

SECURITIZATION AS A MECHANISM IN AUSTRALIA’S BIOSECURITY LAWMAKING AND DISEASE RESPONSE

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Statement of Original Authorship

I, Timothy Vines, declare that this thesis is the outcome of the research I have undertaken during my candidacy; that I am the sole author unless otherwise indicated; and that I have fully documented the source of ideas, references, quotations or paraphrases attributable to other authors or organisations.

Some of the material presented in this thesis on the development of the *Defence Trade Controls Act 2012* (Cth) has been published under my name in the *Journal of Law and Medicine* and presented at the 2017 Law and Society Annual Conference, Mexico City.¹ Likewise, some of the material in this thesis on the use of ‘securitizing speech-acts’ by public servants was presented at the 2018 International Studies Association Annual Conference, San Francisco. These publication and dissemination activities were undertaken as part of my candidacy.

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Other disclosures: I was an employee at the National Health and Medical Research Council (NHMRC) between 2009–2019 and was involved with NHMRC’s work on the Defence Trade Controls Bill 2011 (Cth). In 2020, I was an employee of the New Zealand Ministry of Business, Innovation and Employment and I am currently an employee of the New Zealand Ministry of Health. All opinions are mine alone.

Status of law: Extracts from the legislation may not reflect the current state of the law and should not be relied upon for legal purposes.

Signature:



Timothy Vines

Date:

31/03/2023

¹ Timothy Vines, ‘Beakers and Borders: Export Controls and the Life-Sciences under the Defence Trade Controls Act 2012’ (2018) 25(3) *Journal of Law and Medicine* 655 (hereafter ‘Beakers and Borders’).

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Tim Vines, Wellington, March 2023

Abstract

Four years into a global pandemic of COVID-19, the threat that infectious diseases and public health emergencies present to human prosperity and individual and community wellbeing is clear to all. While the response to COVID-19 saw the use of exceptional public health measures, the regulatory basis for these measures did not emerge from a vacuum, with many of the regulatory levers present in Australia prior to the pandemic.

Pandemics have been a longstanding concern of government and non-government actors and officials and lawmakers have adopted regulatory measures designed to prepare for and, if possible, mitigate the risk from, infectious diseases. Existing literature, particularly within the security studies field, has centred a trilogy of ‘biosecurity’ issues that such measures seek to respond to: bioterrorism, emerging and reemerging infectious diseases, and ‘dual-use’ pathogen research. Academics, health practitioners and humanitarian organisations alike, have expressed concern that the ‘securitization of health’ implicit in the concept of ‘biosecurity’ risks distorting regulatory responses and priorities, and creating space for ‘exceptionalism’ and norm violation.

Drawing on the Copenhagen School’s theory of ‘securitization’, and the insights of Braithwaite and Drahos (2000) on the mechanisms for the globalisation of rules and principles, this thesis adopts a case study research design to assess the role of securitization as a ‘mechanism’ in the development of biosecurity legislation and pandemic response measures in Australia. Cases examined include legislation and policymaking responding to fears in the mid-2000s about a hypothetical avian influenza pandemic in humans and post-2001 concerns about bioterrorism and dual-use research. Australia’s response to the 2009 H1N1 influenza pandemic and 2013–16 West Africa Ebola outbreak are also explored.

The study identifies multiple instances of securitization in Australia’s pandemic preparedness law and policymaking. Securitization also features, in unexpected ways, in disease response. Novel findings from this study include a lack of genuine contestation between key legislative actors, and the use of hidden or implied threats and referent objects, for example the Australia-US security alliance. Likewise, this study found that superficially positive terms such as ‘proportionality’ were often deployed in aid of efforts to securitize a topic or profession, such as researchers.

The significance of this study is its detailed analysis of the presence and use of security discourse in the development of biosecurity legislation and health measures. Its strength also arises from the use of multiple methods to examine and critique the analytical attention that security analysts commonly place on Ministers and public fora, offering a deeper examination of the role of public servants in deploying securitizing moves.

Australia and the world are now moving to manage COVID-19 as an endemic disease. This transition will involve reflecting on what happened during the early years of the COVID-19 pandemic, and how the world can prepare for the next health emergency. It is hoped the thicker understanding this thesis provides of how Australia's pre-COVID-19 regulatory settings came to be, will support the development of future regulation and health measures that are clear-eyed as to the risks – and possible benefits – of securitizing disease.

Keywords

Public health, pandemics, securitization, public health law, Australia, dual-use technology, pathogen research, Ebola, avian influenza

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Members of supervisory panel

Professor Sharon Friel (Primary Supervisor and Chair of Panel)

Associate Professor Jeremy Youde (Associate Supervisor) (from July 2017)

Professor Anthea Roberts (Associate Supervisor) (from July 2020)

The late Professor Thomas Alured Faunce (Associate Supervisor) (until July 2019)

Professor Peter Drahos (Associate Supervisor) (until July 2017)

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List of Abbreviations

AAP	Australian Associated Press
ABC	Australian Broadcasting Corporation
ACT	Australian Capital Territory
AGD	Attorney-General's Department
AMA	Australian Medical Association
ANU	The Australian National University
APH	Australian Parliament House
AQIS	Australian Quarantine and Inspection Service – now part of Border Force, an operational arm of the Department of Home Affairs (formerly the Department of Immigration)
ARC	Australian Research Council
ASPI	Australian Strategic Policy Institute
AUSMAT	Australian Medical Assistance Team
BWC	The Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their Destruction (also referred to as the Biological Weapons Convention)
CBRN	Chemical, Biological, Radiological, Nuclear
chBO	chief Human Biosecurity Office – a state and territory role created under the <i>Biosecurity Act 2015</i> (Cth)
CHO	Chief Health Officer (usually of an Australian state and territory health Department)
CMO	Chief Medical Officer (in Australia, the Commonwealth officer exercising similar functions to a CHO at the federal level)
CoAG	Council of Australian Governments
Cth	Commonwealth (of Australia)
CWC	The Convention on the Prohibition of the Development, Production, Stockpiling and Use of Chemical Weapons and on their Destruction (also referred to as the Chemical Weapons Convention)
DAFF	Department of Agriculture, Fisheries and Forestry
DFAT	Department of Foreign Affairs and Trade
DHHS [US]	US Department of Health & Human Services
DirHB	Director of Human Biosecurity – a role created under the <i>Biosecurity Act 2015</i> (Cth)
DoH	Department of Health
DSGL	<i>Defence and Strategic Goods List</i>
DTCA	<i>Defence Trade Controls Act 2012</i> (Cth)
DTC Bill	Defence Trade Controls Bill 2011 (Cth)
DURC	Dual-use research of concern
ECHR	European Court of Human Rights
ETC	Ebola Treatment Centre
EU	European Union
EVD	<i>Ebolavirus</i> disease
FoI	Freedom of Information (also known as 'Official Information Access' in some jurisdictions)
FoI Act	<i>Freedom of Information Act 1982</i> (Cth)
Go8	Group of Eight [Universities]
GoF	Gain of Function [research]

HPAI	Highly pathogenic avian influenza
HREC	Human Research Ethics Committee. Also known as an Institutional Review Board (IRB) in other jurisdictions.
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IHR	International Health Regulations 2005, 3 rd edition (unless specified otherwise)
MP	Member of Parliament
MSF	Médecins Sans Frontières 'MSF Australia' used to refer to the Australian branch
MSM	Men who have sex with men
NHMRC	National Health and Medical Research Council
NHS Act	<i>National Health Security Act 2007</i> (Cth)
HHS Bill	National Health Security Bill 2007 (Cth)
NSW	New South Wales
NT	Northern Territory
OAIC	Office of the Australian Information Commissioner
PHEIC	Public Health Emergency of International Concern
PIP Framework	Pandemic Influenza Preparedness Framework
PM	Prime Minister
DPMC	Department of the Prime Minister and Cabinet
PPE	Personal Protective Equipment
Qld	Queensland
RegNet	The School of Regulation and Global Governance, ANU
SA	South Australia
SES	Senior Executive Service (Australian Public Service)
SRS	Second Reading Speech
Tas	Tasmania
UA	Universities Australia
US	United States
USD	US dollars
Vic	Victoria
WA	Western Australia
WHO	World Health Organization
WMA	World Medical Association
WMD	Weapons of Mass Destruction

Influenza Terminology

At times, this thesis uses colloquial language (such as ‘swine flu’) to discuss specific outbreaks – or threatened outbreaks – of influenza in humans. At other times, formal nomenclature (such as ‘H1N1’) is used. Table 1, below, sets out the alternative terms for various influenza subtypes and their usage during the outbreaks that are examined in this thesis.² Influenza type B is included because of its role in seasonal epidemics of flu. For simplicity, this table does not refer to influenza C and D, or lineages of influenza B.

Type (non-exhaustive)	Pandemic subtypes (examples)	Clinical or full definition	Popular usage
Influenza A (Non-pandemic)		Seasonal influenza	‘seasonal influenza’ ‘the flu’
Influenza B	Not known to cause pandemics in humans	Seasonal influenza	‘seasonal influenza’ ‘the flu’
Influenza A (pandemic)	A(H5N1) or HPAI H5N1	Highly pathogenic avian influenza (type A) H5N1	‘avian influenza’ ‘bird flu’ ‘highly pathogenic avian influenza’
	A(H1N1)2009	2009 pandemic influenza in humans	‘swine flu’ ‘H1N1’ ³
	A(H7N9)	Highly pathogenic avian influenza (type A) H7N9	‘avian influenza’ ‘bird flu’ ‘highly pathogenic avian influenza’

Table 1: Influenza types, pandemic subtypes, and nomenclature

² For a simple overview of influenza naming conventions see Jennifer McKimm-Breschkin, ‘H1N1, H5N1, H7N9? What on Earth Does It All Mean’, *The Conversation* (online), 4 June 2013 <<https://theconversation.com/h1n1-h5n1-h7n9-what-on-earth-does-it-all-mean-14815>>. For a technical overview of the formal nomenclature see: World Health Organization (hereafter ‘WHO’), ‘A Revision of the System of Nomenclature for Influenza Viruses: A WHO Memorandum’ (1980) 58(4) *Bulletin of the World Health Organization* 585.

³ Note: the ‘Spanish Flu’ was also a global pandemic of H1N1, although its case-fatality rate was, notoriously, much higher.

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Appendix 7 – Timeline of Australia’s response to 2009 pandemic influenza and Department of Health’s response to the 2013–16 Ebola outbreak

Appendix 8 – List of agencies represented on the Ebola Inter-Departmental Committee

Notes on Terminology and Referencing

- This thesis applies the *Australian Guide to Legal Citation* (3rd edition) for formatting and citation, with modifications to accommodate the greater use of interviews as a research method.
- Australian English spellings are adopted except for terms connected to Securitization Theory, eg, ‘securitizing’ and ‘medicalization [of insecurity]’. Capitalisation and naming conventions for diseases and viruses follow WHO and CDC guidelines.
- Ebola and COVID-19 case figures refer to the number of ‘confirmed’, ‘probable’ and ‘suspected’ cases reported by the WHO using its case definitions.⁴
- Monetary values are in Australian dollars and not adjusted for inflation.
- To reflect common and legal usage in Australia, the terms ‘public servant’ and ‘public service’ are used instead of ‘civil service’ and ‘civil servant’.⁵
- To minimise repetition, Buzan, Wæver and De Wilde’s *Security: A New Framework for Analysis* (1998) and Braithwaite and Drahos’ *Global Business Regulation* (2000), are cited in text as ‘*Framework for Analysis*’ and ‘*Global Business Regulation*’, respectively.
- Unless otherwise stated, all references to departments (eg, ‘Attorney-General’s’, ‘Health’) are to the departments of State established by the Commonwealth of Australia. State, territory, and foreign equivalents are designated by a bracketed appellation, for example, ‘Department of Health [NSW]’, State Department [US], Ministry of Health [NZ].

⁴ Noting that the ‘sensitivity’ and ‘specificity’ of disease clinical case definitions may vary during an outbreak and may result in under or over-reporting of cases. See, eg, Rony Zachariah and Anthony D Harries, ‘The WHO Clinical Case Definition for Suspected Cases of Ebola Virus Disease Arriving at Ebola Holding Units: Reason to Worry?’ (2015) 15(9) *The Lancet Infectious Diseases* 989 for one example of how clinical definitions come to be refined during an outbreak.

⁵ For example: *Public Service Act 1999* (Cth).

Chapter 1: Introduction

Mr Varvaris: My question is to the Minister for Immigration and Border Protection. Will the minister update the House on measures the government is taking to ensure the safety of all Australians given the outbreak of Ebola in West Africa?

Mr Morrison: ...the government has strong controls for the entry of persons to Australia, under our immigration program, from West Africa. These measures have been put in place in partnership with the Minister for Health who leads the government's response. These measures include temporarily suspending our immigration program, including our humanitarian program, from EVD [Ebola Virus Disease] affected countries. This means we are not processing any application [*sic*] from these affected countries. ... We are cancelling and refusing non-permanent or temporary visas for persons from EBV [*sic*] affected countries that have not yet departed for Australia.

(Question Time, the House of Representatives, Parliament of Australia, 27 October 2014)

Much has changed since Mr Varvaris MP asked this ‘Dorothy Dixier’ of the then Minister for Immigration in October 2014.⁶ On the political front, Mr Morrison became Prime Minister of Australia in August 2018, serving during the initial years of the COVID-19 pandemic before losing government at the 2022 election. The Ebola outbreak in question, first recognised in March 2014,⁷ determined a Public Health Emergency of International Concern (PHEIC) by the Director-General of the World Health Organization (WHO) in August 2014,⁸ would ultimately claim 11,310 lives by June 2016. Over 28,000 people in the worst-hit countries of Guinea, Sierra Leone and Liberia were infected, with the disease taking a heavy toll on the healthcare workers in the countries at the centre of the outbreak.⁹ Most significant of all, a new pandemic,

⁶ Commonwealth, *Parliamentary Debates*, House of Representative, 27 October 2014, 11985 (Nickolas Varvaris and Scott Morrison, Minister for Immigration and Border Protection).

⁷ However, the first individual to contract Ebola – a young boy in Guinea – contracted the disease in December 2013. Lawrence Gostin and Eric A Friedman, ‘A Retrospective and Prospective Analysis of the West African Ebola Virus Disease Epidemic: Robust National Health Systems at the Foundation and an Empowered WHO at the Apex’ (2015) 385(9980) *The Lancet* 1902.

⁸ This declaration came after various WHO officials had declared in June that year that a PHEIC was a ‘last resort’ measure and something that could be seen as a ‘hostile measure’: Lawrence Gostin and Eric A Friedman, ‘Timeline of Ebola Virus Disease Progress in West Africa’ (2015) 385(9980) *The Lancet* <<https://www.thelancet.com/pb/assets/raw/Lancet/infographics/Ebola-timeline.pdf>>.

⁹ WHO, *WHO Situation Report - Ebola Virus* (10 June 2016) <https://apps.who.int/iris/bitstream/handle/10665/208883/ebolasitrep_10Jun2016_eng.pdf>.

neither of Ebola nor influenza, would sweep the world and disrupt life, governments and commerce in a way not seen for generations. As at March 2023, over 759 million cases of COVID-19 have been confirmed by the WHO, and more than 6.8 million people have died from the virus. Tragic enough, these figures likely undercount COVID-19 cases, deaths caused by COVID-19 and excess mortality brought on by the pandemic, which remains ongoing and likely to ‘end’ with COVID-19 being declared an endemic disease with seasonal peaks.¹⁰

But this research commenced before COVID-19 and, for the author, the Australian Government’s decision to ‘suspend’ the granting of visas to individuals in Ebola-affected countries in October 2014 was one of the catalysts for beginning this project. It was spurred by the question of why, in the face of an epidemic, the Australian Government was seemingly taking actions that appeared motivated by fear, disproportionate to the risk of the disease and inconsistent with its international obligations? And, as several Governors in the United States (US) sought to impose quarantine orders on returning healthcare workers, the question ‘why?’ started to apply beyond Australia. What was the reason that these developed nations did not abide by the rules and norms they had often been instrumental in putting in place?¹¹ Why did the actions of government seem so incommensurate with principles of humanitarianism and contrary to scientific principles, medical evidence and the expressed preference of public health officials?

¹⁰ Kaspar Staub et al, ‘Historically High Excess Mortality During the COVID-19 Pandemic in Switzerland, Sweden, and Spain.’ (2022) 175(4) *Annals of internal medicine* 523; F Sanmarchi et al, ‘Exploring the Gap Between Excess Mortality and COVID-19 Deaths in 67 Countries’ (2021) 4(7) *JAMA Network Open* e2117359; Nazrul Islam et al, ‘Excess Deaths Associated with Covid-19 Pandemic in 2020: Age and Sex Disaggregated Time Series Analysis in 29 High Income Countries’ [2021] *BMJ* n1137. Ariel Karlinsky and Dmitry Kobak, ‘Tracking Excess Mortality across Countries during the COVID-19 Pandemic with the World Mortality Dataset’ (2021) 10 *eLife* <<https://elifesciences.org/articles/69336>>.

¹¹ Whether directly as States, or indirectly via large philanthropic bodies (such as the Rockefeller Foundation), or international bodies such as the League of Nations, WHO and United Nations Security Council: Alison Bashford, ‘Global Biopolitics and the History of World Health’ (2006) 19(1) *History of the Human Sciences* 67; Jeremy Youde, ‘Private Actors, Global Health and Learning the Lessons of History’ (2016) 3699(April) *Medicine, Conflict and Survival* 1; Anne-emmanuelle Birn, ‘Backstage: The Relationship between the Rockefeller Foundation and the World Health Organization, Part I: 1940s-1960s’ (2014) 128(2) *Public Health* 129; Lawrence Gostin and Rebecca Katz, ‘The International Health Regulations: The Governing Framework for Global Health Security’ (2016) 94(2) *The Milbank Quarterly* 264.

The Australian decision to suspend processing visas came in for criticism from the WHO,¹² civil society¹³ and other nations¹⁴ as deviating from the established global rules for dealing with the spread of disease.¹⁵ As a State Party to the 2005 *International Health Regulations* (IHR 2005), Australia had an obligation to act ‘in ways that are commensurate with and restricted to public health risks’ and to ‘avoid unnecessary interference with international traffic and trade.’¹⁶ Yet here was a rich nation, with a healthcare system that its Health Minister had only days earlier claimed had the ‘best capacity to deal with’ an imported case of Ebola,¹⁷ suspending refugee programs and cancelling visas for individuals from large sections of Africa where less drastic options might have been available. As a good ‘middle power’, Australian Governments have repeatedly claimed to support a ‘rules-based international order’ and, in so doing, to be a ‘good international citizen’.¹⁸ So why did Australia feel it could break *these* global rules?

¹² Then Director General of the WHO was reported to have said of Australia’s (and Canada’s) decisions to suspend visa processing: ‘I understand the fear in the community, but the fear factor is way too high and out of proportion to the risk...No evidence exists to support the effectiveness of travel bans as a protective measure.’ Helen Branswell, ‘Ebola: Canada Suspending Visas for Residents of Outbreak Countries’, *CBC News* (online), 31 October 2014 <<https://www.cbc.ca/news/politics/ebola-canada-suspending-visas-for-residents-of-outbreak-countries-1.2820090>>.

¹³ ABC News, AAP and Reuters, ‘Ebola Crisis: AMA Criticises Australia’s Response to Virus Outbreak; West Africa Cases Exceed 10,000’, *ABC News* (online), 26 October 2014 <<https://www.abc.net.au/news/2014-10-25/ama-criticises-australias-ebola-response-as-chaotic/5841878>>.

¹⁴ From both traditional allies and affected countries: John Kehoe, ‘US Criticises Australia’s Ebola Effort’, *Australian Financial Review* (online), 10 November 2014 <<https://www.afr.com/politics/federal/us-criticises-australia-s-ebola-effort-20141110-11jgwx>>; Reuters, ‘Ebola Crisis: Visa Ban for Visitors from Ebola-Affected Countries Creates Panic, Discourages Health Workers Needed to Fight Disease, African Leaders Say’, *ABC News* (online), 29 October 2014 <<https://www.abc.net.au/news/2014-10-29/visa-ban-to-hurt-ebola-fight-african-leaders-say/5849500>>; Greg Dyett, ‘Australia Criticised over Ebola Visa Decision’, *SBS News* (online), 29 October 2014 <<https://www.sbs.com.au/news/article/australia-criticised-over-ebola-visa-decision/bj209a68j>>.

¹⁵ Ali Tejpar and Steven J Hoffman, ‘Canada’s Violation of International Law during the 2014-16 Ebola Outbreak’ (2017) 54 *Canadian Yearbook of International Law* 366. Tejpar and Hoffman note that 58 States imposed measures beyond those recommended by the WHO Director General. See also: Wendy Rhymer and Rick Speare, ‘Countries’ Response to WHO’s Travel Recommendations during the 2013–2016 Ebola Outbreak’ (2017) 95(1) *Bulletin of the World Health Organization* 10.

¹⁶ Art. 2, *The International Health Regulations* (2005), adopted 23 May 2005, [2007] ATS, (entered into force 15 June 2007) (hereafter ‘IHR’ or ‘IHR 2005’). All references to the IHR are to the 3rd edition published on the WHO website.

¹⁷ Commonwealth, *Parliamentary Debates*, House of Representatives, 23 October 2014, 11820 (Peter Dutton).

¹⁸ On ‘middle power’ diplomacy and the need for such power’s to ‘care about the [international] system’ see: Andrew F Cooper, ‘Testing middle power’s collective action in a world of diffuse power’ (2016) 71(4) *International Journal* 529 and Andrew F Cooper, ‘Entrepreneurial states versus middle powers: Distinct or intertwined frameworks’ (2018) 73(4) *International Journal* 596. For Australia’s self-identification as a (‘creative’) middle power and good global citizen see: Gareth Evans, ‘Good International Citizenship: Values and Interests in Foreign Policymaking’ (Speech delivered at the Sydney University Law School, 27 August 2015) <<https://gevans.org/speeches/speech580.html>>; Stephen Fallon ‘Australia’s security relationships’ in Australian Parliament, *Parliamentary Library Briefing Book: Key issues for the 47th Parliament* (Commonwealth of Australia, June 2022); Kevin Rudd PM, ‘From fitful engagement to strategic partnership’ (Speech delivered at the Indian Council of World Affairs, Delhi, 12/11/2009). Foreign Minister Julie Bishop critiqued the label (‘middle of what?’), suggesting a more leading role for Australia: Julie Bishop, ‘Address to

While suspending and limiting entry by West Africans to Australia, the Australian Government had not – at this point – deployed any healthcare workers to Sierra Leone, Guinea or Liberia, despite the Labor Opposition, peak medical groups and non-government organisations (NGOs),¹⁹ international organisations, medical unions and members of its own Australian Medical Assistance Team (AUSMAT) calling for urgent action.²⁰ When Australia finally committed human resources to fight Ebola it was via an out-sourcing arrangement: with a private company, Aspen Medical, engaged by the Australian Government to build and run a small Ebola Treatment Centre (ETC) for an estimated cost of \$18.3 million.²¹ The ETC ran from December 2014 to April 2015, admitted 216 patients, and successfully treated 36 individuals who tested positive for Ebola (120 admitted patients tested negative to EVD).²²

This project was spurred by questions over how decision-makers in Australia had reached their decisions during the Ebola outbreak. But these questions were not limited to one disease; rather, a number of contemporary policy initiatives (including some the author was involved in as a public servant) seemed to suggest new principles and framings were coming to (or had come to) dominate how governments were addressing the hazard of infectious disease.

Since 2001, the Australian Parliament had enacted several laws which, in their titles at least, suggested a security-focused approach to understanding and mitigating the risk of infectious diseases. Alongside provisions implementing the IHR, the *National Health Security Act 2007* (Cth) (emphasis added) introduced a ‘select-agents regime’ to control the possession and use of certain pathogens. Meanwhile, the replacement of the century-old *Quarantine Act 1908* (Cth) with the new *Biosecurity Act 2015* (Cth) (emphasis added) suggested at least a

Tourism and Transport Forum’ (Speech delivered at the Tourism and Transport Forum dinner, Parliament of Australia, 19 March 2014). For Australia’s stated commitment to a rules-based order (including to prevent pandemics) see: Australian Government, *2017 Foreign Policy White Paper* (Commonwealth of Australia, 2017) 80. For one appraisal of Australia’s conduct as a good international citizen see: Fiona Mcgaughey and Mary Anne Kenny, ‘Lashing out at the UN Is Not the Act of a Good International Citizen’, *The Conversation* (online), 10 March 2015 <<https://theconversation.com/lashing-out-at-the-un-is-not-the-act-of-a-good-international-citizen-38587>>.

¹⁹ For a chronology of one NGO’s efforts, see: Médecins Sans Frontières, Submission No 151 to the Senate Select Committee on Health – One Day Hearing in Relation to Australia’s Response to the Ebola Crisis in West Africa, Parliament of Australia, 3 July 2015, 2.2-2.11.

²⁰ For example, the Australian Nurses and Midwifery Federation reported that many of its members had expressed a desire to contribute to Australia’s response: Tanya Plibersek, ‘Doorstop Interview’ (Transcript, 10 November 2014) <http://www.tanyaplibersek.com/transcript_doorstop_interview_monday_10_november_2014>.

²¹ Finding a final figure for the cost of the ETC is difficult. Official statements only reference an ambiguous ‘underspend’, and the released contract does not include all final cost values: Mike Secombe, ‘The Truth about Australia’s Ebola Hospital’, *The Saturday Paper* (online), 5 December 2015 <<https://www.thesaturdaypaper.com.au/news/health/2015/12/05/the-truth-about-australias-ebola-hospital/14492340002715>>.

²² Julie Bishop, ‘Next Steps for Australia’s Ebola Response’ (Media Release, 20 April 2015).

comingling of ‘health’ and ‘security’ – if not the prioritisation of the latter over the former. Finally, the author’s involvement in the development of the *Defence Trade Controls Act 2012* (Cth) provided an insider’s perspective on the creation of a new regulatory regime for researchers, led by the Department of Defence.

The question of whether there was a link between the rise of ‘security’ language in these legal and regulatory tools and Australia’s actions during the 2013–2016 Ebola outbreak served as the spark for this thesis. Who was pushing this new framing? How were those individuals deploying security rhetoric and framings, and what were the consequences of this new regulatory landscape on regulatory design and disease response?

1. Overview of Chapter

Section 2 of this Chapter sets out the background to this research project, with a focus on global health governance of pandemics. Section 3 situates the project within a broader context of scholarly interest in the ‘securitization’ of infectious disease. Narrowing from these bigger issues, Section 4 focuses on the purpose and specifics of the research: outlining the research aims, objectives and central hypothesis. Section 5 explains the significance of the research and its relevance to academics, policy makers and other actors involved in – or affected by – the actions taken by governments to prepare for, respond to and mitigate the risk of pandemics. Section 6 introduces some key definitions, in advance of a fuller exploration in Chapter 2. Finally, Section 7 outlines the remaining Chapters of this thesis.

2. Confronting pandemics and infectious diseases

Four years into a global pandemic of a novel coronavirus, *SARS-CoV-2*, (hereafter usually referred to by the disease the virus causes: ‘COVID-19’), the threat of infectious diseases to human prosperity and individual and community wellbeing is not academic – it is lived and being lived. Limiting human health, development and health systems, and with the potential to spread quickly via the global circulation of people, animals and goods, outbreaks of infectious diseases have long wrought misery and brought about rapid social and political change.²³ The ‘Spanish Flu’, an outbreak of pandemic influenza, killed by various estimates 40–100 million people in 1918–1919, and subsequent incidents of pandemic influenza have resulted in significant mortality and morbidity globally.²⁴ Indeed, despite periods of medical optimism in the third-quarter of the 20th Century, emerging and ‘re-emerging’ infectious diseases remain a common hazard to humans and communities.²⁵ The failure of nation states to contain and eradicate *SARS-CoV-2* (or achieve sustained elimination) has likely added another seasonal hazard to the elderly and vulnerable.

Novel infectious diseases, such as COVID-19 and, before it, severe acute respiratory syndrome (SARS) and Middle Eastern Respiratory Syndrome (MERS), have driven major reforms to global disease surveillance and detection systems.²⁶ Meanwhile, outbreaks of Ebola continue to cause misery, weaken fragile healthcare systems, and evoke ‘dread’ in populations far removed from the locus of the outbreak.²⁷ In response to the adverse effects of infectious diseases, and their ability to quickly and easily cross and circumvent human borders,²⁸ a global

²³ Stefan Elbe, ‘Securitizing Epidemics: Three Lessons from History’ in Christian Enemark and Michael J Selgelid (eds), *Global Health: Ethics and Security Aspects of Infectious Disease Control: Interdisciplinary Perspectives* (Ashgate Publishing, 2012) 79; Alfred J Bollet, *Plagues & Poxes* (Demos, 1st ed, 2004); Mark Wheelis, ‘Biological Warfare at the 1346 Siege of Caffa’ (2002) 8(9) *Emerging Infectious Diseases* 971.

²⁴ S L Knobler et al (eds), *The Threat of Pandemic Influenza: Are We Ready? Workshop Summary* (National Academies Press, 2005) < <https://www.ncbi.nlm.nih.gov/books/NBK22148/> >.

²⁵ Sara E Davies, ‘Securitizing Infectious Disease’ (2008) 84(2) *International Affairs* 295, 298. Brad Spellberg and Bonnie Taylor-Blake, ‘On the Exoneration of Dr. William H. Stewart: Debunking an Urban Legend’ (2013) 2(1) *Infectious Diseases of Poverty* 3.

²⁶ For a brief, WHO-centred, history see: David L Heymann and Guénaél Rodier, ‘Global Surveillance, National Surveillance, and SARS’ (2004) 10(2) *Emerging Infectious Diseases* 173. See also David Heymann’s ‘vision’ for the IHRs cited in Sara E Davies, Adam Kamradt-Scott and Simon Rushton, *Disease Diplomacy: International Norms and Global Health Security* (John Hopkins University Press, 2015) 31.

²⁷ The concept of ‘dread’ is discussed by Enemark in: Christian Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia* (Routledge, 2007); Christian Enemark, *Biosecurity Dilemmas: Dreaded Diseases, Ethical Responses and the Health of Nations* (Georgetown University Press, 2017).

²⁸ According a 1999 study by P Gould, the world’s 4000 international airports were all within 36 hours of each other, cited in Lucy Budd, Morag Bell and Tim Brown, ‘Of Plagues, Planes and Politics: Controlling the Global Spread of Infectious Diseases by Air’ (2009) 28(7) *Political Geography* 426, 427. See also: Davies, Kamradt-Scott and Rushton, above n 26, 21.

health governance system emerged over almost two centuries to ‘prevent, protect against, control and provide a public health response to the international spread of disease....’ These systems reflected and embedded key norms, principally that health measures imposed by nations to control the spread of disease must be ‘commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.’²⁹ The development of this system by ‘norm entrepreneurs’ (principally) at the WHO has been clearly and thoroughly documented by Davies, Kamradt-Scott and Rushton.³⁰ How and why those norms continue to be violated or ignored by national governments – even if they have been ‘internalised’ by health officials within those nations – is a central focus of this study.

In addition to their deleterious impact on individual human health and societies, infectious diseases and their causative agents (an important distinction, particularly relevant in the context of export controls, research and healthcare) are also treated as threats to a national and global security.³¹ International and national security bodies have sought to minimise the risks of a pandemic arising from the accidental or deliberate release of a pathogen through new ‘biosecurity’ regulatory frameworks, integrating with earlier counter-proliferation regimes.³² Meanwhile, ‘optimistic’ arguments in the mid-2000s that the new global health governance regime promised by the IHR reflected a ‘post-Westphalian world’ on international collaboration have been challenged by assertions of state-sovereignty over disease surveillance reporting, viral sample sharing and the imposition of public health measures.³³ ‘Vaccine

²⁹ IHR 2005 art 2; Jeremy Youde, ‘High Politics, Low Politics, and Global Health’ (2016) 1(2) *Journal of Global Security Studies* 157; Sophie Harman, *Global Health Governance* (Routledge, 2012) 2-4, 31-34.

³⁰ Collectively in Davies, Kamradt-Scott and Rushton, above n 26. See also, Sara Davies, above n 25.

³¹ Enemark, above n 27. Individual security has also been considered within an agenda of ‘Human’ or ‘Health’ security: Frederick M Burkle, ‘Global Health Security Demands a Strong International Health Regulations Treaty and Leadership From a Highly Resourced World Health Organization’ (2015) 9(5) *Disaster Medicine and Public Health Preparedness* 568; United Nations Development Program, *Human Development Report* (United Nations, 1994); Human Security Unit, *Human Security in Theory and Practice: An Overview of the Human Security Concept and the United Nations Trust Fund for Human Security* (United Nations, 2009); Oscar A Gómez and Des Gasper, ‘Human Security: A Thematic Guidance Note for Regional and National Human Development Report Teams’ (Human Development Reports, United Nations Development Program, 2013) <<https://hdr.undp.org/content/human-security-guidance-note>>.

³² For example, the UN 1540 Committee established by: SC Res 1540, UN SCOR, 4956th mtg, UN Doc S/RES/1540 (2004); Wassenaar Arrangement on Export Controls for Conventional Arms and Dual-Use Goods and Technologies - Guidelines & Procedures, including the Initial Elements (2016), art VIII; the Australia Group; G Fink et al, *Biotechnology Research in an Age of Terrorism* (National Academies Press, 2004); *The Pandemic and All-Hazards Preparedness Act of 2006* (US), Pub L No 109-417, 120 Stat 283; *The Public Health Security and Bioterrorism Preparedness and Response Act of 2002* (US), Pub L No 107-188, 116 Stat. 594.

³³ Davies, above n 25. See also discussion in: Sara E Davies, ‘The International Politics of Disease Reporting: Towards Post-Westphalianism?’ (2012) 49(5) *International Politics* 591, 598-600, noting Davies ultimately posits an alternate, less-pessimistic argument. But cf, Harman, above n 29, 28 ‘the state [sic] is the primary site of global health governance’.

nationalism' in the current COVID-19 pandemic, may likewise point to the continued strength of the state in disease governance.³⁴ Notwithstanding this global health governance regime, States retain an important role in their domestic implementation of prevention and response measures. And, while they may be held to account for the extent to which their local regulatory regimes cohere with international regimes, norms and preferences, their choice of domestic regulatory measures also speaks to (and responds to) local calls. A nation's regulatory settings, therefore, are not a neutral or static act, and this thesis seeks to explore why certain choices have been made in Australia to prevent and respond to the risk of infectious diseases.

The study of regulatory responses to health emergencies allows the researcher to address several questions of relevance to policymakers, public health practitioners and the public generally. For example, did the repeal and replacement of the *Quarantine Act 1908* (Cth) with the *Biosecurity Act 2015* (Cth) reflect a shift in focus of quarantine laws from public health to the security interests of the State?³⁵ Is the use of security language by Parliamentarians enacting these laws evidence of attempts to legitimise new institutions and practices of public health and reconfigure the relationship between individuals, communities, practitioners and the State? What have been the consequences of the successful securitization of infectious diseases in a country, such as Australia, without a constitutionally entrenched Bill of Rights? And, just as issues around 'access to medicines' brought intellectual property and the role of the World Trade Organization (WTO) to a more central position within public health policymaking (if not lawmaking),³⁶ will the 'securitization of health' modify the content of public health law by

³⁴ On vaccine nationalism see: Thomas J Bollyky and Chad P Brown, 'The Tragedy of Vaccine Nationalism: only Cooperation can end the Pandemic' (2020) 99(5) (September/October) *Foreign Affairs* 96. See also: Olivier J Wouters et al, 'Challenges in Ensuring Global Access to COVID-19 Vaccines: Production, Affordability, Allocation, and Deployment' (2021) 397(10278) *The Lancet* 1023; Samantha Vanderslott et al, 'Vaccine Nationalism and Internationalism: Perspectives of COVID-19 Vaccine Trial Participants in the United Kingdom' (2021) 6(10) *BMJ Global Health* e006305; James Darwin and N Lagman, 'Vaccine Nationalism: A Predicament in Ending the COVID-19 Pandemic' (2021) 43(2) *Journal of Public Health* e375; Nick Dearden, 'Developing nations may give up on the WTO for good if it won't budge on vaccine patents', *The Guardian* (online), 29 November 2021 <<https://www.theguardian.com/commentisfree/2021/nov/29/developing-nations-wto-vaccine-patents-covid-britain>>.

³⁵ It is acknowledged that a Foucauldian or biopolitical account would likely dispute that there is any meaningful difference between the two positions: Michel Foucault, *Discipline and Punish*, (Alan Sheridan trans, Vintage Books, 2nd ed, 1995); Michel Foucault, *Society Must Be Defended*, Mauro Bertani and Alessandro Fontana (eds) (David Macey trans, Picador, 1997); Paul Rabinow and Nikolas Rose, 'Biopower Today' (2006) 1(2) *BioSocieties* 195; B Braun, 'Biopolitics and the Molecularization of Life' (2007) 14(1) *Cultural Geographies* 6. For a Foucauldian analysis of Australia's public health regime since the early 19th Century see the works of Alison Bashford, eg, Alison Bashford, 'Global Biopolitics and the History of World Health' (n 12); Alison Bashford, 'At the Border Contagion, Immigration, Nation' (2002) 33(120) *Australian Historical Studies* 344; Alison Bashford, *Imperial Hygiene* (Palgrave Macmillan, Revised, 2014).

³⁶ John Braithwaite and Peter Drahos, *Global Business Regulation* (Cambridge University Press, 2000) Chapter 15; Peter Drahos, 'Intellectual Property and Pharmaceutical Markets: A Nodal Governance Approach' (2004) 77 *Temple Law Review* 401.

‘breaking’ traditional rules which underpinned its practice, for example humanitarianism, legality, beneficence, autonomy, respect and non-maleficence?³⁷

3. The securitization of infectious disease and the rise of ‘biosecurity’

The study of infectious diseases, and effective measures to prevent their spread and (if possible) emergence has driven the development of several professional disciplines, practices, and medical, social and regulatory interventions. It has also supported an extensive scholarly literature. However, as explored more thoroughly in Chapter 2, limitations in the existing literature open spaces that this project can usefully fill.

Shadowing the ‘globalisation of infectious diseases’, and the emergence of the systems of global health governance discussed above, the field of security studies has analysed health and infectious diseases as security concerns.³⁸ Securitization theory, as propounded by the Copenhagen School, has produced a useful framework for undertaking empirical analysis of the creation and dissolution of ‘security problems’ at the domestic and international level.³⁹ This includes the securitization of infectious diseases by national governments and international organizations such as the WHO and United Nations Security Council (UNSC).⁴⁰ Configured as a ‘radically constructivist’ theory,⁴¹ the classical conception of Securitization

³⁷ A discussion of these values is set out in Chapter 2, Literature Review.

³⁸ David P Fidler, SARS, *Governance and the Globalization of Disease* (Palgrave Macmillan, 2004); David P Fidler, ‘Biosecurity: Friend or Foe for Public Health Governance?’ in Alison Bashford (ed), *Medicine at the Border: Disease, Globalization and Security: 1850 to the Present* (Palgrave Macmillan, 2007) 196; David P Fidler and Lawrence Gostin, *Biosecurity in the Global Age: Biological Weapons, Public Health, and the Rule of Law* (Stanford University Press, 1st ed, 2008); Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia*, above n 27; Christian Enemark and Michael J Selgelid (ed), *Global Health: Ethics and Security Aspects of Infectious Disease Control: Interdisciplinary Perspectives* (Ashgate Publishing, 2012); Jeremy Youde, ‘Who’s Afraid of a Chicken? Securitization and Avian Flu’ (2008) 4(2) *Democracy and Security* 148; Youde, above n 29.

³⁹ Thierry Balzacq, ‘Constructivism and Securitization Studies’ in Myriam Dunn Cavelty et al (eds) *The Routledge Handbook of Security Studies* (Taylor and Francis, 2009) 56.

⁴⁰ David L Heymann et al, ‘Global Health Security: The Wider Lessons from the West African Ebola Virus Disease Epidemic’ (2015) 385(9980) *The Lancet* 1884; Brittany Walter, *Is Ebola a Matter of National Security?* (18 August 2016) Lint Center for National Security Studies <<http://www.lintcenter.info/blog/entry/3788834/is-Ebola-a-matter-of-national-security>>; Burkle, above n 31; Tine Hanrieder and Christian Kreuder-Sonnen, ‘WHO Decides on the Exception? Securitization and Emergency Governance in Global Health’ (2014) 45(4) *Security Dialogue* 331.

⁴¹ Dagmar Rychnovská, ‘Securitization and the Power of Threat Framing’ (2014) 22(2) *Perspectives* 9, 11, 12.

Theory applies Austin's speech theory to argue that the construction of security problems is an 'illocutionary' act (ie, a performative act of communication) involving:⁴²

- a '**securitizing actor**' who attempts, usually through 'speech acts', to convince an '**audience**' that...
- ...some object or ideal (a '**referent object**'), 'with a legitimate claim to survival', is threatened by some 'existential' (*Framework for Analysis*) or 'extreme' issue and that...
- ...the threat posed to the referent object by this issue justifies 'rule breaking', moving the 'issue beyond the established rules of the game [or frame] the issue either as a special kind of politics or above politics...'.⁴³

Referent objects can be physical (eg, dams), intangible (eg, health), emergent (eg, the energy market) or a mix (eg, a 'way of life', 'health systems', 'the nation'). A 'securitizing move' fails if the audience does not accept the justifying of rule-breaking or the relevant 'threat framing'.⁴⁴

Against a background of Australia's response to the Ebola outbreak in 2014, this framework and its conception of biosecurity threats had an intuitive not just theoretical appeal. However, while it is possible to examine securitization purely as a performative act (ie, security *utterances*), such a narrow focus on discursive practices is unlikely to address significant 'so what' questions or provide useful insights on the users of security framing and language, the consequences of securitization in regulatory design, and tactics to resist or desecuritize an issue. If a securitizing move seeks to justify 'breaking free of rules' that normally bind,⁴⁴ an empirical study of securitization ought to consider and assess the securitizing move (and its outcome) against both the pre-existing rules and any resultant regime. Such an approach is consistent with to Securitization Theory as developed through empirical studies applying the theory,⁴⁵ but requires looking beyond discourse analysis and extending the research horizon to include 'tools of securitization' or – as Balzacq called them

⁴² Barry Buzan, Ole Wæver and Jaap De Wilde, *Security: A New Framework for Analysis* (Lynne Rienner Publishers, 1998); Ole Wæver, 'Politics, Security, Theory' (2011) 42(4-5) *Security Dialogue* 465; John Austin, *How to do things with words* (Oxford University Press, 2nd edition, 1975); see also: Moya Lloyd, 'From Linguistic Performativity to Social Performance: the Development of a Concept' in Gerard Delanty, Stephen P Turner (eds) *Routledge International Handbook of Contemporary Social and Political Theory* (Routledge, 2011).

⁴³ Rychnovská, above n 41.

⁴⁴ Buzan, Wæver and De Wilde, above n 42.

⁴⁵ For example: Mark B Salter, 'Securitization and Desecuritization: A Dramaturgical Analysis of the Canadian Air Transport Security Authority' (2008) 11(4) *Journal of International Relations and Development* 321.

– the ‘empirical referents of policy’.⁴⁶ For this study, this meant examining regulatory responses to biosecurity issues – legislation and policy outcomes – and responses to live health emergencies.

For the reasons discussed in Chapter 2 and 3, engagement with regulatory theory was considered necessary to provide a more complete explanation for the design of domestic regulatory responses to biosecurity issues. To examine how the design of regulation may have been affected by efforts to securitize public health issues, this study applied several analytical concepts and findings from Braithwaite and Drahos’s study of the globalization of business regulation as published in *Global Business Regulation* (2000). Braithwaite and Drahos argue in *Global Business Regulation* that ‘principles’ stand behind ‘rules’ (which ‘constitute an agreed standard of conduct’). They propel action in a certain direction’ while lacking the specificity of rules in terms of how they can determine decisions, impose obligations or control actions.⁴⁷ At the level of actor-relations, Braithwaite and Drahos argue that principles ‘bring about mutual orientations between actors’. Importantly, principles can conflict and this ‘conflict of principles’ is ‘settled by decision-makers assigning “weights” to the relevant principles in order to reach a decision’ over the shape of a specific decision, rule or (in aggregate) regulatory regime.⁴⁸ For this project, it was the usage and effect of securitization in these conflicts of principles that was of primary interest.

4. Research aims and scope

Research aims

The aim of this thesis is to gain insight into the use and implications of securitization in law and policymaking related to the design and use of regulatory measures to address biosecurity threats. To do this, the study focuses on the development of Australia’s post-2001

⁴⁶ Thierry Balzacq, ‘The Policy Tools of Securitization: Information Exchange, EU Foreign and Interior Policies’ (2008) 46(1) *Journal of Common Market Studies* 75, 76.

⁴⁷ Braithwaite and Drahos, above n 36, 18.

⁴⁸ This conclusion, which Braithwaite and Drahos reached empirically, is – as they acknowledge (ibid, 18-19) – also reflected in analytical legal theory and disputes between positivist legal theorists and those who argue that ‘law’ extends beyond merely formal rules (and rules about rules): for example, Tom Campbell, *Rights A Critical Introduction* (Taylor & Francis, 1st ed, 2005); Ronald M Dworkin, *Taking Rights Seriously* (Bloomsbury Academic, 2013); Tim Dare, ‘Tom Campbell’s Ethical Positivism’ (2009) 34 *Australian Journal of Legal Philosophy* 294; Scott J Shapiro, ‘The “Hart-Dworkin” Debate: A Short Guide for the Perplexed’ (Working Paper No 77, University of Michigan Law School, March 2007); Jeremy Waldron, *Law and Disagreement* (Oxford University Press, USA, 1st ed, 1999).

biosecurity legislation and pandemic preparedness and response measures in two public health emergencies: the 2009 influenza pandemic⁴⁹ and the 2013–16 West Africa Ebola outbreak (hereafter ‘the Ebola outbreak’). The specific questions that drove the initiation and design of this study were:

1. To what extent did the use of ‘securitizing acts’ by Ministers, governing parties and public servants between 2001–2016 serve as a ‘mechanism’ to promote or secure those actors’ preferred regulatory values or principles in a given regulatory response, including (but not limited to) legislation?
2. What, if any, were the outcomes and consequences of embedding those particular values or principles in the ultimate regulatory response?

Consistent with the epistemological approach adopted by this study and the situating of its theoretical framework in an interpretist-constructivist ontology, the above questions are not intended to state a formal hypothesis. Rather, they identify general research prompts, with more specific research aims and objectives detailed below. Combined, these supported an abductive research strategy, through which the author explored the processes by which Australia’s biosecurity laws were developed and pandemic response measures applied. As such, these questions were not intended to limit the emergence of findings, for example the use by other actors of security rhetoric and securitization as a mechanism to promote their own values or principles.

In contrast to most securitization literature, this study’s analysis extends over a significant length of time and uses a series of case studies that allows the actions of Ministers and public servants to be differentiated and examined as a more dynamic and interactive Executive. In adopting a longer time horizon, it seeks to more confidently assess whether securitization was present in the development and implementation of specific laws, policies and responses to biosecurity threats and during contests of principles between different actors and communities. Finally, in examining the use of securitization across policy and lawmaking activities, as well as disease response, this study also seeks to gain an understanding of the motivations and the principles of a wider range of parties to those contests and the values they sought to embody in the design.

⁴⁹ WHO designation A(H1N1)pdm2009. Hereafter commonly cited as ‘H1N1’ to reflect common usage.

As a thesis that draws on two existing theoretical frameworks, from differing disciplinary fields, three sub-aims are addressed.⁵⁰ First, this study sought to test the applicability of Securitization Theory as a useful explanation for changes in *domestic* policy and relationships between a nation-state and subcomponents, including individuals, bureaucratic entities and subnational authorities (eg, state and territory governments). As discussed in Chapter 2, although Securitization Theory developed in response to theoretical opportunities and challenges that arose with the end of the Cold War,⁵¹ it has subsequently been applied to consider domestic issues such as migration and climate change.⁵² Similarly, it is hoped that the explanatory model and concepts set out in *Global Business Regulation*, developed from an exhaustive study of various case studies of *business* regulation, might apply more broadly in areas related to the provision of traditional ‘public goods’ such as health, global health security and national security.

A second aim is to extend existing theories by offering new insights gained using novel research methods. For example, Chapter 5 opens with a report on the findings from a series of Freedom of Information (FoI) requests that were used as a research-tool to ‘disaggregate’ the Commonwealth Executive into its constitutive ‘political’ and ‘administrative’ arms, with a view to identifying the extent to which Ministers and public servants used securitizing language in the development of biosecurity legislation. Such findings are useful, not simply for security analysts, but also for legal scholars contemplating the extent to which judicial deference to ‘legislative-intent’ can be sustained on democratic grounds, given the routinisation of the lawmaking process and control exerted by professional (ie, apolitical) public servants.

At its highest, this study seeks to contribute to wider debates on how individuals, societies, States and the international system should best prepare and respond to pandemics and other supra-national risks consistently with principles of distributive justice and human rights? In doing so, this thesis engages in the pragmatic and active task of identifying any strategies and forums through which actors can resist efforts to securitize (or further securitize)

⁵⁰ A detailed outline of this thesis’s theoretical framework is set out in Chapter 3.

⁵¹ Buzan, Wæver and De Wilde, above n 42, 2.

⁵² For example: Georgios Karyotis, ‘Securitization of Migration in Greece: Process, Motives, and Implications’ (2012) 6(4) *International Political Sociology* 390; Michael Durant Thomas, ‘Climate Securitization in the Australian Political–Military Establishment’ (2015) 1158(July) *Global Change, Peace & Security* 97.

infectious diseases. This aim is consistent with the ‘normative goal’ of Securitization Theory and efforts to return subjects from a state of ‘exception’ to that of ‘normal politics’.⁵³

Research objectives

To address the aims of the study, there were three specific research objectives. First, to identify whether securitizing speech-acts and moves were present in the debates over the following Australian laws:

- Post-2001 amendments to the *Quarantine Act 1908* (Cth)
- The *Biosecurity Act 2015* (Cth) (which replaced the *Quarantine Act 1908* (Cth))
- The *National Health Security Act 2007* (Cth) (NHS Act)
- The *Defence Trade Controls Act 2012* (Cth) (DTCA).

Chapters 2 and 3 provide a justification for the choice of legislation, which are seen as addressing the chief biosecurity threats identified in the scholarship: emerging and rapidly spreading infectious diseases; deliberate and accidental release of pathogens and the related risk of bioweapon proliferation and ‘dual-use research of concern’.

A second objective was to look behind the parliamentary debates that culminated in these laws and to examine the role of bureaucracy in the development of biosecurity policy. A final objective was to examine whether securitization was in practice in Australia’s planning for a potential outbreak of pandemic bird flu (H5N1) in the mid-2000s, Australia’s response to the 2009 ‘swine flu’ pandemic of H1N1 influenza and the 2013–2016 Ebola outbreak. Pursuit of these aims and objectives was undertaken to explore a more fundamental question of whether, at least since the anthrax bioterrorism scare in United States in 2001, securitization has been used strategically to shape, influence and justify the design of Australia’s pandemic preparedness and response legislation and health measures.

As outlined in Chapter 3, this thesis used a series of case-studies; applying a mixed data-collection approach, including documentary analysis of parliamentary debates (*Hansard*) delivered in the Commonwealth Parliament, Second Reading Speeches (SRS) by Ministers, and other parliamentary sources, to identify whether securitizing speech-acts and moves were

⁵³ Stefan Elbe, ‘Should HIV/AIDS Be Securitized? The Ethical Dilemmas of Linking HIV/AIDS and Security’ (2006) 50(1) *International Studies Quarterly* 119; Paul Roe, ‘Is Securitization a “negative” Concept? Revisiting the Normative Debate over Normal versus Extraordinary Politics’ (2012) 43(3) *Security Dialogue* 249; Rita Floyd, ‘Can Securitization Theory Be Used in Normative Analysis? Towards a Just Securitization Theory’ (2011) 42(4–5) *Security Dialogue* 427.

present in the design of the biosecurity laws identified above. Other data were obtained through documentary analysis of official advice, public and parliamentary statements by Ministers, and semi-structured interviews with public servants, Ministers and non-government representatives involved in the development of Australia's biosecurity legislation, planning for a potential outbreak of pandemic bird flu and in Australia's response to the 2009 H1N1 pandemic and the Ebola outbreak.

Scope

As discussed above and in Chapter 3, this study is a time limited and geographically bounded examination of biosecurity and health emergency regulatory measures, with a central period of focus of 2003–2016 and with a focus on activities conducted at the national level in a single, national jurisdiction: Australia. This period under examination excludes the SARS outbreak, which peaked in 2003, and the 2017 Zika outbreak, although both outbreaks are referenced in the thesis: SARS as a key initiating event (SARS); and Zika, because it was occurring while data collection and interviews were ongoing (Zika).

The period under examination occurred within a window of amplified political disruption at the Commonwealth level. Between 1992 and 2006 Australia had had one change in Prime Minister; but between 2007 and 2016 Australia had five changes in Prime Minister, with a sixth before the decade was out. Figure 1 provides an overview of the Government-of-the-day during the period under review.

1997-2007 (Howard)	2007- 2010 (Rudd)	2010-2013 (Gillard)	2013 (Rudd)	2013-2015 (Abbott)	2015-2018 (Turnbull)	2018-2022 (Morrison)
<u>NHS Bill</u>	<u>NHS Bill</u>	<u>Biosecurity</u>	<u>Biosecurity</u>	<u>Biosecurity</u>		
[<u>Anthrax attacks in</u> <u>Washington DC</u>]	[<u>Swine</u> <u>flu</u>]	[<u>Bill 2012</u> <u>DTC Bill</u>]	[<u>Bill 2012</u>]	[<u>Bill 2014</u> <u>[Ebola]</u>]	[Ebola] [Zika]	[COVID-19]
[<u>Localised H5N1</u> <u>outbreaks in SE</u> <u>Asia</u>]						

Figure 1: Political timeline

Periods in blue represent centre-right, Liberal-National Coalition Governments. Periods in red represent Labor Governments. The Prime Minister's name is in parentheses, key Bills are underlined, and health events are in square brackets. Periods of time are not to scale.

An interdisciplinary project, it is positioned at a nexus of fields – namely, governance and regulation, security studies and ‘traditional’ legal scholarship – and adopts elements of each to address its central aims. The COVID-19 pandemic was not examined as part of this study; however, at various points the thesis directs the reader’s attention to relevant links between the thesis and the response to COVID-19. A short discussion of COVID-19 is included in Chapter 7, Section 3.

The study’s theoretical and legal foundations cannot be excised completely from an *international* health governance regime. Nonetheless, this is not a direct study of how international health governance systems emerge. Others have produced excellent accounts on the role of ‘norms’ in the emergence of the modern international health regulations.⁵⁴ Nor does this study take as its single focus the formal content of public health law in Australia, pandemic plans or international public health law. For accounts of international public health law, see the reference works of Gostin and Fidler; while Carney, Bailey and Bennett have written excellent reviews and assessments of Australia’s pandemic plans.⁵⁵

This thesis is also not a ‘first-principles’ [bio]ethical inquiry into infectious diseases. Rather, the author acknowledges the insightful works of Selgelid and others.⁵⁶ To the extent that ethics is discussed, it is done in the context of identifying (rather than interrogating) professional ethics that may embody or reflect various ‘principles’ that are held as important by different actors engaged in a process of determining the content of a new law or regulatory response. Finally, although it always maintains a critical eye on power, this is not a biopolitical exploration of infectious disease regulation and the works of Bashford, applying a critical lens to Australia’s sanitation, immigration and public health laws and critiqued the interplay of colonisation, race and the technologies of population health are recognised as providing

⁵⁴ Davies, Kamradt-Scott and Rushton, above n 26; Jeremy Youde, ‘MERS and Global Health Governance’ (2015) 70(1) *International Journal: Canada’s Journal of Global Policy Analysis* 119.

⁵⁵ Terry Carney, Richard Bailey and Belinda Bennett, ‘Pandemic Planning as Risk Management: How Fared the Australian Federation?’ (2012) 19(3) *Journal of Law and Medicine* 550; Terry Carney and Belinda Bennett, ‘Framing Pandemic Management: New Governance, Science or Culture?’ (2014) 23(2) *Health Sociology Review* 136; Lawrence Gostin, *Public Health Law: Power, Duty, Restraint* (University of California Press, 2nd ed, 2008); Lawrence Gostin, *Global Health Law* (Harvard University Press, 2014); David P Fidler, *International Law and Infectious Disease* (Clarendon Press, 1999); Fidler, *SARS, Governance and the Globalization of Disease*, above n 38.

⁵⁶ Seumas Miller and Michael J Selgelid, *Ethical and Philosophical Consideration of the Dual-Use Dilemma in the Biological Sciences* (Australian National University ePress, 2006); Michael J Selgelid, ‘Governance of Dual-Use Research: An Ethical Dilemma’ (2009) 87(9) *Bulletin of the World Health Organization* 720; Michael J Selgelid, ‘Pandethics’ (2009) 123(3) *Public Health* 255; Michael J Selgelid, Paul M Kelly and Sleigh Adrian, ‘TB Matters More’ in Michael Boylan (ed), *International Public Health Policy and Ethics* (Springer Dordrecht, 2008) 233; Frida Kuhlau et al, ‘A Precautionary Principle for Dual Use Research in the Life Sciences’ (2011) 25(1) *Bioethics* 1; Kevin Smith, ‘Synthetic Biology: A Utilitarian Perspective’ (2013) 27(8) *Bioethics* 453.

important insights.⁵⁷ The works of Bashford and others that explore the ‘discourse’ of disease and sanitation serve a valuable role in challenging a particular form of Western, scientific ‘myth-making’.⁵⁸ Although this study does not apply this critical lens directly, similar arguments find a place within the theoretical framework via an acknowledgement and engagement with the literature criticising the ‘securitization of health’ (see Chapter 2).

5. Significance of this study

Notwithstanding the biological reality of infectious diseases, the designation of an outbreak as a ‘crisis’, ‘biosecurity’ threat or, in the words of the UNSC, a ‘threat to international peace and security’, has consequences that extend beyond the semantic.⁵⁹ The decision to use the language of threat and security can affect an issue’s prioritisation and the principles and regulatory tools to be deployed to resolve the issue. International health governance regimes predicated on decision-making informed by ‘scientific principles’ and ‘scientific evidence’ may be challenged or ignored where an issue is framed as an existential threat, justifying exceptional action.⁶⁰ While not drawing firm conclusions, we have seen evidence of this during COVID-19. The taking of exceptional actions may result in long-lasting changes to professional practices and relationships between health professionals and the State; between members of the community and between States themselves.

If securitization does serve as a mechanism to shape regulatory action, what effect would that have on the field of public health law, whether grounded on concepts of ‘power, duty and restraint’ or a ‘scientific’ approach that values information sharing and proportional responses that centre human-dignity and human rights?⁶¹ Identifying who is engaged in these acts of

⁵⁷ Bashford, Imperial Hygiene, above n 35; Alison Bashford and Peter Hobbins, ‘Science and Medicine’ in Alison Bashford and Stuart Macintyre (eds), *The Cambridge History of Australia* (Cambridge University Press, 2013), 263; Helen Irving, ‘Making the Federal Commonwealth, 1890-1901’ in Alison Bashford and Stuart Macintyre (eds), *The Cambridge History of Australia* (Cambridge University Press, 2013) 242; Alison Bashford and Bernadette Power, ‘Immigration and Health: Law and Regulation in Australia, 1958-2004’ (2005) 7(1) *Health and History* 86; Alison Bashford, *Global Population: History, Geopolitics, and Life on Earth* (Columbia University Press, 2014) Chapter 5.

⁵⁸ For example, Alexandre I R White, *Epidemic Orientalism: Race, Capital, and the Governance of Infectious Disease* (2023, Stanford University Press) 11.

⁵⁹ SC Res 2177, UN Doc S/RES/2177 (18 September 2014).

⁶⁰ ‘Scientific principles’ is explored below. The concept of ‘framing’ is discussed in Chapter 2, Literature Review.

⁶¹ ‘Power, duty, restraint’ are key framing concepts in Gostin’s influential public health law tome: Gostin, *Public Health Law: Power, Duty, Restraint*, above n 55. ‘Scientific principles’ are embodied in the IHR 2005, as is the protection of ‘dignity, human rights and fundamental freedoms of persons’: art 3(1), 43(2).

threat designation or construction and their consequences on policy and regulatory responses (including legislative responses), is therefore of analytical and normative interest within and beyond the Academy.

A more direct significance of the proposed thesis derives, partially, from its focus on Australia and, secondly, from its contribution to broader questions of practical and theoretical concern. Australia is a unique and understudied location for the study of securitization in regulatory design. While it has robust political and judicial institutions, is an active participant in the WHO, and possesses an advanced economy and health system, it alone of the world's 'democratic nations', lacks a Bill or national Charter of Human Rights.⁶² Indeed, political and judicial antipathy towards legislative entrenchment of rights has been common throughout its history.⁶³ Combined with its Westminster-style parliamentary democracy – where the Executive largely dominates one chamber of the Legislature – there are few extra-political mechanisms and domestic forums through which to challenge laws that ignore non-majoritarian interests and trend towards the (disputed) intended endpoint of securitization: 'Schmittian' exceptionalism, where 'Sovereign is he who declares the exception'.⁶⁴

For the Australian reader, health practitioner or researcher, this factor ought not be understated. The lack of entrenched human rights protections arguably makes the consequences of a successful 'securitizing move' more serious. The obligations imposed by binding, domestic and supra-national human rights instruments feature in the literature either as specific tools of analysis or as instrumental embodiments of desirable or self-evident norms that would bind conduct by practitioners and the state in the event of a health emergency.⁶⁵ In Australia,

⁶² George Williams, 'The Victorian Charter of Human Rights and Responsibilities: Origins and Scope' (2006) 30 *Melbourne University Law Review* 880, 883 (citing Gareth Griffith, 'The Protection of Human Rights: A Review of Selected Jurisdictions' (Briefing Paper No 3, Parliament of New South Wales, 2000). As of February 2023, only three sub-national units of Australia – the Australian Capital Territory and the states of Victoria and Queensland – have Human Rights Acts (or Charters of Rights).

⁶³ See Williams, above n 62, 884–885 for historical antecedents. Constitutional human rights entrenchment has also failed to secure popular support: Scott Bennett, 'The Politics of Constitutional Amendment' (Research Paper No 11 2002-03, Parliament of Australia, 23 June 2003) <<https://web.archive.org/web/20221128000927/www.aph.gov.au/binaries/library/pubs/rp/2002-03/03rp11.pdf>> 6. For judicial comment see: *Momcilovic v The Queen* [2011] HCA 34 [389] Heydon J; Timothy Vines and Thomas Faunce, 'A Bad Trip for Health-Related Human Rights: Implications of *Momcilovic v the Queen* (2011) 85 ALJR 957' (2012) 19 *Journal of Law and Medicine* 685.

⁶⁴ Carl Schmitt, *Political Theory: Four Chapters on the Concept of Sovereignty* (George Schwab trans, the MIT Press, 1985 [2nd edition, 1934]); Michael C Williams, 'Words, Images, Enemies: Securitization and International Politics' (2003) 47(4) *International Studies Quarterly* 511; Giorgio Agamben, *Sovereign Power and Bare Life* (Daniel Heller-Roazen trans, Stanford University Press, 1998).

⁶⁵ For example: Richard J Coker, S Mounier-Jack and R Martin, 'Public Health Law and Tuberculosis Control in Europe' (2007) 121(4) *Public Health* 266; R Martin, 'The Role of Law in Pandemic Influenza Preparedness in Europe' (2009) 123(3) *Public Health* 247; Gostin, *Public Health Law: Power, Duty, Restraint*, above n 55;

the absence of significant rights protection requires a different analysis of ‘power’, ‘duty’ and ‘restraint’ in the context of public health.⁶⁶ It is therefore important that research be undertaken in jurisdictions where some of the usual background ‘rules’ associated with countries in the Global North cannot be assumed.⁶⁷

Finally, this thesis also seeks a practical significance, namely engaging in the task of questioning and transforming the negative outcomes of securitization by identifying non-judicial remedies and strategies for desecuritization. As mentioned earlier, challenging securitizing moves, disputing the nature or significance of the ‘threat’ and attempting to move topics away from emergency politics has been considered the ‘political ethic’ and [potentially] normative role of Securitization Theory.⁶⁸ Likewise, embedded in the conclusion of *Global Business Regulation* is an optimism that the ‘domination’ in the ‘story of the globalization of regulation’ can be challenged by citizens adopting various strategies, magnifying their individual power through collectivising, issue-based NGOs and infiltrating established ‘webs of dialogue’ and ‘influence’ and building their own to further their interests and principles.⁶⁹ While both theories are directed towards an international realm, it is hoped that they can be transposed, with necessary adjustments, to the microcosm of domestic regulation-making. In the absence of constitutionally entrenched rights, discursive strategies and ‘forum shifting’ may provide an effective tactic for individuals and marginalised groups in Australia seeking to challenge securitization. The creation of coalitions of ‘mass publics’ and ‘webs of influence’

Lawrence Gostin, ‘Legal Foundations of Public Health Law and Its Role in Meeting Future Challenges’ (2006) 120(SUPPL. 1) *Public Health* 8; Kristen Hessler, ‘Exploring the Philosophical Foundations of the Human Rights Approach to International Public Health Ethics’ in Michael Boylan (ed), *International Public Health Policy and Ethics* (Springer Dordrecht, 2008) 31; George J Annas, ‘Bioterrorism, Public Health, and Human Rights.’ (2002) 21(6) *Health Affairs* 94.

⁶⁶ S Guy and B Hocking, ‘Times of Pestilence: Would a Bill of Rights Assist Australian Citizens Who Are Quarantined in the Event of an Avian Influenza (Bird Flu) Pandemic?’ (2006) 17(3) *Current Issues in Criminal Justice* 451, 454.

⁶⁷ The importance of acknowledging ‘socio-political context’ (especially outside the Global North) was a focus in Monika Barthwal-Datta, ‘Securitisating Threats without the State: A Case Study of Misgovernance as a Security Threat in Bangladesh’ (2009) 35(2) *Review of International Studies* 277, although her concern was on the theory’s focus on the Westphalian-State as the main securitizing actor.

⁶⁸ Williams, ‘Words, Images, Enemies’, above n 64; Buzan, Wæver and De Wilde, above n 42; Thierry Balzacq, ‘The “Essence” of Securitization: Theory, Ideal Type, and a Sociological Science of Security’ (2015) 29(1) *International Relations* 103; Floyd, ‘Can Securitization Theory Be Used in Normative Analysis?’, above n 53.

⁶⁹ Braithwaite and Drahos, above n 36, Chapter 26. ‘Republicanism’ as a preferred form of governance/government infuses much of this political program. On republicanism see: Richard Bellamy, ‘Republicanism’ in Gerard Delanty and Stephen P Turner (eds), *Routledge International Handbook of Contemporary Social and Political Theory* (Routledge, 1st ed, 2011) 130; P Pettit, ‘Freedom and the State: Nanny or Nightwatchman?’ (2015) 129(8) *Public Health* 1055, compare: Stephen R Latham, ‘Political Theory, Values and Public Health’ (2016) 9(2) *Public Health Ethics* 139.

may overcome the embedded (or sedimented)⁷⁰ power relations that would normally assist a security actor.

6. Definitions and key terms

In this section I set out preliminary definitions of some of the key terms and phrases that feature in this thesis. As a qualitative research project, these terms were not fixed at conception and have shifted because of statements by research participants or through the documentary analysis.⁷¹

Disease [vs pathogen]

As with many other terms used in this thesis, the definition of disease used is that adopted in IHR 2005, namely: ‘an illness or medical condition, *irrespective of origin or source*, that presents or could present significant harm to humans’ (emphasis added). Importantly, this definition does not limit the IHR (and WHO) to only ‘naturally’ arising illnesses, such as seasonal influenza or Ebola, but includes illnesses that are caused by the deliberate or accidental release of a pathogen or other ‘CBRN’ event – an acronym used in security discourse to refer to ‘Chemical, Biological, Radiological or Nuclear’ events.

Because of this broad definition of disease, it is essential to distinguish measures to control a ‘disease’ from measures to control a ‘pathogen’. For example, the *Biosecurity Act 2015* (Cth) authorises the making of a list of ‘quarantinable disease’. Individuals with a confirmed or suspected case of a disease on this list may be subject to isolation or other human biosecurity measures. In contrast, ‘pathogen’ refers to the organism, process, or agent capable of causing disease. Most pathogens in this thesis are ‘wild’ (ie, naturally occurring), isolated or modified viruses, toxins, bacteria or fungi. Access to pathogens can be controlled, for example through the select agents’ regime in Part 3 of the *National Health Security Act 2007* (Cth). However, as examined further, certain *information* can also be treated the same as a living specimen in a petri-dish, such as genomic information related to the pathogenicity of a virus or bacteria.

⁷⁰ Braithwaite and Drahos, above n 36.

⁷¹ John W Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (Sage Publications, 4th ed, 2014) 42–45.

Health

References to ‘health’, may simply refer to a state of freedom from illness or disability or, as per the *Constitution of the World Health Organization*, ‘a state of complete physical, mental and social well-being.’⁷² Conceptually, health can be seen as an economic ‘public good’, a ‘transcendent’ value or as an instrumental right protected under international human rights treaties or domestic law.⁷³ It can even be approached as a technique of government that exercises biopower over a population through a variety of biopolitics.⁷⁴

In general, nothing turns on these different conceptual approaches to health in this thesis with two exceptions. First, as is argued in later Chapters, ‘health’ (generally or, more commonly, of a specific population group) can be identified by a security-actor as a ‘referent object’ in a securitizing-move. A risk to the health of a population could arise from a ‘biosecurity’ threat. (Already the language of ‘biosecurity’ points to a biological/disease-centred concept of health). Second, the ‘health’ that is the subject of a particular securitizing move may – by process or consequence – ‘silence’ or ‘disappear’ other ‘healths’, for example the health of individuals overseas, the health of the infected vs an uninfected population or the occupational health of workers and medical practitioners who interact with potentially infected populations.⁷⁵

Public Health (as a discipline or field)

Public Health and ‘global public health’ connote more than a simple aggregation of the health of multiple individuals. Likewise, it is more than ‘the art and science of promoting and protecting good health, preventing disease, disability, and premature death, restoring health when it is impaired, and maximizing the quality of life when health cannot be restored.’⁷⁶ This

⁷² *Constitution of the World Health Organization*, signed 22 July 1946 [1948] ATS 7 (entered into force 7 April 1948).

⁷³ Latham, above n 69, 139; Jonny Anomaly, ‘Public Health and Public Goods’ (2011) 4(3) *Public Health Ethics* 251; Gostin, ‘Legal Foundations of Public Health Law and Its Role in Meeting Future Challenges’, above n 65; *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1976, [1976] ATS 5 (entered into force in Australia 10 March 1976) (‘ICESCR’) art 12.

⁷⁴ Achille Mbembe, ‘Necropolitics’ (2003) 15(1) *Public Culture* 11; Foucault, *Society Must Be Defended*, above n 35; Michael Foucault, *Security, Territory, Population*, Michael Senellart (ed) (Graham Burchell trans, Picador, 2007); Nikolas Rose, Pat O’Malley and Mariana Valverde, ‘Governmentality’ (2006) 2(1) *Annual Review of Law and Social Science* 83; Stephen Legg, ‘Foucault’s Population Geographies: Classifications, Biopolitics and Governmental Spaces’ (2005) 11(3) *Population, Space and Place* 137.

⁷⁵ Silencing may be a theoretical/process implication of securitization: see discussion in, Roe, above n 53. For an example of ‘disappearing’, see: Niamh Stephenson, ‘The Disappearing Act of Global Health Security’ in Enemark and Selgelid (eds), *Global Health: Ethics and Security Aspects of Infectious Disease Control: Interdisciplinary Perspectives* (Ashgate Publishing, 2012).

⁷⁶ John M Last, *A Dictionary of Public Health* (Oxford University Press, 1st ed, 2007) Preface.

is a goal, rather than a description of what public health *involves* as a discipline or field. As a field, public health involves ‘solutions or strategies [including] the implementation of education programs, recommending public health legislation or policies, administering services and through conducting research.’ In a liberal democracy, these solutions and strategies should conform to some high-level principles, such as the ‘rule of law’, ‘legality’, or respect for the rights of individuals.⁷⁷

In 2015-2016, the World Federation of Public Health Associations, in conjunction with the WHO, developed a ‘Global Charter for the Public’s Health’.⁷⁸ An extract of this charter is included at Table 2. Given its prominence, this thesis adopts the Charter’s ‘components’ of public health, noting that only some of these components are directly relevant to an exploration of biosecurity.

Governance: public health legislation; health and cross-sector policy; strategy; financing; organisation; assurance: transparency, accountability and audit.

Information: surveillance, monitoring and evaluation; monitoring of health determinants; research and evidence; risk and innovation; dissemination and uptake.

Protection: international health regulation and co-ordination; health impact assessment; communicable disease control; emergency preparedness; occupational health; environmental health; climate change and sustainability.

Prevention: primary prevention: vaccination; secondary prevention: screening; tertiary prevention: evidence-based, community-based, integrated, person-centred quality healthcare and rehabilitation; healthcare management and planning.

Promotion: inequalities; environmental determinants; social and economic determinants; resilience; behaviour and health literacy; life-course; healthy settings.

Advocacy: leadership and ethics; health equity; social-mobilization and solidarity; education of the public; people-centred approach; voluntary community sector engagement; communications; sustainable development.

⁷⁷ This argument forms the basis for the ‘power, duty, restraint’ framework of Gostin’s concept of public health law: Gostin, ‘Legal Foundations of Public Health Law and Its Role in Meeting Future Challenges’, above n 65, 8; Gostin, *Public Health Law: Power, Duty, Restraint*, above n 55, cited with approval in Richard Coker, ‘Communicable Disease Control and Contemporary Themes in Public Health Law’ (2006) 120(SUPPL. 1) *Public Health* 23, 23; RJ Coker et al, ‘Public Health Law and Tuberculosis Control in Europe’, above n 65, 267. Others adopt more value-neutral definitions of public health law, eg, G Howse, ‘Formulating a Model Public Health Law for the Pacific: Programme Methods’ (2009) 123(3) *Public Health* 237, 237; B Bennett, ‘Legal Rights during Pandemics: Federalism, Rights and Public Health Laws - a View from Australia’ (2009) 123(3) *Public Health* 232, 233. On legality, see: *Coco v The Queen* (1994) 179 CLR 427, 437 (Mason CJ, Brennan, Gaudron and McHugh JJ). Bruce Chen, ‘The French Court and the Principle of Legality’ (2018) 41(2) *University of New South Wales Law Journal* 401; Bruce Chen, ‘The Principle of Legality: Issues of Rationale and Application’ (2015) 41(2) *Monash University Law Review* 329.

⁷⁸ M Lomazzi, ‘A Global Charter for the Public’s Health—the Public Health System: Role, Functions, Competencies and Education Requirements’ (2016) 26(2) *The European Journal of Public Health* 210; Michael Moore et al, ‘The Global Charter for the Public’s Health’ (2016) 26(2) *European Journal of Public Health* 207.

Capacity: workforce development for public health, health workers and wider workforce; workforce planning: numbers, resources, infrastructure; standards, curriculum, accreditation; capabilities, teaching and training.

Table 2: The elements of the Global Charter for the Public's Health⁷⁹

The extent to which the goals of public health justify such breaches of normal practice or 'paternalistic' regulation is not the subject of the thesis.⁸⁰ However, it *is* important to identify the 'values' that are traditionally associated with public health as a field, body of law and practice.

The values of Public Health

An initial set of public health values was identified from a review of Australian and international professional statements, legislation and literature and supplemented as the project developed. These values were:

- a preference for decisions to be based on 'scientific evidence'⁸¹
- that public health measures should be proportional to risk (determined according to scientific evidence, as assessed by experts), in terms of their severity, intrusiveness and longevity
- a preference for embedding expert-led and technocratic decision-making processes in regulation – but subject to...
- ... an ideal of promoting collaboration between government and the community
- respect for the dignity, human rights and freedoms of individuals
- a spirit of collective action, whether local, national or international that imposes reciprocal obligations on States and individuals to 'take all reasonable and practicable steps to prevent or minimise any harm to public health that might foreseeably result from anything done or omitted to be done...'.⁸²

⁷⁹ World Federation of Public Health Associations, *The Global Charter for the Public's Health* (no date) <<https://www.wfpha.org/wfpha-projects/14-projects/171-a-global-charter-for-the-public-s-health-3>>.

⁸⁰ But see, for example: Lawrence Gostin, 'General Justifications for Public Health Regulation' (2007) 121(11) *Public Health* 829; Pettit, above n 69.

⁸¹ IHR 2005 art 1 provides for definitions of 'scientific principles' and 'scientific evidence'.

⁸² This is expressed as a binding, individual 'general public health duty' in *Public Health Act* 2016 (WA) s 34(1). See also *Public Health and Wellbeing Act* 2008 (Vic) and the *Health Act* 1956 (NZ).

Regulation

Regulation, as examined in this thesis, is not confined to ‘legal requirements developed by executive agency pursuant to its enabling statutory authority’.⁸³ Regulation does not only take the form of primary and secondary legislation, wherein the state is the central (and possibly only) regulating subject. Drawing on the governance and regulation literature, ‘regulation’ is conceived of more as the ‘sustained and focused control over activities that are valued by the community’.⁸⁴ In analytical terms, this ‘de-centres’ the regulatory function away from the exclusive jurisdiction of the state and emphasises ‘complexity, fragmentation, interdependencies, and government failures, and suggest the limits of the distinctions between the public and the private and between the global and the national.’⁸⁵ This analytical decentring emphasises the need for empirical studies of regulation to look beyond the statute book and to identify the actors, mechanisms and strategies used to embed the ‘norms, standards, principles and rules’ that govern conduct and relationships.⁸⁶

7. Thesis outline

This Chapter has introduced the background and context to the project and established its purpose, scope and significance to a range of audiences. Chapter 2, discusses the emergence of ‘biosecurity’ as a trilogy of threats: emerging and re-emerging infectious diseases (in particular those that cause dread); bioterrorism, and dual-use life science research. This forms part of a broader literature review, which outlines the leading research in this area, synthesises its findings and outlines the space in which this thesis usefully fits.

The theoretical framework and research design for this study is detailed in Chapter 3.

Chapter 4 presents the findings from analysis of biosecurity related lawmaking processes in Australian’s national Parliament, with a particular focus on the language adopted by

⁸³ See this usage in: Benjamin M Meier, Patricia W Stone and Kristine M Gebbie, ‘Public Health Law for the Collection and Reporting of Health Care-Associated Infections’ (2008) 36(8) *American Journal of Infection Control* 537, 539; Gostin, *Public Health Law: Power, Duty, Restraint* (n 56).

⁸⁴ Based on Selznick’s 1985 definition of regulation, as quoted in David Levi-Faur (ed), *Handbook on the Politics of Regulation* (Edward Elgar, 2nd ed, 2013) 5. See generally: Peter Drahos (ed), *Regulatory Theory: Foundations and Applications* (ANU ePress, 2017).

⁸⁵ Julia Black, *Critical Reflections on Regulation* (Centre for Analysis of Risk and Regulation at the London School of Economics and Political Science, 2002) <<http://www.lse.ac.uk/CARR>>; Julia Black, ‘Constructing and Contesting Legitimacy and Accountability in Polycentric Regulatory Regimes’ (2008) 2(2) *Regulation & Governance* 137.

⁸⁶ Braithwaite and Drahos above n 36, 10.

Government Ministers in their ‘Second Reading Speeches’ and the use of parliamentary tactics to steer debate.

Chapter 5 presents the findings from semi-structured interviews conducted with public servants (including health officers), researchers, industry groups and other stakeholders involved in biosecurity policymaking. Seeking to answer research questions on the extent of, and use of, securitization as a ‘mechanism’ in biosecurity regulatory regimes, this chapter focuses on how policymakers identified biosecurity threats, determined appropriate regulatory responses to those threats and then deployed particularly tactics and ‘mechanisms’ to design and – where necessary – secured agreement from key audiences to the proposed reforms.

