Administrative process, practice and law in a pandemic — how much is enough?

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When the COVID-19 pandemic emerged in early 2020, the world of Australian public administration was required to adjust very quickly to a whole new operating environment. Ordinary processes were unsuitable for the task because they required behaviour which risked transmission of the virus, because they did not lend themselves to the type of innovation required and because they were simply not fast enough.

By straining, side-stepping or exempting activity from the ordinary processes, dramatic reforms and novel responses were able to be implemented in time to stem spread of the infection and counter the economic impact. This work all happened at enormous and uncharacteristic speed. Many of the usual brakes on action were absent: financial constraints were few, the government and consultative processes which usually accompany new measures were radically truncated or dispensed with all together, and the operation and availability of traditional public law accountability mechanisms was limited.

There will be ongoing debate about the content, manner and timing of the actions which Australian governments took in response to the pandemic. My starting point is that the fundamental role of government and government processes is to protect and promote the wellbeing of the people of Australia. The actions taken in response to the pandemic were designed and intended to this end and did in fact contribute to Australia's success in avoiding the death rate and health system impact seen in other countries — especially in 2020.

During this period, I was a senior executive in the Commonwealth Department of Health — acting as Secretary from February to July 2020 and then as Associate Secretary until mid-2021. In this role I was responsible for developing and implementing Commonwealth health policy and programs in accordance with my obligations as a public servant. I was the senior accountable officer for various health system issues concerning the pandemic, including the emergency measures under the *Biosecurity Act 2015* (Cth), the introduction of telehealth and electronic prescribing, the procurement of huge volumes of medical equipment, and collaborations with the states and territories on funding and practical activity to prepare for an increase in patients. Of course, I was supported on all these issues by a highly skilled and effective team which deserves credit for the successes. The views I express in this article are my own and not those of the department or the Commonwealth.

This paper focuses on actions taken during the first six months of the pandemic at a time when little was known about the virus, no guaranteed or even prospective vaccine had been developed and the widely reported impact on communities around the world, in such places as New York and Madrid, was stark and frightening.

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General challenges to ordinary process

While the case for speed and relaxed processes was clear and the aim widely supported, it is also undeniable that the approach increased the risk that measures would be ineffective,be financially wasteful, unduly impinge on the lives of Australians or have serious unanticipated consequences. There will be significant reflection over the coming period as to the extent to which these additional risks were realised and whether the benefits outweighed those realised risks. More fundamentally, the question remains whether the quality of decision-making was impaired by the increased speed and reduced process and the extent to which the processes which were reduced or avoided are required.

What is ordinary process?

It is important to be clear about what is being referred to as the ordinary processes which were, in large part, altered, expedited or dispensed with in early 2020. For the purposes of this article, 'ordinary processes' include formal processes, conventions and administrative practices in relation to: (a) Cabinet processes and the related processes of ensuring government authority; (b) processes which underpin and lead up to funding appropriations and allocations; (c) primary and subordinate legislative processes; (d) consultation processes within and outside government; (e) procurement rules; (f) administrative procedures; and (g) the pre-existing architecture of the Commonwealth, state and territory relations under the Council of Australian Governments (COAG) umbrella.

In relation to the health measures discussed in this article, many of these processes were dramatically truncated in terms of time and extent, temporarily suspended in the case of procurement rules and fundamentally abandoned and recast in the case of engagement with the states and territories.

Speed

A common element across all aspects was that decisions were made and measures implemented at a much faster pace than was usual. For example, the new Medicare items to support telehealth and COVID testing which were part of the initial health package of measures announced in early March 2020 were commissioned, developed, authorised and announced within a fortnight, processes which would usually take many months and perhaps years.[1] They were introduced without the customary level of financial assessment or comprehensive compliance arrangements. Such speed has natural disadvantages. Truncated, narrow or short consultation and processes mean that relevant views and alternative ideas may not be considered, mistakes may not be picked up and the opportunities to stress test or consider unintended consequences are reduced. There tends not to be the opportunity for external scrutiny. In addition, the relevant officials are tired and harried given the enormous workload and pressure.

