Queensland Government

Queensland Health

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Ms Corrine McMillian MP
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Community Support and Services Committee
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Dear Ms McMillan

Thank you for the opportunity to respond to public submissions to the Community Support and Services Committee's inquiry into the Public Health and Other Legislation (Extension of Expiring Provisions) Amendment Bill 2022.

Please find attached Queensland Health's response to the public submissions. Given the large number of submissions received, Queensland Health has responded to the key themes and issues raised rather than responding to each individual submission.

Should you require further information, Queensland Health's contact is Ms Kirsten Law, Director, Legislative Policy Unit, on telephone [redacted] or via email at [redacted]

Yours sincerely

Shaun Drummond
Acting Director-General

Encl.

Community Support and Services Committee inquiry into the Public Health and Other Legislation (Extension of Expiring Provisions) Amendment Bill 2022

Departmental response to issues raised in written submissions

The Community Support and Services Committee has published 1,000 public submissions as part of its Inquiry into the Public Health and Other Legislation (Further Extension of Expiring Provisions) Amendment Bill 2022 (Bill). The Departmental response addresses the issues raised in the submissions numbered 1 to 1000, as published by the Committee as at 5 pm on 10 March 2022.

Due to the large number of submissions received, Queensland Health has responded to the key themes and issues raised rather than responding to each individual submission.

	Issue	Response
1.	**Support for extension of expiring provisions** The Queensland Law Society (QLS), the Royal Australian and New Zealand College of Psychiatrists and the Australian College of Nursing supported provisions in the Bill to extend COVID-19 legislative provisions that are directly related to the public health response. Submissions in support of the Bill recognised the need to extend the emergency measures related to the public health response considering the continuing risks posed by the evolving COVID-19 pandemic. QLS, while supporting the Queensland Government's public health response, suggested changes or improvements that could be made to the legislative framework.	The support for extending the COVID-19 legislative provisions that are directly related to the public health response until 31 October 2022 is noted. Issues raised by QLS are addressed in the responses below.
2.	**Opposition to or concerns with extension of expiring provisions** Almost all of the published submissions opposed the extension of the temporary COVID-19 legislative framework in the Bill. A number of submissions opposed the extension on the basis that the powers and discretion delegated to the Chief Health Officer and emergency officers under the *Public Health Act 2005* are too broad or are not subject to appropriate constraints, including adequate parliamentary and public scrutiny. The Queensland Human Rights Commission (QHRC) submitted that the current COVID-19 legislative framework should not be extended and should be replaced with more transparent, accountable, and human rights compatible pandemic legislation. In particular, QHRC considers additional human rights protections, oversight, review and transparency is needed in decision-making under any pandemic legislation. QLS and QHRC submitted that the framework should be amended to require parliamentary scrutiny of the use of COVID-19 legislation and the need for a review or appeal mechanism for decisions made by emergency officers using the powers in the legislation. Other objections to extending the current legislative framework included: • the extension of these measures is contrary to the Government's messaging about the reduced need for restrictions once the eligible Queensland population reached 90% vaccination; • the extension of the measures is unjustified because COVID-19 no longer poses a serious risk to the community or the health system; • the restrictions enabled by the Bill are not proportionate to the current COVID-19 risk; and • the Bill is contrary to international law, the Australian Constitution or Commonwealth Acts. Queensland Council of Civil Liberties (QCCL) and the Business Union did not support the extension, citing insufficient justification for the extension of the COVID-19 public health emergency. QCCL submitted that the combination of high vaccination rates, the passing of the Omicron peak in early February 2022 and assurances from the Chief Health Officer the health system was not overwhelmed by the influx of cases, means that the COVID-19 public health measures should cease on 30 April 2022.	Queensland Health acknowledges stakeholders have strong views about the Government's legislative response to COVID-19, including whether it is appropriate to delegate certain powers and the extent to which Parliament should directly manage or oversee the public health response. While these are ultimately matters for Parliament, Queensland Health notes the Government's successful management of the COVID-19 pandemic under the temporary legislative framework has enabled high vaccination rates across the Queensland population, which has successfully mitigated the impact of COVID-19 on our health system and the community, particularly in relation to the first Omicron peak. The Bill extends those parts of the temporary legislative framework that support the Government's public health response to COVID-19. While a public health emergency declaration is in place, the framework enables, for example: • a regulation to extend the declaration of public health emergency for 90 days at a time, instead of every seven days; • an emergency officer to quarantine a person with, or suspected of having, COVID-19 for up to 14 days; and • the Chief Health Officer to issue public health directions that implement National Cabinet decisions or recommendations of the Australian Health Protection Principal Committee such as requiring residential aged care workers to be vaccinated against COVID-19 including with a booster dose. The framework extended by the Bill enables a proportionate response tailored to the Queensland context, as the public health measures can be agilely reduced, removed or introduced according to the level of epidemiological risk across Queensland or in specific locations. The framework does not require powers to be exercised if the risk level is low. The global pandemic continues to present a serious risk to human health. Australia will be one of the first developed countries to experience winter after the global Omicron wave. Even though the peak of the first Omicron wave has passed, Queensland still has around 27,000 active cases reported as at 11 March 2022 and likely many more that are unreported.

