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International Health Regulations

Introduction

6.1 *The International Health Regulations (2005)* (IHRs) were adopted by the World Health Organisation Assembly in May 2005. The IHRs are designed to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with, and restricted to, public health risks, and which avoid unnecessary interference with international traffic and trade.[1]

Background

6.2 Australia was not a party to the previous IHRs which were adopted by the World Health Organisation (WHO) in 1969. The 1969 IHRs were originally intended to monitor and control six serious infectious diseases: cholera, plague, yellow fever, smallpox, relapsing fever and typhus. Under the current IHRs, only cholera, plague and yellow fever are notifiable, meaning that States are required to notify WHO if and when these diseases occur within their territory.[2] Australia

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1 Article 2; National Interest Analysis (NIA), para. 5.

2 World Health Organisation, viewed 16 August 2006, 'What is the history of the IHR?', <www.who.int/csr/ihr/howtheywork/faq/en/index.html>

advocated revising the 1969 IHRs, as among other things, they were not applicable to the spread of new or emerging diseases.[3]

> The revision was needed to address limitations in the current IHR(1969) identified through experience in detecting and responding to disease outbreaks with international dimensions…The focus on just three diseases (cholera, plague and yellow fever) by the IHR(1969) does not address the multiple and varied public health risks that the world faces today.[4]

6.3 Representatives from the Department of Health and Ageing informed the Committee that Australia played a lead role in the negotiation and drafting of the new IHRs.[5] The revised IHRs will replace the 1969 IHRs when they enter into force on 15 July 2007.[6]

The International Health Regulations

6.4 Under the revised IHRs, States are required to notify WHO of all events that may constitute a public health emergency of international concern.[7] A public health emergency of international concern is intended to be a broader trigger for notification and refers to a public health event determined:

- to constitute a public health risk to other States through the international spread of disease, and
- to potentially require a coordinated international response.[8]

6.5 In order to comply with the obligation to notify, States are required to develop, strengthen and maintain the capacity to assess, notify and report events in accordance with the IHRs.[9] States are further required to develop, strengthen and maintain their capacity to

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3 NIA, para. 9.

4 World Health Organisation, viewed 16 August 2006, 'Why were the IHR revised?' <www.who.int/csr/ihr/howtheywork/faq/en/index.html>

5 Ms Cath Halbert, *Transcript of Evidence,* 14 August 2006, p. 39; NIA, para. 9.

6 NIA, para. 3; World Health Organisation viewed 16 August 2006, <www.who.int/csr/ihr/howtheywork/faq/en/index.html>

7 Article 6.

8 Article 1 Definitions, 'public health emergency of international concern'.

9 Article 5.

respond promptly and effectively to public health risks and public health emergencies of international concern.[10]

6.6 To assist States in identifying a public health emergency of international concern, Annex 2 of the IHRs is a 'decisions instrument' and directs States to assess events based on the following criteria:

- the seriousness of the public health impact of the event
- unusual or unexpected nature of the event
- potential for the event to spread internationally and/or
- the risk that restrictions to travel or trade may result because of the event.[11]

6.7 States are required to consult with the WHO in relation to public health risks and events, including to comply promptly with requests for health information.[12] Where a State has notified the WHO of a public health emergency of international concern, the WHO will offer to collaborate with the State in assessing the potential for international disease spread, possible interference with international traffic and the adequacy of control measures.[13]

6.8 States are required to designate a National IHR Focal Point which will be responsible for communication with the WHO and coordination of the implementation of the IHRs.[14]

6.9 States are required to develop, within five years of entry into force, core capacities relating to surveillance, monitoring reporting, notification, verification and response, including various routine inspection and control measures for persons, goods and vessels at points of entry.[15]

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10 Article 13.

11 World Health Organisation, viewed 16 August 2006, 'What is meant by a "public health emergency of international concern" in the IHR(2000)?' <www.who.int/csr/ihr/howtheywork/faq/en/index.html>

12 Articles 6, 7, 8, 9 and 10.

13 Article 10.

14 Article 4.

15 Parts IV to VI and Annex 1.

Implementation

6.10 The Committee was informed that Australia has until 2012 to fully implements its obligations under the IHRs:

> Our legislative framework and existing administrative practices only need minor amendment to meet the requirements of the International Health Regulations. Consultations are already under way with states and territories to address any legislative and administrative reform necessary to implement the International Health Regulations.[16]

6.11 To ensure Australia's compliance with the IHRs, some changes to Commonwealth, State and Territory legislation will be required:

- amendments to Commonwealth, State and Territory privacy legislation to enable the exchange of health information between States and Territories, the Commonwealth and the WHO;
- amendments to State and Territory legislation (other than in Queensland and the Australian Capital Territory) to make the process of notifying relevant diseases more timely and flexible;
- possible additional legislative powers to ensure border agencies can implement obligations concerning exit-screening of people and goods, including the sanitisation of containers upon export; and;
- relatively minor, ad-hoc amendments to the *Quarantine Act 1908* and related regulations.[17]

Consultation

6.12 In October 2004, the IHRs Interdepartmental Committee (the IHRs IDC) was established to develop Australia's position for negotiating at the WHO's intergovernmental working group on the IHRs.[18]

6.13 The Australian Health Ministers' Advisory Council (AHMAC) tasked the new Australian Health Protection Committee (AHPC) to identify necessary changes to current State and Territory legislation and

16 Ms Cath Halbert, *Transcript of Evidence*, 14 August 2006, p. 39.

17 NIA, para. 13.

18 NIA, Consultation Annex, para. 2.

administrative practices to enable Australia to comply with the obligations contained in the IHRs.[19]

6.14 Consultation with the Commonwealth-State/Territory Standing Committee on Treaties (SCOT) was initiated in November 2004, the IHRs were listed on the treaty schedule for two SCOT meetings in 2005 but were not discussed, and SCOT was provided with a further update on the IHRs on 17 May 2006.[20]

Costs

6.15 Australia's obligations under the IHRs are not expected to require any significant funding increase as they will be implemented through existing surveillance and reporting mechanisms and administrative practices.[21]

6.16 Additional funding may be required to strengthen Commonwealth, State and Territory infrastructure to develop 'surge' capacity to respond to public health emergencies of international concern. Funding requirements are currently being evaluated.[22]

Conclusion and recommendation

6.17 The IHRs establish mechanisms for information exchange, joint risk assessment, liaison and coordination between the WHO and States Parties. The Committee recognises that the IHRs will prepare Australia to respond to a public health emergency or to combat a global pandemic.

Recommendation 6

The Committee supports the *International Health Regulations (2005)* and recommends that binding treaty action be taken.

19 NIA, Consultation Annex, para. 6.
20 NIA Consultation Annex, para. 5.
21 NIA, para. 21.
22 NIA, para. 22.

Dr Andrew Southcott MP

Committee Chair