Queensland Parliamentary Library

# Notifiable Conditions and Public Health Emergencies under the Public Health Bill 2005 (Qld)

*The Public Health Bill 2005 (Qld) is the culmination of a review of the public health provisions of the* Health Act 1937 *(Qld). A consultation draft of the Bill was released in October 2004 for public input. While the* Health Act 1937 *(Qld) has served its purpose in supporting a vast array of public health measures to protect Queenslanders from diseases, it has become somewhat dated and unwieldy.*

*The introduction of the new legislation is timely in view of recent public concern about diseases such as SARS and the 'bird flu'. The Bill paves the way for the management and control of public health issues into the future. Among other public health measures, the Bill provides mechanisms to trace and monitor notifiable conditions and, in the case of more serious conditions, allows action to be taken such as detention and medical examination of a person in order to control the spread. The Bill contains measures for minimising the transmission of contagious conditions in schools and child care centres and provides powers to declare public health emergencies.*

**Nicolee Dixon**

**Research Brief No 2005/10**

**Queensland Parliamentary Library**
**Research Publications and Resources Section**

| | |
|---|---|
| Ms Karen Sampford, Director | (07) 3406 7116 |
| Mrs Nicolee Dixon, Senior Parliamentary Research Officer | (07) 3406 7409 |
| Ms Renee Giskes, Parliamentary Research Officer | (07) 3406 7241 |


Research Publications are compiled for Members of the Queensland Parliament, for use in parliamentary debates and for related parliamentary purposes. Information in publications is current to the date of publication. Information on legislation, case law or legal policy issues does not constitute legal advice.

Research Publications on Bills reflect the legislation as introduced and should not be considered complete guides to the legislation. To determine whether a Bill has been enacted, or whether amendments have been made to a Bill during consideration in detail, the Queensland Legislation Annotations, prepared by the Office of the Queensland Parliamentary Counsel, or the Bills Update, produced by the Table Office of the Queensland Parliament, should be consulted. Readers should also refer to the relevant Alert Digest of the Scrutiny of Legislation Committee of the Queensland Parliament.



**ISSN 1443-7902**
**ISBN 1 921056 08 8**
**APRIL 2005**



Inquiries should be addressed to:
Director, Research Publications & Resources
Queensland Parliamentary Library
Parliament House
George Street, Brisbane QLD 4000
Ms Karen Sampford. (Tel: 07 3406 7116)
Email: Karen.Sampford@parliament.qld.gov.au

Information about Research Publications can be found on the Internet at:
http://www.parliament.qld.gov.au/Parlib/Publications/publications.htm

# CONTENTS

## EXECUTIVE SUMMARY

The **Public Health Bill 2005 (Qld)** (the Bill), introduced into the Queensland Legislative Assembly on 22 March 2005, is the culmination of a review by Queensland Health of the public health provisions of the *Health Act 1937* (Qld). A consultation draft of the Bill was released in October 2004 for public input. Among other public health measures, the Bill provides mechanisms to trace and monitor notifiable conditions and allows action to be taken to control the spread of more serious diseases. It also contains measures for minimising the transmission of contagious conditions in schools and child care centres and provides powers to declare public health emergencies (**page 1**).

As originally enacted in 1937, the *Health Act* contained provisions for containing and managing the spread of infectious or contagious diseases. Tuberculosis (TB) and many other potentially fatal and contagious diseases rarely occur in Australia these days. The outcome regarding TB appears to be a result of Australian Governments' commitment to TB control from the 1950s to the 1970s. Many childhood diseases such as measles, whooping cough, polio and diphtheria have been prevented by immunisation programs. Australians have become more complacent and less concerned about the outbreak of disease. However, Governments, health professionals and the community must be aware of emerging new diseases and a resurfacing of older ones (**pages 1-3)**.

The need for more comprehensive, strong and unambiguous legislative powers to underpin other mechanisms to deal with public health situations has been highlighted by recent outbreaks of Sudden Acute Respiratory Syndrome (**SARS**) and Avian Influenza A (type H5N1) ('**bird flu**') in overseas countries and fears about those diseases reaching Australia. Since the terrorist attacks on the United States on 11 September 2001, there have been heightened concerns around the world about the potential for **biological** warfare (**pages 3-5**).

At a **national level**, an *Action Plan for Pandemic Influenza* has been developed and funding totalling $133.6 million over five years has been provided by the Commonwealth Government's 2004-2005 Budget to protect the Australian public from potential outbreaks of human pandemic influenza and bird flu. A number of approaches form part of the national response to any potential outbreak of disease in the Australian community (**pages 5-7**). A brief overview of some key mechanisms and bodies involved is provided on **pages 7-10**.

Queensland Health has operational measures in place concerning control of infectious diseases (**pages 10-11)**.

The **Public Health Bill 2005 (Qld)** covers a range of public health issues including the management of public health risks (which will also enable prevention and control programs to be declared in the event of an outbreak or likely outbreak of disease transmitted by pests, such as dengue fever), environmental health event registers, management of notifiable conditions, child abuse and neglect, infection control, public health information, public health inquiries, and a modern framework for monitoring and enforcing compliance (**page 11**).

**Chapter 3** deals with '**notifiable conditions**' and '**controlled notifiable conditions**' and replaces the provisions under Part 3 of the *Health Act 1937* concerning notifiable diseases and controlled notifiable diseases (**pages 11-13**). The Bill seeks to protect public health regarding highly contagious or life threatening diseases, but it is also recognised that there may be individual liberty and privacy issues involved. To achieve a balance, **guidelines** for achieving the purpose of the chapter are established (**pages 13-14)**. The establishment of the **Notifiable Conditions Register**, obligations for **reporting notifiable conditions**, and provisions for **contact tracing** are discussed on **pages 14-16**.

The various orders under **Chapter 4**, **Part 3** for managing **controlled notifiable conditions** that may be made by the **chief executive** of Queensland Health in specified circumstances (allowing detention for up to 24 hours) and by a **Magistrate** (that allow for initial examination, control of behaviour, and detention) are considered on **pages 16-19**.

**Chapter 5**, **Part 2** deals with **children** at **school** or in **child care** with a contagious condition (i.e. a condition that has been prescribed by regulation as a contagious condition). It imposes obligations on parents not to send a child who has such a condition to school or child care and allows a child to be removed from school or child care if they could spread the condition or if a child is at risk of contracting a condition that the child has not been vaccinated against. Schools and child care centres can be temporarily closed in some situations (**pages 19-21**).

**Chapter 8** gives the Minister for Health power to declare a **public health emergency** in particularly serious circumstances and this triggers a range of extensive emergency response powers and the ability to deal with **emergency notifiable conditions** (**pages 21-23**).

Comparable public health **legislation** in **other Australian jurisdictions** is discussed on **pages 23-28**.

# 1 INTRODUCTION

The Public Health Bill 2005 (Qld) (the Bill) is the culmination of a review by the Queensland Department of Health (Queensland Health) of the public health provisions of the *Health Act 1937* (Qld). There have been two earlier policy documents – *Review of the Health Act 1937: New Population Health Legislation for Queensland Discussion Paper* (October 1995) and the Draft Policy Paper, *Review of the Health Act 1937 (Qld) (Public Health)* (February 1998). A consultation draft of the Bill was released in October 2004 for public input.

The introduction of the new legislation is timely in view of recent public concern about diseases, such as Sudden Acute Respiratory Syndrome (SARS) and Avian Influenza A (type H5N1) ('bird flu'), which have emerged in other countries and may pose risks to Queenslanders. The Bill paves the way for the management and control of public health issues into the future. While Queensland Health undertakes research and programs for the prevention and control of disease and collects information allowing response to disease outbreaks, it is necessary to have a supportive and strong legislative framework.[1]

Among other public health measures, the Bill provides mechanisms to trace and monitor notifiable conditions and allows action to be taken, such as detention to enable medical examination of a person, to control the spread of more serious diseases. The Bill contains measures for minimising the transmission of contagious conditions in schools and child care centres and provides powers to deal with public health emergencies. This Brief will focus only on provisions of the Bill that concern notifiable conditions, contagious diseases in children, and public health emergencies. However, attention is given to health information management and enforcement provisions as they relate to those matters.

# 2 BACKGROUND

The *Health Act 1937* (Qld) contains a number of public health provisions dealing with issues such as management of public health risks, emergency and inquiry powers, protection measures for coping with certain notifiable conditions, infection control in health care facilities, response to child abuse and neglect, and management of public health information.