1 A large number of health insurance determinations commenced on 13 March 2020 and the following days. See, for example, *Health Insurance (Section 3C General Medical Services — Specialist, Consultant Physician and Consultant Psychiatrist COVID-19 Telehealth Services) Determination 2020*.

However, speed also minimises the chance that new ideas are lost in the bureaucracy or delayed or blocked due by those with vested interests or who are simply conservative. Most of all, it enables urgent measures to be implemented when they are needed. The challenge in an emergency situation, and perhaps in all circumstances, is to balance the risk of things going wrong against the risks of acting too late or not acting at all.

Remote working and record keeping

A further notable unforeseen impact of the pandemic with respect to decision-making and, in particular, record keeping arises from the sudden and widespread transition to remote working. While public administration had been moving to electronic document management over numerous years, paper was still at the centre of many processes in early 2020. One basic example of the challenges was the need to sign and witness important contracts for the purchase of goods and services when the delegate is working from home. A printer and scanner overcome many of the challenges but the good practice of finding a non-family member to act as witness hits a major hurdle in the context of a household isolating and socially distancing from colleagues, neighbours and friends.

In addition, hard copy filing becomes all but impossible whether as the primary or back-up system and adherence to prior systems is difficult as senior staff act without the customary assistance of support staff. Unless an electronic record system is easy to use and senior officers are accustomed to using it themselves, scanning and email become the cumbersome work-around.

Coupled with this challenge in early 2020 was the move from physical face-to-face conversation to various online platforms. Many organisations rapidly implemented video conferencing systems (Webex in the case of the Department of Health) but even the herculean efforts of IT departments required implementation times. Teleconferencing was very frequent and the use of messaging services such as WhatsApp proliferated. Security was a further issue with the need to circulate classified documents much more quickly than had previously been the case. Again, the technical security protocols were not designed, or compatible with the need, to share information widely and quickly in order to provide a base for good decision making.

All these elements incorporated greater risk of mis-filed or lost documents in the paper trail and of security breaches in the sharing of confidential material. Again, the gravity of the potential health and economic outcomes of the pandemic meant that officials were faced with stark choices on which processes could or should be complied with.

The underpinning Biosecurity Act determinations

Declaration and determinations under the Biosecurity Act

Fundamental to the altered landscape was the Biosecurity Declaration (the Declaration) made under the *Biosecurity Act 2015* by the Governor-General on 18 March 2020[2] that declared that a human biosecurity emergency existed. The requirements for such a Declaration were, in summary, that a listed human disease posed a severe and immediate threat, or was causing harm to human health on a nationally significant scale, and the declaration was necessary to control the entry or spread of the disease.[3] This Declaration enlivened in the Minister the power to exercise special powers, in addition to those generally available under the Act.[4] These included providing emergency requirements by determinations — for example, preventing the movement of persons between places[5] — and directions to any person.[6] Before making such requirements or directions, the Minister was required to be satisfied that they were necessary, and the legislation required in summary a proportionality assessment of the measures.[7] Failure to comply was an offence.[8]

It is notable that the administrative processes established to support the making of the Declaration, and its amendment, by the Governor-General were observed in full. This reflected the gravity of the action and the magnitude of the powers assumed by the Minister as a result. The Declaration was published on the Federal Register of Legislation with an explanatory statement. Such declarations are not disallowable by the Parliament,[9] and because of this do not require a human rights statement of compatibility[10] and are not routinely assessed by the Senate Standing Committee for the Scrutiny of Delegated Legislation.[11]

Also notable is the fact that the powers were employed by the Minister on only a few occasions and in relation to limited circumstances. There were, of course, a wide range and large number of other COVID-19 instruments which have been usefully collected by the Senate Standing Committee for the Scrutiny of Delegated Legislation.[12]

