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An Analysis of Victoria's Public Health Emergency Laws: 1865-2020

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ABSTRACT

In response to the COVID-19 pandemic, the state government of Victoria in Australia has under the Public Health and Well-being Act 2008 declared a prolonged State of Emergency and given to the Chief Health Officer emergency powers to impose a draconian social and economic lockdown. While times of emergency will necessitate greater government action, there has been little scepticism to the assumption that the measures adopted are a normal exercise of government emergency powers, and the claim that the response has been proportionate to the threat has been in many cases been accepted at face value. The purpose of this article is to explore the history of public health emergency laws in Victoria since the Public Health Statute of 1865, to highlight how the modern emergency powers are ahistorical and atypical, while the costs of the policy response indicates that Victoria's modern public health legislation gives too much scope to ministers and the Chief Health Officer to exercise its powers without oversight and accountability. COVID-19 has exposed serious structural flaws in the legislation that require genuine reform and a reassessment of whether historical public health legislation achieved a more desirable balance of protecting public health and protecting the freedoms of Victorians.

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I INTRODUCTION

On 24 August 2020 the Premier of Victoria, the Hon Daniel Andrews MLA, announced that the state government would seek to extend the declared State of Emergency beyond the statutory limit of six months.[1] The State of Emergency was initially declared on 16 March 2020 by the Victorian premier to confer on the Chief Health Officer the power to 'do whatever is necessary to contain the spread of the [coronavirus] and reduce the risk to the health of Victorians.' These extraordinary powers have been used to impose the most severe regime of social and economic restrictions restriction in Australian history, while democratic government and the rule of law have been effectively suspended in favour of ministerial declarations announced in press conferences and rule by decree of the unelected Chief Health Officer.

The power to declare a State of Emergency is allowed under section 198 of the *Public Health and Wellbeing Act 2008* (Vic) ('PHWA') and such a declaration 'continues in force for a period not exceeding four weeks specified in the declaration'. The declaration may however be 'extended by another declaration for further periods not exceeding four weeks but the total period that the declaration continues in force cannot exceed six months.' However by August 2020 the state government asserted that it was not willing to allow the State of Emergency to lapse, and announced that it would seek to extend it effectively indefinitely. In a press conference, Premier Andrews said the government was not seeking an "unlimited extension," instead seeking to extend the time limit of State of Emergency's by an additional 12 months. However, the Premier conceded that it could be extended again if for instance a vaccine was not available.[2] While it had been speculated that the state government might use the powers under the

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[1] Daniel Andrews, 'Keeping the tools we need to continue Coronavirus fight' (Press Release, Premier of Victoria, 24 August 2020) (accessed 27 August 2020) <https://www.premier.vic.gov.au/keeping-tools-we-need-continue-coronavirus-fight>.

[2] Calla Wahlquist, 'Victorian plan to extend state of emergency by 12 months prompts human rights concerns,' *The Guardian*, 24 August 2020 (accessed 3 October 2020) <https://www.theguardian.com/australia-news/2020/aug/24/victorian-plan-to-extend-state-of-emergency-by-12-months-prompts-human-rights-concerns>.

declared State of Disaster to override legislation that is currently in force to negate the six month limit under the PHWA,[3] this step was ultimately not required to be taken. Parliament quickly accepted the *Public Health and Wellbeing Amendment (State of Emergency Extension and Other Matters) Bill 2020* which temporarily amended the PHWA so that the State of Emergency as it related to COVID-19 could stay in force for a total of 12 months. Each of the options explored by the government represented a unique threat to Australia's democratic norms of constitutional parliamentary government that that has not been seen since the constitutional crises in the Commonwealth in 1975 and New South Wales in 1932, both of which resulted in the vice-regal representative dismissing the governments led by Gough Whitlam and Jack Lang, respectively.