There has historically been power to manage infectious diseases in Queensland and, until 1904, plague, yellow fever, cholera and smallpox were a charge on local

---

[1] Hon G R Nuttall MP, Minister for Health, Public Health Bill 2005 (Qld), Second Reading Speech, *Queensland Parliamentary Debates*, 22 March 2005, pp 633-635, p 633.

authorities. Due to a plague scare, the State Government assumed responsibility for infectious diseases of this type from that time.[2] As originally enacted in 1937, the *Health Act* contained provisions for containing and managing the spread of infectious or contagious diseases. At the time, there were concerns about tuberculosis and infantile paralysis (polio). The approach to contagious diseases was to isolate persons with those conditions in hospitals for treatment in the interests of public health and to minimise the danger of contamination becoming a charge on the community in the process.[3]

Indeed, for earlier generations of Australians, communicable diseases were matters of huge anxiety with diseases such as plague and smallpox threatening large sections of the population. Many parents feared that their children would contract potentially fatal childhood diseases such as diphtheria, whooping cough, measles, and polio.

However, tuberculosis (TB) and many other potentially terminal and contagious diseases rarely occur in Australia these days. The outcome regarding TB appears to be a result of Australian Governments' commitment to TB control from the 1950s to the 1970s. Many childhood diseases such as measles, whooping cough, polio and diphtheria have been prevented by immunisation programs. As the 20th century progressed, Australians became more complacent and less concerned about the outbreak of disease in this country. Immunisation rates in children have dropped. It was not really until the emergence of HIV/AIDS in the 1980s that people began to once again become aware of the possible consequences of communicable diseases in society. Swift action in the public health sector contained the incidence of HIV/AIDS in the Australian population. However, Governments, health professionals and the community must be aware of emerging new diseases. Even 'older' diseases can still pose a threat. For example, TB still causes 2-3 million deaths worldwide each year and, on occasions, can be resistant to the usual antibiotics. If such a resistant strain reaches Australia, it would be difficult to cure and place a huge strain on health care services.[4]

There were three influenza pandemics in the 20th century, with the worst being the Spanish influenza of 1918-1919. A pandemic exists where a disease spreads to all parts of the world, usually within 12 months, and causes illness in more than a

---

2 Hon E M Hanlon MLA, Secretary for Health and Home Affairs, Health Bill 1937 (Qld), Address in Reply, *Queensland Parliamentary Debates*, 11 November 1937, p 1353.

3 Mr E B Maher MLA, Health Bill 1937 (Qld), Second Reading Debate, p 1345.

4 Commonwealth Department of Health and Ageing (DHA), *Protecting Australia From Communicable Diseases: Everybody's Business*, Special Report from the Commonwealth Chief Medical Officer, January 2004, p 21-22, http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-pubhlth-publicat-document-metadata-cmo.htm.

quarter of the total population. The 'Spanish flu' killed around 20 million people throughout the world, including Australian troops in France during the First World War. It spread around the world in less than a year. The Australian Director of Quarantine attempted to control the disease by quarantining 174 'infected vessels'. Nevertheless, the influenza did come to Australian shores, causing 12,000 deaths in a population of five million. Health services were disrupted and there was considerable panic in the community. The mortality rate over the short period involved was proportionally greater than that from HIV/AIDS over almost 20 years. The fatalities were mainly young adults. It is likely that any new influenza pandemic will reach Australia and spread globally much more quickly because of the speed and frequency of human travel.[5]

## 3 RECENT EVENTS

The need for more comprehensive, strong and unambiguous legislative powers to underpin government measures to deal with public health situations has been highlighted by recent outbreaks of SARS and 'bird flu' in overseas countries and fears about those diseases reaching Australia. Since the terrorist attacks on the United States on 11 September 2001, there have been heightened concerns around the world about the potential for biological warfare, given recent advances in genetic engineering and biotechnology. Even traditional agents have been employed by terrorist groups. For example, anthrax has been used as a 'weapon' of terrorism. In 2001, US mail workers were killed by spores that were being posted to congressmen. The anthrax incident created considerable panic throughout the world, sparked off hoaxes, caused general social disruption and prompted large publicly funded decontamination programs.[6]

While SARS appears to have been controlled as of June 2003, it is believed that at least 47 people in the past year have died from the bird flu in Asia, mostly in Vietnam. Avian influenza is a contagious viral infection and there are 15 types of viruses. It is spread through bird faeces and contaminated water or dust. The strain that has killed humans in recent years is the highly pathogenic avian influenza (HPAI) strain H5N1. The spread is thought to have been through the transmission of the virus from migrating wild birds to domestic bird flocks. The disease kills 75% of those who contract it. While it has apparently existed for around 50 years, it was not until 1997 that it began to take hold in chickens in Hong Kong, leading to a rapid mass culling of the birds which halted the spread of the disease. However, it recently resurfaced in a number of Asian countries in a slightly altered form. The World Health Organisation (WHO) has warned of a

---

5 DHA, *Protecting Australia From Communicable Diseases: Everybody's Business*, Preface.

6 DHA, *Protecting Australia From Communicable Diseases: Everybody's Business*, p 34.

possible pandemic which will place a huge strain on medical response measures such as vaccines. The threat of bird flu becoming a pandemic seems less likely as it appears that it is not easily transmitted between people but could alter to a form that enables it do so.[7] A cluster of cases in Vietnam which involve three members of one family and, possibly, two health care workers, is being investigated by the Vietnamese Ministry of Health and the WHO. However, there remains no evidence of the spread of the virus as would occur in an influenza pandemic.[8]

To date, there have been no reported cases of bird flu in Australia. It is reported that the Commonwealth's Chief Medical Officer (CMO), Professor John Horvath, considers that Australia is well placed to deal with the threat of an outbreak of the bird flu because it has border inspectors watching for poultry products attempting to be smuggled into the country and monitoring of domestic flocks is also occurring.[9] Australia has shown the way in influenza control with research leading to the production of vaccines and antiviral drugs. The new drugs can prevent infection if administered before exposure and can reduce the severity and spread of the disease if administered soon after the first symptoms appear.[10] As will be discussed below, the Commonwealth Government has provided $133.6 million over five years to protect Australians from potential outbreaks of pandemic influenza and from the entry of the bird flu.

An immunologist at the Australian National University has noted that smallpox, a disease eradicated in 1980, could pose a biological terrorist threat. It might be possible to genetically engineer a new smallpox disease or manufacture similar diseases such as monkey pox.[11] Indeed, the Commonwealth Government has considered the possibility, while very low, as worthy of taking the precaution of importing 50,000 vials of smallpox vaccine. The Commonwealth Department of Health and Ageing (DHA) has in place *Guidelines for Smallpox Outbreak Preparedness, Response and Management* regarding overall policy in relation to

---

7 DHA, Avian Influenza Webpage, http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-avian_influenza-index.htm-copy3; Michael Corkill, 'Danger when Asia sneezes', *Courier Mail*, 18 March 2005, p 19.

8 DHA, Avian Influenza Webpage.

9 Michael Corkill.

10 DHA, *Protecting Australia From Communicable Diseases: Everybody's Business*, p 22.

11 Ean Higgins, 'Armed for bioterror', *Australian*, 12 June 2004, p 29.

national response codes for a smallpox threat or outbreak and for the mobilisation of vaccine.[12]

## 3.1 AUSTRALIAN PREPAREDNESS AND RESPONSES TO DATE

Australia has developed an *Action Plan for Pandemic Influenza* and funding totalling $133.6 million over five years has been provided by the Commonwealth Government's 2004-2005 Budget to the Commonwealth DHA to protect the Australian public from potential outbreaks of human pandemic influenza and the entry of bird flu.[13]

As of March 2005, the following measures taken at the national level include –[14]

- purchasing stocks of antiviral treatments and protective masks;
- developing response plans with the National Influenza Pandemic Action Committee;
- improving Australia's capability to detect cases of influenza at the border including publishing health information sheets to raise travellers' awareness of the issue and purchasing thermal imaging cameras for major airports to detect passengers who may have been infected with a potentially deadly virus;
- providing $10.1 million over four years to improve Australia's infectious diseases surveillance system to allow for the rapid detection and reporting of infectious diseases of public health significance, emerging diseases, or a deliberate release of a biological agent into the population. The funding is directed at establishing a Secure Information Sharing Network and the development of a web-based reporting system for outbreaks of disease to be used by state and territory public health workers to access data across Australia and to disseminate outbreak alerts and infection control advice. Funding is also provided to improve the National Notifiable Diseases Surveillance System and National Sentinel General Practice Surveillance System (see below).

---

[12] DHA, *Guidelines for Smallpox Outbreak*, http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-pubhlth-publicat-document-metadata-smallpox.htm.

[13] DHA, 'Health Fact Sheet 1 – Addressing Emerging or Potential Health Risks: Budget 2004-2005', 11 May 2004, http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/health-budget2004-hbudget-hfact1.htm.

[14] See DHA, Avian Influenza Webpage and DHA, 'Addressing Emerging or Potential Health Risks: Budget 2004-2005'.