2 *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020.*
3 *Biosecurity Act 2015* (Cth) s 475.
4 I note that early on some actions were taken under these general powers: see *Biosecurity (Human Health Response Zone) (North West Point Immigration Detention Centre) Determination 2020*.
5 Biosecurity Act s 477.
6 Ibid s 478.
7 Ibid ss 477(4) and 478(3).
8 Ibid s 479.
9 Ibid s 475(2) referring to the *Legislation Act 2003* (Cth) s 42.
10 *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth) s 9(1); L Fletcher, 'In These Uncertain Times: (A Lack of) Oversight of the *Biosecurity Act 2015* (Cth)' (2020) 41(2) *Adelaide Law Review* 641, 649–51.
11 Parliament of Australia, 'Role of the Committee', (Web Page) <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Scrutiny_of_Delegated_Legislation/Role_of_the_Committee>; Fletcher (n 10) 651.
12 Parliament of Australia, 'Scrutiny of COVID-19 Instruments', (Web Page) <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Scrutiny_of_Delegated_Legislation/Scrutiny_of_COVID-19_instruments>.

Determinations under the Biosecurity Act

There is no doubt that determinations under the Biosecurity Act and the Declaration are capable of making a substantial impact on the usual freedoms of Australians and others. The prohibition on Australians leaving the country and citizens of other countries arriving, which was implemented by a range of mechanisms including under the Biosecurity Act,[13] was a dramatic approach. However, this was arguably a predominant — and perhaps *the* predominant — measure which resulted in the low COVID-19 rates in Australia. Other determinations included the banning of cruise ships[14] and the closing of airport shops;[15] and a prohibition on price gouging for essential items.[16] Arguably, the bar on return of Australian citizens from India for 14 days made on 30 April 2021 represented the high water mark on Commonwealth infringement of usual freedoms.[17] This Determination was challenged in the Federal Court but upheld in the decision of *Newman v Minister for Health and Aged Care*.[18] Mr Newman was an Australian citizen and, although the Court held he had a common law right to return, this could be restricted by clear legislation, which the Act, Declaration and Determination provided. The Court noted that 'the power to restrict movement of persons across borders is a necessary incident of a power to prevent the entry of a human disease into Australia or to prevent the spread of such a disease from Australia to another country'.[19]

Interestingly one of the other arguments of the applicant was that the Minister could only have considered the relevant submission in relation to the Determination for one day, which Justice Thawley did not regard as surprising and he noted that indeed 'it would be hoped that the Minister acted expeditiously in an emergency situation'.[20] Indeed for many of the actions taken during that period, a full day of consideration would have been an unaffordable luxury.

The uses of the Biosecurity Act to make these determinations were not accompanied by a truncation or reduction in process other than in the sense that officials worked through the night to complete them. In this sense, the legislative basis precluded the risk taking discussed above and underscores the importance of non-discretionary requirements to limit arbitrary action. These instruments were also published on the Federal Register of Legislation with their explanatory statements and were similarly not subject to disallowance by the Parliament,[21] or required to be accompanied by a human rights statement of compatibility or routinely

13 *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Overseas Travel Ban Emergency Requirement) Determination 2020*; *Biosecurity (Exit Requirements) Determination*, made under the Biosecurity Act s 45(2); *Biosecurity (Human Coronavirus with Pandemic Potential) (Preventive Biosecurity Measures — Incoming International Flights) Determination 2021*.

14 *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements) Determination 2020*; then *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements for Cruise Ships) Determination 2020.*

15 *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirement — Retail Outlets at International Airports) Determination 2020*.

16 *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Essential Goods) Determination 2020*.

17 *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements — High Risk Country Travel Pause) Determination 2021*.

18 [2021] FCA 517 (Thawley J).