	Issue	Response
		Retaining the temporary legislative framework ensures existing restrictions can be eased in a gradual, considered way, based on the public health risk in Queensland. For example, the requirement to wear masks indoors was lifted on 4 March 2022. Queensland Health is monitoring the impact of this change carefully before considering whether other changes to restrictions are appropriate. Retaining the framework beyond 30 April 2022 is also necessary to ensure the Queensland Government can respond quickly to the emergence of any new variants. The measures will enable Queensland Health to manage health system capacity during future waves, particularly during winter. This is particularly critical as it is likely future waves will overlap with flu season in the winter months. The Queensland community is expected to have less immunity in the upcoming flu season, due to reduced exposure to flu in 2020 and 2021 as a result of border closures and quarantine requirements. If the temporary legislative framework ceased on 30 April 2022: • people with COVID-19, or suspected of having COVID-19, could only be required to quarantine for a maximum of 4 days by a direction given by a doctor, which is inconsistent with the current recommendation of the Australian Health Protection Principal Committee that COVID-19 cases and close contacts quarantine for a minimum of 7 days; • the Chief Health Officer would not be able to issue public health directions that support the national response to COVID-19, such as requiring residential aged care workers to be vaccinated against COVID-19; and • the Chief Health Officer would not be able to issue public health directions that respond to the unique epidemiological conditions in Queensland, such as requiring face masks during times of increased community transmission; • a public health emergency declaration would need to be extended by regulation every 7 days. Importantly, even though the Bill proposes to extend the framework until 31 October 2022, all measures would cease earlier if the public health emergency is ended. Under the *Public Health Act 2005*, the Minister for Health and Ambulance Services must declare the end of the public health emergency if the declaration is no longer necessary to prevent or minimise serious adverse effects on human health.
	Scrutiny, transparency and safeguards A number of submissions called for parliamentary scrutiny or other oversight of all COVID-19 legislation. Many called for greater transparency and oversight in relation to the exercise of emergency powers and implementation of the legislation. The Queensland Council for Civil Liberties (QCCL) and QLS recommended that a Parliamentary Committee be empowered to provide regular and ongoing scrutiny of the legislation, including scrutiny of the justification for continuing the legislation, and consistency with the *Human Rights Act 2019*. QLS and QCCL also submitted that the exercise of the powers and decisions made under the powers should be subject to review by a court or tribunal. QHRC submitted that the current legislative framework is not fit-for-purpose, and requires greater transparency and oversight including: • independent oversight and review of quarantine requirements;	Queensland Health notes the powers in the Bill are already subject to legislative constraints. • The Chief Health Officer and emergency officers can only give directions that are reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community. • The Chief Health Officer must revoke public health directions as soon as reasonably practicable once they are no longer required for this purpose. • If at any time the Minister for Health determines that COVID-19 no longer presents a risk to public health, the Minister must declare the end of the public health emergency, which means that the emergency powers provided to the Chief Health Officer and emergency officers under the Public Health Act also end. • All of the measures extended by the Bill, including the power to issue public health directions, are subject to the Human Rights Act and, as such, must not be exercised in a way that limits human rights unless the limitation is reasonable and demonstrably justified.