While times of emergency will often necessitate a more active government in the affairs of its citizens, there has been relatively little scepticism of the claim that the measures adopted, including business closures, stay at home orders to all Victorian residents, and restrictions on any small, private gatherings, are a proportional response to a public health crisis. The ongoing claim for the need to exercise these powers is reminiscent of the claim made by the Austrian economist, philosopher, and the 1974 recipient of the Nobel Prize in Economics, Friedrich Hayek in 1981. In his seminal work, *Law, Legislation and Liberty*, Hayek noted that nothing is so permanent as the "temporary" measures introduced to respond to an emergency:

> The conditions under which such emergency powers may be granted without creating the danger that they will be retained when the absolute necessity has passed are among the most difficult and important points a constitution must decide on. 'Emergencies' have always been the pretext on which the safeguards of individual liberty have been eroded – and once

[3] See for instance Chip Le Grand and Sumeyya Ilanbey, "We can't keep living like this': COVID-19 state of emergency opens political divide,' *The Age*, 23 August 2020 (accessed 27 August 2020) <https://www.theage.com.au/politics/victoria/we-can-t-keep-living-like-this-covid-19-state-of-emergency-opens-political-divide-20200823-p55oi7.html>.

> they are suspended it is not difficult for anyone who has assumed such emergency powers to see to it that the emergency will persist.[4]

This article will explore the background and evolution of the public health emergency powers in Victoria. For these purposes, public health emergency laws refer to the provisions in state legislation which purport to give to ministers or senior government officials the power to make declarations to respond to a perceived threat to the general health of the public.

As this article will show, the concept of public health legislation in Victoria has dramatically evolved, at first slowly during the 20th Century and more rapidly during the 21st Century. Also explored is the accelerated legislative change that took place in the 21st century and how the World Health Organization's *International Health Regulations (2005)* influenced that reform, raising questions about how international law is influencing domestic legislative change and the repercussions that has for individual liberties. Finally, the question of whether the illiberal response has been proportional to the threat will be considered.

II THE EVOLUTION OF VICTORIAN PUBLIC HEALTH EMERGENCY LAWS PRE-2000

Victorian health legislation has long made provision for authorities to deal specifically with persons infected with contagious diseases and for disinfecting property. Section 14 of *The Public Health Statute 1865* provides an early example of giving to central board of health the power to issue orders for the 'prevention as far as possible or mitigation of such epidemic endemic or contagious diseases' followed by a discrete list of responsibilities including the power to order the cleansing, purifying, ventilating and disinfecting of buildings, the speedy interment of the dead, and to treat infected persons. Part VI of the Statute is targeted to quarantining vessels, goods and passengers

[4] Friedrich A Hayek, *Law, Legislation and Liberty* (University of Chicago Press, 1981) vol 3, ch 17.

arriving from a place declared to be infected with an infectious or contagious disease that may be likely to be transmitted to Victoria, including under s 90 the right of the Governor-in-Council to make orders 'as shall be deemed expedient upon any unforeseen emergency' to 'cut off all communication between any persons infected with any such disease and the rest of Her Majesty's subjects'. A read of the Statute reflected the appropriate role of the state in mitigating a public health crisis, but was appropriately limited to a specific list of activities and responsibilities.

Section 14 was rewritten under section 15 of the *Health Act 1890* (Vic) ('1890 Act') to clarify that the powers were to be exercised in 'any emergency or sudden necessity' as determined by the Board of Public Health. Additionally the powers were defined to extend to do exercise any or all powers and duties vested in local councils by any Act of Parliament relating to the public health. Part VIII of the 1890 Act covers 'Infectious Diseases and Quarantine' which gave the Board of Public Health the powers to order sanitisation of property or detail or control the movement of infected persons, and imposed criminal penalties for failing to disinfect property when required to do so or infecting others or failing to notify the authorities of an infection.

By 1915 declaratory public health emergency powers were beginning to take a more concrete form. Section 5 of the *Health Act 1915 (No. 2)* (Vic) ('1915 Act'), the Board was permitted to, if authorised in writing by the Minister, exercise a range of 'special powers' in any case of emergency or sudden necessity. This included the power to declare land and buildings insanitary and forbid their use, order the destruction of insanitary property, isolate or disinfect persons or things as he saw fit and the inspection and examination of houses and buildings. In 1918 the 1915 Act was amended so that the Board could declare any specified area to be an infected area, from which no person was permitted to leave without the satisfaction of the chairman that the person was not liable to convey a contagious disease. Section 5 of the 1915 Act eventually became section 123 of the *Health Act 1919* (Vic).