19 Ibid [83].

20 Ibid [58].

21 Biosecurity Act s 475(2) referring to the Legislation Act s 42.

assessed by the Senate Standing Committee for the Scrutiny of Delegated Legislation.[22] They were not required to be accompanied by a human rights statement of compatibility but nonetheless the Minister did give a response to a request by the Parliamentary Joint Committee on Human Rights.[23]

The fact that only a fraction of the potentially available power to restrain individual freedoms and activities was in fact activated can be attributed to the stringent legislative framework around the making of the Declaration and the determinations.

An example of relative restraint is evidenced by the determination to limit entry to remote Aboriginal communities on the basis of the elevated risk to people with high burdens of pre-existing disease and the difficulty in preventing spread in overcrowded conditions.[24] These limits were implemented in the context of close consultation with representatives of communities affected and the relevant states and territories and they were lifted immediately the relevant state or territory had alternative, less intrusive arrangements in place.

In the event, most of the stringent restrictions in place around Australia were effected under the relevant state and territory legislation and not under the Biosecurity Act at all. This was a fact not always well understood as is evidenced by the proceedings of the Senate Standing Committee for the Scrutiny of Delegated Legislation's inquiry into the exemption of delegated legislation from parliamentary oversight hearing on 3 September 2020.

In asking about the appropriateness of the Declaration and determinations under the Biosecurity Act not being disallowable, the then chair of the committee, Senator Ferravanti Wells, prompted the following exchange:

> Chair: … when you look at the consequences of those declarations not just at the Commonwealth level but also at the state level and then at the local level. Understandably, for Australians who have now been impacted at the local level as a consequence of those declarations, that nexus now needs to be explained to them. That's really why we are concerned, particularly in relation to what's happened with COVID.
> …
>
> Ms Edwards: Thanks, Senator; we welcome the scrutiny. I just want to make the point for those listening that many of the restrictions that have been imposed on Australians are under state legislation. Those restrictions that apply under the Biosecurity Act are reasonably limited and are really only to do with international travel, cruise ships and some price-gouging issues. There was the remote communities element, which was done at the request of the states early on, but the vast majority of the restrictions as we know them all over the country are under pre-existing, completely separate state regimes which have no nexus whatsoever to the Biosecurity Act.
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> Chair: … but as a consequence of what is declared at a federal level, without that federal declaration — correct me if I'm wrong, Ms Edwards — the states could not do what they've done. It's the declaration at the federal level, the Governor-General's declaration, that cascades then to enable the states to do their —
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> Ms Edwards: The Governor-General's declaration gave a sense that there was a national emergency, but their legislation, completely separate from anything the Commonwealth does, would enable them to do exactly what they've done already. There is no flow-on from us having made that declaration.

22 Parliament of Australia (n 12); Fletcher (n 10) 649–51.
23 Human Rights (Parliamentary Scrutiny) Act s 9(1); Fletcher (n 10) 649–51.
24 *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements for Remote Communities) Determination 2020*.

The context of Australian administrative law and the processes built into the Biosecurity Act itself were influential in limiting recourse to the powers available to the Minister. The potential for litigation was evident as was the scrutiny which would be applied to determinations. Of course, a culture in which individual freedoms are respected and emergency powers are viewed with caution also played a part.

Nonetheless many of the measures taken under the legislative frameworks of the Commonwealth and the states and territories caused hardship and distress to Australians. The restrictions on the ability of people to leave their homes, their area and their state or territory were significant, families were separated, funerals were missed and children missed learning and social opportunities. There is also considerable debate and discussion as to the relative impact of measures on different sectors of the community and the extent to which the negative impact fell disproportionately on already disadvantage communities and people and on women.[25] These implications of the policy decisions taken and the extent to which they were warranted and proportionate will be long debated and the lessons learnt will be incorporated into future planning. To date, no procedural or administrative law issue has successfully been employed to demonstrate a failure in decision making. They were fundamentally in the nature of political assessments, based on health and economic advice, and will be judged on those bases.[26]