	Issue	Response
	• scrutiny from a range of sources, including parliament and the courts; • transparency and publication of information about limits on human rights; • pandemic laws should be time-bound; and • additional safeguards and supports to minimise limitations on human rights. QHRC referred to the Victorian pandemic model passed in December 2021 as an example of a fit-for-purpose model.	Parliament has scrutinised the temporary legislative framework through relevant Parliamentary Committees' inquiries into previous amending legislation.[1] Regulations to extend the declared public health emergency are also subject to Parliamentary scrutiny and disallowance. Parliament has provided oversight of the Queensland Government's health and economic responses to COVID-19, through the relevant Parliamentary Committees, to ensure the suitability of these measures and provide an opportunity for the public to provide feedback about the health response. Following the urgent passage of amendments in response to the COVID-19 declared public health emergency in March 2020, the former Health, Communities, Disability Services and Prevention of Domestic and Family Violence Committee conducted several public hearings from June to August 2020, sought public submissions and issued an interim report about the Queensland Government's health response in September 2020.[2]
	Compatibility with human rights Many of the submissions from individuals expressed the view that the public health measures extended by the Bill impose limitations on human rights that are unjustified or that should be subject to additional statutory and administrative safeguards. QHRC provided a detailed submission analysing a range of human rights issues under the Bill. Overall, the QHRC believes that additional safeguards should be included in the legislation to ensure that the temporary public health and other emergency measures are no broader than necessary and do not unnecessarily limit human rights. These include: • Publishing a human rights statement of compatibility with each public health direction issued by the Chief Health Officer, either immediately or within 3–5 days of the direction being published. • Providing more specific parameters for what matters public health directions may regulate. • Clarifying that public health directions automatically expire when the public health emergency declaration ends. • Providing a clear process for review or appeal arising from the making of a direction for a person to quarantine or isolate. • Requiring that all public health directions include exemptions for persons to leave their principal place of residence or move freely to obtain medical treatment or for other essential reasons. • Clarifying when the Chief Health Officer would be empowered to mandate vaccination for certain persons. • Requiring that persons who apply for and are denied an exemption from a particular public health direction be provided with a statement of the reasons for the decision. QHRC stated that the statement of compatibility tabled with the Bill should provide additional justification of certain potential limitations of human rights. QLS and QCCL reiterated the QHRC's views that human rights statements should be published for public health directions and the legislative framework should provide a right of appeal for temporary COVID-19 powers in the *Public Health Act 2005*. QCCL proposed that to minimise potential impacts on human rights, amendments should be made to part 7A of the *Public Health Act 2005* to: • set criteria for imposing testing, isolation and mask wearing;	Queensland Health considers the Bill is compatible with human rights for the reasons set out in the Statement of Compatibility with Human Rights.[3] The State has a fundamental obligation to ensure the right to life of its citizens. While there have been instances where other human rights, such as the right to freedom of movement, have had to be restricted, these restrictions have been necessary to save lives and to protect the health and safety of Queenslanders during an unprecedented global public health emergency. While some of the measures extended by the Bill vest relatively broad powers and discretion in ministers, the Chief Health Officer and other public officials, this approach has allowed the Government to act quickly and decisively to contain or respond to new outbreaks in Queensland; to impose restrictions where necessary to contain the spread of COVID-19; and to continually re-evaluate and make adjustments to public health policies based on new evidence and lessons learned. Under this temporary legislative framework, Queensland has been successful in limiting the spread of COVID-19 without the need for extended lockdowns and other measures that would impose more severe and enduring limitations on human rights and without risking the lives of Queenslanders when there has been widespread community transmission. Queensland Health takes seriously its obligations under the Human Rights Act and is committed to ensuring that the exercise of emergency powers does not limit human rights more than is necessary to achieve the legitimate purposes of the Bill. Queensland Health gives careful consideration to ensuring potential limitations on human rights are justified during the development of all COVID-19 legislation, including primary legislation, subordinate legislation, statutory instruments and public health directions issued under the Public Health Act. Queensland Health notes that legislative amendments to narrow the scope of existing powers or impose additional conditions or constraints on how these powers are exercised may undermine the Government's ability to respond to public health risks in a swift and targeted manner. Flexibility to respond quickly has been essential to protecting the health and safety of the public and reduces the potential need for more severe limitations on human rights.

[1] Health and Environment Committee, Report No. 4, 57th Parliament, available at https://www.parliament.qld.gov.au/work-of-committees/committees/HEC/inquiries/past-inquiries/PublicHealth2020. Economics and Governance Committee, Report No. 6, 57th Parliament, available at https://www.parliament.qld.gov.au/work-of-committees/former-committees/HCDSDFVPC/inquiries/past-inquiries/COVID-19. Economics and Governance Committee, Report No. 11, 57th Parliament, available at https://www.parliament.qld.gov.au/Work-of-Committees/Committees/Committee-Details?cid=167&id=4097.

[2] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Inquiry into the Queensland Government's health response to COVID-19*, https://documents.parliament.qld.gov.au/tableoffice/tabledpapers/2020/5620T1653.pdf.

[3] Public Health and Other Legislation (Extension of Expiring Provisions) Amendment Bill 2022, Statement of Compatibility, available at https://www.legislation.qld.gov.au/view/pdf/bill.first.hrc/bill-2021-062