The Health Acts were reconsolidated in 1928 and 1958, in both

cases providing an extensive list of responsibilities and permitted actions for the government to take to respond to infectious diseases. The last major revision to the public health emergency powers under the consolidated *Health Act 1958* (Vic) ('1958 Act') in the 20th Century took place in 1988 with the passage of the *Health (General Amendment) Act* (Vic). The Part dealing with infectious diseases was substituted and the power of the Governor in Council to proclaim emergency for the purposes of stopping, limiting or preventing the spread of an infectious disease was included in s 123. Notably the last iteration of emergency powers was quite narrow: when an emergency was proclaimed the Chief General Manager was empowered to make an order to prevent people from entering or leaving a proclaimed area, that persons of a specified class may be arrested without warrant and detained in the proclaimed area; that land, buildings or things in the proclaimed area may be seized to be used, disinfected or destroyed to stop the spread of infection, and any other provision required to ensure that the order is carried into effect. Importantly, s 123 provided for some democratic control of the emergency proclamation process. Subsection 123(3)(b) and (4) provided that a proclamation may be revoked by a resolution of either house of the state parliament, and that if the parliament was not sitting at the time the emergency was proclaimed that a petition of 20 members of the Legislative Assembly or 30 members of the whole parliament requesting parliament be summoned must meet as soon as possible.

III THE *INTERNATIONAL HEALTH REGULATIONS* (2005) AND THE *PUBLIC HEALTH AND WELLBEING ACT 2008* (VIC)

In the 21st century international law had begun to take a more prominent role in the domestic policy settings in relation to public health and the control of infectious diseases. In 2001 the federal Minister for Foreign Affairs and Trade gave approval for the Department of Health and Ageing to lead consultations relating to the revisions of the *International Health Regulations 1969* ('IHR69'). In October 2004 an

International Health Regulations (2005) Interdepartmental Committee comprising representatives from various Commonwealth departments was convened to develop Australia's position for negotiating at the World Health Organization's Intergovernmental Working Group on the IHRs in Geneva in November of that same year.[5]

The scope of IHR69, which the Commonwealth was not a signatory to, was limited to obliging member states to develop a reporting framework in relation to the occurrence in their territories of cholera, plague, and yellow fever. As a part of the Intergovernmental Working Group, Australia supported the extension of the scope of the IHRs. At a meeting of the Standing Committee on Treaties ('SCOT') on 25 November 2004 the Commonwealth government advised the States and Territories of its intention to adopt the IHRs.[6]

Australia was present at the 58th meeting of the World Health Assembly (the main constituent body of the World Health Organization) on 23 May 2005, which unanimously adopted Resolution WHA58.3 approving the revised International Health Regulations 2005 ('IHR05'). Although the justification for the revisions were said to be made on the basis that the focus on a small number of listed diseases meant the IHR69 did not address the multiple and varied public health challenges facing the world,[7] the World Health Organization nonetheless took the opportunity to call on states to expand their domestic capacity for dealing with public health issues. As provided under Article 13.1 of the IHR05:

> Each state party shall develop, strengthen and maintain, as soon as possible but no later than five years from the entry into force of these Regulations for that State Party, the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern as set out in Annex 1.

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[5] *National Interest Analysis* [2006] ATNIA 27, Attachment on Consultation [1]-[2].

[6] Ibid [5].

[7] World Health Organization, "Why were the IHR revised?" <www.who.int/csr/ihr/howtheywork/faq/en/index.html.>.

