Frameworks for Australia's COVID-19 emergency public health response

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1. Background

As for so many countries around the world, the COVID-19 pandemic brought extraordinary changes to Australia's social and economic life over the space of just a few weeks in March and April 2020. Commonwealth, State and Territory Governments exercised public health emergency powers of which few Australians had previously been aware, regulating aspects of daily life that had largely been assumed to be beyond the interest or reach of Australian governments.

Cafes, restaurants, pubs, cinemas, libraries, concert halls, theatres, fitness centres, beaches and places of worship were closed. Almost all international travel from and to Australia was halted, with those allowed to travel to Australia (mostly Australian citizens, permanent residents and their immediately family members, returning home) required to go into quarantine in hotels and other accommodation facilities. The number of people allowed to attend funerals and weddings, and to gather together in other circumstances, was restricted. And finally, people were prohibited from leaving their homes other than for specified reasons – mostly to shop for food or other supplies; to receive or provide care; to exercise; and to participate in work or education that could not be performed from home.

These restrictions have begun to be eased over the last few weeks, at different times and different rates across Australia's six States and two Territories.

Australia's response to this point has largely been regarded as a success in containing the spread of COVID-19. In noting this success, I do not mean to ignore the many impacts that these emergency measures have had on individuals, families and communities through their enormous disruptions to social and economic life – including those who have lost jobs or businesses, whose mental health has been affected, who have endured medical treatment without the support of loved ones, who have suffered family violence, or who have lost educational opportunities. These impacts have been and will continue to be experienced differently by different people and groups, often exacerbating existing health, social and economic inequities. Many of these impacts will be long-lasting.

2. Legal frameworks for Australia's emergency public health response

Australia's public health regulatory responses to COVID-19 have been carried under two complementary – and, to some extent, overlapping – legal frameworks:

- State and Territory responsibility for infectious disease control
- Commonwealth responsibility for the management of biosecurity threats

[1] This paper draws on the author's blog COVID-19 and Administrative Powers in Australia published on adminlawblogorg on 30 March 2020.

2.1 State and Territory responsibility for infectious disease control

In Australia, States and Territories have primary responsibility for infectious disease control. This can be seen as part of the broader responsibilities of the States and Territories for the running of health systems and the management and delivery of health care.

In Victoria, for example, the *Public Health and Wellbeing Act* provides for a range of classic infectious disease control measures including for notification of cases of certain infectious diseases (ss.127 and 128);[2] examination and testing of individuals believed to have or to have been exposed to certain infectious diseases, and be likely to transmit the disease (ss.113-116); and for isolation of individuals with the disease (s.117). Other States and Territories have equivalent legislation.

Such powers are understood to be highly coercive, and a range of constraints are to govern their exercise. The Victorian legislation is to be administered with regard to a number of guiding principles (s.4(3)), including evidence based decision-making (s.5); accountability – that as far as practicable, decisions should be transparent, systematic and appropriate (s.8); and proportionality – decisions and actions that are proportionate to the public health risk, and not arbitrary (s.9). The management and control of infectious diseases are to be conducted in accordance with the principle that 'the spread of an infectious disease should be prevented or minimised with the minimum restriction on the rights of any person' (s.111).

In more 'ordinary' circumstances, the spread of infectious diseases is controlled through the application of the above kinds of control measures to a relatively small number of individuals. and/or in certain geographical locations where outbreaks have occurred or might occur without appropriate government intervention. But these are not ordinary circumstances. The population wide public health measures outlined earlier[3] have been introduced under 'emergency powers' triggered by the declaration of a 'state of emergency'. Strict frameworks govern virtually all aspects of these emergency powers including criteria for their exercise, and requirements for their contents, length (and variation, continuation and review), specificity, and presentation to Parliament: see generally Part 10, Div 3 of the Act.

In Victoria, the Health Minister may 'declare a state of emergency arising out of any circumstances causing a serious risk to public health': s.198. The term

> ***serious risk to public health*** *means a material risk that substantial injury or prejudice to the health of human beings has or may occur having regard to—*
> *(a) the number of persons likely to be affected;*
> *(b) the location, immediacy and seriousness of the threat to the health of persons;*
> *(c) the nature, scale and effects of the harm, illness or injury that may develop;*
> *(d) the availability and effectiveness of any precaution, safeguard, treatment or other measure to eliminate or reduce the risk to the health of human beings; (s.3 Definitions)*

The Minister makes such a declaration on the advice of the State's Chief Health Officer and after consultation with the Minister for Emergency Services and the Emergency Management

[2] Novel coronavirus 2019 (2019-nCoV) has been declared a 'notifiable condition' in Victoria.