	Issue	Response
	• set criteria for declaring and endling a public health emergency; • remove contract tracing provisions; • add sunset provisions for all temporary measures; • allow a person to claim compensation for loss or damage suffered; and • allow isolation orders to be subject to review by a Magistrate. Many of the individual submissions that raised human rights concerns did not engage with the statement of compatibility for the Bill or offer any analysis as to whether any potential interference with human rights is reasonably necessary to protect the health, safety and welfare of the community during a serious and ongoing public health emergency. Most of the submissions simply state that the measures extended by the Bill have limited and will continue to limit human rights. Among other limitations, the submissions contend that the Bill will restrict freedom of movement and association; interfere with religious and educational activities; infringe the right to liberty and personal security by requiring the wearing of face masks and mandating vaccination requirements for high risk settings; violate the right to privacy by enabling the collection and use of information for contact tracing; and interfere generally with the rights and liberties of individuals by quarantining or isolating persons, imposing physical distancing requirements, limiting gatherings, restricting access to hospitals, aged care facilities and other premises.	As noted above, the measures extended by the Bill are already subject to meaningful legislative constraints and safeguards that provide protection for human rights while also allowing the flexibility needed to respond effectively during the public health emergency. • The Chief Health Officer and emergency officers may only give directions that are reasonably necessary to assist in containing, or to respond to, the spread of COVID-19 within the community. • The Chief Health Officer must also revoke public health directions as soon as reasonably practicable once they are no longer required for this purpose. Many public health directions have been revoked or relaxed on this basis, including the recent removal of the mask mandate. • Further, if at any time the Minister for Health and Ambulance Services determines that COVID-19 no longer presents a risk to public health, the Minister must declare the end of the public health emergency. The declaration of the end of the public health emergency means that the emergency powers provided to the Chief Health Officer and emergency officers under the Public Health Act also end. QHRC submits that it is not clear whether the Human Rights Act applies to the Chief Health Officer's power to issue public health directions. Queensland Health considers all of the public health measures extended by the Bill, including the Chief Health Officer's power to issue directions, are subject to the requirements and protections of the Human Rights Act. The Human Rights Statement of Compatibility for the Bill makes this clear, stating "… the Chief Health Officer is a public entity for the purposes of the Human Rights Act and when making public health directions under section 362B of the Public Health Act is required to consider human rights impacts when exercising decision making or taking actions, including whether there is any disproportionate impact on certain classes of people'.[4]
	Comments on exercise of the public health legislative measures including Chief Health Officer public health directions QLS raised concerns about restrictions imposed by public health directions on visitors providing legal services to hospital and disability accommodation settings. QLS recommended that these public health directions are amended to align with the direction relating to residential aged care facilities which permits vaccinated legal practitioners to enter to provide legal services. Many submissions outlined how the exercising of the Chief Health Officer's powers are adversely affecting their life. For example, many submissions stated the public health directions requiring people to isolate, quarantine or lockdown has caused sickness, distress, fear and mental health concerns for many Queenslanders. Some submissions suggested mask mandates were ineffective while others suggested that the removal of the mask mandate suggests there is no longer a compelling need for the Bill. Many stakeholders also expressed that the restrictions and directions issued by the Chief Health Officer have caused significant financial loss and emotional suffering. Many submissions raised concerns with or are against COVID-19 vaccine mandates under a public health direction. Some of the common concerns include, but are not limited to: • the vaccine mandates have caused job loss and loss of public life; • the vaccine mandates are an overreach of government power;	Queensland Health acknowledges that public health directions and other public health measures can have a significant impact on individuals and businesses. Queensland Health always seeks to strike the right balance between those impacts and the need to protect public health. The Bill continues the current safeguards in the Public Health Act including that the Chief Health Officer must revoke a public health direction as soon as reasonably practicable after the Chief Health Officer is satisfied the direction is no longer necessary to assist in containing, or to respond to, the spread of COVID-19. Queensland Health considers that the content of particular public health directions is outside the scope of the Bill. However, the following information is provided to assist the Committee. COVID-19 vaccines are a proven, safe and effective means of reducing the risk of moderate to severe disease with COVID-19, and up to date vaccination reduces both the severity of infection and transmission. Individuals who become infected despite vaccination (break-through infection) may be at reduced risk of transmitting due to a generally lower viral load and shortened duration of shedding. Shane Knuth MP's submission suggested vaccine mandates be revoked and instead require daily Rapid Antigen Tests for education staff, as they currently are for nurses. Under the current legislative framework, such a change could only occur by a public health direction being issued by

[4] Page 8.

	Issue	Response
	• there are adverse reactions happening in response to vaccinate mandates, including mental health concerns; • vaccine mandates are increasing the workload strain on businesses and the under-resourced vaccinated workforce; • the vaccine mandates are causing segregation and divide in community; and • people should be entitled to make their own choices and manage their own risks. The submission made by Shane Knuth MP included letters from 700 educators outlining the impact that the vaccine mandates has had on their lives. Strata Community Association Qld acknowledged the benefit that the power to close access to schemes under the public health directions provided throughout the pandemic has had to ensure safety of patrons. Submissions also raised the issue of whether Queensland's vaccine requirements for certain high-risk settings impinge upon human rights.	the Chief Health Officer requiring daily testing. This illustrates the importance of continuing the Chief Health Officer's powers to be able to respond to the rapidly changing risks of COVID-19. Vaccination mandates are in place for a number of key workforces, including our health workforce. Both vaccinated and unvaccinated people can still access essential services and activities. This means unvaccinated people are still be able to go to grocery stores, pharmacies, post offices, news agents and clothing stores, and participate in activities like going to the gym for exercise. High vaccination coverage remains a key determinant of positive health outcomes for all Queenslanders, while also minimising the impact of COVID-19 cases on our hospital system and the impact of COVID-19 on ongoing operations of businesses and public facilities and community life in general.
	Comments on the health risk justification for continuing COVID-19 emergency A number of submissions raised concerns that the risks of COVID-19 are low, non-existent or not supported by sufficient evidence to justify the extension of temporary COVID-19 public health measures in Queensland or the continuing declaration of a public health emergency. Common themes that were raised in submissions included: • the risks of COVID-19 are similar to the influenza therefore should be treated in the same way; • the death rate of the Omicron variant has been lower than the Delta and Alpha variants therefore the extension is not justified; • case numbers have been lower than predicted by modelling; • the original modelling that initially justified the implementation of COVID-19 legislation in Queensland is no longer relevant; • the peak of Omicron has passed in Queensland; • the evidence base for COVID-19 case numbers and death rates due to COVID-19 (including data and modelling) has been inflated and/or exaggerated; • there is no risk of the health system breaking if the temporary COVID-19 measures are removed; • there is no pandemic; • the COVID-19 legislative measures are causing more harm than good; and • death rates due to COVID-19 are lower than other diseases.	In-depth consideration about the risks of COVID-19 is a matter for health experts and is beyond the scope of the Bill. However, as stated in the explanatory notes accompanying the Bill, and reiterated by the Chief Health Officer at the Committee's public briefing on the Bill on 7 March 2022, the risks of COVID-19 remain a concern to Queensland. Even after the peak of the first Omicron wave, COVID-19 cases continue to circulate in Queensland's community with over 27,000 active cases reported as at 11 March 2022 around the state. The true number of cases in the community is much higher. Now that international borders have reopened, Queensland is experiencing a high volume of international travellers into Queensland and transiting through airports. As Queensland moves into winter, higher transmission of the COVID-19 virus is expected. The ability to respond rapidly and flexibly to the risks of COVID-19 will be crucial during winter and influenza season, particularly if new variants emerge or new peak periods of transmission occur. This may also coincide with the community's waning immunity from COVID-19. Since the beginning of the COVID-19 pandemic, similarities and differences have frequently been drawn between COVID-19 and influenza. Although influenza and COVID-19 may have similar symptoms in acute phase for mild illness and some longer-term consequences they are very different infections. For example, the risk of severe outcomes including death is much higher for COVID-19, particularly in an unvaccinated individual. In 2017, there were 2,002 deaths in Australia with any mention of influenza on the death certificate (Source: 3303.0 - Causes of Death, Australia, 2017 (abs.gov.au)), while in the first two months of 2022 there have been 2,703 COVID-19 deaths in Australia.[5] The longer-term outcomes of COVID-19 infection are still not well understood, but there are early indications that long-COVID is not uncommon and can occur even with mild illness. Given both influenza and COVID-19 have the potential to put significant pressure on the health system, the ability to respond quickly and effectively to any impact on the health system will be crucial. Additional information about influenza and COVID-19 is provided in Attachment 1.