Chapter 6 presents the findings from semi-structured interviews conducted with individuals involved in preparing for pandemics and responding to two public health emergencies: the outbreak of pandemic H1N1 influenza in 2009 and the Ebola outbreak. In contrast to the pre-emptive activities examined in Chapters 4 and 5, Chapter 6 seeks to identify the use of securitization in Australia’s pandemic planning activities and responses to the 2009 pandemic of H1N1 and the Ebola outbreak.

Chapter 7 discusses the results of this study and draws several conclusions of relevance to security analysts, practitioners, and policymakers. Interrogating the scholarship, the chapter closes with a reflection on the research objectives and draws attention to the value of adopting an interdisciplinary and multi-method approach.

Chapter 2: Literature Review

This review of the international literature begins by setting the historical and social context for examining regulatory responses to infectious diseases and their causative agents. Section 2 discusses how diseases and infectious agents have come to be framed as security threats. This section also outlines the Copenhagen School's Securitization Theory and how it has been applied to examinations of a trilogy of biosecurity threats: emerging and re-emerging infectious diseases; bioterrorism, and dual-use life science research. Distinguishing the use of the term 'biosecurity' in the literature, this section includes a discussion of the multiple meanings of biosecurity, particularly within an Australian context. This is particularly relevant in the context of Chapters 4 and 5's examination of biosecurity lawmaking and policymaking, respectively.

Having established the basis for augmenting Securitization Theory with other theoretical frameworks, Section 3 provides a brief overview of the governance and regulation literature and introduces Braithwaite and Drahos' work on the role of mechanisms and principles in the globalization of regulation. Section 4 of this Chapter concludes by outlining the gap in the current literature in which this thesis usefully fits.

1. Fear and control: a historical and social context for examining regulatory responses to infectious diseases

The study of infectious diseases, and effective measures to prevent their spread and, if possible, emergence has driven the development of multiple disciplines, practices and medical, social, religious and regulatory interventions.⁸⁷ In studying pandemics, it is necessary to go

⁸⁷ Leviticus 11, 13, *The Bible* (New International Version). See also historic and literary depictions of pandemics, eg, the character of the priest in Albert Camus, *The Plague* (trans Stuart Gilbert, Penguin, 1960). Chairman Mao farewelled the 'God of plague' in sonnet after reading that schistosomiasis had been wiped out in Yukiang County: Mao Zedong, *Farewell to the God of Plague* (unknown trans, 2007 [1958]) Marxists.org <<https://www.marxists.org/reference/archive/mao/selected-works/poems/poems25.htm>>. Religious interventions have also manifested in the form of discrimination and murderous violence, for example the pogroms launched against Europe's Jews during the Black Death: Robert S Gottfried, *The Black Death: Natural and Human Disaster in Medieval Europe* (The Free Press, 1983), 52-53; 73-74; Sylvia Tesh shows xenophobia was a common 'embellishment' to the 'contagion theory' of disease: *Hidden Arguments: Political Ideology and Disease Prevention Policy* (Rutgers, 1st ed, 1988) 13-14.

beyond clinical analysis and consider the social context in which they exist. The pandemics of old, arising suddenly, falling indiscriminately on rich and poor, and all consuming, would have appeared to many, as sharp and unappealable a judgement as any executioner's blade. Consequences from these outbreaks were social as well as medical and biological. Introducing the situation that presaged the events of the *Decameron*, Italian author Giovanni Boccaccio, himself a survivor of the pandemic of plague that swept through Europe in the 14th Century, reflected on the dissolution of the bonds of kinsfolk:

Tedious were it to recount, how citizen avoided citizen, how among neighbours was scarce found any that shewed fellow-feeling for another, how kinsfolk held aloof, and never met, or but rarely; enough that this sore affliction entered so deep into the minds of men and women, that in the horror thereof brother was forsaken by brother, nephew by uncle, brother by sister, and oftentimes husband by wife; nay, what is more, and scarcely to be believed, fathers and mothers were found to abandon their own children, untended, unvisited, to their fate, as if they had been strangers.⁸⁸

With no real countermeasures – save isolation, exclusion and often counter-productive purification efforts – pandemics have been humanity's *danse macabre* partner, a horse-bound bringing of the end-times and solvent of the bonds of nation and family.⁸⁹

Despite advances in the understanding of the biological basis for disease and the aetiology of modern pandemics, human responses to disease based on fear and suspicion continue to confront and challenge communities, national and subnational governments and – potentially – global systems of governance.⁹⁰ Fear of pestilence and contagion make pandemics as much a social, cultural and political phenomena as a scientific one.⁹¹ A book released by Médecins Sans Frontières (MSF) shortly after the 2013–16 Ebola Outbreak recognises the centrality of 'fear' by making it a titular figure.⁹² Modern responses to outbreaks (particularly those where a response occurs 'to' a community) are alien and alienating. For example, the

⁸⁸ Giovanni Boccaccio, *Collected Works of Giovanni Boccaccio* (trans J M Rigg, Delphi Classics, eBook ed, 2017). Lamentations about the 'breakdown in human intercourse' can be found in other chronicles of epidemics, eg, Tesh, above n 87, 12-13.

⁸⁹ At least since the agricultural revolution: Andrew T Price-Smith, *Contagion and Chaos: Disease, Ecology, and National Security in the Era of Globalization* (MIT Press, 2009), 34. See also introductory chapters in: William H McNeill, *Plagues and Peoples* (Anchor Books, 3rd ed, 1998); Bollet, above n 23; Roy Porter, *The Greatest Benefit to Mankind: A Medical History of Humanity from Antiquity to the Present* (HarperCollins, 1997).

⁹⁰ Michiel Hofman and Au Sokhieng (eds), *The Politics of Fear: Médecins Sans Frontières and the West African Ebola Epidemic* (Oxford University Press, 2017); Peter Doherty, *Pandemics: What Everyone Needs to Know* (Oxford University Press, eBook ed, 2013).

⁹¹ Alison Bashford, 'Global Biopolitics and the History of World Health', above n 11; Tesh, above n 87.

⁹² Hofman and Sokhieng, above n 90.

involvement of ‘space-suited’ (Figure 2), foreign healthcare workers who, during the 2013–2016 Ebola outbreak, would remove victims to distant hospitals, render them ‘unvisited’ and, in death, a stranger unto their own community by imposing ‘modern’ but alien approaches to burial.⁹³ Reports of individuals with COVID-19 being whisked away from their family members by hazmat-suited paramedics, only to die separated from loved ones, suggests such experiences are not culturally-specific.



Figure 2: Ebola healthcare workers wearing PPE during training. Credit: Nahid Bhadelia (2014)

Supposedly ‘enlightened’ nations have likewise, adopted public health measures seemingly driven by fear of the spread of contagion or in response to public and media demands for action – shifting rapidly from neglect to reportage as spectacle.⁹⁴ On the Ebola outbreak, João Nunes observed that, in Western media, the outbreak ended up being treated as a staged event, a dramatic occurrence punctuated by ritualistic moments: images from infirmary wards, nameless individuals in mourning, the health workers in biohazard suits, the rioting crowds, sombre declarations in Washington and Geneva, the arrival of Western personnel. In a similar vein, Price-Smith suggests that policy responses to the risk of contagious disease similarly cycle between periods of apathy and panic, driven in part by the ‘truncated attention span[s]’

⁹³ Ibid, 204. Referring to ‘unsafe burial practices’, Gostin and Friedman also adopted an Economist article’s designation of traditional practices as creating ‘underground transmission chains’: Gostin and Friedman, above n 7, 1902. For a discussion on the ‘mediating’ role of personal protective equipment (PPE) in Ebola see: Polly Pallister-Wilkins, ‘Personal Protective Equipment in the Humanitarian Governance of Ebola: Between Individual Patient Care and Global Biosecurity’ (2016) 37(3) *Third World Quarterly* 507.

⁹⁴ João Nunes, ‘Ebola and the Production of Neglect in Global Health’ (2016) 37(3) *Third World Quarterly* 542, 552. See also: Mita Saksena, *Framing Infectious Diseases and U.S. Public Opinion* (PhD Dissertation, Florida International University, 2011).

of humans, prominence bias and the difficulty of observing ‘attenuated processes’ – such as environmental destruction, which might drive disease emergence.⁹⁵

The pandemic’s dimension of fear can evoke stigma in populations and, as Enemark and others identified, in ‘dread’: a ‘visceral’ fear that arises from a recognition that the ‘*manner*’ of one’s death is perhaps a stronger motivator than knowledge of, or the inevitability, of death.⁹⁶ This dread can occur in populations outside affected territories and result in adverse outcomes, such as discrimination against suspected populations, the application (even welcomed) of draconian legislation to prevent the spread of infection and – as outlined above – deviation from previously agreed governance regimes.⁹⁷

The term ‘pandemic’ itself is fluid, serving epidemiological, symbolic and rhetorical purposes. As White says, epidemics have multiple ‘registers’.⁹⁸ Epidemiologically, the label ‘epidemic’ serves as a classification tool for outbreaks with specific, ‘objective’ characteristics;⁹⁹ while its symbolic and rhetorical functions may include as a threat amplifier or as a linguistic tool of authorisation.¹⁰⁰ Indeed, the WHO recognised the rhetorical power of the term, despite it not featuring in the IHR 2005. For example, in justifying applying the appellation ‘pandemic’ to COVID-19 on 11 March 2020, the WHO’s Director-General remarked that the label reflected ‘the alarming levels of spread and severity’ of the disease as the ‘the alarming levels of inaction’. In doing so, Dr Ghebreyesus cautioned that ‘Pandemic is not a word to use lightly or carelessly. It is a word that, if misused, can cause unreasonable

⁹⁵ Price-Smith, above n 89, 196–197.

⁹⁶ Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia* above n 27, 8–10. For an examination of stigma in a previous Ebola outbreak, see: John Kinsman, “‘A Time of Fear’: Local, National, and International Responses to a Large Ebola Outbreak in Uganda” (2012) 8(15) *Globalization and Health*.

⁹⁷ Alexander Abdo et al, *Fear, Politics, and Ebola* (ACLU Foundation Yale Global Health Justice Partnership, 2015) 29–30.

⁹⁸ Alexandre I R White, *Epidemic Orientalism: Race, Capital, and the Governance of Infectious Disease* (2023, Stanford University Press) 3.

⁹⁹ See for example, the WHO’s influenza pandemic ‘phases’: WHO, *About Pandemic Phases* (15 April 2022 [archived]) WHO Europe <<https://web.archive.org/web/20220415190804/https://www.euro.who.int/en/health-topics/communicable-diseases/influenza/data-and-statistics/pandemic-influenza/about-pandemic-phases>>; WHO, *Pandemic Preparedness and Response: A WHO Guidance Document* (WHO, 2009). See also remarks by Dr Anthony Fauci in February 2020: ‘Pandemics mean different things to different people’ cited in Jacqueline Howard, ‘Coronavirus outbreak has ‘pandemic potential’ but it’s not there yet, WHO says’, *CNN* (online), 24 February 2020 <<https://edition.cnn.com/2020/02/24/health/coronavirus-outbreak-pandemic-who-bn/index.html>>.

¹⁰⁰ WHO, ‘WHO Director-General’s opening remarks at the media briefing on COVID-19’ (Press Conference, 11 March 2020). Executive Director of the WHO’s Health Emergencies Programme, Dr Mike Ryan, pointed to the risk that declaring an outbreak a pandemic may lead to fatalism on the part of countries and individuals: ‘I’m ... concerned about that the world’s reaction will be to that word [pandemic]. Will we use it as a call to action? Will we use it to fight? Or will we use it to give up?’ cited in Helen Branswell, Andrew Joseph, ‘WHO Declares the Coronavirus Outbreak a Pandemic’, *Scientific American* (online), 11 March 2020 <<https://www.scientificamerican.com/article/who-declares-the-coronavirus-outbreak-a-pandemic/>>.

fear, or unjustified acceptance that the fight is over, leading to unnecessary suffering and death.’¹⁰¹

As a study grounded in a constructivist ontology, the symbolic and rhetorical power of the term pandemic matters more than whether it meets an epidemiological threshold. A disease that has pandemic *potential* is therefore as relevant as a ‘true’ pandemic. Consequently, it is important to examine how the threat of disease is problematised, attached to other issues and, also, what means are proposed to prevent and respond to outbreaks. Complicating matters is the paradoxical nature of pandemics. On the one hand, they represent a collectivising event: by definition large populations and widespread communities are affected and come to share the experience.¹⁰² Yet, as the extract from the *Decameron*, chronicles of past epidemics and testimony and photos from the 2013–16 Ebola outbreak reveal, they can serve as isolating and atomising experiences – with ‘victims’ cast out, quarantined, excluded, or abandoned to their own fate.¹⁰³ During COVID-19, early lockdowns in Australia and New Zealand were collective events but also divided individuals and families into ‘bubbles’ and ‘households’. Later, region-specific lockdowns in Melbourne (2020) and Auckland (2021) extended this act of division to geographic in and out-groups.

As evidenced in past pandemics, in- and out-group dynamics can flare, with scapegoating of individuals and minority groups (such as European Jews during the Black Death) transmuting practices of hygiene and sanitation into ethnic-cleansing.¹⁰⁴ Treatment of gay men and men-who-have-sex with men (MSM) communities during the AIDS crisis and 2022–2023 mpox (formerly known as ‘monkeypox’) outbreak reflect modern examples of scapegoating.¹⁰⁵ Pre-germ theory notions of disease, such as the ‘supernatural and ‘personal

¹⁰¹ WHO, ‘WHO Director-General’s opening remarks at the media briefing on COVID-19’ (Press Conference, 11 March 2020).

¹⁰² The narrator in *The Plague* remarked how ‘once the town gates were shut, every one of us realised that all...were, so to speak, in the same boat...for example, a feeling normally as individual as the ache of separation from those one loves suddenly became a feeling in which all shared alike...’ Albert Camus, above n 87 [location 721]. For an all too brief recitation of instances of sacrifice and solidarity in the 2014–16 Ebola outbreak see Suerie Moon et al, ‘Will Ebola Change the Game? Ten Essential Reforms before the next Pandemic. The Report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola’ (2015) 386(10009) *The Lancet* 2204, 2207.

¹⁰³ During the 2013–2016 Ebola outbreak, several Western media outlets published photos of supposed Ebola victims who had been left abandoned in the streets. Healthcare worker reflections on the barriers PPE creates are referenced in: Pallister-Wilkins above n 93.

¹⁰⁴ Gottfried, above n 87, 52–53, 73–74; Tesh, above n 87, 13–14; Elbe, ‘Securitizing Epidemics: Three Lessons from History’ above n 23; Price-Smith, above n 89, 41–43.

¹⁰⁵ See a short list of examples in Jeremy Youde, *Biopolitical Surveillance & Public Health in International Politics* (Palgrave MacMillan, 2010) 101. On stigma associated with gay and MSM in the 2022–2023 mpox outbreak, see WHO, ‘Second meeting of the International Health Regulations (2005) (IHR) Emergency

behaviour’ theories of disease, find a contemporary echo in ‘modern’ notions of ‘recklessness’.¹⁰⁶ To these and other ‘reckless’ individuals, a new label is fixed: ‘super-spreader’, cloaking – as Youde argues – familiar notions of blame in a newer, clinical term.¹⁰⁷ Then and now, our responses to diseases present challenges to individual and collective rights.

Likewise, pandemics can both lead to an increase in the authorised role of the state, with wide-spread calls for ‘action’ and a greater acceptance of inconvenience or intrusion, whether that is the establishment of formal quarantine zones, privacy-intruding thermal scanners and a lack of tolerance for individuals such as healthcare workers whose actions, however noble, are seen as presenting a risk to the community.¹⁰⁸ As the literature traced below has revealed, states or others may ultimately feel that a specific disease or outbreak presents such an extreme or existential risk – either to the state itself or its population – that it seeks to frame it as a security concern justifying the use of exceptional measures.

At the community level, responding to health emergencies, therefore, requires acknowledging their cultural dimensions and viewing outbreaks and pathogens within a broader context than the merely clinical.¹⁰⁹ Conversely, gaining insight into how some biological agents/disease/outbreaks come to be constructed as ‘threats’ can assist those who seek to challenge such constructions. If politically normative goals of ‘emancipatory politics’,

Committee regarding the multi-country outbreak of monkeypox’ (Press Release, 23 July 2022). In November 2022, the WHO recommended that the term ‘monkeypox’ be replaced with ‘mpox’, identifying stigmatisation as one of the rationales for the change: WHO, ‘WHO recommends new name for monkeypox disease’ (Press Release, 28 November 2022).

¹⁰⁶ Tesh, above n 87, 21-25. In the preface to *Plagues and People*, McNeill laments the fate of individuals ‘persist[ing] in reckless behaviour’ in relation to AIDS: McNeill, above n 89, 13. In contrast, Youde discusses the leadership of the gay community domestically and internationally in elevating HIV/AIDS as a public health matter and ‘connecting their work’ with human rights instruments and frameworks: Youde, *Globalization and Health*, (Rowman & Littlefield, 2020) 95-99; Youde, above n 105, 100-101.

¹⁰⁷ See discussion of ‘super-spreaders’ in Youde, *Globalization and Health*, above n 106, 21-22. Contemporary practice is to refer to superspreading ‘events’ to reduce stigma dehumanisation. For example: Max SY Lau et al, ‘Spatial and Temporal Dynamics of Superspreading Events in the 2014–2015 West Africa Ebola Epidemic’ (2017) 114(9) *Proceedings of the National Academy of Sciences* 2337; Davies, Kamradt-Scott and Rushton above n 26, 20.

¹⁰⁸ Elbe writes of the disciplinary consequences of the ‘vast international “curing machine”’ on the bodies of individuals with (or suspected of having) HIV: Stefen Elbe, *Virus Alert: Security, Governmentality and the AIDS Pandemic* (Columbia University Press, 2009) 19-20. Gostin, ‘Legal Foundations of Public Health Law’, above n 65; Gostin, *Public Health Law: Power, Duty, Restraint* above n 55; Hofman and Sokhieng above n 90. Thermal scanners and the political response to returning Ebola healthcare workers are examined later in this thesis.

¹⁰⁹ For example, during the 2013–2016 Ebola outbreak, the International Federation of the Red Cross introduced a ‘Safe and Dignified Burials’ program and anthropologists were brought in to work with health organisations and local populations: Max SY Lau et al, above n 107. On the role of anthropologists see: Catherine Bolten and Susan Shepler, ‘Producing Ebola: Creating Knowledge In and About an Epidemic’ (2017) 90(2) *Anthropological Quarterly* 349. For an overview of a community-led approach, see: John Kinsman et al, ‘Development of a Set of Community-Informed Ebola Messages for Sierra Leone.’ (2017) 11(8) *PLoS neglected tropical diseases* e0005742.

human rights conformance or ‘restraint’ by the state are to be achieved, it is important to understand the way in which infectious disease can be deployed by individuals and governments to justify the creation of new laws and policies – especially when they are configured as ‘security threats’.¹¹⁰ Even for the researcher or policymaker who consider their work less normative and more centred on ‘practical’ questions of ‘effective’ regulation and counter-measures, it is vital to approach the issue from multiple disciplinary perspectives.¹¹¹

2. Securitizing infectious diseases and Securitization Theory

The harmful consequences of infectious diseases are not limited to their direct physiological impact on humans, animals or plants or the social and stigmatising effects discussed above. Reports from domestic security and intelligence bodies, and statements from international institutions such as the WHO, have positioned infectious disease (and their causative agents) as a risk to national and/or global ‘human’ or ‘health security’.¹¹² Works by Elbe, Davies, Rushton and Price-Smith (among others) provide overviews of these reports – their antecedents - and summarise key literature in this area.¹¹³ Elbe’s early work, for example, focused on efforts and consequences of the international community securitizing HIV/AIDs;¹¹⁴ while Davies, Kamradt-Scott and Rushton consider the governance implications of securitizing global health.¹¹⁵ WHO reports on global health security from the early and mid-2000s have been cited by Fidler, Gostin and others as representing an inflection point for the

¹¹⁰ João Nunes, *Security, Emancipation and the Politics of Health: A New Theoretical Perspective* (Routledge, 2013), 120-124; Gostin, ‘Legal Foundations of Public Health Law’, above n 65; Gostin, *Public Health Law: Power, Duty, Restraint*, above n 55.

¹¹¹ John Braithwaite, ‘For Public Social Science’ (2005) 56(3) *British Journal of Sociology* 345.

¹¹² For example National Intelligence Council, *The Global Infectious Disease Threat and Its Implications for the United States* (United States, 2000). A 2001 report by the WHO likewise pointed to wider security dimensions, including ‘intentional or accidental release of biological agents’: WHO, *Global health security - epidemic alert and response* (Report by the Secretariat), WHO A54/9, Provisional agenda item 13.3, (2 April 2001). See also: Price-Smith, above n 89, 189-190. Price-Smith’s provides a short, US-centric account of the ‘derailment’ of health security into a traditional “‘guns, bombs, and terror” paradigm’ at 191-192.

¹¹³ See also: Alan Ingram (ed), *Health, Foreign Policy & Security* (The Nuffield Trust, 2004); Colin McInnes et al, ‘Framing Global Health: The Governance Challenge’ (2012) 7(SUPPL. 2) *Global Public Health*; and Lorna Weir, ‘Inventing Global Health Security, 1994-2005’ in Simon Rushton and Jeremy Youde (eds), *Routledge Handbook of Global Health Security* (Routledge, 2015), 18-27.

¹¹⁴ Elbe, ‘Should HIV/AIDS Be Securitized?’, above n 53; Stefan Elbe, *Virus Alert: Security, Governmentality and the AIDS Pandemic*, above n 108.

¹¹⁵ Davies, Kamradt-Scott and Rushton, above n 26; Sara E Davies, ‘The International Politics of Disease Reporting: Towards Post-Westphalianism?’, above n 33. See also: Youde, ‘MERS and Global Health Governance’, above n 54. Davies work builds on earlier work on ‘post-Westphalian’ disease governance by Fidler: eg, Fidler, *SARS, Governance and the Globalization of Disease*, above n 38.

organisation.¹¹⁶ In *Disease Diplomacy: International Norms and Global Health Security*, for example, Davies, Kamradt-Scott and Rushton trace how WHO officials (acting as ‘norm entrepreneurs’) seized on this new framing to reshape the global governance of disease and the role of the WHO in it via the 2005 IHR. Such a shift in approach is evident in a 2007 WHO report subtitled *A safer future: global public health security in the 21st century*. In a preface to that report, then Director-General of the WHO Dr Margaret Chan argued that the new IHR represented a ‘significant departure from the past’ and ‘move away from a focus on *passive* barriers at borders, airports and seaports to a strategy of proactive *risk management*.’¹¹⁷

The reference to ‘risk management’ points to another development in the conceptualisation of disease outbreaks as a threat to security; indeed, to the concept of ‘security’ itself. While a review of the literature debating and critiquing the concept of security is beyond the scope of this thesis,¹¹⁸ the WHO’s adoption of the language of risk management is consistent with the theoretical use of the concept of ‘risk’ to extend the range of security threats away from ‘hard’ and quantifiable military concerns.¹¹⁹ The shift from using a pre-determined list of diseases (eg, cholera, yellow fever or plague) in previous iterations of the IHR to the open-ended coverage in the 2005 IHR of any ‘illness or medical condition, irrespective of origin or source, that presents *or could present* significant harm to humans’

¹¹⁶ David P Fidler and Lawrence Gostin, ‘The New International Health Regulations: An Historic Development for International Law and Public Health.’ (2006) 34(1) *The Journal of Law, Medicine & Ethics* 85; David P Fidler, ‘Influenza Virus Samples, International Law, and Global Health Diplomacy’ (2008) 14(1) *Emerging Infectious Diseases* 88; Fidler and Gostin, *Biosecurity in the Global Age*, above n 38.

¹¹⁷ WHO, *The World Health Report 2007: A Safer Future: Global Public Health Security in the 21st Century* (WHO, 2007) vii (emphasis added).

¹¹⁸ A helpful introductory overview can be found in: Johnathan Herington, ‘The Concept of Security’ in Christian Enemark and Michael J Selgelid (eds), *Global Health: Ethics and Security Aspects of Infectious Disease Control: Interdisciplinary Perspectives* (Ashgate Publishing, 2012) 7. See also: Jonathan Herington, ‘Philosophy: The concepts of security, fear, liberty, and the state’, in Philippe Bourbeau (ed), *Security: Dialogue across Disciplines* (Cambridge University Press, 2015) 22. See also Richard H Ullman, ‘Redefining Security’ (1983) 8(1) *International Security* 129 and Buzan’s discussion of this ‘essentially contested’ term in: Barry Buzan, *People, States and Fear* (Harvester Wheatsheaf, 2nd ed, 1991) 16-18.

¹¹⁹ On ‘risk society’ see: Ulrich Beck, *Risk society: Towards a new modernity* (Sage, 1992). Beck’s work and examination of the paradoxical process by which modernisation creates its own risks (‘reflexivity’) has found cross- and trans-disciplinary appeal. Some examples: Stephen J Collier and Andrew Lakoff, ‘Vital Systems Security: Reflexive Biopolitics and the Government of Emergency’ (2015) 32(2) *Theory, Culture & Society* 19; Carney and Bennett, ‘Framing pandemic management’, above n 55; David Malet and Mark Korbitz, ‘Accountability between Experts and the Public in Times of Risk’ (2014) 73(4) *Australian Journal of Public Administration* 491; Matt McDonald, ‘Securitization and the Construction of Security’ (2008) 14(4) *European Journal of International Relations* 563; Didier Bigo, ‘Security and Immigration: Toward a Critique of the Governmentality of Unease’ (2002) 27(Suppl 1) *Alternatives* 63.

shows a similar widening of what hazards can be positioned as risks and threats to health security.¹²⁰

As discussed below, the widening of the security agenda to capture infectious diseases and the concept of health security itself has been interrogated and critiqued. Questioning the claim in some of the health literature that disease outbreaks present some novel, existential threat to humanity, Elbe argues that – before germ theory, public health works and medical prophylactics and treatments – pandemics would have constituted genuinely ‘existential’ events for individuals and civilisations.¹²¹ (This author suggests that, except for marching Generals and those who exclaimed *L’état, c’est moi*, it is questionable whether individuals in pre-Enlightenment Europe would have seen pandemics as existential in the sense Elbe uses. For example, supernatural theories of disease (eg, as divine punishment or wrath) situate outbreaks within a different ontology. Indeed, while Pestilence rode with the horsemen of the Apocalypse, those horsemen were to usher in a new kingdom of heaven on Earth, presaging the eventual return of the messiah – offering *some* distant hope for the faithful, even if it required fatalism in the face of an outbreak).¹²²

Elbe’s critical engagement with the health securitization literature leads him to posit an alternate thesis: that it is not health that has been securitized, but rather that *insecurity* and the practice of security have been ‘medicalized’.¹²³ In addition to the securitizing of potential diseases (eg, in the IHR 2005), other examples cited by Elbe of the ‘transformation’ of security practice include the greater role (and therefore ‘political influence’) afforded to a range of health experts.¹²⁴ Another is the ‘increased development, stockpiling and development of new *medical* countermeasures’ (such as vaccines and PPE).

¹²⁰ IHR 2005 art 1 (definition of ‘disease’) (emphasis added). WHO, *International Health Regulations (IHR): Background* (no date) WHO Regional Office for the Eastern Mediterranean <<https://www.emro.who.int/international-health-regulations/about/background.html>>.

¹²¹ Elbe, ‘Securitizing Epidemics: Three Lessons from History’, above n 23, 80–82. A similar argument is made by Kamradt-Scott: Adam Kamradt-Scott, ‘Health, Security, and Diplomacy in Historical Perspective’ in Rushton and Youde (eds), *Routledge Handbook of Global Health Security* (Routledge, 2015), 189–191.

¹²² See, for example, fatalism by Christian and Islamic adherents in the face of the Black Death in Gottfried, above n 87, 81–83. On the ‘supernatural theory’ of disease see Tesh, above n 87, 17–21, including a discussion of the role of this theory on political philosophy. Susan Peterson likewise suggests that situating disease within a religious context may also reduce the extent that the community blames the government for its actions and inactions: Susan Peterson, ‘Epidemic Disease and National Security’ (2002) 12(2) *Security Studies* 43, 63.

¹²³ Stefan Elbe, ‘Pandemics on the Radar Screen: Health Security, Infectious Disease and the Medicalisation of Insecurity’ (2011) 59(4) *Political Studies* 848, 849; Elbe, ‘Securitizing Epidemics: Three Lessons from History’, above n 23.

¹²⁴ Elbe, ‘Pandemics on the Radar Screen’, above n 123, 863.

However, only *some* diseases, *some* biological agents and *some* activities and consequences have been positioned as security threats. This selectivity suggests that disease and biological risks have been identified via constructivist rather than objectivist approaches to security.¹²⁵ Diseases are not risks worthy of response because of objectively determined biological characteristics (such as annual mortality rates or mode of transmission) but through social processes of construction. As Youde summarised, a constructivist approach does not ‘assum[e] that self-evident material capabilities determine the presence or absence of security’ but, rather, ‘[security] issues emerge from how actors conceptualise them.’¹²⁶ Accepting this argument supports this study’s adoption of theoretical frameworks grounded in constructivism.

Many of the studies that examine how health security problems ‘emerge, evolve and dissolve’ draw on Securitization Theory as developed by Buzan, Wæver and De Wilde and others within the ‘Copenhagen school’ of security studies.¹²⁷ Introduced in Chapter 1, Securitization Theory was developed in response to theoretical opportunities and challenges that arose with the end of the Cold War and ‘dissatisfaction’ with the ‘narrow’ military focus of security studies during that period.¹²⁸ Seeking to ‘broaden’ the security agenda, Securitization Theory drew on Austin’s speech theory,¹²⁹ to argue that the construction of security problems is an intersubjective process, centred around one or more ‘illocutionary’ (ie performative) act/s.¹³⁰

In the classical, ‘radically constructive’, application of Securitization Theory the utterances of a securitizing actor take centre stage. As Wæver argues:

By uttering ‘security’ a state-representative [actor] moves a particular development into a specific area, and thereby claims a special right to use whatever means are necessary to block it.¹³¹

¹²⁵ Balzacq, ‘Constructivism and Securitization Studies’, above n 39, 56, 57; Buzan, Wæver and De Wilde, above n 42; Williams, ‘Words, Images, Enemies’, above n 64; Wæver, ‘Politics, Security, Theory’, above n 42.

¹²⁶ Jeremy Youde, ‘The Securitization of Health in the Trump Era’ (2018) 72(6) *Australian Journal of International Affairs* 535, 536.

¹²⁷ Buzan, *People, States and Fear*, above n 118; Buzan, Wæver and De Wilde, above n 42; Balzacq, above n 39, 59-60.

¹²⁸ Buzan, above n 118; Buzan, Wæver and De Wilde, above n 42, 2.

¹²⁹ Austin, above n 43; Lloyd, above n 43.

¹³⁰ Buzan, above n 118, 23; Buzan, Wæver and De Wilde, above n 42, 26, 32-33, 46-47(note 5).

¹³¹ O Wæver, ‘Securitization and desecuritization’ in: R Lipschutz (ed), *On Security* (Columbia University Press, 1995) 46, 55 quoted in: Jef Huysmans, ‘What’s in an Act? On Security Speech Acts and Little Security Nothings’ (2011) 42(4-5) *Security Dialogue* 371, 372.

Once positioned as a security issue, the actor claims ‘a right to handle the issue through extraordinary means.’¹³² Such means usually include a claimed right to ‘break the normal rules that bind’, be they political or legal; and to move the ‘issue beyond the established rules of the game and frames the issue either as a special kind of politics or above politics...’.¹³³ As part of the ‘grammar of security’ utterances must identify some referent object whose continued existence is threatened by the threat and whose defence thus justifies an exceptional response. Initial insistence on threats being presented as ‘existential’ has been convincingly challenged by some scholars as too limiting, and that positioning an issue as representing an ‘extreme’ threat to a referent object is sufficient to satisfy the ‘internal’ conditions (or logic) of security.¹³⁴ In the context of disease, Enemark recognises that certain diseases can invoke a sense of dread in populations that make them more susceptible to being securitized. Thus, it may not be necessary that the disease presents an existential risk to a referent object, especially one as depersonalised as the state.

As an inter-subjective process, a ‘securitizing move’ is usually said to have failed if the audience does not accept the justification for the rule-breaking,¹³⁵ or the relevant ‘threat framing’.¹³⁶ While primarily focused on speech-acts, the theory’s foundational text *A new Framework for Analysis* (*‘Framework for Analysis’*) admits of the role of conditions ‘external’ to the speech act, including ‘the social capital of the [securitizing actor], who must be in a position of authority, although this should not be defined as official authority.’¹³⁷

The necessity of acceptance by an audience (or even the need for an audience) as a condition for determining the ‘success’ of a securitizing move has been challenged by some scholars.¹³⁸ Others have sought to better distinguish audiences who provide formal as opposed

¹³² Buzan, Wæver and De Wilde, above n 42, 24; Huysmans, above n 131, 372.

¹³³ Buzan, Wæver and De Wilde, above n 42, 23.

¹³⁴ Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia* above n 27; Colin McInnes, ‘Health and Security Studies’ in Ingram, above n 113, 53-54. See also Rita Floyd, ‘Extraordinary or Ordinary Emergency Measures: What, and Who, Defines the “Success” of Securitization?’ (2016) 29(2) *Cambridge Review of International Affairs* 677.

¹³⁵ Buzan, Wæver and De Wilde, above n 42; Youde, above n 29.

¹³⁶ Rychnovská, above n 41, but cf, Floyd, ‘Extraordinary or Ordinary Emergency Measures’, above n 134.

¹³⁷ Buzan, Wæver and De Wilde, above n 42, 33, 212. The ‘sociological/sociopolitical’ stream of Securitization Theory has drawn on Bourdieu theories of ‘social field’ and concepts of sedimentation. See, eg, Salter, above n 45; Bigo, above n 119. For a general discussion of these strands see: Balzacq, ‘The “Essence” of Securitization’, above n 68, 103; Balzacq, ‘Constructivism and Securitization Studies’, above n 39; Holger Stritzel, ‘Towards a Theory of Securitization: Copenhagen and Beyond’ (2007) 13(3) *European Journal of International Relations* 357.

¹³⁸ Floyd, ‘Extraordinary or Ordinary Emergency Measures’, above n 134.

to ‘moral’ ‘authorisation’ for the security move.¹³⁹ The normative and even ‘emancipatory’ possibilities of the theory have been explored,¹⁴⁰ while the theory’s similarities with and linkages to ‘legacy’ of Carl Schmitt’s concept of ‘the exception’ have been plumbed by Williams.¹⁴¹ Indeed, it is this engagement with Schmittian concepts of exceptionalism, rule breaking and the role of ‘the Sovereign’ that makes Securitization Theory an intuitively attractive theoretical foundation from which to approach topics likely to invoke dread in a population, such as a pandemic or bioterror attack and where emergency measures are likely.¹⁴² As such, it is no surprise to see it applied in examinations of international and national responses to infectious disease generally, HIV/AIDS, pandemic influenza and Ebola.¹⁴³ As a negative concept, examinations of the security-exceptionalism nexus have highlighted how pre-existing prejudices and discriminatory attitudes can be deployed as part of a security response to a problem.¹⁴⁴ Whether a security actor is looking outwards or inwards, a pandemic or disease outbreak provides an opportunity to leverage off existing in and out-group dynamics, or (per Schmitt) of friend-enemy. For Buzan and others, the logic of security and of amity-enmity can turn inwards ‘into the domestic construction and life of the state’ and, presumably, the relationship between the state and those within its borders. Other scholars have examined how such framings can be deployed in the exercise of political power, to justify sovereign violence or the unmaking of people.¹⁴⁵

More optimistically, Securitization Theory’s normative position that desecuritization (and a return to normal politics) is usually optimal, combined with its ontological positioning of security as an *inter*-subjective process, carries the possibility that security moves can be defeated or reversed, no matter the authority of the security actor.¹⁴⁶

¹³⁹ Paul Roe, ‘Actor, Audience(s) and Emergency Measures: Securitization and the UK’s Decision to Invade Iraq’ (2008) 39(6) *Security Dialogue* 615. On the audience in Securitization Theory see: Thierry Balzacq, ‘The Three Faces of Securitization: Political Agency, Audience and Context’ (2005) 11(2) *European Journal of International Relations* 171.

¹⁴⁰ João Nunes, *Security, Emancipation and the Politics of Health*, above n 110; McDonald, above n 119, 580; Roe, ‘Is Securitization a “negative” Concept?’, above n 53, 260; Floyd, ‘Can Securitization Theory Be Used in Normative Analysis?’, above n 53.

¹⁴¹ Williams, ‘Words, Images, Enemies’, above n 64; Schmitt above n 64.

¹⁴² In a different field see: Latham, above n 69; David Dyzenhaus, ‘States of Emergency’ in Michel Rosenfeld and András Sajó (eds), *The Oxford Handbook of Comparative Constitutional Law* (Oxford University Press, 2012).

¹⁴³ Hanrieder and Kreuder-Sonnen, above n 40.

¹⁴⁴ Buzan, Wæver and De Wilde, above n 42, 50.

¹⁴⁵ Mbembe, above n 74; Muneer I Ahmad, ‘Rethinking Guantanamo: Rights at the Brink’ (2009) 103(4) *Northwestern University Law Review* 1683; Rabinow and Rose, above n 35.

¹⁴⁶ Buzan, Wæver and De Wilde, above n 42, 29; Paul Roe, ‘Securitization and Minority Rights: Conditions of Desecuritization’ (2004) 35(3) *Security Dialogue* 279. Going further, McDonald suggests that desecuritization

Relevant to this study, subsequent theoretical work has placed greater emphasis on the context of speech-acts and other ‘pragmatic acts’, ‘security practices’ (including legislation and policy) that represent the outputs of a securitizing move.¹⁴⁷ Engagement with the ‘social’ aspects of securitization has seen these studies draw upon other disciplines and theoretical frameworks, including framing and governance.¹⁴⁸ Studies undertaken by Salter and Karyotis have also eschewed Securitization Theory’s traditional preference for ‘discourse analysis’ – undertaken as a largely textual activity – and demonstrated the potential for applying, respectively, new analytical approaches and research methods (eg, elite interviews).¹⁴⁹

Threats from what? Diseases and the biosecurity constellation

Securitization theory and constructivist approaches to security have proven fruitful in analysing the ‘securitization of health’ and critiquing such practices for their adverse consequences on individuals, developing nations and even global health.¹⁵⁰ These critiques span disciplines, from international relations, public health studies, ethical perspectives on public health, and works aimed at a general audience.¹⁵¹

These works also identify a common set of security ‘problems’. Simon Rushton, in a critical analysis of ‘global health security’, summarised these disease-related security issues:

- ‘fast moving’ infectious diseases in a ‘globalised world’
- weaponised pathogens and their use by terrorists (bioterrorism) or state actors (biowarfare)

need not always be the end goal, and that security discourse can be progressive where it does not silence less dominant voices but allows for the articulation of ‘alternative visions for what security means and how it might be realized’, McDonald, above n 119, 580; discussed in Roe, ‘Is securitization a “negative” concept’, above n 53, 260.

¹⁴⁷ Balzacq, ‘The Policy Tools of Securitization’, above n 46; Balzacq, ‘Constructivism and Securitization Studies’, above n 39; Mark B Salter and Geneviève Piché, ‘The Securitization of the US-Canada Border in American Political Discourse’ (2011) 44(4) *Canadian Journal of Political Science* 929; Salter, above n 45; Nuria Lorenzo-Dus and Steve Marsh, ‘Bridging the Gap: Interdisciplinary Insights into the Securitization of Poverty’ (2012) 23(3) *Discourse & Society* 274.

¹⁴⁸ Scott Burris, ‘From Security to Health’ [2006] *Democracy and the Governance of Security* 196; Rychnovská, above n 41.

¹⁴⁹ Salter, above n 45; Karyotis, above n 52.

¹⁵⁰ Most of the texts already cited contain cautions about the adverse implications of applying a security framing to [global] health, notwithstanding the potential for such framings to secure short-term attention and resources. For other works, it is a dominant theme: eg, William Aldis, ‘Health Security as a Public Health Concept: A Critical Analysis’ (2008) 23(6) *Health Policy and Planning* 369. See summary of literature in: Colleen O’Manique and Pieter Fourie, ‘Security and Health in the Twenty-First Century’ in Mauer and Cavelti, above n 39, 243, 249–251.

¹⁵¹ On ethical dimensions of securitization see: Michael J Selgelid, ‘Ethics, Tuberculosis and Globalization’ (2008) 1(1) *Public Health Ethics* 10; Selgelid, Kelly and Adrian, above n 56; Selgelid, ‘Pandethics’, above n 56. An example of a public facing work is: Hofman and Au, above n 90.

- particularly in the case of HIV/AIDS, the ‘social , political, economic and military impacts [of a severe disease burden] which threaten the stability of states and regions.’¹⁵²

Other diseases that have been problematised as security issues include avian influenza (H5N1) and pandemic influenza, with related implications for virus sharing. To the list above, Gostin, Koblenz, Enemark and Selgelid would add a fourth problem: the accidental release of pathogens (bioerror) stored in containment and research facilities.¹⁵³ As discussed below, a related activity associated with bioterror/error/warfare is ‘dual-use research of concern’ (DURC) and particularly ‘gain of function’ life-science research, which has been problematised as the ‘dual-use dilemma’, with the potential public health benefits of such research weighed against the risk of accidental release and proliferation concerns. This thesis adopts the label of ‘biosecurity’ to cover these four threats. The next section provides an overview of interdisciplinary work examining these issues.

Biosecurity: meaning, content and agenda

In 2008, Fidler and Gostin described biosecurity policy as a ‘conceptual and practical minefield’.¹⁵⁴ One explanation for this unsteady terrain is the difficulty of objectively or consensually delimiting the ‘essentially contested’ root-term ‘security’.¹⁵⁵ A second, related, difficulty is that the use and content of the term ‘biosecurity’ is itself a tactical and political act that offers insights into the motives and interests of various interest groups and actors who deploy the term to serve particular ends or reflect certain principles.¹⁵⁶

The term’s content and meaning can also be shaped by institutional and even national histories. Relevantly, Australia’s geographic situation, and bureaucratic and ‘sanitary’ histories

¹⁵² Simon Rushton, ‘Global Health Security: Security for Whom? Security from What?’ (2011) 59(4) *Political Studies* 779, 782. See also Harley Feldbaum and Kelley Lee, ‘Public Health and Security’ in Alan Ingram (ed), *Health, Foreign Policy & Security* (The Nuffield Trust, 2004), 22-24; Aldis, above n 150.

¹⁵³ This is one of the ‘biosecurity dilemmas’ discussed in Enemark, *Biosecurity Dilemmas*, above n 27; Nicholas G Evans and Michael J Selgelid, ‘Biosecurity and Open-Source Biology: The Promise and Peril of Distributed Synthetic Biological Technologies’ [2014] *Science and Engineering Ethics* 1065; Enemark and Selgelid (eds), above n 38; Fidler and Gostin, *Biosecurity in the Global Age*, above n 38.

¹⁵⁴ Fidler and Gostin, *Biosecurity in the Global Age*, above n 38, cited in Gregory D Koblenz, ‘Biosecurity Reconsidered Calibrating Biological Threats and Responses Biosecurity Reconsidered’ (2010) 34(4) *International Security* 96, 104.

¹⁵⁵ Herington, ‘The Concept of Security’, above n 118 quoting J Gray, ‘On Liberty, Liberalism and Essential Contestability’ (1983) 8 *British Journal of Political Science* 385, 392.

¹⁵⁶ A mapping of different uses of the term is presented in Andrew Dobson, Kezia Barker and Sarah L Taylor, *Biosecurity: The Socio-Politics of Invasive Species and Infectious Diseases* (Routledge, 2013) Table 1.1.

reveal different actors involved in shaping the term's meaning.¹⁵⁷ For example, the Australian Department of Agriculture, Fisheries and Forestry (DAFF) uses 'biosecurity' to refer to a limited range of agricultural and health issues, namely 'the management of risks to the economy, the environment, and the community, of pests and diseases entering, emerging, establishing or spreading'.¹⁵⁸ Here the key referent object is Australia's status as 'free from many pests and diseases that affect agriculture, natural and built environments, and people in other parts of the world'.¹⁵⁹ As a definition, it signals a centrality of zero-sum economic interests and, for the biopolitical scholar, a colonial imagining of Australia as uncontaminated.¹⁶⁰ It is notable that in New Zealand (NZ), another isolated, settler-nation, the equivalent government department adopts a similar definition.¹⁶¹

Chapter 1 of this thesis distinguished this study from more critical examinations of the role of race, racism and colonial power in Australian disease prevention and response. These themes are not examined directly in this study nor, as is outlined in Chapter 3, was the research method designed to explicitly uncover and interrogate them. Nonetheless, Australia's historic approach to the management of disease and the diseased (real or imagined) warrant brief acknowledgement. Newly federated in 1901, one of the first acts of the new Parliament of the Commonwealth of Australia was to pass laws regulating the body of the population by expelling or preventing the entry and establishment of certain individuals via laws such as the *Immigration Restriction Act 1901* (Cth) and *Pacific Islander Labourers Act 1901* (Cth). These two laws formed a cornerstone of Australia's 'White Australia' policy. Studies such as those undertaken by Bashford, trace the lineage and influence of these laws and state and territory public health measures on populations, and the bodies of immigrants and Australia's first nations people. While the specific regulatory measures may have changed, the 'discourse' around disease may, as White argues for a global context, have stayed the same.¹⁶² For instance,

¹⁵⁷ On these histories see: Bashford, *Imperial Hygiene*, above n 35; Alison Bashford, 'At the Border', above n 35; Bashford and Howard, 'Immigration and Health: Law and Regulation in Australia, 1901-1958' (2004) 6(1) *Health and History* 97.

¹⁵⁸ Australian Government, *Intergovernmental Agreement on Biosecurity - An Agreement between the Commonwealth of Australia, State and Territory Governments to Strengthen the National Biosecurity System* (Commonwealth of Australia, 2012) [1.1]. This Agreement was replaced in 2019 but the definition remained the same: Australian Government, *Intergovernmental Agreement on Biosecurity - Intergovernmental Agreement on Biosecurity - An Agreement between all Australian Government* (Commonwealth of Australia, 2019) [9].

¹⁵⁹ Australian Government, *Intergovernmental Agreement on Biosecurity - Intergovernmental Agreement on Biosecurity - An Agreement between all Australian Government* (Commonwealth of Australia, 2019) [2].

¹⁶⁰ Bashford, 'At the Border', above n 35; Bashford, *Imperial Hygiene*, above n 35; Bashford and Macintyre, above n 57.

¹⁶¹ Ministry for Primary Industries [NZ], *Introduction to biosecurity legislation* (16 November 2020) <<https://www.mpi.govt.nz/law-and-policy/legal-overviews/biosecurity/>>.

¹⁶² White, *Epidemic Orientalism*, above n 58.

it is observed that while the *Immigration Restriction Act 1901* (Cth) sought to exclude from admission to the Australia polity ‘any person suffering from an infectious or contagious disease of a loathsome or dangerous character’,¹⁶³ today’s *Migration Act 1958* (Cth) likewise provides the Minister with the power to cancel and remove from Australia any non-permanent resident whose presence in Australia ‘may be, or would or might be, a risk to... the health, safety or good order of the Australian community or a segment of the Australian community’.¹⁶⁴ Certain classes of migrants are subject to prior health screening; meanwhile all non-citizens are required to declare their Tuberculosis Status on arrival – next to a question asking if they have any criminal convictions, as if those two questions are somehow related.¹⁶⁵

Notwithstanding antipodean idiosyncrasies, the content of biosecurity has been shaped by global events and trends in academic literature. Most prominently, in recent years, the label ‘biosecurity’ has been applied to justify new security dimensions to traditional laboratory ‘biosafety’ practices and additional oversight of research involving pathogens.¹⁶⁶ This evolution incorporated an older, international concern about the development and use of biological and chemical weapons. At an international level, this particular threat has been managed through the formal regime of the 1972 *Biological and Toxin Weapons Convention* (BWC) and the 1993 *Chemical Weapons Convention* (CWC) and international arms-control bodies such as the Australia Group and the *Wassenaar Arrangement on Export Controls for Conventional Arms and Dual-Use Goods and Technologies* (‘Wassenaar Arrangement’).¹⁶⁷ This bioterror concern can also be discerned in the IHRs, which no longer focus solely on naturally occurring disease but on disease ‘irrespective of origin or source’.¹⁶⁸ In this context, biosecurity agenda is seen as ‘impos[ing]’ an obligation on States and (through regulation) individual citizens to marshal ‘existing [domestic and international health] systems to protect public health.’¹⁶⁹ These systems include imposing domestic regulation for ‘controlling’ ‘select’

¹⁶³ *Immigration Restriction Act 1901* (Cth) s 3(d).

¹⁶⁴ *Migration Act 1958* (Cth) s 116(1)(e).

¹⁶⁵ Australian Border Force, *Incoming Passenger Card (IPC)* (22 February 2023)

<[https://www.abf.gov.au/entering-and-leaving-australia/crossing-the-border/at-the-border/incoming-passenger-card-\(ipc\)>](https://www.abf.gov.au/entering-and-leaving-australia/crossing-the-border/at-the-border/incoming-passenger-card-(ipc)>).

¹⁶⁶ Koblenz, above n 154; Vines, above n 1.

¹⁶⁷ *Convention on the Prohibition of the Development, Production and Stockpiling of Bacteriological (Biological) and Toxin Weapons and on their Destruction*, opened for signature 10 April 1972, 1977 ATS 23 (entered into force generally: 26 March 1975; for Australia: 5 October 1977) (hereafter ‘BWC’); *Convention on the Prohibition of the Development, Production, Stockpiling and Use of Chemical Weapons and on their Destruction*, opened for signature 13 January 1993, 1997 ATS 3 (entered into force for Australia and generally: 29 April 1997) (hereafter ‘CWC’).

¹⁶⁸ IHR 2005 art 1 (definition of ‘disease’).

¹⁶⁹ David L Heymann quoted in: WHO, *Public Health Response to Biological and Chemical Weapons WHO Guidance* (WHO, 2nd ed, 2004), viii.

biological agents, such as the *National Health Security Act 2007* in Australia (see Chapter 4) and the US PATRIOT Act and *Public Health Security and Bioterrorism Preparedness and Response Act of 2002*.¹⁷⁰

The evolution and codification of these threats does not close off contests over whether a specific issue should be treated as a biosecurity threat or the values and norms that should inform responses. At a practitioner-level, the interest of governments in preventing the proliferation of ‘dual-use’ biological research and the sometimes-conflicting interests of scientists in open science have shaped the definitions of biosecurity adopted by learned academies and government agencies tasked with ‘finding the balance’¹⁷¹ in the design of appropriate ‘controls’ over dual-use research.¹⁷² For example, the US National Academies of Science’s centres its definition of biosecurity on security against the human misuse of biology:

“biosecurity” is used to refer to security against the inadvertent, inappropriate, or intentional malicious or malevolent use of potentially dangerous biological agents or biotechnology, including the development, production, stockpiling, or use of biological weapons as well as outbreaks of newly emergent and epidemic disease.¹⁷³

This definitional focus on the ‘inadvertent, inappropriate...malicious or malevolent use’ of biology can be seen as an effort to minimise the case for (and intensiveness of) certain regulatory controls on what is implied by the definition-makers to be the more normal case: namely, well-planned, appropriate, and benevolent research, ably regulated by researchers themselves, such as with the Asilomar conference on recombinant DNA research in the 1970s.¹⁷⁴ In this definition, naturally occurring diseases are almost an afterthought, possibly because they are not relevant to the tactical purpose the definition is intended to serve.

¹⁷⁰ *Uniting and Strengthening America by Providing Appropriate Tools Required to Intercept and Obstruct Terrorism (USA PATRIOT Act) Act of 2001* Pub L No 107-56, 115 Stat 386 § 817; Pub L No 107-188, 116 Stat 594.

¹⁷¹ Public Health Emergency [US], *United States Government Policy for Institutional Oversight of Life Sciences DURC*

(13 November 2015) Science Safety Security

<<https://www.phe.gov/s3/dualuse/Pages/InstitutionalOversight.aspx#>>.

¹⁷² Fink et al, above n 32. For practitioner-focused works, see Brian Rappert (ed), *Education and Ethics in the Life Sciences: Strengthening the Prohibition of Biological Weapons* (ANU ePress, 2010); Brian Rappert and Michael J Selgelid (eds), *On the Dual Uses of Science and Ethics: Principles, Practices, and Prospects* (ANU ePress, 2013).

¹⁷³ Committee on Advances in Technology and the Prevention of Their Application to Next Generation Biowarfare Threats, *Globalization, Biosecurity, and the Future of the Life Sciences* (National Academies Press, 2006) 32.

¹⁷⁴ P Berg et al, ‘Summary Statement of the Asilomar Conference on Recombinant DNA Molecules’ (1975) 72(6) *Proceedings of the National Academy of Sciences of the United States of America* 1981; Jeremy Youde, ‘Safe for Humanity: Taming Biological Research through Norm Awareness’ (2013) 3260(July) *Contemporary Security Policy* 1.

Alternatively, their sidelining may be an effort to distance acts involving biological agents (isolated and controllable) from the disease they manifest as in human or living beings (amorphous and wild).

In *Biosecurity in the Global Age: Biological Weapons, Public Health, and the Rule of Law*, Fidler and Gostin seek to place biosecurity within a wider agenda of addressing global public health risks. This extends to defining biosecurity in cosmopolitan terms: namely, that biosecurity '[means] society's collective responsibility to safeguard the population from dangers presented by pathogenic microbes – whether intentionally released or naturally occurring.'¹⁷⁵ Echoing the language of the IHR 2005, this responsibility is said to arise 'because of the dangers infectious diseases pose to human societies in the twenty-first century...whatever their source or origin'.¹⁷⁶ Fidler and Gostin's work traces the history of biosecurity as an analytical and policy concept and claims that biosecurity has initiated a 'policy revolution' in 'integrating two policy realms previously separate from one another – security and public health'.¹⁷⁷ Finding limitations with previous theoretical approaches to reconciling the interface between public health and security via a 'synergy thesis', the normative project for the authors is to instead place biosecurity within a 'rule of law' framework.¹⁷⁸

Constituting the 'center of governance gravity' of this biosecurity framework are the 2005 IHR, and the authors propose capacity building and internalisation of norms by states of the IHR in order to ensure that '[w]hen biosecurity crises hit' Government's do not 'exercise broad emergency powers [first] and ask rule of law questions later.'¹⁷⁹ The importance of norms and their internalisation reflects similar findings by Davies and others (see above), and by Youde – including in the context of DURC.¹⁸⁰

The usefulness of placing biosecurity within a wider agenda of norm setting and governance regimes is the space it opens for researchers undertaking empirical studies of the

¹⁷⁵ Fidler and Gostin, *Biosecurity in the Global Age*, above n 38, [location 70].

¹⁷⁶ Ibid, used in title to Chapter 1 [location 34] then repeatedly throughout text.

¹⁷⁷ Ibid, [location 48].

¹⁷⁸ Ibid. Examination commences at [location 1789]. Simply stated, the synergy thesis suggests 1) efforts in the security domain (eg, bio-defence laboratories and bioterrorism detection systems) can have benefits in the public health domain (eg, for disease surveillance, public health research and public health interventions) and vice versa; 2) emergent benefits should be maximised. While different from Braithwaite's use of the term, one cannot help but see links with the regulation and governance literature's call for regulatory approaches that involve 'contextual, integrated, joined-up strategies that will work in synergy.' John Braithwaite, 'The Essence of Responsive Regulation' (2011) 44(3) *UBC Law Review* 475, 490.

¹⁷⁹ Fidler and Gostin, *Biosecurity in the Global Age*, above n 38.

¹⁸⁰ Youde, 'Safe for Humanity', above n 174.

influence of biosecurity on the ‘pragmatic’ outcomes of security (Balzacq): policy and legislation. Enemark’s examination of biosecurity policy as a series of ‘dilemmas’ recognises these normative and tactical issues.¹⁸¹ Likewise, this study examines the use of biosecurity as a rhetorical marker and tool to ‘integrate’ policy work programs within an Australian context.

3. The contribution of regulation and governance literature

The discussion above demonstrates how definitions of and even the process of defining ‘biosecurity’ can serve tactical purposes and reflect inherent or institutionalised cultures. Once constructed as a ‘biosecurity’ threat, new opportunities arise to shape (or limit) normal politics, expand parts of the bureaucracy, or adopt new regulatory regimes.

It is noted that an application of Securitization Theory as a purely linguistic study of discourse would not require an examination of the content of any subsequent ‘exceptional’ measures. As argued in Chapter 1, however, this is unlikely to answer important questions about the motivations of actors, the strategies and framings used by audiences opposed – or opposing – a securitizing move and the degree to which a securitizing move represents anything more than a ‘warning’ or unfilled ‘promise’.¹⁸² These concerns echo common critics of constructivist studies, which ‘overemphasise the “discursive processes”...whereas their focus should be on what causes phenomena and what effect they produce.’¹⁸³ Put plainly, if securitization is a way to justify breaking ‘the rules that bind’, then a study of biosecurity should consider what pre-existing rules have been broken and what (if anything) they have been replaced with. Only then can an attempt be made to assess the consequences of securitization on *x*.¹⁸⁴

The regulation and governance literature provides analytical tools and frameworks for this task. Too broad and diverse to do justice to in this Chapter, this part instead focuses how this literature has been applied to the problem of infectious diseases, the key theoretical shifts that have ‘decentred’ the role of the state as the sole or even dominant regulatory entity and

¹⁸¹ Enemark, *Biosecurity Dilemmas*, above n 27.

¹⁸² Floyd, ‘Extraordinary or Ordinary Emergency Measures’, above n 134.

¹⁸³ Martyn Hammersley, *Questioning Qualitative Inquiry* (Sage, 2008) 173 cited in Ibolya Losoncz, ‘Methodological approaches and considerations in regulatory research’ in Drahos (ed), *Foundations and Applications*, above n 84, 77 at 81. See discussion of Securitization Theory’s ‘constructivist deficit’ in Floyd, above n 134.

¹⁸⁴ Where *x* might be a body of law, a ‘regulatory regime’, or – adopting the language of *Framework for Analysis* ‘effects on interunit relations’: Buzan, Wæver and De Wilde, above n 42, 26.

introduces the work of Braithwaite and Drahos that forms part of this study's theoretical framework (see further, Chapter 3).

Scholars have examined the governance of pandemics, including as manifestations of global governance regimes, domestic regimes and as the products of techniques of government. This is not just limited to traditional legal analysis of legal regimes.¹⁸⁵ Davies and others, building on early work by Fidler,¹⁸⁶ have examined how the 2005 IHR, multinational disease surveillance networks, and agreements on virus sharing agreements promised a 'post-Westphalian' global governance of infectious diseases.¹⁸⁷ The focus of these authors on norms in regulation-setting reflects debates in the governance literature over the social dimensions of regulatory activities and the use of 'nodal relationships' by actors within a 'social system' to 'enhance' and deploy power to shape that system.¹⁸⁸ Likewise, Fidler and Gostin's vision¹⁸⁹ of states and other actors internalising the norms inherent in the IHR (such as respect for human rights) represents an example of 'governing at a distance.'¹⁹⁰ In less theoretical works, Bennett, Carney and Baily have analysed Australia's pandemic plans (and planning) as examples of 'network governance' and as applications of regulatory techniques of 'risk management'.¹⁹¹ Whether explicitly identifying the governance and regulation literature, these studies reflect advances in both fields that no longer posit the State (or States) as the main (let alone only)

¹⁸⁵ But see examples in Martin, 'The Role of Law in Pandemic Influenza Preparedness in Europe', above n 65; R Martin, 'The Exercise of Public Health Powers in Cases of Infectious Disease: Human Rights Implications' (2005) 14(1) *Medical Law Review* 132; Gostin, *Public Health Law: Power, Duty, Restraint*, above n 55.

¹⁸⁶ Fidler, *International Law and Infectious Disease*, above n 55; Fidler, *SARS, Governance and the Globalization of Disease*, above n 38.

¹⁸⁷ Davies, above n 25; Youde, 'MERS and Global Health Governance', above n 54; David P Fidler and Lawrence Gostin, 'The WHO Pandemic Influenza Preparedness Framework: A Milestone in Global Governance for Health' (2011) 306(2) *JAMA* 200.

¹⁸⁸ See for example, Davies and others' reference to the role of the WHO secretariat as a 'political actor' in its own right and how the secretariat set out a vision of global health governance based on 'new networks of information sharing and capacity building...' and 'cooperative networks of knowledge and response': Davies, Kamradt-Scott and Rushton, above n 26, 9, 30, 40. On nodal governance see: Scott Burris, Peter Drahos and Clifford D Shearing, 'Nodal Governance' (2005) 30 *Australian Journal of Legal Philosophy* 30; Burris, above n 148.

¹⁸⁹ Fidler and Gostin, *Biosecurity in the Global Age*, above n 38.

¹⁹⁰ On this phrase and its application in studies of power and governmentality see: Rose, O'Malley and Valverde, above n 74. See also: Rabinow and Rose, above n 35. This work draws on the work of Foucault, and Latour's 'notions of power as translation or enrolment': Braithwaite and Drahos, above n 36, 482. The phrase has been used somewhat differently in the context of 'regulation-at-a-distance', where 'self-regulation' is frequently cited as one example – for example: John Braithwaite, 'The New Regulatory State and the Transformation of Criminology' (2000) 40 *British Journal of Criminology* 222; S S Silbey, 'Organizational Challenges to Regulatory Enforcement and Compliance: A New Common Sense about Regulation' (2013) 649(1) *The Annals of the American Academy of Political and Social Science* 6; critiqued in Gabrielle Simm, 'Regulatory sex in peace operations' in Drahos (ed), *Foundations and Applications*, above n 84, 424.

¹⁹¹ Carney, Bailey and Bennett, above n 55; Carney and Bennett, 'Framing Pandemic Management: New Governance, Science or Culture?' above n 55; Terry Carney and Belinda Bennett, 'Governance, Rights and Pandemics: Science, Public Health or Individual Rights?' in Enemark and Selgelid (eds), above n 38, 201.

governor,¹⁹² nor limit definitions of regulation to ‘directly binding’ and prescriptive ‘command and control’ approaches to “sustain[ing]...focused control...over activities that are valued by the community.”¹⁹³

While no single conception of ‘regulation’ has emerged supreme, the academic literature drawn on for this study has ‘de-centred’ regulation away from the exclusive provenance of States.¹⁹⁴ This has involved both recognising ‘poly-centric’ and pluralistic models of governance,¹⁹⁵ involving non-state actors, and the use of ‘flexible, imaginative and innovative forms of social control’ to regulate behaviour (such as codes of conduct).¹⁹⁶ As the works of Carney and others have shown, this wider conception of regulation provides a useful tool to examine and critique the governance approaches to a given issue and the norms and principles that ultimately shaped the regulatory instrument.¹⁹⁷ This study adopts this wider conception of regulation and does not assume that biosecurity regulation in Australia was simply the product of domestic, political or administrative actors.

Likewise, as securitization theorists are not united on the need for securitization to result in new, ‘exceptional’ laws (or suspension of the law), it is appropriate to examine how securitization may affect non-binding and non-State regulatory instruments. It is also appropriate to consider the principles that underpin those instruments, particularly during what Roe calls the ‘mobilization’ stage of securitization (which might include, for example, policy reform and implementation).¹⁹⁸

¹⁹² Or State-dominated fora, such as the UNSC or WHO, at the international level.

¹⁹³ Paraphrasing P Selznick, ‘Focusing organizational research on regulation’, in R Q Noll (ed.), *Regulatory Policy and the Social Sciences* (University of California Press, 1985) 363, quoted in Margit Cohn, ‘Law and Regulation: The Role, Form and Choice of Legal Rules’ in David Levi-Faur (ed), above n 84, 185. For a typology of legal forms of regulation see generally Margit Cohn, ‘Law and Regulation: The Role, Form and Choice of Legal Rules’ in David Levi-Faur (ed), above n 84, 185.

¹⁹⁴ See survey of the literature in: Braithwaite, ‘The New Regulatory State and the Transformation of Criminology’, above n 190; Michael Moran, ‘Understanding the Regulatory State’ (2002) 32(2) *British Journal of Political Science* 391; Colin Scott, ‘Regulation in the Age of Governance: The Rise of the Post-Regulatory State’ in J Jordana and David Levi-Faur (eds), *The Politics of Regulation: Institutions and Regulatory Reforms for the Age of Governance* (Edward Elgar Publishing, 1st ed, 2004) 145.

¹⁹⁵ Black, *Critical Reflections on Regulation*, above n 85; Black, ‘Constructing and Contesting Legitimacy and Accountability in Polycentric Regulatory Regimes’ above n 85; R W Rhodes, ‘The New Governance: Governing without Government’ (1996) 44(4) *Political Studies* 652; R W Rhodes, ‘Understanding Governance: Ten Years On’ (2007) 28(8) *Organization Studies* 1243.

¹⁹⁶ For example, Gunningham and Sinclair identify codes as a part of a pluralistic recognition of ‘flexible, imaginative and innovative forms of social control’ (ie, regulation): Neil Gunningham and Darren Sinclair, ‘Smart Regulation’ in Peter Drahos (ed), *Regulatory Theory*, above n 84, 133, Box 8.1; Mirjan Oude Vrielink, Cor van Montfort, and Meike Bokhorst, ‘Codes as hybrid regulation’, in David Levi-Faur (ed), above n 84, 486.

¹⁹⁷ Carney et al, for example, critique the technocratic and scientific approach of the WHO, positing that a social and democratic approach to the governance of pandemics is required: Carney and Bennett, ‘Framing Pandemic Management: New Governance, Science or Culture’, above n 55.

¹⁹⁸ See discussion in Roe, ‘Actor, Audience(s) and Emergency Measures’, above n 139, 621–622.

This study does not go so far as to deny a central role for the State in regulatory activity. Indeed, this study's main targets of inquiry are the Ministerial, bureaucratic, and legislative arms of the Australian State. However, the State does not simply act through primary and secondary laws. Building on the theoretical and empirical writing studies of Braithwaite, Ayres and others, where the State does exercise its authority as the 'Regulatory State', it does so through a variety of 'responsive' regulatory strategies and through the enrolment of private actors in self- and meta-regulatory regimes.¹⁹⁹ Nonetheless, where regulatory measures are imposed through formal laws, the initiating and sustaining forces for regulatory change may not rest elsewhere. Focusing on just one of many studies on this phenomena, *Global Business Regulations* shows how States may receive and adopt rules produced in other fora (ie, as 'rule taker'), rather than produce them *sua sponte*. Actors, of which States are just one, use webs or dialogue and coercion to pursue strategic, regulatory change at the global, regional and domestic level. As an optimistic finding,²⁰⁰ the authors argue convincingly that even weak actors (including non-state actors), 'if they understand the possibilities of webs of...dialogue, may entrench principles that pattern regulator outcomes in ways that serve their interests.'²⁰¹

Braithwaite and Drahos show this across several domains, including food standards, transport safety and nuclear energy. Their chapter in *Global Business Regulation* on nuclear energy, for instance, includes an examination of regulatory measures and models for the control of atomic research, both peaceful and military.²⁰² Immediate similarities with concerns over DURC and information flows in the life sciences were noted, first intuitively, then later in the literature review, where authors have indeed applied concepts from *Global Business Regulation* to this topic.²⁰³

¹⁹⁹ John Braithwaite and Ian Ayres, *Responsive Regulation: Transcending the Deregulation Debate* (Oxford University Press, 1992); Braithwaite, 'The New Regulatory State and the Transformation of Criminology', above n 190; Valerie Braithwaite, Kristina Murphy and Monika Reinhart, 'Taxation Threat, Motivational Postures, and Responsive Regulation' (2007) 29(1) *Law and Policy* 137; Neil Gunningham and Peter N Grabosky, *Smart Regulation: Designing Environmental Policy* (Oxford University Press, 1998); Gunningham and Sinclair, above n 196.

²⁰⁰ This optimism is self-identified by the authors and others, eg: Shubha Ghosh, 'Modeling Globalization from the Bottom Up: A Review Essay of John Braithwaite and Peter Drahos, *Global Business Regulation*' (2005) 39(4) *Law Society Review* 965.

²⁰¹ Peter Drahos, 'Regulatory globalisation' in Drahos (ed), above n 84, 249-264. See also: Braithwaite and Drahos, above n 36, Chapters 23, 26.

²⁰² Braithwaite and Drahos, above n 36, 13. For a short history on controls on atomic research, with relevance to debates over GoF research see: Howard Morland, 'Born Secret' (2005) 26(4) *Cardozo Law Review* 1401.

²⁰³ Caitriona McLeish and Paul Nightingale, 'Biosecurity, Bioterrorism and the Governance of Science: The Increasing Convergence of Science and Security Policy' (2007) 36(10) *Research Policy* 1635; Caitriona McLeish, 'Science and Censorship in an Age of Bio-Weapons Threat' (2006) 15(3) *Science as Culture* 215. Although some authors have questioned the extent to which regulation has truly been 'de-centred' from the

Braithwaite and Drahos argue in *Global Business Regulation* that ‘principles’ stand behind ‘rules’ and ‘constitute an agreed standard of conduct’. Principles propel action in a certain direction while lacking the specificity of rules in terms of how they can determine decisions, impose obligations or control actions.²⁰⁴ At the level of actor-relations, Braithwaite and Drahos argue that principles ‘bring about mutual orientations between actors’. Importantly, principles – unlike rules – can conflict and this ‘conflict of principles’ is ‘settled by decision-makers assigning “weights” to the relevant principles in order to reach a decision’ over the shape of a specific decision, rule or (in aggregate) regulatory regime. In this study, as in *Global Business Regulation*, a ‘regime’ is constituted by the ‘principles, norms, rules, and decision-making procedures around which actor expectations converge in a given issue-area.’²⁰⁵ It is suggested that there is an analytical alignment between securitization’s focus on ‘interunit relations’²⁰⁶ with the ‘mutual orientations’ that are altered through contests of principles. This argument is developed further in Chapter 3.

How does a ‘conflict of principles’ result in a body of rules? Braithwaite and Drahos suggested that actors adopt a variety of ‘mechanisms’ to give their preferred principles additional weight²⁰⁷ and to persuade (or coerce) others to agree to those principles as forming the basis of a ‘pattern of regulation’ in their state. In a global context, powerful actors, such as large States, can use military and economic coercion as mechanisms to promote their principles.²⁰⁸ These coercive mechanisms could, for example, be used to overcome a weaker State’s preference for a regulatory principle of ‘national sovereignty’ (ie, ‘The prescription that the nation-state should be supreme over any other source of power on matters affecting its citizens or territory’).²⁰⁹ However, Braithwaite and Drahos found that less powerful States, and actors without access to the resources of a State (eg, multinational companies, environmental groups and even individuals), could use different mechanisms to promote their principles – even over the wishes of the largest states.²¹⁰ Other mechanisms include creating systems that

State – relevantly in domains such as security and policy and where Governments believe that ‘something must be done’, eg, Adam Crawford, ‘Networked Governance and the Post-Regulatory State?’ (2006) 10(4) *Theoretical Criminology* 449.

²⁰⁴ Braithwaite and Drahos, above n 36, 18.

²⁰⁵ Braithwaite and Drahos, above n 36, 26 citing Stephen D Krasner, ‘Structural Causes and Regime Consequences: Regimes as Intervening Variables’ (1982) 36(2) *International Organization* 185, 185-186. See also discussion in Braithwaite and Drahos, above n 36, 26.

²⁰⁶ Buzan, Wæver and De Wilde, above n 42, 26.

²⁰⁷ Braithwaite and Drahos, above n 36, 19.

²⁰⁸ Ibid 532; see also, Chapter 22.

²⁰⁹ Braithwaite and Drahos, above n 36, 25.

²¹⁰ See discussion in Ibid, 559-562 on the power of individuals, especially those well-placed ‘individual [regulatory] entrepreneurs’ to implement change.

‘reward’ parties who adopt or do not adopt a preferred principle, ‘modelling’ a preferred principle or rule to another party or building capacity in other states that reflect the preferred patterns and principles of regulation.²¹¹ These final two mechanisms, in particular, would be familiar to global public health scholars, well acquainted with the library of literature developed by the WHO to support states assess their public health systems and implementation of the IHR, including pandemic planning.²¹² Mechanisms can be supported by tactics or strategies that States and other actors adopt to promote their preferred principles. These included deploying ‘webs of dialogue’, webs of ‘coercion’ and the strategy of ‘forum shifting’, the latter of which involves, three discrete tactics (shown visually in Figure 3):

- moving an agenda from one organisation (or deliberative forum) to another
- leaving an organisation/deliberative forum; and/or
- pursuing agendas simultaneously in more than one organisation/deliberative forum.

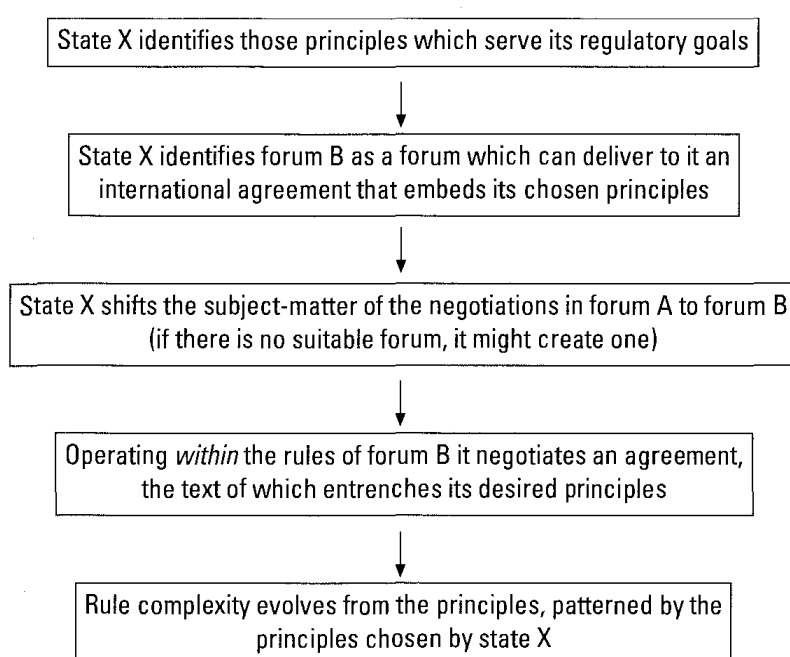


Figure 3: Forum shifting in the international domain (*Global Business Regulation*, 570)

²¹¹ For a definition of the various mechanisms see, Braithwaite and Drahos, above n 36, 25–26.

²¹² For example: WHO, *International Health Regulations (2005): Toolkit for Implementation in National Legislation - Questions and Answers, Legislative Reference and Assessment Tool and Examples of National Legislation* (WHO, 2009); WHO, *Guide to Hygiene and Sanitation in Aviation* (WHO, 2009); WHO, *International Health Regulations (2005): Toolkit for Implementation in National Legislation - The National IHR Focal Point* (WHO, 2009); WHO, *A Checklist for Pandemic Influenza Risk and Impact Management - Building Capacity for Pandemic Response* (WHO, 2018).

The intention on a party seeking to forum shift is to ‘constitut[e] a new game’ where the party may achieve a more optimal regulatory outcome.²¹³ Forum shifting has been examined and found in studies of global health governance, regulation of biotechnology and international contests over intellectual property rights.²¹⁴ A similar, but narrower concept of ‘regime shifting’ has also been used in studies of international regimes.²¹⁵

4. Summary and the space for this study

The review above has shown how literature across multiple academic and literary fields, has grappled with disease as a social, security and regulatory problem. It has also identified and explained the concept of ‘biosecurity’ and the problems to which that label is often applied. Having discussed some of the theoretical and methodological critiques and developments of Securitization Theory, this Chapter has also briefly introduced the regulation and governance literature and, in particular, the theoretical underpinnings of and concepts set forth in *Global Business Regulation*.

Despite the extensive body of literature, this study will fill important gaps: theoretical, methodological and empirical. Michael Williams once asked: ‘Is securitization a theory? A method? A concept? A philosophy? Or all of these?’²¹⁶ This study critically engages with the first three of these questions. Theoretically, it engages with the researcher’s concern that many of the studies of securitization which focuses on acts by the Executive approach government as a single entity, or analyses the speech-acts of selected Ministers or ‘authorised state representatives’ do so without also exploring the provenance of those speech-acts.²¹⁷ This is a

²¹³ Drahos, ‘Intellectual Property and Pharmaceutical Markets’, above n 36, 406; Braithwaite and Drahos, above n 36, Chapter 24.

²¹⁴ W Hein and L Kohlmorgen, ‘Global Health Governance: Conflicts on Global Social Rights’ (2008) 8(1) *Global Social Policy* 80; Catherine Rhodes, *International Governance of Biotechnology: Needs, Problems and Potential* (Bloomsbury Academic, 2010); Susan K Sell and Assem Prakash, ‘Property Rights Between Business and NGO Networks in Using Ideas Strategically: The Contest Intellectual Property Rights’ (2004) 48(1 (March 2004)) *International Studies Quarterly* 143.

²¹⁵ L R Helfter, ‘Regime Shifting: The TRIPS Agreement and New Dynamics of International Intellectual Property Lawmaking’ (2004) 29(1) *The Yale Journal of International Law* 1. Identified in the context of global health in David P Fidler, ‘The Challenges of Global Health Governance’ (2010) 86(May) *Tobacco Control* 1, 13.

²¹⁶ Michael C Williams, ‘Securitization as Political Theory: The Politics of the Extraordinary’ (2015) 29(1) *International Relations* 114.

²¹⁷ Buzan, Wæver and De Wilde, above n 42; Carsten Bagge Laustsen and Ole Wæver, ‘In Defence of Religion: Sacred Referent Objects for Securitization’ (2000) 29(3) *Millennium - Journal of International Studies* 705; Barry Buzan, ‘Will the “global War on Terrorism” Be the New Cold War?’ (2006) 82(6) *International Affairs* 1101; Lorenzo-Dus and Marsh, above n 147.

particular issue with the ‘philosophical’ branch of Securitization Theory (which privileges the rhetoric of security) and studies that focus solely on final policy outputs such as White Papers, legislation or speeches to the UNSC. Research that has focused on the Executive treats this branch of government as a single entity – through metonymic and synecdochic terms such as ‘administration’ or ‘White House’²¹⁸ – or approaches it through the speech-acts of selected Ministers or ‘authorised state representatives’.²¹⁹ Missing from these studies is an exploration of how the public service may script the security speech-acts delivered by Ministers and even engage in the ‘political work’ of legislating new security instruments. And, as Salter, Piché and others in the ‘sociological’ branch have demonstrated, Ministers and departments can each serve as actor and audience at different times, adopting security language to increase their mandates.²²⁰ How has this played out in Australia in relation to biosecurity problems described above?

In undertaking a sustained examination of how biosecurity operates/ed as a ‘mechanism’ in the development of Australia’s pandemic preparedness and response activities, this study will adopt a wider range of methods and closely interrogate the differing roles of Ministers, parliamentarians, public servants, and others. With a particular focus on actor-audience relationships, it also answers Wæver’s call for ““more case studies” concerning the relationship between actor and audience (and emergency measures) ... [to develop] a “more general formulation” of the securitization concept.”²²¹

²¹⁸ Buzan, above n 217; Lorenzo-Dus and Marsh, above n 147.

²¹⁹ Laustsen and Wæver, above n 217; Dagmar Rychnovská, above n 41.

²²⁰ Salter, above n 45; Salter and Piché, above n 147.

²²¹ Ole Wæver, ‘Securitisation: Taking Stock of a Research Programme in Security Studies’, unpublished paper, University of Copenhagen (2003) quoted in: Roe, ‘Actor, Audience(s) and Emergency Measures’, above n 139, 616.

