section 51A of the *Hospital and Health Boards Act 2011*.

### 4. Application

This HED applies to all health service employees employed, and prospective employees to be employed, under the *Hospital and Health Boards Act 2011* in Hospital and Health Services and Queensland Health (the department).

### 5. Related documents

- Recruitment and Selection HR Policy B1 (QH-POL-212)
- *Anti-Discrimination Act 1991*
- *Disability Discrimination Act 1992*
- *Human Rights Act 2019*
- *Industrial Relations Act 2016*
- *Information Privacy Act 2009*
- *Public Health Act 2005*
- *Public Records Act 2002*
- *Work Health and Safety Act 2011*

**Directive:**

### 6. Risk management

The COVID-19 virus has been shown to disproportionately affect healthcare workers and health support staff and poses a significant risk to Queensland Health patients, and the broader community.

In recognition of the risks posed by the virus, as well as workplace health and safety obligations incumbent upon both the organisation and employees, this HED requires health service employees who are identified as being in high risk groups to be vaccinated against COVID-19.

Prospective and existing health service employees subject to these requirements have been identified based on the following risk profile:

- They are working in an area with suspected or confirmed COVID-19 patients or an area that a COVID-19 patient may enter.
- They are coming into direct or indirect contact with people who work in an area with COVID-19 patients or an area that a suspected or actual COVID-19 patient may enter.
- They are unable to observe public health requirements (e.g. physical distancing, working in areas of high population density, rapid donning/doffing of personal protective equipment (PPE) in emergent situations).
- They have the potential to expose patients, clients, other staff or the broader community to the virus (e.g. occupying shared spaces such as lifts, cafeterias, car parks, with people working with suspected or actual COVID-19 patients).

## 7. Requirement for vaccination

7.1 In acknowledgment of the risks posed by the COVID-19 virus to the health and safety of Queensland Health employees, patients and the broader community, clauses 8 and 9 of this HED require all existing and prospective employees who are or are to be employed to work in the cohorts as categorised in accordance with Table 1 (below), to be vaccinated as a condition of employment, subject to certain limited exemptions described in clause 10 of this HED.

| **COVID-19 vaccination requirements for health service employees** | |
|---|---|
| **Group No.** | **Employee cohort** |
| **Group 1** | All health service employees in residential aged care facilities and residential aged care within a multipurpose health service. |
| **Group 2** | All health service employees who are employed to work in a hospital or other facility where clinical care or support is provided.<br>This may include:<br>• both clinical and non-clinical employees.<br>• 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.<br>• public health officers/teams, emergency operations centre staff including employees working in Hospital Emergency Operation Centres and Retrieval Services Queensland. |
| **Group 3** | 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.<br>This may include:<br>• 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. |

*Table 1: COVID-19 Vaccination requirements for health service employees*

## 8. Existing employees

8.1 Existing employees currently undertaking work or moving into a role undertaking work listed in a cohort of Table 1, must:

a. have received at least the first dose of a COVID-19 vaccine by 30 September 2021; and
b. have received the second dose of a COVID-19 vaccine by 31 October 2021.

- An existing employee must provide to their line manager or upload into the designated system:

a. evidence of vaccination confirming that the employee has received at least the first dose of a COVID-19 vaccine by no later than 7 days after receiving the vaccine.
b. evidence of vaccination confirming that the employee has received the second dose of a COVID-19 vaccine by no later than 7 days after receiving the vaccine.

- An existing employee must maintain vaccine protection. Therefore, an existing employee is required to receive the prescribed subsequent dose/s of a COVID-19 vaccination (i.e. booster), as may be approved by the Australian Technical Advisory Group on Immunisation (ATAGI), within any recommended timeframe following the second dose. Evidence of vaccination, confirming the employee has received prescribed subsequent dose/s of the vaccine, is to be provided to their line manager or other designated person within 7 days of receiving the vaccine.

- An existing employee who is required to have received a first or second dose of a COVID-19 dose at an earlier date under a Chief Health Officer public health direction must be vaccinated by the dates specified in the public health direction.

- The requirements of this clause 8 do not apply to existing employees who have been granted an exemption under clause 10 of this HED.