[3] Other than those introduced by the Commonwealth Government – see Section 2.2.

Commissioner. It is the declaration of a state of emergency that activates the extraordinary 'public health risk powers' and 'emergency powers' of the State's Chief Health Officer (s.199). The population wide public health measures outlined above have been introduced by way of Directions made by the Deputy Chief Health Officer (to whom the powers of the Chief Health Officer have been delegated).

2.2 National responsibility for the management of biosecurity threats

In Australia, the Commonwealth Government has responsibility for the management of biosecurity threats, which covers threats to plant, animal and human life, through both diseases and pests. Responsibility for administration of the biosecurity framework is shared across the Ministers, Departments and statutory officers of Health, and of Agriculture, Water and the Environment.

The Commonwealth *Biosecurity Act* requires individuals entering Australia to provide information about their health (s.44) and provides for a range of 'biosecurity measures', such as managing contacts (s.85); remaining at a particular place of residence for a specified period and/or not visiting a specified place or class of place (s.87); and remaining isolated at a specified medical facility (s.97).

The Act provides for the declaration of a 'human biosecurity emergency' by the Governor-General if the Commonwealth Health Minister is satisfied that (s.475)(1)):

> *(a) a listed human disease is posing a severe and immediate threat, or is causing harm, to human health on a nationally significant scale; and*
>
> *(b) the declaration is necessary to prevent or control:*
>
> *(i) the entry of the listed human disease into Australian territory or a part of Australian territory; or*
>
> *(ii) the emergence, establishment or spread of the listed human disease in Australian territory or a part of Australian territory.*[4]

Such a declaration has been made with respect to COVID-19.

The declaration of a 'human biosecurity emergency' activates a wide range of powers that may be exercised by the Commonwealth Health Minister (s.477(1) and (3)) – known as 'emergency requirements' – to prevent or control the entry of the relevant infectious disease into Australian territory or a part of Australian territory; its emergence, establishment or spread in Australian territory or a part of Australian territory; or its spread to another country. Before determining such requirements, the Minister must be satisfied of all of the following (s.477(4)):

> *(a) that the requirement is likely to be effective in, or to contribute to, achieving the purpose for which it is to be determined;*
>
> *(b) that the requirement is appropriate and adapted to achieve the purpose for which it is to be determined;*
>
> *(c) that the requirement is no more restrictive or intrusive than is required in the circumstances;*

[4] Human coronavirus disease with pandemic potential is a listed human disease in Australia.

(d) *that the manner in which the requirement is to be applied is no more restrictive or intrusive than is required in the circumstances;*

(e) *that the period during which the requirement is to apply is only as long as is necessary.*

While the Commonwealth Health Minister's emergency powers are extremely broad, and would on their face extend to most of the population wide public health measures outlined earlier, in practice, relatively few of the public health emergency measures implemented in Australia have been introduced through these powers. This practice recognises that the primary responsibility for infectious disease management and control rests with the States and Territories, and that the Commonwealth Health Minister's powers should be exercised in relation to matters that are best addressed at the national level.

In accordance with this approach, the Commonwealth Health Minister has determined emergency requirements in relation to travel from Australia; retail outlets at international airports; international cruise ships; access to prescribed remote indigenous communities; use of data provided through the COVIDSafe app (the contact tracing app developed by the Commonwealth Government); and price gouging in relation to 'essential goods' such as face masks, disposable gloves, disposable gowns, goggles, glasses, alcohol wipes and hand sanitizer.

3. Reflections on the distribution of responsibility for public health emergency measures

The COVID-19 experience has shown the wisdom of primary responsibility for the public health aspects of infectious disease control lying with the States and Territories. This has become increasingly apparent as restrictions are being eased.

On 8 May, the National Cabinet – the newly established body consisting of the Prime Minister of Australia and Premiers and Chief Ministers of the States and Territories – agreed to a 'Roadmap to a COVIDSafe Australia' (Figure 1) – 'a pathway for jurisdictions to move towards COVID safe communities in a way that best suits their individual circumstances'.