On 2 March 2006 the Australian Health Ministers' Advisory Council tasked the new Australian Health Protection Committee to analyse the scope of necessary action required by States and Territories to enable Australia to comply with the obligations contained in the IHRs. A National Interest Analysis of the IHR05 notes that necessary changes to current legislation and administrative practices had been discussed during consultations and the AHPC had confirmed that jurisdictions expressed willingness to comply with the IHR05. An Interdepartmental Committee was 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.[8]

In 2008 the Council of Australian Governments ('COAG') adopted the *Model Arrangements for Leadership During Emergencies of National Consequence* to facilitate a coordinated approach to emergency management. The Australian Health Protection Committee was established by the Australian Health Ministers' Advisory Council in 2006, representing each of the states and territories. The responsibilities of AHPC include *inter alia* reviewing and refining the framework for coordination of the health sector in responding to public health events of national significance. Additionally a National Incident Room has been established 'to ensure a nationally consistent and coordinated response to a national health emergency' and national capability audits have been undertaken to identify strengths and gaps in Australia's ability to manage and respond to health disasters.[9]

The consequence of these developments was to add significant pressure on the political system and reform environment to expand the legal measures for the prevention and control of infectious diseases, whereas there has been no corresponding pressure ensuring that legal reform retains individual liberties and ensuring that the role of government in re-

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[8] National Interest Analysis [2006] ATNIA 27, Attachment on Consultation [6]-[7].

[9] Belinda Bennett, Terry Carney, and Richard Bailey, 'Emergency powers & pandemics: Federalism and the Management of Public Health Emergencies in Australia,' (2012) 31(1) *University of Tasmania Law Review* 37, 47.

sponding to public health threats is appropriately limited. The outcome for this pressure is that, between 1997 and 2016, each State and Territory has revised their respective public health legislation..[10]

In Victoria, the legislative reform effort was led by Daniel Andrews, who was at the time the Health Minister in the Labor Government. Andrews introduced into the Victorian Legislative Assembly the *Public Health and Wellbeing Bill 2008* ('2008 Act'), which represents a significant expansion of the state's ability to control the movement and actions of its citizens in the event of a declared state of emergency. Under s 198 of the 2008 Act, the Minister for Health may, on the advice of the Chief Health Officer and after consultation with the Emergency Management Commissioner, declare a state of emergency 'arising out of any circumstances causing a serious risk to public health.' A declaration made under this provision 'continues in force for a period not exceeding 4 weeks but the total period that the declaration continues in force cannot exceed 6 months.'

Under the terms of the new laws, a state of emergency gives to the Chief Health Officer or authorised officer emergency powers under s 200(1) of the 2008 Act, including the power to

- ... detain any person or group of persons in the emergency area for the period reasonably necessary to eliminate or reduce a serious risk for public health;
- restrict the movement of any person or group of persons within the emergency area;
- prevent any person or group of persons from entering the emergency area;
- give any other direction that the authorised officer considers is reasonably necessary to protect public health.

[10] *Public Health Act 1997* (Tasmania); *Public Health Act 1997* (Australian Capital Territory); *Emergency Management Act 2004* (South Australia); *Emergency Management Act 2005* (Western Australia); *Public Health Act 2005* (Queensland); *Emergency Management Act 2006* (Tasmania); *Public Health and Wellbeing Act 2008* (Victoria); *Public Health Act 2010* (New South Wales); *Public Health Act 2011* (South Australia); *Public and Environmental Health Act 2011* (Northern Territory); *Public Health Act 2016* (Western Australia).

As can be observed, the powers in the 2008 Act to limit and restrict the movement of people from entering or leaving a public health emergency area was expanded to include the power to restrict the movement of people of within the emergency area. The importance of this should not be understated. Since it was not possible to control the movement of non-infected people within an emergency area under the 1958 Act, it would have been necessary for the government to declare a specific area if it intended to control the movement of people in a meaningful way. But having now the power to control the movement of people within an emergency area, there is no reason not to extend the definition of the emergency area to the entirety of the state. And this is exactly what occurred under the first declared State of Emergency of 16 March 2020.

A further substantive change that prepared the state for its departure from Victoria's democratic norms. Section 123(3) and (4), which gave the parliament the right to overrule the declaration of a state of emergency, was not included in the new public health legislation, and there is nothing comparable in the present law to restrain the government's exercise of its emergency powers.

IV WAS THE EXERCISE OF VICTORIA'S PUBLIC HEALTH EMERGENCY POWERS DISPROPORTIONATE TO THE PUBLIC HEALTH THREAT?