In the 2004-2005 Budget, the Commonwealth Government announced that it would increase its focus on further improving its emergency health response structure for protecting the community from infectious disease outbreaks and threats from biological, chemical or radiological agents. Over the current four years, $40.2 million is being directed at initiatives to strengthen national health security and preparedness and response capability in the event of a terrorist attack or national health emergency.[15]

The Commonwealth Government also maintains a National Emergency Medicines Stockpile which was established in 2002 following terrorism activities in overseas countries. The Stockpile is a strategic reserve of essential vaccines, antibiotics, antiviral drugs, chemical and radiological antidotes and personal protective equipment for health workers designed to supplement other medical stocks so that supplies do not deteriorate in the event of an incident in Australia. Included in the Stockpile is a smallpox vaccine and antiviral medications worth $123.8 million to cope with pandemic influenza. The Stockpile is located at a number of secret Australian locations.[16] In the 2004-2005 Budget, an additional $15.3 million was allocated to expand the Stockpile to further enhance the ability to respond to terrorist, or naturally occurring, threats to health.[17]

In the 2004-2005 Budget, the Commonwealth Government committed $2.4 million over four years to support and improve planning, preparation and coordination of health responses to major health incidents arising from natural events or from terrorist attack. This will occur through the inter-Government Australian Health Disaster Management Policy Committee (which includes the Commonwealth's CMO and all Australian chief health officers, and high level persons from Emergency Management Australia (EMA) and the Australian Defence Force).

In 2002, Commonwealth, State and Territory Governments signed an Intergovernmental Agreement to enhance Australia's counter-terrorism capability, recognising that all Governments have joint responsibilities in this endeavour. The Commonwealth Government will have the responsibility for developing policy and strategies in a declared terrorist situation in consultation with affected States and Territories. States and Territories will deal with the situation in their own jurisdictions. There is also a National Counter-Terrorism Plan and Handbook detailing arrangements for managing a situation of this type. The Commonwealth Government's *Disaster Response Plan* outlines that Government's primary response to terrorist events.

---

15 DHA, 'Addressing Emerging or Potential Health Risks: Budget 2004-2005'.

16 DHA, National Emergency Medicines Stockpile Fact Sheet, http://www.health.gov.au, last updated 22 September 2004.

17 DHA, 'Addressing Emerging or Potential Health Risks: Budget 2004-2005'.

Hospitals and medical practitioners must be vigilant and notify authorities about patients presenting with symptoms for six specified diseases suspected of bioterrorist potential. Those diseases are smallpox, anthrax, tularaemia, botulism, plague and viral haemorrhagic fevers such as Ebola.[18]

Public health authorities have developed contingency plans to deal with threats posed by a bioterrorist incident or an outbreak of an infectious disease, however remote they might be. The plans are nationally coordinated by the Commonwealth DHA together with EMA and other Commonwealth agencies.

In addition, $1.6 million will be spent over three years to develop and introduce new health security legislation to improve the ability of the Government to protect the health of the Australian community and to respond to terrorist acts or naturally occurring epidemics. The adequacy of current legislation is being reviewed with a view to new laws dealing with protecting health, detecting disease and reporting.[19]

Ongoing research by Government and other bodies (e.g. the National Health and Medical Research Council, CSIRO) ensures that new ways of tackling disease, both existing and emerging strains, are continually forthcoming. Other agencies are also involved in protecting Australians, including the Australian Quarantine and Inspection Service (AQIS) which maintains surveillance at the border to ensure that potentially infectious goods (or insects such as mosquitos on goods such as car tyres) do not enter the country.

### 3.1.1 Communicable Diseases Network Australia (CDNA)

The CDNA comprises communicable disease authorities from Commonwealth, State and Territory health agencies and other experts. It provides leadership and coordination of communicable disease surveillance and actions to minimise the impact of outbreaks. Responses to national outbreaks of a disease are coordinated through the CDNA. Its work is supported by the Public Health Laboratory Network which provides national level expertise for laboratory diagnosis of disease. Both bodies provided responses to the anthrax related 'white powder' scares in 2001.

---

[18] Professor R Smallwood, Commonwealth CMO, 'Vaccines to combat bioterrorism', Speech at World Vaccine Conference, Sydney, 27 November 2002.

[19] DHA, 'Addressing Emerging or Potential Health Risks: Budget 2004-2005'.

### 3.1.2 National Notifiable Disease Surveillance System (NNDSS)

The NNDSS was established in 1990 and is administered by the Commonwealth DHA (under auspices of the CDNA). Since January 2001 each jurisdiction has been obliged to forward non-identifying data regarding disease notifications made to State and Territory health agencies pursuant to relevant public health legislation. This enables the detection of national trends and of outbreaks across borders and thereby allows for cooperative action.[20] More sophisticated surveillance methods are being considered and developed, particularly as there is no single nationwide system to monitor influenza (see below).

### 3.1.3 Australian Action Plan for Pandemic Influenza

The *Australian Action Plan for Pandemic Influenza* (*Australian Action Plan*) was released in 2003 to facilitate an organised national response to the possibility of an influenza pandemic and is consistent with the WHO *Influenza Pandemic Plan*. It was developed by the Influenza Pandemic Planning Committee of the CDNA. The *Australian Action Plan* provides specific advice regarding preparation for, and action in, such an event. For example, in terms of preparedness, it suggests that States and Territories establish a register of health professionals in urban, regional and rural areas, including those who are retired and who could be called on quickly in a pandemic event; and that accurate information about treatment of influenza should be readily accessible to the public through pharmacies, clinics, hospitals and doctors' surgeries. Policies on vaccine supply and distribution are being developed.

An important priority is the improvement of surveillance in order to provide timely advice to health departments, service providers and the public. There is no single national surveillance system to monitor influenza and a number of diverse systems currently operate (e.g. the NNDSS and the WHO annual report on strains; Sentinel surveillance by general practitioners in NSW and Victoria).[21]

The *Australian Action Plan* will be progressed primarily by the Commonwealth DHA in conjunction with State and Territory Governments and the National Influenza Pandemic Action Committee chaired by the Commonwealth CMO. State

---

[20] Summary data for notifications of communicable diseases reported to the NNDSS is available from 1991 for each State and Territory at http://www1.health.gov.au/cda/Source/CDA-index.cfm.

[21] DHA, *Australian Action Plan for Pandemic Influenza*, October 2003, pp 4-6. The Plan should be consulted for the full range of actions during all phases of the pandemic.

and Territory health agencies have prepared, or are also preparing, their own action plans.[22]

### 3.1.4 Australian Health Ministers' Conference

The Australian Health Ministers' Conference (AHMC) comprises all Australian Health Ministers and seeks to provide a consistent and coordinated national approach to the development of health policy and its implementation. The AHMC meetings discuss matters of mutual interest and determine public health policies. The Australian Health Ministers' Advisory Committee (AHMAC) is the main advisory body reporting to the AHMC and consists of the heads of health agencies of Commonwealth, State and Federal Governments. The AHMAC facilitates Governments' participation in national programs and works through the National Public Health Partnership Group.[23] The AHMAC has established a Disaster Management Policy Committee to improve health disaster preparedness in Australia (explained earlier).

## 3.2 LEGISLATIVE ACTION

Apart from Constitutional powers with respect to quarantine, the Commonwealth has limited powers in relation to public health matters. It is essentially a matter for the States and Territories to have appropriate public health legislation to manage communicable and infectious diseases.

The Commonwealth *Quarantine Act 1908* (s 28) does, however, enable the Commonwealth Minister for Health to apply a national approach to the control of a national epidemic. Under that legislation, the Governor-General can proclaim an epidemic if satisfied the epidemic is caused by a quarantinable disease or a danger of an epidemic exists. This enables the Minister to give directions and take necessary action to control and eradicate the epidemic or remove the danger of such. This can be through quarantine measures or measures incidental thereto. The Governor-General can also declare that any or all measures of quarantine prescribed by State legislation be suspended for the duration of the proclamation.

---

[22] For example, Queensland Health has a *SARS Action Plan* (December 2003, reviewed in February 2004) which outlines measures to be put in place at various levels of alert including accommodation in case isolation is needed, clinics, infection control procedures, disease surveillance, infrastructure, workforce capacity and other needs.

[23] National Public Health Partnership (NPHP), 'National Coordinating Mechanisms', at http://www.nphp.gov.au/publications

These powers have not been resorted to as yet. During the SARS outbreak, the few Australians involved voluntarily submitted to home isolation.[24]

The Commonwealth *Criminal Code 1995* (Ch 5, Part 5.3) also provides sanctions for terrorist activities harming Australians' health.

## 4 QUEENSLAND

While the *Health Act 1937* has served its purpose in supporting a vast array of public health measures that have protected Queenslanders from diseases, it has become dated and unwieldy, given that it has been amended 87 times.