Chapter 3: Methodology

Chapter 3 sets out and justifies the research design and methods that underpin the study, including document analysis and semi-structured interviews all related to Australia's post-2001 biosecurity law and policymaking; pandemic planning activities undertaken in the mid-2000s; and responses to two public health emergencies: the 2009 influenza pandemic of H1N1 and the 2013–16 West Africa Ebola outbreak ('Ebola outbreak').

Section 1 of this Chapter sets out the study's methodological orientation, while Section 2 outlines the theoretical framework that informed the collection and analysis of data. As part of its novel contribution to the study of biosecurity lawmaking and disease response, this study draws upon theoretical concepts developed by Buzan and colleagues in *Framework for Analysis* and the findings and models identified by Braithwaite and Drahos in *Global Business Regulation*. The processes by which the collected data were analysed and interpreted are explained in Section 3 of this Chapter. Ethical considerations are discussed in Section 4.

Practical implications of COVID-19 for this thesis

Fieldwork and data collection were completed prior to the outbreak of COVID-19 in December 2019, with the researcher being in the write-up stage of the project during the pandemic. No additional, COVID-related fieldwork or data collection was undertaken for the purpose of this thesis. At the time the outbreak began (and continuing at the time of submission), the researcher was living in New Zealand – a country that maintained a successful 'elimination' approach towards the coronavirus until the arrival of the delta variant in August 2021 and the omicron variant in late December 2022.²²² At the start of the pandemic, the researcher was working for the New Zealand public service; in the Ministry responsible for developing advice on immigration and border measures. These measures were initially designed to reduce the risk of importing COVID-19 from Hubei province, China; then from anywhere in China *and* the Diamond Princess cruise ship. Entry from ever more countries and

²²² Eva Corlett, 'New Zealand Covid elimination strategy to be phased out, Ardern says' *The Guardian* (online), 4 October 2021 <<https://www.theguardian.com/world/2021/oct/04/new-zealand-covid-strategy-in-transition-ardern-says-as-auckland-awaits-lockdown-decision>> but see also: Strategic COVID-19 Public Health Advisory Group, *Advice to Dr Ayesha Verrall, Associate Minister of Health*, (10 June 2021) the Beehive <<https://www.beehive.govt.nz/sites/default/files/2021-08/Embargoed%20Skegg%20advice.pdf>>.

regions was restricted until a ‘hard border’ was imposed in March 2020 and all international movements into and out of New Zealand were effectively stopped.²²³

1. Methodological orientation

A constructivist-interpretivist paradigm informs the design of this study’s research aims and questions. As a simple example, ‘security threats’ (and especially a specific national security threat) are not objective entities but are constructed by individuals, groups and communities through intersubjective and interpretive processes ranging from the ‘performative’ functions of speech through to strategic acts of ‘framing’.²²⁴ The theoretical framework, and research methods, follow from this initial positioning, consistent with the theories from which key research themes and concepts were drawn.

Chapter 1, Section 4 outlined the principal aims of this project and the central research questions, namely:

1. To what extent did the use of ‘securitizing acts’ by Ministers, governing parties and public servants between 2001–2016 serve as a ‘mechanism’ to promote or secure those actors’ preferred regulatory values or principles in a given regulatory response, including (but not limited to) legislation?
2. What, if any, were the outcomes and consequences of embedding those particular values or principles in the ultimate regulatory response?

To investigate these questions, this study adopted a qualitative, case-study research design, utilising documentary analysis and semi-structured participant interviews. Cases are temporally, geospatially and thematically bounded. That is to say, the examined cases all fall within the same time-period: 2001–2016; fall within the same geo-political setting: Australia

²²³ On 29 April 2020 New Zealand reported no individuals entering the country via air, likely for the first time in the jet airplane-era. Zero entries were reported on a further five occasions, with at least one day reporting no entries or departures: Customs [NZ], *Arriving and Departing Air Passenger Movement Numbers in NZ 1 January – 31 October 2020* (30 November 2020) <<https://web.archive.org/web/20201113035442/https://www.customs.govt.nz/contentassets/915cfead8a504d89baee0cbf02c10555/air-pax-movements-between-1-jan-and-31-oct-2020.pdf>>

²²⁴ See also discussion of securitization in Chapter 2. On performativity of language see Austin, above n 42; Lloyd, above n 42. For an application of Goffman’s conception of ‘framing’ to public health see: Jeremy Shiffman, ‘A Social Explanation for the Rise and Fall of Global Health Issues’ (2009) 87(8) *Bulletin of the World Health Organization* 608; Jeremy Shiffman and Stephanie Smith, ‘Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality.’ (2007) 370 *Lancet* 1370. For an explicit use of frame-analysis in securitization see Rychnovská, above n 41.

(and, more specially, ‘Australia’ acting as a national body); and are centred on ‘biosecurity’ threats: emerging infectious diseases, bioterrorism and the risks associated with dual-use research. A timeline of cases is set out in Figure 4 below:

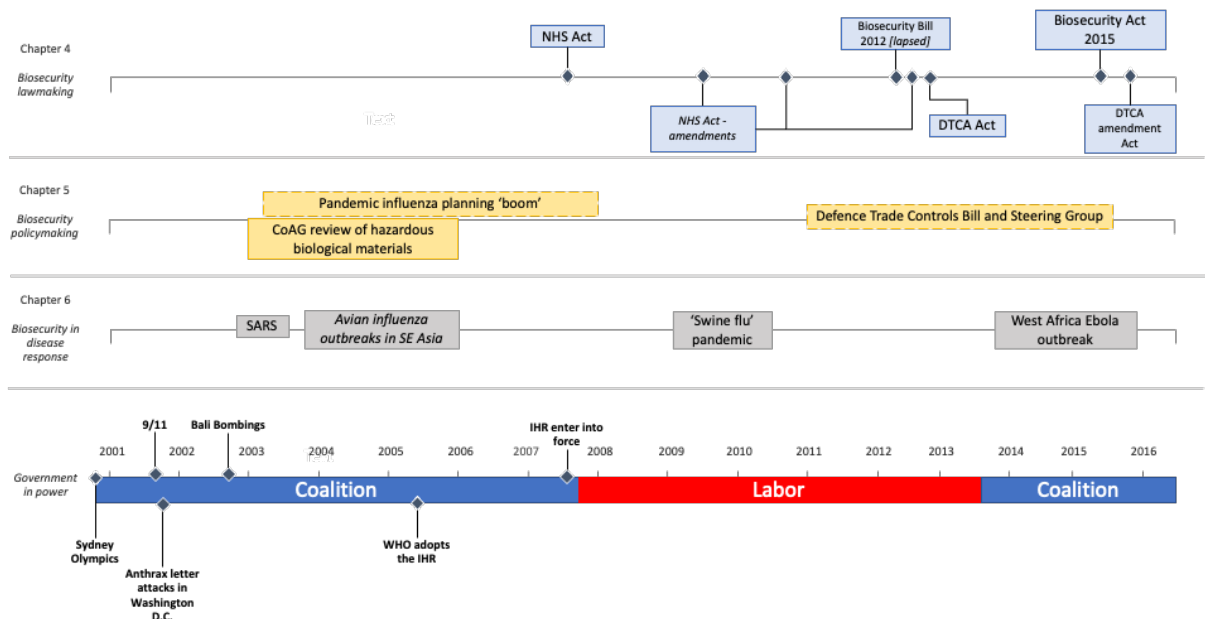


Figure 4: Timeline of cases and key events

The adopted methodology assumes a ‘constructionist epistemology’ in which ‘knower and subject create understandings’ and largely rejects objectivist explanations of social, and legal, facts.²²⁵ This choice of methodology is justified on three grounds. First, it aligns with the project’s aims and objectives.²²⁶ The thesis asks questions about processes and meaning-making and, to do so, it surfaces and interrogates the views of individuals involved in (and responding to) biosecurity activities. The project’s data sources are not simply inert by-products of human activity but are intended to create and communicate meanings to specific and general audiences, to perform certain authorising, explanatory or justifying functions or to cause a legal, political or social effect on an individual or community. Second, the chosen methodology corresponds with the ontology of Securitization Theory as propounded by members of the ‘Copenhagen School’, as well as Braithwaite and Drahos’s explanation for the globalization of norms and rules, reducing the risk of inconsistency or incoherence in the

²²⁵ Norman K Denzin and Katherine E Ryan, ‘Qualitative Methodology (Including Focus Groups)’ in William Outhwaite and Stephen P Turner (eds), *The SAGE Handbook of Social Science Methodology* (Sage, 2007) 578, 587–588.

²²⁶ Stacy M Carter and Miles Little, ‘Taking Action: Epistemologies, Methodologies, and Methods in Qualitative Research’ (2007) 17(10) *Qualitative Health Research* 1316; Norman K Denzin and Yvonna S Lincoln (eds), *The Landscape of Qualitative Research* (Sage Publications, 3rd ed, 2008).

qualitative process of inquiry and analysis.²²⁷ Finally, as argued in Chapter 2, our ability to understand and respond to pandemics and disease outbreaks depends on seeing them as cultural and political events, not merely medical proceedings that are handled clinically; ‘objectively’. A constructivist approach better allows us to explore why certain responses were pursued and, more hopefully, to seek more just ways of responding in the future, whether that is through ideas of emancipation, or the rule of law.²²⁸ Such objectives are sympathetic to Securitization Theory’s ‘normative goal’: namely, ‘exposing the limits imposed by the securitization of specific issues’ and adopting discursive and other techniques to desecuritize an issue.²²⁹ This normative political goal of returning policy matters to ‘normal politics’ is narrower but broadly consistent with the wider ‘political project’ outlined in *Global Business Regulation*.²³⁰

2. Theoretical framework

This study drew on the theoretical insights of Braithwaite and Drahos’s account of the globalisation of regulatory principles and rules in *Global Business Regulation* and the Securitization Theory outlined by Buzan, Wæver and De Wilde in *Framework for Analysis*, with a particular emphasis on the inter-subjective construction of ‘security threat’ through ‘performative utterances’. The following discussion outlines the elements from each of these works that were adopted as components of a single theoretical framework for this study. This section also introduces several key terms, in addition to those defined in Chapter 1, Section 6.

The contribution of Securitization Theory to this study

The foundations, developments and critiques of Securitization Theory have been examined in Chapter 2. This study largely adopts the ‘classical conception’ of Securitization Theory as outlined in *Framework for Analysis* as the basis for its theoretical framework.

²²⁷ That is not to say that other important explanations could not be obtained with a different research paradigm and methodology: Braithwaite, ‘For Public Social Science’, above n 111; J Shaw and R DeForge, ‘Qualitative Inquiry and the Debate Between Hermeneutics and Critical Theory’ (2014) 24(11) *Qualitative Health Research* 1567.

²²⁸ See the normative positioning in the title of Nunes’ work: *Security, Emancipation and the Politics of Health: A New Theoretical Perspective*, above n 110 and Gostin, *Public Health Law: Power, Duty, Restraint*, above n 55 (emphasis added).

²²⁹ Williams, above n 64, 524; see also: Rita Floyd, ‘Can Securitization Theory Be Used in Normative Analysis?’, above n 53.

²³⁰ Buzan, Wæver and De Wilde, above n 42, 212; Braithwaite and Drahos, above n 36, Chapter 26.

However, and noting the critiques of Securitization Theory discussed in Chapter 2, the study's framework also reflects the important theoretical contributions of subsequent research, such as McInnes's contention (later adopted by Enemark) that 'existential' was too high a threshold for a threat to be securitized, and that a security actor need only point to an 'extreme' negative affect on 'life, lifestyle and livelihood.'²³¹ Likewise, the author agrees with those researchers who have argued that a narrow focus on 'speech-acts' may be too limiting and that legislation, policies or other 'pragmatic acts' may also be security constitutive events.²³² Finally, the adoption of Securitization Theory embraces calls from security analysts to apply a wider range of research methods to the study of securitization, such as interviews with policy elites.²³³

The following elements form Securitization Theory informed the study's research methodology:

- 'security' as an inter-subjective construct that is constituted by speech and other performative, visual and pragmatic acts;
- avoiding a State-centric ('critical')²³⁴ approach to conceiving of the concept of security; and
- a view that securitization can usually only be assessed *post facto* and through an analysis of 'discourse and political constellations' – although this need not limit researchers to discourse analysis.²³⁵

Consequently, the research methods adopted were intended to examine the use of threat-language to justify the taking of exceptional measures and to prioritise a response, or form of response, over 'normal politics'. A theory-driven approach to data analysis was, likewise, focused on the constitution of 'threats', 'referent objects', and the identification and characterisation of individuals or institutions as 'security actors' and 'audiences'. Central questions for each results Chapter were the degree to which a biosecurity-related 'securitizing

²³¹ McInnes, 'Health and Security Studies', above n 134, 54, adopted in Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia*, above n 27, 12.

²³² Karyotis, above n 52; Balzacq, 'The Policy Tools of Securitization', above n 46; Balzacq, 'Constructivism and Securitization Studies', above n 39.

²³³ Karyotis, above n 52.

²³⁴ McInnes, above n 134, 46. As noted by McInnes and others, while Securitization Theory seeks to move away from 'State-centric' approaches to security its language still reflects a tendency to view 'subunits' as homogenous bodies (eg, 'bureaucracies') and a tendency to drift back towards positioning the State as the key referent object: eg, Buzan, above n 118, 21–22; Buzan, Wæver and De Wilde, above n 42, 6–7. For one critique see Barthwal-Datta, above n 67. Human security theory (which includes 'health security') has taken a more explicit turn, centring notions of security on individuals: UNDP, Human Development Report 1994, above n 31.

²³⁵ Buzan, Wæver and De Wilde, above n 42, 25.

move’ could be identified in each case study, and whether there had been acceptance of that move by an ‘audience’.²³⁶

A theoretical assumption underpinning the adoption of Securitization Theory is that disease and disease-causing agents can be constituted as threats even in the absence of an actual outbreak and where an outbreak of a particular disease would – for epidemiological or health infrastructure reasons – likely be extremely limited. A line of academic literature – discussed in Chapter 2 – supports this assumption. Ullman cites ‘decimating epidemics’ as a ‘fairly obvious’ example of the kind of event that could fall within his definition of a threat to ‘national security’.²³⁷ Buzan approved this open approach to defining security risks in *People, States, and Fear* and, later, in *Framework for Analysis*.²³⁸ In this later work, epidemics are briefly identified as a kind of security threat that could arise within the ‘environmental sector’ (ie, as a ‘population problem’).²³⁹ Finally, Enemark’s insights on the importance of human emotions, such as ‘dread’ point to a basis for a disease being securitizable even in the abstract or where it is highly unlikely to cause a ‘decimating’ epidemic.²⁴⁰ Hence, it was expected that the mere threat of an Ebola outbreak in Australia would be more likely lead to securitization than a disease with a higher annual mortality rate, for example tuberculosis or yellow fever, or a non-communicable disease, such as diabetes, cancer, stroke or chronic obstructive pulmonary disease.²⁴¹ This latter expectation arose both from Ebola’s symptoms matching (often literally) Enemark’s descriptor of ‘visceral’; the candidate’s knowledge of how the disease had been prefigured in the public’s imaging by media and popular culture; and – in contrast to non-communicable diseases – the superficially less complex interplay between disease and lifestyle and social determinants.

²³⁶ Ibid. Buzan and others recognise that acceptance may be coerced, but the question is whether the ultimate coercion is to the ends of justifying the breaking of rules that normally bind. ‘Acceptance’ may take multiple forms, including popular acceptance and legitimation or legal or moral ‘licensing’ – see discussion in Adam Côté, ‘Agents without Agency: Assessing the Role of the Audience in Securitization Theory’ (2016) 47(6) *Security Dialogue* 541, 543–545 and Roe, ‘Actor, Audience(s) and Emergency Measures’, above n 139.

²³⁷ Ullman, above n 118, 133.

²³⁸ Buzan, above 118, 17.

²³⁹ Buzan, Wæver and De Wilde, above n 42, 74–75.

²⁴⁰ Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia*, above n 27, 10, 20. Enemark’s thesis stems from the not unreasonable premise that ‘People are often more concerned with the manner in which they might die than they are with calculations of probability [for other – more ordinary – causes of death], 10 (emphasis in original); and that certain diseases present a very unpleasant mode of death.

²⁴¹ Selgelid, ‘Ethics, Tuberculosis and Globalization’, above n 151; Selgelid, Kelly and Adrian, above n 56.

The contribution of global business regulation to this study

Biosecurity hazards are subjects ripe for political, governmental and intergovernmental intervention and the exercise of control. The mere language of ‘threat’ can be invoked to impel efforts for social control (and sanction) of actors and deviants, or to lead to behaviour change in individuals. For example, researchers may change their research agenda to avoid research that may be seen as problematic to funders; or parents may decide to vaccinate their children or keep them home from school or other social venues during a disease outbreak even in the absence of a school-closure order. While it is possible to examine securitization purely as a performative act (eg, security utterances), such a narrow focus on discursive practices is unlikely to address significant ‘so what’ questions or provide useful insights on the *consequences* of securitization on the relations between actors, be they governmental instrumentalities; or between the Executive and Legislative branches of government; or between the State and professionals, including researchers. If a securitizing move seeks to justify breaking free of *rules* that normally bind,²⁴² an empirical study of securitization ought to consider and assess the securitizing move (and its outcome) against both the pre-existing rules and any resultant regime. Such an approach requires looking to the ‘tools of securitization’ or, per Balzacq, the ‘empirical referents of policy’.²⁴³ For this study, this means regulatory responses to biosecurity issues.

This study assumes that in liberal states, even in times of crisis, some legal principle (eg, ‘legality’ or ‘rule of law’) or constitutional framework will continue to exist to direct, control, restrain executive action and hold decision-makers to account.²⁴⁴ Efforts to hold the executive to account may be deferred or delayed depending on the circumstances, or sanctions and restraints may be lessened or nominal only; but they exist – even if only on the statute books.²⁴⁵

²⁴² Buzan, Wæver and De Wilde, above n 42, 26.

²⁴³ Balzacq, ‘The Policy Tools of Securitization’, above n 46, 76.

²⁴⁴ For definitional and explanatory purposes ‘constitutional’ includes a ‘rule of recognition’ in the sense explained in H L A Hart, *The Concept of Law* (Oxford University Press, 3rd ed, 2012) and, to a lesser extent, Kelsen’s grundnorm: Hans Kelsen, *Pure Theory of Law* (trans Max Knight, University of California Press, 1967); Tony Blackshield, George Williams and Sean Brennan, *Australian Constitutional Law and Theory: Commentary and Materials* (Federation Press, 6th ed, 2014) 1.55-1.59; Scott J Shapiro, ‘What Is the Rule of Recognition (And Does It Exist)?’ in Matthew Adler and Kenneth Himma (eds), *The Rule of Recognition and the U.S. Constitution* (Oxford Scholarship Online, 2009).

²⁴⁵ There is a rich vein of case law, famous dissents and literature concerning judicial responses to (and often accommodation of) such efforts by the Executive in wartime, or what is claimed to be a ‘war-like time’, wherein concepts such as the ‘waxing and waning’ of power (Australia), ‘ordered liberty’ and ‘pragmatism’ (US) are used to justify such measures: eg, *Australian Communist Party v The Commonwealth* (1951) 83 CLR 1; *Thomas v Mowbray* (2007) 233 CLR 307; *Korematsu v. United States*, 323 U.S. 214 (1944); *Hirabayashi v. United States*, 320 U.S. 81 (1943); *Liversidge v Anderson* [1941] UKHL 1, [1941] 3 All ER 338, [1942] AC 206

Indeed, such a legal framework may be worked to the ends of securitizing an issue, for example through the judicial accommodation of securitizing activities through the authorisation of legal ‘grey holes’;²⁴⁶ or in the legislature granting, via its own processes, all the emergency powers requested by security agencies and police;²⁴⁷ or through a constitutional rule recognising the role of the Executive in emergencies.²⁴⁸ What matters is the extent to which ‘securitization’ can be identified as behind the new policy, law, regulatory regime or ‘empirical referent’ and how other state institutions might – through their accommodation of a securitizing actor’s attempt at rule breaking – demonstrate ‘acceptance’ of the securitizing move.

This study focuses on the rules that, collectively, make up a regulatory regime. The term ‘rules’ includes laws or formal instruments possessing either a ‘constitutional’ or ‘directly binding’ normative character.²⁴⁹ It also includes those instruments captured by the wider conceptions of regulation within the governance and regulation literature. For this study, ‘regulation’ is conceived of as the ‘sustained and focused control over activities that are valued by the community’.²⁵⁰ In analytical terms, this ‘de-centres’ the regulatory function away from the exclusive jurisdiction of the State and emphasises ‘complexity, fragmentation, interdependencies, and government failures, and suggests the limits of the distinctions between the public and the private and between the global and the national.’²⁵¹ This analytical decentring emphasises the need for empirical studies of regulation to look beyond the statute books and to identify the actors, mechanisms and strategies used to embed the ‘norms, standards, principles and rules’ that govern conduct and relationships.²⁵² Relevant to this study, institutional conventions might include which Minister or Department takes the lead in developing, implementing and overseeing the response to a crisis and whether a proposed law

(‘Liversidge’); compare the dissent by Lord Atkin LL in *Liversidge*; Justice Scalia’s dissent in *Hamdi v. Rumsfeld*, 542 U.S. 507 (2004) and decisions such as *Ex parte Milligan*, 71 U.S. 2 (1866); *Terminiello v. Chicago*, 337 U.S. 1 (1949); Dyzenhaus, above n 142.

²⁴⁶ Cian C Murphy, ‘Counter-Terrorism and the Culture of Legality: The Case of Special Advocates’ (2013) 24(1) *King’s Law Journal* 19.

²⁴⁷ For an example, see discussion below about Australia’s period of anti-terrorism ‘hyper-legislation’. Kent Roach, *The 9/11 Effect: Comparative Counter-Terrorism* (Cambridge University Press, 2011) cited in George Williams, ‘A Decade of Australian Anti-Terror Laws’ (2011) 35 *Melbourne University Law Review* 1136, 1145.

²⁴⁸ Dyzenhaus, above n 142.

²⁴⁹ Cohn, above n 193, 189.

²⁵⁰ Based on Selznick’s 1985 definition of regulation, quoted in Levi-Faur (ed), above n 84, 5. For a recent overview of leading regulatory theories and models see: Drahos (ed), *Regulatory Theory: Foundations and Applications*, above n 84.

²⁵¹ Levi-Faur (ed), above n 84, 6; Black, *Critical Reflections on Regulation*, above n 85; Black, ‘Constructing and Contesting Legitimacy’, above n 85.

²⁵² Braithwaite and Drahos, above n 36, 10.

proceeds through the usual parliamentary scrutiny processes. Likewise, a relevant pre-existing rule might be that Ministers will not personally interfere in the research grants process.²⁵³

However, the further one moves away from the statute books and more narrowly tailored ‘directly binding rules’ the greater the risk of being overwhelmed by the number of possible ‘rules’ to assess for securitization. As such, this study has a closed set of case studies. Further, the study’s analytical focus is concerned with the *principles* that motivated the framing, drafting, justification or implementation of the regulation or response. The study used the approach adopted in *Global Business Regulation* which addressed a research agenda restricted in a similar manner.²⁵⁴ *Global Business Regulation* sets out a compelling account of how a particular ‘rule’ can become globalised through actors adopting a range of ‘mechanisms’ to promote the ‘principles’ and norms that underpin a specific rule’s manifestation. Although a theory of the globalisation of rules this study applied the concepts and analytical frameworks from *Global Business Regulation* set out in Table 4, below, to examine changes in domestic regulation.

The non-realist account of State power put forward in *Global Business Regulation* also informed the study’s research methodology. Just as a State’s ‘power’ on the international stage is the product of a ‘process of structuration’, involving various state and non-state actors and networks,²⁵⁵ this study assumes a similar process of structuration on a domestic level. In practical terms, this means that an analysis of regulatory responses must move beyond a ‘State-centric’ model and allow for ‘polycentric’ regulatory regimes, wherein regulation occurs at different levels and multiple sites.²⁵⁶ Consequently, the research methods adopted were intended to examine (and ultimately explain) the emergence of regulatory regimes through the intentional use of various ‘mechanisms’ and strategies by actors involved in the design and implementation of biosecurity regulatory measures. One strategy expected to be identified in the study was the use of ‘forum shifting’ (described in detail below).²⁵⁷ Adopting the definitions

²⁵³ This principle exists in different forms – in Australia it is implicit; whereas in the UK the ‘Haldane principle’, which first emerged in 1918, was formalised in legislation in 2017: *Higher Education and Research Act 2017* (UK) s 103(3); UK Research and Innovation, *Haldane 100 - Marking the Centenary* (14 October 2020)

<<https://webarchive.nationalarchives.gov.uk/ukgwa/20201014012846/https://www.ukri.org/research/themes-and-programmes/haldane/>>.

²⁵⁴ Braithwaite and Drahos, above n 36, 19.

²⁵⁵ Ibid, 482–483.

²⁵⁶ Black, *Critical Reflections on Regulation*, above n 85; Black, ‘Constructing and Contesting Legitimacy’, above n 85.

²⁵⁷ Described in Chapter 2. Drahos, ‘Intellectual Property and Pharmaceutical Markets’, above n 36, 406.

in *Global Business Regulation*,²⁵⁸ data analysis focused on identifying the key ‘principles’, ‘norms’ and rules that actors either explicitly or implicitly invoked in justifying their regulatory preferences.²⁵⁹

The framework: Securitization as a mechanism in pandemic preparedness and response regulation

Tables 3 and 4 below summarise the different elements of each theory and their contribution to this study’s theoretical framework.

Contribution of Securitization Theory	Examples
Research question	To what extent can we identify efforts by the Australian Government to securitize infectious disease in: • Pandemic influenza planning (2005) and response to the H1N1 influenza pandemic (2009) • The response to the 2013–2016 West Africa Ebola Outbreak, and • Biosecurity legislation (2001–2016), in particular the DTCA
Methodology	• Ontology – constructivism • Epistemology – <i>post hoc</i> analysis of events • Methods – discourse analysis and elite interviews
Analytical concepts	• Security, referent object, ‘extreme’ threat • Security actor, securitizing move • Audience and acceptance/rejection of securitizing move • Desecuritization

Table 3: Summary of Securitization Theory's contribution to theoretical framework

Contribution of <i>Global Business Regulation</i>	Examples
Contribution to the research question	If we can identify efforts by the Australian government to securitize infectious disease, can we explain the design of Australia’s responses to biosecurity measures as the outcome of a conflict of principles, with securitization used as a mechanism to promote certain principles over others?
Methodology	• Ontology – constructivism • Epistemology – <i>post hoc</i> analysis of events • Methods – elite interviews and legal analysis.
Analytical concepts	• Principles • Rules • Mechanisms

²⁵⁸ Braithwaite and Drahos, above n 36, 24–26.

²⁵⁹ Ibid, 18–20. The author notes the conceptual pedigree of these terms in legal theory scholarship, for example: Dworkin, above n 48.

Table 4: Summary of *Global Business Regulation*'s contribution to theoretical framework

Combining elements of both theoretical frameworks provides a means to answer the research questions identified above and test the researcher's hypothesis that securitization represents a way for actors to engage in a conflict of principles and, in justifying the breaking of previous rules (which were based on existing 'principles'), allow for the substitution of new rules. As such, securitization represents another 'mechanism' by which domestic actors can disrupt existing rules operating in a given sector – in this case the practice of public health and disease response. This hypothesis is represented diagrammatically in Figure 5, below.

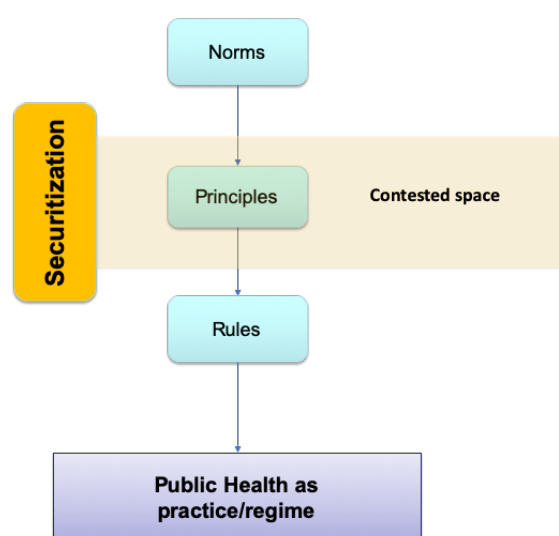


Figure 5: Proposed operation of securitization as a mechanism in content of principles and rule generation

As outlined by Buzan and colleagues, securitization can shift from an 'ad-hoc' act to an institutionalised process. The 'persistence' of a threat is one factor that may lead to the institutionalisation of a securitized response.²⁶⁰ This thesis draws on this insight and Braithwaite and Drahos's observation of how initial victories in conflicts of principles and rules can shift the ground of norms so that the next conflict commences from a new starting point. In this way, incremental victories by one party (eg, a securitizing actor) operate like a 'ratchet', forcing other actors to argue from a new, pre-securitized starting point each time, with the costs of returning to an idealised, pre-reform regulatory regime raised significantly.²⁶¹

The raising of the cost of change is amplified as different publics – such as medical practitioners, researchers and policy advisers – adjust and internalise the new order and new security grammars, and 'epistemic communities' (such as government appointed specialists

²⁶⁰ Buzan, Wæver and De Wilde, above n 42, 27–29.

²⁶¹ For a discussion of 'ratchets' see: Braithwaite and Drahos, above n 36, 519–523.

who attend groups including the Australia Group and meetings of State parties to the Wassenaar Agreement) form around, and reproduce, the new orthodoxy.²⁶² In short, subsequent securitizing moves within the same field are expected to start with norms that reflect the post-securitized ‘new normal’. As this study’s temporal frame extends over a decade and a half, data could also be analysed to draw findings on whether certain securitizing moves became institutionalised or served as a ‘floor’ for a subsequent and new securitizing move.

3. Research design

Study design and methods

This thesis draws on multiple data sources and methods, including document analysis and interviews. Document analysis involved records of parliamentary debates (*Hansard*), parliamentary and official documents, and public statements by Ministers and Members of Parliament. This documentary analysis was complemented by semi-structured interviews with public servants, Ministers and non-government representatives involved in the development of Australia’s biosecurity legislation, planning for a potential outbreak of pandemic bird flu, and in Australia’s response to the 2009 H1N1 pandemic and the Ebola outbreak. Data collection was undertaken in parallel, with insights gained via one method used to inform others.

Timeline of data collection

A timeline for data collection is set out in Figure 6 below. As this project adopted an iterative research strategy, data collection and analysis did not occur in a purely sequential fashion. Rather, an initial round of document collection occurred in parallel with – and helped inform – the FoI requests and interview phase. Likewise, insights gained from documents released under FoI and the early interviews helped direct future general document collection.

²⁶² Braithwaite and Drahoš also recognised the way in which dialogue can lead to internationalisation of principles and ‘cultivation’ of a habit of rule-compliance: *ibid*, 563. On ‘epistemic communities’ see *ibid*, 501.

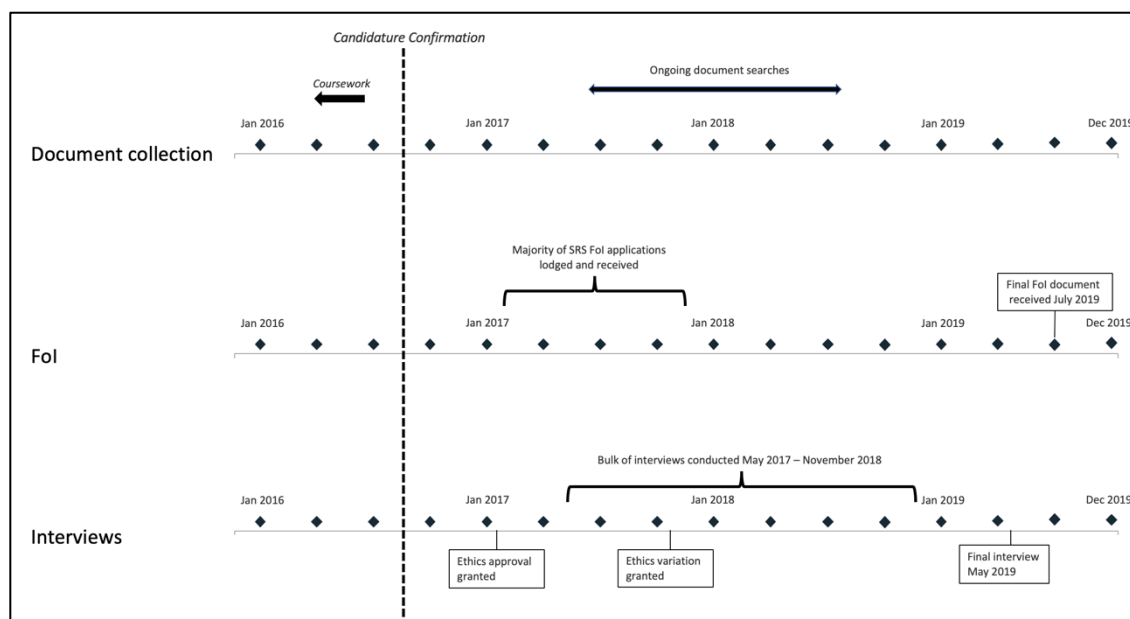


Figure 6: Timeline of data collection by method (document collection; FoI requests; and interviews).

In the case of the CoAG review (Chapter 5), interviewees were able to ‘fill in’ for an identified primary source that – due to it being classified as ‘Secret’ – was unlikely to be released through an FoI request.²⁶³

Documentary analysis

The study utilised discourse analysis of a range of official and unofficial government documents. As well as providing useful insights itself, analysis of these materials offered the opportunity to triangulate data gained through interviews.²⁶⁴ In keeping with the approach outlined in *Framework for Analysis*, this discourse analysis did not apply ‘sophisticated linguistic or quantitative techniques’. The exception was the comparative analysis of second reading speeches developed by Departments and those delivered by Ministers – and even here the quantitative analysis was simple.²⁶⁵

In general, discourse was ‘studied as a subject in its own right’ to identify ‘specific rhetorical structure(s)’ that might signify a securitizing move.²⁶⁶ The selection of texts,

²⁶³ An impediment to research in this area is that inclusion of even one sentence in a record that warrants a high security classification: Attorney-General’s Department, *Sensitive and classified information (Protective Security Policy Framework Policy 8)* (28 September 2018)

<<https://www.protectivesecurity.gov.au/information/sensitive-classified-information/Pages/default.aspx>>.

²⁶⁴ Roger Pierce, *Research Methods in Politics* (Sage, online ed, 2011); Susan E Kelly, ‘Qualitative Interviewing Techniques and Styles’ in Ivy Bourgeault, Robert Dingwall and Raymond De Vries (eds) *The SAGE Handbook of Qualitative Methods in Health Research* (Sage, 2012), 307.

²⁶⁵ Buzan, Wæver and De Wilde, above n 42, 176.

²⁶⁶ Ibid.

particularly in Chapter 4's analysis of biosecurity lawmaking, reflects this. Parliamentary debates are one of the 'occasions' where 'it should be expected [for securitization] to materialise'; hence, past research looking at this 'scene to battle' where we might expect to find actors engaging in rhetorical contests.²⁶⁷

More pragmatically, formal records of dialogue (such as *Hansard* or 'door-stop' interviews) afford a degree of certainty, in that they represent a fixed record of what was *said* and the immediate context in which it was said (eg, a parliamentary debate or court proceeding).²⁶⁸ In many cases, a document or recorded speech act is or can be attributed to a specific person or agency – although, as is discussed in the opening to Chapter 5, the individual identified as delivering a particular security 'utterance' may not have been responsible for its authorship.

Data sources:

Data for the documentary analysis component of the project was obtained from the following sources, divided into three broad categories:

Category A sources (legal, official and formal sources)

- Constitutions, primary and secondary legislation and international treaties;
- UNSC Resolutions;
- Judicial decisions relating to quarantine, defence export controls and the control and management of infectious diseases;
- Professional medical and research codes of conduct;

²⁶⁷ Ibid, 177. Tim Legrand and Lee Jarvis, 'Enemies of the State: Proscription Powers and Their Use in the United Kingdom' (2014) 9(4) *British Politics* 450; Lee Jarvis and Tim Legrand, 'Legislating for Otherness: Proscription Powers and Parliamentary Discourse' (2016) 52(3) *Review of International Studies* 558; Lee Jarvis and Tim Legrand, "'I Am Somewhat Puzzled": Questions, Audiences and Securitization in the Proscription of Terrorist Organizations' (2017) 48(2) *Security Dialogue* 149; Roe, 'Actor, Audience(s) and Emergency Measures', above n 139. Parliament also has constitutional, sedimented authority that supports its efforts to securitize or resist securitization.

²⁶⁸ These records cannot – of their own – provide evidence of what was subjectively meant by a given speech act. And it is acknowledged that selective editing or 'doctoring' of *Hansard* proofs does occur, although the political consequences of egregious editing can be swift: Louise Yaxley, 'Labor Says Barnaby Joyce Broke Parliamentary Rules by Altering Hansard to Correct His Error', *ABC News* (online), 27 October 2014 <<http://www.abc.net.au/news/2014-10-27/labor-says-barnaby-joyce-broke-parliamentary-rules/5845564>>; Latika Bourke, 'Barnaby Joyce Has Hansard Changed Back after Being Caught out over Correction', *Sydney Morning Herald* (online), 27 October 2014 <<http://www.smh.com.au/federal-politics/political-news/barnaby-joyce-has-hansard-changed-back-after-being-caught-out-over-correction-20141027-11cf02.html>>; Lenore Taylor, 'Twist in Barnaby Joyce's Hansard Saga as Department Head Unexpectedly Takes Leave', *The Guardian* (online), 10 March 2015 <<https://www.theguardian.com/australia-news/2015/mar/10/twist-in-barnaby-joyces-hansard-saga-as-department-head-unexpectedly-takes-leave>>.

- National and professional guidelines for ethical conduct; and
- Australian pandemic plans.

Category B sources (extrinsic materials)

- Transcripts of parliamentary debates (Hansard), in particular the SRS delivered in Parliament;
- Explanatory Memorandums to Bills and Explanatory Statements to regulations and other secondary legislation;
- Reports from parliamentary committees;
- Media releases and transcripts of interviews with Ministers and Members of Parliaments; and
- The Australian Constitutional Convention Debates.

Category C sources (other sources)

- Documents, including guides, advice, forms and pictures, produced by Commonwealth Departments with a role in pandemic preparedness and response, including:
 - The Department of Health (Health)
 - The Department Defence (Defence)
 - The Department of Foreign Affairs and Trade (DFAT)
 - The Department of Agriculture and Fisheries and Forestry (DAFF)
 - The Department of Immigration and Border Protection – later ‘Home Affairs’
 - The National Health and Medical Research Council (NHMRC)
- Departmentally prepared versions of the SRS (via FoI);
- Departmental briefs and advice to Ministers (via FoI);
- Reports and advice issued by the WHO and relevant UN institutions;
- Government contracts;
- Submissions to Senate Committee inquiries;
- Transcripts of evidence to Senate Estimates hearings;
- Newspaper articles;

- Agency websites; and
- Documents provided by interview participants.

The division of documents into categories is primarily based on their legal standing and reflects the author's legal training and disciplinary biases. In brief, Category A documents are primary sources of legal rules or professional duties that can both 'stand-alone' as an embodied form of regulation and which can also be analysed according to the methodologies of traditional legal scholarship: for example, doctrinally or through processes of 'statutory interpretation'. But, as with Category B and C documents, they can also be examined post-facto via the theoretical framework outlined above.

Category B documents, again, hold a special legal position. They are those 'extrinsic materials' that, by force of judicial decisions and statute, can, and frequently are, used by the courts in interpreting the law.²⁶⁹ For this study, however, these documents should be considered no more or less important (analytically) than those in Category A or C.

Finally, Category C, includes many of the documents that provide the most direct insight into the motivations and states of minds of the actors of interests. While they may not constitute binding rules, they can capture evidence of securitizing moves or the consequences of particular policy framings. For example, the contract between the Commonwealth of Australia and Aspen Medical (a commercial health services provider) to deliver Australia's medical contribution during the Ebola outbreak is analysed in Chapter 6 as a key product of a period of possible securitization.

Data collection

As part of a structured search, primary legal materials (ie, 'Category A' documents) were sourced from authorised or reputable repositories, for example the Federal Register of Legislation (www.legislation.gov.au) and state, territory and international equivalents. Reputable databases of judicial decisions, for example Austlii (www.austlii.edu.au), were searched for relevant legal cases and precedent. Snowballing was adopted to expand the number of documents to be analysed. For example, each federal law includes a table of all other Acts that amended the primary law. This allowed for a wider scope of Bills to be reviewed.

²⁶⁹ *Acts Interpretation Act 1901* (Cth) s 15AB; Dennis P Pearce and Robert S Geddes, *Statutory Interpretation in Australia* (LexisNexis, 8th ed, 2014). For an example of media releases serving an important role in the construction of a factual context that licensed exceptional, Executive action see *Pape v Commissioner of Taxation* (2009) 238 CLR 1; [2009] HCA 23, [8], [31], [133] per French CJ.

Doctrinal legal research, likewise, involved tracing precedent through earlier judgments and assessing the influence of past decisions on the emergence of a given legal principle.

Category B documents were obtained directly from the central repository, usually the website of the relevant legislature (eg, www.aph.gov.au).

The collection of documents did not proceed in an atheoretical manner and Boolean queries drew on terms related to the specific cases under examination and terms that drew on the literature outlined in Chapter 2. Specifically, the search of Parliament's document repository and *Hansard* used the following search terms:

- anthrax;
- biosecurity Bill
- biosecurity;
- bioterrorism;
- Defence Trade Controls Bill;
- Ebola;
- existential threat;
- existential;
- H5N1;
- National Health Security Bill;
- pandemic;
- pandemic influenza;
- quarantine;
- Quarantine Act;
- security-sensitive biological agents;
- September 11 and 9/11;
- Swine flu;
- white-powder.

A second, more targeted, search of *Hansard* (ie, Parliamentary debates) produced useful findings on how key terms of interest, ‘existential’, ‘existential threat’, ‘biosecurity’, ‘ebola’, ‘pandemic’ and ‘bioterrorism’, waxed and waned over the years – including the years prior to 2001. Figure 7, below, shows that the term biosecurity emerged quickly in the late 1990s, and slowly increased in use. Meanwhile, although the Ebola outbreak saw a spike in references to the disease, it was cited consistently in the years preceding the outbreak. ‘Bioterrorism’, in contrast, emerges suddenly in the years following 9/11, only to disappear after 2013.

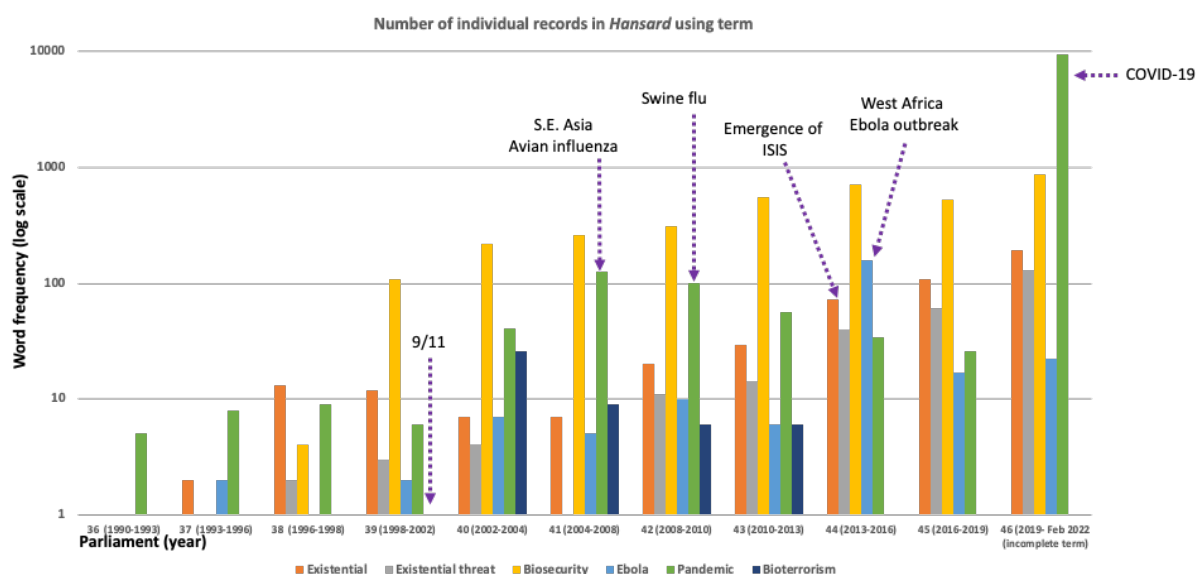


Figure 7: Number of events in Commonwealth *Hansard* records using specific terms (as at 23/02/22).

Category C documents had the least structured approach to collection. Submissions and evidence to parliamentary committees were located through a similar approach to Category B documents. Policy advice and the draft SRS were obtained through FoI requests. Particularly in the case of official documents and websites prepared for the 2009 H1N1 pandemic, the researcher relied on web archiving services such as the Wayback Machine or – in Australia – the National Library of Australia’s Pandora service.²⁷⁰

One specific strategy worth mentioning for other researchers seeking to use FoI to access federal documents, is the use of the ‘Harradine list’ published on each Department’s website to narrow the scope of a FoI request. This eponymous list is prepared in accordance with a 1994 Senate order that requires all Australian Government departments and agencies to ‘produce an indexed list of files every six months for tabling before parliament’, with the intention that this will ‘make the operations of government more transparent to the Australian

²⁷⁰ <https://web.archive.org/> and <https://pandora.nla.gov.au/>, which is now part of the National Library of Australia’s TROVE repository: <https://trove.nla.gov.au/website>.

public.’²⁷¹ For research that is contemporaneous with the events under investigation, the Harradine list and the list of past FoI requests can help identify useful legislative, policy and other work being undertaken by the public service and save time and cost for subsequent FoI requests.²⁷² Because Departments replace these lists after a period of time, historic research will need to either approach the Department for a copy of their previous list or utilise a web archiving service. A similarly useful research tool for past Australian Government contracts with a value more than \$10,000, is the AusTender website (www.tenders.gov.au/). This can also be used to obtain specific contract number that can then be used in future FoI requests.

Why look at Second Reading Speeches?

Before outlining the methods of analysis, it is important to briefly explain the role of Second Reading Speeches (SRS) in this study, and how they were collected. For democratic systems, parliamentary debate is not simply a procedural step in a ritualised process of legislating. For legal researchers and public servants, it represents the nucleation of ‘parliamentary’ or ‘legislative intent’, to which courts may defer or from which they may draw guidance.²⁷³ For security analysts they can point to the existence of ‘moral’ and/or ‘formal’ support for a securitizing actor to move from ‘rhetorical’ securitization to ‘active’ securitization (eg, by moving from debate to the enactment of a specific law).²⁷⁴

Within the ritual of parliamentary debate, a Bill’s SRS (or local equivalent) should be of particular interest to security analysts. In Australia, these serve an essential role in the legislative process, wherein they:

[explain] the Bill’s background and its key policy objectives. The minister’s objectives in relation to the Bill, political considerations and intentions, and broader policy

²⁷¹ For example: Attorney-General’s Department, *Senate Order for the Production of Indexed Lists of Departmental and Agency Files* (Commonwealth of Australia, 2022) <<https://www.ag.gov.au/about-us/publications/senate-order-production-indexed-lists-departmental-and-agency-files>>.

²⁷² For a record of past Australian Government contracts with a value more than \$10,000, researchers can search the AusTender website: <https://www.tenders.gov.au/>. This will provide users with a specific contract number that can then be requested under FoI (again reducing time, cost, and possible grounds for rejection).

²⁷³ Ian McLeod, ‘Legislative Intention’ in Constantin Stefanou (ed), *Drafting Legislation: A Modern Approach* (Taylor and Francis, 2008) 35; Richard Ekins, ‘The Intention of Parliament’ [2010] *Public Law* 709; Richard Ekins and Jeffrey Goldworthy, ‘The Reality and Indispensability of Legislative Intentions’ (2013) 36 *Sydney Law Review* 39; Justice Steven Rares, ‘Legality, Rights and Statutory Interpretation’ (Speech delivered at the 2013 AGS Administrative Law Conference, Canberra, 20-21 June 2013) <<http://www.fedcourt.gov.au/digital-law-library/judges-speeches/justice-raises/raises-j-20130620>>; Pearce and Geddes, above n 269; Justice Robert Mitchell, ‘Statutory Construction as an Expression of Constitutional Relationships: Approaches of the French High Court’ in Henry Jackson (ed), *Essays in Honour of Chief Justice Franch* (Federation Press, 2019). In the United Kingdom, see Cabinet Office (UK), *Guide to Making Legislation*, (United Kingdom, 2017) 6.40.

²⁷⁴ Balzacq, above n 139, 185. For an extended discussion on the role audiences in supporting ‘active’ securitization see Roe, ‘Actor, Audience(s) and Emergency Measures’, above n 139.

strategies which may span areas beyond the specifics of the Bill are appropriately spelled out ²⁷⁵

Second, unlike other formal documents associated with a Bill, such as an Explanatory Memorandum (EM), an SRS must be *spoken* by the member moving the Bill (usually a Minister) or, in some circumstances, incorporated into the formal record as a ‘speech’.²⁷⁶ This means that a specific public actor can, at least in theory, be identified as the owner or mover of a specific securitizing speech-act. However, as described below, using FoI laws to look behind this public performance provides a useful method for researchers. Finally – and what ought to make an SRS most important for analysing securitizing moves – is that the ‘meaning-making’ effect of an SRS extends beyond the parliamentary chamber and persuades individuals involved in interpreting and applying the law as to the correct manner of doing so and the ‘intention’ of the lawmakers. In seeking to identify the purpose of a law, judges can take into account materials ‘extrinsic’ to an Act of Parliament to determine what the ‘legislative intent’ was behind a specific provision.²⁷⁷ Australian law explicitly authorises the use of SRS to discern the purpose of a statute or provision (eg, *Acts Interpretation Act 1901* (Cth)) and, in other Westminster countries, a Minister’s speech introducing a Bill is likewise given special interpretative status.²⁷⁸

Consequently, an SRS can serve a few analytical tasks. As a ‘performative utterances’ (per Austin), the speech performs an essential illocutionary and procedural role: under the Standing Orders of the deliberative chamber, it commences a formal and ritualised process of legislating.²⁷⁹ Beyond that act, it also performs (as all parliamentary debates do) the perlocutionary function of persuading one’s parliamentary colleagues to support the Bill. This can be represented as a linear process, as shown in Figure 8:

²⁷⁵ Department of the Prime Minister and Cabinet, *Legislation Handbook* (Commonwealth of Australia, 2017) [7.48].

²⁷⁶ Parliament of Australia, ‘Legislation’ in *House of Representatives Practice* (Commonwealth of Australia, 7th ed, 2018).

²⁷⁷ Pearce and Geddes, above n 269; Lawrence M Solan, *The Language of Statutes: Laws and Their Interpretation* (University of Chicago Press, 2014).

²⁷⁸ Edward C Page, ‘The Civil Servant as Legislator: Law Making in British Administration’ (2003) 81(4) *Public Administration* 651, 665. While Australian Courts may be more permissive in their use of SRSs and extrinsic material, such speeches are also used by Courts in New Zealand and the United Kingdom: Catherine J Magallanes, ‘The “Just Do It” Approach To Using Parliamentary History Materials’ (2009) 15 *Canterbury Law Review* 205; Justice Susan Glazebrook, ‘Do They Say What They Mean and Mean What They Say? Some Issues in Statutory Interpretation in the 21st Century’ (2015) 14(1) *Otago Law Review* 61; *Pepper v Hart* [1993] 1 All ER 42, 60-61; The Hon Keith Mason, ‘The Intent of Legislators: How Judges Discern It and What They Do If They Find It’ (2006) 27 *Australian Bar Review* 253, 261.

²⁷⁹ Building off an example of John Austin, it is the ‘Dearly beloved...’ spoken by a Catholic Priest to begin a wedding performed according to the precepts of the Roman Missal.

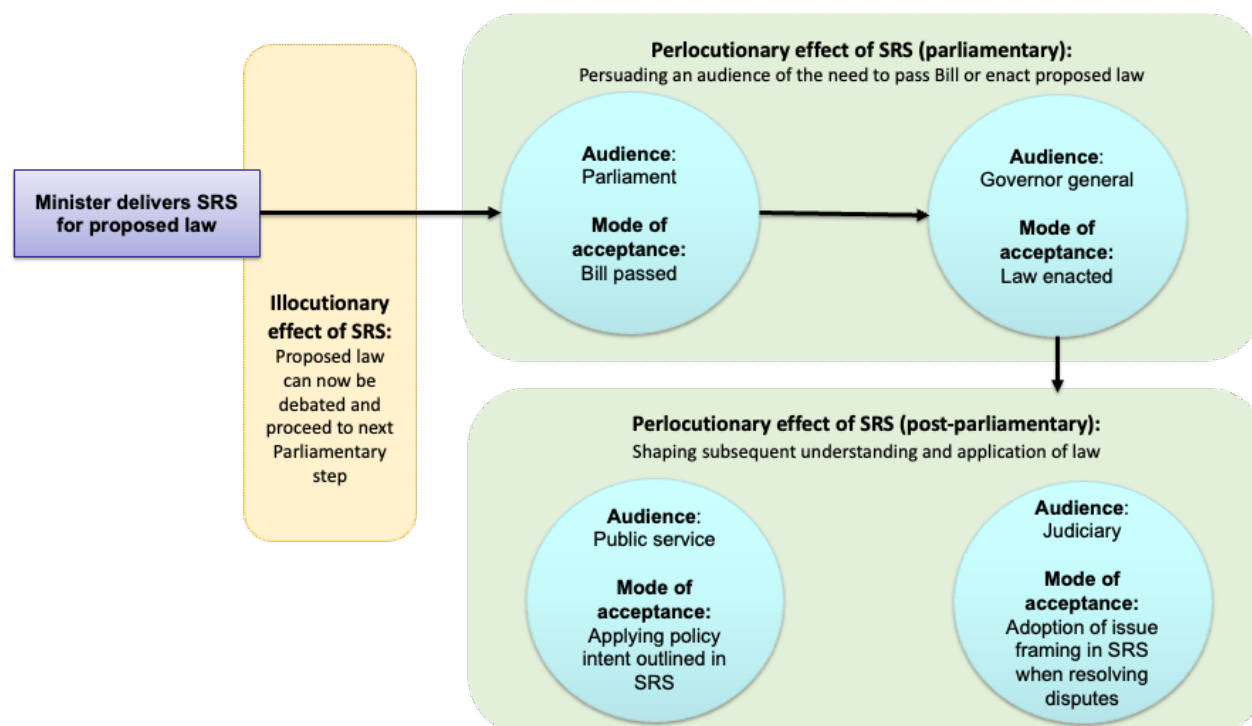


Figure 8: Second Reading Speech as an illocutionary and perlocutionary act for formal ‘audiences’ in a Westminster parliamentary democracy

However, as Figure 8 shows, the perlocutionary effect of an SRS extends beyond Parliament and serves a quasi-legal function that directs or guides public servants who apply the law, or judges who interpret it.²⁸⁰

Importantly for this study, Ministers do not deliver their speeches *ex tempore* to Parliament. Recognising their value to the subsequent interpretation of the law, the SRS is a carefully constructed text; and, for Government Bills in Australia and elsewhere,²⁸¹ the task of drafting both falls to the ‘apolitical’ public service.²⁸² However, Ministers retain an unfettered discretion over the delivered speech. They may modify it to make it more persuasive in the face of a hostile parliamentary chamber, to emphasise one argument over another, or to

²⁸⁰ An SRS cannot override the language of an Act, correct a drafting error, or fill a gap where the Act is silent: *Plaintiff S157/2002 v The Commonwealth* (2003) 211 CLR 476 at 499 per Gaudron, McHugh, Gummow, Kirby and Hayne JJ; *Re Bolton; Ex Parte Beane* (1987) 162 CLR 514 at 518 per Mason CJ, Wilson and Dawson JJ; *Northern Territory v Collins* (2008) 235 CLR 619 at 623 per Gummow ACJ and Kirby J. “The statutory text must be considered in its context. That context includes legislative history and extrinsic materials. Understanding context has utility if, and in so far as, it assists in fixing the meaning of the statutory text. Legislative history and extrinsic materials cannot displace the meaning of the statutory text” *Commissioner of Taxation v Consolidated Media Holdings Ltd* (2012) 250 CLR 503 per French CJ, Hayne, Crennan, Bell and Gageler JJ at 39.

²⁸¹ For an academic study in the UK, see: Page, above n 278.

²⁸² As opposed to ‘political staffers’ appointed by Ministers and Parliamentarians, the Australian Public Service is legally constituted to be ‘impartial’ and ‘apolitical’: *Public Service Act 1999* (Cth) s10(5).

introduce a new argument entirely.²⁸³ The ease and dynamic way in which Ministers can modify an SRS ‘in the moment’ distinguishes them from Explanatory Memorandums, which otherwise share a number of similar qualities. As a result, if an SRS contains securitizing speech, it is an open question of who put it there. Was it the Minister, or the public servant who drafted it? If the Minister, why? What did he or she want to achieve? If the public service, how does that affect empirical studies of securitization?

This potential difference between the speech as drafted and the speech actually delivered is why the researcher undertook a comparative analysis of the draft SRS prepared by the public service with the delivered speech (recorded in *Hansard*). Departmental versions of the speeches were obtained via FoI requests. To the researcher’s knowledge, this was the first time a comparative exercise was undertaken to go ‘behind’ the words spoken in Parliament and examine draft speeches alongside the delivered speech.²⁸⁴

Biosecurity legislation and second reading speeches – collection

A purposive sampling strategy was adopted in the selection of Bills to be analysed as representing biosecurity lawmaking and whose draft SRS would be sought for via FoI requests. As an actor does not need to utter the word ‘security’ for a move to be a securitizing move,²⁸⁵ selected laws were not limited to those whose ‘Short Titles’ included the terms ‘security’ or ‘biosecurity’. Rather, any Government Bill that engaged with a biosecurity threat identified in Chapter 2 was assessed for inclusion. Non-Government Bills (‘private Member’s Bills’) were not included.²⁸⁶ This exclusion was both practical – between 1901 and December 2017, the Australian Parliament only enacted 30 private Member’s Bills – and in keeping with the research design: private member Bill’s and their supporting material are not developed by a

²⁸³ Indeed, this was given as a ground for initially refusing access under FoI to a draft SRS.

²⁸⁴ For an Australian example of a study focused on delivered second reading speeches see: Ann D Villers, ‘Legislating for Women’s Rights and Conservative Rhetoric - Lessons for Feminists’ (1987) 59(2) *The Australian Quarterly* 128. For a UK example see: Jarvis and Legrand, “‘I Am Somewhat Puzzled’”, above n 267; Jarvis and Legrand, ‘Legislating for Otherness’, above n 267.

²⁸⁵ Buzan, Wæver and De Wilde, above n 42, 33.

²⁸⁶ For more information on non-Government business in the Australian Parliament see: House of Representatives, *House of Representatives Practice* (Parliament of Australia, 7th ed, 2018) Chapter 16; Nicolee Dixon, ‘The Role of Private Members’ Bills’ (2004) 19(1)(Spring) *Australasian Parliamentary Review* 88. Analogous procedures apply in other Westminster jurisdictions.

sponsoring Department.²⁸⁷ The researcher wishes to acknowledge the willingness of all relevant Departments to release the requested SRS for the ‘biosecurity’ legislation sample.²⁸⁸

Individual Bills were identified through a review of the Federal Register of Legislation and Austlii. Bills that made only ‘consequential amendments’ to other laws were excluded as these Bills are introduced alongside a substantive Bill and it is to the substantive Bill that an SRS is likely to be directed. Table 5 lists the five Bills that were identified through this preliminary search:

National Health Security Bill 2007	Biosecurity Bill 2012
Quarantine Amendment (National Health Security) Bill 2008	Biosecurity Bill 2014
Defence Trade Control Bill 2011	

Table 5: Biosecurity legislation, initial sample.

Except for the Biosecurity Bill 2012, all Bills had been enacted at the time of analysis. To account for subsequent amendments to these laws that may, themselves, have constituted further securitizing moves, a review was made of the ‘legislation and amendment history’ for each Act and relevant, amending Bills were located and assessed for inclusion. Amending Bills were included in the sample if they constituted a substantive change to the law and they related to the same subject matter as the principal law. This resulted in an additional four Bills being identified and included in the sample for a sample size of nine Bills (listed in Table 6). This sample of Bills also formed the sample analysed in Chapter 4 – biosecurity law making.

National Health Security Bill 2007	Biosecurity Bill 2012
Quarantine Amendment (National Health Security) Bill 2008	Biosecurity Bill 2014
Defence Trade Control Bill 2011	National Health Security Amendment Bill 2009
National Health Security Amendment (Background Checking) Bill 2010	National Health Security Amendment Bill 2012
Defence Trade Controls Amendment Bill 2015	

Table 6: Biosecurity legislation sample, with amending Bills.

The delivered SRS for each Bill was located using the ‘Bills and Legislation’ search tool on the Australian Parliament House (APH) website.²⁸⁹ The author lodged FoI requests with the

²⁸⁷ House of Representatives, *House of Representatives Practice*, above n 286.

²⁸⁸ In the case where a Department refused to release the draft SRS for a comparative, subset of Bills not focused on biosecurity issues, the appeals processes resulted in a delay of **799 days** before the original decision was reversed following an appeal to the independent Information Commissioner.

²⁸⁹ Australian Parliament House, *Bills and Legislation*
<https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation>.

sponsoring Department, requesting ‘the final 2nd reading speeches prepared by the Department (ie, as provided to the Minister and their office).’ A sample FoI request is included at Appendix 1. To minimise the chance that the Department would simply provide the publicly available SRS, the letter clarified that it was ‘the differences (if any) between the speech prepared by the Department and the speech delivered that is of particular interest.’²⁹⁰

Document data analysis

All documents were analysed by the researcher through multiple close readings. Category B and C texts were analysed as examples of ‘discourse’. Category A documents, particularly primary legislation, were read first as a legal text and second as a discursive text. Findings in Chapter 4 point to how these two readings differ. Analysis drew on the themes and concepts set out in the theoretical framework described in Section 2. Texts were analysed for their contribution to the securitization of a specific topic and whether they engaged in, constituted, or identified:

- a ‘securitizing actor’;
- one or more ‘securitizing moves’, which may include ‘speech-acts’, visual references or other ‘pragmatic acts’;²⁹¹
- a ‘threat’;
- a ‘referent object’;
- designation of a ‘threat’ as an ‘existential’ or ‘extreme’ risk to the referent object;
- using this designation as a ‘justification’ for ‘breaking existing rules’ or moving the threat beyond politics as normal; and
- urgency and prioritisation.

Use of the term ‘security’ is a possible indicator of an effort to securitize a topic but was neither required nor determinative.

The analysis of documents also sought to identify the concepts outlined in *Global Business Regulation*, including the extent to which participants identified or associated with particular ‘principles’, ‘rules’, ‘norms’ and ‘mechanisms’. Unable to ‘prompt’ documents for

²⁹⁰ This clarification helped and hindered the FoI process. The single department that refused to release the draft SRS did so, partly, on the perceived legal harm of having two versions of the SRS in the public.

²⁹¹ Williams, ‘Words, Images, Enemies: Securitization and International Politics’, above n 64.

further information, inferences on the use of ‘strategies’ and ‘mechanisms’ were drawn from the texts for the purpose of Chapter 4. In the case of biosecurity legislation and surrounding parliamentary debates, an assessment of a principle’s relative priority was inferred from the frequency by which it or a proxy were used; whether it was used by multiple members of Parliament and contextual clues as to its importance to the speaker. For Chapter 5 and 6, the use of semi-structured interviews provided a way to triangulate inferences drawn from the documentary analysis.

Second Reading Speeches – analysis and coding

Prior to coding and analysis, a marked-up, comparison of each SRS-pair (ie, Department Draft—Delivered) was auto-generated via Microsoft Word. Each marked-up speech was reviewed by the researcher and differences between the speeches manually highlighted. Although fundamentally a qualitative analysis, some quantitative values for difference were derived from a simple count of the words removed and added between the two versions of the speech. This analysis helped to quantify the *size* of any change in text, while the subsequent qualitative analysis sought to assess the *significance* of the change. Procedural text added by Parliament’s tabling office was excluded from the analysis, as were differences in capitalisation and minor typographical changes (eg, ‘travellers’ v ‘travelers’).

Quantitative analysis of data was undertaken in Microsoft Excel to identify the number of words in each speech, the number of words removed from and added to a Department’s SRS and the percentage difference between the Department’s SRS and the Minister’s SRS. The political party of the moving Minister was also recorded. The mean and median number of words added and removed, and the speech length, were calculated in whole numbers. Percentages were calculated to two decimal places.

Qualitative analysis involved the author reviewing each speech in Microsoft Word to identify which words had been added to or deleted from the Department’s SRS and any reordering that might signify a difference in priority or emphasis. No pre-determined coding schema was applied at this point. However, the final, marked-up texts underwent a review similar to that described above for other Category B and Category C documents.

Semi-structured interviews

Study participants

Semi-structured interviews were undertaken to collect data on the motivations, values and principles of individuals involved in the design and implementation of biosecurity laws and policies and Australia's responses to pandemic influenza and the Ebola outbreak. Interviews also served to help triangulate data collected as part of the documentary analysis. A purposive, snowballing sampling strategy was used to identify interviewees and three main categories of participants were identified.²⁹² Interviewees fell into three main groups. First, politicians, public servants, including policy officers and individuals occupying designated public health roles (eg, Chief Health/Medical Officers).²⁹³ A second group included individuals who represented (either officially, via their employment with a sector's representative body or in an *ad hoc* capacity) the research/higher education communities. Finally, individuals representing NGOs involved in Australia's response to the Ebola outbreak were interviewed. This last group was especially useful in helping to corroborate (or not) statements made by public servants and provided additional insight into political announcements made during the Ebola response by, for example, the Foreign Minister.

Some initial participants were professionally known to the researcher while others were identified by reviewing Senate Committee transcripts to identify relevant Departmental personnel. If an organisation was known to be relevant, a review of the Department's Organisational Charts, was undertaken to identify possible areas/teams within the Department to approach. Finally, specific individuals were identified from a review of submissions to relevant Senate Committees, such as the Senate committees that reviewed the DTC Bill and the Government's response to the West Africa Ebola Outbreak. Once an initial list of potential interviewees and Departments were identified, contact details were acquired using the Government Online Database (formerly known as 'GOLD') and the GovTree website;²⁹⁴ introductions from friends and colleagues, and online searches, including of social media. All

²⁹² This sampling approach mirrors, on a micro-level, the 'theoretical-sampling' approach to the choice of cases for this study: Michael Quinn Patton, *Qualitative Research and Evaluation Methods* (Sage Publications, 3rd ed, 2002) 289.

²⁹³ The title 'Chief Health Officer' (CHO) is used by equivalent officers in the Australian states and territories. Other Commonwealth Departments (such as the Department of Veterans Affairs) may also have a 'Chief Health Officer' – although this role appears largely advisory in nature. In contrast the CMO and state and territory CHOs exercise significant legislated powers under public health legislation.

²⁹⁴ <https://www.directory.gov.au> and <https://govtree.io>.

contacts, except one,²⁹⁵ were initially approached by direct email or via a central contact point, such as a generic agency email address. Where an email was sent, it included a copy of the Participant Information Sheet and a formal invitation. Follow up emails were sent two to three weeks later if no reply or acknowledgment had been received.

In total, approximately 48 individuals were approached to participate in the research, with 24 agreeing to participate. Only two invited individuals refused outright to participate, with a nil-response more common (despite repeated approaches). In a few cases, individuals were initially willing to participate but then failed to respond to repeated follow-up emails seeking to confirm times. Before going silent, some of these individuals had provided written comments or relevant documents. As these individuals had not signed a consent form, their written comments were not included in the dataset for this study. It was notable that the strongest views on participating or, more commonly, *not* participating came from academics involved in the development of the DTCA. This is discussed further in Chapter 5.

A breakdown of participants by sector and pre-determined area of relevance to the study is set out below (Tables 7 and 8). Often participants were able to discuss more than one case. For example, CHOs were often able to discuss their experiences during the Ebola outbreak, previous outbreaks of pandemic influenza and the planning undertaken for a hypothetical outbreak of pandemic avian influenza. Other officials had often been involved in multiple pieces of biosecurity legislation, for example the NHS Act and DTCA. In relation to the NHS Bill, the researcher was able to interview individuals directly responsible for the underlying policy that formed the basis for the final drafting instructions. Interviewees for the DTC Bill did not include Defence officials but did include Government officials involved in the policy work undertaken between the introduction of the Bill in 2011, its passage in 2012 and amendment in 2015. Due to the passage of time and staff turnover, the researcher was unable to interview individuals who were responsible for developing the policy that led directly to the human biosecurity provisions in the *Biosecurity Act 2015* (Cth). However, interviewees did include those whose span of responsibility included the day-to-day administration of the legislative frameworks put in place by the NHS Act and the *Biosecurity Act 2015* (Cth). At least one of these interviews had had practical and relevant experience operating under the *Biosecurity Act 2015* (Cth) and the earlier *Quarantine Act 1908* (Cth).

²⁹⁵ Shooting for the stars, the researcher sent hard copy invitations to the electorate and Parliamentary offices of Tony Abbott MP, who was Prime Minister during the critical stages of Australia's response to the Ebola outbreak. Sadly, no response was received.

Case study	Number of interviewees	Number of interviews conducted
DTCA	8	9 ²⁹⁶
Other biosecurity legislation (NHS Bill, Biosecurity Bills)	9	8
2013–2016 Ebola outbreak	9	9
Pandemic Influenza, specially H5N1 planning and 2009 pandemic H1N1 influenza response	8	5

Table 7: Interviewee breakdown by case

Sector	Number of interviewees	Interview dealt with
Public service	14	DTCA – 3
- CMO/CHO	2	Biosecurity legislation – 6
- CHO-nominees	2	Ebola - 6
		Pandemic influenza - 5
NGO	9	DTCA – 6
- Humanitarian	2	Biosecurity legislation – 2
- Interest group	4	Ebola – 3
- Private Sector	1	
- Academic	2	
Political	1	Ebola - 1
Total	24	

Table 8: Interviewee breakdown by sector

Interview instrument

Interviews undertaken for this project followed a ‘semi-structured’ approach, with the researcher using pre-determined, high-level questions derived from the theoretical framework explained in Part 2 of this Chapter. Semi-structured interviews are a common technique for undertaking ‘elite interviews’ in qualitative research, including studies on securitization.²⁹⁷

²⁹⁶ Includes a two-part interview with one individual, which is counted here as two interviews.

²⁹⁷ Some studies of the securitization of infectious diseases have also used elite interviews, but the interviews appear to have served as a support to the primary method of documentary analysis: eg, Adam Kamradt-Scott and Colin McInnes, ‘The Securitisation of Pandemic Influenza: Framing, Security and Public Policy’ (2012) 7(SUPPL 2) *Global Public Health* 95; Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia*, above n 27. For an example of interviews more tightly within security studies, see: Karyotis, above n 52. For an exploration of the intersection of multiple values and the health-foreign policy

Questions were piloted with the researcher's supervisory panel and additional refinements to individual questions (but not the high-level themes) were made during data collection. To avoid 'priming' the interviewee, no question specifically used the term 'securitization', and the term 'threat' was avoided unless used by the interviewee. Individuals were asked, instead, to speak about their 'organisation's goal' in relation to *x* policy/piece of legislation and, as a follow up question: 'What was the risk/hazard/concern you were trying to address?' If an interviewee used the term 'biosecurity', the researcher sought clarification from the participant on its meaning.

The conduct of interviews was generally consistent, and followed the pattern outlined in Figure 9 below. Interviews could diverge from the planned order of questions to explore new themes and issues as they arose. What was analytically important was for each participant to discuss the actors involved in each case; the priorities, principles or values (if any) that guided their actions; and their perception of the same in other parties. Questions also sought information on any strategies used to resolve any conflict of priorities, principles or values ('strategies' serving as a non-jargon synonym for 'mechanisms').

The interview questionnaire, example letter of invitations, participant information and consent form were approved by the ANU Ethics Committee and are included at Appendices 2, 2A and 3.

nexus see: Michelle L Gagnon and Ronald Labonté, 'Understanding how and why health is integrated into foreign policy - a case study of *Health Is Global*, a UK Government Strategy 2008 – 2013' (2013) 9 *Globalization and Health* 24. For general discussion of semi-structure interviews see: Pierce, above n 264; Lisa Webley, 'Qualitative Approaches to Empirical Legal Research' in Peter Cane and Herbert M Kritzer (eds), *The Oxford Handbook of Empirical Legal Research* (Oxford University Press, online ed, 2010).

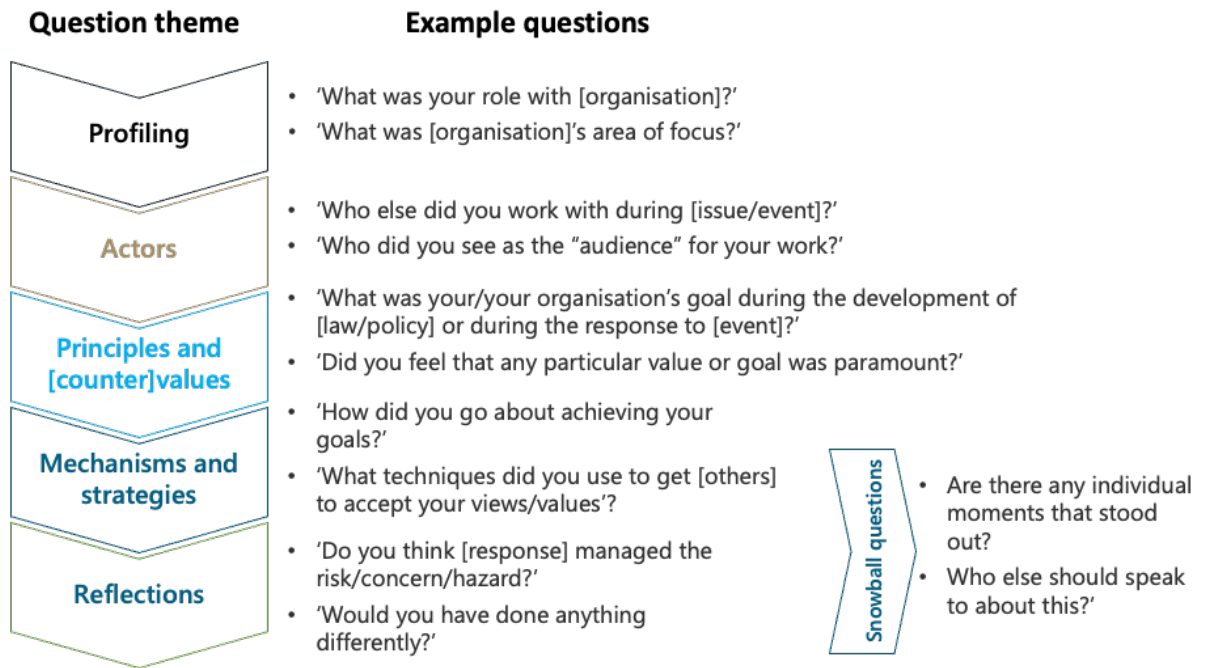


Figure 9: Approach to semi-structure interview questions

Interviews – procedure where no response

In some cases where an individual (including non-public servants) was reluctant to participate or did not respond to the initial approach, the researcher followed-up with another invitation and/or, as relevant, an option to respond to written questions. Where no response at all was received from a government official for an interview, an FoI for documents was made to the relevant FoI Officer within the Department (see Figure 10 below).

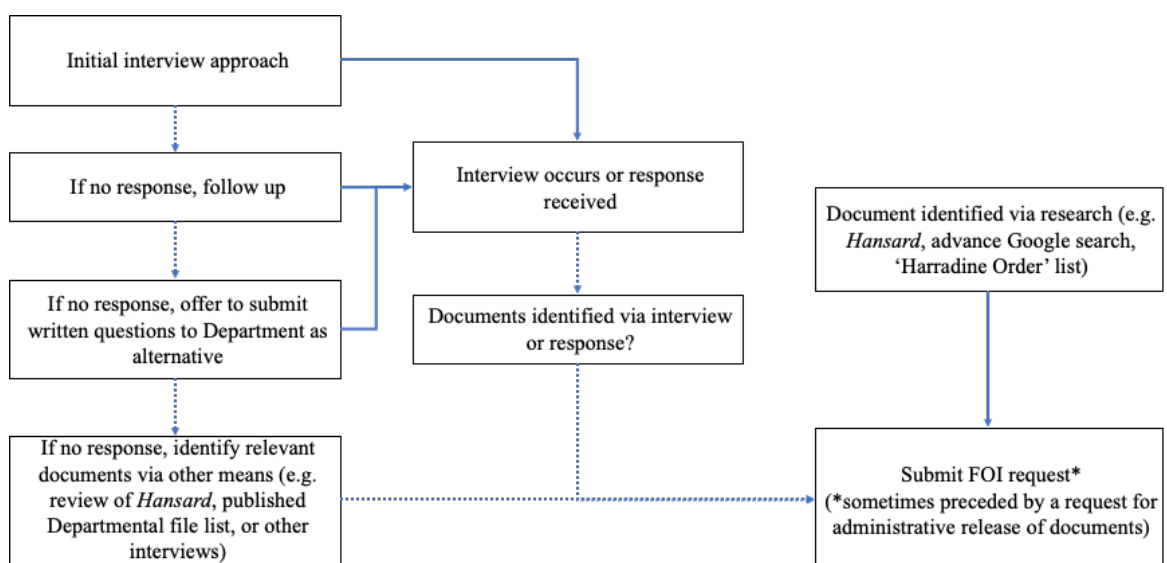


Figure 10: Data collection – interviews and FoI requests (non-SRS)

To the extent that a consensus exists around the ideal number of interview participants in a qualitative study,²⁹⁸ the researcher is confident that, when combined with the documentary analysis, a sufficient number and range of interviews were conducted to ensure that the research question had been explored sufficiently and data saturation had been reached. Relevantly, by the end of data collection, recommendations for other individuals the researcher ought to speak to included people already interviewed or approached.

The activities covered in the interviews occurred throughout the period under investigation (2001–2016) and, in many cases, were not tied to a specific Bill. Interviews were supplemented by documentary analysis of materials produced by government agencies and stakeholder groups and the transcribed remarks of officials during the Senate scrutiny of the DTC Bill (ie, *Hansard*). Use of *Hansard* was necessary at times where key informants were unwilling (or unable) to speak with researcher and extracts are included here in the same way as interview text is reported. For example, the use of transcribed remarks was necessary in presenting the viewpoint of key Department of Defence employees who – despite initial interest – were unable to be interviewed for this project. As far as possible, their remarks have been sourced from official, public *Hansard* transcripts (therefore their comments are attributed).

With the explicit permission of participants, all interviews, except for one, were audio-recorded using Apple’s default *Voice Memos* app on the researcher’s iPhone. Recordings were copied to a password-protected and separately encrypted folder on the researcher’s computer and the original recording on the researcher’s secured phone were deleted at the conclusion of the project. Several factors are suggested as mitigating the risk that interview participants modified their responses in a meaningful manner due to the presence of a recording device:

1. some interviews were conducted over the phone, where the phone was not visible;
2. interviewees were, in the main, senior within their organisations or no longer working with the organisation – and so had less to ‘fear’ from being recorded;²⁹⁹
3. with some exceptions, interviews were conducted one-to-one, contributing to a more personal style interaction;

²⁹⁸ For a discussion of the differing ‘ranges’ and ‘acceptable minimums’ recommended by various researchers see: Greg Guest, Arwen Bunce and Laura Johnson, ‘How Many Interviews Are Enough?: An Experiment with Data Saturation and Variability’ (2006) 18(1) *Field Methods* 59, 61; and Mark Mason, ‘Sample Size and Saturation in PhD Studies Using Qualitative Interviews’ (2010) 11(3) *Forum: Qualitative Social Research* Article 8.