The test of whether a policy response is proportionate or disproportionate will turn on whether a policy response achieves a reasonable balance between its costs and the benefits that are derived from the policy, as well as a consideration of the means that were used to achieve the ends of the policy. In other words, in the context of a pandemic, proportionality should consider the type and rationale of the response, the means used to implement the response, whether the lockdown strategy was successful in Victoria or elsewhere, and a consideration of the economic and social costs of prolonged lockdown and isolation.

There can be no doubt that the Victorian state government has made

full use of the powers available s 200 of the 2008 Act. The declaration was made under s 198 on 16 March 2020, initially to implement and enforce the recommendations of the National Cabinet to prohibit large mass gatherings and to enforce quarantine measures for persons returning from overseas travel, both of which were implemented on 18 March 2020.[11] The strategy initially adopted by Australian governments was to flatten the curve, meaning to reduce the spread of the virus so that, rather than allowing the health system to overwhelmed at one, it would have time to prepare capacity to treat the patients who would inevitably be infected with the virus. Over time the strategy evolved to a strategy of suppression and de facto elimination of the virus. In August the Deputy Chief Health Officer said cases must be 'substantially lower' than they were at the time, meaning cases would need to be in the range of 'single digits or even low double digits' before restrictions could be eased.[12] Moving to a strategy that makes the timeline for relaxing restrictions uncertain and indefinite is not consistent with proportionality.

On 25 March 2020 *Prohibited Gatherings Directions* were issued limiting the number of people who could attend weddings, funerals, social sports gatherings. These directions were ultimately replaced with *Stay at Home Directions*. On 30 March 2020 the stay at home directions required every person in Victoria to limit their interactions with others by 'restricting the circumstances in which they may leave the premises where they ordinarily reside… and placing restrictions on gatherings.'[13] By 31 May 2020 the *Stay at Home Directions* were replaced by the *Stay Safe Directions*, loosening restrictions and permitting gatherings of 20 people in homes. However by 22 July Mel-

[11] 18 March 2020 – first mass gatherings direction was issued, limiting gatherings of 500 or more in a single outdoor space, and 100 or more in an undivided indoor space. These directions were "firmed" on 21 March.

[12] Lucy Mae Beers, 'Victoria coronavirus cases should be single digits to leave Stage 4, deputy chief medical officer says', *7news.com.au*, 20 August 2020 <https://7news.com.au/lifestyle/health-wellbeing/victoria-coronavirus-cases-need-to-be-single-digits-to-leave-stage-4-c-1253300>.

[13] *Stay at Home Directions*, 30 March 2020.

bourne and Mitchell Shire were placed on tighter restrictions again and a person was only permitted to leave their home if they 'wear a face mask at all times', unless an exception applies.[14] At 6pm on 2 August 2020, Victoria entered a State of Disaster and moved to the harshest round of restrictions to date, known as "Stage 4" lockdown which would go into force on 5 August 2020. Stage 4 includes imposing a curfew from 8pm to 5am, subject to exceptions for work, medical care and caregiving, limiting exercise to a maximum of one hour per day and no more than five kilometres from home; no weddings in Melbourne; and closure of early childhood services. The following day the Premier announced new restrictions for businesses and workers, listing which businesses were permitted to operate and which were to cease operations, and those which were required to operate under significantly different conditions.[15]

During the course of the pandemic, the State of Emergency has been extended on eight occasions and the emergency powers have been used to limit the movement of people in Victoria for extended periods of time. For instance, at one point in August, over five months after the initial declaration of a State of Emergency, people in Melbourne were directed to:

- observe a curfew which prohibited Melburnians from being in the public between 5am and 8pm;[16]
- stay at home subject to strictly limited exceptions for essential shopping and exercise for one hour each day within five kilometres of the persons home;[17]
- perform their work at home unless it was permitted to be done outside the home and the person is permitted to leave home for work;[18]

[14] *Restricted Activity Directions (Restricted Areas) (No 3)* and *Stay at Home Directions (Restricted Areas) (No 4)* and *Stay Safe Directions (No 7)*, 22 July 2020.

[15] Premier of Victoria, Statement from the Premier, media release, 3 August 2020.