In 1994, the Queensland Government began a full scale review of the *Health Act 1937* (Qld) and, due to the diverse range of matters dealt with by the Act, chose to divide the review into three areas. One major focus was on the public health provisions of the Act with one of the endeavours being to respond to recent concerns regarding infection control and public health emergencies coming from chemical, biological or radiological attacks.[25]

At an operational level, Queensland Health has an 'infection control' webpage (http://www.health.qld.gov.au/HealthyLiving/Infection_Control_HP.htm). It has links to a number of fact sheets relating to topics on diseases such as SARS, bird flu and dengue fever. The site provides information and links to documents concerning current issues (e.g. the *SARS Action Plan* and guidelines) and to contacts including the Communicable Diseases Unit (CDU). The CDU (at http://www.health.qld.gov.au/phs/cdu/) leads Queensland's strategy development, service planning, implementation and evaluation in notification, prevention and control of communicable diseases, HIV/AIDS, mosquito-borne disease and infection control.

Along with other health agencies throughout Australia, Queensland Health has programs and information to make health service providers and the general community aware of communicable diseases, how these are spread, and appropriate risk management procedures. Examples of such include the safe-sex campaigns and education to reduce the incidence of HIV/AIDS. An illustration of the effectiveness of response action taken by Queensland Health was observed in late 2002 when its rapid diagnosis and treatment prevented the spread of malaria beyond Cape Tribulation in Far North Queensland. A camper who was carrying infective malaria parasites after visiting Africa spread malaria to nine other

---

24 DHA, *Protecting Australia From Communicable Diseases: Everybody's Business*, p 41.

25 Queensland Government, Queensland Health, *Draft Public Health Bill 2005 (Qld) – Overview*, October 2004, p 6.

campers at the Cape Tribulation site. Mosquitoes around the campsite were sprayed and mosquito traps were laid near the homes of the nine infected people. The malaria-bearing mosquitoes were quickly detected and eradicated to remove the threat of further transmission.[26]

## 5 THE PUBLIC HEALTH BILL 2005 (QLD)

The Public Health Bill 2005 (Qld) (the Bill) was introduced into the Queensland Legislative Assembly on 22 March 2005 by the Minister for Health, the Hon Gordon Nuttall MP. It covers a range of public health issues including the management of public health risks (which will also enable prevention and control programs to be declared in the event of an outbreak or likely outbreak of disease transmitted by pests, such as dengue fever), environmental health event registers, management of notifiable conditions, child abuse and neglect, infection control and public health information. In addition, the Minister will be able to establish a public health inquiry to examine a serious public health matter (see **Chapter 7**). A modern framework for monitoring and enforcing compliance with the requirements of the Bill is contained in **Chapter 9** which reflects, to a large extent, similar powers given to authorised persons in other legislation dealing with health, environmental, and local government matters.

The Bill will replace the public health sections of the *Health Act 1937*.

## 6 MANAGEMENT OF NOTIFIABLE DISEASES AND NOTIFIABLE CONDITIONS

Powers such as requiring a person with a condition that poses a risk to the public to undergo examination, treatment and/or detention do have an impact on personal freedom and privacy. However, the availability of such powers as a 'fall back' position, after all attempts have failed to obtain the cooperation of the person concerned, is a recognised safeguard for public health. It may be necessary to act quickly and decisively to prevent serious and, possibly, fatal risks to the community. For example, persons with a potentially grave disease such as SARS need to be isolated and their contacts (i.e. persons with whom infected individuals have come into contact and who may have been exposed to the disease) quarantined for the duration of the infection period. Such restrictions on freedom of movement would be hard to accept in normal circumstances. Fortunately, people who were potentially infected with SARS voluntarily submitted to

---

[26] DHA, *Protecting Australia From Communicable Diseases: Everybody's Business*, p 23.

confinement for the duration of the infection period.[27] An appropriate balancing of individual and community interests is a necessary part of public health measures in any legislation.[28]

## 6.1 NOTIFIABLE DISEASES UNDER THE HEALTH ACT 1937

Under Part 3 of the *Health Act 1937*, there are two categories of diseases which may impact on public health because they are highly contagious, life threatening or an indicator of an environmental health risk.[29] The first is a 'notifiable disease' and the second is a 'controlled notifiable disease', the latter being of a type that has serious long-term deleterious consequences for public health.

A regulation may declare a disease or disability as a 'notifiable disease' and examples from Part 1 of Schedule 2 of the *Health Regulation 1996* (Qld) are AIDS, Japanese encephalitis, brucellosis, Chlamydia trachomatis infection, hepatises (A, B, C, D and E), HIV infection, measles, mumps, syphilis, tuberculosis and typhoid.

A medical practitioner examining or treating a patient who appears to have a notifiable disease must report (in the specified form) their belief to the chief executive of Queensland Health.[30] Failure to report is an offence.

The Department can than carry out investigations requiring (or an offence is committed) the person suffering the notifiable disease to provide certain information concerning possible communication of the disease to others. In addition, regulations can be made for things such as prevention of outbreaks, or requiring persons suspected to have a disease to stop working in prescribed works, and also about matters such as cleansing and disinfection. Moreover, the chief executive can require a public hospital to provide isolation and treatment facilities for such persons.

With Ministerial approval, the chief executive can establish and maintain or requisition or manage places for the temporary isolation and treatment of a person believed to have a notifiable disease and require the person to be treated, examined or tested there. If the person refuses, they can be ordered by a justice to be removed to that place or to a public hospital by a police officer. Reasonable force

---

27 DHA, *Protecting Australia From Communicable Diseases: Everybody's Business*, Preface.

28 Victorian Department of Human Services, 'Review of the Health Act 1958: A new legislative framework for public health in Victoria', *Discussion Paper*, August 2004, p 46, http://www.health.vic.gov.au/healthactreview/downloads/dhs_rha_paper.pdf.

29 Public Health Bill 2005 (Qld), *Explanatory Notes*, p 3.

30 Notification requirements apply to pathological examinations also: s 32A(4).

can be used to effect the detention. If a person refuses to obey the order, they commit an offence and are liable to a fine of up to $15,000.[31]

A 'controlled notifiable disease' is any of those set out in Part 2 of Schedule 2 of the Health Regulation 1996 and includes AIDS, hepatises A, B, C and D, HIV, leprosy and tuberculosis. Under s 48, it is an offence for a person to deliberately or recklessly put another person at risk of infection from such a disease (unless the other person knew about the infection and voluntarily accepted the risk of being infected) and such person is liable to a fine of $11,250 or prison for 18 months. To deliberately or reckless infect another person with a controlled notifiable disease carries a maximum penalty of $15,000 or two years in prison (unless the other person knew about the infection and voluntarily accepted the risk of being infected).

The Act includes provisions regarding disclosure and use of information relating to controlled notifiable diseases.

## 6.2 NOTIFIABLE CONDITIONS UNDER THE PUBLIC HEALTH BILL 2005

**Chapter 3** of the Bill deals with 'notifiable conditions' and 'controlled notifiable conditions' and replaces the provisions under Part 3 of the *Health Act 1937* concerning notifiable diseases and controlled notifiable diseases.

The Bill seeks to legislate in a more comprehensive and modern way in line with contemporary standards. Thus, the Bill aims to protect public health by managing highly contagious or life threatening diseases, but it is also recognised that there may be individual liberty and privacy issues involved. Accordingly, various mechanisms will be employed to strike a balance between these two objectives.[32]

Similarly to public health provisions of this type in some jurisdictions such as the Australian Capital Territory and Victoria, guiding principles for achieving the purpose of the notifiable conditions provisions are set out in **cl 66**. These state that the spread of the conditions should be prevented or minimised without unnecessarily infringing the liberty or privacy of individuals and that persons at risk of contracting the notifiable condition should take reasonable precautions to avoid contracting or being infected with it. People who suspect they may have

---

[31] See also s 37 (detention in hospital of person where there would not be proper precautions taken to avoid spread of disease if released and allowed to go 'home'); s 38 (cleansing and disinfection of premises etc); s 39 (power of local government regarding disinfection etc.); s 40 (compensation to owners where things destroyed to control disease etc.).

[32] Public Health Bill 2005 (Qld), **cl 65**; *Explanatory Notes*, p 3.

such a condition should ascertain if they do have it and what precautions they should take to avoid it spreading to others.

The Bill continues to provide for mandatory notifications, contact tracing, and detention and examination of persons but more safeguards surround the measures for dealing with people with these conditions.

Under **cls 63-64**, more stringent prerequisites apply to the making of a regulation prescribing a notifiable condition and a controlled notifiable condition than exists under the Act. Before a condition can be prescribed as a **notifiable condition**, the Minister has to be satisfied that the condition is a significant risk to public health.

Before a regulation can be made prescribing a notifiable condition as a **controlled notifiable condition**, the Minister must be satisfied that the condition may have a substantial impact on public health, and the ordinary conduct of a person with such condition is likely to spread the condition, and the transmission of it could, will, or is likely to, result in long-term or serious deleterious consequences for the health of other persons.