²⁹⁹ Compare the situation of nurses in N Al-Yateem, ‘The Effect of Interview Recording on Quality of Data Obtained’ (2012) 19(4) *Nurse Researcher* 31.

4. the researcher made clear that the recordings would be used for confirming the accuracy of quotes, but would not be published as formal transcripts; and
5. many participants are accustomed to speaking to the public, media and researchers. What was a priority for them – as expressed to the researcher – was accuracy and ensuring statements had the appropriate ‘context’, rather than anonymity.³⁰⁰

In the sole instance where an interview was not recorded, this was due to the nature of the location where the interview took place. It is common in large Departments for certain meeting rooms or areas to be designated as ‘secure’ areas. The Department of Health’s ‘National Incident Room’ (now the ‘National Incident Centre’) is one such venue.³⁰¹ As access to these areas requires individuals to leave their phones outside, the final interview conducted by the researcher could not be audio-recorded.

Data analysis

Recorded interviews were reviewed multiple times by the researcher, first as a whole and second to support a limited transcription of the recordings.³⁰² All but one interview was recorded, and long quotes transcribed from audio recordings. Unless considered relevant, fillers (eg, ‘ums and ahhs’) and repetitions were removed.³⁰³ Non-verbal communications, including long pauses, laughter and tone shifts are [bracketed], while words in **bold** or ALL CAPS represent a strong emphasis (ALL CAPS is used where part of a word was emphasised). These written transcripts were analysed in Microsoft Word with the theory-driven approach to documentary analysis, previously described.

³⁰⁰ See similar remarks on interviews with political elites in Brian C Rathbun, ‘Interviewing and Qualitative Field Methods: Pragmatism and Practicalities’ in Janet M Box, Henry E Brady and David Collier (eds), *The Oxford Handbook of Political Methodology* (Oxford University Press, 2008). Contrary to the view expressed by Pierce, all public servant asked were happy to be recorded, with a number particularly enjoying the opportunity to tell their story: Pierce, above n 264, 117.

³⁰¹ The change in name likely occurring during the COVID-19 pandemic and more accurately reflects the scale of the response infrastructure. Department of Health, *National Incident Room* (8 June 2022) <<https://www.health.gov.au/our-work/national-incident-centre>>.

³⁰² Handwritten notes from the non-recorded interview were used ‘as is’ and not revised prior to analysis.

³⁰³ This includes some discourse markers (eg, ‘You know’) that likely arose due to the pre-existing relationship between the researcher and some informants, or the informant’s awareness of the researcher’s employment in the Australian Public Service.

Although most participants were willing to be identified by name, remarks have been anonymised and the following key adopted:

- PS – public servant
- PS(H) – public servant (health officer), this is a narrower class of individuals who occupy statutory roles such as a CMO or CHO.
- R – researcher, including individuals who occupied senior, administrative roles within universities such as Deputy Vice-Chancellors of Research (DVC-R)
- NG – non-government actors
- P – politician

4. Ethics

The aspects of this research that required ethics approval were approved by the ANU Human Research Ethics Committee (HREC) (Protocol 2016/701). These aspects included the semi-structured interviews and interview collateral (a sample interview guide is at Appendix 2, full questions at Appendix 2A, and the Participant Information Sheet is available at Appendix 3). Prior to each interview, participants were provided with a formal invitation and a copy of the Participant Information and Consent form (PICF). Written consent was obtained at the start of each interview (or earlier, in the case of phone-interviews, where the participant completed the form beforehand). In a limited number of telephone interviews, the participant did not provide a signed consent form prior to the interview. In these circumstances, the author discussed the PICF (which had previously been provided), read through the consent form options and noted the participant's preferences. These 'audio consents' were recorded and saved.

Research ethics, of the kind addressed through ethics application forms and HREC review, are only one example of ethical frameworks that applied to this project. As a public servant who had been involved in some of the issues under investigation, the author had a number of professional ethical duties and legal obligations that needed to be satisfied during the course of this project.³⁰⁴ Chief among these was the obligation on public servants 'not to

³⁰⁴ These obligations are enshrined in the APS Values and Code of Conduct, which is given legal effect through the *Public Service Act 1999* (Cth) ss 10, 13.

disclose information...the APS employee obtains or generates in connection with the APS employee's employment.'³⁰⁵ Relevantly, the researcher's involvement in the development of the DTCA included being involved in discussions that were held in confidence and working with a range of information and documents that were sensitive and could not be treated as 'research materials' for this study. Mindful of the dual responsibilities as a public servant and researcher, several strategies were used to maximise the amount of material that could be used for this study within ethical limits. First, the researcher's employers were made aware of this study and supported it. Second, interviews with consenting public servants and other stakeholders allowed for recollections and accounts of past events to be put on the academic record. Finally, FoI requests served as an opportunity for documents held under a general duty of confidence to be reviewed and released free of any restrictions of confidentiality.

³⁰⁵ *Public Service Regulations 1999* (Cth) reg 2.1. Breach of this obligation can result in administrative and disciplinary sanctions, *Australian Public Service Act 1999* s 15 (Cth), or up to two years imprisonment, *Criminal Code 1995* (Cth) s 122.4.

Chapter 4: Biosecurity Lawmaking and the Public Processes of Securitization

1. Introduction

Chapter 4 presents the findings from an analysis of biosecurity lawmaking in the Australian Parliament (hereafter ‘Parliament’) between 2001–2016. Specifically, the analysis focuses on the text of and the parliamentary debates surrounding:

- the National Health Security Bill 2007 (NHS Bill)
- the Defence Trade Controls Bill 2011 (DTC Bill)
- the Biosecurity Bill 2012 and Biosecurity Bill 2014 (collectively, ‘Biosecurity Bills’).

Chapter 3 outlined the approach to identifying the sample of Bills. Each of these Bills were introduced to create regulatory regimes that sought to address or respond to the three biosecurity issues identified and discussed in Chapter 1 and Chapter 2, namely:

- emerging and re-emerging infectious diseases and pandemics (eg, Part 2 of the NHS Bill and the biosecurity Bills)
- the deliberate or accidental release of harmful biological agents (eg, Part 3 of the NHS Bill)
- bioterrorism, biological warfare, and dual-use research of concern (eg, the DTC Bill and Part 3 of the NHS Bill)

The assignment of Bills against specific biosecurity threats is an oversimplification. In practice, there are intentional and unintentional overlaps across the laws. For example, Part 3 of the NHS Bill sets out a regime to regulate research involving certain biological agents. Research involving those agents (and others) would also be regulated under the DTC Bill. However, the focus of the NHS Bill was on physical access and handling of the agents, while the DTC Bill was concerned with the export (or ‘transfer’) of ‘information’ associated with the agents. Importantly for this thesis, the assignment in the dot points above also does not map directly to the identification of specific case studies. For example, while Chapter 5 reports on the role of avian influenza (H5N1) in biosecurity policymaking, this specific threat was not seen in the debates over the Bills examined in this Chapter. The diseases that *were* raised during

the parliamentary debates are discussed below, including in relation to what that says about the potential of certain diseases to be used to advance legislative interests. Analysis undertaken for this Chapter also includes legislation that amended the regimes established by these laws. This can help show how a regime evolved over time, as well as how the securitizing language of governments changed or remained consistent over time. Together, the three Bills listed above, as amended over time constitute a general body of ‘biosecurity law’ (Figure 11).

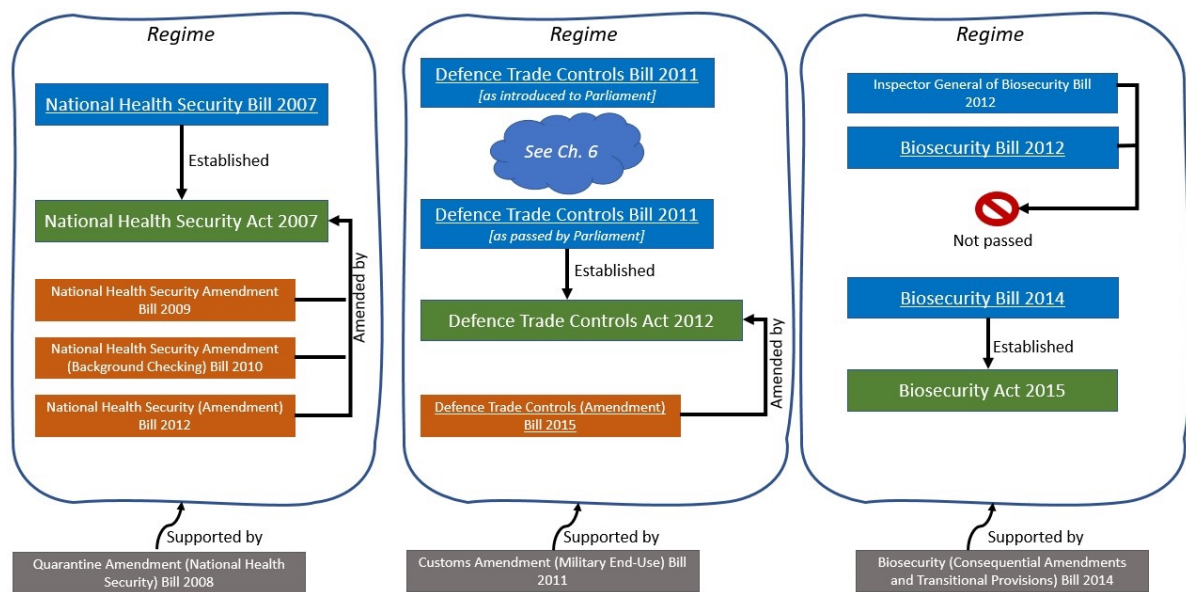


Figure 11: Overview of biosecurity laws and ‘regimes’

(Underlined Bills are discussed further in Section 2, below)

Drawing on Securitization Theory, the purpose of this part of the research was to ascertain the extent of securitizing language in the parliamentary debates around Australia’s biosecurity legislation, to assess how (and by whom) it was being deployed and how it worked alone or in tandem with other parliamentary ‘tactics’. As such, the focus of the analysis is on the voice of ‘Parliament’: Ministers, Opposition Members of Parliament (MPs), backbenchers, chairs of parliamentary committees, and the text of the Bill and final Act. These voices are expressed through written words (eg, the text of the Bills, and extrinsic material such as the Explanatory Memorandum and committee reports) and spoken words – the speeches delivered in Parliament – and Second Reading Speeches (SRS). Combined, these utterances serve a range of procedural and interpretive functions (see Chapter 3). The wider policy debates that informed this process, including the words and actions of Departmental officers, professional and industry representatives, foreign officials, and members of the public who provided written and oral submissions to Parliament are examined more closely in Chapter 5.

Chapter 4 has two substantive sections. Section 2 provides a high-level overview of the biosecurity legislation. Section 3 provides an analysis of the legislation within the context of its parliamentary debates. This analysis is conducted against the theoretical framework outlined in Chapter 3. Prior to the analysis of findings, a traditional legal analysis of the Bills was undertaken by the researcher.

Based on the existing literature around securitization, it was anticipated that an analysis of the biosecurity lawmaking would reveal a two-part process of securitization. First, the introduction of the Bill, would constitute an initiation of the public securitizing move by the Government. However, the text of the Bill would be just one part of the move. Providing more than technical information or context to the Bill, the Minister's SRS and Explanatory Memorandum (EM) are integral to the construction of the security issue, aiding the Minister moving the Bill undertake 'threat identification', 'referent object identification' and justification of the breaking any pre-existing values, principles or 'rules that bind'.

The parliamentary debate would then function as the second element of securitization: the test of audience acceptance of the securitizing move and the identification of counter-values and principles that ought not to be overridden in the name of addressing the security threat. Within the context of legislating as a parliamentary act, political parties and independent Members of Parliament are the relevant audience. This is due to their constitutional and formal role in accepting (by voting up or down) legislative proposals of the Government. While many other individuals and groups are interested in, and comment on, parliamentary proceedings (including the media, public and lobbyists) the formal act of acceptance is constitutionally for parliamentarians alone. Chapter 6 and, to a lesser extent, Chapter 5 discuss different types of audiences; however, in the context of this Chapter, this stricter approach is consistent with the Securitization literature on 'formal' modes of acceptance and also the special significance of parliamentary debate – largely immune from impeachment by all other branches of government.³⁰⁶

As securitizing moves are likely to be iterative and interactive, the *tactics* deployed by various parties in the parliamentary debates are also relevant, such as appeals to bipartisanship, short-circuiting usual parliamentary processes (ie, 'urgency') and the deliberate, strategic use

³⁰⁶ Roe, 'Actor, Audience(s) and Emergency Measures: Securitization and the UK's Decision to Invade Iraq', above n 139. This immunity has an historical and constitutional basis, for example: art 9, *Bill of Rights 1688 1 Will & Mar Sess 2 c 2 (Eng)*; s 16 *Parliamentary Privileges Act 1987 (Cth)*; ss 9, 11 *Parliamentary Privilege Act 2014 (NZ)*.

of forums to widen or restrict scrutiny of a Bill. However, a key finding from the analysis was the largely uncontested nature of the biosecurity legislative process and, except for the DTC Bill, how little parliamentary debate was devoted to activities such as threat and referent object identification. This finding is discussed further in Chapter 7.

2. Australia's biosecurity laws

This part provides a short overview of each of the laws analysed in this Chapter. The purpose of the summaries is to provide context of a Bill's explicit, legislated purpose and intent, which is then compared to how the Bill is presented and the issues framed in the parliamentary debates (Section 3).

The National Health Security Bill 2007 (NHS Bill)

The NHS Bill 2007 established two distinct regimes, addressing different dimensions of biosecurity: 'naturally occurring epidemics' and the risk of 'terrorist attacks involving chemical, biological and radiological agents'.³⁰⁷ Part 2 of the NHS Bill introduced a new national regime for 'public health surveillance', including new institutions and data sharing arrangements.

The formal 'objects' of this Part were to:

- (a) to provide a national system of public health surveillance to enhance the capacity of the Commonwealth and the states and territories to identify, and respond to, public health events of national significance which include:
 - (i) the occurrence of certain communicable diseases; or
 - (ii) certain releases of chemical, biological or radiological agents; or
 - (iii) the occurrence of public health risks; or
 - (iv) the occurrence of overseas mass casualties; and
- (b) to provide for the sharing of information with:
 - (i) the World Health Organization; and
 - (ii) countries affected by an event relating to public health or an overseas mass casualty; and

³⁰⁷ Explanatory Memorandum, National Health Security Bill 2007 (Cth) 1.

- (c) to support the Commonwealth and the states and territories in giving effect to the International Health Regulations (other than as mentioned in paragraphs (a) and (b)).³⁰⁸

To support this surveillance and information sharing, the Bill established a range of public health infrastructure, including:

- a *National Health Security Agreement* between the Commonwealth and the states and territories
- a ‘National Focal Point’ (NFP) to serve as a coordination and liaison body between relevant state, territory and Commonwealth bodies, and between Australia and the WHO to give effect to Australia’s obligations under the IHR.³⁰⁹
- a ‘National Notifiable Disease List’ of diseases that ‘the Minister considers...would be a public health risk’ in the event of an outbreak³¹⁰
- authority for the federal Minister of Health to take certain actions (for ‘permissible purposes’) in the event of a ‘public health event of national significance’
- authorising data and information sharing practices between the Commonwealth and the states and territories; and between the WHO, the Commonwealth and the states and territories.³¹¹

Part 3 of the NHS Bill establishes a national regime for the regulation of ‘entities’ that handle security sensitive biological agents (SSBAs), implementing the recommendations of the *Report on the Regulation and Control of Biological Agents*, Council of Australian Governments (CoAG) only four months before the Bill was introduced to Parliament in September 2007 (the ‘CoAG Review Report’).³¹² This report was culmination of work that commenced five years previously and which is explored more fully in Chapter 5. During the period under examination for this thesis CoAG was the primary Commonwealth, state and

³⁰⁸ National Health Security Bill 2007 (Cth) cl 6.

³⁰⁹ National Health Security Bill 2007 (Cth) cl 10. The NFP is the Secretary of the Commonwealth Department of Health, supported by the National Incident Room (NIR) (now ‘National Incident Centre’), located in the Department of Health.

³¹⁰ National Health Security Bill 2007 (Cth) cl 11(2).

³¹¹ Other divisions in Part 2 of the Bill relate to confidentiality of information (Division 8) and individuals under ‘public health observation (Division 7).

³¹² This Report was subject to a security classification that prevented it being released to the researcher or public. Luke Buckmaster, Matthew Thomas and Patrick O’Neill, *National Health Security Bill 2007 - Bills Digest*, No 53 of 2007-08, 19 September 2007.

territory consultative forum. CoAG was replaced with a new body known as the ‘National Cabinet’ during the COVID-19 pandemic (see Chapter 7).

The stated object of Part 3 is ‘to give effect to Australia’s obligations to establish controls for the security of certain biological agents that could be used as weapons.’ To achieve this objective, the Bill empowers the Minister to establish a list of SSBA, which could include any biological agent ‘that the Minister considers to be of *security concern to Australia*’ (emphasis added). What constitutes a ‘security concern to Australia’ is not a closed class, with subclause 31(2) providing that:

Without limiting subsection (1), the Minister may consider a biological agent to be of security concern to Australia if the biological agent could be developed, produced, stockpiled, acquired or retained in types and quantities that could allow the biological agent to be used as a weapon (emphasis added).

As is evident from the list in Table 9, below, an ability to be weaponised is not the only factor that governs whether a particular biological agent is a security concern to Australia. Although the Bill did not require it, the SSBA list ultimately developed under the NHS Act applied different ‘tiers’ of security sensitivity.³¹³ Assignment to a specific tier is made according to a methodology that was not, until a review in 2015, made public (and, even then, in part only).³¹⁴

SSBA List (initial list, 11 January 2008)	SSBA List (current list, 16 March 2023)
Tier 1	Tier 1
Abrin (5 mg)	Abrin (5 mg)
Bacillus anthracis	Bacillus anthracis (Anthrax – virulent strains)
Botulinum toxin (0.5 mg)	Botulinum toxin (0.5 mg)
Ebolavirus	Ebolavirus
Foot and mouth disease virus	Foot-and-mouth disease virus
Highly pathogenic Influenza A virus, infecting humans (including Avian Influenza H5N1)	Highly pathogenic influenza virus, infecting humans ³¹⁵
Marburgvirus	Marburgvirus
Ricin (5 mg)	Ricin (5 mg)
Rinderpest	Rinderpest virus

³¹³ See for example: *List of Security-sensitive Biological Agents Determination 2008* (Cth); *List of Security-sensitive Biological Agents Variations No 1 of 2009* (Cth); *List of Security-sensitive Biological Agents Variations No 1 of 2016* (Cth).

³¹⁴ In contrast to the National Notifiable Diseases List, the list of SSBA is explicitly not a Legislative Instrument (*National Health Security Act 2007* (Cth) s31(4)). As such, it does not need to be accompanied by an Explanatory Memorandum.

³¹⁵ A note to the list of SSBA provides that ‘Highly pathogenic influenza virus infecting humans’ includes influenza viral strains that fulfil all the criteria listed below: considered highly pathogenic in usual host animal; proven infection of humans; and involved in an outbreak of human disease. Examples of such viral strains include the 1918 pandemic Influenza virus A and Influenza virus A H5N1.’ [formatting removed]: Department of Health, *Security Sensitive Biological Agents* (25 August 2020) <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/ssba.htm>>.

SARS coronavirus	SARS coronavirus
Variola virus (Smallpox)	Variola virus (Smallpox)
Yersinia pestis (Plague)	Yersinia pestis (Plague)
Tier 2	Tier 2
African swine fever	African swine fever virus
Capripox virus (Sheep pox virus and Goat pox virus)	Capripoxvirus (Sheep pox virus and Goat pox virus)
Classical swine fever virus	Classical swine fever virus
Clostridium botulinum	Clostridium botulinum (Botulism; toxin-producing strains)
Francisella tularensis	Francisella tularensis (Tularaemia)
Lumpy skin disease virus	Lumpy skin disease virus
Peste des petits ruminants virus	Peste-des-petits-ruminants virus
Salmonella Typhi (Typhoid)	<i>[removed from SSBA List in 2016]</i> ³¹⁶
Vibrio cholerae (Cholera) (serotypes O1 and O139 only)	<i>[removed from SSBA List in 2016]</i>
Yellow fever virus	Yellow fever virus (non-vaccine strains)

Table 9: List of Security-Sensitive Biological Agents (the SSBA List)

The Bill gives the Minister a broad power to set standards for the handling of SSBA (the ‘SSBA Standards’), including the ability to determine:

- where and how SSBA are stored (cl 35(2)(a)) and transported (cl 35(2)(c)); and
- the ‘security-status’ of individuals entitled to handle SSBA (cl 35(2)(b)).

A failure to comply with the SSBA Standards may mean that an entity may not be registered to handle SSBA or may be directed by the Secretary of Health to dispose of all its SSBA.³¹⁷

Central to Part 3’s regulatory regime is the introduction of a new ‘legitimate purpose’ test for research involving SSBA in clause 41. Legitimate purposes include:

- (a) to carry out scientific or medical work with the security-sensitive biological agent:
 - (i) to develop or produce a vaccine or treatment for it; or
 - (ii) to better understand a disease it causes;
- ...
- (d) *to carry out research that the Secretary considers is responsible and legitimate;*
- ...
- (g) any other purpose *determined by the Minister*, by legislative instrument, to be a legitimate purpose (emphasis added).

³¹⁶ *List of Security-sensitive Biological Agents Variations No 1 of 2016 (Cth)*.

³¹⁷ National Health Security Bill 2007 (Cth) cl 58. Offence punishable by 500 penalty units (\$111,000) or 2,500 penalty units (\$555,000) if the entity is a body corporate. Penalties correct at 1 July 2020. The EM to the National Health Security Amendment Bill 2009 (Cth) reported that 67 entities ‘self-identified’ as handling SSBA. These included: 22 ‘academic organisations’, 35 ‘clinical/diagnostic organisations’ 2 government agencies, 1 water quality testing laboratories and 7 ‘industrial/commercial organisations’: Explanatory Memorandum, National Health Security Amendment Bill 2009 (Cth) 3.

This legitimate purpose test serves as the chief assessment framework for decisions made by the Secretary under the SSBA regulatory regime, including whether an entity can continue to hold and deal with SSBAAs. It is notable that, although the virus that causes SARS is listed as a tier 1 SSBA, the SARS-CoV-2 virus that causes COVID-19 is not (as of September 2022) listed in either tier. The author suggests that this is due to the onerous restrictions that would be placed on laboratories and researchers engaged in routine testing and response and research activities.³¹⁸ This is a useful example of how the SSBA regime is about *containment* and not *control* of infectious diseases and, potentially, the limitations of the ‘legitimate purpose’ test. Put simply, when a disease (particularly a novel one) is circulating in public, it is a public health matter that requires timely health interventions that control its spread. In these circumstances, relying on a government official to determine what activities are ‘legitimate’ is likely to hamstring public health response efforts (especially when, as is the case, determining if an activity is ‘legitimate’ involves a multi-stage process, including consultation with external experts and security agencies). However, when there is not the urgency of needing to deliver a health intervention to a priority target (eg, domestic population), tighter regulatory measures can be justified in the name of containing a threat to that target (that target, in the language of Securitization Theory, might be a ‘referent object’). It is noted, however, that there may still be a pressing public health need (eg, the disease-causing agent is causing an outbreak overseas) but, for some reason, the regulatory objective of containment outweighs the countervailing public health goals of disease control. Chapter 5’s discussion of the development of the DTC Bill, and its potential and real impacts on the development of vaccines and diagnostic tools, further examine this dynamic.

The evolution of the National Health Security Act 2007

The NHS Bill was passed on the cusp of a federal election, and the *National Health Security Act 2007* (Cth) came into effect around the same that the near 12-year-old, centre-right Coalition government was replaced by a centre-left, Labor government. Following the change in government at the 2007 election, the new Labor government introduced the Quarantine Amendment (National Health Security) Bill 2008 (Cth) – essentially a companion law to

³¹⁸ In 2020, Health conducted ‘an impact risk assessment with experts from the health, agriculture, gene technology and Australian intelligence sectors to determine whether SARS-CoV-2 should be included on the List of SSBAAs’. The recommendation was not to list it. Department of Health, *SSBA Newsletter Issue 30 - August 2020* (Commonwealth of Australia, 2020).

Part 2 of the NHS Bill. This Bill sought to amend Australia's *Quarantine Act 1908* (Cth) (Quarantine Act) to implement other requirements of the 2005 IHR, including for:

‘travellers who are subject to quarantine, or people performing quarantine, to submit themselves to vaccination or other prophylaxis if this is necessary for the prevention of the spread of a quarantinable disease, or if the vaccine or other prophylaxis is specified in the IHR or recommended by the WHO’³¹⁹

Except for the Quarantine Amendment (National Health Security) Bill 2008 and a small (but material) change to the definition of ‘biological agent’ in a 2009 amending Bill (discussed below), Part 2 of the NHS Act has been left relatively untouched.³²⁰ In contrast, the SSBA control regime established under Part 3, was amended in 2009, 2010 and 2012.

The National Health Security Amendment Bill 2009 (2009 Amendment Bill) introduced substantial reforms to Part 3 of the NHS Act. It followed a period of ‘extensive consultation... with stakeholders to develop the administrative and operational detail of the scheme.’³²¹ Relevant changes introduced by the 2009 Amendment Bill included:

- providing new powers for [non-law enforcement] inspectors under the NHS Act to enter a premises under a search and seize warrant.³²² Previously, they could only enter a premises with the consent of the occupier.
- amending the definition of ‘biological agents’ so that a virus can be a SSBA even if it is not one ‘that can spread rapidly’.³²³
- a power for the Minister for Health to suspend parts of the SSBA regime. This power was to be exercised, ‘following advice from relevant experts’.³²⁴

The National Health Security Amendment (Background Checking) Bill 2009 introduced ‘National Health Security Checks’ for individuals who handle or dispose SSBA. Similar requirements were introduced for individuals who would have ‘access [to] a facility where

³¹⁹ Commonwealth, *Parliamentary Debates*, House of Representatives, 19 March 2008, 2203 (Nicola Roxon, Minister for Health and Aged Care).

³²⁰ The NHS Act initially defined a biological agent as including ‘bacteria and viruses that can spread rapidly’ and ‘toxins derived from biological sources, including animals, plants and microbes’: s3(1). The qualifier ‘that can spread rapidly’ was removed in 2009 via the *National Health Security Amendment Act 2009* (Cth).

³²¹ Explanatory Memorandum, National Health Security Amendment Bill 2009 (Cth) 1. This consultation had been foreshadowed in the SRS and EM to the NHS Bill in 2007.

³²² National Health Security Amendment Bill 2009 (Cth) Sch 1, Part 3.

³²³ National Health Security Amendment Bill 2009 (Cth) Sch 1, Part 6.

³²⁴ Explanatory Memorandum, National Health Security Amendment Bill 2009 (Cth) 1.

Tier 1 SSBA's are handled or to access sensitive information relating to Tier 1 SSBA's.³²⁵ Finally, the National Health Security Amendment Bill 2012 made largely minor amendments to the SSBA regime to 'streamline' the reporting obligations for some facilities.³²⁶

The Defence Trade Controls Bill 2011

The Defence Trade Controls Bill (DTC Bill) had two principal aims:³²⁷ first, to implement the *Australia-United States Defense Trade Cooperation Treaty* (the Defense Trade Cooperation Treaty)³²⁸ and, second, to address the security risks arising from dual-use information (including research of concern involving pathogens). While this second aim is more obviously related to this thesis' research question, as the interviews analysed as part of Chapter 5 suggest, the security alliance that underpinned the Defense Trade Cooperation Treaty strongly influenced how and why the Bill would attempt to regulate research.

In summary, the DTC Bill sought to introduce a new regulatory regime to control the intangible 'supply' of certain 'dual-use' technology listed on Australia's Defence and Strategic Goods List (DSGL). It would apply to researchers and universities, defence manufactures and their employees, and others dealing with controlled technology. The intangible supply of DSGL-listed technology by an 'Australian person' to a 'foreign person' would require a permit from the Minister for Defence. Supplying DSGL-technology without a permit, or in contravention of a permit condition, was punishable by 10 years imprisonment and a fine of up to 2,500 penalty units (currently \$550,000).³²⁹

A permit could be granted if the Minister was 'satisfied that the activity would not prejudice the security, defence or international relations of Australia.'³³⁰ Breaching a permit was an offence, also punishable by 10 years imprisonment or a fine of 2,500 penalty units.³³¹

³²⁵ Department of Health, *Security Sensitive Biological Agent (SSBA) Standards* (Commonwealth of Australia, 2nd ed, 2013) (hereafter 'SSBA Standards') [3.3]. For standards applying to recruitment of personnel see [3.4].

³²⁶ Commonwealth, *Parliamentary Debates*, House of Representatives, 19 September 2012, 11173 (Tanja Plibersek, Minister for Health).

³²⁷ Defence Trade Controls Bill 2011 (Cth) s 3; Commonwealth, *Parliamentary Debates*, House of Representatives, 21 November 2011, 12434-12439 (Jason Clare, Minister for Defence Materiel).

³²⁸ *Treaty between the Government of Australia and the Government of the United States of America Concerning Defense Trade Cooperation*, opened for signature 5 September 2007 [2013] ATS 17 (entered into force 16 May 2013).

³²⁹ Defence Trade Controls Bill 2011 (Cth) cl 10.

³³⁰ Defence Trade Controls Bill (Cth) cl 11(6). The vagueness of this criteria was highlighted by the Senate Scrutiny of Bills Committee and the Senate Foreign Affairs, Defence and Trade Committee: Scrutiny of Bills Committee, Parliament of Australia, *Alert Digest*, No. 14 of 2011 (23 November 2011) 10-11; Senate Foreign Affairs, Defence and Trade Committee, *Preliminary report: Defence Trade Controls Bill 2011 [Provisions]* (2011), [2.13]. More detailed criteria are now included in the *Defence Trade Controls Regulations 2013* (Cth).

³³¹ Defence Trade Controls Bill 2011 (Cth) cl 10(1), 13.

Additionally, the Minister would have the power to give a notice to a person prohibiting them from supplying DSGL technology to ‘another person’ if the Minister ‘believes or suspect’ that the supply ‘would prejudice the security, defence or international relations of Australia.’³³²

The Bill following parliamentary debate

As a result of parliamentary debate and resistance from the academic community (explored in Chapter 5), the Bill was significantly revised, including to limit what technology would require a permit prior to supply. For instance, information ‘lawfully’ in the public domain was exempt from the permit regime. Although it was no longer an offence to supply DSGL-technology that was ‘in the public domain’, a new criminal offence was inserted that criminalised ‘publishing’ DSGL-technology: ‘Publishing’ was not confined to formal publications but included other acts of public dissemination.³³³ For instance, presenting a paper containing DSGL technology at an international conference would fall afoul of the publishing offence as it puts the technology into the public domain.³³⁴ Further changes to clause 10 of the Bill meant that supplies of DSGL technology to individuals within Australia were no longer subject to the Act, addressing concerns that the Act would impact teaching and research activities involving foreign researchers and international students.³³⁵ As Defence explained before the Senate inquiry, the effect of this amendment was to create a ‘virtual border’ around Australia.³³⁶

The DTC Bill 2011 came into effect 2012 as the *Defence Trade Controls Act 2012* (Cth) (DTCA) but the commencement of several provisions (including the offence provisions) was delayed for two years. As examined in Chapter 5, a victory for the research and academic community was the establishment of the ‘Strengthened Export Controls Steering Group’ (Steering Group) under the DTCA. The Steering Group included government, industry and academic and researcher members. The creation and role of the Steering Group is examined further below and in Chapter 5. Relevantly, the Steering Group played a leading role in

³³² Defence Trade Controls Bill 2011 (Cth) cl 14. Since amended to require the Minister to have a ‘reasonable belief’: *Defence Trade Controls Act 2012* (Cth) s 14. Some detail on the export control policy is available at Department of Defence, *Defence Export Controls* (Commonwealth of Australia) <<https://www.defence.gov.au/business-industry/export/controls>>.

³³³ Copyright restrictions and pay-to-access requirements do not affect the status of a publication as being ‘in the public domain’: *Defence and Strategic Goods List 2021* (Cth) Div 4.

³³⁴ This general audience dimension is the key difference between acts of ‘supply’ and ‘publishing’: Department of Defence, *Publication of Export Controlled Technology* (Commonwealth of Australia, 2016).

³³⁵ Foreign students can be (and are) refused a visa to study in Australia on counter-proliferation grounds.

³³⁶ Evidence to the Senate Foreign Affairs, Defence and Trade Committee, Parliament of Australia, Canberra, 21 March 2012 (Michael Shoebridge) 10.

developing further amendments to the DTCA implemented in the Defence Trade Controls (Amendment) Bill 2015 (Amendment Bill).

The Amendment Bill further reduced the application of the DTCA in relation to technology listed on Part 2 of the DSGL. Consequently, many routine activities that may have required permits, such as speaking by phone or via video conference, were no longer subject to the Act except where the person knew or was reckless as to the technology's military or WMD end-use.³³⁷ Another exemption secured under the Amendment Bill was for supplies that take place as 'preparatory to the publication of the DSGL technology to the public or to a section of the public', provided the DSGL-technology was within the scope of Part 2 of the DSGL (which lists various 'dual-use' technologies, including microorganisms and toxins) *and* that the Minister or Secretary of Defence had not issued a notice prohibiting the publication under section 14B or 14C of the Act.³³⁸ Finally, the publication offence was narrowed to only apply to technology listed on Part 1 of the DSGL (the higher risk 'munitions' list) or where a person published technology in defiance of a notice prohibiting publication issued by the Minister or Secretary of Defence.³³⁹

The amended DTCA represented a significant evolution from the Bill introduced in 2011. While the Act and regime will likely never be accepted by all in the research community,³⁴⁰ it looks set to remain part of Australia's research governance framework for the foreseeable future.

The Biosecurity Bill 2012 and Biosecurity Bill 2014

Since 1908, the *Quarantine Act 1908* (Cth) had formed the basis of Australia's national system of 'prevent[ing] or control[ing] the introduction, establishment or spread of diseases or pests that will or could cause significant damage to human beings, animals, plants, other aspects of the environment or economic activities.'³⁴¹ The Quarantine's Act's title drew, not just from

³³⁷ Military end-use is defined in *Defence Trade Controls Act 2012* (Cth) s 4.

³³⁸ *Defence Trade Controls Act 2012* (Cth) s 10(3A).

³³⁹ *Defence Trade Controls Act 2012* (Cth) s 14(1A).

³⁴⁰ D Matthews, 'Paranoid defence controls could criminalise teaching encryption', *The Conversation* (online), 19 May 2015 <<https://theconversation.com/paranoid-defence-controls-could-criminalise-teaching-encryption-41238>>; K Korb, 'New defence trade controls threaten academic freedom and the economy', *The Conversation* (online), 1 March 2016 <<https://theconversation.com/new-defence-trade-controls-threaten-academic-freedom-and-the-economy-55310>>; Geoffrey Robertson in J Stapleton, 'Malcolm Turnbull's doublespeak on encryption', *The New Daily* (online), 25 November 2015 <<https://thenewdaily.com.au/news/national/2015/11/25/turnbull-doublespeak-encryption/>>; K Korb, *Support Science and Technology in Australia* (Online Petition) (21 February 2016) (GoPetition) <<https://www.gopetition.com/petitions/support-science-and-technology-in-australia.html>.

³⁴¹ 'Scope of quarantine': *Quarantine Act 1908* (Cth) 4 [repealed].

the historical understanding and concept of ‘quarantine’ but the explicit constitutional ‘head of power’ that granted the Commonwealth Parliament power over quarantine matters.³⁴² Although amended ‘no less than 50 times’ by the time the Biosecurity Bill 2012 was introduced,³⁴³ few Commonwealth laws had the same length of service as the *Quarantine Act 1908* (Cth) or institutional significance. The 1908 Act’s establishment of a ‘Director of Quarantine’ within the then Department of Trade and Customs was the seed of Australia’s Department of Health, which emerged 13 years later as its own department of State.³⁴⁴ As such, its proposed repeal and replacement by the Biosecurity Bill 2012 and Biosecurity Bill 2014 (collectively ‘the Biosecurity Bills’) represented more than an update to the law but seemingly an effort to reformulate the role and basis for Commonwealth involvement in the control of the circulation of people, goods and diseases.

The Biosecurity Bill 2012 sought to regulate an extensive range of activity across a ‘biosecurity continuum’ that extended in space and time to pre-border, border, and post-border activities. The researcher conducted a comparison between the 2012 and 2014 versions of the Bill and observed no differences relevant to this study. As such, the 2012 version is cited in this Chapter, with any difference to the final *Biosecurity Act 2015* (Cth) noted.

Provisions in the Bills relating to ‘human biosecurity’ only feature as a small part of the Bills and only those relevant to human biosecurity are discussed here. The objectives of the Bills were:

- (a) to provide for managing the following:
 - (i) biosecurity risks;
 - (ii) the risk of contagion of a listed human disease;³⁴⁵
 - (iii) the risk of listed human diseases entering Australian territory or a part of Australian territory, or emerging, establishing themselves or spreading in Australian territory or a part of Australian territory;
 - (iv) risks related to ballast water;
 - (v) biosecurity emergencies and human biosecurity emergencies;

³⁴² *Australian Constitution* s51(ix). John Quick and Robert Garran, *The Annotated Constitution of the Commonwealth of Australia* (Angus & Robertson, 1901) 567.

³⁴³ Explanatory Memorandum, Biosecurity Bill 2012 (Cth) 1.

³⁴⁴ Bashford and Howard, ‘Immigration and Health: Law and Regulation in Australia, 1901-1958’, above n 157, 98, fn 4.

³⁴⁵ The Bill defined ‘disease’ as meaning ‘(a) the signs or symptoms of an illness or infection caused by a disease agent; or (b) a collection of signs or symptoms that is clinically defined, for which the causal agent is unknown; or (c) a disease agent that has the potential to cause, either directly or indirectly, an illness or infection.’ A ‘disease agent’ included ‘but is not limited to, a microorganism, an infectious agent and a parasite.’ Biosecurity Bill 2012 (Cth) cl 9.

(b) to give effect to Australia's international rights and obligations, including under the International Health Regulations....³⁴⁶

Unlike the previous Bills discussed in this Chapter, the biosecurity Bills are the only ones to explicitly use and define the term 'biosecurity'. In the 2012 Bill, 'biosecurity risks' was defined as:

- (a) the likelihood of a disease or pest:
 - (i) entering Australian territory or a part of Australian territory; or
 - (ii) establishing itself or spreading in Australian territory or a part of Australian territory; and
- (b) the potential for any of the following:
 - (i) the disease or pest to cause harm to human, animal or plant health;
 - (ii) the disease or pest to cause harm to the environment;
 - (iii) economic consequences associated with the entry, establishment or spread of the disease or pest.³⁴⁷

However, as discussed in Chapters 1 and 2, this Bill's definition of 'biosecurity' – with its particular focus on 'economic consequences' and the use of certain techniques of governance to manage risks – only reflects one understanding of this contested term.³⁴⁸ Indeed, the term itself could be seen as a mere evolution of the previous term 'quarantine risk' used in the previous *Quarantine Act 1908* (Cth), which served a similar risk-management function.³⁴⁹

The Biosecurity Bills proposed a vast biosecurity infrastructure, including several key statutory roles. Relevantly, the Bills establish the parallel roles of the 'Director of Biosecurity' and the 'Director of Human Biosecurity' (DirHB). The Director of Biosecurity is – *ex officio* – the Secretary of the Department of Agriculture. Meanwhile, the functions of the DirHB are to be exercised by 'the person who occupies...the position of Commonwealth Chief Medical Officer'.³⁵⁰ As the day-to-day administration of the Biosecurity Bills was to be overseen by the Ministry of Agriculture, these provisions served to incorporate the Department of Health into

³⁴⁶ Biosecurity Bill 2012 (Cth) cl 4.

³⁴⁷ Biosecurity Bill 2012 (Cth) cl 9. A slightly different definition of 'biosecurity' was used in clause 309 of the Bill (which related to invasive pests). The differences are not material for this discussion.

³⁴⁸ Chapter 5 includes a discussion of the internal debate within Government over the use and 'ownership' of the term 'biosecurity'.

³⁴⁹ 'A reference ... to a level of quarantine risk is a reference to: (a) the probability of:...a disease or pest being introduced, established or spread in Australia...; [and] the disease or pest causing harm to human beings, animals, plants, other aspects of the environment, or economic activities; and (b) the probable extent of the harm' (formatting omitted): *Quarantine Act 1908* (Cth) 5D [Repealed].

³⁵⁰ Biosecurity Bill 2012 (Cth) cl 582. As discussed above, the CMO also plays an important part in the administration of the *National Health Security Act 2007* (Cth). Relevantly, the CMO is not the Secretary of the Department of Health. Thus, they possess a different status to the Director of Biosecurity.

the formal administration of the Bill. It also crystalises the distinction between human biosecurity and all other biosecurity activities.

The Bill provided the Minister of Health, the DirHB and state based Human Biosecurity Officers (HBOs) with expansive powers to ‘prevent’ and ‘manage’ ‘risks to human health’.³⁵¹ These powers are predicated on a given *disease* being designated by the DirHB as a ‘listed human disease.’³⁵² A disease may be listed if the DirHB ‘considers that the disease: (a) be communicable; and (b) cause significant harm to human health.’³⁵³ Prior to listing a disease, the DirHB must consult with the ‘chief health officer’ in each state and territory (this person may or may not also be the state or territory’s chief Human Biosecurity Office – ‘CHBO’) and with the Director of Biosecurity.

In comparison with the National Notifiable Disease List and the SSBA list established under the NHS Act, and the list of controlled biological technology under the DSGL and DTCA, only a small number of diseases are designated as listed human disease, shown in Table 10.³⁵⁴ Previously known as ‘quarantinable diseases’, as of March 2023 over a third of listed human diseases are coronaviruses. The role of this list in Australia’s quarantine function illustrates why COVID-19 is listed here, but not in the SSBA list.

Human influenza with pandemic potential	Severe Acute Respiratory Syndrome (SARS)	Yellow fever
Middle East respiratory syndrome	Smallpox	Human coronavirus with pandemic potential [ie, COVID-19]
Plague	Viral haemorrhagic fevers	

Table 10: Current Listed Human Diseases (as of 16 March 2023)³⁵⁵

Once a disease is listed, the Bill provides for a range of measures that are designed to ‘prevent risks to human health’ and ‘manage risks to human health’.³⁵⁶ Preventive measures are those intended to ‘to manage the risk of: (a) contagion of a listed disease; or (b) [the disease] entering, or emerging, establishing itself or spreading in...[Australia].’³⁵⁷ There is an extensive array of preventative powers available to biosecurity officers, the Minister and other officials. Some relevant preventative powers include:

³⁵¹ Biosecurity Bill 2012 (Cth) chapter 2, generally.

³⁵² In contrast to the SSBA regime and the DTCA, the Biosecurity Bill 2012 (Cth) focused on diseases rather than the wider category of ‘biological agents’ or toxins controlled under the DSGL.

³⁵³ Biosecurity Bill 2012 (Cth) cl 41(1).

³⁵⁴ A comparison table is included at Appendix 4.

³⁵⁵ *Biosecurity (Listed Human Diseases) Determination 2016* (Cth) reg 4.

³⁵⁶ Parts 2 and 3 of Chapter 2 of the Biosecurity Bill 2012 (Cth), respectively.

³⁵⁷ Biosecurity Bill 2012 (Cth) cl 33(1).

- The Minister may determine certain ‘entry and exit’ requirements for all individuals or classes of individuals.³⁵⁸
- The Minister may issue ‘preventative biosecurity measures’ to ‘prevent a behaviour or practice that...may cause a listed human disease to enter...Australia.’³⁵⁹ During COVID-19, this power has been used to mandate mask-wearing by passengers and aircrew arriving in Australia and the requirement to obtain a prior negative COVID-19 test result.³⁶⁰

The powers to manage risks to human health are more individualised and feature the kinds of measures commonly associated with ‘quarantine’, notwithstanding their new designation: ‘biosecurity measures’. The list of biosecurity measures available is extensive and include restrictions that had the potential to be highly restrictive. Measures include:

- a requirement to provide details of all individuals the person has been in contact with (or will be in contact with)³⁶¹
- ‘behaviour’ restriction requirements (eg, stay at home orders) or a requirement to not visit a specified place or class of place, or come into contact with a specified class of individuals³⁶²
- ‘risk minimisations interventions’, such as a requirement to wear a mask or other form of personal protective equipment (PPE)³⁶³
- a requirement to undergo a medical examination, or to provide a ‘body sample’ (eg, nasal swap or blood sample)³⁶⁴
- a requirement to receive a specified vaccine or treatment, or to receive (and continue to take a specified medication).³⁶⁵

³⁵⁸ Biosecurity Bill 2012 (Cth) cl 43(1) (Entry requirements) and cl 44 (2) (Exit requirements).

³⁵⁹ Biosecurity Bill 2012 (Cth) cl 50. As with other powers in the Bill, this is subject to a proportionality requirement, in which the Minister must be ‘satisfied that the biosecurity measure is appropriate and adapted to prevent, or reduce the risk of, the disease entering, or emerging, establishing itself or spreading in, Australian territory or a part of Australian territory’, cl 50(5). The measure automatically expires after one year (cl 50(6)) if not earlier.

³⁶⁰ *Biosecurity (Human Coronavirus with Pandemic Potential) (Preventative Biosecurity Measures—Incoming International Flights) Determination 2021*(Cth) [Note: this was made under the current *Biosecurity Act 2015* (Cth)].

³⁶¹ Biosecurity Bill 2012 (Cth) cl 84.

³⁶² Biosecurity Bill 2012 (Cth) cl 85(1), (3). ‘Isolation measures’ (ie, quarantine at a medical facility) are authorised at cl 95.

³⁶³ Biosecurity Bill 2012 (Cth) cl 86.

³⁶⁴ Biosecurity Bill 2012 (Cth) cl 87, 88, 89.

³⁶⁵ Biosecurity Bill 2012 (Cth) cl 90, 91.

Most of the powers described above are applied to people or groups at or before they reach the Australian border: domains where the Commonwealth's competency over public health matters is at its constitutional maximum.³⁶⁶

Chapter 2 of the Bill focuses on the ordinary exercise of biosecurity powers. These powers were intended to operate concurrently with consistent state and territory legislation and with the Commonwealth and jurisdictions respecting the constitutional sphere of the other.³⁶⁷ In contrast, Chapter 8 'human biosecurity emergencies', sets out 'special' powers which provide the Commonwealth (specifically, the Health Minister) with an expanded role to deal 'with emergencies involving threats or harm to human health on a nationally significant scale.'³⁶⁸ The special powers in Chapter 8 can be invoked in response to a 'human biosecurity emergency declaration' (declaration), made by the Governor-General (GG) on the advice of the Health Minister. Before recommending the GG make a declaration, the Health Minister must be satisfied that:

- (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.³⁶⁹

Once a declaration is in place, the scope of the Health Minister's powers to 'prevent or control' the 'entry...emergence, establishment or spread' of the 'declaration disease' are extremely broad.³⁷⁰ Section 475, for example provides that the Health Minister can determine 'any requirement' and such a requirement applies 'despite any provision of any other Australian law'.³⁷¹ Any 'other Australian law' would include an inconsistent federal law (such as the *Disability Discrimination Act 1992* (Cth) or *Privacy Act 1988* (Cth)), or state or territory

³⁶⁶ There is also a limited power to prevent a person from leaving Australia once they arrive if there is a risk they may spread a listed disease to another country: Biosecurity Bill 2012 (Cth) cl 44(1).

³⁶⁷ Biosecurity Bill 2012 (Cth) cl 8.

³⁶⁸ Biosecurity Bill 2012 (Cth) cl 471 (now section 473 of the *Biosecurity Act 2015* (Cth)). As the Guide to this Chapter of the Act provides, and as has been seen with Australia's response to COVID-19, these special powers can be used alongside the regular powers in Chapter 2.

³⁶⁹ Biosecurity Bill 2012 (Cth) cl 473 (emphasis added).

³⁷⁰ Biosecurity Bill 2012 (Cth) cl 475 ('requirement power'); see cl 476 for the Minister's 'direction' power. The powers can also be used to 'to prevent or control the spread of the declaration listed human disease to another country.'

³⁷¹ Determinations likewise operate despite any provision of any other Australian law, Biosecurity Bill 2012 (Cth) cl 476(4) (emphasis added).

law (include a local Human Rights Act).³⁷² While a requirement or direction is a ‘legislative instrument’ they are not subject to parliamentary disallowance.³⁷³ A person who fails to comply with a requirement or direction commits an offense punishable by a fine of 300 penalty units (\$60,000) or five years imprisonment.³⁷⁴ While extremely broad, the human biosecurity emergency powers under Chapter 8 were not intended to be used in an arbitrary or capricious manner and they include a proportionality test.³⁷⁵ However, there is no easy way to challenge the Health Minister’s decision.³⁷⁶

Ultimately, the Biosecurity Bill 2012 and an accompanying Bill to establish an Inspector-General of Biosecurity lapsed at the 2013 federal election.³⁷⁷ Prior to it lapsing there was no parliamentary debate (other than the Minister’s SRS) and no Committee hearings into the Bill. This election saw the defeat of the centre-left Labor government and the return of a centre-right Liberal National Party ‘Coalition Government’. However, despite the change in government (and the general approach of the new Government towards initiatives of its predecessor), a new Biosecurity Bill was listed on the parliamentary notice paper in 2014 that – as indicated above – largely replicated the provisions of the 2012 Bill. However, the global context had changed between the introduction of the 2012 version of the Bill and the introduction of the new version in November 2014. Foremost was the then contemporaneous outbreak of Ebola in West Africa and, while the EM to the 2012 version of the Bill made scant reference to human diseases, the EM to the 2014 Bill included a new section on ‘Providing protection from public health risks’ that referenced ‘recent announcements by the World Health

³⁷² A requirement or direction would, in theory, only be subject to the *Australian Constitution* and the relevant empowering provisions of the *Biosecurity Act 2015* (Cth). Even here, an applicant may struggle to find a constitutional ground to challenge a direction. See, for example, the High Court’s consideration of Victoria’s lockdown laws and, variously, federalism, freedom of movement and the implied freedom of political communication in *Gerner v Victoria* [2020] HCA 48.

³⁷³ See discussion on parliamentary scrutiny below.

³⁷⁴ Biosecurity Bill 2012 (Cth) cl 477.

³⁷⁵ Biosecurity Bill 2012 (Cth) cl 475(4). Nor can they be used to impose a ‘biosecurity measure’ on an individual: Biosecurity Bill 2012 (Cth) cl 476 (6). A similar test existed for the Minister’s exercise of an emergency ‘direction’ power: cl 476(3).

³⁷⁶ A challenge on the grounds of reasonableness will face evidential hurdles and unfriendly precedents, which were set out in Justice Thawley’s dismissal of a challenge to the India flight ban in *Newman v Minister for Health and Aged Care* [2021] FCA 517; eg, *Avon Downs Pty Ltd v Commissioner of Taxation* [1949] HCA 26; (1949) 78 CLR 353 at 360 (Dixon J) cited at [51]. Framing challenges also arise if decisions are based on a ‘precautionary’ approach to assessing public health risk, as this approach is likely to be accepted by the Court as appropriate and encourages significant deference to health officials: *Palmer v State of Western Australia (No 4)* [2020] FCA 1221, per Rangiah J at [302]; discussion at [73]–[81].

³⁷⁷ Inspector-General of Biosecurity Bill 2012 (Cth) [lapsed]. As the functions of the Inspector-General were primarily focused on the non-human biosecurity elements of the Biosecurity Bill 2012 (Cth) it is not considered further.

Organization that diseases such as polio and Ebola virus disease have met the conditions for Public Health Emergencies of International Concern.³⁷⁸

The *Biosecurity Act 2015* (Cth) was enacted in June 2015 and most provisions came into effect on 16 June 2016.³⁷⁹ The *Quarantine Act 1908* (Cth) was no more. Less than four year later, the new emergency powers under the Biosecurity Act's emergency powers were employed to respond to a global pandemic.

The preceding sections have provided an overview of the legal regimes set in place by Parliament during 2005-2015. In many cases, these Bills were more than incremental developments in regulatory measures to prepare and respond to pandemics. Rather, they represented part of a wider [bio]securitizing process that was buttressed by official extrinsic material designed to persuade Parliamentarians and shape post-enactment legal interpretation of the law. The next section examines the lawmaking process in more detail.

3. Biosecurity lawmaking: the parliamentary debates

This part of Chapter 4 analyses the language of the Bills, the official extrinsic material that accompanied them, and the second reading speeches (SRS) of the Ministers as a securitizing move. It also examines the parliamentary record to identify if and how these moves were accepted or challenged. Finally, it also considers the way language and parliamentary *tactics* were deployed to secure passage of the Bill and overcome any challenge to the securitizing legislative moves.

Based on Securitization Theory, the researcher expected to see evidence of threat and referent object identification with the governing parties appealing to the parliamentary audience (and wider public) to support the legislative reforms on the basis that they would protect the referent objects/address the identified threat. This response would be justified, notwithstanding that it might break long-established or deeply held principles or values (ie, 'rules that bind'). As will be shown below, this featured to some extent. However, the parliamentary record reveals that there was often a disjunction between the threat identification codified in the text of the Bill and that undertaken in the parliamentary debates themselves. Further, the degree to which a Bill was challenged (including over its justification and

³⁷⁸ Explanatory Memorandum, Biosecurity Bill 2014 (Cth) 10-11.

³⁷⁹ Along with the *Biosecurity (Consequential Amendments and Transitional Provisions) Act 2015* (Cth).

regulatory reach) was far less than might be expected given the degree to which the laws usurped supposedly important values, such as academic freedom and parliamentary scrutiny of the Executive. Indeed, in the case of the National Health Security Bill 2011 (Cth) (NHS Bill) there was negligible debate and even in the case of the Defence Trade Controls Bill 2011 (Cth) (DTC Bill), the parliamentary challenge to the proposed Bill occurred late and seemingly by accident.

Threats and 'referent objects' identification

The NHS Bill and Biosecurity Bills adopt the modern formula of stating their purpose and objectives in discrete parts of the Bill. Prominently located (usually within the first 10 sections), these provisions identify various threats requiring legislative action and, in some cases, one or more referent objects worthy of protection.

Explicit threat identification in the law

In clause 6 of the NHS Bill, five 'threats' were identified as justifying legislative action: 'the occurrence of certain communicable diseases; certain releases of chemical, biological or radiological agents; the occurrence of public health risks;³⁸⁰ and the occurrence of overseas mass casualties.³⁸¹ Meanwhile, the Biosecurity Bills identified a list of threats that the Bills were expected to address, relevantly:

- biosecurity risks
- the risk of contagion of a listed human disease
- the risk of listed human diseases entering Australian territory or a part of Australian territory, or emerging, establishing themselves or spreading in Australian territory or a part of Australian territory;
- risks related to ballast water; and

³⁸⁰ A 'public health risk' was further defined as an 'event: (a) that might adversely affect the health of human populations; and (b) that ... the health effects of the event might spread within Australia; [and/or] the health effects of the event might spread between Australia and another country; [and/or] the health effects of the event might spread between 2 other countries; [and/or] the event might present a serious and direct danger: National Health Security Bill 2007 (Cth) cl 3.

³⁸¹ An 'overseas mass causality event' means 'an event occurring overseas, if: (a) more than one person (whether an Australian or otherwise)...is affected by a disease, or is injured or dies; and...needs to be repatriated, identified or treated, or needs to be brought to Australia for treatment; and...a responsible Commonwealth, State or Territory body is involved in responding to the event': National Health Security Bill 2007 (Cth) cl 3.

- biosecurity emergencies and human biosecurity emergencies.³⁸²

The DTC Bill lacked a similar objectives clause. However, the requirement that a permit to supply controlled technology would only be given if the Minister is ‘satisfied’ that the ‘the supply would not prejudice the security, defence or international relations of Australia’ points to a series of referent objects that the Executive sets itself out to. Explicit threat identification in the text of the law was strengthened in the 2015 amendments to the DTCA. These amendments clarified that certain supply was only prohibited if it had a ‘military end-use’ or use in a ‘Weapons of Mass Destruction program’.³⁸⁴

Differences in threat identification: what the law says, what it means in practice and what the parliamentary record suggests it was meant to achieve

Frequently, however, the parliamentary debate and even the Bills’ provisions suggested that other threats (explicit and implicit) were being targeted by the legislation. As one example, although ‘disease’ is mentioned as the type of event that may give rise to an ‘overseas mass casualty event’ – a threat identified in the NHS Bill –³⁸⁵ the EM and Minister’s invocation of the Bali Bombings, suggests the real threat was conventional international terrorism, as opposed to the international disease outbreaks.³⁸⁶ A more complex picture emerges with the risk identification in Part 3 of the NHS Bill that established the SSBA regime. Clause 30 of the NHS Bill declares the primary object of Part 3 is:

to give effect to Australia’s obligations to establish controls for the security of certain biological agents that could be used as weapons.

On its face, this section appears to articulate a singular threat: ‘certain biological agents that could be used as weapons.’ Addressing this threat would appear to fulfil Australia’s global obligations, including under the Biological Weapons Convention (BWC) and commitments to the Australia Group and other arms control bodies. Yet the process by which biological agents are designated as SSBA suggests a wider scope of threats and referent objects had been

³⁸² Biosecurity Bill 2012 (Cth) cl 4. Formatting removed.

³⁸³ For example, *Defence Trade Controls Act 2012* (Cth) s 11(4). See also the Minister’s power to issue a notice prohibiting activities at section 14.

³⁸⁴ *Defence Trade Controls Act 2012* (Cth) 10(1A)(c).

³⁸⁵ The threat of an overseas mass casualty event (ie, one affecting overseas citizens) is less commonly described in the literature as a ‘biosecurity threat’ distinct from the generalised threat of a disease outbreak. In some senses this is contrary to the theory’s history, as the security implications of disease on a State’s nationals and armies abroad were the focus of the early ‘hard’ security analyses of infectious disease: see discussion in Elbe ‘Should HIV/AIDS Be Securitized?’, above n 53; National Intelligence Council, above n 112; Central Intelligence Agency, *Sub-Saharan Africa: Implications of the AIDs Pandemic* (SNIE 70/1-87) (United States, 1987).

³⁸⁶ Explanatory Memorandum, National Health Security Bill 2007 (Cth) 5; Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing).

identified. As outlined above, the provision of the NHS Bill that related to the establishment of a list of SSBAAs, provided the Minister with the power to list any biological agent ‘that the Minister considers to be of *security concern to Australia*’ (emphasis added); and security concerns extended beyond those agents able to be weaponised. That Part 3 of the NHS Bill is intended to address other threats is made clear in the Minister’s SRS: while the Minister does refer to ‘terrorist attacks involving chemical, biological and radiological agents’,³⁸⁷ they also refer to a generalised threat from ‘infectious agents, such as bacteria and viruses *that can spread rapidly within a population*, and toxins derived from animals, plants or microbial material’.³⁸⁸ How they come to spread (eg, bio-error or bioterror) is left ambiguous; however, the Minister’s reference to the Bill’s requirement for entities that handle SSBAAs to ‘comply with biosecurity standards relating to...storage and security requirements for personnel and transport’ suggests the accidental release of harmful biological agents was considered an equal threat to the ‘health of the nation’.³⁸⁹ Moreover, viruses that are more likely to present a pandemic risk than a weapon of choice for a bioterrorist are included, such as SARS and avian influenza. Future speeches on amendments to the NHS Act would more explicitly list other behaviours as threats: Peter Dutton MP, for example, stated that ‘Bacterial and viral pathogens and toxins derived from living organisms have the potential to do untold damage *through unintentional release, lax handling or, worse, malicious intent*’.³⁹⁰

Finally, the list of SSBAAs deemed a security concern to the ‘health of the nation’ is not limited to those that affect *human* life or health (see Table 9, above).³⁹¹ The inclusion of

³⁸⁷ As does the ‘Bill digest’ accompanying the Bill: Buckmaster, Thomas and O’Neill, above n 312.

³⁸⁸ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing) (emphasis added). The qualifier ‘that can spread rapidly’ was removed from the Act with the enactment of the *National Health Security Amendment Act 2009* (Cth).

³⁸⁹ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing). In the context of the SSBA regime, ‘biosecurity’ is given a specific meaning in the SSBA Standards, namely ‘the protection, control and accountability for biological agents and toxins within facilities, in order to prevent their loss, theft, misuse, diversion, unauthorised access or intentional unauthorised release’, Department of Health, *SSBA Standards*, above n 325, 11. This definition is adapted from WHO, *Biorisk management: Laboratory biosecurity guidance* (WHO, September 2006). These standards are binding on entities under section 56 of the Act.

³⁹⁰ Commonwealth, *Parliamentary Debates*, House of Representatives, 11 February 2010, 1165 (Peter Dutton) (emphasis added).

³⁹¹ The 2008 list is sourced from a 19 March 2008 webcapture of: Department of Health and Ageing, *Biosecurity* (Commonwealth of Australia), 11 January 2008 <<https://web.archive.org/web/20080319144405/https://www1.health.gov.au/internet/main/publishing.nsf/Content/ssba.htm>>. The current, 2016 List was sourced from: Department of Health, *Security Sensitive Biological Agents* (Commonwealth of Australia), 25 August 2020 <<https://www1.health.gov.au/internet/main/publishing.nsf/Content/ssba.htm>>.

diseases such as foot and mouth disease virus, swine fever virus and rinderpest reveal that the economic health of Australia was considered a referent object worthy of protection.³⁹²

A theme that emerged from the parliamentary debate over the SSBA regime (such as it was) was that the risk presented by SSBA was compounded by the lack of national government oversight of who was handling these agents, or where they are stored. Then Health Minister, Tony Abbott MP, remarked:

Currently, there is no nationally consistent legislation that covers all facilities and entities that handle security-sensitive biological agents. Indeed, it is not possible to accurately identify those facilities and entities that handle security-sensitive biological agents, or their location. *This legislation addresses this risk* by providing for the registration of entities handling security-sensitive biological agents and the ongoing regulation and monitoring of those registered facilities.³⁹³

This passage suggests that the lack of government knowledge and control over SSBA, not merely their existence *per se*, was perceived as a risk. Thus, in addition to the previously identified referent object of the ‘health of the nation’, the Minister identifies another: ‘Australia’s capability to protect’ it. That this was an ‘official view’ is supported by the ‘regulatory impact’ discussion in the EM, where ‘mandatory national regulation by the Australian Government’ was considered the option with the ‘lowest likelihood of failure and the most effective and efficient means of minimising the security risks posed by SSBA.’³⁹⁴

Indeed, the lack of government knowledge and control over sensitive biological agents was adopted by the Opposition’s health spokesperson, Nicola Roxon MP, as a key threat justifying government intervention – both into the research field but also an area previously regulated by the states and territories. In her own SRS, Roxon singles out:

‘the potential for either the deliberate or the unintentional use or release of security-sensitive biological agents to cause serious harm...’³⁹⁵

Like Abbott, Roxon places significance on the risks that arise with the previous status quo, saying it ‘seems remarkable that there is currently no nationally consistent legislation that

³⁹² Foot-and-mouth disease also features strongly as an identified threat in the debate over the Biosecurity Bills. The Methodology for the assessment of biological agents – Appendix 6 – also sets out a process for assessing viruses that present an economic, as opposed to public health, risk.

³⁹³ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing).

³⁹⁴ Explanatory Memorandum, National Health Security Bill 2007 (Cth) 2.

³⁹⁵ Commonwealth, *Parliamentary Debates*, House of Representatives, 20 September 2007, 21 (Nicola Roxon MP).

addresses the security risks associated with all facilities and entities that handle these agents, nor their location.’³⁹⁶ A lack of consistency – it was argued – had created a ‘legislative vacuum’ and this Bill *was needed* to fill it with a national mandatory regulatory scheme.³⁹⁷ Five years after the NHS Act came into effect, ‘the national imperative to actively improve our capacity to maintain adequate controls on security sensitive biological agents’ was still being raised by Health Ministers as a justification for reforms to the regime.³⁹⁸

Legislative ‘gaps’ also featured as a threat that the DTC Bill was intended to address. As with SSBA regime, the Minister introducing the DTC Bill argued that it sought to address a ‘gap’ in Australia’s biosecurity regimes; that, while there were laws to control the export of a CD containing blue-prints for controlled technology, there were no laws to prevent the ‘intangible’ transmission of that same information via electronic means.³⁹⁹ The EM to the Bill also identified the risk to national security arising from the intangible supply of technology within a classroom setting, especially in advanced post-graduate courses.⁴⁰⁰

Applying a close securitization lens to the Minister’s SRS across all Bills shows elements of threat and referent objective identification that go beyond the explicit text of the relevant Bills. For example, in introducing the NHS Bill, Minister Abbott opened:

I am pleased to introduce the National Health Security Bill 2007. This is an *important Bill* that delivers on the Government’s ongoing commitment to enhance Australia’s *capability to protect the health of the nation* and to respond to *naturally occurring epidemics or to terrorist attacks* involving chemical, biological and radiological agents.⁴⁰¹

Other features in this speech include prioritisation (‘important Bill’) and threat framing, capturing the biosecurity risks of epidemics and bioterrorism. Both the ‘health of the nation’ and a ‘capability to protect’ it, are identified as referent objects worthy of new rules that ‘enhance’ the Government’s capabilities. Throughout the speech, terms such as ‘imperatives’

³⁹⁶ Ibid.

³⁹⁷ Ibid.

³⁹⁸ Commonwealth, *Parliamentary Debates*, House of Representatives, 19 September 2012, 11174 (Tanya Plibersek, Minister for Health). This line was either prepared by Party officials or the public service as it was repeated verbatim by another Minister during their own speech on the Bill: Commonwealth, *Parliamentary Debates*, Federation Chamber, 9 October 2012, 11712 (Catherine King, Parliamentary Secretary for Health and Ageing).

³⁹⁹ Explanatory Memorandum, Defence Trade Controls Bill 2011 (Cth) (html version).

⁴⁰⁰ Explanatory Memorandum, Defence Trade Controls Bill 2011 (Cth) (html version).

⁴⁰¹ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing) (emphasis added).

and ‘urgent’ are used to prioritise action. Table 11, below, provides a summary of threats identified in the SRS that accompanied each Bill, noting any changes made between the version of the SRS prepared by the Minister’s Department and the version delivered by the Minister. As discussed in section 2 of Chapter 5, the minimal changes made by Ministers to the speeches prepared by apolitical public servants provided an empirical basis for not limiting this study’s examination of securitizing acts (and actors) to Ministers and MPs.

Bill	Threats identified in Minister’s Second Reading Speech	Notes
National Health Security Bill 2007	‘naturally occurring epidemics or to terrorist attacks involving chemical, biological and radiological agents...’ ‘international spread of disease’ ‘public health events of national significance’ ‘the security risks posed by security-sensitive biological agents. These include infectious agents, such as bacteria and viruses that can spread rapidly within a population, and toxins derived from animals, plants or microbial material.’ ‘health emergencies and mass casualty situations...’ ‘national health security issues’	No changes to the threats identified by the Department
Quarantine Amendment (National Health Security) 2008	‘international spread of disease’ and ‘public health risks that can spread internationally and with devastating effect’ ‘communicable disease, releases of chemical, biological or radiological agents’ ‘other public health events of national significance’ ‘spread of a quarantine disease’ ‘existing, or new, diseases’	No changes to the threats identified by the Department
National Health Security Amendment Bill 2009	‘biological agents that could be used as weapons... [including] Ebolavirus and Foot-and-mouth disease virus.’ ‘...an SSBA-related disease outbreak’ <i>‘[keep Australia secure from] potential threats’</i>	Text in <i>bold italics</i> was added to the Minister’s version of the SRS The SRS also explicitly identified the threat from biological agents ‘that do not spread between humans but are highly dangerous’

National Health Security (Background Checking) Bill 2009	‘certain biological agents that could be used as weapons...[including] the <i>causative</i> agents of diseases such as anthrax, smallpox and the plague’ ‘...the risks and threats posed by biological agents...’ ‘...controls on biological agents.’	The word ‘causative’ was removed in the Minister's SRS
National Health Security Amendment Bill 2012	‘certain biological agents <i>that could be used as weapons</i>, such as <i>Bacillus anthracis</i> (Anthrax) and foot-and-mouth disease virus’	Text in <i>bold italics</i> was removed from the Minister's version of the SRS
Biosecurity Bill 2012	‘People and cargo move from one side of the world to another within 24 hours....’ ‘It [the law] also needs to be more responsive to the threat of communicable diseases...’ ‘...the risks posed by the movement of people, aircraft, vessels and goods.’	No changes to the threats identified by the Department
Biosecurity Bill 2014	‘the threat of communicable diseases’ ‘...serious communicable diseases ...highlighted by the recent announcements by the World Health Organization of polio and Ebola Virus disease as Public Health Emergencies of International Concern.’ ‘...exotic pests and ...diseases such as foot-and-mouth.’	No changes to the threats identified by the Department
Defence Trade Controls Bill 2011	‘export of defence and strategic goods, technology and related services ...to destinations that may prejudice Australia’s security, defence or international relations.’	No changes to the threats identified by the Department
Defence Trade Controls (Amendment) Bill 2015	‘...higher-risk activities with respect to the non-physical supply and transfer of Defence controlled goods...’	No changes to the threats identified by the Department

Table 11: Threat identification in Second Reading Speeches

Characterisation of threats

Security analysts often look to the characterisation of a threat as ‘existential’ or, per Enemark, ‘extreme’, as evidence of securitization. However, references to the seriousness of a threat were more oblique in the debates studied.⁴⁰² While some SRS spoke of ‘emergencies’ (NHS Bill) or ‘devastating impacts’ (National Health Security Bill (Quarantine Amendments) 2008), explicit characterisation was rare. Nonetheless, similar characterisation could be

⁴⁰² Figure 7 above shows that the use of the term ‘existential’ and phrase ‘existential threat’ rose in prominence in tandem with the emergence of the Islamic State in the mid-2010s. This period saw a renewed burst of anti-terrorism legislation.

achieved through other rhetorical strategies; for example, linking a new threat to an issue that is known by the actor to already be highly securitized: threat-by-association. For example, when the Minister argued that the NHS Bill was necessary to respond to ‘terrorist attacks’ or, later in the same speech ‘mass causality events’ such as the ‘horrific events ...[of] the Bali Bombings’⁴⁰³ he raised the seriousness of the other threats: ‘naturally occurring epidemics’ and SSBA. Thus, the extension of a single set of rules to these different threats became, not simply justifiable, but logical. The regulation of domestic research took on the importance and urgency of an anti-terrorism law. A similar strategy involved citing some horror or dread: whether the Bali Bombings (NHS Bill) or Ebola and anthrax – diseases which featured in the SRS for the NHS Bill, later amending Bills, and the two Biosecurity Bills.

The use of specific biological agents as a threat or other justification

Debates on the various Bills also reveal the evocative power of certain diseases and how the rhetorical ‘usefulness’ of a disease in a securitizing move can ebb and flow. The rhetorical different use of diseases in the debates over biosecurity legislation, provides support to Enemark’s argument that certain diseases are peculiarly susceptible to being securitized. For example, debates over the NHS Bills saw increasing reference to specific diseases. Speaking on the NHS Background Checking Bill, Dutton singled out ‘Ebola virus, the plague, SARS and anthrax’ as part of a ‘threat [that] is all too apparent’.⁴⁰⁴ Labor MP Jodie Campbell likewise singled out ‘anthrax, smallpox and the plague’ in her contribution.⁴⁰⁵ This trilogy of biological agents was also used in the opening of the Minister’s SRS,⁴⁰⁶ a change from Abbott’s SRS in 2007 which only referred to non-specific ‘infectious agents, such as bacteria and viruses that can spread rapidly within a population, and toxins derived from animals, plants or microbial material.’⁴⁰⁷ Debates over the 2009 amendments to the NHS Act 2007, likewise centred on a few biological agents on the ‘particularly horrible [SSBA] list’, with a special focus on Ebola, ricin and smallpox.⁴⁰⁸ Whereas Ebola was frequently cited in debates as an exemplar biological threat to humans, foot-and-mouth disease was the preferred example of a threat to *economic*

⁴⁰³ On 12 October 2002, suicide bombings in Kuta, Bali killed 202 people, including 88 Australians.

⁴⁰⁴ Commonwealth, *Parliamentary Debates*, House of Representatives, 11 February 2010, 1165 (Peter Dutton MP).

⁴⁰⁵ Commonwealth, *Parliamentary Debates*, House of Representatives, 11 February 2010, 1166 (Jodie Campbell MP).

⁴⁰⁶ Commonwealth, *Parliamentary Debates*, House of Representatives, 19 November 2009 (Nicola Roxon, Minister for Health and Ageing).

⁴⁰⁷ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing).

⁴⁰⁸ See speeches by Labor MP Graham Perret and Liberal MP Luke Simpkins: Commonwealth, *Parliamentary Debates*, House of Representatives, 9 September 2009, 9189 and 9191, respectively.

health.⁴⁰⁹ Indeed, in the context of the two Biosecurity Bills (which were introduced by Ministers responsible for agriculture – not health) foot-and-mouth disease appeared to take on Ebola and smallpox’s rhetorical role of the embodied biosecurity threat the Bills sought to address.⁴¹⁰

While smallpox and plague have, historically, resulted in high mortality, the decision to focus on Ebola, foot-and-mouth disease and other specific disease appears to be driven by a biological agent’s popular perception – with familiar diseases more likely to build audience support for the regulatory measures. For instance, after listing most of the Tier-1 SSBA agents, Luke Simpkins MP appeared confident that the public were aware of the diseases (and thus why they *needed* to be controlled) because, ‘[m]ost of those [biological agents] are familiar to us here in Australia because they are all extremely dangerous *and have been reported at various times in the media*’ (emphasis added).⁴¹¹ As explored further in Chapter 6, Ebola’s particular prominence in the debates over the NHS Bills – all of which occurred before the Ebola outbreak – may be due in no small part to the 1995 ‘action film’ *Outbreak*. In fact, two paragraphs of Labor MP Greg Perrett’s short contribution to the debate on the 2009 amendments to the NHS Act were a description of this film and its representation of a ‘fictional Ebola like virus’.⁴¹²

A final factor that appeared to influence the rate at which certain biological agents were referenced was, perhaps not unsurprisingly, any recent use by or connection with terrorists. As already identified in Chapter 1, the anthrax attacks in the US played a key role in shaping that toxin’s modern, public configuration as a biosecurity threat. These events, along with the attacks on the Twin Towers on 11 September 2001 and the 2002 Bali Bombings, all feature in the parliamentary debates. One MP draws a connection between ricin’s inclusion on the SSBA and the 1995 Tokyo subway sarin attack by members of the Aum Shinrikyo movement.⁴¹³

⁴⁰⁹ Indeed, Minister Elliot’s SRS for the 2009 NHS Amendment Bill only singles out two biological agents: Ebola and foot-and-mouth disease: Commonwealth, *Parliamentary Debates*, House of Representatives, 24 June 2009, 6954 (Maria Elliot, Minister for Ageing); see also Minister Roxon’s contribution, Commonwealth, *Parliamentary Debates*, House of Representatives, 9 September 2009, 9196 (Nicola Roxon, Minister for Health and Ageing). The threat to livestock *per se* did not feature in the debates on the NHS Bills nor the Biosecurity Bills.

⁴¹⁰ As discussed above, the EM to the Biosecurity Bill 2012 (Cth) did not mention any specific human diseases other than cholera –raised only in the context of ballast water reforms.

⁴¹¹ He then proceeded to focus on Ebola, SARS and smallpox: Commonwealth, *Parliamentary Debates*, House of Representatives, 9 September 2009, 9191 (Luke Simpkins MP).

⁴¹² Commonwealth, *Parliamentary Debates*, House of Representatives, 9 September 2009, 9189 (Greg Perrett MP). He refers again to the movie later in his speech.

⁴¹³ Ibid.

Less common were specific cases of ‘bioerror’. When past instances were referenced in support of the biosecurity measures, the examples – again – focused on anthrax and Ebola.⁴¹⁴

Identifying referent objects

The parliamentary debate and SRS also served to identify referent objects whose protection demanded the passage of new biosecurity legislation. These referent objects were usually broad and nebulous. For example, in the SRS to the Biosecurity Bill 2014, one object was Australia’s ‘way of life’; in the DTC Bill, it was the US-Australia Alliance and ‘Australia’s security, defence or international relations.’ In general, there was a high degree of similarity in referent objects identified from a review of SRS, shown in Table 12, suggesting a common core of objects that are likely to be positioned as referent objects.

Referent object identified in SRS	Bill (reference)	Notes
‘Australia’s capability to protect the health of the nation’ (1), (2)	(1) - NHSB 2007	Text in <i>bold italics</i> was a suggested inclusion in the draft SRS
‘public health security’ (2)	(2) - QA(NHS)B 2008	
‘public health’ (2), ‘public health and safety’ (4)	(3) - NHSB (BC) 2009	
‘our capacity to maintain adequate controls on security sensitive biological agents’ (2), (3), (4), (5)	(4) - NHSB 2009	In (4) the Minister added ‘uphold the health and security of all Australians’
‘...Australia’s obligations for securing certain biological agents that could be used as weapons’ (4)	(5) - NHSB 2012	
‘ <i>all Australians</i> ’ (4)	(6) - BB 2012	
‘Australia’s world class biosecurity system’ (6)	(7) - BB 2014	In (7) the Department had added ‘plants’ to the list objects warranting protection.
‘Australia’s unique pest and disease status’ (6), (7)	(8) - DTCB 2011	
‘our environment, human health, the wellbeing of our domestic animals and our way of life’ (6), (7)	(9) - DTC(A)B 2015	
‘Australia’ (7)		
‘Australian farmers... the Australian economy... the Australian community’ (7),		
‘our way of life’ (7)		
‘Australia’s Alliance with the United States’ (8)		
‘our foreign policy and national security arrangements’ (8), (9)		

⁴¹⁴ Commonwealth, *Parliamentary Debates*, House of Representatives, 9 September 2009, 9191-2 (Luke Simpkins MP).

'national security' (9), 'Australia's national security' (9) 'our national security interests' (9)		
Key: NHSB 2007 - National Health Security Bill 2007 (Cth); QA(NHS)B 2008 - Quarantine Amendment (National Health Security) Bill 2008 (Cth); NHSB (BC) 2009 - National Health Security Amendment (Background Checking) Bill 2009 (Cth); NHSB 2009 - National Health Security Amendment Bill 2009 (Cth); NHSB 2012 - National Health Security Amendment Bill 2012 (Cth); BB 2012 - Biosecurity Bill 2012 (Cth); BB 2014 - Biosecurity Bill 2014 (Cth); DTCB 2011 - Defence Trade Controls Bill 2011 (Cth); BTC(A)B 2015 - Defence Trade Controls Amendment Bill 2015 (Cth)		

Table 12: Referent object identification in Second Reading Speeches

Domestic interests dominate the list of referent objects. The Biosecurity Bills provided the longest lists of these interests: environmental, human, and animal health; climaxing in a totalising object – 'our way of life'. While the focus on the domestic may be unsurprising for the Biosecurity Bills, it may disappoint some that the speeches on the NHS Bills did not elevate global health interests to the level of a referent object, especially given the role of the NHS Bill in implementing Australia's commitments under the IHR. Across these Bills it is 'public health', not global health, that features. And, even when foreign policy is mentioned in the SRS to the DTC Bill and DTC amendment Bill, the protection attaches to '*our* [ie, Australia's] ...arrangements.'

