THE INTERNATIONAL HEALTH REGULATIONS (2005)

(GENEVA, 23 MAY 2005)

[2006] ATNIF 12

Documents tabled on 8 August 2006:

National Interest Analysis [2006] ATNIA 27

with attachment on consultation

Text of the proposed treaty action

Background information:

Current status list of Parties

NATIONAL INTEREST ANALYSIS: CATEGORY 1 TREATY

SUMMARY PAGE

International Health Regulations (2005) (Geneva, 23 May 2005) [2006] ATNIF 12

Nature and timing of proposed treaty action

1. At its 58th meeting on 23 May 2005, the World Health Assembly (the WHA), the main constituent body of the World Health Organisation (the WHO), unanimously adopted Resolution WHA58.3 approving the Revised International Health Regulations 2005 (the IHRs). Australia was present at this meeting and voted in favour of the resolution.

2. The IHRs build on a previous set of IHRs that were adopted by the WHO in 1969. Australia was not a party to the previous set of IHRs and has been a strong advocate of their revision.

3. The IHRs will enter into force automatically on 15 June 2007 for all WHO Member States that do not reject them, or lodge reservations to them, by 15 December 2006. As the Australian Government sees no policy reason to lodge a reservation, it is likely that the IHRs will enter into force automatically for Australia on 15 June 2007. As such, ratification is not strictly necessary. However, for completeness, the Australian Government proposes to lodge an instrument of ratification with the WHO.

4. The IHRs will replace and modernise the provisions of a number of earlier treaties to which Australia is party[1].

Overview and national interest summary

5. The purpose and scope of the IHRs are 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.

6. The IHRs establish a single international code of procedures for routine public health measures at international border crossings. This is likely to provide a minimum safeguard against the international spread of disease, minimising the risk of disease introduction to Australia.

7. The IHRs also outline a framework for identifying public health risks and events of international concern, and for implementing a coordinated public health response to them. Through this framework, Australia will gain access to important information and assistance relating to public health risks. Australia would also be in a strong position to contribute to the formulation and implementation of a coordinated and integrated international response.

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[1] The *International Sanitary Convention* signed in Paris, 21 June 1926 [1928] ATS 3; the *International Sanitary Convention for Aerial Navigation*, signed at The Hague, 12 April 1933 [1935] ATS 22; the *International Agreement for dispensing with Bills of Health*, signed in Paris, 22 December 1934 [1935] ATS 25; the *International Agreement for dispensing with Consular Visas on Bills of Health*, signed in Paris, 22 December 1934 [1936] ATS 16; the *Convention modifying the International Sanitary Convention of 21 June 1926*, signed in Paris, 31 October 1938 [1939] ATS 4; the *International Sanitary Convention, 1944, modifying the International Sanitary Convention of 21 June 1926*, opened for signature in Washington, 15 December 1944 [1945] ATS 7; the *International Sanitary Convention for Aerial Navigation, 1944, modifying the International Sanitary Convention of 12 April 1933*, opened for signature in Washington, 15 December 1944 [1945] ATS 8; the *Protocol of 23 April 1946 to prolong the International Sanitary Convention, 1944*, signed in Washington [1946] ATS 3; the *Protocol of 23 April 1946 to prolong the International Sanitary Convention for Aerial Navigation*, 1944, signed in Washington [1946] ATS 4.

Reasons for Australia to take the proposed treaty action

8. The spread of infectious disease can cause severe social, economic and political disruption. This has an increasingly international dimension, as the increasing movement of people and goods across borders heightens the risk that disease may spread internationally, as is highlighted by recent experiences overseas with the SARS, Ebola and the Avian Influenza viruses. As such, a global response to public health risks and events which are of international concern is in Australia's interest.

9. The previous set of IHRs adopted by the WHO in 1969 do not provide such a response because their focus is narrowly limited to the spread of specified diseases, namely cholera, plague and yellow fever. They are not applicable to the spread of new or emerging diseases, such as Avian Influenza. Australia is not a party to the previous set of IHRs. However, Australia was a strong advocate for their revision and improvement, and was a key player in the negotiation and drafting of the new IHRs. As such, there is considerable expectation that Australia will become a party to the new IHRs and will implement in full the obligations contained within them.