### 6.2.1 Notifiable Conditions Register

The chief executive of Queensland Health (the chief executive) will have to keep a **Notifiable Conditions Register** (the Register) of persons for whom notifications have been given (**Ch 3**, **Pt 2**, **Div 1**). Its purposes are set out in **cl 68**; they include to supply data to help monitor and analyse the incidence and patterns of notifiable conditions; to identify outbreaks so governments can take necessary action, and to help with tracing the transmission of notifiable conditions. Information that the chief executive already holds as a result of mandatory notifications under the *Health Act 1937* will be incorporated into the Register.

A number of statutory obligations are imposed on various persons to notify the chief executive about notifiable conditions (even in relation to persons who have died). The obligation is imposed on doctors, a person in charge of a hospital, and directors of pathology laboratories.[33] Non-compliance with the notification requirements is an offence. Statutory protections in **cl 75(7)** and **(8)** are provided to persons giving required further information (e.g. no breach of any code of professional ethics is committed for giving the required information to the chief executive).

A number of safeguards are set out (**Ch 3**, **Pt 2**, **Div 3**) regarding confidential information obtained under the notifiable condition provisions. The information

---

[33] Public Health Bill 2005 (Qld), *Explanatory Notes*, p 33. The nature of the obligation varies depending upon the diagnosis or nature of the notifiable condition. See **cls 70-73** for details.

must not be disclosed unless allowed under **cls 78-85**.[34] Note that information from the Register can be provided to the coroner or a police officer investigating the death of a person. **Clause 87** places limitations on the use of information from the Register in judicial or administrative proceedings apart from proceedings under the Bill.

Information can be obtained from the Register by a State entity if it is needed to investigate a serious offence provided that the chief executive and the entity have entered into an agreement as specified by **cl 84(1)(b)**. A 'serious offence' is an offence under s 90 of the *Prostitution Act 1999* which prohibits a person from working as a prostitute while the person knows that he or she is infective with a sexually transmissible disease. A 'serious offence' is also one under s 317 of the *Criminal Code* which imposes a life prison term if a person intentionally transmits a disease to another person.

### 6.2.2 Contact Tracing

**Contact tracing** powers of the chief executive are currently found in s 32B of the *Health Act 1937*. These powers are reframed, expanded and clarified in **Chapter 3**, **Part 3** of the Bill. The intention of contact tracing is to control the spread of the condition through measures which include locating all those people who may have been exposed to the condition. Contact tracing may also assist in finding the source of an outbreak. Under the Bill, a person appointed as a contact tracing officer (see **cls 90-97**) identifies persons who may have contracted a notifiable condition and persons who may transmit it to others with whom they have contact. The contact tracing officer also informs persons who may have contracted a notifiable condition so that they can seek examination and treatment and provides them with information that helps to prevent or minimise the spread of the condition. The officer can also seek information about how a person has contracted the condition or has, or may have, exposed others so that the transmission can be prevented or minimised.

Where a contact tracing officer reasonably suspects that a person has a notifiable condition, or has been in contact with a person who has or may have such a condition, and they have explained that information is required to attempt to control the spread of the notifiable condition, the officer may ask the person to provide information such as their name and address and the contact details and whereabouts of persons who may have given the person the condition or to whom the condition may have been transmitted. The person might also be asked about the circumstances of any possible exposure or transmission. The person might also be asked to verify the correctness of any of the foregoing information.

---

[34] See **cls 78-85** for the full range of circumstances when disclosure is permissible.

Failure to provide the contact information or evidence of correctness is an offence unless the person has a reasonable excuse (although self-incrimination is not a reasonable excuse).[35]

Note that the Bill goes further than the *Health Act 1937* by applying similar contact tracing information requirements to businesses where a person may have contracted a notifiable condition while receiving or providing goods or services (see **cls 101-102**). For example, there might be a food poisoning outbreak on an airline.[36]

**Confidentiality** provisions, similar to those applying to information on the Register, apply to limit the circumstances in which contact tracing information can be disclosed (see **cls 104-111**).

### 6.2.3 Controlled Notifiable Condition Orders

Pursuant to **Chapter 5**, **Parts 4** and **5**, the chief executive or a Magistrate will be empowered to make orders for managing 'controlled notifiable conditions' (defined earlier).

In practice, in the majority of situations, the infected or potentially infected person would voluntarily cooperate with doctors and health professionals to ensure that their condition is controlled and treated. Certainly, the powers provided in the legislation are more or less 'last resort' measures where other avenues to seek the person's consent and cooperation have been tried and exhausted. For example, it is expected that health professionals and service providers would explore counselling options with the person so they could be advised about their condition, what treatment options are available, risks associated with certain conduct and activities, and possible consequences.[37]

Education and information, particularly through the media, are also important at the initial stages. The effectiveness of public awareness and education campaigns

---

35 See also **cl 100** (use of contact tracing information or other evidence derived information in proceedings).

36 *Draft Public Health Bill 2005 (Qld) – Overview*, p 7. See also **cl 103** that enables a contact tracing officer to inspect certain limited health information held by Queensland Health where the officer cannot find a person to seek the contact information.

37 National Public Health Partnership (NPHP), *Principles to be Considered when Developing Best Practice Legislation for the Management of Infected Persons who Knowingly Place Others at Risk*, December 2003, p 8; Victorian DHS, *Discussion Paper*, p 66.

in the 1980s with regard to controlling the spread of HIV/AIDS was acknowledged around the world.[38]

### *Chief Executive Orders*

In certain circumstances, the chief executive may make a written order for the detention of a person at a public health sector service for a maximum of 24 hours. Those circumstances are that the chief executive:

- reasonably suspects that a person presenting to a public sector health service has or may have a controlled notifiable condition; and
- reasonably suspects that the person's condition, or their condition and likely behaviour, constitutes an immediate risk to public health (for example, if a person has active tuberculosis, any social contact with another person, such as catching the same bus, poses a risk of infection so the condition alone may justify the order. On the other hand, a person with HIV would not pose a threat by virtue of having the condition alone); and
- is satisfied that the person has been counselled or reasonable attempts at counselling have been made about the condition and its possible effects. This provision reflects the general practice that counselling is a first essential step in the management of the condition.[39]

It is an offence to fail to comply with such an order (maximum fine of $15,000) and it can be enforced by the person in charge of the health service using the force that is reasonable in the circumstances.

### *Magistrates' Orders*

The chief executive can apply to a Magistrate for certain controlled notifiable condition orders.[40] The first is an **initial examination order** which can be made if the Magistrate is satisfied of the same circumstances founding the chief executive's order (set out above) and, also, that it is necessary for the person to undergo a medical examination to determine if the person has the condition. That order may require the person to be detained at a certain place, and/or undergo a medical examination, and/or be isolated for a certain period. The use of this order would

---

38 DHA, *Protecting Australia From Communicable Diseases: Everybody's Business*, p 52.

39 NPHP, p 9.

40 Appeals against the Magistrate's decision are taken to the District Court: **cl 142**.

depend on the type of condition.[41] The period of detention is a maximum of 72 hours unless a longer period is necessary because of the nature of the condition – some conditions take longer to diagnose.

The second type of controlled notifiable condition order is a **behavioural order**. The Magistrate can make the order if satisfied about the same circumstances pertaining to the chief executive's order (set out above) and if also satisfied that the person needs to do, or not do, certain things to avoid the spread of the disease. The order may, among other things, require the person to undergo counselling and/or to not engage in certain conduct or visit certain places (e.g. not go to work), and/or for supervision of the person.

The third type of order is a **detention order** which can be made if the Magistrate is satisfied of the same circumstances applying to the chief executive's order (set out above) and that the person needs to be detained for a stated period to avoid the condition, or the condition and the person's likely behaviour, constituting a public health risk. The order may provide for a number of things such as a maximum of 28 days detention at a stated place and for medical examination or treatment.[42]

Various requirements regarding service and explanation about the medical examination or treatment to the person against whom it is made apply in relation to the Magistrates' orders (see **cls 120, 127** and **131**). For initial examination orders or detention orders, the person to whom they apply must be permitted to voluntarily submit to the medical examination but if the person does not take that opportunity, the doctor can undertake the examination or treatment using the reasonable force necessary in the circumstances. Note that both orders may also allow an 'authorised person'[43] to do things such as search a place to find a person subject to the order and the authorised person can use reasonable force in the exercise of the powers.

Non-compliance with a Magistrate's order is an offence carrying a maximum $30,000 fine. In addition, a Magistrate can issue an **apprehension warrant** if a person absconds while subject to an initial examination order or detention order (see **cls 136-139**).

**Clauses 140-141** establish procedures that authorised persons must follow before entering a place under an initial examination order or detention order or a warrant.