Chapter 5 explores the role and importance of different departmental policy interests (or 'equities') in more depth, but a sense of those equities emerges from a review of the referent objects. For example, a more explicit focus on 'national security' features in speeches moved by Ministers representing the Department of Defence. Likewise, agricultural and environmental interests feature most strongly in the Biosecurity Bills (moved in Parliament by the Minister responsible for Agriculture). The singling out of Australia's biosecurity 'system' as its own object worthy of protection is consistent with Australia's historic and somewhat idiosyncratic approach to conceptualising quarantine. This framing of Australia's biosecurity/quarantine system as an end in itself has been examined above in section 2 of Chapter 2.

Just as the case with threat identification in the SRS (Table 11, above), Ministers made minimal changes to the referent objects identified by the departmental drafters. Referent objects, once identified in an earlier speech, tended to persist over time and changes in Government and Prime Minister. For example, there was consistent identification of threats and referent objects across the SRS for the various NHS Bills between 2007 and 2012. In contrast, some objects changed to serve the changing needs of the actor. When major amendments to the *Defence Trade Controls Act 2012* were introduced in 2015, the Department focused attention less on the Australia-US alliance and more on ‘*our* national security interests’ [emphasis added]. Some possible reasons for this are explored more fully in Chapter 5.

Identifying, defending and dismissing values, principles and rules that bind

Biosecurity lawmaking reveals a process of explicit and implicit identification of values and principles (ie, ‘rules that bind’). Values and principles that emerge through a textual analysis of the Bills and debates reflect four overlapping categories:

1. Procedural principles, including:⁴¹⁵
 - a. Onus of proof (Crown to prove element of offence)
 - b. Right against self-incrimination
 - c. Rights of appeal against executive decision-making
 - d. Parliamentary oversight of executive decision-making.
2. Normative principles valued by particular communities, including:
 - a. Proportionality as the basis for decision-making
 - b. Respect for individual autonomy and human dignity
 - c. Respect for individual privacy and doctor-patient relationship
 - d. Evidence-based (ie, ‘non-political’) decision-making
 - e. Individualised action: considering individual circumstances and differences

⁴¹⁵ There are several other principles that fall within this general category, but practical constraints limit their discussion. Examples include requirements around the requisite ‘state of mind’ for officers able to exercise statutory powers and the inclusion of ‘strict liability’ offences. An example of the ‘conversation’ between Parliament and the Executive on these and other matters can be found in the reports of the Senate Scrutiny of Bills Committee, eg, Senate Standing Committee for the Scrutiny of Bills, ‘Biosecurity Bill 2014’ in *Fourth Report* (25 March 2015), 272; and Senate Standing Committee for the Scrutiny of Bills, ‘Biosecurity Bill 2014’ in *Fifth Report* (13 May 2015), 316.

- f. Deference to health professionals and experts
 - g. Academic freedom.
3. Regulatory principles:
- a. Regulation should be ‘proportionate’, in that it be the least restrictive measure to achieve the desired policy goal. In some cases, an *a priori* standard may exist (eg, ‘deregulation’) as an optional regulatory setting.
4. International and domestic comity, including:
- a. being a good global citizen (eg, by upholding treaty obligations)
 - b. respect for the Federal-state division of powers

Many of the procedural principles listed above represent a default position, with deviation requiring justification and approval from Parliament.⁴¹⁶

In many cases, SRS identified countervailing norms or principles and sought to position the Bill’s provisions as consistent with those principles even while overriding them. This was common in the case of regulatory proportionality and, at times, occurred in speeches from Government MPs and opposition MPs. For example, speaking on the NHS Bill, then opposition MP Nicola Roxon spoke of the threats the Bill sought to address and argued that the threat they present justified a security-focused response. However, Roxon sought to assure the sector that ‘[t]he regulatory scheme is founded on *risk management principles* to ensure that its *effectiveness is maximised* and that the *regulatory impacts are minimised* (emphasis added).’ In his own SRS, Abbott similarly drew attention to what the Government was trying to achieve: ‘an appropriate balance between ensuring protection of the public and also minimising the impost on business’, perhaps being more explicit about what principle stood in potential opposition to ‘risk management principles’, namely the protection of the public.⁴¹⁷ Nonetheless, it is noteworthy that the legislative requirements for making and varying the

⁴¹⁶ After introduction, all Bills are considered by the Senate Standing Committee on the Scrutiny of Bills, which assesses each Bill against ‘against a set of accountability standards that focus on the effect of proposed legislation on individual rights, liberties and obligations, and on parliamentary scrutiny.’ The Committee may request a Minister to provide further information on any concerns it raises, although it cannot prevent the Bill proceeding further: Parliament of Australia, *Standing Orders and other orders of the Senate* (Parliament of Australia, July 2021) Chapter 5, [24]. A similar body exists to scrutinize delegated legislation (at [23]).

⁴¹⁷ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 4 (Tony Abbott, Minister for Health and Ageing).

SSBA List and SSBA Standards do not require any decision of the Minister to be ‘proportionate’.⁴¹⁸

Similar attempts at mollification continued as the SSBA regime evolved: the proposal to introduce enhanced background checks on researchers and to seize evidential material was accepted by the opposition as being subject to ‘sensible safeguards’.⁴¹⁹ Likewise, the 2015 amendments to the DTCA were justified as ‘better target[ed]’ and ‘more balance[d]’.⁴²⁰ All speeches, however, still positioned reform as necessary and essential to addressing some identified threat, risk or regulatory ‘gap’.

All the Bills deviated from one or more of the procedural rights and in ways too numerous to report in a qualitative study. The DTC Bill, for example, abrogated the right against self-incrimination, as did both versions of the Biosecurity Bills.⁴²¹ In the case of the Biosecurity Bill 2012, its EM argued that:

Upholding the privilege in relation to individuals who have information regarding a biosecurity risk could have significant consequences such as reduced agriculture, fisheries or forestry productivity, serious environmental damage and increased costs associated with controlling pests and diseases. A disease outbreak (such as foot and mouth disease) has the potential to cause significant and long term damage to the Australian industries and the reputation of Australia and Australian products overseas.⁴²²

Interestingly, although abrogation of the right in the Biosecurity Bills applies to both human and non-human biosecurity matters, the EM only deals with the latter. This suggests the Department of Health did not contribute a justification. For the DTC Bill, justification of the abrogation relied on appeals to regulatory effectiveness, rather than the nature of the threat. Effective ‘administration’ of the regulatory regime was declared to be of ‘*major public importance*’ and is integral to the multilateral effort to control proliferation of defence and dual-use goods and technology’. Non-compliance with the regime would ‘affect national security

⁴¹⁸ Compare certain decision-making rules for Human Biosecurity Officers, described below in the discussion over the Biosecurity Bills.

⁴¹⁹ Commonwealth, *Parliamentary Debates*, House of Representatives, 11 February 2010, 1165 (Peter Dutton).

⁴²⁰ Commonwealth, *Parliamentary Debates*, House of Representatives, 26 February 2015, 1399 (Kevin Andrews, Minister for Defence).

⁴²¹ Defence Trade Controls Bill 2011 (Cth) cl 44, 57; eg, Biosecurity Bill 2012 (Cth) s 661. In both cases a ‘use/derivative use’ protection limits the ability of information and answers that are compelled from being used in most future prosecutions.

⁴²² Explanatory Memorandum, Biosecurity Bill 2012 (Cth) 9.

and international relationships.’⁴²³ In contrast, the NHS Bill explicitly retained the right of against self-incrimination – even in the context of the SSBA regulatory regime.⁴²⁴

The SSBA regime and defence trade controls regime each provide for appeal mechanisms, including internal review, external ‘merits review’, and the possibility of more limited judicial review.⁴²⁵ However, as both regimes have been situated within a national security context, external review is likely to be limited in practice. For example, any external challenge to a decision to list (or not list) a biological agent as a SSBA will likely be confronted by the challenges faced by litigants in ‘national security’ matters. In particular, the *National Security Information (Criminal and Civil Proceedings) Act 2004* (Cth) may apply and even preliminary steps such as a request under the *Freedom of Information Act 1982* (Cth) may be denied on national security grounds (as was the case with the researcher’s own attempt to access the 2002 CoAG report on hazardous biological agents).⁴²⁶ Likewise, although most decisions made by the Minister or their delegate under the DTC Bill were reviewable, the Minister was not obliged to give notice of any reasons that ‘would prejudice the security, defence or international relations of Australia.’⁴²⁷ The experiences of individuals who have sought to challenge decisions made on the basis of undisclosed (and hence unexaminable) intelligence, suggests that researchers who have a permit refused will struggle to mount a successful appeal.⁴²⁸

In contrast, the Biosecurity Bills provided for a comprehensive regime of internal and external review options for day-to-day matters. A specific requirement for a human biosecurity control order under Chapter 2 of the Biosecurity Bill 2012 was inclusion of information on

⁴²³ Explanatory Memorandum, Defence Trade Controls Bill 2011 (Cth) [219] (emphasis added).

⁴²⁴ National Health Security Bill 2007 (Cth) cl 79.

⁴²⁵ For example, *National Health Security Act 2007* (Cth) Part 3, Division 8.

⁴²⁶ The *National Security Information (Criminal and Civil Proceedings) Act 2004* (Cth) allows the Commonwealth to seek closed court hearings, limit the ability of witnesses to answer questions (or even be called as a witness) or to require that counsel for a party obtain a security clearance.

⁴²⁷ Defence Trade Controls Bill 2011 (Cth) cl 68.

⁴²⁸ A similar regime governing the disclosure of ‘protected information’ is established under section 503A of the *Migration Act 1958* (Cth) and was, for all practical purposes, upheld by the High Court: *Graham v Minister for Immigration and Border Protection*; *Te Puia v Minister for Immigration and Border Protection* [2017] HCA 33. A formal scheme for restricting the disclosure of evidence before the Courts in national security matters is established by the *National Security Information (Civil and Criminal Proceedings) Act 2004* (Cth). The administrative and judicial use of practically unexaminable intelligence has been upheld by the High Court: *Assistant Commissioner Michael James Condon v Pompano Pty Ltd* [2013] HCA 7 [169] (Hayne, Crennan, Kiefel and Bell JJ), cf. concurring remarks of Gageler J [177]-[178]; *K-Generation Pty Limited v Liquor Licensing Court* [2009] HCA 4; *Kuczborski v Queensland* [2014] HCA 46, but cf. dissenting remarks of Hayne J [82]-[84], [115]-[116], [127]); *Gypsy Jokers Motorcycle Club Incorporated v Commissioner of Police* [2008] HCA 4; M Greg, ‘Outlaw Motorcycle Gangs and Secret Evidence: Reflections on the Use of Criminal Intelligence in the Control of Serious Organised Crime in Australia’ (2014) 36 (3) *Sydney Law Review* 501.

rights of review.⁴²⁹ The Bill also imposes positive obligations on officials to facilitate the exercise of appeal rights.⁴³⁰ Unlike this facilitative approach – which embedded or explicitly recognised the principle of reviewability of decisions – no such requirements apply to the powers of the Governor-General to declare a human biosecurity emergency, nor to the Health Minister’s decisions made in consequence of the declaration of a human biosecurity emergency. Of more significance, were attempts to limit parliamentary oversight of Executive rulemaking.⁴³¹ Limiting parliamentary scrutiny and the ability for Parliament to ‘disallow’ a regulation is a significant action and will usually attract attention from Parliament’s Scrutiny of Bills Committee and, less commonly, may be raised in the parliamentary debate.⁴³² (The value of these mechanisms to resist securitization is discussed in later chapters.)⁴³³

The NHS Bill adopted different rules for the two lists that were established under that Bill, with one, the National Notifiable Diseases List, subject to parliamentary disallowance.⁴³⁴ In contrast, the narrower list of ‘listed human diseases’ in the Biosecurity Bills is not subject to parliamentary disallowance.⁴³⁵ While many of the same disease/biological agents are included on both lists (see Appendix 4) it is only the latter, non-disallowable list, that triggers the ability for officials to exercise a wide range of invasive biosecurity powers. The EM to the Biosecurity Bill 2012 does not provide a clear rationale for this (let alone invoke a securitizing justification), merely stating that the exemption from disallowance ‘ensures the Commonwealth will have the continual use of powers and functions in this chapter to control

⁴²⁹ Biosecurity Bill 2012 (Cth) cl s59(i)(iii). See generally Biosecurity Bill 2012 (Cth) Chapter 2, Part 3, Division 2, Subdivision D.

⁴³⁰ For example, the DirHB must ‘inform the individual that the individual may communicate, or attempt to communicate, with anyone in relation to that right’ and ‘if the individual wishes to apply to the Tribunal for review of the decision, or to communicate in relation to that right—ensure that the individual is provided with reasonable facilities to enable him or her to do so.’ Biosecurity Bill 2012 (Cth) cl 73(1)(b), (c).

⁴³¹ The *Legislative Instruments Act 2003* (Cth) provides mechanisms and default rules that protect and engage Parliamentary oversight of executive rule making.

⁴³² The Senate Standing Committee on the Scrutiny of Bill made ‘no comment’ or determined ‘no response required’ for the NHS Bill, Quarantine Amendment (National Health Security) Bill 2008 (Cth), National Health Security Amendment (Background Checking) Bill 2009 (Cth) and Biosecurity Bill 2012 (Cth). Comment from relevant Ministers was sought by the Committee on the National Health Security (Amendment) Bill 2009 (Cth), the Defence Trade Controls Bill 2011 (Cth), Biosecurity Bill 2014 (Cth) and Defence Trade Controls (Amendment) Bill 2015 (Cth). Copies of the Committee’s reports are available at:

<https://www.apf.gov.au/Parliamentary_Business/Committees/Senate/Scrutiny_of_Bills/Reports/2016/index>.

⁴³³ It is noted, for example, that the Biosecurity Bill 2014 (Cth) had passed the Senate before the Senate Standing Committee on the Scrutiny of Bill could issue its final report on the Bill. See discussion below about the belated acknowledgement of the scope of the powers under the *Biosecurity Act 2015* (Cth).

⁴³⁴ National Health Security Bill 2007 (Cth) cl 11(1), (4); 12(2), 12(7).

⁴³⁵ Biosecurity Bill 2012 (Cth) cl 41 (3).

serious communicable diseases.’⁴³⁶ As with abrogating the right to silence, appeals to administrative ‘efficiency’ – rather than explicit reference to security interests – serve as the basis for justifying the breaking of established rules. Appeals to ‘efficiency’ are discussed below in the context of the DTC Bill and in Chapter 7. While the author suggests that ‘efficiency’ can operate as part of a coded rhetoric of security (alongside appeals to urgency and proportionality), in the case of the human biosecurity provisions of the Biosecurity Bills, this does not appear to be the case. As is examined in Chapter 5, an organisation’s culture is relevant to assessing the extent to which securitization is being used as a mechanism to advance a particular regulatory goal and the Department of Health was generally not found to use such strategies in its policy development work.

In contrast, the list of SSBA (and any variation to the list) is not a legislative instrument, thereby totally excluding parliamentary scrutiny.⁴³⁷ A minimum degree of transparency is achieved with a provision that requires that the current SSBA list be published online.⁴³⁸ This secrecy was consistent with that surrounding the development of the initial SSBA list.⁴³⁹ Secrecy also extended to the details held on the ‘National Register’, which includes information on all the entities that handle SSBA – including basic information such as the number and names of entities. The EM justified the secrecy of such ‘protected information’ on ‘public safety and security considerations....’⁴⁴⁰

While ‘public safety and security considerations’ were cited here as the basis for breaking the rule that Parliament ought to be able to scrutinise Executive action, the need to take swift action in an ‘emergency’ is the implicit basis for excluding Parliament’s disallowance power in the human biosecurity emergency provisions of the Biosecurity Bills.⁴⁴¹ Both Bills state that

⁴³⁶ Explanatory Memorandum, Biosecurity Bill 2012 (Cth) 148. A more detailed rationale is provided in the context of non-human biosecurity actions which are also exempt from disallowance; justified on the basis that, ‘Subjecting these determinations to disallowance could undermine the technical and scientific based decision making and frustrate risk management processes. These determinations are critical to the management of biosecurity risks posed by the importation of certain types of goods. If these determinations were to be disallowed, a large majority of imports would be likely to cease due to the uncertainty caused. This would have a significant impact on the economy... [and] could lead to inadequate management of the biosecurity risks posed to human, plant and animal health, Australia’s local industries, the environment and the economy.’ Ibid, 188.

⁴³⁷ National Health Security Bill 2007 (Cth) cl 31(4), 32(2).

⁴³⁸ National Health Security Bill 2007 (Cth) cl 34.

⁴³⁹ However, in practice, the Department of Health did publish some information as part of its 2016 review of the SSBA list.

⁴⁴⁰ Explanatory Memorandum, National Health Security Bill 2007 (Cth) 43.

⁴⁴¹ The EM is silent on this issue. As discussed above, this is possibly because few officials expected the powers to be used and so had not turned their minds to justifying them. Supporting this view is that a justification is provided in the context of non-human biosecurity emergencies: ‘...the decision of whether to impose an

the Governor-General's declaration of a human biosecurity emergency is a legislative instrument but not one subject to disallowance.⁴⁴² Likewise, emergency requirements determined by the Health Minister during an emergency period are non-disallowable legislative instruments.⁴⁴³ While it may be that the inclusion of a 3-month limit on the duration of any emergency declaration was considered an appropriate safeguard, this accommodation to the usual rule of parliamentary scrutiny is rendered largely symbolic by the ability for the Governor-General to extend the declaration for unlimited 3-month periods. These extensions are also not disallowable.

One of the most significant deviations from the principle of parliamentary scrutiny arose with the proposed National Health Security (Amendment) Bill 2009, which provided a limited power to the Health Minister to suspend, by legislative instrument, the operation of primary legislation: in this case to suspend parts of the SSBA regulatory regime in Part 3 of the NHS Act. This power is conditioned on the Minister being satisfied 'after considering advice from [a semi-closed group of individuals] that there is a threat to one or more of... the health or safety; the economy; the environment... and that the making of the legislative instrument would help to reduce the threat and maintain adequate controls for the security of all security-sensitive biological agents.' While these instruments *were* disallowable, in practice there would be little meaningful opportunity for parliamentary scrutiny as the instruments came into effect on the day they were signed and they could operate retrospectively – a deviation from another principle of law-making.⁴⁴⁴ In both cases, the justification in the EM for these deviations was 'the *extreme* nature of a threat posed by an SSBA-related disease outbreak... [which warranted] an appropriate and immediate response to the challenge of safeguarding public health and safety in a [sic] emergency disease situation which presents unpredictable scenarios'.⁴⁴⁵

emergency requirement should be scientifically based and made in accordance with an assessment of the relevant biosecurity risks. If an emergency requirement was disallowed, this would severely affect the Commonwealth's ability to manage nationally significant biosecurity risks by implementing a fast and urgent response to the threat or harm posed to Australia's local industries, economy and the environment.' Explanatory Memorandum, Biosecurity Bill 2012 (Cth) 309.

⁴⁴² Biosecurity Bill 2012 (Cth) cl 473; as is an extension: cl 474.

⁴⁴³ Biosecurity Bill 2012 (Cth) cl 475(2). This exclusion of Parliament's oversight was a source of parliamentary consternation during COVID-19.

⁴⁴⁴ The provisions are now set out in Division 5A of the *National Health Security Act 2007* (Cth).

⁴⁴⁵ Emphasis added. The Minister provided a further example in response to a request for further information from the Senate Standing Committee for the Scrutiny of Bills that centred on how the power could be used to improve a response to pandemic: 'For example, if the pandemic (H1N1) 2009 had been caused by an SSBA, I may have suspended the requirement for laboratories undertaking testing for the virus from reporting to the National Register on the transfer of samples Such a decision would have taken away an onerous

The debate on the National Health Security (Amendment) Bill 2009 included one of the only spoken reflections on the importance of parliamentary scrutiny. During debate, then Opposition Health spokesperson Peter Dutton MP noted that the Bill ‘does raise some concern about parliamentary oversight of decisions that could be critical not just to the situation unfolding but to the nation as a whole.’⁴⁴⁶

Normative principles: medico-bioethical, public health values and academic freedom

In common with many Australian laws, most of the Bills reviewed do not explicitly enunciate normative principles, whether bioethical or otherwise. Likewise, recognition of or deviation from medico-bioethical and public health principles in the Bills was usually tacit. Two notable contrasts were the Biosecurity Bills, which included explicit lists of ‘principles’ that aimed ‘to ensure that [powers are] exercised only if exercising the power is likely to be effective in, or to contribute to, achieving the purpose for which the power is to be exercised, is appropriate and adapted for its purpose, and is no more restrictive or intrusive than is required.’⁴⁴⁷ In a section titled ‘general protections’ a series of ‘principles affecting decision-making’ were specified. A person (eg, a Human Biosecurity Officer – ‘HBO’ – or DirHB) had to be ‘satisfied’ of all the following before exercising most powers to manage biosecurity risk to human health:

- (a) that exercising the power, or imposing the biosecurity measure, is likely to be effective in, or to contribute to, managing the risk;
- (b) that exercising the power, or imposing the biosecurity measure, is appropriate and adapted to manage the risk;
- (c) that the circumstances are sufficiently serious to justify exercising the power, or imposing the biosecurity measure;
- (d) that the power, or the biosecurity measure, is no more restrictive or intrusive than is required in the circumstances;
- (e) that the manner in which the power is to be exercised, or the biosecurity measure is to be imposed, is no more restrictive or intrusive than is required in the circumstances;

administrative burden which might otherwise have impeded their ability to undertake essential laboratory testing during the pandemic.’ Senate Standing Committee for the Scrutiny of Bills, *Tenth Report of 2009* (9 September 2009) 396-397.

⁴⁴⁶ Commonwealth, *Parliamentary Debates*, House of Representatives, 9 September 2009, 9187-9188 (Peter Dutton MP). See results below on the general nature of Parliamentary debate.

⁴⁴⁷ Biosecurity Bill 2012 (Cth) cl 30. These principles did not apply to the use of certain emergency powers.

- (f) if the power is to be exercised or the biosecurity measure imposed during a period—that the period is only as long as is necessary.⁴⁴⁸

In addition, ‘the exercise of a power, or the imposition of a biosecurity measure...[could] not interfere with any urgent or life-threatening medical needs of the individual’,⁴⁴⁹ prioritising the wellbeing of the individual over the threat to the referent objects identified by the Bill. This restriction and the other principles do not apply to the Minister’s emergency powers.

The regime for imposing orders under the Biosecurity Bills had several other safeguards – ‘medico-bioethical’ and ‘procedural’. As an example of the former, only officers with appropriate medical and clinical experience (eg, cHBOs and HBOs) could impose the medical biosecurity measures, such as vaccination requirements, examination and body sampling requirements, and isolation measures.⁴⁵⁰ These measures had to be carried out ‘in a manner consistent with’ ‘appropriate medical standards’ and/or other ‘relevant professional standards.’⁴⁵¹ Not only were these new legislative provisions consistent with important biomedical principles, they also represented a significant improvement on the previous regime that empowered non-medically trained staff to require and possibly administer vaccination and other prophylactic treatments.⁴⁵²

An additional safeguard, drawing on medico-bioethical and procedural fairness principles, is the individualised nature of an order. This requires an officer to consider each individual’s circumstances before imposing an order and prevents the mass use of orders. This individualised decision requirement is common in public health laws,⁴⁵³ and its perceived breach has been the focus of legal challenges to COVID-19 pandemic measures in Australia, New Zealand and the UK.⁴⁵⁴

⁴⁴⁸ Biosecurity Bill 2012 (Cth) cl 33(2).

⁴⁴⁹ Biosecurity Bill 2012 (Cth) cl 34.

⁴⁵⁰ For example, Biosecurity Bill 2012 (Cth) cl s 80, 92.

⁴⁵¹ Biosecurity Bill 2012 (Cth) cl 92. Further compliance with bioethical principles (in this case ‘justice’) is the requirement for the Commonwealth to pay for all reasonable expenses incurred by an individual in complying with a biosecurity measure included in an order (cl 106).

⁴⁵² Alexandra L Phelan, ‘Human Rights and Infectious Disease: Articulating Protections under the International Health Regulations’ in *The Fragmentation of International Law and Infectious Diseases: Opportunities and Challenges for Global Health Leadership* (SJD Thesis, Georgetown University, 2019), 107-118.

⁴⁵³ Examples: *Public Health Act 1997* (ACT) s 113; *Public Health Act 2010* (NSW) s 62; *Public Health and Wellbeing Act 2008* (Vic) s 190(1)(j); *Health Act 1956* (NZ) s92I. The Queensland *Public Health Act 2005* goes further in requiring a magistrate to issue a ‘detention’, ‘behaviour’ or ‘examination’ order against an individual (Part 5).

⁴⁵⁴ For example, the plaintiff in *Borrowdale v Director-General of Health* [2020] NZHC 2090 (Borrowdale) challenged the lawfulness of New Zealand’s lockdown on the basis, inter alia, that the relevant provision of the *Health Act 1956* (NZ) did not authorise the Director-General to order the entire population into isolation. This

Recognition of the bioethical principle of ‘autonomy’ is reflected in the way the Biosecurity Bill 2012 deals with consent. For example, the use of force is not authorised to require compliance with a biosecurity measure (except to detain a person who fails to comply with an isolation measure). Likewise, while an officer may impose an order on an individual, the order itself, does not compel compliance with all the biosecurity measures contained within it. Rather an ‘individual *may* consent to the measure[s]’ (emphasis added).⁴⁵⁵ To ‘require compliance’ with a measure, the cHBO, HBO or biosecurity officer must request the DirHB (ie, the national Chief Medical Officer) to direct the individual to comply with the measure.⁴⁵⁶ Failure to comply with a measure once directed is a criminal offence, punishable by a fine of 300 penalty units (\$60,000) or up to five years imprisonment.⁴⁵⁷ Thus, the requirement under the Bill for the officer imposing the order to notify the DirHB as soon as reasonably practicable after imposing the order is not merely for record keeping or monitoring purposes, but is a key step in the process of compelling compliance.⁴⁵⁸

As a *de facto* ‘internal review’ mechanism for decisions to impose a biosecurity measure, this provision arguably serves as an additional safeguard and, because the DirHB must have medical qualifications, is consistent with medico-bioethical principles of clinical independence and deference to medical-expertise (or respect for the health practitioner-‘patient’ relationship). This latter principle is most clearly reflected in one of the few limitations on the exceptionally broad powers given to the Minister under Chapter 8’s emergency provisions, which did not authorise the Minister to impose a biosecurity measure on an individual.⁴⁵⁹

Deference to experts was a common principle recognised and, to varying extents, embedded in the Bills. Where this deference was to medical experts it is considered further a ‘medico-bioethical’ or ‘public health’ value; where it is to other experts as well, it is considered a principle of ‘regulatory’ design. However, embedding this principle often came with a critical

was rejected by the High Court at [119] and upheld on appeal by the Court of Appeal in 2021: *Borrowdale v Director-General of Health* [2021] NZCA 520, [145]-[146], [163]. *Borrowdale* was cited with approval in a similar case in Victoria: *Loiello v Giles* [2020] VSC 722 per Ginnane J at [125]. For a similar result see *Dolan & Ors v Secretary of State for Health And Social Care & Anor* [2020] EWHC 1786 (Admin) per Lewis J at [37]. A similar objection was raised in a challenge to Australia’s COVID-19 departure ban on citizens: *LibertyWorks Inc v Commonwealth of Australia* [2021] FCAFC 90.

⁴⁵⁵ Biosecurity Bill 2012 (Cth) cl 69(1). This consent should be recorded in writing on the order if practicable (cl 69(2)). See also cl 72(2), (4).

⁴⁵⁶ Biosecurity Bill 2012 (Cth) cl 69(3). The power of the DirHB to give a direction requiring compliance is at clause 70 and is subject to the DirHB conducting their own assessment of the necessity of the measure and any reasons the individual gives for not refusing to consent to the measure.

⁴⁵⁷ Biosecurity Bill 2012 (Cth) cl 105.

⁴⁵⁸ Biosecurity Bill 2012 (Cth) cl 65.

⁴⁵⁹ Biosecurity Bill 2012 (Cth) cl 475 (6).

caveat: we may defer to experts, but they will be *our* experts. This is most clear in the case of the SSBA list, the SSBA Standards and the DSGL. Section 33 of the NHS Act requires the Minister to ‘obtain *and have regard to* expert advice’ (emphasis added) from security and technical experts as well as the states and territories. Specifically, under section 33 the Minister:

- (1) ...must not include a biological agent, or a reportable quantity of a biological agent, in the List of Security-sensitive Biological Agents, or otherwise vary the list, unless
 - (a) the Minister has obtained advice from:
 - (i) an agency or instrumentality of the Commonwealth *that has responsibility for obtaining and assessing information about the risks and threats posed by biological agents that may be of security concern to Australia; and*
 - (ii) persons with scientific or technical knowledge of biological agents that may be of security concern to Australia; and....
 - (b) the Minister has sought advice from the States, the Australian Capital Territory and the Northern Territory.

Importantly, the Minister must go beyond merely obtaining advice or consulting with experts and the jurisdictions, they must also ‘have regard to’ that advice (ss 33(3)).⁴⁶⁰ But the scientific and technical experts referred to in subparagraph 33(1)(a)(ii) do not need to be independent of the Government or even the intelligence community: subsection 33(2) allows for the possibility that these experts ‘may be officers or employees of an agency or instrumentality of the Commonwealth referred to in subparagraph (1)(a)(i). As such, it is probable that advice will be drawn from a specific ‘epistemic community’ – whose members align around similar principles and norms. Indeed, seeking advice from a ‘trusted community’ appears to have been the case with the most recent review of the SSBA list, which ultimately resulted in the removal of two biological agents (described in Appendix 6). Likewise, there is no requirement in the DTCA for the Defence Minister to engage widely prior to listing technology under the DSGL.⁴⁶¹ Nor does the Act that empowers the making of the DSGL require any specific form of consultation.⁴⁶² Rather, as described in the case of the most recent

⁴⁶⁰ Compare with the lower threshold applying to the Minister’s when making or varying the National Notifiable Disease List, where the basis for inclusion is if the ‘Minister considers’ *x* and requires the Minister to ‘consult’ with the CMO and the jurisdictions; but does not require the Minister to ‘have regard to’ advice received: *National Health Security Act 2007* (Cth) s 11.

⁴⁶¹ One of the functions of the Steering Group was to ‘advise the Department in relation to obtaining appropriate technical and scientific expertise regarding Australian Government consideration of the control lists of international regimes and of the [DSGL]’: *Defence Trade Controls Act 2012* (Cth) s 74A(4). The author is unaware of any specific actions taken in response to the advice provided (if any was provided).

⁴⁶² *Customs Act 1901* (Cth) s 112(2A)(aa).

update to the DSG (and interrogated further in Chapter 5), consultation is primarily between the Department of Defence and ‘other participating states of the export control regimes.’ Defence will formulate its own position on each proposal, seeking to ‘strike an appropriate balance between national and global security and the impact on Australian industry and researchers.’⁴⁶³ The discretion afforded to Ministers (in practice, their Departments) in both of these cases points to a means by which the securitization of disease research can become institutionalised over time, with strong, closed, epistemic communities forming around key regulatory decision making processes.

The principle of academic freedom was strongly engaged in the DTC Bill and is examined in Chapter 5. To a lesser extent, the SSBA regime also limited the principle of academic freedom. The establishment of an ‘legitimate purpose’ test (and its application to research) took control from universities and individual researchers and their informal peer-review networks and placed final decision-making in the hands of a (non-expert) government official. Likewise, the SSBA Standards impose a range of controls over research activities, facilities and individuals. The controls over individuals have only tightened over time, with strengthened background checks required after passage of the 2010 amendment Bill.⁴⁶⁴

In contrast to the DTC Bill, elements of the SSBA regime made overt gestures towards the value of allowing freedom for medical and scientific researchers, even if the regime ultimately broke that principle. For example, the regime authorised research on SSBA to ‘better understand a disease it causes’ or ‘scientific or medical work in relation to the applications of the toxin (for example, in treating cancer or, in the case of Botox (botulinum toxin), for medical or cosmetic use).’⁴⁶⁵ Nonetheless, the debates on the DTC Bill and the NHS Bill (and amendments) reflected an increasing security interest in *who* was undertaking research in Australia’s universities, rather than just *what* they were learning.⁴⁶⁶

Principles of international and domestic comity

Many of the Bills analysed refer to or incorporate international treaties directly. This was most explicit in Part 2 of the NHS Bill and, to a lesser extent, the Biosecurity Bills. Likewise,

⁴⁶³ Explanatory Statement, Defence and Strategic Goods List 2021

<<https://www.legislation.gov.au/Details/F2021L01198/Explanatory%20Statement/Text>>.

⁴⁶⁴ Compare the length and requirements in the 2008 edition of the *SSBA Standards* with the current, 2013 edition.

⁴⁶⁵ Biosecurity Bill 2012 (Cth) cl 41(1)(a)(ii), (b).

⁴⁶⁶ See, for example the comments of Peter Dutton in: Commonwealth, *Parliamentary Debates*, House of Representatives, 9 October 2012, 11710 (Peter Dutton MP).

Ministers and Members of Opposition positioned this incorporation of international rules into domestic biosecurity laws as representing something about how Australia behaves: as ‘a good global citizen’.

Attempts to satisfy the good global citizen principle are apparent in the manner the NHS Bill implements the requirements of the IHR 2005. In addition to the explicit reference to IHR 2005 at clause 6(c), the Bill adopts and embeds language and concepts from the IHR. Two legislative ‘notes’ to the Bill’s definition of ‘urgent events’ refer the reader to question ‘I of Annex 2 of the IHR’ for examples of ‘events that might have a serious impact on public health.’ Another note on how the Minister can use ‘protected information’ mentions Public Health Emergency of International Concern and lists three specific articles from the IHR. Another note directs readers to ‘question II of Annex 2 of the IHR’ for examples of ‘events that are unusual or unexpected.’⁴⁶⁷

As Table 13 below shows, further alignment with the IHR was achieved through shared definitions, or definitions that were incorporated *mutatis mutandis* for a domestic context. Similarities have been underlined.⁴⁶⁸

Term	Definition in the National Security Act (Cth) 2007 ⁴⁶⁹	Definition in the International Health Regulations
Disease	<u>means an illness or medical condition (other than an injury), irrespective of origin or source, that presents or could present significant harm to humans.</u>	<u>means an illness or medical condition, irrespective of origin or source, that presents or could present significant harm to humans</u>
Event	for the purposes of Part 2 [of the Act], means: (a) an occurrence of disease, injury or death; or (b) an occurrence, including the release of a chemical, biological or radiological agent, <u>that creates the potential for disease, injury or death.</u>	means a manifestation of disease or an <u>occurrence that creates a potential for disease</u>
Public health risk	means an event: (a) that might <u>adversely affect the health of human populations</u> ; and (b) that satisfies any one or more of the following conditions: (i) the health effects of the event might spread within Australia; (ii) the health effects of the event might <u>spread between Australia and another country</u> ; (iii) the health effects of the event might spread between 2 other countries;	means a likelihood of an event that may <u>affect adversely the health of human populations</u> , with an emphasis on one which may <u>spread internationally</u> or may <u>present a serious and direct danger.</u>

⁴⁶⁷ *National Health Security Act 2007* (Cth), s 3(1).

⁴⁶⁸ This harmonisation was (and is) intended to be ongoing and to pick up the IHR ‘as in force from time to time’: Explanatory Memorandum, *National Health Security Bill 2007* (Cth) 3-4.

⁴⁶⁹ *National Health Security Act 2007* (Cth) s 3(1).

	(iv) the event might <u>present a serious and direct danger</u> .	
Public health observation	<u>means the monitoring of the health of a person for the purposes of determining the risk of transmission of a disease.</u>	<u>means the monitoring of the health status of a traveller over time for the purpose of determining the risk of disease transmission.</u>
Urgent event	means an event: (a) that causes, or creates the potential for, levels of disease, injury or death above the levels that would otherwise be expected <u>for the time and place where the event occurs</u> ; and (b) in respect of which any of the following applies: (i) the event has or might have a <u>serious</u> impact on public health; (ii) in the case of a disease—the event is <u>unusual or unexpected</u> , and has a high potential to <u>spread</u> (whether within Australia or between Australia and another country); (iii) otherwise—the event is <u>unusual or unexpected</u> , and the health effects of the event have a high potential to spread (whether within Australia or between Australia and another country).	Drawn from the ‘decision instrument’ in Annex 2. See extracted questions. “Is the number of cases and/or number of deaths for this type of event large <u>for the given place, time or population</u> ?” “Is the public health impact of the event <u>serious</u> ?” “Is the event <u>unusual or unexpected</u> ?” “Is there a significant risk of international <u>spread</u> ?”

Table 13: Overlap between the NHS Act 2007 and IHR 2005

The implementation of the IHR into the human biosecurity provisions in the Biosecurity Bill 2012 is less extensive and explicit.⁴⁷⁰ It is, however, potentially more impactful on individuals. For example, a bodily sample voluntarily or involuntarily obtained under a human biosecurity control order can ‘at the request of the World Health Organization’ be provided to ‘the Organization for the purposes of detecting, assessing or responding to a listed human disease.’⁴⁷¹ Likewise, a basis on which the Health Minister can exercise their emergency powers under Chapter 8 includes giving effect to a ‘recommendation of the [WHO]’ under Part III of the IHR.⁴⁷² Combined with the health data sharing provisions under the NHS Bill, the two Bills integrate the bodies of Australian’s into a global framework for disease detection and response in a significant manner. As Phelan has noted, the implementation of the IHR into Australian law via the NHS Act and the *Biosecurity Act 2015* (Cth), did not necessarily import the full measure of human rights protections that form a fundamental pillar of the IHR.⁴⁷³

⁴⁷⁰ An example of faithfulness in IHR implementation in the Biosecurity Bill 2012 (Cth) is the requirement in clause 257(3) for a prescribed ‘scheme in relation to ship sanitation’ to ‘be appropriate and adapted to give effect to Australia’s rights and obligations in relation to ship sanitation under the International Health Regulations.’

⁴⁷¹ Biosecurity Bill 2012 (Cth) cl 89(4).

⁴⁷² Biosecurity Bill 2012 (Cth) cl 475(1)(c).

⁴⁷³ Phelan, above n 452.

The source of Australia's international 'obligations' is less explicit in the establishment of the SSBA regime under Part 3 of the NHS Bill. References throughout Part 3 to the *Crimes (Biological Weapons) Act 1976* (Cth) imply that these obligations arise from the BWC.⁴⁷⁴ However, as discussed further in this Chapter and Chapter 5, while the BWC serves an important normative role, other international and domestic factors and events drove the development of the SSBA regime – most directly the CoAG review. Unlike several definitions used in Part 2, key terms in Part 3 such as 'legitimate purpose' appear to be creations of domestic policy. As such, while the Bill clearly signals in its 'Objects clause' its intention to comply with the good global citizen principle by 'giving effect to Australia's obligations to establish controls for the security of certain biological agents that could be used as weapons' the scope of the regulatory regime imposed, the nature of the SSBA list and listing process, and the wider threats identified by the Minister suggest that other objects were being pursued.

Finally, while parts of the DTC Bill are explicit in their international ambitions – ie, to implement the Defense Trade Cooperation Treaty - the provisions which caused most concern for the research sector pointed to no explicit international treaties or obligations. Indeed, this disconnect may have spurred lobbying by the academic sector for more transparency on the 'international regimes' that underpin the creation and amendment of the Defence and Strategic Goods List (DSGL) that sits at the heart of the DTCA.⁴⁷⁵

Reference to Australia's good global citizen obligations featured in SRS delivered in the context of the NHS Bills. Introducing the NHS Bill in 2007, Health Minister Abbott, stated that the Bill 'addresses... Australia's treaty commitments' and 'authorises government to meet international obligations....'⁴⁷⁶ Similar sentiments are echoed in the second reading debate speech given by then Opposition Health spokesperson Nicola Roxon MP – who became the new Health Minister following the 2007 federal election later that year.⁴⁷⁷ In the debates over amendments to the NHS Act in 2009, 2010 and 2012 it was notable that Ministers usually emphasised international obligations (either IHR or non-proliferation) and generalised 'emerging health and security threats', while other members of Parliament focused on the threat of specific diseases.

⁴⁷⁴ For example, National Health Security Bill 2007 (Cth), cl 47(3)(b).

⁴⁷⁵ Defence Trade Controls Bill 2011 (Cth) cl 74A(4).

⁴⁷⁶ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing).

⁴⁷⁷ Commonwealth, *Parliamentary Debates*, House of Representatives, 20 September 2007, 19 (Nicola Roxon MP).

A focus on international obligations also featured in the debate over the Quarantine Amendment (National Health Security) Bill 2008, which Minister Roxon stated implemented ‘Australia’s international obligations relating to public health security – obligations of course that this government takes extremely seriously.’ As a companion Bill in many respects to Part 2 of the NHS Act, Roxon summarised its purpose as ‘ensuring that we deliver on both our international commitments as well as the national imperative to actively improve our capacity to respond to public health risks.’⁴⁷⁸

International obligations and Australia’s obligations to its ally, the United States, featured in the initial SRS for the DTC Bill.⁴⁷⁹ By the end of the parliamentary debate over the Bill (and following significant resistance from the academic sector), focus had also widened to include Australia’s wider obligations under other arms-controls regimes (see also discussion in Chapter 5). On the need to discharge Australia’s obligation to the United States, Opposition Defence spokesperson, Senator David Johnson, stated that the Liberal Party’s ‘first concern in dealing with this aspect of the Bill [related to the Defence Trade Cooperation Treaty] is to see that it achieves its purpose.’ This Treaty was described as ‘a very important treaty and something that the parliament should be proud of and work towards.’ Turning to the second part of the Bill, the Senator focused on the Wassenaar Arrangement and reflected that the Arrangement is a ‘very serious piece of international public policy.’ Substituting the collectivising term ‘our’ for ‘Australia’, he solemnly declared that ‘[o]ur participation in this [arms control regime] comes with considerable responsibility and indeed we need to conduct ourselves in an exemplary way in adhering to the provisions and in going forward.’⁴⁸⁰

Many of the Bills reflected efforts to comply and faithfully fulfil Australia’s international obligations.⁴⁸¹ As shown in the debate over the DTC Bill, Australia did not just want to follow international law, it wanted to conduct itself as an ‘exemplar’ – as a good global citizen. For a more mixed attempt to act as a good global citizen see Chapter 6. Ultimately, what emerges from the parliamentary debates is how securitizing speech can operate on multiple levels, with threats explicit (eg, in the title of a Bill) or implicit. Formal speech acts, such as SRS contain

⁴⁷⁸ Commonwealth, *Parliamentary Debates*, House of Representatives, 19 March 2008, 2203 (Nicola Roxon, Minister for Health and Aging).

⁴⁷⁹ For example: Commonwealth, *Parliamentary Debates*, House of Representatives, 2 November 2011, 12434 (Jason Clare, Minister for Defence Materiel).

⁴⁸⁰ Commonwealth, *Parliamentary Debates*, Senate, 29 October 2012, 8115 (Senator David Johnson).

⁴⁸¹ This is not to suggest that securitization has not occurred, merely that it is not present on the face of Part 2 of the Bill or in the debate that surrounded it. If securitizing moves had occurred, they may have occurred elsewhere, for example the WHO or UNSC: see discussion in Chapter 2 and Davies, Kamradt-Scott and Rushton, above n 26.

elements of securitizing rhetoric, such as threat and referent object identification, but this appears to be largely drafted by public servants, sitting outside the chamber. On occasions, the threats identified in the SRS, other extrinsic material and other speeches only partially aligned with the formal content of the Bills being debate. As the most prominent example, and despite the reference to ‘national’ in the title of the *National Health Security Bill*, the focus of the text in Part 2 of the NHS Bill was on harmonising Australia’s disease surveillance arrangements with a global health security regime established under the IHR.⁴⁸² All of the objectives listed in section 6 of the Bill were intended to support the Commonwealth and states and territories ‘give effect’ to the IHR. The bulk of supporting material and the Ministers SRS focused on these elements, rather than the SSBA regime established in Part 3. If the Bill’s title was intended to serve as part of a domestic-focused securitizing rhetorical, it only partially aligned with the Bill’s actual content. However, as identified above, the speeches and parliamentary debates (to the extent there were debates) focused on domestic implications of the laws and the threats to domestic referent objects (as opposed to international objects such as ‘global health’). Similar priority for domestic referent objects was evident in the two Biosecurity Bills.

Domestic comity and respect for federalism

Even more than a desire to be a good global citizen, many of the Bills reflected an effort to maintain the inter-governmental compact between the Commonwealth and states and territories over the management of public health. This manifested in the deference each level of government gives to the other to operate in its constitutional ‘sphere’. The division between federal and state constitutional competencies is strongest in public health – where the Commonwealth lacks an explicit constitution power beyond ‘quarantine’. However, even in exercising its quarantine powers, Commonwealth law provides that consistent state and territory legislation can (in general) operate alongside the *Quarantine Act 1908* (Cth) and *Biosecurity Act 2015* (Cth).⁴⁸³

The NHS Bills clearly demonstrated a regard to respecting jurisdictional boundaries, for instance in sections dealing with the sharing of information between the states and territories and the Commonwealth. As the Minister commented, the Bill ‘has been drafted to “authorise” rather than “compel” the exchange of information [between jurisdictions]. This approach

⁴⁸² Indeed, this was repeatedly stated as one of the reasons for developing the legislation: Explanatory Memorandum, *National Health Security Bill 2007* (Cth) 3, 4.

⁴⁸³ Concurrent operation of Commonwealth and state and territory law is implied in section 2A of the *Quarantine Act 1908* (Cth) [repealed] and explicit in *Biosecurity Bill 2012* (Cth) cl 8 (now section 8 of the *Biosecurity Act 2015* (Cth)).

reflects existing cooperative arrangements.’⁴⁸⁴ Similar ‘cooperative arrangements’ are entrenched in the processes around the new National Notifiable Disease List (the List); for, in ‘making’ and ‘varying’ the List, the Minister ‘must consult...each State and Territory Health Minister’ (cl 11(5)(b)).⁴⁸⁵ Similar consultation requirements are specified for the designation of SSBA and the development of the SSBA Standards.⁴⁸⁶ Likewise, the development of ‘listed human diseases’ under the Biosecurity Bills required the DirHB to consult with ‘the chief health officer (however described) for each State and Territory’,⁴⁸⁷ and the Bill provides for a federated exercise of biosecurity powers (see discussion in Section 2).

Moreover, the powers and functions newly assumed by the Minister, Department of Health and Ageing (as it was then known) and CMO under the NHS Bill are constrained and inclined towards cooperation: ‘liaising’ (seven references in Part 2), ‘facilitating’ (three references), ‘consult’ (three positive references), ‘sharing’ (four references) and ‘give’ (four action references). And even these powers can only be used for ‘permissible purposes’, defined in clause 8 as including:

- (a) preventing, protecting against, controlling or responding to a public health event of national significance (other than an overseas mass casualty);
- (b) giving effect to the International Health Regulations (other than as mentioned in paragraph (a))....

A further example of the inter-governmental compact principle are the provisions authorising the Minister of Health to establish the (non-legally binding) *National Health Security Agreement* with the states and territories. Indeed, the inclusion of the Agreement in the Bill appears to be an effort to embed and strengthen the inter-governmental compact principle, rather than to depart from it. This intention is explicitly articulated the Bill: it refers to the Agreement being used to ‘formalise and enhance consultation between the Commonwealth and States and Territories...’.⁴⁸⁸ The inclusion of a specific power (albeit a discretionary one) for the Minister to enter into an Agreement with the states and territories

⁴⁸⁴ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing).

⁴⁸⁵ Section 12 of the NHS Act provides a unilateral power to the Minister or Commonwealth Chief Medical Officer to temporarily vary the list in limited circumstances. However, this variation lapses after six months unless the Minister then consults appropriately.

⁴⁸⁶ National Health Security Bill 2007 (Cth) cl 33(1)(b), 35(4)(b).

⁴⁸⁷ Biosecurity Bill 2012 (Cth) cl 41(2)(a).

⁴⁸⁸ National Health Security Bill 2007 (Cth) cl 7(1)(b).

elevates and entrenches the principle as a ‘rule’ (to adopt the terminology used by Braithwaite and Drahos).

Limits to domestic comity

Nonetheless, behind these attempts to support domestic comity, is a claim of right for the Australian Parliament and Government to resume or assume leadership in policy areas that affect the ‘health of the nation’. In his opening speech, Minister Abbott emphasises that the NHS Bill ‘delivers on the [Commonwealth’s] government’s ongoing commitment to enhance Australia’s capability to protect the health of the nation...’ In claiming that ‘Australia’ needs to ‘do more’ – in the context of justifying Part 2 of the Bill – he speaks in terms of ‘we’, the ‘we’ ambiguously referring to either Australia the nation or the Australian Parliament (or both).

As discussed above, this principle to act to fill a legislative vacuum (as identified by the Commonwealth) featured strongly in justifying Part 3 of the NHS Bill and the SSBA regime, which was framed as the federal Parliament stepping in to ‘address’ a risk by introducing ‘nationally consistent legislation...’,⁴⁸⁹ implicitly critiquing a failure by the states and territories to appropriately ‘protect the health of the nation’.

Audience acceptance and mechanisms and parliamentary tactics to overcome resistance

This concluding section looks at some of the mechanisms and parliamentary tactics present in the parliamentary debate on the Bills. These included appeals to urgency and invocation of bipartisanship. A common and surprising feature with all Bills assessed, except for the later stages of the DTC Bill 2011, was the limited ‘debate’ over the moves by the government of the day to introduce significant biosecurity powers.

Appeals to urgency and limitations on debate (imposed or agreed)

As discussed above, verbal invocation of urgency featured in many SRS, in particular around ‘threats’. It also manifested in the opportunity provided for parliamentary debate. For instance, and notwithstanding the significance of the reforms in the NHS Bill, it received no significant parliamentary debate and was not referred to a committee in the House of Representatives (‘House’) or Senate for review. The Bill was introduced to the House on the 13th of September 2007, when the Minister delivered his SRS. Debate resumed the following

⁴⁸⁹ Commonwealth, *Parliamentary Debates*, House of Representatives, 13 September 2007, 3 (Tony Abbott, Minister for Health and Ageing).

week when the Opposition's Health spokesperson delivered their own speech.⁴⁹⁰ These two speeches constituted the entire debate in the House and – as identical speeches were tabled in the Senate – that chamber too.⁴⁹¹

Following Roxon's speech, the 'Third Reading' (ie, final vote) was moved immediately by Minister Abbott and the House passed the Bill 'on the voices' (ie, without a division). The Senate debate was more perfunctory, with the Bill formally introduced for 'debate' alongside a revised EM to an unrelated piece of social security legislation.⁴⁹² Constituting his entire contribution to the Senate debate, the Parliamentary Secretary to the Minister for Health and Ageing stated: 'I simply commend the National Health Security Bill 2007 to the Senate.'⁴⁹³ The Bill passed on the voices and, after a total of no more than 30 minutes of parliamentary debate across both chambers, Parliament's legislative role was complete.⁴⁹⁴ The Bills Digest, prepared by the Parliamentary Library to assist Parliamentarians, had noted dryly: 'To date, there has been no significant public commentary on the measures contained in the Bill. The legislative timeframe has not invited this.'⁴⁹⁵ Parliament did not add much to this limited commentary.

There are several possible reasons for the short debate. First, it could be argued that the content of the Bill was possibly uncontested and did not warrant scrutiny. This seems unlikely. Labor (then in opposition) was not happy about the speed with which the Bill was being progressed. In her speech, Roxon remarked:

...we are a tad frustrated that, *yet again*, Labor have been *given a very short time frame* for consideration of this Bill. We first sighted the Bill just last Thursday, when it was introduced into the parliament, and here *it is being rushed through the House only a week later*. ...I am wondering *why legislation of such importance is being pushed through here at such a rapid pace*. Nevertheless, Labor support the Bill... (emphasis added).⁴⁹⁶

⁴⁹⁰ Commonwealth, *Parliamentary Debates*, House of Representatives, 20 September 2007, 19 (Nicola Roxon).

⁴⁹¹ Commonwealth, *Parliamentary Debates*, Senate, 20 September 2007, 57 (Senator David Johnson, Minister for Justice and Customs); Commonwealth, *Parliamentary Debates*, Senate, 20 September 2007, 185 (Senator Jan McLucas).

⁴⁹² Commonwealth, *Parliamentary Debates*, Senate, 20 September 2007, 57 (Senator David Johnson, Minister for Justice and Customs).

⁴⁹³ Commonwealth, *Parliamentary Debates*, Senate, 20 September 2007, 189 (Senator Brett Mason, Parliamentary Secretary to the Minister for Health and Ageing).

⁴⁹⁴ The Bill received Royal Assent on 28 September 2007 and its commencement was phased over 18 months.

⁴⁹⁵ Buckmaster, Thomas and O'Neill, above n 312.

⁴⁹⁶ Commonwealth, *Parliamentary Debates*, House of Representatives, 20 September 2007, 19 (Nicola Roxon).

Why then would they still support the Bill then? One reason was that there would be further private briefings on the Bill. Although Roxon comments that it was ‘unclear what format a national health security agreement will take’, she alludes to receiving a future briefing from government officials: ‘I would welcome clarification from the Minister or departmental staff on this issue.’ In his concluding reply, Abbott promises ‘that the additional briefings that have been requested by the shadow minister will be provided as quickly as possible.’⁴⁹⁷ A second reason may have been that the regulatory regimes under the Act would come into effect over time – providing opportunity for future parliamentary scrutiny (eg, via usual accountability mechanisms).⁴⁹⁸ A third, and more pressing reason, is likely that a federal election was scheduled for later that year; indeed the House was dissolved less than four weeks later. Being aware that ‘this legislation has been in the pipeline for some time’, Labor may not have wanted to let the Bill lapse with the end of Parliament.

Of course, had it been considered a necessary or urgent reform, an incoming government could have simply ‘restored’ the Bill to the Notice Paper after the election and enacted the Bill then. And, if the Bill had been considered controversial and an affront to ‘rules that bind’, an Opposition might have wanted to obstruct the passage of the Bill to generate public support. That it passed the Bill might suggest the Bill was perceived as an ordinary and non-controversial measure – rather than an instrument of securitization. Finally, in 2007, the Coalition Government had a historically rare majority in both the Senate and Parliament and could have passed the Bill over Labor’s objections.

Nonetheless, the Coalition did not use its numbers to cut short (‘guillotine’) parliamentary debate and no Labor backbenchers took the opportunity to speak on or against the Bill. This suggests political arithmetic did not play a dominant role. Rather, the author suggests that Labor’s support for the Bill was consistent with its practice since 2001 to support every piece of ‘national security’ legislation put forward by the Liberal-National Party (in power 1996-2007, and again from 2013-2022).⁴⁹⁹ As a successfully securitized subject, legislation relating to terrorism has seen Labor move ‘in complete lockstep’ with the Liberal-

⁴⁹⁷ Commonwealth, *Parliamentary Debates*, House of Representatives, 20 September 2007, 23 (Tony Abbott, Minister for Health and Ageing).

⁴⁹⁸ Section 2 of the Act provided that Part 2 would commence within 6 months of enactment and Part 3 would commence within 18 months; Explanatory Memorandum, National Health Security Bill 2007 (Cth), 2-3.

⁴⁹⁹ This has been to the disquiet of some academics and civil society generally: see, eg: Jack Waterford, ‘Trust Labor on National Security? Sure can’t’, *The Canberra Times* (online), 9 June 2018 <<https://www.smh.com.au/politics/federal/trust-labor-on-national-security-sure-can-t-20180608-p4zkc4.html>>; George Williams, ‘Legal Legacy of the War on Terror’ (2013) 12 *Macquarie Law Journal* 11, 26.

National Party resulting in a period of national security ‘hyper-legislation’.⁵⁰⁰ The eve of an election was not the time to open the Party to accusations of being ‘soft’ on national security. Although not specifically an anti-terrorism law, the very title of the *National Health Security Bill* summoned an association with this topic and, as if to make it explicit, the Minister’s SRS and the EM invoked the 2002 Bali bombings terrorist attacks. Furthermore, any Parliamentarian who read the Bills Digest on the NHS Bill would have been reminded about ‘terrorist attacks and anthrax incidents in the US in recent years.’⁵⁰¹ Hence, Roxon’s criticism over the Bill is directed not to the substance of the Bill but rather procedural issues.⁵⁰²

The debate over the NHS Bill points to the role of multiple audiences in securitizing moves. As a parliamentary Party, Labor MPs represented a formal and authorising audience; however, using the words ‘national’ and ‘security’ in the title of the Bill, could be seen as directed to a wider, public audience of voters.

Similar complaints over rushed legislation arose in Senator David Johnson’s remarks on the DTC Bill, which he called ‘a damning indictment of the way in which this government does business. This is incompetence on steroids’.⁵⁰³ The Senator’s Party still supported the Bill, with Johnson stating that ‘we [the Opposition] must fall on the side of the Government’s intent to control much of this material, its transmission and its trade.’⁵⁰⁴ In a different instance of incomplete review, the Senate Standing Committee on the Scrutiny of Bills was forced to issue its report raising questions about the human biosecurity provisions of the Biosecurity Bill 2014 *after* the Bill had already passed the Senate.

Appeals to bipartisanship

Bipartisanship features strongly in the parliamentary debates over the Bills examined. As discussed above, parliamentary debate over the initial NHS Bill was brief but still afforded time for the Opposition Health spokesperson to state that her Party supported the Bill: ‘Labor believe the purposes outlined are important and worthy of our support.’⁵⁰⁵ While more MPs sought to speak in the debates over subsequent amendment Bills, all speeches were supportive

⁵⁰⁰ Nicola McGarrity and Jessie Blackbourn, ‘Australia has enacted 82 anti-terror laws since 2001. But tough laws alone can’t eliminate terrorism’, *The Conversation* (online), 30 September 2019 <<https://theconversation.com/australia-has-enacted-82-anti-terror-laws-since-2001-but-tough-laws-alone-cant-eliminate-terrorism-123521>>; Williams, ‘A Decade of Australian Anti-Terror Laws’, above n 247.

⁵⁰¹ Buckmaster, Thomas and O’Neill, above n 312.

⁵⁰² Commonwealth, *Parliamentary Debates*, House of Representatives, 20 September 2007, 19 (Nicola Roxon).

⁵⁰³ Commonwealth, *Parliamentary Debates*, Senate, 29 October 2012, 8116 (Senator David Johnson).

⁵⁰⁴ *Ibid*, 8117.

⁵⁰⁵ Commonwealth, *Parliamentary Debates*, House of Representatives, 20 September 2007, 19 (Nicola Roxon).

of the Government's proposals: regardless of which Party was in power. Indeed, some Opposition MPs' comments suggested that the new Government was merely continuing the good work of the previous one. Speaking on the Labor Government's National Health Security Amendment (Background Checking) Bill 2009, Liberal Senator Fierravanti-Wells reminded the Senate:

The Bill before us today continues the reforms in this area made by the Coalition Government. The Coalition Government provided an investment in national health security capability in the 2004 Budget. *The Coalition action* strengthened national health security, preparedness and response capability in the event of a national health emergency or terrorist attack.⁵⁰⁶

Both the Senator and Liberal MP Peter Dutton highlighted that the original Bill was introduced by then Health Minister Tony Abbott MP (who, by the time of the 2009 Bill's second reading debate was Leader of the Opposition).⁵⁰⁷ And, even though it was a Labor Government moving the DTC Bill, Coalition Senator's referred to the legislative work as putting 'flesh on the bones' of a 'John Howard–George Bush treaty' – John Howard, having been the Prime Minister of the previous Liberal Government.⁵⁰⁸

A bipartisan approach also extended to an acknowledgement that the government of the day must have all necessary means at its disposal to deal with biological threats. In outlining the basis for the Coalition's support for the 2009 amendments to the NHS Bill, Senator Cormann not only remarked that the NHS Act was 'an important part of Australia's national security framework' but also pointed to an imperative duty of a government to '... in the circumstances of a biological threat to Australian citizens or institutions...be able to use all means at its disposal to negate the threat.'⁵⁰⁹ Similar sentiments were expressed by then Shadow Health spokesperson Peter Dutton MP, who grounded the right of a government to use 'all means at its disposal' in 'common-sense'.⁵¹⁰

Even in cases where a Bill's passage was less smooth, bipartisanship emerged as a key feature, all but guaranteeing its passage. For example, in the debate over the DTC Bill, the

⁵⁰⁶ Commonwealth, *Parliamentary Debates*, Senate, 25 February 2010, 1198 (Senator Concetta Fierravanti-Wells) (emphasis added).

⁵⁰⁷ Ibid. Commonwealth, *Parliamentary Debates*, House of Representatives, 11 February 2010, 1165 (Peter Dutton MP).

⁵⁰⁸ Commonwealth, *Parliamentary Debates*, Senate, 29 October 2012, 8115 (Senator David Johnson).

⁵⁰⁹ Commonwealth, *Parliamentary Debates*, Senate, 9 September 2009, 9187 (Senator Mathias Cormann).

⁵¹⁰ Commonwealth, *Parliamentary Debates*, House of Representatives, 9 September 2009, 9187 (Peter Dutton MP).

major parties initially tied the Bill to the Australia-US Alliance, an alliance that neither Party had questioned in nearly 50 years.⁵¹¹ An Opposition Senator opened his speech on the DTC Bill by stating ‘from the outset... the Coalition Senators will be supporting this legislation.’ This was done to ‘put the government and its officers at their rest’.⁵¹² In accepting the Government’s argument that an amendment to the Bill made by the opposition in the Senate had to be removed, then Shadow Defence, Science, Technology and Personnel spokesperson, Robert Stuart MP stated:

The government has indicated to us in the strongest possible terms that our amendments will render the Bill ineffective. The government's reasoning on this has been largely unconvincing; however, there is a time when it is necessary to err on the side of caution. This is one such time, *given the serious subject matter* encompassed by this Bill and given the fact that *the minister knows that I take bipartisan support on military operations and military engagement seriously*.⁵¹³

Forum control

Bipartisanship and other efforts to shape and control the parliamentary debate emerged to varying degrees with the Bills. It is noteworthy, though, that many of the Bills that sought to amend and extend the SSBA regime were ‘debated’ in Parliament’s ‘Federation Chamber’ as opposed to the main chamber of the House. The Federation Chamber is an Australian innovation designed to ‘[operate] in parallel with the Chamber of the House to allow two streams of business to be debated concurrently.’⁵¹⁴ One function of the Federation Chamber is to debate ‘non-controversial’ Bills and the Chamber operates ‘on the principle of cooperation’.⁵¹⁵ As a Bill must be referred from the main Chamber of the House to the Federation Chamber, it can be assumed that the referral of Bills amending the NHS Act reflected a bipartisan approach to the Bill’s subject matter and a desire for the parliamentary

⁵¹¹ Gary Brown and Laura Rayner, *Upside, Downside: ANZUS After Fifty Years*, Current Issues Brief No 3 of 2001-2002, 28 August 2001. Questioning does occur once out of office: eg, Malcolm Fraser, *Dangerous Allies* (Melbourne University Press, 2014).

⁵¹² Commonwealth, *Parliamentary Debates*, Senate, 29 October 2012, 8116 (Senator David Johnson).

⁵¹³ Commonwealth, *Parliamentary Debates*, House of Representatives, 30 October 2011, 12598 (Stuart Robert). See also: Commonwealth, *Parliamentary Debates*, Senate, 29 October 2012, 8116 (Senator David Johnson) (emphasis added).

⁵¹⁴ Parliament of Australia, *The Federation Chamber (Infosheet 16)* (no date) <https://www.aph.gov.au/About_Parliament/House_of_Representatives/Powers_practice_and_procedure/00_-_Infosheets/Infosheet_16_-_The_Federation_Chamber>.

⁵¹⁵ House of Representatives Standing Committee on Procedure, Parliament of Australia, *The role and operation of the Federation Chamber* (2015) [3.1], [3.8].

debate to occur within an arena where bipartisanship (ie, ‘cooperation’) was an institutional norm.

Control over forums also reflects choices over which subject matter (and expertise and outside voices) to prioritise. For example, in addition to being introduced by the Minister for Agriculture, the Biosecurity Bill 2014 was referred to a Senate Committee with a special focus on agriculture, rather than health. Finally, as examined in Chapter 5, forum control can also be used by opponents of securitizing moves, and the debate over the DTC Bill and use and creation of new forums to challenge proposals and develop counter-proposals provides important insights.

4. Summary of findings in Chapter 4

This Chapter analysed legislation that sought to respond to various biosecurity threats and the parliamentary debates that surrounded their enactment. Following a traditional legal analysis of the Bills, the proposed legislation, extrinsic materials, and parliamentary debates were analysed against the theoretical framework outlined in Chapter 3. While this analysis found securitizing rhetoric, including threat identification and appeals to urgency, the most notable finding was the general absence of contestation between political parties. Bipartisanship was forthcoming (and appeals to it seemed unnecessary), parliamentary pathways intended to support bipartisan (eg, the Federation Chamber) were used frequently and the security rhetoric in SRS remained consistent across Governments of different ideological persuasions.

Other key findings from the Chapter are:

- Legislation could be identified within the relevant period (2001–2016) that engaged with all three biosecurity threats identified in the literature: bioterrorism, bio-error, proliferation of DURC and rapidly spreading infectious diseases.
- Despite their names suggesting a significant connection with these biosecurity threats, the 2012 and 2014 Biosecurity Bills were primarily focused on agricultural threats, with only limited involvement from the Department of Health in their drafting.
- A comparison of the parliamentary debate with the text of the Bills showed frequent mismatches in what the mover of the Bill (ie, the potential securitizing actor) identified as the relevant threats and referent object and what the text of the Bill identified or was written to address.
 - Further, speeches delivered by Ministers and other parliamentarians often focused on threats only tangentially related to the subject-matter of the Bill and focused on domestic referent objects.
- Second reading speeches (SRS) were the key method to deliver security rhetoric in Parliament, identifying threats and referent objects, and engaging in discursive practices to elevate the urgency or priority of an issue.
 - When Ministers delivered their SRS, they were engaging in the rhetoric of securitization (but see Chapter 5's introduction for caution on ascribing a securitizing intention to Ministers based solely on these utterances).

- Regulatory and legislative ‘gaps’ and ‘vacuums’ can be constructed as threats in and of themselves, justifying – as in the case of the SSBA regime and DTC Bill – federal intervention into domains traditionally within the responsibility of the states, territories, or non-government sector.
- In contrast to expectations from the literature, reference to threats in the debate was not used as a basis to justify ‘exceptional’ responses. On the contrary, actors usually couched their proposals as ‘proportionate’ or ‘reasonable’ measures – even if they represented a paradigm shift in how an activity – eg, research – was to be regulated.
- Bipartisanship extended to the explicit and implicit identification of key values and principles. Key principles included being a good global citizen, domestic comity between the Commonwealth and states and territories.
 - Proportionality of regulation emerged as a key principle – although this principle usually served as a rhetorical tool to cloak proposals in acceptability.
- In the case of the DTC, forum control played a central role in allowing external actors to attempt to advance contrary principles and norms. This manifested both through a reference to a Senate Committee and the establishment (under the DTCA) of a Steering Group to develop the amendments to the 2012 Act.

Chapter 5: Biosecurity policymaking

1. Introduction

Chapter 5 presents the findings from semi-structured interviews conducted with public servants (including health officers), researchers, industry groups and other key stakeholders involved in biosecurity policymaking. Seeking to answer research questions on the extent of, and use of, securitization as a ‘mechanism’ in biosecurity regulatory regimes, this Chapter focuses on how policymakers identified threats, determined appropriate regulatory responses to those threats and then deployed particular tactics and ‘mechanisms’ to design and – where necessary – secure agreement from key audiences to the proposed reforms.

Section 2 of this Chapter provides an empirical justification for the use of semi-structured interviews in addition to Securitization Theory’s traditional preference for discourse analysis of texts based on a novel examination of Second Reading Speeches (SRS) obtained via Freedom of Information (FoI) requests.

Section 3 examines the role of events and different policy ‘communities’ in initiating biosecurity policymaking, including contests over identifying various issues as ‘biosecurity’ threats and the relevant referent objects. A central finding of this section is the role of the attacks on September 11, 2001 (‘9/11’), the 2001 anthrax and ‘white powder’ scares in Washington D.C. (‘anthrax attacks’), and the Bali bombings in 2002, in forcing different policy programmes, actors (eg, researchers and Defence officials) and government departments together in the development of biosecurity regulatory regimes. To the consternation of some, this usually occurred within the security-oriented approach to the biosecurity issues identified in Chapter 2. The [re]-orientation helped drive the policy reforms that led to the Security Sensitive Biological Agents (SSBA) regime within the *National Health Security Act 2007* (Cth) (NHS Act) and the *Defence Trade Controls Act 2012* (Cth) (DTCA). As crystallisations of policy processes, these regulatory measures represent a trumping of alternate policy projects engaged in by the academic and research communities as well as a shift from devolved and self-regulatory approaches to the governance of research to more restrictive licensure and permit regimes.

A surprising – albeit minor – finding was that the choice to adopt ‘biosecurity’ in the *Biosecurity Act 2015* (Cth) (as a replacement of ‘quarantine’) was divorced from how the term

was applied in other policy communities. Disputes over the term's 'ownership' within the bureaucracy are examined below.

Section 4 considers the actors and audiences involved in biosecurity policymaking, and the less examined but equally critical roles of brokers and intermediaries who played a central role in securing some form of acceptance in the development of the Defence Trade Controls Bill 2011 (DTC Bill). Section 5 considers the contests of principles that played out during the policymaking process, focusing on the principles of academic freedom and proportionality.

In contrast to expectations on the likely role of the rhetoric of security in policymaking, it was the language of 'proportionality' and 'risk-based approaches' to regulation that were most frequently cited by policy leaders as justifying proposed regulatory measures. Indeed, the application of risk-assessment techniques by these individuals was used to resist efforts by 'harder' elements within the security, intelligence, and arms-controls community to adopt more rigorous or onerous controls. Combined with the findings from an analysis of SRS obtained under FoI laws, this points to the importance of analysing intra-actor (public servant vs public servant) relationships as a securitising actor-audience relationship.

Substantive findings conclude in section 6 with an examination of how securitization sits alongside other 'mechanisms' of regulation design, in particular 'modelling' and the influence of the Australia-US security alliance ('the Alliance'). Although a *sotto voce* presence, the Alliance nonetheless lent an irresistible momentum to the development of the DTC Bill. Indeed, in the eyes of minor party MPs at least, deference to the Alliance was seen as inappropriately trumping Australia's own national sovereignty.

Chapter 5 adopts the thematic structure of the previous Chapter, with sections focused on threat and referent identification, the identification of key values, principles and rules and the justification (if any) for their breaking.

It was notable that many of the senior public servant involved in leading biosecurity policymaking were willing to be personally identified. It was clear that these officials enjoyed reflecting on their work and looked back on it with pride (one interviewee even rehearsed a line during the interview to perfect it for the recording). An inference from this was that public servants involved in leading this work were not simply delivering reforms at the behest of others (eg, Ministers) that they were personally uncomfortable with.⁵¹⁶ Notably, researchers and

⁵¹⁶ In contrast, some remarks reported in Chapter 6 did reflect a level of discomfort or resignation on elements of disease responses.

university sector representatives involved in the development of the DTC Bill did not generally take pleasure from reflecting on the process. While willing to speak with the researcher, the interviews suggested a strong desire by many to move on from what seemed to have been a personally, if not professionally, bruising experience.⁵¹⁷ This is examined further below. One limitation in this Chapter is that the researcher was unable to secure in-person interviews with officials from the Department of Defence responsible for the development of the DTC Bill. However, testimony from these officials was obtained from *Hansard* transcripts and supplemented by documentary material. In addition, interviews with non-Defence officials involved in both the SSBA regime and DTC Bill, and non-government individuals involved in the development of the DTC Bill, inform the findings in this Chapter.

What is meant by policymaking?

It is important to quickly distinguish between ‘policymaking’ and ‘lawmaking’ for the purpose of this Chapter. This distinction is important analytically as, in applying Securitization Theory, these activities occur in different forums (Parliament / bureaucracy), with different actors (Ministers and MPs / public servants) potentially engaging in securitizing moves to potentially different ‘audiences’ (Parliament as a deliberative body and, potentially, the public / other public servants, ‘stakeholders’ and Ministers). These assumptions underpin the division between Chapters 4 and 5 and were tested in the interviews with a specific question on who was considered the ‘audience’ for the policymaker’s work.

For the NHS Bill and the Biosecurity Bills, policymaking ended when federal Cabinet gave its approval to the Bill’s formal drafting. This reflects a distinction captured in the *Cabinet Handbook*: imposing a requirement for Cabinet approval of policy (or, in exceptional circumstances, the approval of the Prime Minister alone), prior to the commencement of drafting a Bill.⁵¹⁸ Work by officials that preceded this point is considered ‘policy’. A benefit of this formalist division is that it does not matter whether the policymaking follows an idealised model or, arguably, more realistic ‘black box’ model of bureaucratic policymaking:⁵¹⁹ the division between policymaking and lawmaking remains the same.

⁵¹⁷ Interview with Researcher 1 (Phone Interview, 4 June 2018) (hereafter ‘R1’); Interview with Researcher 2 (Phone Interview, 27 September 2017) (hereafter ‘R2’); and Non-Government Sector Representative 4 (Phone Interview, 14 November 2017) (hereafter ‘NG4’).

⁵¹⁸ Department of the Prime Minister and Cabinet, *Legislation Handbook*, above n 275.

⁵¹⁹ To use a term from the public administration literature: Paul ‘t Hart and Anchrut Wille, ‘Bureaucratic Politics: Opening the Black Box of Executive Government’ in B G Peters and Jon Pierre (eds), *The SAGE Handbook of Public Administration* (Sage Publications, 2nd ed, 2012) 369.

In the case of the DTC Bill, this division breaks down, as the Bill underwent significant changes after its introduction to Parliament in 2011 and again between its enactment in 2012 and the introduction of the Defence Trade Controls (Amendment) Bill in 2015. Indeed, revisions occurred both within the political crucible of Parliament (with amendments proposed by the Opposition and the Australian Greens ('Greens')) and, over a longer period, through bureaucratic processes led by the public service. However, the focus on this Chapter is primarily on the activities that occurred outside Parliament's debating chambers and out of hearing of *Hansard's* reporters.

2. An empirical basis for seeking securitization within the bureaucracy

As outlined in Chapter 2, securitization studies often focus on the speech acts of members of the Executive, legislators, or senior officials such as ambassadors. Chapter 4's examination of biosecurity lawmaking reflects a similar approach. However, this study adopted a more critical view, questioning whether and to what extent a 'speaker' in a securitizing move is the principal author of the security rhetoric.

Department-prepared versions of SRS for the Bills examined in Chapter 4 were obtained via FoI requests and compared with the speeches delivered by the Minister in Parliament. To the best of the researcher's knowledge, this is the first study to attempt to examine the differences between draft and delivered SRS.

Based on the existing literature and professional experience as a civil servant, the researcher anticipated that Ministers would contribute at least some securitizing flair to otherwise flat technical products and, hence, would be a dominant or at least active player in securitization. However, during the analysis, it became apparent that the differences between a Department's SRS and the speech delivered in Parliament were minimal. The average number of words removed from the departments' SRS was just 16 (median 11; range 0-50), while the median number of words added was 9 (range 0-61) (Table 14).⁵²⁰ For the Defence Trade Controls (Amendment) Bill 2015 (Cth), implementing significant amendments to the controversial DTCA, no changes were made whatsoever.

⁵²⁰ Reviewing these figures revealed that some 'removed' words were typographical changes, eg, 'red tape' becoming 'red-tape'.

Bill Title	Words Count (Dept SRS)	Word count (APH SRS)	Words removed by Minister	Words added by Minister	Party of moving Minister
National Health Security Bill 2007	703	699	11	9	LP
Quarantine Amendment (National Health Security) Bill 2008	624	641	1	12	ALP
National Health Security Amendment Bill 2009	874	885	50	61	ALP
National Health Security Amendment (Background Checking) Bill 2010	413	393	36	16	ALP
National Health Security Amendment Bill 2012	952	943	16	7	ALP
Defence Trade Controls Bill 2011	2283	2256	33	3	ALP
Defence Trade Controls (Amendment) Bill 2015	487	487	0	0	LP
Biosecurity Bill 2012	1897	1898	0	0	ALP
Biosecurity Bill 2014	1983	2031	1	49	NP
Key: ALP - Australian Labor Party; LP - Liberal Party; NP - The National Party Note: zero change is recorded where the difference in word count was attributed to a typographical change - eg, 'red-tape' (1 word) becomes 'red tape' (2 words).					

Table 14: Changes in SRS as prepared by Department vs delivered SRS

Ministers, it appears, adopted the speeches prepared by public servants almost unchanged. It is important to restate that departmental SRS are prepared by officers engaged under the *Public Service Act 1999* (Cth), rather than professional speechwriters or political staffers employed personally by the Minister and under their immediate direction. Public servants operate with a high-degree of independence in the preparation of these materials – subject always to the overriding right of a Minister to add to or amend anything when they deliver the SRS in Parliament.⁵²¹

While it is possible for a small number of changes to result in a meaningfully different speech, this was not established in the subsequent analysis of SRS. As the dominant authors of the SRS, therefore, public servants were responsible for rhetorical choices over threat and referent object identification, as well as efforts to raise the prioritisation and urgency of the reform (see also Tables 11 and 12 in Chapter 4, and that Chapter's discussion of the use of urgency in the Parliamentary debates).

⁵²¹ A similar dynamic was reported in Page, above n 278.

Consistent with a conception of SRS as spoken and persuasive acts,⁵²² when a Minister did make substantial changes, they were more likely to occur in the introduction and concluding paragraphs of the speech. Modifications included partisan statements that, in some speeches, positioned a particular Government as the active agent protecting the referent object. For instance, in the SRS that accompanied Bills to amend the NHS Act in 2009 and 2010, Ministers added content to the prepared speeches that emphasised that the legislation ‘reinforces the Rudd Government’s ongoing commitment to seek to protect all Australians from emerging health and security threats’ and ‘builds on the Rudd Government’s continuing commitment to protect all Australians from potential threats’. Not all modifications introduced language of significance to a security analyst and some quantitatively large additions proved of limited consequence. One of the largest contributions by a Minister to a prepared SRS was in the context of introducing the Biosecurity Bill 2014. However, the additional context was a (possibly spontaneous) reflection on the length of the Bill and Explanatory Memorandum (EM), rather than a difference in policy objectives or emphasis.

The above results may not be of surprise to public administration scholars, but they raise important issues for securitization’s focus on specific utterances and the association of securitizing moves with actors who speak publicly. It also provides an empirical basis for the researcher’s decision to look beyond the parliamentary debating chamber for evidence of securitization and provides a firmer methodology justification for investigating the ‘black box’ of bureaucratic policymaking.

3. Initiating biosecurity policymaking: owning terms and the use of events

Setting the boundaries of biosecurity policy

An initial question this research sought to examine was what (if anything) initiated biosecuritizing. Were there one or more events that catalysed activity or created a ‘policy window of opportunity’ for securitizing moves to emerge or, perhaps, find a more receptive

⁵²² In the Parliament of Australia, many ‘speeches’ are now tabled and incorporated into *Hansard* directly, rather than being spoken. This does tend to suggest that SRS are now seen as more procedural than persuasive. However, they remain the dominant, sometimes only, opportunity for Ministers to outline their ‘objectives in relation to the Bill, political considerations and intentions, and broader policy strategies which may span areas beyond the specifics of the Bill’ Department of the Prime Minister and Cabinet, *Legislation Handbook*, above n 275, [7.48].

audience than previous moves?⁵²³ Were there key individuals who initiated securitizing dialogues or did Braithwaite and Drahos's 'webs of dialogue', help to '[define] issues as a concern, ...[begin] constituting normative commitments, [and nurture] habits of compliance' that, in later and more formal policy and lawmaking processes, become 'institutionalized into bureaucratic routines' and, ultimately, domestic biosecurity laws?⁵²⁴

Perhaps unsurprisingly, interviewees did not identify a single or consistent ignition moment for biosecurity policymaking. This was due to internal debates over the meaning of biosecurity as a policy domain, the role of communities of interest in shaping policy domains and the complex relationship between events and policymaking.