[16] *Stay at Home (Restricted Areas) (No 13)*, 20 August 2020, cl 5 (1AF).

[17] *Stay at Home (Restricted Areas) (No 13)*, 20 August 2020, cls 5 (1AB), (1AD), (1AG), 6, 9.

[18] *Stay at Home (Restricted Areas) (No 13)*, 20 August 2020, cls 5(1), (1AF), 7, 8; *Restricted Activity (Restricted Areas) (No 8)*, 16 August 2020; *Workplace Directions*

- wear a face covering when leaving the house;[19]
- not open certain businesses to the public and observe strict limitations on other economic and social activities;[20]
- not visit hospitals and aged and other care facilities;[21]
- be detained when arriveing in Australia from overseas in a hotel for 14 days;[22] and
- limit the movement of any person diagnosed with COVID-19 and their close contacts.[23]

At the same time, non-metropolitan Victoria was under stage 3 restrictions which meant that persons in those areas were required to stay at home subject to similar restrictions explained above, wear a face covering when they left their home for a permitted reason, limit gatherings and restrict certain activities and businesses from being open to the public.[24]

Many of the isolation and social distancing rules have gone beyond what should be required under social distancing guidelines.[25] The Commonwealth Department of Health explain for instance that keeping 1.5 metres away from other people and practising good hygiene are essential to the social distancing which is necessary to meet the public health regulatory objectives. However many of the rules imposed by the Victorian government, such as prohibitions on outdoor recreational activities and mandatory face covering rules, have

(No 3), 16 August 2020; *Workplace (Additional Industry Obligations) Directions (No 4)*, 16 August 2020; *Permitted Worker and Childcare Permit Scheme Directions (No 4)*, 16 August 2020.

[19] *Stay at Home (Restricted Areas) (No 13)*, 20 August 2020, cl 5(6).

[20] *Restricted Activity (Restricted Areas) (No 8)*, 16 August 2020.

[21] *Hospital Visitor Directions (No 10)*, 16 August 2020; *Care Facilities Direction (No 9)*, 16 August 2020.

[22] *Detention – Detention Notice (No 7)*, 19 July 2020.

[23] *Diagnosed Persons and Close Contacts Directions (No 10)*, 16 August 2020.

[24] *Stay at Home Direction (Non-Melbourne) (No 3)*, 16 August 2020; *Restricted Activity Directions (Non-Melbourne) (No 3)*, 16 August 2020.

[25] Morgan Begg, *States of Emergency: An Analysis of COVID-19 Petty Restrictions* (Research Paper, Institute of Public Affairs, April 2020).

failed to take into account whether activities can be undertaken while maintaining 1.5 metre distancing. The night-time curfew is especially representative of the failure to be proportionate.

Meanwhile the provisions in the 1958 Act which gave the parliament some control over the state of emergency declaration but which were not carried over to the 2008 Act, has had grave consequences for the role of parliament during the COVID-19 pandemic. Aside from a brief resumption in June, the Victorian parliament has been mostly absent between 20 March and 30 August. When the parliament was to sit finally in August, the Legislative Assembly – the chamber which is based on the United Kingdom's House of Commons and is ostensibly meant to be the people's house and the chamber in which the government of the day is formed – was delayed again from sitting on the advice of the Chief Medical Officer. Although the Legislative Council did briefly sit on 5 August 2020 but the Minister for Health refused to answer any questions for her role in the pandemic response.

The Victorian restrictions were deeper and enforced longer than in any other state. In just over 10 years since 2008 Act commenced,[26] the emergency powers have arguably been used to their fullest extent with minimal oversight and accountability during the exercise of those powers. If the exercise of these powers has been disproportionate or if the damage exceeds the benefits then this is a challenge not to the exercise of the powers, but to the scope of the powers that has allowed them to be exercised in this way.