[5] As at 21 February 2022.

	Issue	Response
		Given the current epidemiological situation, legislative powers are still needed to manage overseas arrivals and to rapidly respond to increasing case numbers, particularly into winter. Australia will also be one of the first countries in the world to experience winter following an Omicron peak. This means that there are no other models for Queensland of Australia to look at to enable us to ascertain the potential impact of winter, influenza and COVID-19 in the community. The Bill provides an enabling framework to respond to the point-in-time risks of COVID-19. The powers do not need to be exercised if the risk level remains low and restrictions are continually reviewed in response to risk levels.
	Vaccination Several submissions objected against the efficacy and safety of the COVID-19 vaccinations currently available. Concerns raised included the COVID-19 vaccination: • being in an experimental stage; • being unlawful, killing or hurting people; and • not preventing transmission or infection. Some individuals also suggested adverse actions to the COVID-19 vaccination are underreported.	While the efficacy and safety of the COVID-19 vaccinations is a policy matter that is outside the scope of the Bill, the following information is provided for assistance. COVID-19 vaccines are a proven, safe and effective means of reducing severity of disease with COVID-19 as well as the risk of infection and transmission, where vaccination is up to date. There is a rigorous vaccine efficacy and safety approval process undertaken by the Therapeutic Goods Administration to allow use of vaccines in Australia. The prima facie evidence at a population level for the safety and effectiveness of COVID-19 vaccines has been established. Individuals who become infected despite vaccination (break-through infection) may be at reduced risk of transmitting due to a generally lower viral load and shortened duration of shedding. With no innate immunity to COVID-19, COVID-19 transmission and infection occurs at the highest rate among unvaccinated and previously uninfected people. The best way to reduce the risk of a variant occurring is to reduce the amount of viral reproduction within people and reduce the number of people infected. Unfortunately, there has been a lot of misinformation in the community about vaccination. While it is true that there have been hospitalisations and deaths among vaccinated people, including people who have had boosters, this should not be considered evidence that the vaccines are not effective. There will always be deaths and hospitalisations in the vaccinated, however unvaccinated people are disproportionately represented in these figures. Based on the currently available data for COVID-19 in Queenslanders aged 60 years or more, those cases who were unvaccinated were 5 times more likely to die than those cases who were partially vaccinated (people who have started their vaccination program but were not up to date). Unvaccinated Queenslanders aged 60 years or more were 15 times more likely to die than those cases who were fully vaccinated (people who were up to date with their vaccination program). Queensland Health epidemiologists conservatively estimate at least an additional 3,722 Queenslanders aged 60 or older would have died since 13 December 2021, if it weren't for vaccination. Data from the United Kingdom shows that the vaccine remains 75-85 per cent effective against hospitalisation following infection with the Omicron variant after 4-6 months a COVID-19 booster is received. Vaccinations remain crucial and are particularly effective against the more severe outcomes of COVID-19 disease, including hospitalisation, ICU admission and death. Unvaccinated people are overrepresented among those hospitalised. Queensland data shows that there is a significant increase in the likelihood of hospitalisation for people who are not vaccinated against COVID-19 and that the likelihood of being hospitalised increases with age. That is why it is

	Issue	Response
		particularly important for older and more vulnerable Queenslanders to get vaccinated and take their booster shots. Vaccinated and unvaccinated people will continue to need hospital care and, unfortunately, some people will die of the COVID-19 disease. However, this number will be much lower than would have been experienced without the high level of vaccine coverage achieved in Queensland.