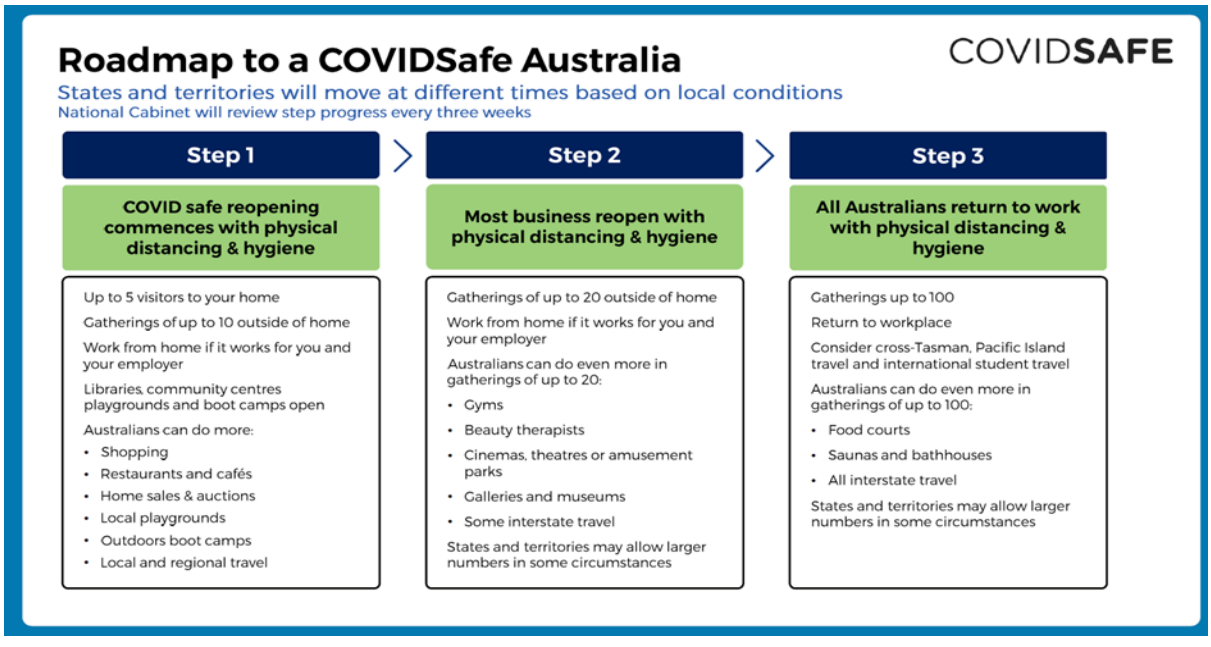

Figure 1: Roadmap to a COVIDSafe Australia

Under this Roadmap, 'States and territories will move at different times based on local conditions'. This has begun to happen, with significantly different approaches adopted by individual States and Territories. While in some respects, a uniform national approach might have been regarded as 'simpler', the COVID-19 situation, and related needs, are markedly different in each State and Territory.

Figure 2 shows the distribution of overall confirmed cases, new cases in last 24 hours and deaths across the States and Territories as at 5 June.

Source: Department of Health, States & Territories Report 5/6/2020

Jurisdiction	Total confirmed cases	New cases in last 24 hours	Deaths
Australia	7,251	11	102
ACT	107	0	3
NSW	3,110	4	48
NT	29	0	0
QLD	1,060	0	6
SA	440	0	4
TAS	228	0	13
VIC	1,681	3	19
WA	596	4	9

Figure 2: Total COVID-19 cases and deaths by states and territories

Approaches need to be carefully calibrated in each jurisdiction, taking into account these case numbers, and a range of related factors such as how much COVID-19 testing has been and is being conducted; what is known about how the virus is being transmitted and in particular the amount of community transmission (see Figure 3); and the capacity of the health system to respond to cases, including both health care capacity considered in its broadest sense (including healthcare workforce, availability of facilities and equipment), and public health capacity (including for enforcing quarantine and isolation requirements, and for rapid contact tracing).