10. Adoption of the IHRs would bring significant benefits to Australia. In meeting international standards for the prevention and control of the international spread of disease, and by cooperating with the WHO and States Parties, Australia will be well placed to respond to public health emergencies, and in particular to combat a global pandemic.

11. The IHRs establish mechanisms for information exchange, joint risk assessment, liaison and coordination between the WHO and the States Parties. By gaining access to these mechanisms Australia can contribute to the formulation and implementation of a coordinated and integrated international response to public health risks and emergencies. Access to these mechanisms would also provide Australia with information and technical assistance that could prove invaluable in formulating and implementing Australia's domestic response.

12. It is anticipated that the IHRs will be broadly supported by other WHO Member States, and even some States and non-State entities who are not WHO Members, which will enhance the benefits to Australia. Other States with which Australia engages in international trade and traffic would become obliged to take steps to prevent and control the international spread of diseases, which in effect minimises the risk of disease being introduced to Australia.

Obligations

13. Australia would assume the following key obligations under the IHRs:

a. to designate a National IHR Focal Point which will be responsible for communication with the WHO and coordination of the implementation of the IHRs (Article 4);

b. 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 (Parts IV to VI and Annex 1);

c. to develop the capacity within five years of entry into force to detect, access, notify and report on public health risks and events (Article 5 and according to the decision instrument in Annex 2) and to notify the WHO where such risks or events may constitute a public health emergency of international concern (Article 6);

d. to consult with the WHO in relation to public health risks and events, including to comply promptly with requests for health information (Articles 6 to 10); and,

e. to develop, strengthen and maintain the capacity to respond to public health risks and emergencies of international concern (Article 13), and to provide support to WHO-coordinated response activities to the extent possible (Article 13).

14. In the event of a public health emergency of international concern, Australia would remain free to implement additional health measures than those provided in the IHRs, so long as such measures are not more restrictive of international traffic, or more invasive or intrusive to persons, than reasonably available alternatives that would achieve the appropriate level of protection (Article 43). In determining whether to implement such health measures, Australia would be obliged to base its determination upon scientific principles, available scientific evidence of risk to human health and any guidance received from WHO.

15. Australia would be obliged to implement the IHRs with the principles of non-discrimination, transparency, full respect for human rights, and consistently with other international law instruments (Articles 3, 42 and 43). The IHRs also acknowledge that States have the sovereign right to implement their own health policies (Articles 3).

16. In the event of a dispute concerning the interpretation or application of the IHRs, States Parties do not have recourse to compulsory dispute resolution mechanisms. However, Article 56 allows States Parties to agree to negotiation, mediation or to referral to the Director-General for a decision and arbitration.

Implementation

17. The Office of International Law (OIL) at the Attorney General's Department has advised that existing Commonwealth, State and Territory legislation and administrative practices provide a strong foundation for Australia to comply with the obligations contained in the IHRs. However to ensure full compliance, it would be necessary to make some changes to legislation and administrative practices at both the Commonwealth and State and Territory levels.

18. The necessary legislative changes would be:

a. amendments to Commonwealth, State and Territory privacy legislation to enable the exchange of health information between States and Territories, the Commonwealth and the WHO;

b. amendments to State and Territory legislation (other than in Queensland and the ACT) to make the process of notifying relevant diseases more timely and flexible,

c. 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,

d. relatively minor, ad-hoc amendments to the *Quarantine Act 1908* and related regulations.

19. The Department of Health and Ageing (DHA) is engaged in ongoing consultations regarding changes to administrative arrangements.

20. It should be noted that the IHRs provide States Parties with five years from the date of the entry into force of the IHRs to develop the requisite capacities.

Costs

21. The obligations contained in the IHRs would be implemented through existing surveillance and reporting mechanisms and administrative practices. Therefore, significant funding increases are not anticipated.