Examples of pandemic-related activity where ordinary processes were challenged

Purchase and distribution of the national medical stockpile

Early in 2020, it became apparent that the availability of and supply chain for the purchase of personal protective equipment (PPE) would be an issue. The pre-existing system was for face masks for use in a clinical setting as well as gowns, goggles and other items to be purchased directly by states and territories for public hospitals and private clinics from established suppliers importing the items, primarily from China and primarily from Wuhan province. The supply was generally on an 'as needed' timing basis and limited products were stockpiled, especially given the fact that the usability of products is time limited due to degradation of elastic straps et cetera.

The use of PPE to prevent the spread of pathogens in a clinical setting is a core element of infection control practice. In 2020, there were frequent alarming reports of hospitals overseas facing a deluge of seriously ill COVID-19 patients without adequate supplies of PPE. It was in this context that fears that the Australian supply was inadequate grew.

The National Medical Stockpile is a longstanding facility which had traditionally been focused on preparation for a potential chemical or biological attack or disaster. PPE in the form of masks was held but in relatively small numbers in anticipation of a localised incident. It was not designed, and it did not hold anywhere near the numbers of PPE items which would be required, to support hospital operations and medical practice across the country.

25 See, for example, talk by Samantha Lee of Redfern Legal Centre at AIAL seminar entitled 'Administration in an emergency: Lessons learned from past two years', 15 June 2022.

26 See, for example, *Palmer v Western Australia* [2021] HCA 5; (2021) 272 CLR 505.

It was decided in February 2020 to embark on a procurement process to bolster supplies in order to help meet shortfalls or failures in direct supply and to distribute supplies as needed.

The process involved searching out providers, manufacturers and potential manufacturers of PPE. Supplies of ventilators and new treatments for which there were claims of efficacy for combatting COVID-19 were also sourced. This process was arduous and urgent as the Chinese supply of PPE was interrupted or diverted and countries all over the world scrambled to purchase product and quarantine local production for their own needs. The stockpile was dramatically expanded through contracts for much larger quantities than had ever been procured previously and which were much more rapidly drafted than ever before. Also under stress were the existing systems for storage, inventory and distribution. Bespoke and expensive initiatives to freight the material to Australia in the face of a collapse of supply chain were also implemented.

Decision-making was required also as to the identity of eligible recipients, and the timing and manner of distribution. In the initial period as supply was sourced and began to arrive in country, the quantities in the stockpile were carefully rationed to ensure that supplies were released in order of priority for infection control. At the same time, many groups who had previously not used PPE, or used it only in small quantities, such as police, aged care workers, transport workers and others in essential industries, were clamouring for supply in the face of the pandemic. While the fear was understandable, many of these calls were disproportionate with the risk of infection given the low level of infection in Australia and especially given the limited supplies. Resisting calls for PPE from those whom health experts advised were at lower risk was one of the most challenging tasks for public servants.

The purchasing program was also undertaken in the context of rapidly escalating prices which virtually ruled out a stable objective assessment of value for money in accordance with usual processes and benchmarking. The value for money requirement remained at the forefront of consideration but became less evidence based as the market operated as never before. The propriety of price was judged against the backdrop that doctors, nurses and other health workers might be without PPE and exposed to the virus.

The extent of cost recovery (if any) was also considered especially as many of the recipients were already funded by the Commonwealth for PPE — primarily public hospitals — or were ‘for-profit entities’ for whom purchase of PPE was a business expense.

Overall, the whole process posed extreme difficulties and required complex decision-making in the tightest of time frames.

Much of this process is recorded in the Australian National Audit Office's (ANAO) report *COVID-19 Procurements and Deployments of the National Medical Stockpile* published on Thursday 27 May 2021 whose conclusions included that:

> Procurement processes for the COVID-19 NMS procurements were largely consistent with the proper use and management of public resources. Inconsistent due diligence checks of suppliers impacted on procurement effectiveness and record keeping could have been improved.