It will be some time before there is enough research to make conclusions about relative costs of lockdowns and social distancing restrictions, and whether the costs paid contributed meaningfully to managing the spread of COVID-19. There is already some conflicting evidence being published on the efficacy of the lockdown strategy. An analysis of Sweden in July 2020 produced a counterfactual to estimate that if the Scandinavian country had imposed a lockdown COVID-19 infections and deaths would have reduced by one third and one half

[26] *Public Health and Wellbeing Act 2008* (Vic) s 2(2) provided that the Act came fully into force by 1 January 2010.

respectively.[27] In contrast early research is indicating that there is no statistically meaningful relationship between coercive measures and lower COVID-19 related mortality. In one exploratory analysis of data on COVID-19 related deaths across 50 countries, the researchers found no association between the degree of lockdown and death rates.[28] On 6 August 2020, Christian Bjornskov, a professor of economics at Aarhus University in Denmark and the Research Institute of Industrial Economics in Stockholm published an early draft of a research paper which conducted a cross-country comparison asking whether lockdowns have been successful. Approaching the question using a standard approach and standard econometric tools used in economics and political science instead of epidemiological modelling or single-case studies, Bjornskov compared weekly general mortality rates in the first half of the year in 2017, 2018, 2019 and 2020 in 24 European countries that took markedly different policy measures against the virus at different points in time. 'Estimating the effects of these policy measures as captured by the Blavatnik Centre's Covid 19 policy indices and taking the endogeneity of policy responses into account, the results suggest that stricter lockdown policies have not been associated with lower mortality.'[29] On 27 July 2020 Jeffrey A Tucker, the editorial director from the American Institute for Economic Research, compiled statistics from 54 countries, measuring COVID-19 death per million around the world against the Oxford University's government stringency index. As Tucker posited at the time:

> If lockdowns achieved anything you could expect there to be some predictive power here. The more you lock down, the more lives you save. The lockdown countries could at least claim to have bolstered the lives of their citizens. What you

[27] Benjamin Born, Alexander Dietrich and Gernot Müller, 'The Lockdown Effect: A Counterfactual for Sweden,' (CEPR Discussion Paper No 14744, Centre for Economic Policy Research, May 2020).

[28] Rabail Chaudhry et al, 'A Country Level Analysis Measuring the Impact of Government Actions, Country Preparedness and Socioeconomic Factors on COVID-19 Mortality and Related Health Outcomes' *EClinicalMedicine*, 21 July 2020.

[29] Christian Bjornskov, 'Did Lockdown Work? An Economist's Cross-Country Comparison', 6 August 2020 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3665588>.

> see instead is: nothing. There is no relationship. There is the virus. There are lockdowns. The two operate as seemingly independent variables.[30]

The efficacy of the lockdown measures will become clearer over time, but what is clear now are the direct economic and social costs of locking down the economy. On 3 August 2020 the Institute of Public Affairs released calculations that the cost of Stage 4 restrictions would reduce the Gross State Product of Victoria by $3.17 billion per week.[31] This would result in an additional 300,000 jobs being lost in the state, in addition to the 168,600 that had already been lost to that date.[32] According to the Australian Bureau of Statistics, between 14 March 2020 (the week Australia recorded its 100th confirmed COVID-19 case) and the week ending 8 August 2020, payroll jobs in businesses that are Single Touch Payroll enabled had decreased by 4.9 per cent and total wages decreased by 6.2 per cent. For Victoria the change in payroll jobs was -7.8 per cent and the change in total wages was -6.7 per cent.[33]

The economic costs are only one direct cost of the lockdown. Another cost is the severe social costs and harm to mental health caused by prolonged isolation, reduced community connectedness, and extended joblessness. A report by the University of Sydney's Brain and Mind Centre claimed that in a best-case scenario of 11.7 per cent unemployment, 19 per cent youth unemployment, and a 10 per cent reduction in community connectedness, Australia is expected to see mental health-related emergency department presentations, self-harm

[30] Jeffrey A Tucker, 'The Bloodless Political Class and its Lack of Empathy,' *American Institute for Economic Research*, 27 July 2020 <https://www.aier.org/article/the-bloodless-political-class-and-its-lack-of-empathy/>.

[31] John Roskam, 'Stage 4 a $3.17 Billion hit per week to the Victorian economy' (Media Release, Institute of Public Affairs, 3 August 2020).