Debates over terminology

Consistent with the contested nature of the term in the literature, the meaning of 'biosecurity' in Australian policy was disputed by interviewees. As discussed in Chapter 2, in Australia and New Zealand the emergence of 'biosecurity' as a field of policy and governance has been strongly shaped by historically strong quarantine practices and leadership from agricultural and trade portfolios. The link between quarantine and biosecurity is most clear in the replacement of the *Quarantine Act 1908* (Cth) with the *Biosecurity Act 2015* (Cth) (Chapter 4) and Public Servant interviewee 8 (PS8) pointed to an 'evolution of terminology from "quarantine" to "biosecurity"'.

As early as the initiation of the *Council of Australian Governments Review of Hazardous Biological Materials* ('CoAG review') in 2002, the scope of risks associated with the term had moved beyond just plants and animals and the technical world of quarantine risk assessments. Interviewees involved in the CoAG review recognised the Department of Agriculture, Fisheries and Forestry's (DAFF) pre-existing interest in the term, but argued it no longer covered all the relevant risks – or, to adopt a term preferred by PS8, 'equities'. Equities went beyond risks or threats and included a department's interests and areas of concern (this might be considered a department's 'turf').⁵²⁵

⁵²³ To adopt one of Shiffman's factors that shape political priority: Shiffman and Smith, 'Generation of Political Priority for Global Health Initiatives', above n 224, 1371.

⁵²⁴ Braithwaite and Drahos above n 36, 32.

⁵²⁵ Interview with Public Servant 8 (Canberra, 18 July 2017) (hereafter 'PS8'). PS11 and PS1 also spoke in terms of a department's 'role' or 'dimension': Interview with Public Servant 11 (Canberra, 20 November 2017) (hereafter 'PS11'); Interview with Public Servant 1 (Canberra, 11 September 2017) (hereafter 'PS1').

Control over terminology played a central role in defining whose equities would drive biosecurity policy. Responses from interviewees suggested that, in the context of the CoAG review, this terminological dispute manifested in two forms: an accommodating approach to policy demarcation and a less deferential approach, where the definition and equities that secured the interest of politicians could ‘gazump’ that of other ‘communities’. As an example of the former – and noting ‘biosecurity can be...a number of things’ – PS3 (a non-DAFF employee), commented that, for DAFF, ‘biosecurity is ensuring that organisms don’t come into the country’.⁵²⁶ But, PS3 added, ‘biosecurity on the other hand can [also] be ensuring that any organisms, that are used, are appropriately stored and made secure.’⁵²⁷ In contrast to PS3, PS8’s observations of inter-agency interactions during the CoAG review, reveal an approach that was less deferential to DAFF’s sensibilities:

... DAFF thought they owned the term ‘biosecurity’ [but it] only dealt with certain aspects of what others were considering to be biosecurity.... [After] 9/11, and ... the anthrax attacks... [to] the security people ‘biosecurity’ [became] the rage, and “this was the big issue that had to be addressed etc”. And the US, when they talked about ‘biosecurity’ they were not talking about quarantine. They were talking [about] counter-terrorism. They were talking about anthrax attacks and all of that sort of stuff. ... [S]o in the community that I became more and more engaged in ‘biosecurity’ meant the pointy end of security. They were not thinking about quarantine.

Acknowledging that DAFF and the Australian Quarantine and Inspection Service (AQIS) ‘complaints’ that ‘their term had been hijacked by the security community’ were ‘probably right’, PS8 was unsympathetic: ‘it’s not going to get back to [AQIS/Agriculture]. I can tell you [what] the governments are going to focus on [ie, bioterrorism].’

Notwithstanding the disagreements at the time of the CoAG review (2002–2006), at the time most individuals were interviewed (2017–2019), it was notable how little interviewees used the term ‘biosecurity’ to describe their work.⁵²⁸ This was despite this cohort of participants having been identified by the researcher because of their involvement in what the literature would commonly group as biosecurity issues. For example, officials from the Department of Health’s Office of Health Protection (OHP) did not describe their daily work as responding to biosecurity issues, with one breaking down their group’s remit into several functions, with

⁵²⁶ Interview with Public Servant 3 (Canberra, 30 May 2017) (hereafter ‘PS3’).

⁵²⁷ PS3. This definition also conflates biosafety with the national security dimension of biosecurity.

⁵²⁸ PS8 did not like using the term because ‘[if] I talk to the intelligence community then it’s got a very different meaning [than] if I talk to a farmer.’

‘biosecurity’ relating to relatively anodyne matters of policy around: ‘vector control, human remains, importation of things that can affect human health.’⁵²⁹ Yet, in this interview, there was no thematic linkage of ‘health security’ (and Part 2 of the NHS Act) with the ‘biosecurity’ elements of the SSBA regime they also oversaw.⁵³⁰ This may be explained OHP’s joint role in administering the *Biosecurity Act 2015* (Cth) with DAFF and, therefore, a deference to DAFF’s usage of biosecurity.

The effect of events on biosecurity policymaking and threat framing

An equally important influence on biosecurity policy were major domestic and international events. Emerging from the documentary analysis and interviews, were two key effects of events on biosecurity policy:

First – as a ‘forcing factor’, leading either to the initiation *ab initio* of policymaking to address a specific threat or, more commonly, bringing together existing policy ‘streams’ with a resultant contest over which community’s equities or principles would dominate the subsequent policy process. The involvement of a department closer to the centre of government, such as the Department of the Prime Minister and Cabinet (DPMC), was often a sign that a new phase of policymaking was about to commence.

Second – as revealing or making available new issues or hazards that actors could then frame as security threats. The critical eye that government turned on the activities of scientists and researchers in the CoAG review and development of the DTC Bill are two instances explored below.

Consistent with the literature on biosecurity, the events of 9/11 and the anthrax letter attacks were raised by interviewees as events central to initiating the CoAG review and eventual SSBA regime.⁵³¹ PS4 suggested 9/11 and the anthrax letters led to a ‘spike of interest’ ‘around access to biological agents.’ DPMC ‘picked up on that heightened international concern, [and] translated [that] back to a domestic policy agenda’ and shortly afterwards initiated the CoAG review.⁵³² Interviews and documentary analysis suggest more local events also played a role. For example, the Bali Bombings in October 2002 was also identified as a

⁵²⁹ Interview with Public Servant 9 (Canberra, 17 August 2017) (hereafter ‘PS9’).

⁵³⁰ Other OHP staff described the CoAG review and the resultant SSBA regime as having a ‘national security’ focus, in contrast to having a ‘biosafety’ focus: Interview with Public Servants 5 and 6 (Canberra, 25 June 2019) (hereafter ‘PS5’ and ‘PS6’, respectively). This is a similar distinction to that drawn by PS3.

⁵³¹ PS8; PS3; Interview with Public Servant 2 (Canberra, 31 May 2017) (hereafter ‘PS2’); Interview with Public Servant 4 (Canberra, 17 & 29 May 2017) (hereafter ‘PS4’).

⁵³² PS4.

key factor that initiated the CoAG review. For instance, PS8 remarked that ‘for Australia, the Bali bombing and ...the tragic death of 88 Australians...was a very sad reminder that we in Australia are not separate and immune from this global issue of terrorist attack.’ Similar events were raised by PS2. Although both PS8 and PS2 had similar scientific training and expertise, their policy careers unfolded in different communities: PS8 in national security and arms control and PS2 in public health. They therefore provide useful comparators on threat identification.

While these events helped initiate policy work, they also served as a basis to frame regulatory and capability ‘gaps’ as threats. PS8 and PS2 (the latter an employee at OHP), suggested that policy work was not initiated just as a *response* to terrorism, but also that these events caused politicians and policymakers to feel that existing arrangements and capabilities were insufficient. PS8 reflected that:

9/11 was clearly a wakeup call to the governments of the world *to look to whether they had all appropriate arrangements in place to deal with a heightened concern around terrorist attack*. In the same time period, the US had been subject to some malicious use of anthrax and was having to deal with that in terms of response preparedness.... So that raised biological agents to a higher level of awareness in people's minds. ...So all of those things together caused CoAG to determine ...that they needed to do a review of hazardous materials *to make sure that they were adequately controlled*, so that they could not inadvertently get into the hands of would-be terrorist perpetrators.⁵³³

PS2 also pointed to preparations for the 2000 Sydney Olympics as a period when the capabilities (or lack of capabilities) of the states and territories to ‘[detect] and diagnose agents of security concern’ first became a matter of national, policy concern. PS2 outlined how preparations for the Olympics ‘involved ensuring that states and territories had the ability to diagnose or detect agents of security concern.’⁵³⁴ To achieve this, the Australian Government funded equipment, reagents, and training for the states and territories to detect such agents.

The identification of weakness at the state and territory level as a threat of its own, echoes the SRS and extrinsic material supporting the biosecurity laws examined in Chapter 4. In addition, the capabilities of the states and territories were not merely a concern in the context

⁵³³ PS8 (emphasis added).

⁵³⁴ Funding was provided by the Department of Health and the Attorney-General’s Department, which at the time was tasked with ‘national leadership in emergency management’: Attorney-General’s Department, ‘Strategic Priority 6 – Emergencies’ in Attorney-General’s Department, *Annual Report 2016-17* (Australian Government, 2017).

of terrorism and the deliberate release of a biological agent but, according to PS2, also ‘as part of preparation for a potential H5N1 [avian influenza] pandemic...’ in 2002–03.

Similarly, the comments of PS4, PS5 and PS6 underscored how events provided policymakers and politicians with the ability to identify new threats: in this case, the domestic threat of the malicious, ‘disgruntled insider’, and rogue researchers. From a Securitization Theory perspective, this threat identification represents part of a securitizing move. However, it also served a pragmatic effect of allowing securitizing actors to seek to collapse separate policy programs into one more amenable to securitization.

In the case of the CoAG review (and, later, the DTC Bill) it was the separate policymaking of the academic community and research funders – and their attendant regulatory measures – that found itself subsumed into a new debate on the right of the government to regulate research. Just as disputes over terminology led to disagreements between DAFF and the ‘sharper’ security agencies, the elevation of the threat of the rogue scientist was resisted by government entities with strong links to the academic community. As PS4 explained, the characterisation of researchers as potential threats chafed with then CEO of Australia’s National Health and Medical Research Council (NHMRC), Professor Warwick Anderson. PS4 expressed frustration with his interactions with NHMRC on the issues of dual-use research and the security implications of research:

I think that’s where some of the disjunction was. It was just almost naïveté, perhaps, a disbelief? ...[A] sense that ‘sure you know, I’m sure that terrible things could happen with those biological agents; but we’re just scientists! That wouldn’t be us.’ It was... a naïveté is how I would put it. And I think probably a lot of that still exists.

This frustration extended to a perceived unwillingness for NHMRC to engage with the CoAG review and, later, to reflect the security dimensions associated with biological and dual-use research in its own key research standards, such as the *Australian Code for the Responsible Conduct of Research* (the Code):

No [NHMRC did not participate in the CoAG review]. And it’s partly [because of the CEO]. Well not just [the CEO], I guess he probably typified the rest of the community. That ‘but that’s about security! What we do is health?’ That was that kind of disconnect. And NHMRC was probably the epitome of it in some ways. ...But we definitely put in a submission [to the review of the Code] And we heard nothing. It just kind of went into an abyss. ... There was never any acknowledgement at all that we’d submitted it, which I thought was significant. Significant in one of two

ways: either it showed [problems with how the review of the Code was run]; or it [NHMRC] was just burying its head in the sand.⁵³⁵

PS4 felt the ‘disjunction’ and unwillingness to accept the nature of the threat extended beyond NHMRC to the wider academic community:

...it was a lack of understanding. It was with the broader community, including elsewhere in the [Health] Department or the health portfolio.... Just a kind of, a level of naïveté around the threat and the risks and, you know, essentially the assumption often – and you'd see **right** through academia as well...: ‘all we're doing is research. How could that be harmful?’ But not really understanding the nexus between the nature of the research and the security threat that we were trying to address.⁵³⁶

Laws as intentional tools of securitization or opportunistic endpoints?

Intuitively, it seems logical that the enactment of the SSBA regime – the assumed crystallisation of one piece of biosecurity policy – should occur within a law titled the ‘National Health Security Act’. Likewise, that a new regime to regulate the intangible supply of dual-use technology should find form in a Bill that also gave effect to a defence trade agreement (ie, the DTC Bill). A security analyst might be expected to be able to draw some analytical insight from both the title of a law or the fact that it deals with a specific threat. Drawing from the documentary analysis and interviews, this study’s findings undermine such an easy heuristic. For example, during the interviews, the researcher commented on the differences in subject matter, tone and regulatory approach adopted in the main parts of the NHS Bill. Part 2 of the Bill dealt with public health surveillance; Part 3 dealt with SSBA. The regulatory language in Part 2 was cooperative, whereas Part 3 adopted a ‘command-and-control’ approach to regulation. In short, the NHS Act seemed a law with two personalities.⁵³⁷ Did these differences (and *how* those difference manifested, eg, their regulatory approaches) point to a chance merging of multiple pieces of policymaking?

⁵³⁵ PS4. R3 also spoke of the difficulties in getting the academic community to accept guidelines on dual-use research in the context of the DTC Bill: Interview with Researcher 3 (Canberra, 2 November 2017) (hereafter ‘R3’).

⁵³⁶ PS4 (emphasis in the original). PS8 was more generous in his assessment of the engagement of the Department of Health, although his comments were largely focused on praising the work of PS2 during the CoAG review. Remarks by PS9, for example, suggested that there continues to be a distinction drawn between Health’s role and the security community’s ‘guns, bombs, and police [mindset]’: PS9.

⁵³⁷ The very brief overview of the SSBA regime in the NHS Bill’s EM was another suggestion that Part 3 of the Bill had been grafted on at a late stage.

Responses from PS3 and PS2 suggested that this observation was well founded.⁵³⁸ Health official, PS2, commented that the NHS Bill initially ‘came out of two things...the ratification of the International Health Regulations 2005 and the requirement that we [Australia] had to have in place an ability to communicate [health information], in a secure manner, and, with regard to privacy....’⁵³⁹ The inclusion of the SSBA regime in the NHS Bill came much later.⁵⁴⁰

That the content of the NHS Bill covered both policy outputs was opportunistic. Indeed, the interview with Department of Health staff suggested that even the Bill’s title – ‘National Health Security Bill’ – was adopted prior to the insertion of the SSBA regime.⁵⁴¹ A similar view was shared by PS4 who, while noting that ‘[his] job was sort of done by essentially getting agreement that we needed something written into **some** piece of legislation SOMEwhere’ (emphasis in the original), referred to being ‘peripherally’ aware of conversations such as:

“oh well, looks the Health Security Act’s a good deal...a good place... .. the Health Portfolio has decided it will take on the regulatory responsibility”, I think they were just about to enact the IHR, so there was kind of all a whole lot of reasons to put it in that piece of legislation.⁵⁴²

The DTC Bill likewise reflected at least two different work and policy programs within the defence and security community. An analysis of government documents and the parliamentary record reveals that the first work program focused on improving Australia’s defence industry sector’s access to the US market via the Defence Trade Cooperation Treaty;⁵⁴³ the second on implementing Australia’s commitments as a member of the Australia Group (AG) and the *Wassenaar Arrangement on Export Controls for Conventional Arms and Dual-Use Goods and Technologies* (Wassenaar Arrangement), two international groups focused on setting common protocols, ‘control lists’ and norms governing the export of defence items and dual-use goods.⁵⁴⁴ Appendix 5 provides a chronological summary of these two projects.⁵⁴⁵ The

⁵³⁸ PS4. See also the brevity of discussion of the SSBA regime in the EM to the NHS Bill.

⁵³⁹ PS2.

⁵⁴⁰ PS8. PS2 commented that they had moved to Canberra for the SSBA work.

⁵⁴¹ PS9; PS5 and PS6.

⁵⁴² PS4.

⁵⁴³ For example: Evidence to Senate Standing Committee on Foreign Affairs, Defence and Trade Legislation, Parliament of Australia, 2 March 2012, 30-40 (Michael Shoebridge). For the industry focus, see: Prime Minister John Howard PM, ‘Australia-United States Treaty on Defence Trade Cooperation’ (Media Release, 5 September 2007). Joint Standing Committee on Foreign Affairs, Defence and Trade, Australia’s Defence Relations with the United States [Inquiry Report] (Parliament of Australia) (2006), [7.21].

⁵⁴⁴ The Australia Group, *The Australia Group: An introduction* (2007) Department of Foreign Affairs and Trade <<https://www.dfat.gov.au/publications/minisite/theaustraliagroupnet/site/en/introduction.html>>. The Wassenaar Arrangement, *About us* (1 December 2022) <<https://www.wassenaar.org/about-us/>>.

⁵⁴⁵ Critics of the regime, eg, R1 and R2, would likely have argued that it should have also considered a third stream that was dominated by the academic community.

role of these groups is discussed later, but they operate as important forums for the globalisation of arms-control regulation primarily using the Braithwaite and Drahos's mechanism of 'system of rewards' to promote 'harmonisation' of defence export regulatory measures.

Though less noticeable than the differences within the NHS Bill, the split in the DTC Bill was relevant to how actors – particularly those in the academic community – engaged in the contents of principles, over whether the subject matter of the Bill warranted regulation: a) as security issues; and b) by the Department of Defence. Indeed, critical to the conflict that arose in relation to the DTC Bill, was the existence of a third policy program around responsible research practices, led by researchers, the academic community and health research funders. Since the 1970s, this community had focused on issues of [bio]safety and ethical issues associated with emerging biological technologies and techniques: for example, recombinant DNA in the 1970s,⁵⁴⁶ genetically modified organisms⁵⁴⁷ (including, cloning and embryo and stem cell research)⁵⁴⁸ and, more recently, gain of function (GoF) research.⁵⁴⁹ As discussed below, this community allied to different norms and principles and preferences for self-regulation via non-legislated codes of practice, with regulatory decision-making devolved to non-governmental, expert-led groups.

Finally, the reason by which a particular Bill, with a particular security framing may have emerged at a given time was due less to the intentions of policymakers than scheduling considerations. For example, the Joint Standing Committee on Foreign Affairs, Defence and

⁵⁴⁶ See, for example, the 1975 Asilomar Conference on Recombinant DNA: Peter Berg, et al, above 170. Australia saw the establishment of the Recombinant DNA Monitoring Committee and its successor, the Genetic Manipulation Advisory Committee: House of Representatives Standing Committee on Industry, Science and Technology ('SCIST'), Parliament of Australia, *Genetic Manipulation: The Threat or the Glory?* (1992). A timeline provides 'background' to the *Gene Technology Act 2000* (Cth), capturing the seminal scientific, international, and domestic developments in this space: Harris Rimmer and Rosemary Polya, *Gene Technology Amendment Bill 2007 – Bill Digest*, No 131 of 2006-07, 4 May 2007.

⁵⁴⁷ See for example: SCIST, above n 546. The *Australian Gene Technology Act 2000* (Cth), whose object is to 'protect the health and safety of people, and to protect the environment, by identifying risks posed by or as a result of gene technology'; David Tribe, 'Gene technology regulation in Australia' (2012) 3(1) *GM Crops & Food*, 21.

⁵⁴⁸ Resulting, in Australia, in the *Prohibition on Human Cloning Act 2002* (Cth) and the *Research Involving Human Embryos Act 2002* (Cth). A summary of the Australian policy history pre-2002 is provided in Jennifer Norberry, *Research Involving Embryos and Prohibition of Human Cloning Bill 2002 – Bill Digest*, No 17 of 2002-03, 14 August 2002; and for the years up to 2006 in Susan Dudley, Thomas John and Justine Clarke Law, *Prohibition of Human Cloning for Reproduction and the Regulation of Human Research Amendment Bill 2006 – Bill digest*, No 59 of 2006-07.

⁵⁴⁹ For example: National Academies of Sciences, Engineering, and Medicine, *Gene Drives on the Horizon: Advancing Science, Navigating Uncertainty, and Aligning Research with Public Values* (The National Academies Press, 2016); Australian Academy of Science, *Synthetic Gene Drives in Australia: Implications of Emerging Technologies* (Australian Academy of Science, 2017); The Legislative and Governance Forum on Gene Technology, *2017 Review of the National Gene Technology Regulatory Scheme – Background Paper* (Commonwealth of Australia, 2017).

Trade agreed to expedite their review of the DTC Bill explaining: ‘in view of the recent visit of the US President and the 60th Anniversary of the ANZUS Alliance, the Government has requested that [the Bill] be dealt with expeditiously by the Committee and that, if possible, an advisory report be presented ... this week.’⁵⁵⁰ The Committee recommended the House pass the Bill ‘without amendment’. A similar urgency was identified in the lead up to the Bill’s passage in 2012 (when significant policy work was still underway behind the parliamentary scenes). Individuals involved in the opposition to the DTC Bill pointed to a 2012 visit by US Secretary of State Hilary Clinton as one reason why the Department of Defence and relevant ministers wanted to pass the DTC Bill quickly. At the time, one Senator suggested it was being rushed for the ‘announceable [sic]’ and ‘photo-op’.⁵⁵¹

In summary, although the title and substance of a Bill may suggest a unity of purpose – including to shift to ‘active securitization’ – it may also simply be a consequence of what PS8 called ‘good housekeeping and good legislative work’ and acting, opportunistically, ‘when the time is right’.⁵⁵² What emerges overall from the interviews and a review of the documents is that the role of events in biosecurity policy is messy and multifaceted. Certain policy work programs do appear to have their own trajectories and large events can drive those programs together via cross-government reviews or the development of new legislation. But the timing of when policy outcomes are translated into binding rules also appears to feature an element of opportunism.

⁵⁵⁰ The Committee had received the Bill before President Obama’s visit and, although this statement was made following his visit, it is likely the Committee had reached agreement to expedite the Bill earlier. Michael Danby, *Statement to the House of Representatives re. Customs Amendment (Military End-Use) Bill 2011 and Defence Trade Controls Bill 2011* (21 November 2011) Australian Parliament <https://www.aph.gov.au/parliamentary_business/committees/%20%20house_of_representatives_committees?url=jfadt/defbills2011/report/statement%20to%20the%20house%20%2821nov2011%29.pdf>.

⁵⁵¹ Commonwealth, *Parliamentary Debates*, Senate, 29 October 2012, 8120 (Senator Scott Ludlam). R1 remembered there being ‘huge pressure... huge time pressure because Secretary for State Hilary Clinton ... but there was...speculation (and its only speculation) that... that everybody was frantically trying to get this treaty ratified so that there could be an agreement signed [during Secretary Clinton’s visit]’. Also mentioned by R2 and NG1: Interview with Non-Government Sector Representative 1 (Canberra, 6 September 2018) (hereafter ‘NG1’). In response to this allegation, the researcher submitted an FoI request to the Department of Defence seeking any briefings on the visit by Secretary Clinton that referenced the Defence Trade Controls Bill. The Department advised that no such documents existed: FoI Request [1804-F1945], from Department of Defence to author, 12 June 2018. This does not mean that the visit was not referenced in interactions, and the timing of the Bill’s passage and the visit are suggestive (timetable in Appendix 5).

⁵⁵² PS8 clarified that ‘[w]hen the time is right’ might mean “‘okay there is sufficient staff’, or there is some forcing factor, which says “now is the time that we need to- we’ve got to do something”...” (emphasis added).

Threat identification

Although the term was rarely used explicitly, the language of threat did emerge in the interviews. PS8 spoke about DPMC's policy initiatives around 'biological agents that could be used in a terrorism context, and also in the broader proliferation, counterproliferation, non-proliferation [context].'⁵⁵³ Dual-use issues aside, PS4 likewise identified work to address 'the *threat* posed by ... biological weapons either from state actors or from non-state actors.'⁵⁵⁴ PS5 and PS6 – who worked at the Department of Health – spoke of how the CoAG review was responding to an 'evolution in terrorist thinking' beyond 'bombs and guns'.

The events of 9/11 were identified as creating a policy break in the counter-proliferation domain, with non-state actors coming to be seen as the extreme threat that warranted new action. Earlier policy and domestic and international regulatory action (including norm setting) had been centred around state actors, for example the major counter-proliferation treaties (see Timetable in Appendix 5). This shift was stated clearly by PS4:

Definitely non-state actor. It was all about non-state actors. We were able to leverage some systems and structures and, certainly knowledge, from [Australia's prominent role in the development of the Biological Weapons Convention (BWC)]. But it was ... focused solely on the non-state actor threat. Very, very deliberately.

This shift was reported to be controversial, and PS4 and PS8 independently reported that former colleagues who had previously led Australia's involvement in the Australia Group and development of the BWC and Chemical Weapons Convention (CWC) struggled with the shift as reflected in the CoAG review. In speaking of a former colleague, PS4 commented: 'we ended up agreeing to disagree over the security sensitive biological control agents process, because [the former colleague] came from that really pretty hard, extreme, view of the world. That it needed to be or effectively controlled. [They] took over almost a literal Australia group sort of view to the domestic situation....'⁵⁵⁵

Indeed, this disagreement within what could be considered the security and arms-control community appears to have been more heated than the policy disagreements between this community and the Department of Health or DAFF or – in the context of the NHS Bill – the academic community. Combined with the way the assessment of risk was undertaken during the CoAG review (see below), it points to the temporal (if not theoretical) challenges in

⁵⁵³ PS8.

⁵⁵⁴ PS4 (emphasis added).

⁵⁵⁵ PS4. Similar remarks made by PS8.

ascribing a single ‘securitizing’ position to an identified securitizing actor, especially where the actor is a collective, such as a department – let alone an Administration.⁵⁵⁶

Disagreements within this community not only centred on the shift in threat identification but the degree to which Australia should ‘model’ any domestic SSBA regime on international examples. Modelling as a mechanism is examined further below – and compared with the different approach adopted in the DTC Bill.

Of significance to the academic community (who did seek to resist intrusion into their practices by the SSBA regime and the DTC Bill) was that the shift from State to non-State actors was accompanied by a new focus on domestic threats. Terrorists, clearly, were threats; but public servants at DPMC, DFAT and Health also identified ‘rogue’ or ‘mad’ scientists as threats.⁵⁵⁷ To PS8, this threat identification did not require any rhetorical flair, just ‘a straight risk-based approach’:

if you... look at the vulnerabilities and threats, you end up in a situation where you've got to put serious consideration on rogue scientists. Now ...I've changed my language; I've called them 'rogue scientists' not 'terrorists'. But rogue scientists have access. They have the knowledge, the capability, they have access to equipment, as well as access to agents.... they have far more capability to cause havoc than some person without that deep background.

Acknowledging that it would be ‘a confronting thing for the research community to realize: that, by virtue of their expertise, and knowledge, and technical capability, they present a significant potential for malevolent act if they so choose’, PS8 justified his threat assessment on a ‘history of instances’ and concluded that ‘[t]he number datapoints on this issue are significant and can't be ignored.’⁵⁵⁸

In relation to threat identification, two other significant findings emerged from the interviews. The first was the use of formal risk-assessment processes in the design of the SSBA regime to resist the more restrictive outcomes suggested by individuals from traditional security agencies. This finding is discussed below in more detail in the section on ‘modelling’. The second finding related to the tactical role threat and referent object identification can play

⁵⁵⁶ This mirrors – at a domestic level – Braithwaite’s and Drahos’s findings about the division of States, the challenges of securing domestic consensus and the limitations of realist theories in international relations that posit the State as a unity entity: see Braithwaite and Drahos, above n 36, 479–485.

⁵⁵⁷ PS4, PS8, PS5 and PS6.

⁵⁵⁸ PS8.

in the success (or not) of an audience in resisting a securitizing move. A clear case of this emerged in the case of the DTC Bill and is discussed in the following part.

Talking past each other – Defence and academic sector threat identification in the DTC Bill

For Defence, a chief threat that the DTC Bill was intended to address was the risk posed by the diversion of dual-use technology into the hands of malicious, non-State actors and to others deemed ‘prejudicial to the security, defence or international relations of Australia’.⁵⁵⁹ An additional motivation to address this threat was that failure to regulate brokering and intangible supply of dual-use goods would put Australia on the wrong side of the Australia Group and Wassenaar Arrangement – violating the good global citizen principle.⁵⁶⁰ More significantly, failure to implement the DTC Bill would jeopardise the Defence Trade Treaty and embarrass Australia’s most important ally. The DTC Bill, with its licensing system and national security regulatory approach, was an appropriate vehicle to respond to the identified threat and satisfy other commitments (see Appendix 5).

The research community representatives interviewed acknowledged Defence’s threat identification, to an extent at least. For example, R1 remarked: ‘it was never our view that nothing was required. That we were arguing for, you know, “total academic freedom”.... we understood that there were people that you wouldn’t want shared with, broadly.’ As explored below, to the extent that the sector agreed with the threat identification, their dispute centred around the appropriate regulatory response (and here a contest of principles emerged, each though seeking to justify their model as being proportionate to the threats).

As discussed in Chapter 2, the threat from certain dual-use research, particularly Dual-use Research of Concern (DURC) and Gain of Function (GoF) research, was a contemporaneous concern of the research community; but a review of documents and interviews suggests the sector’s work proceeded in parallel to (and seemingly in ignorance of) the early development of the DTC Bill. For instance, academics such as Michael Selgelid – who had written previously on DURC – were also commissioned by governments in Australia

⁵⁵⁹ *Defence Trade Controls Act 2012* (Cth) s11(4); see also regulations made under section 25A of the Act.

⁵⁶⁰ See remarks by then Defence employee Michael Shoebridge: Evidence to Senate Standing Committee on Foreign Affairs, Defence and Trade Legislation, Parliament of Australia, 21 March 2012 (Michael Shoebridge) 10. Neither the Australia Group or Wassenaar Arrangement are Treaty-level organisations and their guidelines and common lists are not binding on members (cf, UNSC Resolution 1540).

and the United States to produce advice on the risks and ethics of DURC and GoF research.⁵⁶¹ To the extent the Australian research community recognised DURC and GoF research as a ‘threat’, it appears from these sources to have been grounded in ethical and moral objections – not arms controls objectives.

This distinction in threats might seem insubstantial, but it was evident to participants involved in the informal group chaired by the Chief Scientist and resulted in difficulties reaching agreement on regulatory approaches. For example, NG4, who had been brought in by Defence to assist with engagement on the DTC Bill, commented that the group’s academic members had ‘just got stuck on’ the ‘ethical’ dimensions of the research and not on how to control it as part of an arms-control regime. Reflecting on their role as an advisor to the Group, NG4 commented:

I think that [one of things that] I did that was most useful was...pull back the Chief Scientist’s office and the ethicists from a ‘this must be controlled because of the ethics’, to ‘you need to separate the issues [ethics and arms-control] and control things because of what they are [ie, defence dual-use goods]’⁵⁶²

The differences in threat identification also manifested in the work the Steering Group commissioned. While Defence was to work on amendments to the DTCA to exempt certain academic activities from regulations (eg, pre-publication and verbal communication), it also commissioned the NHMRC to develop an ‘addendum’ to the Code on DURC (which was never finalised or published)⁵⁶³ Optimistically, this latter work may have represented the academic sector’s attempt to regain initiative over framing biosecurity threats and the design of a regulatory approach that accorded with their preference for ‘soft regulation’. Cynically, it may have been a way for Defence to divert the attention of the sector from the ‘real’ work of implementing the DTCA. Ultimately, what emerges from the interviews and documentary analysis is that this research community-led work was either starved of institutional or political support, for its promised fruits (ie, addendum to the Code) withered and disappeared. Alternatively, and as suggested by R3, it may have been that decision-making rules within the

⁵⁶¹ For outputs of this work, see: Miller and Selgelid, above n 56; Michael J Selgelid, ‘Gain-of-Function Research: Ethical Analysis’ (2016) 22(4) *Science and Engineering Ethics* 923. PS4 had also sought – unsuccessfully – to influence the policy outputs from this stream.

⁵⁶² NG4.

⁵⁶³ NHMRC’s CEO used an informal ‘advisory group’ to assist with this work. Chaired by Professor Mike Caulfield, then Deputy Vice-Chancellor (Research) (DVC-R) at Newcastle University, it included NHMRC staff and representatives from the university sector. Described by R3 as a ‘very loose thing’, it had also previously assisted with NHMRC’s and the sector’s implementation of Australia’s sanctions laws. PS3. The researcher was also involved in developing this addendum in his professional role at the NHMRC.

academic community – for example the reliance by the board of UA on consensus decision making – doomed the addendum to the Code, as that organisation was a co-author to the Code. As suggested in later Chapters, the academic sector’s inability to challenge the *correct* threat early and consistently in the policymaking process was likely another contributing factor to that sector’s inability to engage in effective desecuritization during the 2012 debate over the DTC Bill.⁵⁶⁴

Referent object identification

Interviewees did not frequently cite a specific ‘referent object’ as the object of their policy work. It could be inferred from interviews with public servant that the health and security of the Australian community were the primary objects being protected. These two objects – health *and* security – are not the same; and Department of Health employees drew a distinction in the context of bioterrorism. PS9, for instance, spoke of how, when they had ‘been to national crisis committee meetings for the Chief Medical Officer, looking over some of the terrorist events’, PS9’s question was: is ‘there a health component to this?’. At the same meetings, PS9 noted that Health’s input was always ‘welcomed’ because they [the communities running those meetings] did not have those issues ‘foremost in their mind[s]’, rather they were focused on immediate issues of public safety. Likewise, PS5 and PS6 gave the then recent removal of salmonella from the SSBA list as an example of further focusing the SSBA regime on ‘national security’ issues and away from ‘public health events.’⁵⁶⁵

Referent objectives often aligned with a department’s ‘equities’ and reflected the Department’s dominant ‘stakeholder’ group. For example, Australia’s agricultural industry was identified by multiple individuals, both in the context of the SSBA regime (animal and plant pathogens were considered but few included) and, also, in the context of disease response. Reflecting on industry’s discomfort with the media and public labelling the 2009 pandemic H1N1 influenza ‘Swine flu’, the following exchange occurred:

⁵⁶⁴ In the sector’s defence, the Department of Defence failed to engage or consult appropriately. As Defence conceded, their ‘consultation’ with universities involved sending a letter to Universities Australia (UA) (the sector’s peak body) but taking no other steps: Evidence to Senate Standing Committee on Foreign Affairs, Defence and Trade Legislation, Parliament of Australia, 2 March 2012 (Michael Shoebridge) 31. UA’s response to the letter was not ideal – according to NG1, UA sent a junior officer to a Defence-run workshop.

⁵⁶⁵ They also identified the list as being about addressing security risks rather than ‘biosafety risks’, which are largely described as workplace safety risks experienced by lab workers and communities.

PS2: ...that's why colloquially it became known as swine flu. (Although the Australian pork industry is upset about that, and we [Health] did our best never to call it swine flu).

Researcher: Did they [the industry] make any formal representations on that?

PS2: There were certainly conversations held at a very high level between the Australian pork industry, the Department of Agriculture, and the Department of Health. And while nothing official was ever written we were asked not to - in our written commentary - to use the term 'swine flu'.

This incident serves as a colourful example of what was otherwise a consistent message from interviewees and documents reviewed: Agriculture's primary referent object was its industry sector and the 'unique' advantage Australia's geographic isolation provided to keep out pests and invasive pests and diseases. Secondary objects included food security and Australia's environment ('plant and animal health') but protecting industry was the means to protect them.⁵⁶⁶ In another instance, NHMRC's resistance to any suggestion that national security should play a role in its research grant funding process (ie, whether it should be a criterion alongside 'track record' 'research impact' or as a filter for funding short-listed applications) pointed to a difference in equities. Even if both parties agreed on the relevant threat, the priority placed on the research community's independence by NHMRC meant that a regulatory response would have to be achieved via different means.⁵⁶⁷

As discussed below, most public servants saw the Minister as their main audience but neither individual Ministers (nor 'the Government' and especially a specific Administration) were identified as a referent object. PS8 came closest in his remarks on how the advice of the public service should address the 'dilemma' of what a 'responsible government' would do.

Finally, referent objects could be unspoken. Indeed, the most potent referent object identified in this study was one never mentioned directly by public servants: the Australia-US security alliance (Alliance). Although it was not mentioned in the SRS accompanying the DTC Bill, nor its EM (ie, two key public documents explaining the policy rationale for a law), the passage of the DTC Bill was not merely a matter of Australian legislative preference: it was in order to fulfil a demand imposed on Australia by the US Senate as a condition of it ratifying

⁵⁶⁶ Hence the significant attention given to foot-and-mouth disease. See Chapter 4. Also identified by PS5 and PS6.

⁵⁶⁷ As was the case with both the CoAG review (see PS4's comments above) and the DTC Bill.

the Defence Trade Cooperation Treaty.⁵⁶⁸ In meeting this condition, Defence seemed willing to set to one side national sovereignty over education and research policy.

Disparities in the Defence Trade Cooperation Treaty (and DTC Bill) were noted by Parliament. For example, the Australian Senate questioned why the US could veto the entry of an Australian firm into the 'Community', but that Australia did not enjoy a reciprocal right. When the DTC Bill came back to the House of Representatives following amendment in the Senate, Independent MP Rob Oakeshott likewise asked: 'What on earth is this chamber doing voting against equity for Australian researchers with their US counterparts? Why on earth, in our sovereign interests, would we be voting against that?'.⁵⁶⁹ However, it was evident to the academic community challenging the DTC Bill at the time, that Australia's political commitment to the alliance took priority over almost everything else. R1, NG1 and R2 reported that, while he was chairing the group informing Defence on amendments to the DTC Bill to Chief Scientist had a visit from the US Ambassador to Australia (assumed by interviewees to be for the purpose of influencing his approach). US officials were likewise reported lobbying multiple members of Parliament (principally, Independent and minor party members). An experience reported by R1 suggests that this lobbying was unnecessary for the major parties:

[Liberal Senator] Johnston really understood why [the original DTC Bill] was not good for Australia....[But] I was taken to a meeting with him and [then Deputy Opposition leader and future Foreign Minister] Julie Bishop, in which she formally told him that he was allowed to push [the pro-research amendments to the DTC Bill] as far he could, and as far as he wanted to embarrass the Government. Those were the words that were used. [But], that *ultimately they* [the Party] *would not do anything that the American allies would be unhappy with* (emphasis added).

When Rob Oakeshott MP asked during the final debate on the DTC Bill (during which the Opposition had agreed to reverse their own, successful amendments) 'what on earth has happened in the last 24 hours; who has talked to whom to force that change of position?'.⁵⁷⁰ the answer seems to be that the Opposition's goal of embarrassing the Government had been achieved, and its interest in protecting the Australia-US Alliance had reasserted itself.

⁵⁶⁸ See Appendix 5.

⁵⁶⁹ Commonwealth, *Parliamentary Debates*, House of Representatives, 12603, 30 October 2012 (Robert Oakeshott).

⁵⁷⁰ Ibid. Asking again 'who has got to whom over the last 24 hours', Oakeshott invited 'the Minister for Education and the shadow Minister for Education to...explain why bipartisanship on military affairs matters more than bipartisanship on education affairs in Australia's sovereign interests.'

4. Who were the actors? Who was the audience?

The role of communities in shaping and firming policy boundaries

Where disputes over definitions did arise, the power to shape definitions came from securing political buy-in and marshalling the right kinds of communities. These communities demonstrate many of the features of the ‘epistemic communities’ described in *Global Business Regulation*.

As previously discussed, biosecurity had (and has) a particular meaning and historical relationship with policymaking in Australia that differed from its use by the US-based communities, which took up the term following 9/11 and the anthrax attacks.⁵⁷¹ The influence of this community and international events became apparent during discussions over the use of the term biosecurity. Concluding his views on the case in Australia, PS8 pointed to the role and relative power of security communities: ‘Agriculture might consider they’ve never been gazumped [in policy terms]’ and ‘in their own world, they still might be feeling pretty comfortable with biosecurity’,⁵⁷² ‘when I have the communities [security and Agriculture] together, I know they’re gazumped.’⁵⁷³ Different approaches to threat identification between the communities are examined further below.

Securitization theory focuses on the utterances and actions of an identified securitizing actor. In the context of policymaking, the concept of an actor can be problematic, as responsibility is usually diffused through coordination mechanisms such as IDCs and spread amongst several key individuals.⁵⁷⁴ At the same time, attributing the actions of numerous actors

⁵⁷¹ PS8.

⁵⁷² Such comfort may have been bolstered by high-level, strategic reviews commissioned by DAFF. For example, 2008’s *One Biosecurity: A working partnership: The Independent Review of Australia’s Quarantine and Biosecurity Arrangements*, more commonly known as the Beale Review, raised the prominence of ‘biosecurity’ as a term in the agricultural space and set the direction for DAFF’s policy and lawmaking work, culminating in the *Biosecurity Act 2015* (Cth). The Beale Report’s definition of biosecurity is narrow: ‘the protection of the economy, environment and human health from the negative impacts associated with entry, establishment or spread of exotic pests (including weeds) and diseases’ but it had a lasting effect on policy language, driving the shift from ‘quarantine’ to ‘biosecurity’. This was, in part, based on the argument that quarantine ‘has a largely negative, defensive connotation associated with isolation, segregation and disinfection at the border. Biosecurity is a more pro-active concept, aligned with the pre-, border and post-border continuum, a multi-layered approach, a shift from zero risk to managed risk, from barrier prevention to border management, from ‘no, unless ...’ to ‘yes, provided ...’ [and so] is also conducive to shared responsibility: Australian Government, *One Biosecurity: A working partnership: The Independent Review of Australia’s Quarantine and Biosecurity Arrangements* (Commonwealth of Australia, 2008) 1, XVII. For a critique of this policy shift see: Sam Durant and Thomas Faunce, ‘Analysis of Australia’s New Biosecurity Legislation’ (2018) 25 *Journal of Law and Medicine* 647.

⁵⁷³ PS8.

⁵⁷⁴ See similar observation in: Salter and Piché, above n 147, 934.

to a single artefact – an SRS, or parliamentary speech – risks misidentifying the key securitizing actors and the audiences they were seeking to convince (see Section 2, above).

Nonetheless, the interviews and documentary analysis did show that particular departments and individuals exercised greater influence in initiating policy work, framing issues/threats and – just as importantly – structuring policy processes to constrain the possible forms of regulatory measures to be proposed to government or Parliament. Most obviously, the Department of Defence led the initial development of the DTC Bill and were the primary voices briefing Government on the Bill. However, Defence’s primacy was weakened by the establishment, first, of an informal steering group chaired by the Chief Scientist and, later, the Steering Group, established under the DTCA.⁵⁷⁵ A more subtle weakening came from the growing role of the ‘Research Minister’, who received copies of briefings from the Steering Group and advice from non-Defence agencies such as NHMRC.⁵⁷⁶ In relation to the Biosecurity Bills, the Department of Agriculture led the policy work. This reflected the Bills’ primary focus on agriculture; however, individuals from the ‘border health’ team at the Department wrote the human biosecurity provisions (over the course of about eight years, according to PS9).⁵⁷⁷

The role of DPMC provides the most interesting analytical example of the role of Departments. The CoAG review was overseen by DPMC, with implementation handed over to the Department of Health to achieve via the NHS Bill. While DPMC’s leadership might have been assumed because the DPMC manages CoAG, it was also because DPMC traditionally leads work that requires a whole-of-government approach or because the salience of a topic has increased.⁵⁷⁸

As PS8 remarked,

...there are two pathways for [DPMC] to get engaged in a new issue: one is the [Prime Minister or Cabinet] becomes seized of it. ... Or, alternatively, an agency portfolio becomes seized of an issue, but it's sufficiently whole-of-government that it's difficult for them to coordinate ...[and] PM&C [DPMC] has enhanced coordinating power.

⁵⁷⁵ See discussion below on ‘forum shifting’.

⁵⁷⁶ *Defence Trade Controls Act 2012* (Cth) 74A(2), (3), 6(g), (9), (10).

⁵⁷⁷ PS5 and PS6 identified the border health team at the Ministry of Health as responsible for this policy work. DAFF confirmed that ‘the provisions in Chapter 2 [of the Biosecurity Act 2015 (Cth)] that relate only to human health...were drafted directly between the Department of Health... and the Office of Parliamentary Counsel: FoI Request [2017/18-84] from Department of Agriculture, Fisheries and Forestry to author, 7 June 2018.

⁵⁷⁸ PS8, PS4 and PS2.

This observation was supported by remarks from PS4, the documentary analysis and organisational changes within DPMC in relation to hazardous biological agents and pandemic influenza. For instance, PS8's time in DPMC (2003-2010) coincided with the establishment of a 'science engineering and technology unit' operating as part of the Department's wider national security function. And, as discussed further in Chapter 6, a burst of DPMC's interest and leadership in pandemic influenza policy in 2006, saw the establishment of a CoAG 'Working Group on Influenza Pandemic Prevention and Preparedness' and the signing of a statement of cooperation between Australian governments on human influenza pandemic'.⁵⁷⁹

As such, the involvement of DPMC in a specific domain may be a useful indicator that the topic or subject area is entering a period of contestation, even if it may not involve or result in a securitized outcome.

Commonwealth or state leadership?

A unique issue for federations is which 'sphere' of government has policy leadership over a given subject matter. Constitutions may guide relationships but rarely fully restrict one sphere from deploying strategies to assume control. In the context of Australia, securitizing a threat may, therefore, provide a way for the Commonwealth to assume a new leadership role over a topic previously owned by the states or territories. In a federation, states and territories, therefore, represent a separate audience. The role of the states and territories as an audience was most evident in the CoAG review and regulation of SSBA's where, in contrast to regulatory authority over defence exports, the Commonwealth's role is less explicit.⁵⁸⁰ As PS8 remarked, regulation of biological agents was not 'entirely and exclusively a Commonwealth responsibility or entirely and exclusively a state responsibility.' Consequently, a key step in this policy work was securing agreement from CoAG (in practice from the Premiers/First Ministers of each state and territory) that a review was required and that it was right for the Commonwealth to lead on this work and any resultant regulatory regime. Coming soon after the forcing events of 9/11, the anthrax attacks, and the Bali bombings, PS8 reported that 'it was recognised that it was a Commonwealth responsibility to set up and to manage these risks.'

⁵⁷⁹ Council of Australian Governments, *Communique* (14 July 2006) <https://web.archive.org/web/20091112054132/http://www.coag.gov.au/coag_meeting_outcomes/2006-07-14/docs/coag140706.pdf>.

⁵⁸⁰ Speaking generally on Commonwealth-state health responsibilities PS2 remarked 'The two areas in which [the Commonwealth has a service delivery role] is in what used to be quarantine... now 'human biosecurity', as well as a national terrorism situation [where the] Australian Government can assume the lead.'

Indeed, ‘there really was pretty quick consensus that this was most sensibly implemented as a national and Commonwealth activity.’⁵⁸¹

PS4 likewise did not recall there being any heated ‘discussion’ or ‘concerns’ from the jurisdictions about the Commonwealth leading this work and confirmed that the states and territories did not have representatives on the working groups established to, *inter alia*, design the SSBA regime or the review report.⁵⁸² Nonetheless, it is relevant that the NHS Bill and Biosecurity Bills both provide significant space for the states and territories to be involved in the management of biosecurity risks (see Chapter 4).

Departments and their audience

For public servants involved in policy *design* (eg, the CoAG review and design of the DTC Bill), Ministers and the Government of the day were their principal audience. As stated by PS9: ‘at the end of the day, it’s the government: it’s the Health Minister and Cabinet.’ However, despite the importance of this relationship, no interviewees identified challenges securing the acceptance of their Minister or the Government to their policy proposals. Combined with evidence that Commonwealth public servants are largely responsible for the content of Bills and their extrinsic material (including SRS), this raises interesting questions about how the actor-audience securitization dynamic operates at the bureaucratic-political interface, at least within a single sphere of government. Individuals responsible for the day-to-day administration of the SSBA regime and other health powers identified a wider range of audiences, although these were positioned more as stakeholders. For example, PS5 and PS6 spoke of their engagement with the ‘regulated community’, and they and PS10 agreed that laboratories, ‘pharma’ and researchers were their audience.

However, stakeholders are different – at least analytically – to audiences. A securitizing move requires the acceptance by an audience to be successful, but stakeholders can simply be managed as a routine business practice. Ministers and CoAG had to agree to the SSBA regime; researchers had to adapt to it.⁵⁸³ PS5 and PS6 reported that the initial implementation of the SSBA regime had seen ‘some volatile stakeholders’ but that, by the time of the interview, the

⁵⁸¹ PS8.

⁵⁸² PS8 stated that the states and territories did have an opportunity to comment and agree upon the final report and recommendations of the Review as part of the CoAG process. Interestingly, and seemingly in contradiction to section 33(1)(b) of the *National Health Security Act 2007* (Cth), PS5 and PS6 suggested that the states and territories played no role in what was added or removed from the SSBA list; although this remark was perhaps confined to any initial decision to review the list.

⁵⁸³ Some did so by throwing out their stores of biological agents ‘rather than [have to] report to us’ said PS5.

informants reported that the sector was very supportive and engaged with Health as part of ‘cooperative compliance’.⁵⁸⁴ Other tactics for managing stakeholders identified by interviewees included ‘roadshows’ and annual presentations.⁵⁸⁵ Nonetheless, as discussed below, the identification and enrolment of certain stakeholders in a regulatory regime may provide insight into the principles, norms and rules that bind that – while encroached upon with the introduction of a new regime – might not be entirely discarded.

Notably, ‘the public’ was very rarely cited as an audience and, when it was, their role was largely passive. While noting that ‘it’s really important have the public onside too’, PS9 did not go so far as to suggest that policymakers looked to secure acceptance from the public. Rather it was important for policymakers to consider ‘the consequences in the public’s eye’. These considerations were ‘about risk communication. Just trying to explain why you do things, explaining properly why [you do] things, so the population understands.’ Tactics to engage with the public included making information (eg, pandemic planning documents) public and accessible. However, although ‘every effort is made’ to publish accessibly written material, PS2 concluded that the public are not the intended audience for this material, and it is written for their real audiences: Commonwealth and state and territory public health decision-makers and clinicians.

Nonetheless, PS2 sought to close any distance between subject-object/governors-governed. The views of the public are considered, but through a process of selective co-option by public servant (‘I’ve been in enough meetings where [other public servant] are very happy to pipe in and say “look my neighbour who does x, he or she is not going to like this” or “he or she will think this is great”’) or with public servant acting as a proxy for the public: ‘to be fair, during a pandemic or something that’s going on of national consequence, the majority of us are thinking about this, not only as our job-roles but also as – also as members of the community....’⁵⁸⁶ The obvious issue here is that public servants (and especially senior public servants residing in the Australian Capital Territory) represent a relatively narrow socio-economic class, and the principles, norms and rules that bind, under which they operate (and can accept), may not be those that are broken by a given securitizing move.

⁵⁸⁴ This included engaging a member of the regulated community as part of the external review of the administration of the SSBA regime and operating a dedicated hotline and advice email.

⁵⁸⁵ PS4, PS5, PS6.

⁵⁸⁶ PS2.

One final class of stakeholders mentioned were clinicians. This group is examined further in Chapter 6. While doctors and practitioners did not have to formally ‘accept’ the proposals in the Biosecurity Bills, as discussed in Chapter 4, these Bills strongly reflected the principles and norms that these professions value. Likewise, the day-to-day administration of the *Biosecurity Act 2015* (Cth) ensured that policy and operational decisions were made by individuals trained in or drawn from this community, for example the CMO and the membership of various ‘principal committees’. Other tactics to manage these stakeholders involved included ‘roundtables’ with the heads of medical colleges, calls from the CMO and regular emails and – anachronistically for 2017 – the ‘Friday Fax’.⁵⁸⁷ Compared to the public (or ‘consumers’), engagement with these stakeholders was deeper, more active and more responsive.

The role of individuals, expertise and serendipity

Contrary to assumptions about the role of politics and politicians in biosecurity, none of the individuals interviewed pointed to individual Ministers or politicians as playing a direct or leading role in biosecurity policymaking. No one involved in the CoAG review recalled any instance where a Minister had called the Secretary of a department to request a particular course of action.⁵⁸⁸ Likewise, except for the signing of the Australia-US Defense Trade Cooperation Treaty and visits by US politicians, the initial development of the DTC Bill was – as PS8 suggested – likely undertaken by the Department of Defence as per the standards of ‘good housekeeping and good legislative work’ rather than at the direction of a Minister.⁵⁸⁹

Meanwhile, some non-political individuals do appear to have played highly influential roles. Brought over from the Office of the Gene Technology Regulator (OGTR) to assist with the development of the SSBA list, PS3 and PS4, played an important role in structuring and maintaining its ‘scientific’ and ‘risk-proportionate’ approach to listing pathogens, pushing back against those with ‘harder views’ on what should be regulated. The ability of these individuals to influence and shape the parameters of the SSBA list was enhanced by their scientific expertise (PS3, PS4 and PS8 all had PhDs from the life-sciences) and longevity – PS3 reported a high turnover of government officials on the review panels – thus allowing them to sediment authority.

⁵⁸⁷ PS2 and PS9.

⁵⁸⁸ This was despite the researcher specifically asking.

⁵⁸⁹ See timetable in Appendix 5.

That individuals (PS3 and PS4) with scientific expertise and from an organisation that applied technocratic, risk-management regulatory principles (OGTR)⁵⁹⁰ were tasked with key roles in the design of the SSBA (as opposed to those with security and intelligence backgrounds) seems to have occurred by chance. PS4 considered whether it was ‘serendipitous’ that they ended up working on the review, having been shoulder-tapped by their manager at OGTR. Although this is a case of ‘right person at the right time’ it is notable that OGTR, a small, technical agency, played a larger role than the lead portfolio entity (the Department of Health) in the early stage of the review. Alternatively, the recruitment of scientifically trained, technical experts may have reflected a preference of the more senior official involved in the review: PS8 also had a background as a scientist and had moved from Commonwealth Scientific and Industrial Research Organisation to DPMC in 2003 to help ‘set up the science engineering and technology unit, which was focusing science and tech for support of counter-terrorism.’⁵⁹¹ The somewhat serendipitous way in which policy officers came to be enlisted into the review included the use of academics to produce research that supported the review. Asked how a key outsider had been brought in to advise the review, PS4 conceded that, having attended a workshop where the individual had presented: ‘I was impressed by him, and I thought “this bloke’s got a lot to offer what we’re doing. We should engage him.” It was as crappy and informal as that.’ According to PS4, from this ‘serendipitous’ meeting came ‘formal invitations to roundtables that we might have been holding’ and ‘chats in the margins of meetings’.

If the CoAG review represented the securitization of biological research and a certain class of researcher, it was being undertaken by individuals who were not unfamiliar with the values and principles of that sector and were actively engaging with academics. A similar understanding and approach was absent in the development of the DTC Bill, beginning with the failure of Defence to engage properly with the university sector (in contrast to its engagement with the defence industry).⁵⁹² Interviews with PS4 and NG4 also suggested that another tactical failure by Defence in the DTC Bill was not appreciating the devolved nature

⁵⁹⁰ See for example, the language in the objects clause of the *Gene Technology Act 2000* (Cth) s 3. See further: *Gene Technology Act 2000* (Cth) ss, 4, 27, 50.

⁵⁹¹ PS4 considered whether it was serendipitous that they had ended up working on the review. They had been shoulder-tapped by their manager at OGTR making it a case of being the right person at the right time. However, that a small, technical agency (OGTR) seemed to play a larger role than the lead portfolio Department (the Department of Health) in the early stage of the review – including putting forward secondees – is unexpected.

⁵⁹² Evidence to Senate Standing Committee on Foreign Affairs, Defence and Trade Legislation, Parliament of Australia, 2 March 2012 (Michael Shoebridge, Department of Defence).

of university research and the ability for individual researchers and universities to run their own and policy opposition. Years earlier, this unfamiliarity was apparent to PS4 during the engagement ‘road-shows’ on the proposed SSBA regime:

Of interest, I thought, was that [the academic] sector was not well understood by bureaucrats [Chuckles].... And you could tell that because, you know, you’re running consultation forums with academics who are fronting up in jeans and t-shirts, and you as the Defence Department official or the Foreign Affairs official front up in the suit and flashy cufflinks, there is an immediate disconnect.

Where the CoAG review saw individuals playing an important role structuring policy development, the development of the DTC Bill and 2015 Amendment Bill demonstrated the role of brokers. Professor Ian Chubb, then recently appointed as Chief Scientist, was brought in by the Government to broker a compromise between the academic sector and Defence in 2012 and, later, to chair the Steering Group. It is unclear where the idea for this emerged. Professor Chubb may have involved himself in this work following lobbying from the sector. R1, for instance, recollected:

[I] went to see the Chief Scientist to bring the matter to his attention - he was not aware of it until I brought it to his attention. I explained to him the potential issues for Australian research; he seemed to understand that very well. He said he would take up the issue...

It is also possible that Professor Chubb would have been approached by the Government without the involvement of R1.⁵⁹³ As one public servant (PS3) noted: ‘I can imagine the Chief Scientist had a fair amount of influence there. There really was a train wreck waiting to happen, from memory, when the Department of Defense were going down that initial road.’

Regardless of how he became involved, Professor Chubb was seen as sufficiently influential to both provide comfort to the academic sector (R1 repeatedly referred to the steering group as ‘The Chief Scientist’s steering group’) and to warrant at least one visit from the US Ambassador as part of the US Embassy’s lobbying on the Bill.⁵⁹⁴

⁵⁹³ The use of the Chief Scientist to broker outcomes between government agencies, universities and their lobby groups and researchers (who are not always on the same side) appears to not be an uncommon tactic and was repeated in 2017 in the context of a proposed Office of Research Integrity: Harriet Alexander, ‘Suspected fraud cases prompt calls for research integrity watchdog’, *WA Times* (online), 29 December, 2021 <<https://www.watoday.com.au/national/suspected-fraud-cases-prompt-calls-for-research-integrity-watchdog-20211214-p59hhh.html>>.

⁵⁹⁴ With a resigned laugh, R1 said they ‘we were battling two governments’ over the DTC Bill.

Professor Chubb's role during the more heated debates in 2012 between the academic sector (with opposition primarily led by the University of Sydney) was clearly understood by – in some ways rivalrous – lobby groups Universities Australia (UA) and the Group of Eight (Go8) as that of broker. A critical meeting occurred in Sydney, described by NG1 as a 'last-ditch effort at Ian Chubb brokering a deal [between Defence and the academic sector].' *Global Business Regulation* identifies how individuals enrol the power of institutions and mass publics to shape regulation and win contests of principles.⁵⁹⁵ If the academic community saw the entrance of Professor Chubb into debates as providing them with a similar champion to advance their principles and norms, they made a strategic error. A broker is not the voice for a sector, and it was suggested by NG1 that Professor Chubb was not the 'champion' the academic sector may have hoped for. Instead, NG1 reported that the Chief Scientist saw his role as achieving a pragmatic 'middle position' rather than advancing 'very strong academic freedom arguments':

[In my view] Ian didn't have a huge amount of patience for the very strong 'academic freedom' arguments... because academic freedom was not any kind of absolute thing, and it did need to be balanced against other risks, and that we [the sector] had a responsibility to do that....⁵⁹⁶

Events following that meeting are disputed by individuals who attended the meeting, but the reported personal and professional fallout for individuals from UA and the research organisations that participated in the opposition to the DTC Bill in 2012 were significant and clear to the researcher during interviews conducted many years afterwards. Whatever the characterisation of events, Professor Chubb continued to be seen as a trusted broker by the Government and was appointed as Chair of the Steering Group established under the DTCA.⁵⁹⁷

5. Contesting principles and the role of 'proportionality' as a justificatory tool for securitization

Emerging from the interviews were a series of principles that participants saw as central to biosecurity policymaking. Adopting the high-level categories used in Chapter 4, these principles included normative principles and principles associated with international and

⁵⁹⁵ Braithwaite and Drahos, above n 36, 494-497.

⁵⁹⁶ As the researcher was unable to interview Professor Chubb to confirm his version of events and agreement to have views attributed to him, they have not been quoted directly or, where they have been, care has been taken to frame them appropriately.

⁵⁹⁷ R1 and NG1 also both spoke in generous terms about Professor Chubb.

domestic comity. Importantly, most normative principles informed positions on what was ‘proportionate’ regulation. That regulation should be proportionate is, itself, a principle; but one that manifests as negotiating positions through the application of other principles, usually normative and procedural.

Procedural principles (such as appeal rights) were far less likely to emerge in the interviews.⁵⁹⁸ If procedural principles emerged it was often in the context of how a new regime was better than a previous one (see discussion in Chapter 4). When procedural principles were invoked by those opposing reforms, opposition would be based on some other principle.⁵⁹⁹ As an example of the former, the Biosecurity Bills were described by Department of Health officials as providing more ‘flexibility’. This flexibility both made the law ‘stronger’ – in the sense that it could apply to more activities than the *Quarantine Act 1908* (Cth) – but, conversely, ‘not so strong’ in the sense that its powers were less ‘draconian’ and ‘absolute’ than the Quarantine Act’s.⁶⁰⁰ The COVID-19 pandemic has shown that the powers, in fact, provided the Federal Government with sufficient power to regulate certain activities of the public in a way that (depending on a person’s viewpoint) could be described as ‘draconian’.

Normative principles identified during the interviews included:

- The positive obligation of government to ‘act responsibly’ in the public’s interest – this was a key principle identified by PS8 in justifying the need for a SSBA regime.
- Policymaking should be evidence-based, and preferably ‘scientific’ rather than ‘political’.
 - Relatedly, deference to health professionals and experts, including researchers.
- That research should be conducted in a ‘responsible’ manner.
- Pragmatism – manifesting as a view that it is sometimes ‘better [to be] working within the system than pushing from the outside’.⁶⁰¹

⁵⁹⁸ This is likely because none of the individuals interviewed were involved in the policymaking as lawyers to a department, or Bill drafters, even if they were legally trained. In the debate over the DTC Bill, both sides engaged their own external legal advisors to bolster their policy arguments and the research sector was supported by the Society of University Lawyers (SOUL): R1. In contrast the Senate Committee had a stronger focus on procedural rights.

⁵⁹⁹ See for example: Michael Spence (Sydney University Vice-Chancellor), Submission No 7 to Senate Foreign Affairs, Defence and Trade Committee, *Inquiry into the Defence Trade Controls Bill 2011*, 31 January 2012; Jill Trehwella, Supplementary submission No 7B to Senate Foreign Affairs, Defence and Trade Committee, *Inquiry into the Defence Trade Controls Bill 2011*, 4 October 2012.

⁶⁰⁰ PS9. PS2 described the *Biosecurity Act 2015* (Cth) as a ‘much more modern act. The powers are less draconian and less complete or absolute, compared to the Quarantine Act.’

⁶⁰¹ R3 expressed this principle most explicitly.

- Academic freedom or a principle of ‘freedom of inquiry’. This principle included sub-principles or dependent values, including:
 - the need to exempt ‘fundamental research’ from regulation⁶⁰²
 - autonomy for researchers to follow research interests and leads⁶⁰³
 - promotion of international collaboration⁶⁰⁴
 - an imperative (professional and ethical) to publish and disseminate research findings⁶⁰⁵
 - autonomy to select research collaborators⁶⁰⁶
 - that scientific ‘competitiveness’ is a valuable objective.⁶⁰⁷

As it featured as the most dominant counter-principle to the security interests informing the design of the SSBA regime and DTC Bill, academic freedom is discussed in more detail below.

Academic freedom

The principle of academic freedom featured in the design of the SSBA regime and the DTC Bill. In both cases, security-focused principles won out in the contest of principles. Due to the data that was available to the researcher (documentary and number and range of interviewees), the richest examination of the role of the principle of academic freedom occurred in the case of the DTC Bill. As expected, the principle of academic freedom was most strongly identified and vocally defended by the academic community. To many researchers it was a core value – central to their identity and R3 reported how they and another member of the NHMRC CEO’s

⁶⁰² The concept of fundamental research was central to the amendments UA and the University of Sydney (USYD) sponsored, and R1 especially worked hard to get the Opposition and the Australian Greens to support those amendments in the Senate.

⁶⁰³ Interview with Non-Government Sector Representative 3 (Canberra, 29 September 2017) (hereafter ‘NG3’).

⁶⁰⁴ R3 expressed this as ‘a worldwide collective of research argument, that: “we’re better off sharing everything than hiding things”’. R1, R2 and NG4 also spoke of this principle.

⁶⁰⁵ The ethical imperative to publish and disseminate research findings has been codified in multiple editions of NHMRC, *The Australian Code for the Responsible Conduct of Research* (Commonwealth of Australia, 2007 ed & 2018 ed). Qualifications are limited and are usually policed by researcher-dominated bodies.

⁶⁰⁶ R1 and R2 outlined how they had enlisted health researchers to assist their arguments before the Senate by speaking of the impracticalities of attempting to conduct research in isolation. Reflecting on a different context (sanctions law), R3 spoke of similar discussions in the sector.

⁶⁰⁷ See concerns that preceded the adoption of section 74A(2)(d) of the DTCA, namely that the proposed law would place Australian scientists and researchers ‘at a disadvantage’. See also: Jill Trehwella, Supplementary submission No 7A to Senate Foreign Affairs, Defence and Trade Committee, *Inquiry into the Defence Trade Controls Bill 2011*, 9 August 2012. Some years after the DTCA was enacted, NG3 remarked ‘my impression though is that there’s some concerns that the...Act as it currently stands is still too broad; still, potentially, at least, could hinder research. I did, in passing, note some commentary suggesting that perhaps... particularly in the industry sector some research is not being done here, that would have otherwise be[en] done.’ But they cautioned that ‘I don’t know whether that’s true or not, I’m not close enough in the sector to know.’

advisory panel had been confronted by researchers at an award ceremony after the DTC Bill passed, who ‘accused [us] of putting an end to their research- that they’re going to have to leave the country and work somewhere else’. However, this principle was not immutable, and it was, for many participants in the DTC Bill, tempered by pragmatism.⁶⁰⁸

Uniquely, the interviews revealed that academic freedom was also a principle that could be weaponised by securitizing actors seeking to diminish the legitimacy of opponents to a securitizing move. Those who adopted more pragmatic positions during the policy work, described some opponents of the DTC Bill as pursuing ‘absolute academic freedom’ and – perhaps projecting their own frustrations – one suggested that Defence’s frustration with the sector was due to it ‘being held up by these idealists, who were wanking on about academic freedom, when national security was at risk and the relationship between Australia and its closest ally was on the table.’⁶⁰⁹ NG4 spoke of how researchers expected the academic sector’s peak lobby groups to ‘stand for nothing less [than academic freedom]. It shouldn’t be trying to broker this out. It should be resisting. There is no brokering to be done.’ In contrast, NG4 argued, a middle ground had to be sought because ‘...academic freedom, when taken to its full extreme, was not consistent with ideas of national security when [the latter is also] taken to its extreme.’

In the view of R1 – a central actor in the opposition to the Bill – the ‘absolutist’ position was a strawman argument and not what they were calling for at all. However, the characterisation of opponents as unreasonable ‘idealists’ did appear to weaken the capacity for the sector to mount a unified response to the DTC Bill, notwithstanding that there was some political support for the position, notably the Australian Greens.⁶¹⁰ In a less direct but still no less significant manner, the notion that a biosecurity policy’s opponents represent an ‘extreme’ or ‘absolutist’ or – at best – ‘naïve’ community featured in the CoAG review and the development of the SSBA. As described elsewhere, PS4 spoke of the ‘naïveté’ of researchers (and research funders) as to the ‘threat and the risks’. PS8 echoed this point in the context of what mode of regulation was likely to be acceptable to the Government (ie, not self-regulation

⁶⁰⁸ R3, NG1 and Professor Chubb when he acted as a broker.

⁶⁰⁹ NG4. Care is taken in attributing this to Defence (as they did not participate in the interviews) and – from the researcher’s own observations – Defence employees involved in this work approached it with professionalism. However, NG4’s comment that ‘the stronger it got on the academic freedom side the harder it became to negotiate anything... the harder the discussions became, and the harder it became to really understand what each other was saying, the more entrenched...’ is consistent with R1 and R2’s recollections.

⁶¹⁰ R1, R2 and NG4 all spoke highly of former Greens Senator Scott Ludlam and the ‘impassioned’ speech he delivered on the DTC Bill: Commonwealth, *Parliamentary Debates*, Senate, 29 October 2012, 8119 (Senator Scott Ludlam).

by researchers). Magnifying the effectiveness of turning the principle of academic freedom against its proponents was that ‘rogue scientist’ had been identified as a specific threat, and what was a rogue scientist if not one who was absolutely free of responsibility and restraint? And a cloistered researcher who was reckless – or even neutral – as to how (and by whom) their research findings might be used was no less a threat.

Principles of international and domestic comity

As seen more starkly in Chapter 6, how Australia fulfilled its desire to be a good global citizen differed between actors. Interviewees outside the Department of Health placed significant weight in Australia being a good global citizen (or ‘champion’ or ‘exemplar’) especially with regards to counter-proliferation regimes. However, it being a good global citizen meant something different to those in Health. Pointing to the inherent tension between policy domains, where the good global citizen principle was cited by Health officials it was in the context of behaviour that might have been made problematic under the DTC Bill, for example information and virus-sharing:

while health bureaucrats... appreciate and understand what [the Defence Export Controls Office – DECO] was trying to do, and what the obligations they have under treaties ... getting [the Department of] Health in earlier to discuss what the ramifications could or would be...would have been really helpful. [When I was working in public health in] in the Northern Territory, if I'd known that me sharing information about *burkholderia pseudomallei* with people in various other countries could be seen as being a prohibited action I would have been horrified, because that free sharing of information is just so valuable for [treatment] development.⁶¹¹

Respect for the role of the states and territories was recognised but, in the context of the CoAG review, the Federal-state compact was something to be managed and the issue had been resolved early with a decision to effectively nationalise the regulation of SSBA's.⁶¹² Health officials were more likely to give greater importance to the role of the states and territories. Nonetheless, PS2 acknowledged that for terrorism or a serious pandemic, the Commonwealth

⁶¹¹ PS2. PS2 spoke of how the DTCA ‘inhibits the ability to be innovative and modify assays so that you can respond quickly to it to an emergency’. When asked by the researcher if this was a theoretical risk, PS2 responded that ‘it’s not in theory, it does’.

⁶¹² PS8 reported this was more heated in the context of contemporaneous regulation of ammonia nitrate and security sensitive chemicals. As a counterexample, see the national regulation of animal welfare in research under: NHMRC, *Australian code for the care and use of animals for scientific purposes* (Commonwealth, 2018); *Animal Research Act 1985* (NSW); *Animal Welfare Act 1985* (SA); *Prevention of Cruelty to Animals Act 1986* (Vic); *Animal Welfare Act 1992* (ACT).

could be justified in encroaching and even taking over functions usually performed by local authorities. PS5 and PS6 likewise discounted the role of the states and territories in the decisions over the scope of the SSBA list, notwithstanding their legislated role in various processes. This suggests, at least in the context of bioterror, the usual constitutional principle that the states exercise ‘police powers’ has been undone.⁶¹³

Proportionality: different meanings and different modes of regulation

Advancing the good global citizen principle or respect for the Federal-state compact was usually articulated as justifying the *form* a regulatory measure ought to take. While interviewees all spoke of wanting to see ‘proportionate’ legislation, in truth this was not an objective standard but a subjective one informed by the individual’s normative values and priorities. For an individual, proportionality might dictate the mode of regulation, such as command-and-control with licences, or a looser form of regulation, such as self-regulation or meta-regulation via Codes of Conduct. For example, the academic sector sought, through their opposition to the DTC Bill and later engagement on the Steering Group, to shift regulation of research out of DECO and into the universities, where researchers would apply ‘guidelines’ to their research and researcher-dominated, institutional boards would review research within a familiar web of regulation labelled ‘responsible research’. For individuals within the more pragmatic academic freedom camp, this was believed to be an acceptable regulatory approach that could bridge the divide between actors.⁶¹⁴

Consistent with this endeavour, NHMRC was commissioned to develop an addendum to the Code but, for reasons discussed elsewhere this was never promulgated.⁶¹⁵ Commissioning NHMRC also gave effect to another normative principle: deference to experts. The extent to which DECO possessed the relevant expertise to review researcher’s proposals was another ground for the sector’s opposition to the DTC Bill. ‘So many of these [research] areas, you cannot just have decisions made about them by people that aren’t experts in the areas’ said R2. R1 spoke in stronger terms:

⁶¹³ Importantly, PS5 and PS6 distinguished the SSBA regime from ‘biosafety’ and regulation by the OGTR of accidental release (ie, bioerror), both of which have a higher degree of deference to the states and territories. It is noted that, prior to 2001, Australia had no ‘national laws dealing specifically with terrorism’, let alone bioterrorism: Rebecca Ananian-Welshe, George Williams, ‘The New Terrorists: the Normalisation and Spread of Anti-terror laws in Australia (2014) 38 *Melbourne University Law Review* 363, 365; Williams, above n 247.

⁶¹⁴ R3.

⁶¹⁵ Interviews with R1 and R2 suggest that the 2015 Amendment Bill provided sufficient protection, even while retaining a command-and-control scheme operated out of the Defence Export Office, to ameliorate most of the sector’s concerns.

...it became apparent [during the discussions with Defence] that...there was no scientific expertise within DECO to do the assessments of...to do risk-assessments of the science and technology.... [In addition] there was a culture whereby they really...wanted absolute control and they didn't understand the concept of...an institutional review board...where risks would be identified by people with expertise and they...were therefore not interested or confident...that you could effectively implement a risk-assessment approach.

As discussed below, regulatory culture (actual or perceived) played an important role in the design and operationalisation of each regime. There was a reported impression of Defence as representing a 'command and control' regulatory culture (not unreasonable given the regulatory model embedded in the DTCA). In contrast, Health officials who operate the SSBA regime spoke of how they engage with the regulated community and intelligence community when reviewing whether an entity is holding a SSBA for a 'legitimate purpose', maintaining some deference to scientific expertise.

6. Mechanisms and tactics

This final section discusses two key mechanisms – modelling and forum-shifting – used by actors in policymaking, and the tactics deployed by both proponents and opponents of reform to advance their preferred principles or values. The importance and relevance of these mechanisms is due to the insufficiency of securitization – as a speech act – to specify the detail of an ultimate regulatory outcome (eg, Bill). What emerged from the interviews is that securitization, alone, struggles to explain how nuanced choices are made within a lengthy policy process (such as the choice over which biological agents should be controlled and why). The tactical use of events (discussed above) and forcing events might allow a securitizing actor to swiftly move to securitize an issue, regulatory gap or class of actors (eg, researchers). The mechanisms discussed below could be used by a securitizing actor to advance their securitizing move or by opponents to mitigate or partially or fully desecuritize an issue.

Modelling

The dominant mechanism adopted by policymakers in Australia was predominately one of ‘modelling’.⁶¹⁶ Modelling was frequently framed by public servants as being consistent with Australia’s standing as a good global citizen. For instance, many of the interviewees spoke of their work as implementing or fulfilling Australia’s international obligations in relation to counter-proliferation rules and the IHR. Especially in the arms-control arena, Australia was expected to not just follow global norms but ‘champion’ them.⁶¹⁷ Michael Shoebridge’s presentations to the Senate identified how the DTC Bill provisions on dual-use goods and brokering were based on definitions used in guidelines issued by the Wassenaar Arrangement. Indeed, his presentation on the DTC Bill justified the essential need to pass the Bill on Australia’s membership of the Australia Group and Wassenaar Arrangement.⁶¹⁸ This was an example of a securitizing actor using modelling to support why a foreign regulatory regime (premised on the securitization of biological agents) had to be imported into Australia, regardless of different rules and principles. In contrast, interviewees pointing to how the rights-based language in the Biosecurity Bills was intended to be consistent with the IHR, demonstrates that modelling can also import normatively good principles into domestic laws.

Although modelling dominated in biosecurity policymaking, it was not always a straightforward process of adopting an international guideline or foreign regulatory regime. In the CoAG review and the design of the SSBA regime, for example, the extent to which Australia’s regulatory regime should replicate the regimes in other nations (eg, the ‘select agents’ regime in the US) or the list of controlled agents produced by the Australia Group was a keenly debated issue. As discussed above in the section of threat identification, disputes over the extent to which the SSBA regime and list of controlled biological agents should closely mirror the Australia Group’s lists were a source of intra-bureaucratic contestation.⁶¹⁹

This internal debate suggests that – to the extent the CoAG review represented process of securitizing biological agents and research – the lead securitizing actors disagreed on both the scope of the threat (ie, which agents) and the methods of justifying their securitization (ie, why those agents). On the one side (according to PS4) was a hard-line group who wanted more

⁶¹⁶ As PS8 remarked, modelling went both ways, with Canada using Australia’s SSBA regime as a model for its own regime.

⁶¹⁷ PS8.

⁶¹⁸ Evidence to the Foreign Affairs, Defence and Trade Legislation Committee, Parliament of Australia, Canberra, 2 March 2012 (Michael Shoebridge) 30-40; Evidence to the Foreign Affairs, Defence and Trade Legislation Committee, Parliament of Australia, Canberra, 21 March 2012 (Michael Shoebridge).

⁶¹⁹ PS4.

agents included, either because of a design to more closely model international arms-control groups or a different appreciation of risk. Reflecting on his interactions with this hard-line group, PS4 recollected a conversation around a toxin ‘that comes out of green potatoes’.⁶²⁰

...essentially, the comment was, ‘well we need to have this toxin - which is on the Australia Group list – [on the SSBA list]’. And, I remembered thinking at the time that that was absurd and it didn’t speak to a comprehensive analysis of the risk posed by that toxin.⁶²¹

To PS4, these conversation ‘really rammed home...the importance of having a risk-based regime and not just a list of agents.’

PS3, PS4 and PS8 each spoke of how the design of the Australian SSBA list was undertaken as a ‘risk assessment’ exercise. Copying the US select agents regime or the Australia Group’s list in full was, for PS3 and PS8, not considered an appropriate regulatory approach. The approach adopted diminished the extent to *which* biological agents were securitization but, importantly not fundamental the question of whether some agents needed to be controlled and the justification for overriding pre-existing principles of academic freedom. While ‘it was assumed there’d be a list’, there was a focus ‘around what would be on list..., [and] what mechanisms there would reviewing that list, either to update it with new agents or - possibly - to remove agents if there was an assessment that they posed a lower risk.’⁶²²

In relation to the DTC Bill, decisions over the appropriateness to model the US regime was influenced by perceptions of US regulatory culture. A senior representative of the Go8 and other interviewees, reported that this concern not assuaged by assurances from the Australian Department of Defence that their enforcement culture would be different:

The people in the research offices...quickly realised what it might mean and how broadly the original [DTC Bill] was structured...The research offices staff would immediately go ‘well how do we actually implement this...?’ And they were quickly able to go through the possible ramifications and of course Defence’s response to this

⁶²⁰ Presumably solanine.

⁶²¹ PS4. The researcher sought no identifying information on PS4’s interlocutor in this engagement, and PS4 did not provide any, other than to note that the individual represented ‘part of the Australian Government with a security interest, that had a much harder line view of what should be controlled.’

⁶²² PS4. In contrast, the DSGL, which is based on lists produced by the Australia Group and Wassenaar Arrangement, is very difficult to amend – with consensus of those groups required to add or, more difficult still, remove a technology or agent – see comments from R1 and NG1. Even the US has struggled to secure agreement to modify the lists: Tami Abdollah, ‘US fails to renegotiate arms control rule for hacking tools’ *AP News* (online), 20 December 2016 <<https://apnews.com/article/donald-trump-hacking-international-news-politics-vienna-c0e437b2e24c4b68bb7063f03ce892b5>>.

was ‘well we’d never do that!’ And when certain scenarios are raised then ‘well that’s what the legislation says’. ... [and] here was this American example where clearly they had proceeded by the letter of their law, so why wouldn’t the Defence people here do the same?’⁶²³

The US regulatory approach to biological agents and dual-use goods was seen as ‘more strict’, ‘compliance based’, ‘imposed’ on the university sector and reflecting a ‘much more strong’ regulatory culture and – conversely – a culture of universities of being ‘more accepting of compliance’.⁶²⁴ But, on the other hand, the US regime included an exemption for ‘fundamental research’.⁶²⁵

Finally, constitutional guarantees provided an additional, important counterweight and were a potent tool for US sectors wishing to challenge regulatory action by US Administrations. Referring to the ‘long tradition’ of Bill of Rights cases in helping to shape the limits of the US’s ability to control research, NG4 spoke of the involvement of ‘first amendment people’ and the ‘US gun rights people’.⁶²⁶ Relevant to desecuritization efforts, constitutional rights served not just as a tool to be deployed in legal challenges, but as a rallying standard that could serve to bring together a (perhaps temporary) community of interest.⁶²⁷

Direct modelling, whereby a nation replicates or translates an international principle or norm into its own binding regulation, is only one form of modelling.⁶²⁸ Two other forms that played a central role in the development of the SSBA regime and the DTCA were informal testing of approaches with ‘like-minded’ countries and the use of international representatives to speak to domestic stakeholders on how their own regimes operated. These activities could also be seen as enrolling others to support and amplify the securitizing actor’s claim that

⁶²³ NG3.