And:

> In the absence of risk-based planning and systems that sufficiently considered the likely ways in which the NMS would be needed during a pandemic, Health adapted its processes during the COVID-19 emergency to deploy NMS supplies. Large quantities of PPE were deployed to eligible recipients. Due to a lack of performance measures, targets and data, the effectiveness of COVID-19 NMS deployments cannot be established.

In the event, no reports have been located of hospitals treating patients without PPE and distribution of PPE was made to aged care facilities, GPs, disability services and allied health providers among others. Initially, supplies were limited to locations where an outbreak was actually occurring or highly likely to occur, as wider distribution was limited by supply, but quantities increased as contracts were entered into and delivery into the stockpile realised.

It is well documented, however, that many organisations complained that they had not been provided with PPE or that the provision was too slow or in too small a quantity. Whether the decision-making as to allocation was optimal is unknown and possibly unknowable but the efficacy of the border closures on the spread of the disease meant that this was not tested to a high degree.

There was no suggestion of corruption in the contracting or unacceptable quality standards in the product. The main issue was that obtaining the product was difficult and appropriately managing distribution of limited supply required a hierarchy of priority.

The question which arises in an administrative law context is how should decision-making in these extreme circumstances be judged. The review of the activity is hampered by reduced capacity for record keeping and documentation and the virtually non-existent time available for planning before the need to act.

Stringently proper decision-making is necessary for the rule of law and for good governance and it is also arguable that better record keeping, more careful planning and a wider process of consultation would have yielded a more easily defensible program. However, it might also have led to lost opportunity to close contracts and a delay in the attainment of the supply actually required by Australia's health system facing the pandemic.

To be judged against a standard of ample supply and sufficient time for robust processes and record keeping would be a mismatch with the circumstances in which officials found themselves. In my view an alternative faster approach by which good decision-making can be safeguarded without the red-tape and time frame that has often been the case should be considered. In this regard, the tailored governance and decision-making framework — known as 'live assurance' — created and implemented while the pandemic was at its height will be a model for consideration noting that even this might be too slow in some crisis circumstances.

The question for administrative lawyers is whether the public law system is sufficiently flexible to recognise and facilitate optimal decision-making in circumstances where there is no certainty other than that there is grave risk to the population and where the decision-makers have limited time and resources to draw upon. It is certainly the case that timid decision-makers who are concerned with later analysis of their decisions are at least equally capable of contributing to the realisation of grave consequences. The risk of failing to act must be balanced against the risk of acting with truncated processes.

Other health system measures

A range of other significant policies were implemented during the first half of 2020. Some like telehealth and electronic prescribing were essentially the acceleration of initiatives which were in contemplation and the subject of discussion internal to government and consultation with stakeholders. Telehealth was initially permitted for patients and doctors who were infected with COVID-19 or at particular risk of severe disease, and quickly escalated into a universally available service. Many practitioners delivered telehealth solely or predominantly for periods during the following 24 months and the use of telephones greatly outweighed video consultations. The measure was implemented by the creation of numerous new Medicare rebate items which mirrored existing items other than that the delivery method was by telephone or video rather than face-to-face.[27] The items were initially required to be bulk billed (meaning that the charge was limited to the rebate amount paid by government) but this limit was later removed. A further major change to combat allegations of predatory low value care providers entering the telehealth market was to require that, in most cases, a patient could access telehealth with a practitioner (or practice) only where the patient had received a face-to-face service with that provider within the previous 12 months. This was to combat the potential for low quality telehealth-only services to flood the market and undermine the businesses of existing community-based practices.

Telehealth was immediately popular with practitioners and patients, both as a COVID-19 related measure and for general convenience, and rates of service rose quickly. To give a sense of the take-up, 95.9 million telehealth services were delivered to 16.8 million patients between 13 March 2020 and 12 February 2022, and 91,087 practitioners used telehealth services.[28]

27 See n 2.

28 Australian Digital Health Agency (Digitalhealth), 'Telehealth' (Web Page) <https://www.digitalhealth.gov.au/healthcare-providers/initiatives-and-programs/telehealth>.