---

41 NPHP, p 10.

42 Pursuant to **cl 134**, each of the three orders can be extended on application by the chief executive but a detention order can be extended once only for not more than 28 days. The orders can also be revoked or varied: **cl 135**.

43 See **Ch 9**, **Part 1**.

### 6.2.4 Reckless Spread of Controlled Notifiable Conditions

It will be an offence, carrying a maximum penalty of $15,000 or 18 months in prison, for a person to recklessly put another person at risk of contracting a controlled notifiable condition. If the person recklessly transmits such a condition to someone, they are liable to a maximum fine of $30,000 or two years in prison. It is a defence if the other person knew about the person charged having the condition and voluntarily accepted the risk of contracting it.[44]

# 7 CHILDREN WITH CONTAGIOUS CONDITIONS

## 7.1 PROVISIONS ABOUT CHILDREN WITH DISEASES UNDER THE HEALTH ACT 1937

Under s 47 of the *Health Act 1937* a number of provisions are set out concerning school children who have prescribed diseases. It is an offence for a person to knowingly send to any school a child who has, or within a prescribed period has, suffered from such a disease unless a written certificate from a medical practitioner is presented to the head teacher stating that the child and their clothing is disease or infection free. No teacher must knowingly admit a child in such circumstances. If a notifiable disease occurs amongst children attending a school, certain authorised persons may enter any house and examine all or any children. A school can also be closed down if necessary for the purpose of prevention or suppression of a disease.

## 7.2 CHILDREN WITH CONTAGIOUS CONDITIONS UNDER THE PUBLIC HEALTH BILL 2005

**Chapter 5**, **Part 2** of the Bill deals with children at school or in child care with a **contagious condition** (i.e. a condition that has been prescribed by regulation as a 'contagious condition').

Firstly, a parent[45] must not send a child to school (State or non-State) or to child care if the parent knows, or ought to reasonably know, that the child has a contagious condition or if the person in charge of the school or the child care service has directed the parent to remove the child during the prescribed period for the condition: **cl 161**.

---

[44] **Ch 3**, **Part 6**. The situation is currently governed by s 48 of the *Health Act 1937*. See also s 317 of the *Criminal Code* (deliberate transmission or exposure).

[45] The term 'parent' is broadly defined under **cl 159.**

The period that may be prescribed by Regulation will vary depending on whether the contagious condition is vaccine preventable or non-vaccine preventable and will be based on the National Health and Medical Research Council's *Recommended Minimum Exclusion Periods for Infectious Diseases for Schools, Pre-Schools and Child Care Centres*. It is understood that a condition will only be prescribed as 'vaccine preventable' (e.g. measles, whooping cough) if the vaccine for the condition is listed in the Australian Standard Vaccination Schedule and it is freely available through government programs and preclusion is a recognised method of limiting the spread of the condition.[46]

If a teacher or carer reasonably suspects that a child has a contagious condition, they must tell the person in charge of the school (e.g. the principal) or of the child care service: **cl 162**. The person in charge may then advise the child's parents of their suspicion, and that other children may be at risk of contracting the condition, and of the parents' obligation not to send the child to school or to child care: **cl 163**. If the parents have been so advised and the child keeps attending the school or child care service, the person in charge may then direct the parent to remove the child for the prescribed period for that condition. The person in charge must consult a doctor or other authorised person before giving that direction: **cl 164**.

**Clause 165** applies where the person in charge of a school or child care service reasonably suspects that a child has not been vaccinated for a contagious condition and is at risk of contracting that condition because another child at the school or service has the condition. The person in charge can advise the parent of the child who has not been vaccinated of their suspicion and, if this has no effect, the parent can then be directed to remove the child for the prescribed period for the condition, provided a doctor or authorised person has first been consulted: **cl 166**.[47]

The chief executive can arrange for a doctor to examine some or all children attending a school or child care service if it is reasonably suspected that some or all of them may have a contagious condition but the consent of the parents must be obtained. The parents can have the child examined by another doctor but if they refuse to let the child be examined by any doctor, the parents may be directed to remove the child: **cls 167-168**. If the doctor's examination reveals that the child has, or may have, the condition, and the prescribed period applying for it has not ended, the chief executive may direct the person in charge of the school or child care service to direct the parents (in a notice containing specified information) to remove the child for the prescribed period: **cl 169**. A parent commits an offence if they fail to comply with the direction without reasonable excuse.

---

46 *Draft Public Health Bill 2005 (Qld) – Overview*, p 10.

47 See also **cl 169(1)(c),(d), (2)** (chief executive direction to preclude a child).

The circumstances for allowing a child back into a school or child care service are outlined in **cl 171**.

Various information sharing provisions are set out in **cls 172-173** to assist in administering the foregoing provisions such as, for example, the chief executive seeking information from the person in charge of the school or child care service about whether the children exposed to a contagious condition have been vaccinated against it. Confidentiality provisions also attach: **cls 174-178**. Note that if a person honestly performs a function, such as where a principal directs a parent to remove a child from a school, the person is not civilly or criminally liable: **cl 179**.[48]

If there is an outbreak of a contagious condition at a school or child care service, the chief executive can direct the person in charge about the ways of minimising the spread (e.g. preventing the sharing of eating utensils or drinking cups). If the person in charge does not comply, an offence is committed: **cl 180**. The Minister for Health can also close a school or child care service temporarily for up to a month if it is necessary to control an outbreak of a contagious condition. It is an offence not to comply with the Minister's order. In each situation, the chief executive or Minister, as the case may be, must consult with the Minister of the department administering the *Education (General Provisions) Act 1989*, the *Education (Accreditation of Non-State Schools) Act 2001* or the *Child Care Act 2002*: **cls 181-183**.

## 8 PUBLIC HEALTH EMERGENCIES

Under **Chapter 8** of the Bill the Minister for Health will have the power to declare a **public health emergency** if there has been an event or a series of events that may have a serious effect on the health of the Queensland public. Thus, the measures contained in this chapter will be limited to fairly extreme situations.

The measures contained in Chapter 8 were prompted by recent disturbing events such as the SARS outbreak and acts of terrorism overseas. Australian Governments have been considering the adequacy of legislative and operational responses to public emergency situations that may arise in this country. In Queensland, this has resulted in a greater statutory focus for dealing with emergencies and their consequences. For example, the *Disaster Management Act 2003* was passed to allow for the prevention, mitigation and management of the consequences of severe natural, non-natural, or terrorist related occurrences while the *Public Safety Preservation Act 1986* was amended in 2003 to deal with chemical, biological and

---

[48] Protections under this provision also apply in relation to providing information.

radiological emergencies.[49] The Chapter 8 provisions can operate alongside such other emergency legislation.

**Chapter 8**, **Part 2** deals with a declaration of a **public health emergency** by the Minister where it is necessary for measures to be taken to prevent or minimise serious adverse effects on human health. It must be declared by a written order after the Minister has consulted the chief executive and the chief health officer. The declaration must be published in the Government Gazette and publicised in the media. It must state the area to which it relates, the nature of the emergency, its duration and any conditions relating to the response effort. The order lasts for a maximum of seven days unless it is ended sooner or it is extended by regulation for up to seven days (which can be further extended for seven days at a time).

**Chapter 8**, **Part 3** enables a rapid response during a public emergency to situations where a certain medical condition has not already been prescribed as a controlled notifiable condition. That may be because it is unknown or is of an unknown strain or a variant of a known infectious condition; or is a previously known infectious condition or known strain or variant of it. If the Minister is satisfied that an **emergency notifiable condition** exists and it is appropriate, having regard to the nature of the declared public health emergency, the Minister may declare the emergency notifiable condition to be a **controlled notifiable condition**. The declaration must state the general nature of the emergency notifiable condition, such as signs and symptoms to look for. The declaration lasts for 28 days. Note that the provisions in Chapter 3 of the Bill, discussed earlier, relating to controlled notifiable conditions, will then be triggered.

Pursuant to **Chapter 8**, **Part 4**, the chief executive is in charge of the overall management of the response to the public health emergency and, under **Part 5**, may appoint specified and relevantly qualified and experienced persons as emergency officers, including medical officers. Thus, there will be two types of emergency officers – general and medical. Under **Part 6** emergency officers have power to enter places in the emergency area (subject to conditions) to save lives, prevent or minimise serious adverse effects on health, or do other things to relieve distress and suffering. They also have a range of emergency powers to facilitate response to the emergency if using them is reasonably believed to be necessary. Offences are created regarding failure to comply with certain requirements or directions of emergency officers without reasonable excuse or for failure to help an emergency officer.