[32] Ibid. The calculation of 300,000 job lost is based on the peak 9 per cent drop to payroll jobs experienced during Stage 3 lockdown, as measured by the Australian Bureau of Statistics. Presuming Stage 4 has a similar impact, then at least 300,000 jobs will be lost.

[33] Australian Bureau of Statistics, *Weekly Payroll Jobs and Wages in Australia, Week ending 8 August 2020* (Catalogue No 6160.0.55.001, 25 August 2020).

hospitalisations, and suicide deaths to each increase by between 11.4 and 13.7 per cent.[34] In Victoria in August the Minister for Mental Health announced that in the six weeks prior, there had already been a 33 per cent increase in people under the age of 17 presenting at emergency departments for self-harming, and a 9.5 per cent increase across all age groups when compared to the same time period in 2019.[35] This is a difficult and sensitive topic and while it cannot simply be converted into an economic measure in the way that unemployment rates or the gross state product is, but it must be assessed as an important and direct cost of the lockdown. However, the ministers comments had dropped off the news cycle nearly as soon as it appeared, drowned out by rolling coverage of infection numbers – the overwhelming majority of which will not result in hospitalisation, stays in ICU, or deaths.

In Victoria the evidence is building that the lockdown is objectively a disproportionate response to the COVID-19 pandemic. Strict lockdowns have not been proven to be especially effective in managing the spread of the virus, the specific policies have gone beyond what would be required to ensure 1.5 metre social distancing; parliamentary processes of accountability, scrutiny and review have been set aside for several months; and there has been a failure to consider the steep costs of lockdown. A failure to even consider the costs of a policy is an indicator that the policy is disproportionate.

The policy response in Victoria has been disproportionate to the threat, but the question of whether the law has been exercised in a proportionate way should not ignore the question of whether the law gives too much scope to the government to misuse it in this way. Emergency powers in Victoria are not new but the powers under the 2008 Act are a modern expression of emergency powers which allow for uniquely draconian rule making.

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[34] Jo-An Atkinson et al, *Road to Recovery: Restoring Australia's Mental Wealth: Uncovering the Road to Recovery of our Mental Health and Wellbeing using Systems Modelling and Simulation* (The University of Sydney, Brain and Mind Centre, 27 July 2020).

[35] See Sumeyya Ilanbey, '"Your life is important": $60 million coronavirus support package for mental health,' *The Age*, 9 August 2020.

It is in this context that Victoria has been likened to a 'police state'[36] and which by September become even an more apt description. On 17 September 2020 the government introduced into the Legislative Assembly the COVID-19 Omnibus (Emergency Measures) and Other Acts Amendment Bill 2020, which passed the same chamber a day later. The purpose of the bill is to amend the PHWA give the government the power to appoint any person the Secretary of the Department of Health and Human Services deems to have the right 'attributes' to exercise emergency powers and to effectively detain any person indefinitely based on subjective criteria. It has been widely criticised and was described by the Institute of Public Affairs as the 'most significant violation of human rights in Australian history.'[37] As of writing the Legislative Council has not yet voted on the proposed legislation, but a central part of the debate must be not whether an expansion of the public health legislation can be justified, but what the limits of public health laws more generally should be.

An honest appraisal of the 2020 COVID-19 pandemic will show that the PHWA has had a deleterious impact on Victorian society, democracy, and economy. Currently the law, by giving to the Chief Health Officer and government ministers the power to rule by decree for an extended period of time, the legislation has failed to balance the legal rights and individual freedoms of Victorians in the process. The provisions under ss 198 and 200 of the PHWA are simply expressed too broadly. The specific power to control the movement of people within an emergency and the open ended power to declare any direction to respond to a public health threat has empowered the Chief Health Officer to only manage the public health threat but imposes no obligation to consider the costs of the directions.

These are serious structural flaws in the legislation that are in need of genuine reform and a reassessment of whether the emergency powers in historical legislation achieved a more desirable balance between the protection of public health and maintaining Victoria's freedoms.

[36] See for instance, John Roskam, 'Beautiful one day, police state the next,' *The Australian Financial Review*, 3 April 2020.

[37] Morgan Begg, 'Letter to Members of the Legislative Council of Victoria,' (Institute of Public Affairs, forthcoming, 2020).