## 9. Prospective/new employees

When offering a position to a prospective employee, the relevant advertising and engagement documentation must clearly state that engagement is subject to the person fully satisfying the COVID-19 vaccination requirements. Evidence of satisfying the vaccination requirements must be provided as part of the recruitment process.

## 10. Exemptions

10.1 Where an existing employee is unable to be vaccinated they are required to complete an exemption application form.

10.2 Exemptions will be considered in the following circumstances:

- Where an existing employee has a recognised medical contraindication;
- Where an existing employee has a genuinely held religious belief;
- Where another exceptional circumstance exists.

10.3 If an existing employee is granted an exemption, they do not have to comply with clause 8 or 9 of this HED for the duration of that exemption.

## 11. Transitional arrangements

11.1 From 1 October 2021 until 31 October 2021, transitional arrangements will apply consistent with the Staff Mandatory COVID-19 Vaccination Requirements Implementation Phase Guide.

## 12. Reporting and record keeping

12.1 In accordance with clauses 8.2 and 8.3 of this HED, evidence of COVID-19 vaccination must be provided to the employee's line manager or the person nominated in locally developed processes.

12.2 A record will be kept of all COVID-19 vaccinations reported by an existing or prospective employee (for employees and prospective employees covered by this HED).

12.3 The record must be stored in a secure database that is accessible to authorised persons only and maintained in accordance with the *Information Privacy Act 2009* and the *Public Records Act 2002*.

12.4 Documentary evidence of exemptions, and supporting information must be kept for all existing or prospective employees.

12.5 De-identified information about employee vaccination rates will be reported in accordance with relevant state or federal government requirements.

## 13 Definitions

| | |
|---|---|
| **COVID-19 vaccine** | Means a vaccine approved by the Therapeutic Goods Administration for use in Australia or endorsed by WHO-COVAX where the employee was vaccinated overseas. |
| **Evidence of vaccination** | A copy of the employee's immunisation history statement from the *Australian Immunisation Register.*<br><br>Where a person has been vaccinated overseas, a record of this must be provided. |
| **Hospital and Health Service (HHS)** | A statutory body established under the *Hospital and Health Boards Act 2011* responsible for the provision of public sector health services for a geographical area, which includes one or more health facilities. |
| **Queensland Health (the Department)** | Queensland Health (the Department) includes:<br>• Aboriginal and Torres Strait Islander Health Division<br>• Clinical Excellence Queensland |

| | |
|---|---|
| | • Corporate Services Division<br>• COVID-19 Supply Chain Surety Division<br>• Healthcare Purchasing and System Performance Division<br>• Chief Health Officer and Prevention Division<br>• Office of the Director-General<br>• eHealth Queensland. |
| **Residential aged care facility** | Means a facility, including a *Queensland Health residential aged care facility*, at which accommodation, and personal care or nursing care or both, are provided to a person in respect of whom a residential care subsidy or a flexible care subsidy is payable under the *Aged Care Act 1997* of the Commonwealth, or funding is provided under the *National Aboriginal and Torres Strait Islander Flexible Aged Care Program*. |

## 14 History

| | |
|---|---|
| **HED No. 12/21 September 2021** | Re-issued to:<br>• update the COVID-19 vaccination requirements for health service employees table to remove the State Health Emergency Coordination Centre from Group 2 and provide clarity for Group 3;<br>• included circumstances for exemptions;<br>• include transitional arrangements. |
| **HED No. 12/21 September 2021** | Issued under section 51A of the *Hospital and Health Boards Act 2011* as a condition of employment for health service employees. |

## 15 Approval and implementation

**Directive custodian**

Chief Human Resources Officer

**Approval by Chief Executive**

Dr John Wakefield
Director-General

**Approval date: 30/09/2021**

**From:** CHO COVID
**To:** s.73 - Irrelevant information @premiers.qld.gov.au"
**Cc:** CHO COVID
**Subject:** C-ECTF-22/6999 - Chief Health Officer Letter to the Queensland Government Leadership Board
**Date:** Wednesday, 13 April 2022 2:50:00 PM
**Attachments:** CD NIL - CHO LTR - Queensland Government Leadership Board.pdf
image001.png
image002.png
image003.png
image004.png
image005.png
image006.png

Good Afternoon,

Please see attached Chief Health Officer Letter to the Queensland Government Leadership Board.