**Part 7** gives emergency medical officers additional powers of detention of a person in a public health emergency area reasonably suspected to have a serious disease or illness that of itself, or together with the person's likely behaviour, poses an immediate public health risk and it is necessary to detain the person to effectively

---

[49] *Draft Public Health Bill 2005 (Qld) – Overview*, p 15.

respond to the emergency. An isolation area can be established for this purpose. The duration of the order is for up to 96 hours unless extended by a Magistrate and the order may be enforced (including the use of reasonable force) by the emergency officer or another nominated person. The emergency officer must request that the person to whom the order applies be medically examined as soon as practicable to determine if the disease or illness exists so they can be treated and to decide if they pose an immediate health risk. Non-compliance is an offence. A number of safeguards and appeal provisions are included in relation to the foregoing powers.[50]

A person who suffers loss or damage because of the use of powers under Part 6 or 7 is entitled to be paid just and reasonable compensation for the loss or damage except in certain situations: **Part 9**.[51]

## 9 PUBLIC HEALTH LEGISLATION IN OTHER JURISDICTIONS

Health legislation in all State and Territory jurisdictions contains provisions regarding control and surveillance of notifiable or infectious diseases. The extent of the powers to require a person to be examined or treated or detained appears to vary considerably. For instance, not all jurisdictions have powers to order treatment even if they do allow for detention or isolation. Safeguards of individual rights and for confidentiality and use of information also tend to differ. This lack of consistency makes cross-jurisdictional recognition of orders difficult when to have such recognition makes sense. A person who represents a public health risk in one jurisdiction surely continues to do so when they move interstate.[52]

### 9.1 NEW SOUTH WALES

The main legislation governing notifiable and infectious diseases is the *Public Health Act 1991* and the Public Health Regulation 1991.[53]

Under Schedule 1 of the Act, five categories of scheduled medical conditions are listed (as amended from time to time by regulation) according to the type of action needed to protect public health. Category 2 and Category 3 list notifiable

---

50 See also **Chapter 8**, **Part 7, Division 3**.

51 The procedures concerning compensation applications and appeals are in **cls 368-375**.

52 NPHP, p 2.

53 The Act is under review. The NSW Department of Health advises that the latest information regarding the review is an Issues Paper released in September 1999, at http://www.health.nsw.gov.au/csd/llsb/phareview/index.html.

conditions (by medical practitioners and laboratories); Category 4 consists of communicable medical conditions that may require involuntary public health action for treatment purposes (e.g. SARS, tuberculosis, typhoid); and Category 5 comprises conditions that are communicable, may lead to premature death, in respect of which there is no cure, and may also require involuntary action (e.g. HIV/AIDS).

The Director General of Health can require a person to undergo a medical examination if he or she believes on reasonable grounds that the person is suffering from a Category 4 or 5 medical condition. A public health order can be made where a person is believed to be suffering from such a condition and is behaving in a way that is endangering, or is likely to endanger, public health. That order, which can last for up to 28 days, can require a person to do, or not do, certain things, such as undergo certain treatment or counselling, or submit to supervision, or be detained for treatment. In respect of a Category 5 condition, a person can be detained (even if no treatment is ordered) for the duration of the order but the order must be reviewed by the Administrative Decisions Tribunal as soon as possible. The Tribunal can also extend the order for up to six months if the person would otherwise endanger public health. Offences are created for non-compliance and apprehension powers also exist.[54]

When a school principal or director of a child care facility finds out that a child is suffering from a 'vaccine preventable disease' (which includes mumps, measles, whooping cough) they must inform the district medical officer of health who can then direct the principal or director to inform the parent of the child and of every child at risk that the child will be excluded for the duration of the outbreak unless specified requirements are met and/or to take other specified action.[55]

The Minister can make an order declaring a public health risk and give directions to deal with it and any possible consequences. If a certain area is declared to be a public health risk, the Minister can take action to reduce or remove the risk to public health in the area, segregate or isolate inhabitants thereof, and prevent or conditionally permit access. The order lasts for up to 28 days.[56]

## 9.2 VICTORIA

The relevant legislation concerning infectious diseases is the *Health Act 1958* and the Health (Infectious Diseases) Regulations 2001. Schedules 2 and 3 of the

---

54 *Public Health Act 1991* (NSW), ss 22-36. See additional safeguards in s 23(3A).

55 *Public Health Act 1991* (NSW), Part 3A.

56 *Public Health Act 1991* (NSW), s 5.

Regulations list Infectious Diseases and Notifiable Diseases respectively. Notification of such conditions is mandatory and the requirements vary according to the type of disease. The Act states that the spread of infectious disease should be prevented or limited without unnecessary restrictions on liberty and privacy of individuals and requires persons who might be infected to take certain precautions (recognising the balance between individual liberty and protection of public health).

The Secretary of Health has power to order that a person be examined and tested for a prescribed infectious disease if the Secretary believes that the person has, or has been exposed to, such disease and poses a serious risk to public health. Detention for such purpose can be ordered if the person refuses to voluntarily undergo examination or testing. An order can also be made to restrict a person's behaviour or movements where counselling to achieve a change in behaviour has not worked. There is no specific power to order treatment. Apprehension powers and offence provisions are included. Rights of review and appeal to the Supreme Court are provided regarding isolation orders.[57]

Persons in charge of schools and child care facilities are required to inform a parent or guardian of a child of an outbreak of a vaccine preventable disease. The Regulations require a parent or guardian of a child infected with, or coming into contact with, a prescribed infectious disease (Schedule 6) to inform the school. This enables the person in charge to take action to reduce the spread of the disease or action that leads to exclusion of the child for the prescribed period of the infection.[58]

The Governor in Council can proclaim an emergency for the purposes of stopping, limiting or preventing the spread of an infectious disease. The proclamation must state the area to which it applies and lasts for two weeks, unless renewed for a further two weeks or earlier revoked. The proclamation then paves the way for various emergency orders such as preventing specified persons from entering or leaving the proclaimed area, arrest and detention without warrant etc.

The Victorian legislation is currently undergoing a review with the release of the '*Review of the Health Act 1958: A new legislative framework for public health in Victoria*' *Discussion Paper* in August 2004 and a new Bill is expected to be introduced into the Parliament in late 2005 or early 2006. Matters being considered include possible new provisions for contact tracing (as in the Queensland Bill); whether use of 'reasonable force' should apply to testing and examination; whether the types of restrictions on behaviour that may be ordered by the Secretary should be specified in the Act; whether a specific power to order

---

57 *Health Act 1958* (Vic), Part VI.

58 *Health Act 1958* (Vic), Part VII.

treatment should be included; what orders should be confirmed by a court or tribunal; and possible improvements to notification of notifiable diseases procedures.

## 9.3 OTHER JURISDICTIONS

The discussion below provides a very brief overview of provisions in other States and Territories focusing on powers to deal with persons who have, or are believed to have, infectious diseases (however named). In most jurisdictions there is power to exclude children with contagious diseases from school. The relevant legislation should be consulted for a comprehensive overview of all measures including provisions for enforcement, disclosure of information and keeping of registers.

In **Western Australia** the *Health Act 1911* Act provides a framework for notification of certain specified diseases and various powers to prevent the spread of 'dangerous infectious diseases' (so declared under the Act). Local laws can be made to prevent or control the spread (e.g. for destruction of animals, disinfecting persons and things). The Executive Director of Public Health may, if authorised by the Minister, exercise special powers including ordering that a person whom he or she suspects to be suffering from, or harbouring, a dangerous infectious disease submit to examination by a doctor and/or that a person be isolated. Persons suffering from any infectious disease may be removed to hospital for treatment.[59] Parents must not send a child to school who has or may have contracted a dangerous infectious or contagious disease. The provisions are rather dated and, in a number of respects, lack the safeguards recognising individual liberty and privacy seen in more contemporary legislation such as requirements for counselling as an initial step and confirmation of coercive orders by a tribunal or court.

**Tasmania's** *Public Health Act 1997* covers notifiable diseases (and mandatory reporting) and allows for the implementation of Guidelines and Codes of Practice.[60] The Director of Health can require a person to undergo a medical examination if the Director is aware, or suspects on reasonable grounds that, the person has a notifiable disease (i.e. a disease declared by public notice). Other powers include the ability to direct a person to be isolated or placed in quarantine (not exceeding 48 hours in the case of where the person is to be medically examined, otherwise not exceeding 24 hours unless a Magistrate orders otherwise), or under supervision, or to submit to further examination or treatment or counselling. A Magistrate may order detention or quarantine for up to 6 months and the Supreme Court can

---

59 *Health Act 1911* (WA), Part IX.

60 For example, *Guidelines for Notification of Notifiable Disease, Human Pathogenic Organisms and Contaminants 2000*.

authorise a longer period. Rights of appeal are provided. In addition, the Director may issue a public notice declaring an outbreak of a disease. The Director has the power to order the closure of a school or child care facility if satisfied it is necessary to do so to limit or prevent the spread of a notifiable disease.