	Other issues raised A number of other issues were raised in submissions including: • the temporary COVID-19 legislation is unconstitutional, breaches federal or international law, or sovereign citizen rights; • the restrictions cause mental health issues, economic loss, job loss and divide society; • people do not consent to the restrictions and mandates; • the government needs to listen to the community's views; • funding should be redirected to responding to extreme weather events, like the recent floods in Queensland; and • restrictions are causing disintegration of trust in public institutions. QLS called for the re-enlivening of the modified arrangements to allow wills and enduring documents to be witnessed by electronic means rather than in person to ensure continuity of essential legal services until end of the COVID-19 public health emergency. Strata Community Association QLD (SCA) encouraged the continuation of some of the temporary measures put in place to enable institutions and businesses to continue functioning during COVID-19 such as being able to conduct meetings and decision making in a remote manner as they have been essential to manage affairs during the pandemic. The Australian Logistics Council acknowledged the benefit of relaxing freight curfews and delivery restrictions during COVID-19 and made recommendations to consider implementing these measures permanently like in New South Wales. The Family Responsibilities Commission recommended the extension of the expiry of the *Family Responsibilities Commission (COVID-19 Emergency Response) Regulation 2020* to 31 December 2022. QHRC noted that it was not consulted on the development of the Bill.	These comments are beyond the scope of the Bill as they relate to administrative or operational details, potential program improvements, requirements in specific public health directions or opportunities for future legislative or administrative reform. The measures put in place in other legislation through the pandemic to provide regulatory relief and ensure the continued operation of institutions and businesses are separate from the immediate public health response and are not being amended or effected by this Bill. Rather, they will expire in accordance with their existing expiry provisions set by the Parliament through earlier legislation. As the Bill does not affect these other amendments, any issues in relation to these matters are beyond the scope of the Bill. Queensland Health notes that it was intended that QHRC be consulted on the development of the Bill but this did not occur due to an administrative error.

Influenza and COVID-19

Mortality Queensland

March 2022

- Since the beginning of the COVID-19 pandemic similarities and differences have frequently been drawn between COVID-19 and influenza.
- As we have learned more about the impact and transmission of SARS-CoV-2 it has become evident that, although they have similar symptoms in the acute phase for mild illness and some similar long-term sequelae, these are very different infections:
    - Influenza is predominantly spread via droplets, while COVID-19 is predominantly aerosol spread
    - The reproductive number is higher for COVID-19 (and substantially so for some variants)
    - Risk of severe outcomes including death is much higher for COVID, particularly in an unvaccinated individual
    - COVID-19 infection is associated with increased risk of cardiovascular and neurological sequelae
- With the reopening of international borders and increased international travel more generally, along with the easing of test, trace, isolate and quarantine, and public health and social measures it is expected that there will be a 2022 flu season in Queensland. With international borders reopening in February 2022, we may see a return to more normal levels of flu in the community, and we may experience, due to low community immunity, a larger flu season than average. This may occur for the first time alongside a surge in COVID-19 cases.
- Early in the pandemic the risk of death when co-infected with both COVID-19 and influenza was found to be twice that of COVID-19 infection alone. It is not known what the risk is now that COVID vaccination is widespread, treatments have advanced, and the current dominant variant is less severe. However, the system will need to prepare for waves of both COVID-19 and flu and the potential for co-infection in greater numbers than seen previously.
- Both influenza and COVID-19 have the potential to put significant pressure on the health system, understanding the potential impact of the two through 2022 is important for planning purposes.

International observations

- The threat of simultaneous influenza and COVID-19 waves is a concern for most countries.
- The measures bought in around the world to reduce the spread of COVID-19 has reduced influenza activity to very low levels in 2020 and 2021.
- February is usually right in middle of the typical peak of influenza activity in the northern hemisphere. At this stage it appears that across the USA, UK and European region the 2021/2022 season is a little higher than 2020/2021, however it is still well below pre-COVID-19 levels (Source: ecdc.europa.eu; publishing.service.gov.uk; Weekly U.S. Influenza Surveillance Report | CDC).
- In most countries there are still significant measures in place to stop the transmission of COVID-19, however these are easing in many countries.
- As more countries continue to ease restrictions, it will be important to monitor any increase in influenza and COVID-19 activity.

- It appears that pandemic influenza (type A) viruses are dominant across most areas with influenza activity.