22. However, some Australian Government agencies and States and Territory governments may be required to strengthen their existing infrastructures, and develop 'surge' capacity to respond to public health emergencies of international concern. Areas of increased capacity building may include border protection mechanisms such as the monitoring of outgoing containers and possible exit control of people and goods. The Australian Government is currently evaluating the need for increased funding to meet these requirements.

Regulation Impact Statement

23. The Office of Regulation Review has been consulted and confirms that a Regulation Impact Statement is not required.

Future treaty action

24. Pursuant to Article 54 of the IHRs, the WHA will periodically review the functioning of the IHRs. Article 55 also establishes a specific Review Committee, which may provide technical assistance and advice to either the Director-General, the WHA or to individual States Parties regarding possible amendments to the IHRs. Proposals for amendments to the IHRs must be submitted to the WHA for its consideration, either by the Director-General or a State Party. At least four months before the WHA considers the proposed amendments, the Director-General would communicate the text of any proposed amendment to all States Parties. Amendments to the IHRs which are adopted by the WHA would come into force for all States Parties on the same terms, and subject to the same rights and obligations, as the original entry into force of the IHRs.

25. Any future treaty action would be subject to Australia's domestic treaty-making process, including consideration by JSCOT.

Withdrawal or denunciation

26. Pursuant to Article 59 of the IHRs, WHO Member States have a specified period in which to notify the WHO of its intention to reject or enter a reservation to the IHRs, namely 18 months from the date of the notification by the Director-General of the adoption of the IHRs by the WHA. That period expires on 15 December 2006. Any rejection or reservation received after that period is deemed to have no effect.

27. Generally therefore, 15 December 2006 forecloses the possibility to denounce or withdraw at a later date. There would remain some limited options for suspension or termination, such as

a. by agreement between the States Parties or by between certain of the States Parties;
b. by the conclusion of a later treaty;
c. as a consequence of a material breach by a State Party; or,
d. as a consequence of supervening impossibility of performance or fundamental changes of circumstance.

28. Although not required at international law, Australia’s suspension or termination of the IHRs pursuant to these limited exemptions would likely occur after considerable consultations, in particular with the WHO. Any decision to suspend or terminate the IHRs would be subject to Australia's domestic treaty-making process, including consideration by JSCOT.

Contact details

Legislation Section
Office of Health Protection
Department of Health and Ageing (DOHA)

The International Health Regulations (2005)
(Geneva, 23 May 2005)

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CONSULTATION

1. In 2001 the Minister for Foreign Affairs and Trade gave his approval for the Department of Health and Ageing (DOHA) to take primary policy carriage on consultations relating to the revision of the IHRs.

2. In October 2004 an International Health Regulations (2005) Interdepartmental Committee (the IHRs IDC) was convened to develop Australia's position for negotiating at the WHO's Intergovernmental Working Group on the IHRs (the IHRs IWG) in Geneva in November 2004. The IHRs IDC comprised representatives from relevant Australian Government Departments in areas such as border protection and quarantine. A list of members is attached.

3. As a result of the work of the IHRs IDC, Australia's previous concerns were substantially addressed by the revision process. The proposed new IHRs are now compatible with, and will add to Australia's quarantine and border control measures, and ability to provide an effective and coordinated response to health emergencies (naturally occurring or man-made) requiring a national response.

4. Of the outstanding issues that were addressed at the IHRs IWG, Australia supported the extension of the scope of the IHRs to include accidental and intentional releases of chemical, biological and radio-nuclear agents; the ability of State Parties to apply health measures additional to those recommended by the WHO, both in the normal course of events and in an emergency; and the sovereign concerns in relation to the threshold of votes for State parties to successfully lodge a reservation to the IHRs.

5. At a meeting of the Standing Committee on Treaties (SCOT) on 25 November 2004, the Australian Government advised the States and Territories of its intention to adopt the IHRs. The IHRs were on the treaty schedule for the two SCOT meetings held in 2005, but were not discussed. At its last meeting on 17 May 2006, SCOT was provided with a further update on progress of the IHRs in the treaty-making process.