⁶²⁴ NG4. NG3 could still recall an example of a US-based researcher being imprisoned for breaching US export control laws by taking research overseas without a permit. The example had been used at a US conference several years ‘before the issue [DTC Bill] was raised in Australia.’ It had ‘[stuck] in his mind’ however and ‘... once I...did get the communication about this potential Bill, one of my first reactions was to dig out the PowerPoint of that [US conference] and send that to people saying “well, this is what it might mean here.”’

⁶²⁵ R1 commented on the strictness of the US approach but also that there were greater freedoms for fundamental research.

⁶²⁶ The latter group had recently initiated a case against the US government over proposals to control electronic instructions for 3D printed guns: ‘the Department of State tried to go after [US Company Defense Distributed] for a violation of the defence regulations for putting this information in the public domain. So that got all of the US gun-rights people up in arms and so this whole thing became a very large first amendment issue. But... first amendment, not for the correct reasons. but mostly because of the gun lobby in the US is so strong’:NG4.

⁶²⁷ In relation to the proposed 3D printed guns administrative rule, NG4 reported that the Department of State ended up receiving ‘something like 10,000 comments to this proposed regulation, where normally they might get a couple of hundred. So they actually ended up pulling back from...that proposed rule.’

⁶²⁸ It is a significant feature of the globalisation of the IHR, with the WHO producing guides for member states on model legislation: WHO, *Toolkit for Implementation in National Legislation*, above n 212.

measures were necessary to address an extreme threat. For instance, although PS4 wrote ‘a line [in the CoAG report] that “we would be informed but not directed by other international arrangements” (or something like that)’, it was clear that the SSBA regime was tested against international models. PS8 (who was more senior than PS4 at the time of the review) reflected:

...we were in in close communication and contact with like-minded countries as to how they were handling these things.... US, UK, Canada were the key ones that we were engaging with.... I met with the people that were working...on numerous occasions. So we were sharing our different methodologies, approaches, thoughts, conclusions. There was a high level of openness amongst those four nations.⁶²⁹

For the DTC Bill, the Department of Defence engaged with both the US and the United Kingdom (which had also negotiated a defence cooperation treaty with the US) as part of the treaty-level processes and in the policy space.⁶³⁰ In a form of ‘capacity building’ Australian officials (including from the Chief Scientist’s office) travelled to a US conference on export controls and, through the coordination of the US Department of Commerce, US Government officials and ‘neutral’, private citizens (including NG4) were brought over from US to assist the Australian Department of Defence and,⁶³¹ later on, to help allay concerns from the research community.⁶³²

Modelling was also used as a tactic by opponents to the DTC Bill, for instance, in their demands that the proposed DTC Bill not be more restrictive than equivalent legislation in the US and UK. The effectiveness of this advocacy can be seen in the successful amendment to the DTC Bill which established the Steering Group, one of whose terms of reference was: ‘whether this Act, the regulations and the implementation arrangements are not more restrictive than United States export control regulations in relation to university activities.’⁶³³ Interviews with NG1, NG2, and a review of the documentation, suggests that, for the research sector, modelling was limited to the effect of the law on ‘fundamental research’. As with the Australian Department of Defence, the academic sector turned to their own experts, engaging a ‘very high profile US firm’ to provide advice on how fundamental research was governed under the US

⁶²⁹ Emphasis added. Later, PS8 returned to this point, commenting that there ‘was very good cooperation and information sharing’.

⁶³⁰ NG3 reported ‘I met with Defence at one point, and one of their people was a second[ee] from the US Defense Department, who’d been, presumably, seconded to increase their understanding of what was being expected’.

⁶³¹ NG4. The degree to which these individuals are – in fact – neutral can be debated. However, NG4 saw herself as largely ‘watch[ing] the process from the outside.’

⁶³² NG4.

⁶³³ *Defence Trade Controls Act 2012* (Cth) s74A(2)(d).

regime.⁶³⁴ This advice was then put to the Australian Senate Committee reviewing the DTC Bill.⁶³⁵ But the use of modelling by this community was limited. And, ultimately, while it could be used to mitigate the (real or perceived) impact of the DTC Bill it could not prevent the new regime from being imposed. The power of the Department of Defence and other actors pushing the DTC Bill was too strong and the use of modelling by these actors created an air of inevitability.⁶³⁶ If the sector found any consolation, it may be that the eventual regime did not reflect their worst fears. NG3, for example, noted that ‘once Defence started [the pilots]...there was a realisation that, despite people’s worries, most research in the sciences and engineering is not covered by the Act - even though it [the DSGL] was a long list - which helped allay people’s concerns’.

Forum shifting

An important mechanism that emerged from the interviews was forum shifting, specifically during the development of the DTC Bill and the 2015 Amendment Bill. The mechanism of forum shifting is introduced in Chapter 2 and, briefly, can involve an actor moving an agenda from one organisation (or deliberative forum) to another. In the context of the DTC Bill, the Bill’s referral to the Senate Foreign Affairs, Defence and Trade (FADT) Committee was a – somewhat fortuitous – instance of moving the policy debate away from the control of the Department of Defence and its stakeholder engagements. The establishment of the Steering Group under the DTCA represents a more deliberate effort to create a forum more sympathetic to the principles and interests of the research community.

The public record surrounding the DTC Bill, reveals that the FADT Committee provided the academic sector with a public venue to express their concerns and bring the matter to the attention of others in the wider community. In contrast, interviewees had reported that earlier engagements with Defence had been subject to obligations of confidentiality. As is considered in the Discussion chapter, it was, in some ways fortunate that the DTC Bill was seen by Defence as an almost procedural Bill that implemented a defence trade agreement with the US and fulfilled some esoteric international obligations on dual-use goods, rather than a key piece of national security legislation. Had it been considered a more sensitive Bill, it may have been

⁶³⁴ R1.

⁶³⁵ Jill Trehwella, Supplementary submission No 7B to Senate Foreign Affairs, Defence and Trade Committee, *Inquiry into the Defence Trade Controls Bill 2011*, 4 October 2012.

⁶³⁶ R1 referred to a hardening position at Defence ‘a strong viewpoint developed ...there was this kind of hard-line: ‘it’s going to Wassenaar Convention, the DSGL, everybody’s going to have to know it!’ ‘Any violation can be...you know through publication can result in 10 years goal.’

referred to the Parliamentary Joint Committee on Intelligence and Security (PJCIS) rather than the more open FADT Committee. The operating model of PJCIS would have made it far less likely that the academic sector would have secured even the small ‘wins’ it gained in 2012.

Ultimately, though, it was the successful amendment of the DTC Bill to establish the Steering Group that provided the academic sector with a new forum to influence the Bill: a forum in which they had – in Chair, Professor Ian Chubb – if not an ally, then an individual who could be trusted to understand their concerns and broker a solution. This success was not immediately apparent to the researchers who had led the opposition to the Bill and who reported being devastated when the Senate amendments were overturned in the House of Representatives. R1 remarked:

That first amendment for the Chief Scientist steering committee...was the key in the end of everything. That I didn’t know. ... At the time, I was **devastated** we didn’t get the publication [exemption]...the fundamental science [exemption]. And I...knew we had got the Chief Scientist committee...but it just didn’t seem like a victory. That was the victory as it turned out. So that required patience, optimism, continuing to work with the system and having some faith that it actually could work (emphasis in the original).

Although R1 refers to the Committee as being a forum through which to work ‘with the system’, what remains notable in relation to the DTCA, the DSG and, to a lesser extent the SSBA regime, is how remote the key decision-making forums (the Wassenaar Arrangement and Australia Group for example) are from researchers. These forums are central to what research is regulated and yet they remain opaque and inaccessible to researchers in Australia.

7. Summary of findings in Chapter 5

This chapter analysed policymaking at the Commonwealth level to respond to a series of biosecurity threats. Data was collected through semi-structured interviews and triangulated with public documents and documents obtained via FoI. Key findings from the Chapter are:

- Public servants (not Ministers) were the responsible authors of the securitization rhetoric in the SRS delivered by Ministers when introducing biosecurity laws to Parliament.
 - This provides a strong, empirical basis for engaging with public servants as part of assessments of securitization – even those based on parliamentary activity.
 - Likewise, there were no reported instances of Ministers initiating biosecurity policymaking via a direction to public servants. Rather, public servants proposed the CoAG review and pandemic preparedness planning. The DTC Bill was the culmination of a long work program overseen by Defence.
- The importance of analysing the role of ‘events’ as part of securitizing moves.
 - Forcing events can be used by public servants or Ministers to initiate policy.
 - Events can help one community to take policy ownership of a concept (eg, ‘biosecurity’) or to consolidate multiple policy work programs addressing a related threat (eg, DURC) under a preferred structure and [security] framing.
 - They can provide added momentum to an initial securitizing move, help to constrain debate and limit ‘acceptable’ options.
- The Australia-US Alliance (the Alliance) is a potent referent object, and its protection could trump other principles, including [Australia’s] national sovereignty.
 - As a non-domestic and largely silent presence, the Alliance represents a curious challenge to the ideal form of securitization as a speech act
- In relation to principles:
 - That the principle of academic freedom could be (and was) turned against its proponents by invoking the threat of the rogue scientist. This further weakened the ability of the academic sector to resist securitization of research under the DTC Bill.

- The weakness of appealing to ‘proportionality’ as a principle to prevent a securitizing move. Indeed, the language of proportionality was invoked by securitizing actors and those opposed alike. This is consistent with a similar finding in Chapter 4.
- Policy *outcomes* are less dictated by the initial securitizing moment than by choices over process structure, lead organisation and staff choices. Starting conditions are serendipitous, their paths hard to predict and their existence not directly evident when analysis only focuses on the text of final policy outputs (eg, Bills). This aligns with Braithwaite and Drahos’s description in *Global Business Regulation* of the emergence of global regulatory rules as a ‘non-linear’ process.
- The academic sector’s failure to prevent the securitization of research activities under the DTC Bill was the result of the strength of the Alliance and the sector’s inability to correctly target and respond to the threat identified by the securitizing actor. Fragmentation of advocacy and a lack of legal remedies (eg, constitutional guarantees of free speech) further weakened their position. However, embedding a new forum (the Steering Group), provided a pathway to wind back some restrictions on time.

Chapter 6: Pandemic preparedness and response: securitization in action?

1. Introduction

Chapter 6 presents the findings from semi-structured interviews conducted with individuals involved in preparing for pandemics and responding to two public health emergencies: the outbreak of pandemic H1N1 influenza in 2009 and the 2013–2016 West Africa Ebola outbreak (hereafter the ‘Ebola outbreak’). Interviewees included Chief Medical/Health Officers (CMO/CHOs) at the Commonwealth and state level, a former Commonwealth Health Minister, and representatives from Red Cross Australia (‘Red Cross’), Médecins Sans Frontières Australia (‘MSF Australia’) and a private health services provider, Aspen Medical (‘Aspen’). Interviews with public servants who held formal roles as CMOs or CHOs are cited as ‘PS(H)*n*’. Other public servants are cited as ‘PS*n*’.

Seeking to answer research questions on the extent of, and consequences of, securitization in Australia’s response to a pandemic or disease with ‘pandemic potential’ (PS2), this Chapter focuses on securitization ‘in action’. It presents findings on how outbreaks and diseases were framed as ‘threats’ and how that rhetoric resulted in action or, surprisingly inaction by the Government. The role of government and non-government individuals is examined as the use of securitizing language was not confined to Ministers or public servants. Because of the thematic overlap between ‘planning’ activities and ‘policymaking’, which has already been examined in Chapter 5, this Chapter gives greater attention to activities associated with Australia’s response to the 2009 pandemic of H1N1 influenza and the Ebola outbreak. Interviews were supplemented by documentary analysis of materials produced by government agencies during the period, submissions to parliamentary inquiries (including an aborted inquiry into the Government’s response to the Ebola outbreak) and media releases, transcripts, and parliamentary speeches from key Parliamentarians and Ministers.

Sections 2 and 3 of this Chapter examine how and when specific diseases and outbreaks came to be presented as ‘threats’ by the Government (including public service). While designating H1N1 a pandemic (and scaling up the Government’s response) happened relatively quickly, a key finding for this Chapter is that Ebola’s characterisation as a threat demanding

government action occurred very late. This is despite Chapter 4's findings as to the power of Ebola as a rhetorical tool. Another key finding was that fragile health systems (particularly in the 'Indo-Pacific' region) were, themselves, identified by interviewees as a threat.

Section 4 presents findings on the referent objects identified by interviewees and politicians. The 'Indo-Pacific' region is singled out as a particularly relevant object. The findings suggest that a consequence of prioritising this object (along with more domestic ones) was to reframe Australia's healthcare workers as a strategic resource that needed to be kept home, rather than deployed in a manner consistent with humanitarian principles and, arguably, epidemiology. Section 5 reports findings on the actors involved in securitization disease outbreaks. This section draws attention to the leading, securitizing role of non-government actors during the Ebola outbreak and the narrow role the Department of Health saw for itself in health emergencies.

Finally, Sections 6 and 7 conclude with an examination of key principles and values and mechanisms used by parties who sought to elevate specific diseases and outbreaks to the level of a security threat. A key value in disease response was a priority given to the safety of Australia's health care workers (HCWs), even where that meant undermining other principles – such as humanitarianism and being a 'good global citizen'.

2. The initiation of planning and response activities

The first part in this section examines the initiation of pandemic preparedness activities to identify the actors likely to be involved in leading securitizing moves. Planning activities, which peaked during the mid to late-2000s, were centred on the emergence of a novel and highly pathogenetic influenza virus, capable of causing a pandemic of influenza. With sporadic outbreaks of avian influenza and a small number of cases of human-human transmission, a pandemic of H5N1 [avian] influenza was the primary threat identified by interviewees – although, as discussed below, other viruses (including coronaviruses)⁶³⁷ were considered possible pandemic candidates. In 2009, these plans had their first test with the pandemic of H1N1 influenza.

⁶³⁷ The non-specific nature of a possible coronavirus is emphasised. To the extent coronaviruses were considered, it was SARS and MERS that informed their thinking.

Initiation (planning activities)

The role of international and domestic events in initiating biosecurity policymaking is examined in Chapter 5. That Chapter found that biosecurity legislation often arose from multiple, usually independent policy-streams, with events bringing those streams together via an ‘opportunistic’ legislative vehicle, such as the NHS Bill. Different communities were able to use events as a way to lend additional weight to their community’s ‘equities’ and objectives. In contrast, pandemic *planning* activities appear to have followed a more straightforward course of initiation → development → real world ‘trial’ → review → revision.⁶³⁸

Interviewees pointed to the 2002–2003 SARS outbreak and limited spill-over outbreaks of avian influenza in the late 1990s and early 2000s as events that initiated a review of domestic response capabilities, and the development of Australia’s modern pandemic plans.⁶³⁹ These events promoted a ‘boom’ (PS1) in attention in the mid-2000s, resulting in domestic planning activities led by the Department of Health (‘Health’) and international funding via Australia’s former development agency, AusAID.⁶⁴⁰ On domestic planning, PS2 and PS(H)4 identified the period of 2003–2004 as when work first got underway – ‘as part of preparation for a potential H5N1 pandemic, because of what was happening in Hong Kong and other parts of Asia....’⁶⁴¹ PS(H)4 provided an abbreviated timeline:

At least as early as 2005.⁶⁴² Probably even 2004, the planning started. It was sort of in its peak around - say 2006–2007- and things were pretty well in place ‘round 2008. There was a bit of a maintenance and then of course swine flu came in 2009.

Missing from PS(H)4’s timeline (but identified through the documentary review) was the 2006 establishment of the CoAG Working Group on Influenza Pandemic Prevention and Preparedness; and the July 2006 agreement by CoAG to the *National Action Plan on Pandemic*

⁶³⁸ See, for example, abbreviated timeline provided by PS(H)4 below.

⁶³⁹ A framework for an Australian Influenza Pandemic Plan was first published by the Department of Health in 1999 and revised 2003, likely in response to SARS: Department of Health, *Australian Health Management Plan for Pandemic Influenza* (hereafter ‘AHMPPI’) (Commonwealth of Australia, 2008 ed) Appendix E.

⁶⁴⁰ As with all booms, there is a ‘bust’, which PS1 identified as lasting from the end of the 2009 influenza pandemic through to the Ebola outbreak. A similar concept– ‘pandemic fatigue’ – was identified by the Department of Health in the 2009 review of Exercise Sustain. Indeed, even though the exercise was conducted during a period of heightened interest, the review reported that ‘there was lots of activity around pandemic preparedness until the last couple of years, but “pandemic fatigue” has set in. That is, there has been a wind back of pandemic focus, interest and momentum due to continuing pandemic threat levels to Australia being perceived as low and competition for scarce resources.’ Council of Australian Governments, *Human Influenza Pandemic Exercise Profram: Exercise Sustain 08: Overview* (Commonwealth of Australia, 2009) 29.

⁶⁴¹ PS2.

⁶⁴² The *Australian Management Plan for Pandemic Influenza* was published in 2005. This plan was updated and served as the basis for the AHMPPI: Department of Industry, *Influenza Pandemic: Business Continuity Guide for Australian Businesses* (Commonwealth of Australia, 2006).

Influenza. This July meeting also saw the signing of a ‘statement of cooperation between Australian governments on human influenza pandemic’ by the Prime Minister and First Ministers of the states and territories.⁶⁴³ Two major, national response simulations, ‘*Exercise Cumpston*’ and ‘*Exercise Sustain*’, were undertaken in 2006 and 2008 respectively, with the latter testing the then draft 2008 *Australian Health Management Plan for Pandemic Influenza* (AHMPPI).⁶⁴⁴

During this ‘boom’ period (ie, 2005–2008), work was led by DPMC and its ‘Pandemic and National Health Security Branch’. A dedicated website – www.flupandemic.gov.au (since decommissioned but archived via Pandora) – was established to host the outputs of the work program. However, then DPMC employee PS8 suggested that, notwithstanding DPMC’s leadership and coordinating role, impetus for the planning came from Health:

I can't remember exactly where the impetus came from. I think it came from the Department of Health and not from the Minister. ... I think that the bird flu stuff was one of those, where [Health] recognised, you know, that some work needs to be done in terms of preparedness and plans ... and then came to us [DPMC].

The involvement of DPMC is unsurprising given its role supporting CoAG and most whole-of-government policy work (see similar finding in Chapter 5). Nonetheless, that there was an entire branch within DPMC focused on ‘pandemics and national health security’ points to the prominence of the issue at the time.

For officials at Health, the initiating role of the WHO was frequently highlighted. For example, PS(H)4 remarked that, in or about 2004, the WHO:

...were looking at H1N5 (*sic*) [avian flu]...which is highly pathogenic, and there was a global zoonotic outbreak. And so there was big concern globally that, if this virus became human-human and easily spread then there could be severe disease and cause a big pandemic....there was a big concern that that would be our next pandemic.

This ‘concern’ was reflected in the tone of policy outputs from this period, which are striking in their sense of inevitability. For example, the ‘Context’ section of the 2009 *National action plan for human influenza pandemic* opens with a pronouncement that ‘The World Health

⁶⁴³ Council of Australian Governments, *Communique*, above n 579.

⁶⁴⁴ Interestingly, while both PS2 and PS(H)3 spoke positively of Exercise Cumpston (‘That was a brilliant move by the Australian Government to coordinate that’, remarked PS2), neither referred to Exercise Sustain. The overview of Exercise Sustain noted that it was forced to adopt a more ‘modest scale’ due to ‘limited resources and time constraints’ and this, combined with its proximity to the outbreak of 2009 pandemic influenza likely accounts for it being overlooked: Council of Australian Governments, *Exercise Sustain 08: Overview*, above n 640, 14.

Organization (WHO) has reported that the world is moving closer to an influenza pandemic.’⁶⁴⁵ The ‘Minister’s foreword’ to the 2008 AHMPPI opens with a similarly dire warning that ‘[a]ccording to the World Health Organization, *it is inevitable* that the world will face another influenza pandemic. While there is no certainty about when the next one will occur, Australia must be prepared.’⁶⁴⁶ Although these documents speak of the benefits of ‘preparation’, at times they adopted a tone of epidemiological fatalism, remarking that, while ‘Governments will actively lead the response to a pandemic’, they ‘cannot alone control and manage the spread of disease, or maintain all the essential services the community will require.’⁶⁴⁷ Contemporary documents similarly cautioned about the ability of the Government (or any government) to save lives during a pandemic. Calling for the population to be prepared, the (now defunct) ‘flupandemic’ website noted on its front page in 2009 that ‘Even though Australia is well equipped, governments alone cannot respond effectively to a flu pandemic. It is important that we are all prepared for the possibility of a pandemic and ready to respond to the threat to help slow the spread of infection and lessen the impact.’⁶⁴⁸

The choice in tone is notable, because it suggests a particular mindset of the authors or a deliberate choice to frame official documents this way. Different choices could have – and indeed – were made. For instance, the 2014 and 2019 editions of the AHMPPI moved away from the more alarming tone of its predecessors.⁶⁴⁹ Likewise, comparable documents produced during a similar boom in New Zealand opened with an appeal to hope and resilience:

If a pandemic came, we would get through it. We know this because we have done it before. It would be difficult, but the better prepared we are, the better we would cope.⁶⁵⁰

⁶⁴⁵ Department of the Prime Minister and Cabinet, *National action plan for human influenza pandemic* (Commonwealth of Australia, 2009) [1.1].

⁶⁴⁶ Foreword by Nicola Roxon MP to: Department of Health, *AHMPPI* (2008 ed), above n 639, ix (emphasis added). Similar remarks were made in Council of Australian Governments, *Exercise Sustain 08: Overview*, above n 640, 29: ‘it was noted that while nobody can predict when a pandemic will occur, a pandemic event is likely during our lifetime. Consequently, pandemic planning is essential...’ (emphasis in the original).

⁶⁴⁷ For example, the CoAG Working Group on Influenza Pandemic Prevention and Preparedness, *Pandemic Planning in the Workforce* (Commonwealth of Australia, 2009) 4. Inevitability also emerged through interviews, with PS(H)4 remarking ‘we know that pandemics occur every... [pause]... regularly. It could be once a decade or it could be once in twenty years, but sometimes it will be twice in a decade - and you just can’t be complacent...’.

⁶⁴⁸ Australian Government, *Preparing for pandemic influenza* (30 October 2009) <<https://web.archive.org/web/20091030013813/http://www.flupandemic.gov.au/internet/panflu/publishing.nsf/Content/home-1>>

⁶⁴⁹ Peter Dutton MP, foreword to: Department of Health, *AHMPPI* (Commonwealth of Australia, 2014 ed).

⁶⁵⁰ National Ethics Advisory Committee [NZ], *Getting Through Together: Ethical values for a pandemic* (New Zealand Government, 2007) iv. New Zealand documents provide a useful comparator because of the geographic and cultural and regulatory closeness of the two countries, which includes New Zealand representation on a number of Australian cross-government committees such as CoAG and the Standing Council of Attorneys-

Because these documents had been reviewed prior to conducting the interviews, one issue examined with interviewees was the extent to which the focus on an inevitable pandemic of – presumably devastating – H5N1 influenza influenced actual response activities. As it emerged, the first post-plan pandemic of influenza was porcine not avian in origin. Nor was it ‘the Armageddon scenario[s]’ envisaged in the plans, where ‘potentially you would have ... the whole population – including elderly – vulnerable’ (PS(H)3).⁶⁵¹

Initiation: pandemic influenza a(H1N1) (‘swine flu’)

Initiation of the Government’s response to disease outbreaks varied. Decisions to act emerged in a dynamic fashion as intelligence was gathered and raised with officials through formal and informal mechanisms, including those established by the WHO on which Australia’s CMO served (PS(H)1), and the Australian Health Protection Principal Committee (AHPPC) and its subcommittees, Communicable Disease Network Australia (CDNA) and the Public Health Laboratory Network (PHLN).⁶⁵² These latter groups support ‘disease surveillance’ activities and via the Department of Health feed information to the CMO and, through them, the Minister of Health.⁶⁵³ As discussed below (and as seen during COVID-19), AHPPC plays a critical role in coordinating a national response to public health emergencies and is comprised of all state and territory CHOs and is chaired by the CMO.⁶⁵⁴

Asked when and how Health’s response to 2009 pandemic influenza began, PS2 replied:

General: Attorney-General’s Department, *About the Standing Council of Attorneys-General* (2022) <<https://www.ag.gov.au/about-us/who-we-are/committees-and-councils/standing-council-attorneys-general>>. New Zealand also has observer status on the Public Health Laboratory Network (PHLN).

⁶⁵¹ As PS11 also remarked: H1N1 ‘...was probably [a] different sort of pandemic than what was planned for’.

⁶⁵² CDNA and PHLN became subcommittees of AHPPC in 2006: PS2; see also: Department of Health and Aged Care, *Communicable Diseases Network Australia* (17 October 2022) Commonwealth of Australia <<https://www.health.gov.au/committees-and-groups/cdna>>; Department of Health and Aged Care, *Public Health Laboratory Network* (PHLN) (12 July 2022) Commonwealth of Australia <<https://www.health.gov.au/committees-and-groups/phln>>.

⁶⁵³ These groups also play an important role during disease response, including developing ‘SoNGs’ (the Series of National Guidelines), intended to ‘provide national consistent advice and guidance to public health units in responding a notifiable disease event’, available at: CDNA, *CDNA Series of National Guidelines (SoNGs)* (20 June 2022) Department of Health and Aged Care <<https://www.health.gov.au/resources/collections/cdna-series-of-national-guidelines-songs>>. Some of these guidelines appear to have been produced through normal planning, eg, *Tuberculosis* (2013), while others were evidently produced in response to specific events, eg, *Ebolavirus* (v1.3 in 2014; v2.2 [current] in 2018), *Zika virus* (2017), *COVID-19* (2020). The smallpox SoNG, released in 2018, coincided with the release of Department of Health, *Smallpox Plan: Domestic Health Emergency Response Plan for a Deliberate Release of Smallpox* (Commonwealth of Australia, 2019), developed under the National Health Emergency Response Arrangements (NatHealth Arrangements, 2009), and available at <<https://www.health.gov.au/resources/publications/smallpox-emergency-management-plan>>.

⁶⁵⁴ Department of Health and Aged Care, *Australian Health Protection Principal Committee (AHPPC)* (24 February 2023) <<https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc>>.

...in April 2009, there was a lot of interest in activity in Mexico of a reasonably severe influenza virus infection, that was causing severe infection with some mortality in Mexico. It had spread beyond Mexico into Canada and parts of the United States.

Of particular concern were reports from the Canadian province of Manitoba ‘where there were Canadian Aborigines who were getting very unwell and some [had] died’ (PS2). As examined in Chapter 5, serendipity also played a small role early in the pandemic’s emergence:

We were fortunate that a former medical officer... from this Department, was working [in Canada] as a medical advisor and she was also providing us with insight....⁶⁵⁵

At some point, the information was sufficient to justify the Australian Government ‘activating’ the ‘National Incident Room’ (NIR) and for Australia to ‘undertake a response process. Engaging states and territories in preparation for what was to be a pandemic of influenza’ (PS2). The activation of the NIR occurred around 24 or 25 April 2009, approximately six weeks after the index case developed symptoms, but six or seven weeks before the WHO described H1N1 as a pandemic.⁶⁵⁶

Things moved at a ‘remarkable’ speed after the activation of the NIR. Playing a leading role in the response, PS2 provided the most detailed timeline of internal events:

Within the first couple of days of the activation, we had had two or three emergency teleconferences of the Australian Health Protection Principal Committee; [and] the [AHMPPI] had been activated. We had worked through [Federal] Executive Council;⁶⁵⁷ through to the Minister, through to the Government, the Prime Minister and the Governor General, to make influenza virus – H1N1 – a quarantinable disease [under the then in force *Quarantine Act 1908* (Cth)].

As a comparison, ‘human coronavirus with pandemic potential’ (ie, SARS-CoV-2; aka COVID-19) was given the equivalent designation by the CMO on 21 January 2020: three weeks after the first public reports of the disease’s emergence in China and 16 days after the

⁶⁵⁵ PS2.

⁶⁵⁶ At the time, the WHO was applying its six pandemic ‘phases’, with phase six representing the pandemic stage. The WHO had elevated the pandemic phase from then phase 3 to phase 4 (human-to-human transmission confirmed) on 27 April 2009 and to phase 5 (spread between two countries in a single WHO region) on 29 April 2009. Timeline adopted from: European Centre for Disease Prevention and Control, *Timeline on the pandemic (H1N1) 2009* (11 August 2010) European Union <<https://www.ecdc.europa.eu/en/seasonal-influenza/2009-influenza-h1n1-timeline>>. For WHO pandemic phases see: WHO, *About pandemic phases*, above n 99.

⁶⁵⁷ Under the *Australian Constitution*, the Executive power of the Commonwealth is vested in the King and exercised by the Governor General as his representative (section 61). In practice, the Governor-General exercises almost all their powers (including making H1N1 a quarantinable disease) on the advice of the Federal Executive Council (sections 62 and 63), comprised of the members of the then Government (sections 62 and 64): House of Representatives, *House of Representatives Practice*, above n 286, Chapter 2; Department of the Prime Minister and Cabinet, *Federal Executive Council Handbook* (Commonwealth of Australia, 2021).

formal notification of Australia and other member states by the WHO of the outbreak of ‘pneumonia of unknown cause in Wuhan city, China’.⁶⁵⁸ Less than two months later the Governor General designated the virus a ‘Human Biosecurity Emergency’ under the *Biosecurity Act 2015* (Cth).⁶⁵⁹

It may have been that the speed of the Government’s response to H1N1 in 2009 was due to the pandemic planning activity that had been undertaken less than five years beforehand, although it was not suggested by interviewees that these documents and activities had primed Ministers or governments to respond more quickly. Rather, it was suggested by PS2 that it was the quality of advice provided by officials that led to quick action:

If all of the politicians are aware, and if you get all of the senior bureaucrats up to date on it, things can just go through.... / ...We were fortunate that the relevant section responsible for border health at the time had very experienced officials who were very good...⁶⁶⁰

The role and importance of staff in disease response is examined further in this Chapter.

Initiation: 2013–2016 Ebola outbreak

In contrast to 2009 pandemic influenza, the initiation of Australia’s response to the Ebola outbreak was slower and less structured. As the quotes below suggest, this was due, in part, to Commonwealth and state and territory health officials assessing the threat to Australia as much lower:

I’m not saying it didn’t pose a challenge to our health service, in terms of the identification. But, what I mean is that [there was] never going to be thousands and thousands of cases, you know.... [The] distance did afford us um, the socio-economic um.... It would be a different situation, say for instance if there was an outbreak in Hong Kong or China, as opposed to something that’s a little bit further away from us in terms of time distance and magnitude of travellers (PS(H)3).

It’s important to understand that there was no concern... there was no concern that Australia couldn’t deal with a case or cases of Ebola. It wasn’t ever going to spread like

⁶⁵⁸ Explanatory Memorandum, Biosecurity (Listed Human Diseases) Amendment Determination 2020 (Cth).

⁶⁵⁹ *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) Declaration 2020* (Cth).

⁶⁶⁰ PS2. Remarks by PS(H)1 and PS(9) were also consistent with this. It was suggested by PS2 that changes in staffing at Health impacted negatively on Health’s ability to respond in the same efficient way to Ebola. Staff changes were also identified as a factor by a post-outbreak review, discussed below.

it did in West Africa. We all understood that. It's actually a hard disease to catch and we all knew that. (PS(H)1).⁶⁶¹

In the early stages of the outbreak – between the first case in December 2013 and 1 April 2014 – Health is not reported as having undertaken any response activities.⁶⁶² This is despite the virus moving into the capital of Guinea on 13 March 2014 and the WHO declaring an outbreak of Ebola on 23 March 2014.⁶⁶³

Increased 'monitoring and tracking of international events' only appears to have commenced from 1 April, with a shift in Health's position to a passive response.⁶⁶⁴ During this time the CMO engaged as normal with various WHO Committees and would have been reporting back to the Department's senior leadership.⁶⁶⁵ During this period, PS11 remarked that Health's 'low level' response activities were primarily focused on outbound traveller safety. This 'low level' response activity appears to have been undertaken by officials within OHP and the CMO, with the Department's other senior executive and Ministers receiving only normal briefings (see timeline of Health's activity in Appendix 7). The Ministry reported that it started to respond to queries from the public on Ebola in mid-April 2014 and, on the 28th of April, created its first template 'Question Time Brief' (QTB) on the Ebola outbreak.⁶⁶⁶ This

⁶⁶¹ See also Department of Health information 'for border agencies' from 28 July 2014: 'While Ebola is a very serious disease, it is not highly contagious. Ebola is not influenza. It is not caught through coughing or sneezing' Department of Health, *FoI Request [114-1415]* (5 March 2015) Document 9 <<https://webarchive.nla.gov.au/awa/20171113055637/http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-146-1415>>. A 21 November 2014 media release issued by the Director of Communicable Disease Control Directorate at WA Health included a section titled 'Ebola virus quick facts'. The first fact was 'Ebola virus is far less contagious than the viruses that cause the flu or common cold': WA Health, 'New SMS text system to strengthen Ebola virus monitoring' (Media Release, 21 November 2014).

⁶⁶² Apis, 'Review of the Department's Response to the Ebola Virus' in Department of Health, *FoI Request [063-1516]* (16 October 2015) <<https://webarchive.nla.gov.au/awa/20171112231646/http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-disc-log-2015-16>>; Timeline, Appendix 7. NG5 and NG6 – both from humanitarian NGOs – reported that the relevant local arms of their organisations had become involved at the very start of 2014. NG2 reported that Aspen Medical, through their American arm, had also been alerted to the outbreak early in 2014: '...we were already in Monrovia in Liberia running a commercial clinic, just normal primary care type work': Interview with Non-Government Sector Representative 2 (Canberra, 5 July 2017) (hereafter 'NG2').

⁶⁶³ Gostin and Friedman, 'Timeline of Ebola Virus Disease Progress in West Africa', above n 8; Centres for Disease Control and Prevention ('CDC'), *2014-2016 Ebola Outbreak in West Africa* (8 March 2019) <<https://web.archive.org/web/20220813155459/https://www.cdc.gov/vhf/ebola/history/2014-2016-outbreak/index.html>>.

⁶⁶⁴ Apis, above n 662, 20.

⁶⁶⁵ PS(H)1.

⁶⁶⁶ QTBs are documents developed in anticipation of expected 'questions without notice' that are asked by opposition MPs of Government Ministers during Parliament's daily 'Question Time'. Apis, above n 662, Table 1. See also Department of Health, *FoI Request [146-1415]* (1 April 2015) <<https://webarchive.nla.gov.au/awa/20171113055637/http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-146-1415>>. A review of *Hansard* shows that the first Question Time where Ebola was raised was 1 October 2014: Commonwealth, *Parliamentary Debates*, House of Representatives, 1 October 2014, 10933 (Tanya Plibersek MP).

activity shows a shift in the nature of the Department's response from passive observation to active management of key audiences.

An inflection point in the Australian response to the Ebola outbreak occurred with the confirmed spread of Ebola to Nigeria in July 2014. The emergence of Ebola in Lagos, a large, internationally connected city, collapsed the comforting geographic distance between West Africa and Australia. An email from then then Acting Secretary of the Department of Health to the CMO on 7 July (which linked to a *news.com.au* article about the outbreak in Nigeria) was brief but anxious:

Chris [the CMO], What is the deal here? Risks to Aus? Action required? People in a Nigerian airport *could go anywhere...* (emphasis added).⁶⁶⁷

Before the end of July 2014, Health had established an Ebola information website; published information sheets for travellers, patients and consumers, GPs, clinicians and laboratories; participated in WHO meetings to discuss resource mobilisation and established a 'Rapid Assessment Team' within OHP. In August, a month after the email from the Acting Health Secretary, the CMO presented to the National Security Committee of Cabinet (NSC) on the Ebola outbreak. Based on these activities, July 2014 marked the true initiation of Australia's response to the Ebola outbreak. What form that response would take, took the rest of the 2014 to resolve but, from this point, as PS(H)1 argued 'there was no doubt that [the Departments of] Foreign Affairs, Attorney-General, Prime Minister and Cabinet and so on, were all intensely interested in...the whole Ebola Issue.' This interest led to the first meeting of the whole-of-government Ebola IDC on 6 August 2014 and briefings to the Foreign Minister from DFAT to commence in mid-August 2014.⁶⁶⁸ It is noted that the change in the form and tempo of Australia's response occurred prior to the Director-General determining the Ebola outbreak a PHEIC, suggesting that the Australian Government was reacting in response to pressures coming from elsewhere than the WHO.

⁶⁶⁷ Department of Health, *FoI 114-1415*, above n 661.

⁶⁶⁸ Dates reported in: DFAT, Response to Questions on Notice to Senate Standing Committee on Foreign Affairs, Defence and Trade, Parliament of Australia, *Supplementary Budget Estimates*, 23 October 2014. The membership of the IDC is set out in Appendix 8.

3. Threat identification

Previous Chapters (eg, Chapter 4, Section 3) have shown how diseases like Ebola are more easily used to support securitizing rhetoric than others. In the parliamentary debates analysed in Chapter 4, Ebola's use as a security-threat occurred hypothetically (ie, divorced from an actual outbreak) and built upon a pre-existing media characterisation and sensitisation of a non-medical community.

Interviews for this Chapter revealed how medical and epidemiological training shaped how key policy makers and health officials identified threats, with different viruses identified as threats to relevant referent objects. However, as discussed below, these individuals were not blind to how diseases were perceived by various communities and audiences, and they engaged in a range of strategies to align the epidemiological risk of a disease with its perceived risk. As PS9 stated:

So there's the science, the knowledge or what you really do know about it.... But there is a perception. Public perception is really a big, big thing.

As discussed below, pre-existing audience priming was relevant for both threat identification in the context of pandemic influenza and Ebola.

Pandemic influenza and coronavirus

As discussed above, the threatening nature of a future pandemic was presented in strong terms in the planning document produced during the mid-2000s, and the strength of this view came through in the interviews with Health officials. Pandemic influenza, PS9 remarked, was 'our biggest threat'. The threat of pandemic influenza meant that 'you just can't be complacent' (PS(H)4). Likewise, PS(H)1 – a former CMO – identified threat of a 'nasty' influenza pandemic, presenting it as a greater threat than Ebola:

...pandemics, the nasty ones, ...would affect all sorts in society and the planning for that is way more complex than it was for Ebola – by a **huge** way – because it would affect every aspect of society...every aspect, from shops, from transport, you name it....

The consequences of such a pandemic would be 'mind-blowing' (PS(H)1). The 'worst-case' pandemic (modelled around the 1918 Spanish Flu) was described by one CHO as the 'the Armageddon scenario' (PS(H)3).

A range of factors were identified by PS(H)1, PS(H)3 and PS(H)4, PS9 and PS(H)3 as contributing to the threatening nature of pandemic influenza:

- a history of pandemics and expectation of future ones
- its clinical characteristics, including:
 - ability for an individual to be ‘infectious before the onset of symptoms’
 - difficult in identifying cases on symptoms alone (especially during infectious period)
 - route of transmission (with respiratory diseases the most concerning)
 - severity, either overall or in specific groups (eg, pandemic influenza is often distinguished by high mortality rates outside the very young or old).⁶⁶⁹

This group’s threat identification is consistent with what one might expect from individuals trained in, or adopting, the public health values outlined in section 6 of Chapter 1, namely: evidence-based and expert-driven decision making, informed by medical science. For similar reasons, PS(H)1 and PS(H)3 also identified coronaviruses such as MERS as presenting a similar (albeit less likely) threat. Reflecting on a television interview they had participated in to discuss the Ebola outbreak, PS(H)1 recollected:

I remember being on Sky News, talking to David Spears ... [and] he asked [what] worried me more?’ Ebola or MERS? And I said ‘well, MERS’. Cause that had a high mortality rate, [and] did spread like flu.... the potential for infection was higher than it was for Ebola.

PS(H)3 likewise directly compared pandemic influenza with SARS-like coronaviruses as ‘things that cause the most concern for me’.

Threat identification could modulate over time – for some audiences. For instance, the pre-sensitisation of the public to Ebola made it difficult to shift the disease out of a threat

⁶⁶⁹ The mortality curve for the Spanish Flu, for instance, took a ‘W shape’, with high mortality rates in healthy young adults aged 20-40: D He, et al, ‘Inferring the causes of the three waves of the 1918 influenza pandemic in England and Wales’ (2013) 280(1766) *Proceedings of the Royal Society B* 20131345; J Luk, P Gross and W W Thompson, ‘Observations on mortality during the 1918 influenza pandemic’ (2001) 33(8) *Clinical infectious disease* 1375. Even with the milder 2009 A(H1N1) pandemic influenza the median age of those dying in Australia from the virus was 53, compared to 83 years for seasonal influenza: Australian Government, *History of pandemics* (19 January 2011) <<https://web.archive.org/web/20110311215430/http://www.flupandemic.gov.au/internet/panflu/publishing.nsf/Content/history-1>>. Doherty’s work *Pandemics: What Everyone Needs to Know*, above n 90, self-described as ‘pandemics for dummies’, likewise elevates pandemic influenza as a threat over Ebola, other diseases and bioterrorism.

framing (see discussion below). However, for some audiences a shift was possible. PS(H)1 suggested that a turning point for how health officers, practitioners and Ministers (but not other MPs nor the general public) saw the Ebola outbreak came after Nigeria contained its own local outbreak and when Ebola did not spread within the US following the case of Thomas Duncan:

I would talk to... people [about how Nigeria contained their outbreak, and they] sort of nodded and weren't reassured. And they weren't reassured until I could talk to them about the case of Thomas Duncan... yes [he] did infect a couple of people ... But no one in his household got Ebola. No one. ... [I]t wasn't until it didn't spread in the US that the world started to take a breath.

In contrast, H5N1 had been a threat during the mid-2000s but PS2 now suggested Health officials were less likely to see it as an extreme threat.⁶⁷⁰ Likewise, the degree to which MERS presented an extreme threat shifted as more knowledge was gained about the disease.

'Not just a...' – counter frames

An epidemiological feature or attribute of a disease may assist in constructing it as a threat, but it is not determinative (and certainly not in Securitization Theory). Conversely, familiarity with one form of a disease, may increase the challenge in securitizing a different strain. In the case of pandemic influenza, one challenge for those seeking to present it as a threat was familiarity with seasonal influenza and seasonal influenza's perceived lack of severity (at least in healthy young adults).

As such, official pandemic influenza documents added additional context to the 'threat' of pandemic influenza. Just as many Government websites today try to warn people that 'the flu is *not just* a cold', so too did these resources present pandemic influenza as 'not just a regular flu'.⁶⁷¹ The amplification of threat usually took the form of associating a future pandemic of influenza with past pandemics, and most commonly the 1918 pandemic (Spanish Flu) – the flu pandemic with a strong cultural and historical resonance in Australia, New Zealand, the UK and the US.⁶⁷² The Australian Government's 'www.flupandemic.gov.au'

⁶⁷⁰ PS2: '...while there have been outbreaks [of avian influenza], it's never reached its full [pandemic] potential. ... Also [limiting its pandemic potential] is the fact that so much has been learned about communicable disease control and management since SARS in 2003, H1N1 in 2009....'

⁶⁷¹ For example, websites promoting vaccination: Department of Health, *Influenza and pertussis (whooping cough) vaccination in pregnancy* (29 March 2019) <<https://www.health.gov.au/news/influenza-and-pertussis-whooping-cough-vaccination-in-pregnancy>>; Immunisation Advisory Centre (NZ), *Influenza* (Immunisation Advisory Centre, NZ) (2022) <<https://www.immune.org.nz/diseases/influenza>>.

⁶⁷² On memory (and memorialisation) of Spanish flu in Australia see: Peter Hobbins, *An Intimate Pandemic: The Community Impact of Influenza in 1919* (2019) RAHS <<https://www.rahs.org.au/an-intimate-pandemic-the->

website, for example, contained a ‘History of pandemics’ page, which starts with a description of the Spanish Flu as sweeping ‘across the world’ causing a loss of human lives ‘unprecedented in modern times. More people died during the pandemic than were killed in the First World War.’ Similar invocations of Spanish Flu are present in the 2008 version of the AHMPPI, which also states that ‘We are planning to have the capacity, capability and flexibility to respond to a pandemic as severe as the one that occurred in 1918.’⁶⁷³ Ironically, one of the things that Government officials identified as ‘not going according to plan’ during the 2009 pandemic of H1N1 influenza was that ‘the virus behaved differently from the pandemic we prepared for...[our plan was] predicated on a much more virulent pandemic.’⁶⁷⁴

Ebola, healthcare workers and the ‘Hollywood factor’

While the health officials interviewed did not characterise Ebola as a threat like pandemic influenza or coronaviruses, they acknowledged that (at least in 2014) ‘Ebola was something special’ (PS(H)1) for politicians and the public, which imposed additional pressures to act. Unsurprisingly, all interviewees recognised the special fear associated with Ebola, with the late-stage symptoms (or at least, the symptoms emphasised by the media) and high mortality rate key contributors:

One it’s a very severe disease. Secondly it has a fear factor. A terrible fear factor (PS9).

I’m not dismissive of the people being fearful of a disease like this. The mortality rate was high. The absence of the vaccine at the time presented real risks... (NG5).

...it was, because a lot of the characteristic symptoms of Ebola.... Everybody thinks, because it’s a haemorrhagic fever, you’re going to be bleeding from every eye and ear (NG2).

...if Australians had heard ... ‘there’s a case of MERS at Sydney Airport, they’d go ‘ohhh, mmmm, I wonder what that’s about?’. [But if] they heard it was a case of Ebola, God, they’d run for their bunker! (PS(H)1).

community-impact-of-influenza-in-1919/>. An infographic produced by the Centres for Disease Control and Prevention (US) to commemorate 100 years since the 1918 flu pandemics had the tagline: ‘We remember. We prepare’: CDC, *How Is Pandemic Flu Different from Seasonal Flu?* (7 May 2019) <<https://www.cdc.gov/flu/pandemic-resources/basics/about.html>>. As discussed in Chapter 7, the historic-cultural implications of the Spanish Flu played a particularly strong role in shaping New Zealand’s border and public health measures during COVID-19.

⁶⁷³ Department of Health, *AHMPPI* (2008 ed), above n 639.

⁶⁷⁴ Evidence to Senate Community Affairs Legislation Committee, Parliament of Australia, Canberra, 3 June 2010, CA 17 (Mary Murnane, Department of Health and Ageing).

The special fear associated with Ebola was ‘because of the previous public sensitisation to the disease’ (PS(H)1) and ‘media hysteria’ (NG5, also NG2). PS(H)1 labelled this prior sensitisation as ‘the Hollywood factor’ and singled out the films *Outbreak* and *Contagion* as contributing to the sensitisation.⁶⁷⁵ The sensitising roles of *Outbreak*, in particular, have been discussed in Chapter 4.

The ‘terrible fear’ of Ebola manifested in different ways for different communities within Australia. NGO representatives interviewed considered the Ebola outbreak a threat in and of itself, and humanitarian NGOs tended to position the virus as a threat to global health and the health systems of developing nations (NG5 and NG6).⁶⁷⁶ An individual involved in Aspen Medical’s deployment to West Africa (NG2) adopted the strongest description of the threat of the outbreak:

What we did have was an international contagion, of the likes of which have not really been seen since the Spanish flu outbreak.... A humanitarian crisis of a scale that, really, no one had truly understood from a contagion point of view.

Chapter 4’s examination of Parliamentary debates, provides some evidence that the fear associated with Ebola attached to the disease and not automatically an outbreak of it. Prior to 2014, there had been at least 20 smaller outbreaks of Ebola.⁶⁷⁷ These had received less global attention, although clearly sufficient interest for the virus to enter the Western psyche through films such as *Outbreak* (1995) and Richard Preston’s bestseller *The Hot Zone*.⁶⁷⁸ The size of the 2013–2016 outbreak was unprecedented, however, and it is likely that this (combined with the efforts of NGOs to use the scale of the outbreak to elevate its threatening nature) contributed to the fear associated with the disease at this time. As NG6 reflected, the usual ‘challenge’ for

⁶⁷⁵ *Outbreak* came in for special criticism during the interview with PS(H)1. The film *Outbreak* also featured in Parliamentary debates around biosecurity legislation in the mid-2000s (see Chapter 4). The same films are also interrogated in Doherty, above n 90, [location 425]. *Outbreak* (Directed by Wolfgang Petersen, Punch Productions Inc, 1995); *Contagion* (Directed by Steven Soderbergh, Participant Media, Image Nation, Double Feature Films, 2011).

⁶⁷⁶ For example, the International President of MSF delivered a special briefing on Ebola to the UN on 2 September 2014. Noting that ‘Six months into the worst Ebola epidemic in history, the world is losing the battle to contain it. Leaders are failing to come to grips with this *transnational threat*’ (emphasis added). She called on States to ‘deploy civilian and military assets with expertise in biohazard containment’ and ‘to dispatch your disaster response teams, backed by the full weight of your logistical capabilities.’ Joanne Liu, ‘MSF International President United Nations Special Briefing on Ebola’ (2 September 2014) MSF <<https://www.msf.org/msf-international-president-united-nations-special-briefing-ebola>>.

⁶⁷⁷ B P Bell, et al, ‘Overview, Control Strategies, and Lessons Learned in the CDC Response to the 2014–2016 Ebola Epidemic’ (2016) 65(Suppl 3) *Morbidity and Mortality Weekly Report* 4.

⁶⁷⁸ Richard Preston, *The Hot Zone* (Random House, 1994). The book was based on Preston’s longform article in the New Yorker magazine: Richard Preston, ‘Crisis in the Hot Zone’ *The New Yorker* (online), October 26 1992 <<https://www.newyorker.com/magazine/1992/10/26/crisis-in-the-hot-zone>>.

their NGO was ‘to get anyone to notice and to support what [is necessary to respond to an outbreak]... rather than trying to manage fear and the political motivations amongst the public policy response.’ Perhaps tellingly, there have been multiple, smaller outbreaks of Ebola since 2016, including between 2018-2020 and again in 2021 that have attracted less attention domestically.⁶⁷⁹

As discussed below, the fact that this outbreak came to be seen as a threat to Australia was likely a function of sensitising and awareness raising activities by humanitarian organisations in early and mid-2014. Hence, Government papers in September 2014 acknowledged the need for more action, not necessarily because of the disease or outbreak itself, but because ‘the EVD [Ebola Virus Disease] outbreak has attracted significant media attention, and ...the matter is potentially contentious and politically sensitive.’⁶⁸⁰ Of the shifting attention, PS11 first spoke of ‘a heightened media awareness and raising of the issues’, only then adding ‘obviously, the number of people with Ebola in West Africa...’ as a factor.

Where humanitarian NGOs framed Ebola as a threat to human health and health security, the Australian Government and domestic media framed Ebola primarily as a border threat. NG5 observed:

...from my perspective, *here in Australia, it became more of a border protection issue than a public health issue* and the [media and political] hysteria around ‘what do we do to keep it out?’ as opposed to ‘what do we do to help contain?’ (emphasis added)

This observation by NG5 appears well founded. Whereas it was the emergence *per se* of pandemic influenza that was a threat, the specific threat identified by Departmental officials in relation to Ebola was that the disease would breach the borders. The negative media coverage and panic that would follow any breach was an implied threat.

There was - there was a chance of it getting here. That we had ...to know that we had things in place in case it did (PS9).

... we had to be prepared because we are an international destination, we know with international air travel, people can fly here and be incubating the disease... (PS(H)3).

⁶⁷⁹ CDC, *History of Ebola Virus Disease (EVD) Outbreaks* (27 January 2023) <<https://www.cdc.gov/vhf/Ebola/history/chronology.html>>.

⁶⁸⁰ See Timeline in Appendix 5. On 19 September 2014, the CMO briefed Australian Health Ministers’ Advisory Council on the Ebola situation in West Africa and Australia’s preparedness. A Memo to the Acting Secretary of Health prior to this meeting noted that ‘The EVD outbreak has attracted significant media attention, and although the risk of transmission to Australia is currently considered to be very low, the matter is potentially contentious and politically sensitive’ in: Department of Health, *FoI Request [114-1415]* (5 March 2015) Document 6.

over that entire period it was...as the concern of any risk of a person arriving in Australia with Ebola rose, then the level of response probably increased commensurately (PS11).

Let's just be very clear: we never had a case [of Ebola in Australia]. Imagine if we'd had a case? My God! The media interest would have been explosive... (PS(H)1).

Finally, the concern was shared by the former Health Minister (P1):

the key secur– health security issue for Australians is if someone arrives at one of our ports with the virus. So, every now and then, I would be informed...that there was suspected–...someone had arrived with an elevated temperature or reported symptoms....⁶⁸¹

Public messaging around Ebola therefore focused on measures at the border.⁶⁸² For instance, a joint media release from the Foreign Affairs Minister and Health Minister on 17 September 2014 assured the public that: 'Australia has robust border protection systems and our infection control measures in hospitals are first rate.'⁶⁸³ A media release issued in November 2014 by then Minister for Agriculture Barnaby Joyce likewise focused on the additional 'precautionary measures at our international airports' which would keep 'the risk of Ebola Virus Disease reaching Australia as low as possible.' These measures, combined with 'our world class biosecurity system' would 'ensure Australia's defences against Ebola remain 'world-leading'.⁶⁸⁴

As Australia's response progressed, the 'risk assessment' shifted, and returning HCWs came to be identified as the most likely vector for Ebola to enter Australia:

our...risk assessment was that the most likely source of someone coming [with Ebola] was going...to most likely to be someone coming from West Africa who had been caring for [patients there]...⁶⁸⁵

⁶⁸¹ See also: Tony Abbott PM, 'Joint Press Conference with the Hon Sussan Ley MP, Assistant Minister for Education' (Press Conference Transcript, 16 October 2014).

⁶⁸² For example, an early media release by then Foreign Minister Julie Bishop MP spoke about the 'border protection and infection control measures' that had been 'undertaken by the Australian Government': Julie Bishop MP, 'Australian assistance to control the Ebola outbreak in West Africa' (Media Release, 24 August 2014).

⁶⁸³ Julie Bishop MP and Peter Dutton MP, 'Further assistance to control the Ebola outbreak in West Africa' (Media Release, 17 September 2014). Whole of Government 'talking points' prepared by the Department of Health also reinforced these points: Department of Health, *FoI Request [114-1415]* (5 March 2015) Document 8.

⁶⁸⁴ Barnaby Joyce MP, 'Preventative Ebola measures enhanced at international airport' (Media Release, 6 November 2014).

⁶⁸⁵ PS11.

Although government employees did not use the language of threat when describing returning HCWs and volunteers, HCWs did come to be framed by some individuals as potential threats in Australia and the United States.⁶⁸⁶ This framing accelerated as HCWs and volunteers began to return to Western countries:

...there were healthcare workers that returned to the US that were unwell. ... There were healthcare workers in Spain, as I recall. There was a nurse who returned... to Scotland from West Africa. So there were a number of cases and, I have to say, quite a lot of- quite a lot of heightened community concern about the risk of that happening [here].⁶⁸⁷

The climax of this threat identification in Australia came with the case of a returned nurse presenting to Cairns Hospital with ‘Ebola-like’ symptoms in October 2014. This prompted public calls for mandatory quarantine for returning HCWs and questioning of their motivations. Despite labelling HCWs ‘saints’, Federal Queensland MP, Bob Katter denounced this threat to Australia:

We love these people, and we honour these Australians for being self-sacrificing, but compared to the risk they create for our country - it is not remotely comparable. One person’s moral and humanitarian ambitions are being carried out at a very grave cost to Australia.⁶⁸⁸

Such was the concern about returning HCWs that, according to NG5, ‘the politics of the day was such’ that their organisation was warned that, should one of their Australian volunteers contract Ebola, they could be refused entry to Australia. That such an ‘exceptional’ measure was ‘floating around’ in discussions is remarkable. As NG5 phrased it: ‘[it] was just ... uncharted territory in some respects....’. While such restrictions did not arise during the outbreak, the right of return for citizens was to become a key contest during the COVID-19 pandemic. Although Katter was the most vocal and public representation of the HCW-as-threat, he was not alone. PS1 and PS11 (who both played leading roles in the IDC) spoke about

⁶⁸⁶ The response of certain US Governors to returning HCWs is discussed in Chapter 1.

⁶⁸⁷ PS11.

⁶⁸⁸ Bob Katter MP, ‘Statement regarding reports of a Cairns patient is being tested for Ebola virus in a Cairns hospital’ (Media Release, 9 October 2014). Katter made similar statements over the following days: Bob Katter MP, ‘Katter calls for mandatory quarantine for Ebola’ (Media Release, 10 October 2014); Bob Katter MP, ‘Equine influenza managed better than Ebola: Katter calls for investigation’ (Media Release, 11 October 2014); Bob Katter MP, ‘Katter calls Australia’s handling of Ebola: “A” in medicine, “Z” in logic’ (Media Release, 13 October 2014). For the immediate response by political journalists and health professions to Katter’s statements see: Michelle Grattan, ‘Time for Team Australia to do more on Ebola’, *The Conversation* (online), 10 October 2014 <<https://theconversation.com/time-for-team-australia-to-do-more-on-Ebola-32830>>; Australian Medical Association, ‘AMA urges calm as Australian nurse tested for Ebola’ (Media Release, 9 April 2022).

correspondence their Departments received from the public saying, ‘we shouldn't send anybody there, because they'll just bring it back’ (PS1).⁶⁸⁹

Health systems as a threat

Several critiques of ‘health security’ and the language of ‘emerging infectious diseases’ argue that such framings are often about securing the health of populations in the Global North from diseases which emerge in the Global South.⁶⁹⁰ Based on the literature, it was therefore anticipated that foreign (ie, developing nation) health systems would be identified by interviewees as a threat to Australia, the Australian public or ‘global health’.⁶⁹¹ This was the case – although the threat identification was sympathetic in tone:

There [West Africa] we were talking about very fragile health systems, which is the nicest way to categorise their health systems... (PS(H)1)

I think everyone understands that... in a more challenged, developing country... compliance with infection control and other things become more complicated...(PS(H)3)

Also you consider the environments it [Ebola] happened.... where the education is at its lowest; the health standards are its lowest; and communications are the slowest. And there were cultural practices that actually facilitated the transfer of disease. So, you know, you bring all of those things together and it's a perfect storm, you know (NG2).

Interestingly, at the time interviews were conducted, Australia’s response to this threat had become institutionalised with the establishment in 2017 of the new ‘Ambassador for Regional Health Security’ and Indo-Pacific Centre for Health Security within DFAT.⁶⁹² The Ambassador role built on an earlier ‘Ambassador’ for HIV/AIDS, TB and malaria but represented an explicit shift to both security-focused language (‘health security’ as opposed to

⁶⁸⁹ Reflecting on this, PS(H)3 commented: ‘I was just a little bit concerned where the fear was leading to a lack of generosity of spirit or acknowledgment of the aid workers and the health workers’ contribution.’

⁶⁹⁰ For example: Stephenson, ‘The Disappearing Act of Global Health Security’, above n 75; S Kippax and Niamh Stephenson, ‘Infectious Disease and Globalization’ in Bryan Turner and Robert Holton (eds), *The Routledge International Handbook of Globalization Studies* (Routledge, 2nd ed, 2016); Fidler, ‘Biosecurity: Friend or Foe for Public Health Governance?’, above n 38; Alison Bashford, ‘“The Age of Universal Contagion”: History, Disease and Globalization’ in Alison Bashford (ed), *Medicine at the Border: Disease, Globalization and Security: 1850 to the Present* (Palgrave Macmillan UK, 2007) 216. See further in Chapter 2 and Chapter 7.

⁶⁹¹ Failings in developed nations’ health systems were less commonly identified and when done so, the issues were less structural and more individualised failings, eg, how a ‘lack of vigilance can cause a problem’ (PS2) or how US hospitals could misdiagnose a patient with Ebola (PS(H)1)).

⁶⁹² Julie Bishop MP, ‘Ambassador for Regional Health Security’ (Media Release, 13 June 2017); Julie Bishop MP, ‘Indo-Pacific Health Security Initiative’ (Media Release, 8 October 2017).

specific diseases) and to a specific region ('Indo-Pacific'). The centring of the role's attention on the Indo-Pacific is discussed below in the context of the region emerging as a referent object. PS1 confirmed that, while not solely responsible for the creation of the new Ambassador role and centre, Ebola 'did push it up'.⁶⁹³ Ebola provided 'a framing that helped' including by appealing to those parts of the public that are much more amenable to 'an aid program that [delivers for the] national interest.' NG6 likewise linked the establishment of the role with the Ebola outbreak, calling the outbreak a 'wakeup call'. This new framing also marked a stronger focus on health systems:

... the lesson from Ebola was, it was as much a failure of health systems, as was just about treating pandemics, or treating Ebola.

4. Referent object identification

As in previous Chapters, interviewees did not cite an explicit 'referent object' in planning for pandemics or specific responses. As with biosecurity policymaking (Chapter 5), a generalised referent object of 'the Australian population' or 'the public' or 'the health of the [Australian] community', emerged from interviews with PS(H)4, PS(H)3 and PS(H)1. Similar objects were identified by politicians, including the Prime Minister. For instance, in justifying the 'visa ban' during the Ebola outbreak, Prime Minister Abbott remarked that:

The first priority of the Australian Government is the protection of Australia. That's the first priority of the Australian Government (emphasis added).⁶⁹⁴

Likewise, a letter to the then Health Minister Sussan Ley MP, from Prime Minister Tony Abbott, reflects his concern that any downscaling of domestic (ie, border) measures ensure 'that the Australian community is protected' from Ebola.⁶⁹⁵

Only one interviewee (PS2) spoke of the differing impacts of a pandemic (H1N1) on different demographics (eg, pregnant women) and ethnic groups (First Nations groups in Australia and Canada), suggesting that non-polity-based, sub-national groupings were less

⁶⁹³ PS1 pointed to a 2015 DFAT paper as the genesis for the policy work behind the new role.

⁶⁹⁴ Tony Abbott PM, 'Joint Press Conference with the Hon. Peter Dutton MP, Minister for Health' (Press Conference Transcript, 5 November 2014). A similar remark was made by a Government Senator during the urgency debate on the Ebola response: 'Without question, the primary responsibility of our government is the protection of Australians': Commonwealth, *Parliamentary Debates*, Senate, 29 October 2014, 8180 (Senator Linda Reynolds).

⁶⁹⁵ Letter from Tony Abbott PM to the Hon Sussan Ley MP (Minister for Health) (C15/24754) 20 May 2015.

likely to be identified as a referent object, notwithstanding that a pandemic may have extreme, or even existential, consequences for those groups.⁶⁹⁶ Even the ‘slogan’ adopted by the Government during the 2009 influenza pandemic – ‘mild in most; severe in some; moderate overall’ – downplays the threat to at-risk communities to emphasise a message of assurance for the majority.⁶⁹⁷

The Indo-Pacific as a referent object

Nonetheless, a non-domestic object did emerge during interviews: the health systems of countries within the Indo-Pacific region. In practice, this meant Pacific Island Countries (PICs) with fragile health systems, such as Papua New Guinea (PNG) and Vanuatu.⁶⁹⁸ Interviewees from Health, DFAT and Aspen Medical argued that Australia had a greater duty to act in its region (or ‘neighbourhood’ as NG2 said). Suggesting that ‘you would expect [Australia’s] response to a crisis in the Pacific to be more proportionate than in Africa’, NG2 asked rhetorically:

Could [Australia’s response] have been done earlier? Maybe. ... Did we have a commitment and a stake? Is this like the Pacific? If this [Ebola] had happened in PNG Absolutely, we would have been there **ages, ages** earlier (emphasis in the original).

Describing the region as ‘our area of responsibility’ PS11 reflected on global expectations for Australia:

[A] reasonable consideration of the Government was - given where our location is, if there was an outbreak in any of the pacific islands, the rest of the world would be looking to Australia to actively engage in that. ... And, we had a view that, if something happened in one of those places, we would be expected to assist and so, therefore, we were making sure we had plans in place, in order to do that...⁶⁹⁹

⁶⁹⁶ In contrast, in Chapter 7, the positioning of the populations of PICs as a referent object during COVID-19 by the New Zealand Government is described briefly and tied to a historical sense of guilt for the country’s role in introducing the Spanish Flu to Samoa.

⁶⁹⁷ PS2. See also: Australian Government, *Pandemic (H1N1) Influenza 2009* (2 June 2011) <<https://web.archive.org/web/20110601172726/http://www.flupandemic.gov.au/internet/panflu/publishing.nsf/Content/H1N1%202009-1>>.

⁶⁹⁸ WHO strategies identify the following nations as PICs: the Commonwealth of the Northern Mariana Islands, the Federated States of Micronesia, Fiji, French Polynesia, Kiribati, the Marshall Islands, Nauru, New Caledonia, New Zealand, Palau, Solomon Islands, Tonga, Tuvalu, Vanuatu, and Wallis and Futuna. In this thesis, discussion of PICs excludes New Zealand as it – and Australia – are both developed nations and are usually in the position of being ‘donor’ nations. See, for example: WHO, *Country Cooperation Strategy 2018-2022: Pacific Island Countries and Areas* [WPRO/2017/DPM/027] (WHO, 2018).

⁶⁹⁹ Responsibilities associated with a country’s former colonial status and current ‘donor’ status were also identified by NG2 and PS1: ‘The US, UK, Europe – from a donor perspective – recognise that [they] play a

This regional responsibility manifested in two ways: first, in a regional contingency plan Australia developed;⁷⁰⁰ and, second, in a reluctance by the Government to deploy an AUSMAT team to West Africa, in case a team needed to be sent to a more proximate country to deal with an outbreak that might pose a more direct threat to Australia.⁷⁰¹

Keeping healthcare workers close to home?

It is argued that a consequence of framing Ebola primarily as a border issue, associating it with fragile health systems, and identifying the Indo-Pacific region as a priority referent object for Australia was that it created a reluctance for the Government to accede to requests to publicly deploy HCWs to West Africa. A recurring criticism of the Government during the Ebola outbreak had been a perceived reluctance to send an AUSMAT team to West Africa. Humanitarian organisations suggested that Australia's hesitation stemmed from a desire to 'build up defences' for a possible outbreak in Australia, PNG, Timor-Leste or a PIC. NG5 recalled how they:

...[were] fronting the media on this issue and it was- the line that I was trying to push was: 'we have a responsibility. The best place to deal with Ebola was containing it at source, not building up defences ...if, and when, it comes to Australia' (emphasis in original).

NG6 reported how this was frustrating from both a humanitarian and epidemiological perspective:

To us it seemed like an odd justification from the epidemiological point of view that you'd need to retain your capacity to fight a disease *until* the point that the disease

stronger role or a lead role in Africa, for example, than Australia. And, similarly in the Pacific, Australia's expected to play a lead and stronger role than [the UK]' (PS1). PS1's comments were supported by public remarks by the Government: Tony Abbott PM and Peter Dutton MP, 'New Measures in the Fight Against Ebola' (Media Release, 5 November 2014) 'Consistent with the Government's long-standing priority to keep our country and our region safe from Ebola....'

⁷⁰⁰ A copy of this 'Action Plan' has not been located, although it may have gone under the name of 'Preparedness for a potential outbreak of Ebola virus disease: a framework for action in the Western Pacific Region', cited in: Zhen Xu, et al, 'Ebola Preparedness in the Western Pacific Region, 2014' (2015) 6(1) *Western Pacific Surveillance and Response Journal* 66. It built upon a risk assessment undertaken by the WHO: WHO-Western Pacific Region, *Ebola Virus Disease: Risk Assessment in the Western Pacific Region* (WHO, 2014). The author obtained a copy of the domestic contingency plan via FoI: FoI Request [2018-083] from DPMC to author, 29 June 2018. Available on request.

⁷⁰¹ Discussed further below. But see comments from then Prime Minister Tony Abbott: 'We also have a ready reaction team that can deploy at a moment's notice to our region to deal with any break in countries which are less well prepared than Australia to deal with this matter. That is our priority at home and in our region. Nevertheless, we are continuing to talk to our friends and partners about what more might be done to address the situation in West Africa.' Commonwealth, *Parliamentary Debates*, House of Representatives, 29 October 2014, 11972 (Tony Abbott PM).

comes to your doorstep; rather than going to the epicentre and trying to nip it in the bud, so to speak' (emphasis in original).

Statements from politicians gave substance to the humanitarian sector's frustrations. Prime Minister Abbott was explicit in Australia's priorities on 5 November 2014:

As you also know Australia has been steadily ramping up its response. Yes, *our first priority is always help at home, followed by help in the region* but we are determined to be good citizens globally, as well as regionally, so we have been ramping up our response.⁷⁰²

Such an ordering of priorities was not considered contentious by Abbott but rather reflected what the Australian public would expect:

I think the Australian people expect our priorities to be prevention at home, preparedness in the region, and work in the wider world and that's what we are doing as part of our campaign, to be the very best possible international citizen.⁷⁰³

Politicians were not alone in this prioritisation, although they were the most likely to invoke it explicitly. PS1 recalled that, in providing the Department's advice to the Foreign Minister 'there [were] other national interest considerations as well around, should we keep some of the resources in Australia, for this region as well?' NG2 – who dealt significantly with PS1 during the outbreak – shared a similar version of events, which led (appropriately – in the view of NG2) to the selection of Aspen Medical:

the Australian Government's going "Hang on! So we're going to need someone to do this. Do we send in the Defence Force as we're coming into, you know... tropical cyclones season and all this sort of stuff?" An AUSMAT team and stuff would be relevant. Or do we contract it out?" And, here's an Australian company [Aspen] that's won a world-wide tender against every company in the US to deliver Ebola services.⁷⁰⁴

In the main, however, public servants consistently identified the challenge of repatriating HCW who might contract Ebola as the key reason for the delay in sending HCWs:

there was real concern, real concern that if someone became unwell or had been exposed and they needed to be repatriated to Australia, that they could deteriorate significantly on route ...⁷⁰⁵

⁷⁰² Tony Abbott PM, 'Joint Press Conference with the Hon. Peter Dutton MP, Minister for Health' (Press Conference Transcript, 5 November 2014) (emphasis added).

⁷⁰³ Ibid.

⁷⁰⁴ NG2.

⁷⁰⁵ PS(H)1.

That was [discussed] for quite a long time... And, that was probably something that played into quite a lot of why we ended up contracting Aspen, rather than sending an AUSMAT team.⁷⁰⁶

The absence of agreement with a developed country to accept Australian HCWs who needed to be evacuated from the outbreak site also featured in interviews and public statements.⁷⁰⁷

Notwithstanding the sincerity of statements by public servants about ensuring the safety of deployed Australian HCWs, PS11's comment that this risk was one factor in the Government engaging Aspen Medical is notable. It suggests that, even if an agreement had been struck with a foreign country to treat evacuated HCWs, an AUSMAT or Government-sponsored medical team would never have been deployed to West Africa. This is supported by the author's review of the Government's Pacific contingency plan, which did not suggest that an AUSMAT deployment to West Africa was ever planned.⁷⁰⁸

Justifying contracting out Australia's response, Abbott 'stressed': '...this is a health emergency. It's not a military emergency... which is why we have contracted a private health provider to do this.'⁷⁰⁹ In the same press conference, the Health Minister distinguished between Australia's domestic 'response', its 'regional response' and 'our humanitarian efforts in West Africa'. The Prime Minister's distancing of Australia from its own response stands in contrast to that of his Foreign Minister, whose press release extolled the establishment of the Ebola Treatment Centre (ETC) ('managed and operated by Australia'), stating that 'Australia will be saving lives'.⁷¹⁰ The difference in framing is likely due to the interface between the Foreign

⁷⁰⁶ PS11.

⁷⁰⁷ See, eg, remarks by then Prime Minister Abbott in: Tony Abbott, 'Joint Press Conference with the Hon. Sussan Ley MP, Assistant Minister for Education' (Press Conference Transcript, 16 October 2014). Issues around securing agreement from foreign nations to treat potentially infected Australian HCWs is examined below. An agreement was reached with the UK shortly before Aspen deployed.

⁷⁰⁸ FoI Request [2018-083] from DPMC to author, 29 June 2018.

⁷⁰⁹ Ironically, Aspen Medical's early contracts with the Australian Government were to support military operations: first in the Solomon Islands and, at the time of the interview with NG2, in Mosul, Iraq to support Australian forces engaged with ISIS. Senator Richard Di Natale (Australian Greens) also identified this mismatch in responses: 'Why is it that we can agree to military intervention in Iraq in the name of saving lives and yet we cannot commit a fraction of those resources to an emergency that the UN has said is bigger than the threat of terrorism? I suspect that part of the reason lies in fear and ignorance': Commonwealth, *Parliamentary Debates*, Senate, 29 October 2014, 8170 (Senator Richard Di Natale).

⁷¹⁰ Indeed, all of the Foreign Minister's media releases referred to the ETC as the 'Australia-managed' ETC: Julie Bishop, 'Australian health workers depart for Sierra Leone to fight Ebola' (Media release, 28 November 2014); Julie Bishop, 'Australian-managed Ebola treatment centre begins operations in Sierra Leone' (Media release, 14 December 2014); Julie Bishop, 'First Ebola survivor discharged from Australian-managed Ebola clinic' (Media release, 6 January 2015); Julie Bishop, 'Ebola Treatment Centre update' (Media release, 16 January 2015); Julie Bishop, 'Next steps for Australia's Ebola response' (Media release, 20 April 2015).

Minister, DFAT and the international community: and the stronger pull of the ‘good global citizen’ principle (discussed below).

Combined with the regional Contingency Plan, it is argued that Australia’s response to Ebola highlights how its global health security responsibilities and ambitions are shaped and limited by distinction between humanitarian activities and ‘true’ emergencies. In addition, the response revealed Australia’s prioritisation of its own domestic health capacity and securitization of its immediate regional neighbours and, to a lesser extent, the wider Indo-Pacific.

5. Who were the actors and the audiences?

The role of different actors in initiating the pandemic planning and response activities has been described above in Section 2. Officials within Health and DPMC initiated the peak period of pandemic influenza planning in the early and mid-2000s and took a lead role in the response to the 2009 pandemic of H1N1 (via the NIR). The Ebola outbreak saw the emergence of a new leadership model: an IDC co-chaired by DFAT and Health, with DFAT taking the lead in designing Australia’s international response to the outbreak.

A significant finding from the interviews and documentary analysis was that the classically securitizing language around Ebola outbreak came, not from the Government, but from external parties: the Opposition, non-government MPs and segments of the media and public. In other areas of biosecurity policymaking these groups are usually positioned as the ‘audience’ but, during responses, their actions and language were more akin to a securitizing actor. How this manifested in the context of returning HCWs has already been described above and it was notable how much the Government sought to push back on framing Ebola as a security issue: at least where the threat was in West Africa. The tactics and mechanisms used by the opposition parties and NGOs during the Ebola outbreak to raise urgency around the Ebola outbreak are described in Section 7 below. In contrast to the Ebola outbreak, no similar attempt by non-government, domestic actors to securitize the 2009 pandemic of H1N1 influenza was identified via the interviews or parliamentary search. A few ‘questions without notice’ were asked by members of the Opposition (at the time, the Liberal and National Parties) but, when they were, the focus was on the production and distribution of the H1N1 vaccine and

– following the pandemic – what was to happen to the unused vaccines (ie, concerns about government waste).⁷¹¹

Ministers and Government MPs during health emergencies

Interviewees did not cite Ministers or Parliamentarians as playing an initiating or significant role in the pandemic planning activities examined.⁷¹² That politicians largely stood back from policy is consistent with a reflection of former CMO, PS(H)1:

...if I just take a broader view of my role as Chief Medical Officer, on matters of health and disease, the politicians of all sides listened closely, didn't make it political and really absorbed [the advice] and almost invariably adopted the advice that they were being given...

Even in the response to public health emergencies, Ministers and *Government* Members of Parliament largely adopted a passive role: keen to know that plans are in place and receiving ongoing briefings and updates. Although they only became Minister of Health during the later phases of the Ebola outbreak, P1 described their involvement thus:

I would have received a briefing when I came in and... the architecture of our response would have been described to me. I would have asked questions. I would have clarified where reporting lines lay. ...Another thing I would have clarified was that we had plans in place if the Ebola virus was detected in Australia. So, it was my job to be secure in the knowledge that all those things were being taken care of...

This reflection matched PS11's description of their interactions between Health and the Minister's Office: both generally, and in the case of Ebola.

Nonetheless, there were occasions during the Ebola outbreak (and to a lesser extend the 2009 influenza pandemic) when Ministers acted independently of, or contrary to, advice from their departments. One example during the Ebola outbreak was when the Prime Minister announced a 'pause' on processing visas for applicants in Ebola-affected countries. The

⁷¹¹ For example, see Senator Fierravanti-Wells' line of questioning in: Senate Community Affairs Committee, Parliament of Australia, Canberra, 10 February 2010, CA 141-143 (Senator Concetta Fierravanti-Wells); see also: Commonwealth, *Parliamentary Debates*, Senate, 3 February 2010, 411 (Question from Senator Mathias Corman to Senator Joe Ludwig, Minister representing the Minister for Health and Ageing); Commonwealth, *Parliamentary Debates*, Senate, 4 February 2010, 584 (Question from Senator Mathias Corman to Senator Joe Ludwig, Minister representing the Minister for Health and Ageing); Commonwealth, *Parliamentary Debates*, Senate, 22 February 2010, 773 (Question from Senator Mathias Corman to Senator Joe Ludwig, Minister representing the Minister for Health and Ageing).

⁷¹² PS2 did refer to politicians and Ministers partaking in pandemic exercises and desktop scenarios. See also Council of Australian Governments, *Exercise Sustain 08: Overview*, above n 640.

decision extended to all visa applicants from the region, including for humanitarian and temporary visas and affected about 680 people.⁷¹³ This decision took officials in Health and DFAT by surprise and resulted in some ‘tricky’ (PS1) conversations with the WHO, who saw ‘no justification for restraint of trade nor travel’ (PS(H)1). Conspicuously, this decision was reported by interviewees as occurring after – not a meeting of the NSC – but a more intimate ‘deep dive’ session, organised by the Prime Minister. The ‘deep dive’ involved ‘a mix of Ministers and Secretaries...and other key officials’.⁷¹⁴ When then Minister for Immigration Scott Morrison announced the ‘pause’ in Parliament, it was in the context of a friendly ‘Dorothy Dixier’ question on the ‘measures the government is taking to ensure *the safety of all Australians* given the outbreak of Ebola in West Africa’ (emphasis added):

... the government has strong controls for the entry of persons to Australia, under our immigration program, from West Africa. ... These measures include temporarily suspending our immigration program, including our humanitarian program, from EVD affected countries. ... The government systems and processes are working to protect Australians, and that is our focus in addressing this issue.⁷¹⁵

The Government provided no further information on its decision-making process to suspend visa processing. Indeed, it refused to comply with a Senate order for ‘a copy of the advice which informed the Minister for Immigration and Border Protection’s decision to suspend the humanitarian intake from Ebola affected countries...’. The grounds for refusal were national security and defence considerations and that ‘the Government does not believe it is in the public interest to release the documents [sought]’.⁷¹⁶ FoI requests by the researcher were also declined.