COVID-19 and influenza deaths compared

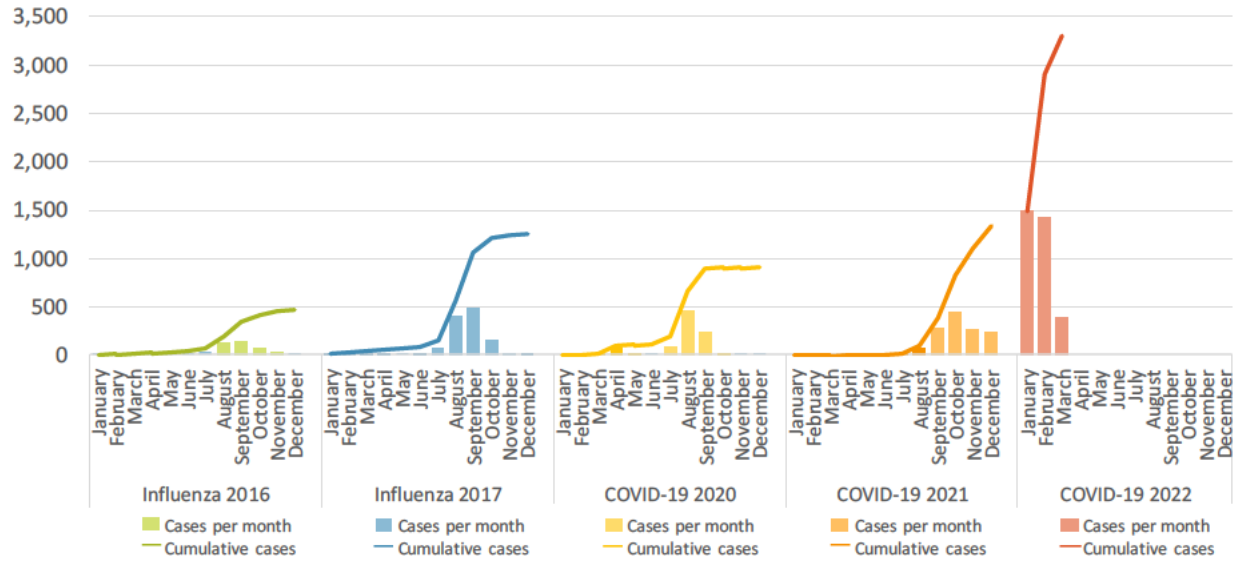
- The 2017 and 2019 flu seasons were among the largest in terms of cases and deaths that we have seen in recent times. The then Minister for Health and Minister for Ambulance services Stephen Miles described the 2019 season case numbers as "staggering" by (3 October 2019). Across the season to 3 October 2019, there had been:
    - **65,000 laboratory confirmed flu cases notified,**
    - **2,930 people hospitalised, and**
    - **191 influenza deaths.**
- In Queensland since the borders opened almost 3 months ago (13 December 2021) to 10 March 2022, we have had a huge surge in COVID-19 driven by the highly transmissible and immune evasive Omicron variant with:
    - **396,136 laboratory confirmed cases notified (note to support comparison with flu cases, this excludes self-reported RATs that don't also have a positive PCR test result, as RATs are not confirmed in a laboratory),**
    - **616 COVID-19 deaths.**
- In 2017, there were 2,002 deaths in Australia with any mention of influenza on the death certificate (Source: 3303.0 - Causes of Death, Australia, 2017 (abs.gov.au)), while so far in 2022 there have been 3,300 COVID-19 deaths (to 11 March 2022) in Australia.
- For both flu and COVID-19 a large proportion of deaths occur in older people—89% of deaths with influenza as the underlying cause in Australia in 2017 were people aged 70 years and older, and 83% for COVID-19 deaths in Australia to date.
- The COVID-19 deaths that have occurred in 2022 are despite very high vaccination rates. As of 31 December 2021, 91.4% of Australians aged 16+ had at least 2 doses of COVID-19 vaccination. This compares to a typically much lower influenza vaccination coverage—in 2019 approximately 64% of adults age 65+ and 43.9% of children aged 6 months to <5 years had an influenza vaccination (Source: Communicable Diseases Intelligence 2021 - Influenza vaccination uptake in Australia in 2020: impact of the COVID-19 pandemic? (health.gov.au)).
- Up to date COVID-19 vaccination is also considerably more effective at preventing severe outcomes including death compared to influenza vaccines.
- Based on data available in mid-February, for COVID-19 in Queenslanders aged 60 years or older, those COVID-19 cases who were unvaccinated were:
    - 5 times more likely to die than those cases who had been partially vaccinated (that is people who have started their vaccination program but were not up to date).
    - 15 times more likely to die than those cases who were fully vaccinated (that is people with COVID-19 who had received two doses and were not yet due for their 3rd or people who had received 3 doses).

Table 1 Influenza and COVID-19 deaths Queensland and Australia

	Deaths mentioning Influenza (U09-U11)^							COVID-19*
	2015	2016	2017	2018	2019	2020	Average 2015-2019	2022 to 11 Mar 22 (7.5 weeks)
Australia								
Underlying cause	289	464	1,255	141	1,080	55	646	n.r.
Any mention	471	692	2,002	219	1,644	90	1,006	3,300
Queensland								
Underlying cause	70	108	269	42	226	22	143	n.r.
Estimated~ any mention	114	161	429	65	344	36	223	616