Kind regards

Queensland Government

**Kristy Johnson**
**Acting Manager**
Office of the Chief Health Officer and Deputy Director-General | Queensland Health

P Call via teams
E s.73 - Irrelevant information @health.qld.gov.au
W health.qld.gov.au
A Level 7, 33 Charlotte Street, Brisbane


Queensland Health acknowledges the Traditional Owners of the land, and pays respect to Elders past, present and future.

Queensland Government

Enquiries to: Office of the Chief Health Officer
and Deputy Director-General
Telephone: s.73 - Irrelevant information
File Ref: C-ECTF-22/6999

Queensland Health

Secretariat
Queensland Government Leadership Board

Email: s.73 - Irrelevant information @premiers.qld.gov.au

Dear Leadership Board

I would firstly like to take this opportunity to thank you all for your efforts in protecting public service employees from the effects of COVID-19 throughout this pandemic, including recently through the promotion of the COVID-19 vaccines. We know that this has prevented serious illness, death and long-term complications of the infection among them.

As you are aware, from 1.00 am 14 April 2022, the *Public Health and Social Measures Linked to Vaccination Status Direction (No. 4)* will be revoked, thereby removing vaccination mandates on a range of discretionary settings, including hospitality settings, stadiums and showgrounds. I write to explain my decision to ease these requirements, and to emphasise that vaccination continues to be the single most important public health measure we have to protect our community from the impacts of COVID-19.

As Chief Health Officer I have a responsibility to protect Queenslanders against this infection. To achieve this, ideally every single Queenslander would get vaccinated, including receiving a booster dose once eligible. Unfortunately, however, there remains a very small proportion of Queenslanders who refuse to be vaccinated, placing their own health and safety at great risk.

The COVID-19 vaccines have been a gamechanger in the way we are able to respond to this pandemic. It is very well documented that, in the first few months after vaccination, people are very strongly protected against both mild and serious infection. While the protection afforded by the initial course of vaccination does wane over time, being boosted dramatically increases a person's protection against symptomatic infection. However, by approximately 6-months post vaccination, protection against mild infection decreases significantly, resulting in even those persons who have been fully vaccinated acquiring and spreading the virus.

At this stage of the pandemic, with vaccination rates over 90 per cent of the population, many of whom will have received their final dose a number of months ago, we are seeing infection rates driven by vaccinated individuals experiencing mild symptoms. As such, it is my position that the public health benefit of excluding a very small percentage of unimmunised people from hospitality and low-risk venues has become marginal and not justified given the burden it is placing on these businesses to effectively 'police' the general public.

At present, Chief Health Officer Directions mandating vaccination still exist for employees and visitors of certain, high risk or vulnerable settings, including health care, residential aged care. disability, education and custodial settings.

It is my position that these mandates continue to be justified as many employees will still be receiving significant protection from any infection through vaccination and boosters as we go through our second Omicron wave. However, as we reach the second half of the year and more people reach six months since their final dose or booster, mandates requiring vaccination will become increasingly difficult to justify given waning efficacy.

As you are aware, transmission of COVID-19 can occur anywhere where people gather, including the work environment. The risk of transmission is proportional to the number of people the employee has direct contact with.

I am not in a position to comment on whether you have a right or obligation to mandate vaccination among your employees. To inform yourself of your options I would encourage you review the resources provided by the Fair Work Ombudsman, last updated on 15 February 2022, entitled 'COVID-19 vaccinations: workplace rights and obligations".

COVID-19 vaccinations: workplace rights & obligations - Fair Work Ombudsman

Again, I must strongly emphasise that vaccination, including boosters, continues to protect your staff against serious infection resulting in hospital admission, intensive care admission, death and long-term complications.

Thank you again for your leadership in this very important matter.

Yours sincerely

s.73 - Irrelevant information

Dr John Gerrard
**Queensland Chief Health Officer**
**Deputy Director-General**
13 April 2022