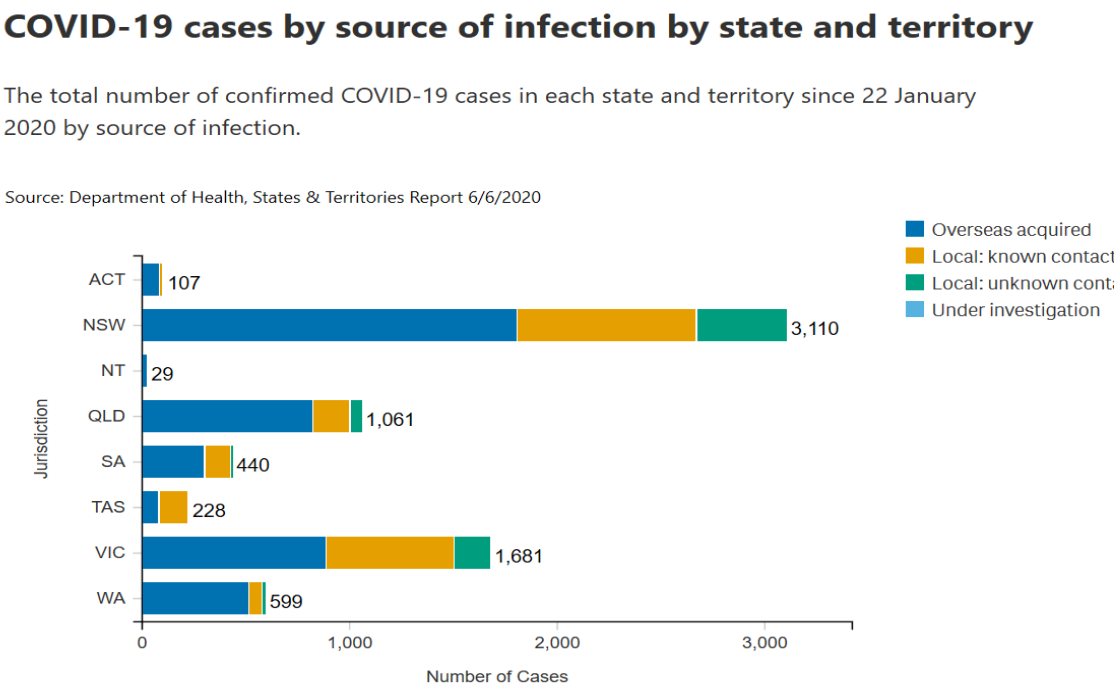

Figure 3: COVID-19 cases by source of infection by state and territory

Comparisons are inevitably made across jurisdictions, particularly where much of Australian news media is national rather than State/Territory-focused. Much can be learned from such comparisons – particularly through well-conducted research that can draw conclusions about the effectiveness of different measures adopted and of the determinants of effectiveness – but comparisons are not always put to helpful use. It has been interesting to observe, as the approaches taken in Australia's two largest States – New South Wales and Victoria – have begun to diverge, the development of a narrative that, in my view, pejoratively casts Victoria as moving more 'slowly' than New South Wales. Under this narrative, Victoria has been expected to 'justify' the relative slowness and caution of its easing of restrictions, as though the approach taken by New South Wales were necessarily the correct approach (or more correct), setting a standard against which Victoria's approach should be measured. I have not seen the alternate narrative – that New South Wales be expected to justify why it is moving more 'quickly' (or more 'recklessly') than Victoria.

One important area of tension across jurisdictions to note has been the introduction of border measures by four States and one Territory. Queensland and Western Australia have closed their borders to interstate travel, other than upon the granting of permission to individuals who meet certain highly restrictive criteria. The Northern Territory, South Australia and Tasmania have required all non-essential travellers to enter 14-day quarantine upon arrival. The Australian Capital Territory, New South Wales and Victoria have not introduced border measures. Such border measures are extraordinary in Australia. As of the time of writing, the Queensland and Western Australian measures were subject to High Court challenges as in breach of the Commonwealth Constitution.

4. Conclusion

As Australia emerges from its COVID-19 'lockdown', it is important to note that we are still in the early stages of our pandemic response, and that the future of COVID-19 in Australia, and its impacts, remain highly uncertain.

It is likely that the regulatory decisions that lie ahead for all Australian governments will be harder, rather than easier, than the ones taken so far. Governments will need to carefully weigh health, social, economic and environmental considerations that will have metrics that cannot easily be tallied or compared, and that will often pull in different directions. It is impossible to predict how many or which such decisions will end up before our courts, but it can be expected that at least some will.

Australia is fortunate to have extremely deep public health research capacity and expertise – and particularly in infectious disease control – to help guide decision-making. While such public health expertise, and the evidence and projections the expertise offers, do not magically yield answers to the difficult policy choices that need to be addressed, they do lie at the heart of sound decision-making.

As a lawyer who has long worked in public health, I often worry that some lawyers, including judges, have a tendency – not necessarily conscious – to frame the complex intersections of public health policy and law in ways that favour their training and preferred conceptual approach to the understanding of problems above those of others. This can sometimes manifest in casting complex policy problems primarily as legal questions of rights or liberties that can be divined upon, rather than wicked policy questions which fall to be addressed within legal frameworks, but for which there is no correct answer. COVID-19 has presented, and will continue to present, many challenges at these intersections. In approaching these challenges, it is important that lawyers reflect carefully on our roles, and particularly on our limitations.