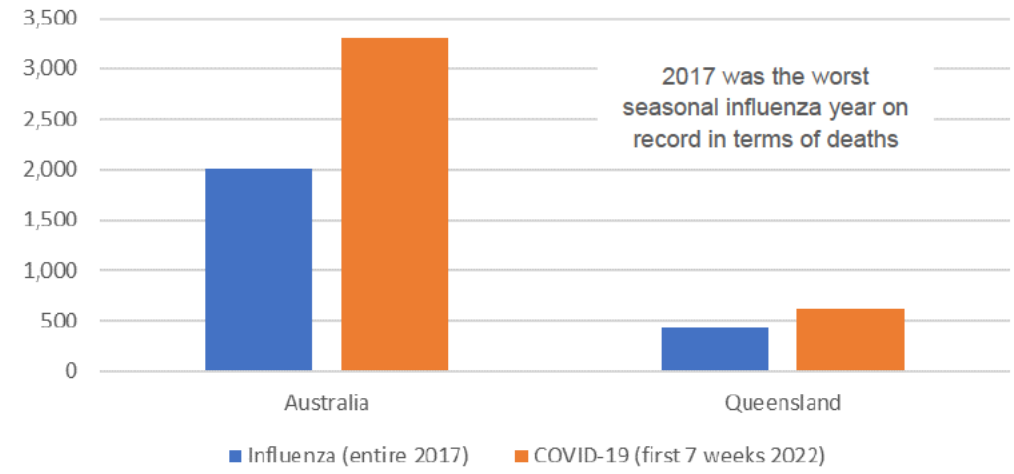
^ABS Cause of Death data
* Reported deaths
~ Deaths with any mention of influenza is not available for Queensland, therefore this is estimated based on the Australian ratio of underlying to any mention deaths
n.r. not reported

Figure 1 Influenza and COVID-19 deaths by month and cumulative, Australia (2022 COVID deaths to 11/3/22)



Notes:
Influenza deaths are those where influenza (U09-U11) was the underlying cause of death
COVID-19 deaths in 2020 and 2021 were predominantly during times of strong PHSM
Sources:
3303.0 - Causes of Death Australia 2017 (abs.gov.au)
Coronavirus (COVID-19) in Australia | Data (covid19data.com.au)

Figure 2 Number of influenza deaths (with any mention) (2017) and COVID-19 deaths (2022)



Patterns of influenza and COVID-19

- Characterised by seasonal epidemics during winter months (generally between May and October in Queensland), influenza typically circulates at very low levels at other times. The year-to-year impact of influenza can vary dependant on predominant strain, and level of immunity in the population from both previous infection and vaccination.
- Influenza has been around for hundreds, if not thousands of years. Over this time patterns of influenza in populations have become largely predictable. We know that typically case numbers rise between April and October often peaking in August, and the strains we see in our flu season are often those that had circulated in the Northern hemisphere during their flu season, and we have a targeted vaccine developed and administered yearly based upon the circulating strains.
- COVID-19 is yet to settle into a predictable cycle of epidemic activity, and there are estimates that this will not happen for 2-10 years. In the absence of major variant shifts (which thus far seems unlikely with COVID) the infection is likely to settle into a cyclical pattern of epidemics driven by increasing population susceptibility—through a combination of waning vaccine and infection induced immunity, and introduction of non-immune people i.e. births, and immigration, and/or new immune evasive variants.
- The heterogeneity in the phylogenetic tree of COVID-19 means that the characteristics of the next dominant variant are impossible to predict beyond the requirement for it to have a growth advantage over other variants. Growth advantage comes through either immune evasion or transmissibility. The virulence (or severity) of the next dominant strain is impossible to predict, and just because Omicron may have been milder, the next variant may not.
- We also may see variants evolving and circulating in localised areas that do not become dominant.

Fatality rates, transmissibility, and population mortality rates

- The case or infection fatality rate (IFR) gives the risk of dying if infected with a disease—this is an important indicator of severity of disease in infected individuals.
- The basic reproductive number (R_0), a measure of transmission, is also important indicator to estimate population level impacts. While for influenza, R_0 is estimated to be around 1.3 and for

the original COVID-19 strain the basic reproductive number has been estimated to be between 2-3 (for the original strain) the emerging dominant variants—Alpha, Delta and Omicron—have been successively more transmissible.

- This means that even if the IFR were the same for influenza and COVID-19, the number of deaths in a population (mortality rate) are likely to be much higher for COVID-19 due to higher transmission potential.
- There are reports that the IFR for the Omicron variant of concern is approaching that of influenza, and lower than Delta due to improved treatments, high levels of vaccine and infection induced immunity, and a possible intrinsic reduced virulence compared to Delta. However, at any point a more virulent variant may emerge, or one that is immune evasive, or does not respond to treatment.
- Waning vaccine effectiveness will also be an important potential driver in any changes in transmission rates as Australia's immunity is largely driven by vaccination.

Reporting and recording deaths by cause

- It is difficult to accurately capture deaths associated with influenza, and this is also the case with COVID-19.
- COVID-19 deaths that are reported daily in Australia include all people that have died with COVID-19.
- The Australian Bureau of Statistics (ABS) codes deaths data provided by state and territory, data is coded to the standardised International Statistical Classification of Diseases and Related Health Problems (ICD).
- Deaths are attributed to an **underlying** cause which is the disease or condition that initiated the sequence of events leading to death. Most deaths also have **associated** causes, these are conditions that contributed to the deaths but did not cause it.
- For surveillance purposes, a COVID-19 death is defined as a death in a confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g. trauma). There should be no period of complete recovery from COVID-19 between illness and death.