The Director may also declare a public health emergency if satisfied it is warranted and it is not practicable to declare a state of disaster under other legislation.[61]

In **South Australia**, the relevant provisions covering notifiable diseases are contained in the *Public and Environmental Health Act 1967* and the Public and Environmental Health (Notifiable Diseases) Regulations 1989. The legislation requires notification of certain diseases and provides for some to be declared 'controlled notifiable diseases' (similar to the Queensland *Health Act*). In the latter case, the SA Health Commission can require persons suspected of being infected with such a controlled notifiable disease to undergo medical examination, and can give various directions to those persons regarding their conduct, or require them to submit to supervision. A Magistrate can issue a warrant if the person does not undergo the examination and the person may be detained for up to 48 hours for that purpose. A person can be detained by a Magistrate's warrant if considered necessary in the interests of public health for up to 72 hours unless extended. Safeguards are provided as are avenues for review and appeal.[62]

The pertinent legislation regarding notifiable and infectious diseases in the **Australian Capital Territory** is the *Public Health Act 1997* and the Public Health Regulations 2000. The Act sets out principles regarding the control and management of notifiable conditions (as determined by the Minister) recognising the need to balance broader community interests of health protection and the rights of persons with, or who may have, a notifiable condition. Mandatory notification requirements are imposed in accordance with a Code of Practice.

Contact tracing type provisions are set out. The steps that the chief health officer may take to notify other persons may include counselling. Powers exist to allow the chief health officer to issue directions if there are reasonable grounds for believing it is necessary to prevent or alleviate a significant public health hazard. Those directions can include requiring a person with a transmissible notifiable condition to undergo a medical examination or counselling, and confining a person or another person in contact with the first person to a place for a specified period. Application can be made to the Magistrates Court for an order that the direction be complied with.[63] Offence provisions and powers of enforcement also exist.

---

61 *Public Health Act 1997* (Tas), Part 3 and s 14.

62 *Public and Environmental Health Act 1987* (SA), Part 4.

63 *Public Health Act 1997* (ACT), Part 6.

The chief health officer can also issue a public health alert if it is necessary to take action to protect the public from a public health risk or provide a rapid response to it. In addition, if satisfied it is justified in the circumstances, the Minister can declare a public health emergency lasting for up to 5 days unless extended for an additional two days. The declaration triggers certain emergency actions reinforced by emergency powers.[64]

The **Northern Territory** has a specific *Notifiable Diseases Act 1981* which covers all aspects of notifiable disease as declared by the Minister. Mandatory notification provisions are set out. Contact tracing is also provided for. A medical officer from the Department of Health may give a written direction for the infected person to do certain things believed necessary for their treatment or to prevent the spread of the disease. The direction is subject to appeal. The chief health officer can order in writing that a person be detained until no longer infectious; that premises where the person was (e.g. residence, workplace, college) be closed or disinfected and other necessary measures. The chief medical officer can require a person or members of a specified class of persons to undergo medical examinations.

The Chief Administrator or the Minister can declare an area to be an isolation area for up to two months. That declaration gives the chief health officer a number of powers such as prohibiting the movement of persons or goods and requiring submission to medical examinations.

---

64 *Public Health Act 1997* (ACT), s 118A and Part 7.

## ACRONYMS

| | |
|---|---|
| **AHMC** | Australian Health Ministers' Conference |
| **AHMAC** | Australian Health Ministers' Advisory Committee |
| **AIDS** | Acquired Immunodeficiency Syndrome |
| **AQIS** | Australian Quarantine and Inspection Service |
| **CDNA** | Communicable Disease Network Australia |
| **CDU** | Communicable Disease Unit (Queensland Health) |
| **CMO** | Chief Medical Officer |
| **DHA** | Department of Health and Ageing (Commonwealth) |
| **EMA** | Emergency Management Australia |
| **HIV** | Human Immunodeficiency Virus |
| **HPAI** | Highly Pathogenic Avian Influenza |
| **NNDSS** | National Notifiable Disease Surveillance System |
| **SARS** | Sudden Acute Respiratory Syndrome |
| **TB** | Tuberculosis |
| **WHO** | World Health Organisation. |

# APPENDIX A – MINISTERIAL MEDIA STATEMENT

**The Hon. Peter Beattie MP, Premier & Minister for Trade**

**21 March 2005**

**Tough New Powers If State's Public Health Threatened: Beattie**

IPSWICH: The Health Minister will have stronger powers to prevent the spread of serious contagious diseases under new laws to be introduced to State Parliament this week, Premier Peter Beattie said today.

Speaking after Community Cabinet at Ipswich Mr Beattie said: "The government will modernise Queensland's main public health legislation to better prevent, control and reduce risks to public health from outbreaks of contagious diseases.

"We would hope that these powers are not needed, but the recent emergence of Avian Influenza (Bird Flu) and SARS highlights the need for Queensland to have stronger powers to respond swiftly and decisively to any public health emergency.

"The new laws will include the power for the Health Minister to declare a public health emergency if there has been an event or series of events that may have a serious impact on the health of Queenslanders.

"The declaration of an emergency can trigger a range of powers, allowing emergency officers to take action necessary to respond to the emergency.

"The Bill allows for a person suspected of having a controlled notifiable condition to be detained for up to 24 hours and for emergency officers to enter premises without a warrant or the consent of the occupier to avert or control public health risks.

"Under the Bill, and only in exceptional circumstances, police will be able to request information on the Notifiable Conditions Register in relation to the deliberate spreading of an infectious disease.

"After seeking appropriate medical advice, school principals will have the power to exclude children from school to minimise the risk of infection during an outbreak of a vaccine-preventable condition, like measles or whooping cough," Mr Beattie said.

The Public Health Bill, 2005 was developed following extensive consultation with local government, professional associations and the public. Health Minister Gordon Nuttall, who will introduce the Bill to the House, said: "The new laws would also extend to enhanced child protection, and complement recent legislative amendments to mandatory notification of child abuse or neglect".

"Child abuse is completely unacceptable and this Bill enshrines and strengthens the powers of appropriately qualified doctors to intervene in cases where a child has been or is at risk of being harmed," he said.

"A designated medical officer can order that the child be held at a health service facility for up to 48 hours days for examination and treatment, with possible extension for another 48 hours.

"To ensure that quick action can be taken in relation to these cases, a designated medical officer must notify the Department of Child Safety as soon as possible if a child is held."

Mr Nuttall said the Public Health Bill 2005 would replace public health provisions in the Health Act 1937.

21 March 2005

Media contact: Minister's Office 3234 1190.

Premier's office 3224 4500

# RECENT PARLIAMENTARY LIBRARY RESEARCH PUBLICATIONS 2005

**RESEARCH BRIEFS**

| | | |
|---|---|---|
| RBR2005/01 | *Standards for Young Workers: The Industrial Relations (Minimum Employment Age) Amendment Bill 2004 (Qld)* | Feb 2005 |
| RBR2005/02 | *Financial Literacy in Queensland: Bankruptcy Trends and Government Initiatives* | Feb 2005 |
| RBR2005/03 | *Identity Fraud* | Feb 2005 |
| RBR2005/04 | *Strengthening Child Pornography Laws: The Criminal Code (Child Pornography and Abuse) Amendment Bill 2004 (Qld)* | Feb 2005 |
| RBR2005/05 | *Objectionable Behaviour by Neighbours: Amending the Residential Tenancies Act 1994 (Qld) to Remove Problem Tenants* | Feb 2005 |
| RBR2005/06 | *Reform of Vagrancy Laws in Queensland: The Summary Offences Bill 2004 (Qld)* | Feb 2005 |
| RBR2005/07 | *A Range of Amendments under the Police and Other Legislation Amendment Bill 2004 (Qld)* | Feb 2005 |
| RBR2005/08 | *Building a bridge between university and employment: Work-integrated learning* | Mar 2005 |
| RBR2005/09 | *Liquor Amendment Bill 2005 (Qld): A 3am 'Lock Out' for Brisbane's Licensed Premises and State-wide Restrictions on Alcohol Advertising* | Apr 2005 |

*Research Papers are available as PDF files:*

- *to members of the general public the full text of Research briefs is now available on the parliamentary web site, URL, http://www.parliament.qld.gov.au/Parlib/Publications/publications.htm*
- *http://www.parliament.qld.gov.au/Library/Query.exe* – e-Documents & e-Articles – Quick display of Library's research publications

A Subject Index to Research Publications is available at the following site: http://www.parliament.qld.gov.au/Parlib/Publications/bysubject.htm

Parliamentary Library - Research Publications & Resources Telephone (07) 3406 7108
Orders may be sent to Karen Sampford, Karen.Sampford@parliament.qld.gov.au


## This Publication:

**RBR 2005/10** ***Notifiable Conditions and Public Health Emergencies under the Public Health Bill 2005 (Qld)*** **(QPL, April 2005)**