6. On 2 March 2006, the Australian Health Ministers' Advisory Council (AHMAC) tasked the new Australian Health Protection Committee (AHPC) to analyse the scope of necessary action required by States and Territories to enable Australia to comply with the obligations contained in the IHRs. During these consultations necessary changes to current legislation and administrative practices have been discussed and the AHPC has confirmed that jurisdictions have expressed willingness to comply with the IHR (2005).

7. A new IHRs IDC has been convened to progress consultations with other Australian Government agencies on specific policy issues to develop a whole-of-government position on the implementation of the treaty including areas such as border protection and quarantine.

International Health Regulations
Interdepartmental Committee
October 2004

Representatives

IDC Chair, Chief Medical Officer
Department of Prime Minister and Cabinet
Australian Quarantine Inspection Service
Department of Defence
Department of Foreign Affairs and Trade
Attorney-General's Department
Australian Customs Service
Department of Immigration and Multicultural and Indigenous Affairs
Department of Transport and Regional Services
Food Standards Australian New Zealand
Department of Health and Ageing

Status List of State Parties under the Constitution of the World Health Organisation 1946[2]

Afghanistan
Albania
Algeria
Andorra
Angola
Antigua and Barbuda
Argentina
Armenia
Australia
Austria
Azerbaijan
The Bahamas
Bahrain
Bangladesh
Barbados
Belarus
Belgium
Belize
Benin
Bhutan
Bolivia
Bosnia and Herzegovina
Botswana
Brazil
Brunei
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Canada
Cape Verde
Central African Republic
Chad
Chile
China
Colombia
Comoros
Democratic Republic of the Congo -
Republic of the Congo
Costa Rica
Côte d'Ivoire
Croatia
Cuba
Cyprus
Czech Republic
Denmark
Djibouti
Dominica
Dominican Republic
Ecuador
Egypt
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia
Fiji
Finland
France
Gabon
Gambia
Georgia
Germany
Ghana
Greece
Grenada
Guatemala
Guinea
Guinea-Bissau
Guyana

[2] There is currently no information available on which Member States will implement the IHRs. The WHA comprises representatives of each of the Member States of the WHO. WHA Member States unanimously voted to adopt the IHRs on 23 May 2005. WHO has 192 Member States, including all UN Member States except Liechtenstein, and 2 non-UN-members, Niue and the Cook Islands. Territories that are not UN Member States may join as Associate Members (with full information but limited participation and voting rights) if approved by an Assembly vote: Puerto Rico and Tokelau are Associate Members. Entities may also be granted observer status - examples include the Palestinian Liberation Organization and the Holy See (Vatican City).

Haiti
Honduras
Hungary
Iceland
India
Indonesia
Iran
Iraq
Ireland
Israel
Italy
Jamaica
Japan
Jordan
Kazakhstan
Kenya
Kiribati
Democratic People's Republic of Korea
Republic of Korea
Kuwait
Kyrgyzstan
Laos
Latvia
Lebanon
Lesotho
Liberia
Libya
Lithuania
Luxembourg
Republic of Macedonia
Madagascar
Malawi
Malaysia
Maldives
Mali
Malta
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia
Moldova
Monaco
Mongolia
Montenegro
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Netherlands
New Zealand
Nicaragua
Niger
Nigeria
Norway
Oman
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland
Portugal
Qatar
Romania
Russia
Rwanda
Saint Kitts and Nevis
Saint Lucia
Saint Vincent and the Grenadines
Samoa
San Marino
São Tomé and Príncipe
Saudi Arabia
Senegal
Serbia
Seychelles
Sierra Leone
Singapore
Slovakia
Slovenia
Solomon Islands
Somalia

South Africa
Spain
Sri Lanka
Sudan
Suriname
Swaziland
Sweden
Switzerland
Syria
Tajikistan
Tanzania
Thailand
Timor-Leste
Togo
Tonga
Trinidad and Tobago
Tunisia
Turkey
Turkmenistan
Tuvalu
Uganda
Ukraine
United Arab Emirates
United Kingdom
United States
Uruguay
Uzbekistan
Vanuatu
Venezuela
Vietnam
Yemen
Zambia
Zimbabwe