Challenges with the rapid implementation of telehealth were significant and remain current including the need to ensure appropriate compliance arrangements, avoid over servicing and maintain quality. The rapid implementation also meant that previous plans to incorporate telehealth into a broader reform of primary health care including to increase continuity of care were largely overtaken.

The implementation of telehealth proceeded as a series of policy changes, and implementation adjustment as issues arose rather than through a global policy development approach in advance. Of course, regardless of the extent and time frame of pre-planning, the reality is that any major reform requires adjustment and monitoring and it is an open question whether the continual improvement would have been avoided by slower implementation.

There is no doubt that the reform was implemented much more quickly than had been expected or had been the case with earlier reforms due to the pandemic imperatives. Whether the speed brought with it disadvantages and unforeseen policy implications of greater impact and longer duration than would otherwise be the case and whether any such negative implications overshadowed the benefits remains to be considered by future review and assessment.

Commonwealth–state collaborative measures

A further area of activity and significant reform related to the areas of collaboration and cooperation between the federal government and the state and territory governments.

A new national partnership implementing a 50:50 share of the health costs of COVID-19 on public health measures (testing and contact tracing in particular) and public hospital costs incurred as a consequence of the COVID-19 case load was agreed in very short order and adjustments to the general cost sharing agreement for public hospitals was also rapidly negotiated.

A truly innovative agreement was also put in place to guarantee the financial position of private hospitals and clinics in the face of pauses imposed on elective surgery and to ensure that nursing staff, hospital and clinic facilities including ICU and equipment, such as ventilators and PPE, could be drawn upon by the public COVID-19 response if needed. The private hospitals and clinics entered into agreements with the relevant state or territory government with the costs of maintaining the arrangements borne by the Commonwealth using the National Partnership on COVID-19 Response Agreement[29] as a mechanism.

The speed at which these arrangements were put in place will be a long-term reminder of how efficient the federation can be. While much media attention and commentary has focused on the significant acrimony that arose from issues such as asynchronous border restrictions, it is important to note the high level of cooperation.

29 Federal Financial Relations, 'National Partnership on COVID-19 Response', <https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-04/covid-19_response_vaccine_amendment_schedule.pdf>.

A further characteristic of this period was for the bureaucracy surrounding interactions between the Commonwealth, states and territories to be greatly reduced. The complex processes of the longstanding committee of Health Department CEOs, the Australian Health Ministers Advisory Council (AHMAC), for example, were predominantly dropped and were replaced with frequent, good faith and collaborative teleconferences and intense bilateral telephone contact. To my mind, this approach was more productive, much quicker and fostered lasting trusting relationships and collaborations.

Conclusion

It was an unprecedented time and the potential health disaster facing the nation called for fast, innovative and novel initiatives.

Much of the legal framework served the process well with the Biosecurity Act emergency provisions working as intended and existing programs such as Medicare and National Partnership Agreement infrastructure lending themselves to fast scale-up and adjustment.

However, many processes were too slow, too paper based and too cumbersome to aid the politicians, officials, health practitioners and advisers charged with protecting the population and especially those most vulnerable to severe disease and death.

In addition, the quality of decision-making is yet to be judged but many of the tools usually used to make that assessment were casualties to the speed of action. Record keeping and traditional consultative processes were supplanted by WhatsApp, the exercise of judgement and informal collaborations.

Administrative law practitioners may need to consider how decision-making should be assessed in these circumstances. It is my view that, at its core, public decision-making should be judged by the impact on Australia and Australians. Where, for reasons forced by the circumstances, there are gaps in the process, or gaps in the documentation of that process, observers should have regard to the context and look to outcomes as the measure.