⁷¹³ The decision extended to all visa applicants from the region, including for humanitarian and temporary visas): Department of Immigration and Border Protection, *Suspension on humanitarian visa applications from Ebola affected countries – FA 14/10/01298*, 9 February 2016. On the announcement see: no author, ‘Federal Government to stop processing visa applications from countries affected by Ebola’, *ABC News* (online), 27 October 2014 <<https://www.abc.net.au/news/2014-10-27/government-visa-applications-Ebola/5845048>>. For immediate reaction see: Matt Siegel, ‘Australia issues blanket visa ban on Ebola-hit countries’, *Reuters* (online), 28 October 2014 <<https://www.reuters.com/article/uk-health-Ebola-australia-idUKKBN0IG29N20141028>>; Reuters, ‘Ebola crisis: Visa ban for visitors from Ebola-affected countries creates panic, discourages health workers needed to fight disease, African leaders say’, *ABC News* (online), 29 October 2014, <<https://www.abc.net.au/news/2014-10-29/visa-ban-to-hurt-Ebola-fight-african-leaders-say/5849500>>.

⁷¹⁴ PS1. Prime Minister Abbott was known to have frequently convened ‘deep dive’ sessions during his tenure. Attendance was at ‘the Prime Minister’s call’ (PS1).

⁷¹⁵ Commonwealth, *Parliamentary Debates*, 27 October 2014, 11985 (Question from Nickolas Varvaris MP to Scott Morrison MP).

⁷¹⁶ Letter from Senator the Hon Michaelia Cash (Assistant Minister for Immigration and Border Protection) to Dr Rosemary Laing (Clerk of the Senate), 30 October 2014.

A document identified late in the project (and after all interviews were complete), suggests that some earlier discussion had occurred between the then Minister for Health, Peter Dutton MP, and the Minister for Immigration and Border Protection, Scott Morrison MP.⁷¹⁷ For the latter, this also involved officials within the Department of Immigration and Border Protection. An unsigned briefing to Minister Morrison which was ‘to be considered by 17 October 2014’ (ie, 10 days before the official announcement of the pause) shows that an official request for a pause had been received from Health Minister Dutton on 15 October 2014.⁷¹⁸ The briefing also sets out the implications of pausing visa processing and the Department’s preferred recommendations. Perhaps anticipating the concerns of the WHO, the briefing also contained background on what travel restrictions had been imposed by the UK, the US and Canada.

This briefing had been prepared by Immigration officials in response to earlier discussions with the Immigration Minister’s Office, consistent with the view that the idea for the pause came from the Ministerial and not bureaucratic arm of the Executive. Neither co-Chairs of the IDC mentioned this correspondence – which would have forewarned them of the visa pause – in their interviews. It is noted that the authors of the briefing (the Department of Immigration and Border Protection) were not co-Chairs of the IDC, although the Department was represented on the committee (Appendix 8).

A letter from Health Minister Dutton dated 15 October 2014 sought a pause in humanitarian visas. This letter pointed to ‘A lack of understanding of our health system [by the humanitarian migrants], poor language and health literacy skills’ as ‘add[ing] to the threat of a presentation of Ebola within this cohort.’⁷¹⁹ Further, the Minister wrote, if people did not present at customs with symptoms of Ebola then the powers under the *Quarantine Act 1908* (Cth) could not be used. With ‘24 persons of interest in Africa’ who had been granted humanitarian visas expected to arrive in Australia in late October 2014, the Health Minister argued that suspending the humanitarian visa program would be ‘prudent’ and ‘a decision [that] strengthens our capacity to keep Ebola from our shores.’⁷²⁰

⁷¹⁷ Department of Immigration and Border Protection, *Suspension on humanitarian visa applications from Ebola affected countries – FA 14/10/01298*, 9 February 2016.

⁷¹⁸ Ibid. The letter from Peter Dutton MP to Scott Morrison MP was included in the document release.

⁷¹⁹ Letter from Peter Dutton MP (Minister for Health) to Scott Morrison MP (Minister for Immigration and Border Protection), 15 October 2014 in *ibid*. A second briefing in this FoI release also referred to ‘concerns’ expressed by the government of Queensland ‘in relation to health checks for [some of] these entrants given they have been living in Guinea.’

⁷²⁰ ‘Persons of interest’ was a term used in the briefing from the Department of Immigration and Border Protection: *ibid*.

PS(H)1 (who also made no mention of the above correspondence), rationalised this unilateral action to suspend visa processing as ‘one of those actions where Government was seen to - by the public - to be acting to reduce the risk of the incursion of Ebola and its spread in the country.’ Similar statements were made by other public servants. This acceptance of a division between ‘policy’ and ‘political’ decision-making is examined further below. It also points to the role of ‘public perception’ (as distinct from ‘the public’) as drivers of securitizing responses, in this instance a [near] violation of the IHR injunction against measures that unreasonably restrict trade and travel.

Unilateral action also occurred at the state and territory level. During the 2009 pandemic of H1N1 influenza, deviation occurred in relation to decisions about school closures. In the Ebola outbreak, different states adopted different quarantine rules for returning HCWs. This is discussed further below in the context of respect for the principle of domestic comity.

The minimal Department of Health

Across all responses, it was notable how narrow the Commonwealth Department of Health conceived its role in disease response. Notwithstanding a pre-COVID-19 pandemic annual ‘departmental’ budget of \$880 million and approximately 3800 staff,⁷²¹ interviews with health officials pointed to a limited role for the Department in health emergency response centred on the following activities:

- Coordinating the development of *non-binding* national guidelines and response plans, usually via Committees with state and territory representatives (eg, AHPPC)⁷²²
- Serving as Australia’s National Focal Point under the IHR⁷²³
- Funding, operating and making decisions around the activation of the NIR and the national medical stockpile⁷²⁴
- Engaging with industry and professional bodies, through formal and informal channels (usually involving the CMO)

⁷²¹ Australian Government, *Budget 2019-20: Portfolio Budget Statements 2019-20 [Budget Related Paper No. 1.9 – Health Portfolio]* (Commonwealth of Australia, 2019), Table 1, Table 1.1.

⁷²² Health also provided administrative support to these committees. On the acceptance by the states of advice produced by the Commonwealth, PS9 remarked: ‘they can ignore it, or they can do it. It’s up to them at the end of the day.... we only provide advice on that.’ Divergence in state and territory approaches arose in the context of school closures during the 2009 pandemic of H1N1 influenza and in relation to quarantine arrangements for returning HCW during the Ebola outbreak.

⁷²³ *National Health Security Act 2007* (Cth).

⁷²⁴ Australian Government, *Budget 2019-20: Budget Related Paper No. 1.9 – Health Portfolio*, above n 721.

- Engaging with Home Affairs and Agriculture in the *design* of human biosecurity measures under, originally, the *Quarantine Act 1908* (Cth) and, currently, the *Biosecurity Act 2015* (Cth)
- Serving (as member, Chair or co-Chair) on various IDC related to disease outbreaks
- Supporting the CMO's engagement with international bodies, such as various WHO committees⁷²⁵
- Briefing the Minister for Health.

While this list includes many activities, it is notable that they are tightly restricted in terms of jurisdiction and mostly include coordinating and advisory roles. Interviewees from the Minister down, consistently emphasised that the Department's proper role was domestic – not international – and did not extend to delivery (whether at home or abroad):

Our response was: the border screening arrangements at our international airports and seaports. Our health response is not the health of the people in West Africa with Ebola. Health's prime response is Australians and screening arrangements... (P1).⁷²⁶

...the role of the Commonwealth is very much a coordination role - so you're getting information in, you're working out what you need to do with it and then you're getting information back out. And you're agreeing a response across states and territories... (PS11).

[The] Commonwealth really isn't particularly operational, it has measures to take at the borders or to advise at the borders...and it sets policies about borders (PS(H)1).

Health resources [are] generally used domestically, rather than internationally. And it's DFAT- [who] is really responsible for any offshore resources... (PS11).

At a governance level, this division manifested in the co-chairing arrangement of the Ebola IDC, with DFAT leading 'any external response' (PS11; also, PS9) and Health taking 'a key role domestically' (PS1). It was also exhibited throughout the process that led to the engagement of Aspen Medical. DFAT led the briefing on options to respond to the outbreak in West Africa and procured the services of Aspen Medical, including negotiating the contract

⁷²⁵ But Australia's WHO funding primarily comes from DFAT: '[Heath] has the formal, technical, lead for the World Health Organization but DFAT works closely with them, and indeed ...we provide additional funding directly to the World Health Organization for their work in a range of countries globally and in our region', PS1.

⁷²⁶ P1 repeated this point later, remarking: 'there's always a lead department and if it's international it's always [DFAT]. So, Health had an important response ...: that was setting up enhanced border screening arrangements at our international airports and seaports; a nationally consistent approach to the public health response....': Interview with Politician 1 (Phone Interview, 9 October 2017).

requirements that included clinical management standards and recruitment of Australian health professionals.⁷²⁷

Even at the border, the Department's biosecurity role was operationalised by others, chiefly the Departments of Home Affairs and DAFF.⁷²⁸ This was noted by representatives from humanitarian organisations:

... [MSF Australia's] interactions with the Department of Health were in relation to ... the risk that we would be bringing Ebola back to Australia via our returned field workers. ... and in fact, it turned out that it was the Department of Agriculture [that] has the responsibilities here, not the Department of Health, because they [DAFF] are managers of quarantine.

Finally, even though Health employees spoke of how the Department (and Commonwealth generally) was able to help if a health emergency 'gets to a level where either a state can't cope or a state asks for help' – or if 'it's big enough that it's a national' issue – the verb commonly used was 'coordinate'.⁷²⁹ No interviewee offered a suggestion for what would happen if a health emergency demanded more than national 'leadership', 'coordination' and management of the national medical stockpile. However, the implication from interviews with PS2, PS9 and – to a lesser extent, PS(H)1 – was that national responses would continue to scale up to meet the demands of the emergency.

Overall, an image emerged of the Department that sees itself operating at the geographic and constitutional boundary between Australia (the country) and the international sphere and the Commonwealth (as a polity) and the states and territories. This is discussed in Chapter 7.

Audiences

Consistent with audience identification in Chapter 5, interviewees identified a range of audiences for their work. Over the course of the interviews, a pattern emerged of how these audiences were perceived, with the researcher identifying three high level groups as shown in Table 15:

⁷²⁷ PS1 and PS(H)1. DFAT was also the contract manager throughout the engagement: see Commonwealth of Australia, 'Sierra Leone Ebola Response Mobilisation Agreement [Contract between the Commonwealth of Australia as represented by the Department of Foreign Affairs and Trade and Aspen Medical Pty Limited – Agreement number 70961]' (17 November 2014) in: DFAT, Response to Questions on Notice to Senate Foreign Affairs, Defence and Trade Legislation Committee, *Additional Estimates*, 26 February 2015, 6.

⁷²⁸ See, eg, the remark by P1: 'what you're describing [management of border processes] is a lot of hands-on work, which is not done at Commonwealth level, it's done at state level.'

⁷²⁹ Used by PS(H)1, PS2, PS11, PS9. For example, on H1N1, PS2 stated that 'the department's role was to coordinate national leadership; to coordinate state and territory responses....'

Audience	Description of audience	Role of audience on securitizing move ⁷³⁰
Political audiences	Ministers or government to whom a public servant was constitutionally accountable ⁷³¹ Members of the Opposition and Parliamentarians within the relevant jurisdiction The WHO (for the imposition of border measures) ⁷³²	Formal and moral support for a securitizing move
Operational audiences	Health practitioners, border-enforcement officers and state and territory health officials (including their CHOs)	<i>De jure</i> moral support but as most measures depended on voluntary acts by staff and clinicians, <i>de facto</i> formal support.
Audiences of trust and confidence	The public and media To a lesser extent, the international community and, during the Ebola response, humanitarian organisations like MSF and the Red Cross.	Moral support

Table 15: Types of audience in disease response securitization

Consistently, public servants identified their Minister(s) as a key audience, particularly as to the appropriateness of measures to respond to an outbreak, for example a border measure such as additional screening of passengers. However, as discussed above, the role of Ministers was largely passive and, even in the case of the political decision to suspend visa processing, there was no evidence that this was made over the objections of public servants or as a Ministerial rejection of the response measures proposed by the public service.

Rather, during the Ebola outbreak, other political audiences, including the then Labor Opposition, the Australian Greens and Bob Katter MP were more vocal and active to the extent that their roles took on the dimension of a securitizing actor, seeking stronger or (as in the case of Katter MP) more rule-violating measures. PS1, PS(H)1, PS(H)4 all reported engaging with

⁷³⁰ Adopting the typology in Roe, ‘Actor, Audience(s) and Emergency Measures: Securitization and the UK’s Decision to Invade Iraq’, above n 139.

⁷³¹ PS1, PS(H)1, CH(H)2 and PS(H)4.

⁷³² For example, on the visa pause during the Ebola outbreak, PS(H)1 reflected that ‘Australia argued with WHO and, in the end WHO dropped us from the list of countries, that [they] had major concerns [with].’

these political actors to assuage concerns and justify the official Australian response and position on quarantine rules that were to apply to returning HCWs.

Humanitarian organisations and Aspen Medical likewise engaged with these political audiences during the Ebola outbreak.⁷³³ However, it is also the case that humanitarian organisations worked through opposition parties to advance their position that the Government's response to the Ebola outbreak was insufficient (NG5 and NG6).⁷³⁴ This further illustrates how parties can switch roles, moving from acting as a securitizing actor to an audience involved in accepting or rejecting a securitizing move.

In relation to whether a specific response or plan was successful, the more important audience identified by Commonwealth Health employees were the operational audiences, in particular state and territory officials. Given the self-described non-operational role of the Commonwealth, it is unsurprising that the states and territories were described as the key audience that needed to accept the measures proposed by the Commonwealth. This extended across planning and response activities. For example, PS2 focused on the implementation role of the states and territories:

... when writing planning documents for decision makers in states and territories, our first thought is to our counterparts in the states and territories having to implement this work.

[*Later remarks*] ...in general most of our work is done for, and with, our counterparts in states and territories....

Importantly, and notwithstanding the goal of committees such as AHPPC in developing 'nationally consistent' approaches (PS(H)3), Commonwealth public servants appeared largely unconcerned when a state or territory deviated from nationally agreed plans. This occurred, for example, in relation to state-based public health measures applying to returning HCWs during the Ebola outbreak and school closures during the pandemic of H1N1. On deviations, PS(H)1, who had moved from a state-level health role to the position of CMO, was philosophical:

I learnt very rapidly: we live in eight countries. Australia's not one country, it's eight countries. With the six states and two territories and those countries make up Australia.

[*Later remarks*] So, if you were from Queensland, you were put in quarantine when you came back from your overseas tour of duty.... compared to other States So... there

⁷³³ Interview with Non-Government Sector Representative 6 (Phone Interview, 1 May 2018) (hereafter 'NG6') and NG2.

⁷³⁴ NG6 and Interview with Non-Government Sector Representative 5 (Canberra, 27 November 2018) (hereafter 'NG5').

was ‘political policy’ really, in contrast to difference in scientific understanding, because the Chief Health Officer all had a similar view...as to understanding the disease.

While less sanguine about deviations, PS2 understood the limits of the Commonwealth’s power:

[During pandemic influenza] we had planned for school closures and there was no way that school closures were going to be adopted in some states [during the pandemic of H1N1], because effectively schools are child minding centres for a large proportion of the workforce. And there were a couple of jurisdictions that basically pushed back very, very hard on school closures. That just wasn't going to happen.

It is possible – even likely – that tolerance and acceptance of state and territory deviations would depend on the nature and degree of deviation and the circumstances of the health emergency (eg, its duration, the level and location of disease spread, and the nature of the disease).

Operational audiences also included HCWs and workers employed as border and customs officers. Indeed, while safety concerns for clinicians were front of mind of Health officials during pandemic planning, during disease responses it was the safety concerns and *attitudes* about safety from non-medical occupations that took on a special significance in determining the acceptability of response measures.⁷³⁵ PS11, PS2, PS9 and PS(H)1, all reflected on the importance of providing assurances to border and customs officers and their union representatives during the 2009 pandemic of H1N1 influenza and the Ebola outbreak. During the Ebola outbreak, the role of the Department of Immigration and Border Protection on the Ebola IDC was not merely advisory but as active partners in securing the acceptance of a key operational audience (ie, its staff). Operational audiences extended still further away from the day-to-day decision makers to include what, since COVID-19, have been more widely recognised as ‘essential workers’, such as bus drivers, and transport workers. Failure to properly consider the role of these groups in accepting response measures (for example, the additional screening at airports or the decision during the 2009 pandemic of H1N1 influenza to not close schools) was identified by PS2 as something that ‘could have [been done] better’.

⁷³⁵ PS2. HCWs were engaged with routinely throughout disease responses with the former CMO and state and territory CHOs speaking of the various forums and mechanisms they used to assure health professionals of the appropriateness of, for example, infection control protocols: PS(H)3 and PS(H)1.

The final audience group included the public and media. In contrast to the formal or legal relationships present in the political and (to diminishing degrees) operational audiences, acceptance by the public and media of planning outputs and response measures was framed as matters of confidence and trust. However, as was the case in Chapter 5, the public were positioned as an audience to manage not one to secure acceptance from. Indeed, a common theme from public health officials was the importance of consistency in public messaging and – during a disease outbreak – the identification of a ‘single point of truth’ to instil public confidence in measures imposed:

...the media response and comms response to the public is very, very important (PS(H)4).

...we had [to] make sure the community was kept calm and proportionate. [And that] people weren’t overly concerned or disproportionately concerned ... with the threat. So giving information to the community and allaying the ... concerns about the level of threat that Ebola [presented]... (PS(H)3)).

...one of the most regular things in any major event is that a trusted person ... regularly is on the media... saying what’s happening and reassuring the public and ...bringing the public along with them to reduce the, you know, that fear that ‘oh they’re not telling us anything’ (PS(H)4).⁷³⁶

I remember giving an interview on Channel 7...[sunrise]... with [an infectious disease doctor who worked with MSF in West Africa] ... So she and I..., and without rehearsal, [gave] the same message. And that made [communicating risk to the public]... more straightforward (PS(H)1).

The engagement with the public was largely to share information. It did not extend to persuading the public that measures were acceptable. Indeed, the following exchange with PS1 suggests this would be outside the proper role of a public servant:

PS1: Like there was a good deal of public that was saying ‘we shouldn’t send anybody [to West Africa], because they’ll just bring it [Ebola] back.’

Researcher: Did you feel that any of your work was to address that public view?

PS1: That’s the Minister’s job.

Researcher: That was a Minister’s job?

⁷³⁶ This quote also invokes a key public health principle of ‘transparency’ in decision making.

PS1 Yep, yep, yep. That's always the Minister's job. Very clear direction. ... The Minister's role is to liaise and brief and advise with the public. There's times when officials can help that, but that needs to be carefully.

Importantly, it is recognised that the passive role of the public across the response activities examined is likely due to the location of the disease (in the case of Ebola: overseas), perceptions around its clinical severity (2009 H1N1) and the nature and point of application of the control measures. For instance, control measures for Ebola were largely imposed at international ports of entry and involved the use of information announcements, declaration cards and temperature screening for those from higher risk points of origins. Light touch, of limited duration and imposed at publicly and judicially accepted sites of exceptional government authority, the effectiveness of airport measures was unlikely to be challenged by the public in a manner that would require additional securitizing exertions. However, it is remarkable how quickly the efficiency of measures could decline once the level of impost increased or distance from sites of Government-control grew. School closures in Victoria in response to the 2009 pandemic of H1N1 would have represented an onerous burden for parents and raised the political cost to state and territory governments of such measures. As such, it is not surprising that some states refused to close schools. Likewise, PS(H)4 commented how some returning HCWs would enter Australia at a non-Queensland airport and then return to the State by other means to avoid Queensland's more onerous Ebola quarantine measures. Consequently, although the public was not identified as a key 'audience' in these responses, certain responses are likely to engage the public as a more critical audience in 'accepting' a securitizing move.⁷³⁷

6. Contesting principles and reconciling the breaking of rules by the public service

In general, normative principles dominated in the interviews. Key findings include the way in which contests over public health principles were defined by geography (ie, internal to Australia or external), tensions between potentially similar groupings of values (public health

⁷³⁷ As, indeed, was the case in COVID-19 and the extraordinary public health measures impose and maintained for months by national and sub-national governments.

and humanitarianism) and the way public servant reconciled the breaking of principles, when the break was the result of ‘political policy’.⁷³⁸

Public health values, humanitarianism and the border

Chapter 1 introduced a set of public health ‘values’ based on existing literature and professional codes. These include:

- a preference for decisions to be based on ‘scientific evidence’
- that public health measures should be proportionate to risk (determined according to scientific evidence, as assessed by experts), in terms of their severity, intrusiveness and longevity
- a preference for embedding expert-led and technocratic decision-making processes in regulation⁷³⁹
- respect for the dignity, human rights and freedoms of individuals.

Interviewing public health officials for this chapter provided an opportunity to examine whether individuals currently occupying central roles in public health identified with the above values. Without prompting, these public health officials interviewed did so, with an emphasis placed on evidence-based and proportionate advice, policy, and decision-making. These values structured their approach to risk identification and the design and implementation of responses – or at least their advice to Ministers and politicians. To adopt public servant phraseology: a desired outcome of the application of these principles to their work was a harmonised approach to regulatory setting at the Commonwealth and state and territory level.⁷⁴⁰

However, it was notable that values identified in Chapter 1, such as promoting ‘collaboration’ between government and the community and ‘a spirit of collective action’ at the international level were less evident from interviews. In the case of the former, there was little evidence from the interviews of a collaborative approach with the community in pandemic planning or the design of response measures; rather, collaboration favoured healthcare

⁷³⁸ PS(H)1’s term.

⁷³⁹ These first three public health values are similar to the principles identified in Chapter 4 and 5: namely, that policymaking should be evidence-based, and preferably ‘scientific’ rather than ‘political’, and with deference to health professionals and experts, including researchers.

⁷⁴⁰ This did not mean every jurisdiction moving as one. For example, as the 2009 pandemic of H1N1 influenza progressed, greater recognition was given to states moving to different response levels based on local conditions. However, local difference was to occur consistently with agreed thresholds and factors.

professionals and state and territory officials.⁷⁴¹ As discussed above, the public were often described as stakeholders or an audience to manage, with evidence positioned as a tool to combat fear. For instance, in describing a media appearance during the Ebola outbreak, PS(H)3 spoke of how they attempted to present ‘an evidence-based, positive framing of the... you know... the risk.’

In relation to domestic and international collaboration, while a spirit of collective action existed between Commonwealth and state and territory officials, Health’s narrow conception of its role afforded little space for international solidarity beyond entity-to-entity engagement with the WHO and formal compliance with IHR. It did not, for example, extend to using global health as a framing to push the Government to intervene more strongly abroad, nor to anything more than sympathy for the impacts of Ebola on West African HCWs.⁷⁴² Indeed, the failure of appeals by MSF Australia and the Red Cross Australia to the epidemiological ‘common sense’ of responding to the Ebola outbreak at its source in West Africa suggests some geographic boundaries to the principle of ‘scientifically informed’ policymaking.

This geographic boundary helps distinguish the *public health* principles on display by officials, from the principle of *humanitarianism* emphasised by the health-oriented NGOs. NGO representatives identified a common set of values under the umbrella of humanitarianism. These included non-discrimination in the provision of care (NG6 described this as ‘radical egalitarianism’) and a preference for selecting a response model that secures the greatest health benefit for the greatest number of people / ‘beneficiaries’.⁷⁴³

⁷⁴¹ This also points to a respect for the Federal-state compact principle.

⁷⁴² A comparison is drawn to the internationalist-ambitions and services of the US CDC and Ministry of Health-led approach of Cuba (whose contingent of doctors, nurses and other health professionals was – at least in October 2014 – reported to be the single biggest non-NGO health force deployed to West Africa): Monica Mark, ‘Cuba leads fight against Ebola in Africa as west frets about border security’ *The Guardian* (online), 12 October 2014 <<https://www.theguardian.com/world/2014/oct/12/cuba-leads-fights-against-Ebola-africa>>; Enrique Beldarraín Chaple and Mary Anne Mercer, ‘The Cuban Response to the Ebola Epidemic in West Africa’ (2017) 47(1) *International Journal of Health Services* 134; Angel A Escobedo et al, ‘Cuba: Solidarity, Ebola and COVID-19’ (2021) 5(1) *BMJ Paediatrics Open* 10; Jorge Pérez-Avila et al, ‘Cuban Strategy and Medical Cooperation to Combat Ebola, 2014-2016’ (2019) 21(3) *MEDICC Review* 53.

⁷⁴³ For example, NG5 commented on the cost of the Aspen Medical contract (approximately \$25 million, with \$20 million eventually spent) and the level of activity at the ETC: ‘216 patients [admitted], with 36 successfully treated for Ebola. A further 120 patients were monitored and discharged after testing negative for Ebola’: Julie Bishop, ‘Next Steps for Australia’s Ebola Response’ (Media Release, 20 April 2015). This was seen to compare poorly with the Red Cross’ and MSF International’s activity: see claims and costings ‘per beneficiary’ in: Australian Red Cross, Submission No 160 to Senate Select Committee on Health, *One day hearing in relation to Australia’s response to the Ebola crisis in West Africa*, 3 July 2015, Table 3; MSF Australia, Submission No 151 to Senate Select Committee on Health, *One day hearing in relation to Australia’s response to the Ebola crisis in West Africa*, 3 July 2015. Neither NG5 or NG6 cared that Australia spent as much as they did on the Aspen contract (and they were not critical of Aspen’s response); rather, it was that they felt that more should have been done earlier and that more could have been done per dollar spent.

Two values which caused some embarrassment to the Australian Government were ‘impartiality and neutrality and independence [from Government]’. In the case of MSF Australia this extended to an institutional rule against accepting money from Government, a stance that caused some embarrassment and discomfort to the Australian Government during the Ebola outbreak.⁷⁴⁴ Although a for-profit entity, Aspen also saw their role as humanitarian in nature. Aspen’s representative felt ‘comfortable’ that the organisation was meeting ‘[its] humanitarian goals’, offering the following ‘fictitious scenario’ as conduct that would be repugnant to Aspen’s values (notwithstanding potential profit):

This has never happened ... but [imagine] a government ... comes to us and said: ‘We’d like to pay you to deliver care in Syria’, right? ‘But you can only treat Muslims. We don’t want you to treat any Christians.’ That would be in breach of humanitarian rights... And I can’t imagine we’d do that. I wouldn’t be comfortable with that contractual requirement.

As Aspen was, at the time of this statement, providing auxiliary healthcare services in Mosul during Australian and US operations against ISIS, this humanitarian dilemma was not a remote possibility. For Aspen’s representative, however ‘humanitarian law’ and its principles were ‘locked in’ to its way of operating. Australia might want to ‘contract out’ (NG2) its response to Ebola, but, for NG2, this would not be at the expense of the organisation’s values.

Nonetheless, a tension between commercial opportunities and humanitarian principles can be seen in the two contracts between the Aspen and the Australian Government in relation to the ETC. In neither contracts do the ‘required services’ and ‘performance standards’ provide for a *positive* duty for Aspen to deliver services in a manner consistent with humanitarian principles.⁷⁴⁵ However, and perhaps having recognised a possible conflict in values, the second contract included a modified form of the standard ‘counter terrorism clause’, which provided some room for Aspen to adopt a ‘don’t ask, don’t tell’ policy – allowing it to treat all people equally.

⁷⁴⁴ PS1 and NG6 discussed the interactions between the International President of MSF, MSF Australia, DFAT and the Foreign Minister’s office.

⁷⁴⁵ It is acknowledged that the contracts required Aspen to develop its clinical management plans in a manner consistent with ‘WHO and MSF guidelines’ – although it is unclear if this would require adherence to the ‘radical egalitarianism’ of MSF. Likewise, the contracts incorporated, by reference, the Australian Public Service values and impose an obligation on the contractor to comply with all relevant Australian, international and foreign laws but this is unlikely to have provided a shield for an Aspen employee to render humanitarian services in contravention of a direction from DFAT. Finally, no measure in DFAT’s ‘Partner Performance Assessment’ – annexed to the second contract as Schedule 5 – would have explicitly assessed compliance with humanitarian principles diminishing the commercial value of demonstrating humanitarian behaviour.

For public servants, the humanitarian nature of the crisis was acknowledged, but as a principle it had little influence on the nature of advice provided. Protecting the referent object of the ‘Australian public’ or ‘community’ or ‘health of Australia’ left no space for ‘radical egalitarianism’ and meant that humanitarianism needed to be weighed against other principles, such as ensuring worker safety. Combined with the reported difficulty in securing agreement from foreign countries to accept and treat ill Australian HCWs, this provides some explanation for why the official Australian response to a securitized disease – Ebola – appeared cautious and hesitant.⁷⁴⁶

Reconciling political breaks of professional values

An underdiscussed element of Securitization Theory is what ‘acceptance’ of a securitizing move looks like in practice. Implicit is an assumption that opponents either acquiesce to the output of the securitizing move (eg, voluntary – albeit grudging – acceptance of the law) or that the securitizing move involves some silencing (metaphorical and corporeal) of opposition. But, as discussed above, where decisions were taken by Ministers over the advice and officials and in contrast with their professional and expressed preferences, they were accepted without a reported sense of loss or disempowerment. Why was this the case?

Interviewees – both public servants and representatives from humanitarian NGOs – identified a division between ‘public policy decision making’ and ‘political’ decision-making, with the latter division more likely to emerge during response activities (rather than planning activities) and more likely to deviate from public health values.⁷⁴⁷ In the case of the Ebola outbreak, PS(H)1 suggested that the ‘attitude of the Australian Government [on] the West African crisis was...a mixture of policy and practical decisions’. NG6 more explicitly distinguished between policy and political decision making, arguing:

When... [you have]... international media sensationalising somewhat, fear-mongering around the outbreak, then it clearly makes it more challenging to get considered and effective public policy responses.

Processes of ‘political decision making’ were likewise identified by NG6 as a root cause of confused government responses to disease outbreaks:

⁷⁴⁶ Or, as NG6 claimed, the Australian response represented ‘very strong risk-management’.

⁷⁴⁷ In the context of this chapter, NG6, PS(H)1, PS2 and NG2 spoke most explicitly about the division between political and policy decision making.

...the influence of the politics, the pressure of the media moment and wanting to be seen to be doing something, without necessarily doing the homework to find out what's the most effective thing you can do...

A political desire or imperative to be 'seen to be doing something' could result in decisions that were not supported by 'scientific evidence' (and, therefore, health officials) or principles of efficiency or proportionality. Quarantine measures for returning HCWs have been discussed above, and thermal scanners at airports were another frequently cited example:

...the thing is, with the thermal scanners: politicians like them. And, we know that there are certainly some politicians...that believe that it's a ... public confidence boosting element. That by showing that the government has got these scanners at airports that it demonstrates that the government is doing something (PS2).

The other one would be the use of say thermal scanners, which ministers often want to do. We know that there's little evidence of their effectiveness but there's a whole human, personal– It gives the public confidence that you're doing something. So is that fair enough? (PS9).⁷⁴⁸

There was no unified answer to PS9's rhetorical question: 'is that fair enough?' PS2 thought not: 'while health decision-makers and health advisers can certainly appreciate the value of confidence building, it's outweighed by the lack of evidence for their effective use and the problems with staffing.'⁷⁴⁹ PS(H)1 and PS9 were more circumspect, with PS(H)1 rationalising these decisions as:

... where Governments do have a role to reassure the public. And...that issue of 'political measures' which is about reassurance. You know, it's not a party-political thing ... It's about providing support and reassurance to the community.

This division between 'political' and 'policy' decision-making is relevant to analysing the extent to which securitization featured in the very public (but relatively narrow) decisions during the Ebola outbreak to 'pause' humanitarian visa processing by Australia, or the imposition of onerous quarantine measures on returning HCWs by some Australian states.

For securitization theorists, what is more interesting is that – even though political decision-making 'broke' professional rules and principles – the effective maintainers of those

⁷⁴⁸ PS(H)1 also cited thermal scanners as an example of 'people in authority ...thinking that [they] might be a good thing – a good security measure...to protect the public'.

⁷⁴⁹ PS2 also reported that 'in preparation for MERS coronavirus ... [Health, AHPPC and] Communicable Disease Network Australia has strongly come out and said thermal scanners should not be used.' In any event, the matter may have become moot. PS9 reported that it was becoming increasingly difficult to service and maintain the 25 thermal scanners purchased by the Australian Government during the H1N1 pandemic.

rules (eg, public servants and health officials) rationalised and accepted the deviations not because a threat had been securitized but rather because they saw it as a legitimate outcome of the democratic system. As PS(H)1 said: ‘We all understand we live in a democracy and if the Government-of-the-day wishes to take a particular stance on something then you work with it.’ As examined above, a similar degree of acceptance extended to deviations by states and territories from national plans and disease response measures, bolstered by an acknowledgement of the Federal-state compact principle.

Words and actions: the good global citizen principle in the Ebola outbreak

Emerging from the interviews was the central role of the good global citizen principle in Australia’s response to the Ebola outbreak. While the good global citizen principle featured to some extent in the 2009 pandemic of H1N1 where (as with COVID-19 more than a decade later) the issue of vaccine inequity arose,⁷⁵⁰ the designation of Ebola by the UNSC in 2014 as a threat to international peace and security and – as shown above – a ‘humanitarian crisis’ more strongly centred the principle in discourse around the adequacy of Australia’s response.

The elements of Australia’s responsibilities as a ‘good global citizen’ were sketched in remarks by public servant from Health and DFAT. For PS9, Health’s (and, by extension, the Australian Government’s) demonstration of being a good global citizen was that ‘we make a commitment to...the WHO... to align ourselves with WHO [programs]’. For PS1, providing funding to help ‘[prevent] global public bads’ was something that ‘Australia should be part of...’ They then suggested that the debate was not whether Australia had a duty to play a part but: ‘what is the quantum [of funding]’.⁷⁵¹ Australia as a good global citizen was made explicit by Australia’s Foreign Minister, who used the term throughout her tenure.⁷⁵² NG6 referred to

⁷⁵⁰ On vaccine distribution during the 2009 H1N1 pandemic see: Niamh Stephenson, ‘Emerging Infectious Disease/Emerging Forms of Biological Sovereignty’ (2011) 36(5) *Science, Technology & Human Values* 616; Stephenson, ‘The Disappearing Act of Global Health Security’, above n 75. For virus sharing see: Michelle F Rourke, ‘Who Are “Indigenous and Local Communities” and what is “Traditional Knowledge” for Virus Access and Benefit-Sharing? A Textual Analysis of the Convention on Biological Diversity and its Nagoya Protocol’ (2018) 25(3) *Journal of Law and Medicine* 707; Dale Fisher et al, ‘Pandemic Response Lessons from Influenza H1N1 2009 in Asia’ (2011) 16(6) *Respirology* 876; Fidler and Gostin, ‘The WHO Pandemic Influenza Preparedness Framework’, above n 187. For other inequities see, eg, Matthew Sparke and Dimitar Anguelov, ‘H1N1, Globalization and the Epidemiology of Inequality’ (2012) 18(4) *Health and Place* 726.

⁷⁵¹ PS1 also invoked a principle of efficient resource-allocation: ‘... there was a cost allocation or kind of efficiency if you like, value for money, part of that. And there was other national interest considerations as well around, should we keep some of the resources in Australia, for this region as well.’

⁷⁵² For example, Julie Bishop and Trevor Evans, ‘Doorstop interview with Member for Brisbane, Trevor Evans MP’ (Press Conference Transcript, 16 June 2017). Other MPs and actors also used this phrase to describe Australia role (real or aspirational): eg, Commonwealth, *Parliamentary Debates*, House of Representatives, 2 May 2016, 4124 (Tanya Plibersek); ‘The Liberals have trashed Australia’s reputation as a good global citizen’,

it as ‘sort of [a] favourite phrase of Julie Bishop’ and one that resonated with the language used by the US and UK Governments. To NG6, this phrase and the principle it represented ‘seemed to be a strong motivation for their action[s].’ But Australia’s response (particularly until the Aspen contract was signed) demonstrated a division between what political audiences (eg, the Opposition) and audiences of trust and confidence, specifically humanitarian NGOs, saw as respecting/breaking the global good citizen principle.

For the Government, their initial actions of committing funding to the United Nations Mission for Ebola Emergency Response and humanitarian organisations was framed as satisfying the principle (‘Australia is committed to doing its part’ said the Foreign Minister).⁷⁵³ Making the most of its non-permanent membership of the UNSC, Australia’s Foreign Minister elevated Australia’s role for international audiences through the negotiation and passage of Resolution 2177 (2014).⁷⁵⁴ However, as discussed above, the prioritisation of the Indo-Pacific created an inherent tension in just how ‘global’ Australia’s citizenship obligations extended.

Likewise, the decision of the Australian Government to suspend visas (occurring at the same time as Australia was chairing the UNSC) suggested that domestic audiences mattered more than international ones. This manifested in the approaches of the respective Minister for Health and Foreign Minister, with PS1 reflecting:

...their statements probably consistent with the stereotypes. [Health Minister] Dutton was more domestic, [with a] slightly more kind of um stronger domestic reaction. Julie Bishop was more internationalist, because that’s her background and exposure.⁷⁵⁵

To the humanitarian organisations interviewed, funding commitments but no promise to send personnel represented a case of words over actions. Indeed, what actions they had seen (the visa pause) sharply broke with the obligations of a good global citizen. Speaking of the

Tanya Plibersek MP quoted in Paul Karp, ‘Scott Morrison blames record-low foreign aid on Labor for “blowing it all”’, *The Guardian* (online), 4 May 2016 <<https://www.theguardian.com/australia-news/2016/may/04/budget-cut-of-224m-leaves-foreign-aid-at-record-low-say-aid-groups>>; Claire Stewart, ‘Women of Influence: What is foreign aid really about’, *Financial Review* (online), 24 June 2016 <<https://www.afr.com/women-of-influence/women-of-influence-what-is-foreign-aid-really-about-20160620-gpn622>>.

⁷⁵³ Julie Bishop, ‘Address to United Nations Security Council, New York’ (Speech delivered at the United Nations Security Council, New York, 21 November 2014). See discussion above and Appendix 6 for an outline of Australia’s funding commitments.

⁷⁵⁴ Indeed, Australia chaired the UNSC during key debates during the Ebola outbreak. Comments from PS1 and see also: Julie Bishop, ‘Australia chairs UN Security Council Meeting on Ebola’ (Media Release, 21 November 2014); Julie Bishop, ‘Address to United Nations Security Council, New York’ (Speech delivered at the United Nations Security Council, New York, 21 November 2014).

⁷⁵⁵ This trend is also apparent in the media releases issued by the Foreign Minister and Prime Minister during the Ebola crisis, see above.

Government's offer of funding to MSF Australia (which the organisation rejected publicly) and slow deployment of resources, NG6 remarked that:

...there was a combination of the perception of being a good global citizen and *actually* being a good global citizen. ...And, really... they were driving towards a compromise where they could be seen to be a good global citizen by being in fact a good global citizen in minimal risk way possible. So the most significant driving motivation was to minimise the risk to Australia of [importing Ebola] (emphasis in original).

Although less critical in their remarks, NG5 likewise lamented that '[it] didn't feel like there was a real willingness [by the Government] to genuinely support a strong Australian response.' They perceived the eventual response (ie, engaging Aspen Medical to run a UK constructed ETC) as 'an arm's length agreement. You know, "we want to be seen to be doing something, let's just throw money here"'.⁷⁵⁶

Balancing the good global citizen principle and humanitarianism with valid concerns over HCW safety is a legitimate political task. The reported difficulty of Australia securing agreement from foreign countries to accept Australian HCWs (PS1, PS(H)1, PS11 and NG2) suggests that the good global citizen principle is an easy rhetorical principle but difficult to use as a justification for a domestic audience.⁷⁵⁷ PS1 stated that 'the public statements of countries, that they would take Australians who may contract Ebola, [were] very different to private assurances... privately they were not signing a dotted line....'

7. Mechanisms and tactics

This section reports on key mechanisms and tactics used by the principal actors involved in the development and implementation of Australia's pandemic plans and response measures to give prominence to their preferred principles, including the attempts by opposition parties and non-governmental organisations to attempt to push the Government to adopt a more urgent and extreme posture in relation to the Ebola outbreak.

⁷⁵⁶ Even a beneficiary of the Aspen contract, NG2, spoke of their engagement as Australia 'contracting out' the response.

⁷⁵⁷ The visa pause decision was not an antipodean special: The Associated Press, 'Canada Restricts Visas amid Ebola Scare', *USA Today* (online), 31 October 2014 <<http://www.usatoday.com/story/news/world/2014/10/31/canada-visas-ebola/18273133/>>; Tejjpar and Hoffman, above n 15. However, the briefing released under FoI does suggest Australia was a first-mover: Department of Immigration and Border Protection, *Suspension on humanitarian visa applications from Ebola affected countries* – FA 14/10/01298 (9 February 2016).

Overall, public servants did not report disagreements or ‘conflicts’ with other public servants in pandemic planning activities, or in the responses to H1N1 in 2009 or Ebola, which could not be addressed through standard bureaucratic practices such as IDCs, informal meetings or (rarely) elevation to higher authorities.⁷⁵⁸ Consistent with other forms of biosecurity policymaking, IDCs provided a forum for different equities and interest to be raised within the closed confines of the civil service (PS11, PS1).⁷⁵⁹ Nonetheless, Health’s control over the NIR (and its activation), provided officials within that Department with significant control over information flow and the presentation of advice during the 2009 pandemic of H1N1. As such, the decision to not activate the NIR during the Ebola outbreak and, instead establish a novel IDC model, with Health and DFAT co-Chairing, is notable.⁷⁶⁰ Co-chairing ostensibly provides a mechanism for resolving disputes over principles but, in the case of the Ebola outbreak, it further highlighted a bifurcation in zones of responsibilities. DFAT and Health provided parallel advice to their Ministers and Health focused on border and domestic measures, such as PPE; with DFAT leading on response options, including the negotiation of the contract with Aspen.

Raising the stakes – the opposition of NGO’s use of the media and politics

This Chapter has revealed the inversion of the roles of audience and actor during the Ebola outbreak: with the opposition parties and NGOs demanding the Government accede to their threat identification of Ebola. Appeals to the Government involved media and political tactics and, in the case of the former, leveraging off the growing international media attention the Ebola outbreak was receiving.

For example, during the peak of the political debate over Australia’s Ebola response (October–November 2014), the deputy leader of the Opposition and ‘Shadow Minister’ for Health adopted the language of ‘crisis’, with appeals to take drastic action due to the urgency

⁷⁵⁸ PS1 referred to it as: ‘[The] usual government stuff. So you talk in the meeting, you talk outside the meeting. You talk before and you talk after and, if you don't win, you go higher.’

⁷⁵⁹ A list of agencies represented on the Ebola IDC was sought under FoI. A copy is included at Appendix 8.

⁷⁶⁰ There was disagreement between Health official interviewees over the requirement for a local case (eg, of Ebola) before activating the NIR. The author notes, that a local case of a disease (or even a domestic event) is not a requirement for activating the NIR. For example, prior to 2013, the NIR had been activated several times for non-domestic events, including the Indian Ocean tsunami (2004), Bali Bombings (2005) and the Christchurch earthquakes (2011). Since 2019, the NIR was also activated for Australia’s response to the Samoan measles outbreak. This suggests political or bureaucratic factors have a degree of importance in determining whether to activate the NIR. Department of Health, *National Incident Room* (4 March 2011) <https://web.archive.org/web/20140712160643/http://health.gov.au/internet/main/publishing.nsf/Content/health-pubhlth-strateg-bio-factsht_inc_room.htm>.

of the situation and the ‘danger’ to ‘the world’ and ‘best interests of Australia.’⁷⁶¹ In its calls for the Government to do more, the Opposition and minor parties enlisted the calls for action from humanitarian organisations, the WHO, the Australian Public Health Association, the Australian Medical Association, members of AUSMAT and the nurses and midwives’ union.⁷⁶² Even the Presidents of the United States and Sierra Leone were cited in an opposition media release, which opened solemnly:

Labor is gravely concerned the Abbott Government is refusing to do more to fight the rapidly escalating Ebola crisis, despite pleas for help from around the world.⁷⁶³

The media release closed with an elevation of the threat, invoked the need for immediate action and identified the threat to Australia:

The *Ebola crisis* is no longer just a humanitarian crisis for West Africa – it now poses a *direct threat to world economic growth* and if not contained, will spread to other countries.

...

Failure to *act now* will have *serious consequences*. As recent Ebola cases in the US and Spain show, *even countries with the most highly developed health and border protection systems are no longer immune*.

... the *window of opportunity is closing fast*. That’s why Australia must significantly increase its efforts, immediately.⁷⁶⁴

Tanya Plibersek MP adopted similar language during a radio interview the same day, noting ‘...the risk of this becoming a global disease burden *that we will lose control of*. The World Health Organisation [sic] is already warning that *we are losing control* of the spread of this virus. It is *in Australia’s interest* that we help fight this virus while it still may be containable’.⁷⁶⁵

These public calls for action evidently stung the Government, with the Health Minister releasing a terse media release titled ‘*Ebola – The Facts*’ in which he demanded the Opposition

⁷⁶¹ Tanya Plibersek MP and Catherine King MP, ‘Ebola; biometric data’ (Press Conference Transcript, 16 October 2014). Even after the Government engaged Aspen Medical to run an Ebola Treatment Centre, Labor continued focus on the need for urgency: ‘[if] we are to have a chance of getting this crisis under control, there isn’t a moment to lose’: Bill Shorten MP, Tanya Plibersek MP and Catherine King MP, ‘Ebola Crisis’ (Media Release, 5 November 2014).

⁷⁶² Tanya Plibersek MP and Catherine King MP, ‘Ebola; biometric data’ (Press Conference Transcript, 16 October 2014).

⁷⁶³ Tanya Plibersek MP and Catherine King MP, ‘Ebola Crisis’ (Media Release, 16 October 2014).

⁷⁶⁴ Ibid, emphasis added.

⁷⁶⁵ Alison Carabine, Interview with the Hon Tanya Plibersek MP (ABC Radio interview, 16 October 2014) (emphasis added).

‘cease playing politics with the serious health issue of Ebola’. He accused the Deputy Opposition Leader and Shadow Health Spokesperson of ‘[being] prepared to do and say anything without regard to the possible consequences’, including ‘trying to denigrate our national capabilities...’.⁷⁶⁶ Such a call to de-politicise the Ebola response – and a particular focus on the ‘reckless statements’ of others – suggests an effort by the Government to move the issue of the Ebola response *away* from the domain of securitized threats.⁷⁶⁷ The Prime Minister, likewise, sought to downplay the threat from Ebola:

I don't want to minimise the seriousness of the outbreak, but I also want to keep it in perspective as well. This is a public health emergency, it's not a security emergency, it's certainly not an economic emergency.⁷⁶⁸

The invocation of the US-Australia alliance by the Opposition is notable, given the role the Alliance played in the development of the DTCA (Chapter 5). An Opposition media release sought to spur or shame the Government into more action by quoting the ‘latest plea’ from ‘the highest levels of the US Government’ for Australia (personalised as ‘the Abbott Government’) to ‘do more to help fight the Ebola crisis in West Africa’.⁷⁶⁹ The same release suggested that calls for action had or would come from President Obama and soberly noted that:

The United States is a great friend to Australia. We must take requests from them to do more very seriously. ... We know there is a need for Australian healthcare workers in West Africa. Our close friend and ally, the United States, is telling us so too - and they're asking for our help.⁷⁷⁰

However, in contrast to the powerful influence of the Alliance in the development of the DTC Bill, its public invocation during the Ebola outbreak did not appear to change Government policy. One likely difference was that, in the development of the DTC Bill, the Alliance itself

⁷⁶⁶ Peter Dutton MP, ‘Ebola – The Facts’ (Media Release, 22 October 2014). This media release also pointed to Australia’s ability to send an AUSMAT team to ‘our neighbouring countries’ in the event of a regional Ebola outbreak – supporting the conclusion that the Government had no plans to send an AUSMAT team to West Africa.

⁷⁶⁷ In answer to another Dorothy Dixier, the Health Minister also made a call for ‘a bipartisan approach’ to the crisis: Commonwealth, *Parliamentary Debates*, House of Representatives, 30 October 2014, 12637 (Peter Dutton MP). The Health Minister also released another, similar media release less than 10 days later titled ‘Tanya Plibersek: Reckless, Clueless, Hopeless on Ebola’, accusing the Deputy Opposition Leader of attempting ‘to incite fear in the community’: Peter Dutton MP, (Media release, 1 November 2014).

⁷⁶⁸ Tony Abbott PM, ‘Joint Press Conference with the Hon Peter Dutton MP, Minister for Health’ (Press Conference Transcript, 5 November 2014). This remark was in response to a question about whether the outbreak would be discussed at the upcoming G20 meeting. The Prime Minister was not keen on the topic being raised: ‘my very, very strong concern is to try to keep the G20 as an economic forum, not as a security forum, not as a public health forum. ... There are other forums to talk about environmental issues, there are other forums to talk about security issues and there are other forums to talk about health issues.’

⁷⁶⁹ Tanya Plibersek MP and Catherine King MP, ‘Ebola Crisis’ (Media release, 10 November 2014).

⁷⁷⁰ Ibid.

featured as a referent object. During Ebola, the Alliance never became a referent object and – in any event – the calls from the Obama Administration were non-specific and oriented around moral, humanitarian responsibilities, not security considerations.

Parliamentary tactics played an important role in attempts by non-government organisations and Opposition MPs to heighten the pressure on the Government. These tactics included:

- moving a Senate motion that, *inter alia*, noted ‘the major threat that this outbreak poses to international peace and security’⁷⁷¹
- questioning Ministers and officials through the Senate Estimates process and through Question Time in the Senate and House of Representatives⁷⁷²
- issuing Senate orders for Ministers to produce documents related to decisions made by the Government during the response⁷⁷³
- an ‘urgency debate’ that pointed to the relative tardiness of Australia’s response to Ebola when ‘we are fairly quick to respond’ to international ‘security issues...and military issues’⁷⁷⁴
- speaking on the outbreak during ‘adjournment debates’⁷⁷⁵
- for one Senator (a GP prior to entering Parliament) visiting Liberia and Sierra Leone during the outbreak.⁷⁷⁶

In July 2015 (after the peak in Ebola cases and the Australian-managed ETC had been handed over), there was a renewed, albeit aborted, attempt to bring further scrutiny on the response, through a ‘one day hearing’ by the Senate Committee on Health. That this hearing did not proceed suggests that the outbreak (and, by extension, health threats arising in developing countries in West Africa) had ceased to be a securitizable ‘forcing event’ by this time. Certainly, the title of MSF Australia’s submission to the hearing – ‘The world is no

⁷⁷¹ Commonwealth, *Parliamentary Debates*, Senate, 25 September 2014 (Senator Christine Milne). The motion passed without division (ie, vote).

⁷⁷² For example: Commonwealth, *Parliamentary Debates*, Senate, 2 October 2014, 7649-7650 (Senator Sarah Richard Di Natale to Senator George Brandis, Attorney-General). Through Senate Estimates, the contract between the Commonwealth and Aspen Medical was released.

⁷⁷³ Commonwealth, *Parliamentary Debates*, Senate, 29 October 2014, 8164 (Senator Sarah Hanson-Young).

⁷⁷⁴ Commonwealth, *Parliamentary Debates*, Senate, 29 October 2014, 8173 (Senator Lisa Singh). Senator Singh closed her speech with an appeal to urgency: ‘This is no longer just a humanitarian issue in West Africa; it poses a direct threat on the rest of the world and we need to act.’

⁷⁷⁵ See, for example: Commonwealth, *Parliamentary Debates*, Senate, 9 February 2015, 217 (Senator Richard Di Natale) and Commonwealth, *Parliamentary Debates*, Senate, 28 October 2014, 8052 (Senator Lisa Singh).

⁷⁷⁶ See: Commonwealth, *Parliamentary Debates*, Senate, 9 February 2015, 217 (Senator Richard Di Natale).

better prepared today than a year ago to respond to Ebola' – points to an effort on the organisation's part to reinvigorate political interest in the issue.⁷⁷⁷ The effort appears to have failed, with the Opposition shifting to a standard approach to questioning officials through the normal Senate 'estimates' process.⁷⁷⁸

⁷⁷⁷ MSF, Submission No 151 to Senate Select Committee on Health, *One day hearing in relation to Australia's response to the Ebola crisis in West Africa*, 3 July 2015.

⁷⁷⁸ See for instance the line of questioning from Labor Senator Penny Wong in: Commonwealth, *Additional Estimates*, Senate Foreign Affairs, Defence and Trade Legislation Committee, 7-22, 26 February 2015 (Senator Penny Wong).

8. Summary of findings in Chapter 6

This chapter analysed Australia's planning and response to disease outbreaks. Data was collected through semi-structured interviews and triangulated with public documents and documents obtained via FoI.

Key findings from the Chapter are:

- Public servants used a range of rhetorical strategies to elevate the threat of pandemic influenza in the mid-2000s. In part this was to overcome audience familiarity with seasonal influenza and the disease's relative lack of dread (but compare, Ebola).
 - One consequence was that when a pandemic of relatively mild influenza occurred in 2009, the plans were found to be not optimal for the response and were revised for tone and content.
- Consistent with the literature, Ebola represented an especially securitizable disease, despite respiratory diseases being identified by public health officials as a greater threat.
 - The 'dread' of Ebola was pre-established before the 2013–2016 outbreak on a foundation of popular culture representations: the 'Hollywood factor'. Government actors did not seek to amplify this latent fear to a security threat.
- During outbreaks, a range of audiences – political, operational and confidence-building – are appealed to. Operational audiences, such as essential workers are an understudied audience who are nonetheless critical in authorising 'active securitization' as implemented via border measures and public health controls.
 - The role of audience and securitizing actor can shift dynamically during an outbreak with relatively 'weak' organisations and individuals (eg, humanitarian NGOs and Independent MPs) using parliamentary tactics and the media in an attempt to securitize an outbreak and break domestic or international rules.
- At least during the period under examination, the Commonwealth Department of Health conceives of its operational role and responsibilities in unambitious and narrow terms. This may have long term implications for its ability to lead in a large scale, domestic health emergency.

- The Ebola outbreak represents a novel study in how a powerful actor (Government) resisted efforts by others to securitize an outbreak, because a successful securitizing move would demand that the Government respond in a way inconsistent with its preferences and other principles, such as HCW safety and being able to respond in the Indo-Pacific.
- Australia's official response to the Ebola outbreak reveals the positioning of the 'Indo-Pacific region' as a referent object. Fragile health systems within this region were also constructed as a threat to Australia's interests.
 - An apparent consequence was that the Government saw domestic, government-employed HCWs as a strategic resource that it was reluctant to deploy further afield (ie, West Africa). Appeals to humanitarianism and even the Australia-US Alliance were unsuccessful in overcoming this resistance.
 - The use of private contractors (eg, Aspen) provided a way for the government to respond and fulfil (in its mind) the good global citizen principle, albeit with the risk that contractual arrangements would compromise other principles such as humanitarianism.

Chapter 7: Discussion and Conclusion

This is the final Chapter of the thesis. Section 1 of this Chapter restates the research problem this study has sought to address, and the theoretical and methodological framework applied in that endeavour. The key findings identified in Chapter 4–6 are briefly summarised.

Section 2 engages in a more detailed discussion of the findings and situates the findings within the relevant literature. Particular attention is given to novel and unexpected findings. Section 3 addresses the inevitable question: ‘what of COVID-19?’ and how this study engaged with, and was affected by, the current pandemic. Section 4 reflects on the study’s limitations.

Finally, Section 5 sets out the study’s conclusions and recommendations. Consistent with the potential of securitization studies to support praxis, these recommendations are directed to both future researchers and those whose practices may be challenged via a security move.

1. Revisiting the research problem

Chapters 1 and 2 explored how domestic and international governance regimes have sought to confront the threat of disease, pandemics and the causative agents of disease. Chapter 2 situated these regimes within a body of literature exploring the elevation of health to the ‘high politics’ of international relations and the construction of health as a security issue. Outlining the Copenhagen School’s framework for analysing the ‘securitization of health’, that Chapter then focused on a constellation of ‘biosecurity’ problems that have been the target of specific regulatory responses: emerging and rapidly spreading infectious diseases, bioterrorism/proliferation and the risks arising from the accidental release of pathogens.

This thesis has sought to contribute to this literature through an examination of biosecurity lawmaking and policymaking, and pandemic planning and response activities. Restating the research questions briefly:

1. To what extent did the use of ‘securitizing acts’ by Ministers, governing parties and public servants between 2001–2016 serve as a ‘mechanism’ to promote or secure those actors’ preferred regulatory values or principles in a given regulatory response, including (but not limited to) legislation?

2. What, if any, were the outcomes and consequences of embedding those particular values or principles in the ultimate regulatory response?

To investigate these questions, this study adopted a qualitative, case-study research design, utilising documentary analysis and semi-structured participant interviews. Cases fell within 2001–2016, with [the Commonwealth of] Australia being the central unit of analysis. Securitization theory, as developed by Buzan and colleagues, was the primary lens applied to the cases. Insights on the globalisation of norms and rules outlined in regulatory theory were then applied to better understand how securitization might move from a ‘performative’ act to a mechanism by which rules were broken and/or new rules and principles substituted in the construction of new regulatory regimes.

Each case looked at a different dimension of potential biosecurity activity:

Domain of activity	Results Chapter	Areas of focus
Biosecurity lawmaking (securitizing in a public forum)	Chapter 4 – Biosecurity lawmaking	Evidence of securitization in biosecurity laws and the public statements of federal Ministers and Parliamentarians engaged in legislative activities. The existence (or not) of a contest of principles between a securitizing actor and audience(s). The use of parliamentary tactics and other mechanisms to secure a desired legislative outcome.
Biosecurity policymaking (behind the scenes securitizing)	Chapter 5 – Biosecurity policymaking	Evidence of securitization in policymaking by federal public servants that underpinned the <i>Defence Trade Controls Act 2012</i> (Cth), the security-sensitive biological agents’ regime within the <i>National Health Security Act 2007</i> (Cth), and the human quarantine provisions within the <i>Biosecurity Act 2015</i> (Cth). The existence (or not) of a contest of principles between different parts of a public service and between the Commonwealth and the states and territories and regulated sectors. The use of particular tactics or mechanisms to secure a desired policy outcome (which may include legislation)
Biosecurity in action: responses to real and hypothetical disease outbreaks	Chapter 6 – Regulatory responses to avian influenza, 2009 pandemic of H1N1	Evidence of securitization by the Australian Government in the response to hypothetical and real disease outbreaks.

	influenza and the Ebola outbreak	The existence (or not) of a contest of principles between the Australian Government (or parts of the public service) and audiences. The use of particular tactics or mechanisms to secure a desired mode of disease response.
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Table 16: Summary and focus of results Chapters

2. Key findings and contribution to academic literature

The first part of this section discusses findings related to the *extent* to which securitization featured as a mechanism across the cases examined. While evidence of securitization was identified across the cases, some notable findings emerged, including a surprising absence of genuine contestation between political audiences; the influence of silent threats and referent objects (eg, the Australia-US security alliance), and the role of actors, such as public servants and non-government actors, who frequently played leading roles in threat identification. While the involvement of these actors in policymaking was anticipated, the dominant (albeit hidden) role of the public service in constructing threat through second reading speeches was unexpected.

Building on the findings from Chapters 4 and 5, this part also critiques the use of the language of ‘proportionality’, arguing that this concept represents less a standalone principle and more a rhetorical framing that can be deployed in support of – or to mask – regulatory action that represents the securitization of a field or practice, such as health research. A discussion of other principles in bolstering or resisting securitizing moves is also explored in this part, including the role of the good global citizen principle.

The next part of this section discusses the *consequences* of securitization, including on regulatory response choices and on ‘interunit’ relations, including between the State and researchers, the State and healthcare workers (HCWs) and between different parts of the public service. Particular attention is drawn to the consequences of constituting the Indo-Pacific as a referent object. While the consequences of securitization on the academic sector under the *Defence Trade Controls Act 2012* (Cth) (DTCA) and security sensitive biological agents (SSBA) regime have already been discussed, this part concludes with some observations on the role of organisational values in moderating the sharper edges of a securitized regulatory

environment. Elbe's thesis on the medicalisation of insecurity is examined in light of the findings on the influence of organisational values and serendipity on biosecurity policymaking.

To what extent was securitization found in the cases examined?

Consistent with the literature,⁷⁷⁹ this study identified law and policymaking activities that sought to address key biosecurity risks, namely bioterrorism, dual-use research of concern (DURC) and rapidly emerging infectious diseases. This manifested in the identification of extreme threats and the use of rhetorical strategies to present an issue as warranting actions outside pre-existing rules.⁷⁸⁰ Reflecting the selection of cases and interviewees, the most explicit and most common threats identified were infectious diseases and bioterrorism – although this latter threat was refracted into sub-threats of proliferation, rogue scientists and pathogen research depending on the forum and regulatory measure under discussion. Chapter 4 showed that, in parliamentary debates, the constitution of these security problems involved the use of rhetorical techniques such as appeals to urgency, invoking events past and hypothetical (eg, a future terrorist attack) and making calls for bipartisanship. The role of bipartisanship is discussed in more detail below.

Across Chapters 4–6, diseases or outbreaks could be framed as security threats whether the outbreak or disease was real or potential. That potential pandemics were situated as co-equal threats with actual pandemics, supports the argument of Elbe and others that the construction of disease as a threat has grown wider and less tangible – potentially enabling the easier deployment of 'disease' as a securitizable issue.⁷⁸¹

One noteworthy consequence of this widening is a splintering of threats and the opening of a space of disagreement between potential securitizing actors. Consistent with Elbe's thesis of the medicalisation of insecurity, public health officials in Chapter 6 framed hypothetical pandemics as 'threats'. These officials were more likely to frame respiratory viruses (eg, the SARS and MERS viruses and a potential, highly pathogenic avian influenza) as the real threats. In contrast, politicians and the public were more likely to see Ebola as the threat justifying

⁷⁷⁹ Rushton, 'Security for Whom? Security from What?' above n 152; Ingram, above n 113; Youde, 'High Politics, Low Politics, and Global Health', above n 29; Enemark, *Biosecurity Dilemmas*, above n 27. See generally, Chapter 2.

⁷⁸⁰ Buzan, Wæver and De Wilde, above n 42, 23–24.

⁷⁸¹ Elbe, 'Pandemics on the Radar Screen', above n 123, 852–853. However, the author challenges elements of Elbe's medicalisation of security thesis below.

more extreme countermeasures. As explored below, this resulted in some novel reversals of the typical security actor-audience roles in the case of the Ebola outbreak.

The different treatment of diseases could also be seen in the parliamentary debates over the NHS Bill and the Biosecurity Bills: Ebola was positioned as terrifying, while diseases which remain serious globally, such as cholera, were positioned as antiquated risks from a bygone age. This finding is consistent with Enemark's arguments about the role of 'dread' in catalysing the securitization of a particular disease and the lamentations of others that the global health security agenda can see diseases neglected, deprioritised or languish in the 'low politics' of public health.⁷⁸² However, in the case of Australia, there is an additional dimension to the 'dread' of a disease: proximity.

Reflecting a concern in the literature that health security is chiefly about the security of the Global North from diseases from the Global South, Chapter 6 found that the primary concern referenced (albeit implicitly) by officials and Ministers about Ebola was that it might pierce the border and – through a case imported by a returning HCWs or migrant – collapse the geographic and rhetorical distancing that kept Ebola 'over there' and out of Australia.⁷⁸³ A key finding from the Australian Government's response to Ebola was that the true threat was to the effectiveness of Australia's borders as a barrier to infection. It is illuminating that a key turning point in Australia's response to Ebola in 2014 was the outbreak of cases in globally connected Nigeria, leading the Secretary of Health to ask: 'Risks to Aus? Action required? People in a Nigerian airport could go anywhere...'. The Ebola outbreak was quickly elevated to a matter warranting the attention of Cabinet's National Security Committee (NSC) and a briefing by the Chief Medical Officer (CMO). Subsequent Ebola outbreaks in Africa have remained largely rural and disconnected from circulatory, transport networks for people, animals and goods that connect to Australia.⁷⁸⁴

⁷⁸² Selgelid, 'Pandethics', above n 56; Selgelid, Kelly and Adrian, above n 56; Knowlton Nicholas, 'Malaria and Security: More than a Matter of Health' in Rushton and Youde, above n 113, 163, 167–168; Michael A Stevenson and Michael Moran, 'Health Security and the Distortion of the Global Health Agenda' in Rushton and Youde, above n 113, 328, 330–331. See discussion of 'attrition process' in Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia*, above n 27, 9.

⁷⁸³ Rushton, above n 152; Stephenson, 'The Disappearing Act of Global Health Security', above n 75; Stevenson and Moran, above n 782. Making the best use of Australia's 'tyranny of distance' for public health purposes has been a constant of Australia's health, immigration and racial politics: Bashford and Howard, above n 157; Bashford, 'At the Border Contagion, Immigration, Nation', above n 35; Bashford, *Imperial Hygiene*, above n 35.

⁷⁸⁴ Collier and Lakoff, above n 119, 21, 43, Table 1; Kezia Barker, 'Infectious Insecurities: H1N1 and the Politics of Emerging Infectious Disease' (2012) 18(4) *Health and Place* 695.

Although there was evidence of securitizing language, direct references to ‘threats’ (whether extreme or existential) were rare. This was particularly so during interviews with public servants, although Chapter 5 sets out how some problems (eg, gaps in the regulation of select agents) were constructed as security problems to be resolved through regulatory reform. In Parliament, Second Reading Speeches (SRS) represented the key vehicle through which more direct security speech-acts were delivered. Such speeches were ‘key’ not because they are inherently more valuable in securitizing but because almost all biosecuritizing legislation reviewed in Chapter 4 proceeded through Parliament with minimal debate or contestation. This surprising finding is examined in more detail below.

Contrary to expectations, evidence that securitization was used as a tactic to *intentionally* justify rule breaking in biosecurity lawmaking was relatively weak, particularly on an examination of the actual laws that the SRS were associated with. As Chapter 4 demonstrated, there was frequently a mismatch between the threats identified in an SRS and what the Bill was primarily addressed to. This even extended to the names of legislation. For example, although the titles of the National Health Security Bill 2007 (Cth) and the 2012 and 2014 Biosecurity Bills appeared to signal an intention to engage in security rhetoric (see also, the PATRIOT Act in the US), closer examination of the text of the law and policymaking process (Chapters 4 and 5) showed otherwise. In the case of the Biosecurity Bills, for instance, the Bills’ titular use of ‘biosecurity’ reflected a peculiar agricultural and technical understanding of the term separate from its use by the ‘pointy end’ of security.⁷⁸⁵

For the NHS Bill, the situation was more complex due to it incorporating two quite distinct parts. However, interviews with the lead policy officer behind the SSBA regime (ie, Part 3 of the NHS Bill) revealed that the use of the NHS Bill as a legislative vehicle to introduce the reform was opportunistic and that the Bill’s name had been settled on beforehand. Accepting this chronology, the difference between the NHS Bill’s title and content becomes even more stark. Rather than seeking to address risks to *national* health security (such as the conventional terrorism alluded to in some SRS), the Bill sought to fulfil Australia’s obligations to deliver on *global* health security, and in particular its obligations under the 2005 IHR. Moreover, while securitization might be expected to trample existing norms, Part 2 of the NHS Bill is striking in how far it respected the constitutional division of responsibilities between the Commonwealth and the states and territories, and other normative principles identified in

⁷⁸⁵ See discussion in Chapter 5.

Chapter 4. That said, the practical effect of Part 3 of the NHS Bill, introducing the SSBA regime, was to securitize a category of health research. Activity within this controlled field became subject to a ‘legitimate purpose’ test, determined by a Health official reportedly with the advice of Australia’s security agencies. As the research suggested in Chapter 4, the prioritisation of security interests (agent ‘containment’) over domestic health interests (agent ‘control’) is evidenced through the choices made about which biological agents are listed as SSBAAs and which are not.

In a similar manner to the disjunction between parliamentary debate and the language of biosecurity legislation, Chapter 5’s examination of biosecurity policymaking included an observation that securitization struggled to explain how nuanced choices were made in a long policy process. What emerged from that Chapter’s examination of the NHS Bill and SSBA regime, in particular, was that the policymaking process that led to the ultimate output (legislation, a CoAG report etc...) was more messy than theoretical models of securitization might imagine. While security framings and rhetoric were used by different officials to advance their Department’s ‘equities’, the serendipitous role of individuals and the more stable but still idiosyncratic effect of organisational culture created barriers to a straightforward or successful application of securitization by any one party. These confounding factors of serendipity and organisational culture are discussed further below, but they present a methodology challenge to studies of securitization that focus too tightly on either the output of a policy process, or a specific moment in time (eg, a debate in Parliament). Such factors were also present in the development of the DTC Bill (albeit to a lesser extent) and the response to Ebola, in which the consequences of staffing and personnel decisions were noted.

From the perspective of the regulated parties, such as researchers under the SSBA regime and DTCA, it may make little practical difference whether the threat identification in the SRS aligned with the content of the Bill, or why policy differences over risk resolved as they did. The consequences for their activities were the same. Nonetheless, this finding is of relevance to security scholars who focus on parliamentary words but not the text of legislation, or on a policy document but not the process of its creation.

Securitization without contestation?

As discussed in the literature review (Chapter 2), Parliament has been studied as a site for securitizing moves: whether as the stage on which securitization is performed or as the

forum in which securitization moves from performative to active forms.⁷⁸⁶ However, an unexpected finding from the analysis of the parliamentary debate surrounding key biosecurity laws (Chapter 4) was the general absence of meaningful debate in Parliament over biosecurity laws – particularly the NHS Bills and the DTC Bill – and the lack of contestation and parliamentary challenge to the securitizing move represented by the Bills. This absence of contestation manifested in two forms: first in the short and minimal debate on Bills or any specific provisions within them that represented something as an ‘exceptional’ measure or a ‘rule breaker’; and, second, in the way bipartisanship featured in parliamentary processes and debates.

The NHS Bill represents a clear example of the first form of absence. There were approximately 30 minutes of speaking time across both houses of Parliament on the Bill. Likewise, the DTC Bill was initially rushed through the House of Representatives (‘House’) with little debate. Even for the Biosecurity Bills, attention and debate focused less on the human biosecurity emergency provisions than on provisions relating to agricultural biosecurity. Other procedural evidence of bipartisanship included the use of Parliament’s Federation Chamber for debates on many of biosecurity laws examined, and the agreement of a House committee to expedite parliamentary consideration of the DTC Bill. Explicit or public appeals to bipartisanship also featured in the parliamentary debates on the NHS Act, future amendment Bills, and the DTC Bill. Bipartisanship reached a rhetorical apotheosis in the final debate over the DTC Bill, where the Opposition referred to the need for bipartisanship in matters of defence and the Australia-US alliance.

From the vantage point of 2022, the absence of parliamentary contestation over the emergency provisions in the Biosecurity Bills takes on a degree of irony. The Biosecurity Bill 2014 (Cth) contained numerous provisions conferring extraordinary powers on the Governor-General, Minister for Health and CMO to declare and respond to a health emergency with onerous public health measures. Yet, as examined in Chapter 4, the ‘regulatory impact’ statements prepared by the Department of Health on these provisions were lacking in detail or critical reflection, downplaying these exceptional provisions on the basis that equivalent emergency powers had never been used under the previous *Quarantine Act 1908* (Cth). Nonetheless, Parliament’s own scrutiny committees did not raise objections to these provisions and – even if they did – their final reports were too late to be effective tools of desecuritization.

⁷⁸⁶ For example, Roe, ‘Actor, Audience(s) and Emergency Measures’, above n 139.

This finding raises important questions about the ability for Parliament to serve as an effective break on securitization (see Recommendations). Did the various checks and balances on legislative action fail for these specific laws due to a lack of understanding of what was being proposed or the consequences of the measures? Or did the speedy passage of many of the biosecurity laws examined reflect something deeper about how issues become securitized?

Parliamentary bipartisanship has been suggested by some researchers as a sign that an issue is not being securitized (rather it exists as a ‘politicised’ or ‘medicalised’ issue).⁷⁸⁷ Conversely, other securitization theorists draw attention to efforts to remove a particular topic from normal politics, where debate is permitted, as evidence of securitization.⁷⁸⁸ Indeed, these interlocutory acts are, for some theorists, the essential act in securitizing a topic, and the invocation of bipartisanship can be a sign of an attempt to remove something from normal politics to a place where dissent (ie, partisanship) is not permitted and debate is not required.⁷⁸⁹ While the speedy passage of Bills and the general lack of contestation may suggest the former interpretation (ie, that an issue is not securitized), the author suggests that this was not the case for the laws examined. Rather, for these Bills, the apparent bipartisanship reflected a pre-existing consensus between the major parties on central threats and referent objects – even if those threats and objects were not always transparent during debates on the relevant Bills.

The hidden role of the public service in building and sustaining this legislative bipartisanship is discussed below. But bipartisanship also arose for more direct political reasons. As identified in Chapter 4, the SRS and other extrinsic materials that accompanied the NHS Bill (and subsequent amending Bills) and the DTC Bill invoked threats related to bioterrorism or conventional terrorism. Likewise, the proposed regulatory measures (eg, the SSBA regime) arose in the context of terrorist attacks and had been positioned by policymakers and previous governments as a response to those events.⁷⁹⁰ A lack of contestation by the ALP is therefore consistent with that Party’s reflexive support for all national security laws post-2001 (whether in Government or Opposition). Securitization of biosecurity issues was partly successful because it built on these already securitized subjects and, likely, a political calculation by Labor of how resistance (even a simple principled questioning of proposals)

⁷⁸⁷ See the model set out in Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia*, above n 27, 8–9.

⁷⁸⁸ Buzan, Wæver and Wilde, above n 42, 29.

⁷⁸⁹ Ibid; cf, discussion in Thierry Balzacq and Stefano Guzzini, ‘Introduction: ‘What kind of theory – if any – is securitization?’ (2014) 29(1) *International Relations* 97; Williams, ‘Words, Images, Enemies’, above n 64.

⁷⁹⁰ See timeline in Appendix 5.

would be used as a political weapon against it.⁷⁹¹ Similar political calculation also existed in the case of the DTC Bill, where a refusal to ‘commit’ to contestation by the Opposition arose from a pre-existing, bipartisan and iron-clad, consensus on the need to protect a particular referent object: the Australia-US alliance. By commitment to contestation, I mean that the Opposition (as an audience for the securitizing move) would be willing to engage in an intentional attempt to reject a securitizing move: such as to vote against an exceptional legislative measure.

In the case of the DTC Bill, the Opposition did not make such a commitment to contestation. It voted against its own amendment and voted in favour of the final Bill. But the reason for these decisions depends on what data one analyses. The parliamentary record reviewed in Chapter 4 implies that the centre-right Opposition parties’ ultimate acceptance of Defence’s regulation of academic research was a reluctant erring ‘on the side of caution’, following appeals by the Government. However, the interviews reported in Chapter 5 suggest that much of the Opposition’s concerns about academic freedom was opportunistic and undertaken to ‘embarrass’ the Government. Senior elected Party members reportedly made it clear that there would never be any threat to the alliance, such as voting down a measure that the US Government wanted. Indeed, the case of the DTC Bill reveals how bipartisanship over a partially-hidden referent object can result in the subordination of a regulatory principle of ‘national sovereignty’.⁷⁹² This important finding further supports recommendations by some securitization researchers and this author (see Chapter 3) to use interviews as part of a security analyst’s research toolbox.⁷⁹³ It also raises theoretical questions about the role of intention and sincerity (both for actors and audiences) as a criterion in assessing securitization.⁷⁹⁴

These findings are not intended to diminish the legislative contribution of the minor parties and Independent MPs. However, lacking the numbers to defeat legislation or to meaningfully slow its passage through Parliament through procedural motions, their role as an audience in securitization is different, particularly in the House where, by Constitutional convention, the Government-of-the-day is formed. Chapter 6 identified a more complex

⁷⁹¹ As an example of the political ‘wedge’ the ALP would wish to avoid see: Lenore Taylor, ‘Tony Abbott: Labor wants to “roll out the red carpet” for terrorists’, *The Guardian* (online), 18 June 2015

<<https://www.theguardian.com/australia-news/2015/jun/18/cabinet-told-citizenship-laws-wont-be-reconsidered-as-already-signed-off>>.

⁷⁹² ‘The prescription that the nation-state should be supreme over any other source of power on matters affecting its citizens or territory’: Braithwaite and Drahos, above n 36, 25.

⁷⁹³ Karyotis, above n 52.

⁷⁹⁴ This finding’s relevance to existing literature on sincerity in securitizing moves is discussed below.

typology of ‘audiences’ for securitization, and future theoretical work on securitization would benefit from a closer examination of the role of political parties as audiences in political systems less dominated by two or three parties.

Of relevance to security scholars who focus solely on parliamentary debates, these findings do point to a weakness of Parliament as an assumed tool or self-contained instrument of desecuritization (see Recommendations below). The presumptive bipartisanship between the major parties on any security-related issue, the inviolability of the Australia-US security Alliance (the Alliance) as a referent object, and structural weaknesses in the parliamentary scrutiny processes meant that many biosecurity laws received little attention by Parliament. When combined with the absence of a legal Bill or charter of human rights, and the failure by advising Departments (eg, the Department of Health) to critically reflect on human rights implications of the laws they are drafting, this can result in laws that *ought* to have had greater scrutiny being passed on the basis of uncontested assumptions and threat constructions. These findings support the concerns raised by Stephenson on the ‘silencing’ effect of security framings.⁷⁹⁵

During COVID-19, Parliament finally recognised that it has been excluded from any meaningful role in overseeing or checking the Executive’s management of pandemics and health emergencies. A submission to a 2021 Senate review of the *National Emergency Declaration Act 2020* (Cth) from the Senate Standing Committee on the Scrutiny of Bills belatedly acknowledged that the powers conferred on the Executive under the *Biosecurity Act 2015* (Cth) were ‘extraordinarily broad’ but had ‘received little consideration when the Biosecurity Bill was being considered in 2014 and early 2015.’⁷⁹⁶ It is expected that this committee will advocate for reform in this area, although it is doubted that – without agitation from outside Parliament – governments will prioritise reform.

Government resistance to securitization?

Interestingly, when it did feature in parliamentary debates, contestation over biosecurity lawmaking and disease response was usually initiated by non-government and non-political actors. As discussed in Chapter 4, it was through forum-shifting that the research community

⁷⁹⁵ Stephenson, ‘The Disappearing Act of Global Health Security’, above n 75.

⁷⁹⁶ Senate Standing Committee for the Scrutiny of Bill, Submission No 2 to Senate Legal and Constitutional Affairs Legislation Committee, *Review of the National Emergency Declaration Act 2020*, 17 March 2021. See also: Senate Standing Committee for the Scrutiny of Delegated Legislation, Parliament of Australia, *Interim report: Exemption of delegated legislation from parliamentary oversight* (2020).

initiated and sustained a meaningful process of contestation over the 2012 DTC Bill and DTCA, resulting in the 2015 DTC Amendment Bill and a regulatory win for the research community. Most striking, however, was the degree to which actors external to Government (eg, the Opposition and Independent MPs and humanitarian NGOs) assumed the role of securitizing actors in Australia's response to the Ebola outbreak and, conversely, how the Government was placed in the role of contesting efforts to securitize the outbreak. The ALP (then in Opposition), Australian Greens and NGOs all demanded a greater commitment of humanitarian aid and personnel to West Africa to assist the 'crisis'. These calls were resisted by the Government, which frequently engaged in counter-security rhetoric (eg, denying that it was a military or security crisis). Indeed, this response saw appeals to bipartisanship from the Government as a rhetorical attempt to try to return the issue to the realm of 'normal politics'. This attempt by the Government to resist an attempt to securitize a topic to achieve a 'progressive', humanitarian end is a useful case study of the challenges for non-dominate actors to use security rhetoric for the 'politics of progressive change'.⁷⁹⁷

The inference from the Government's resistance was that it understood that, to accept this framing, would demand a certain type of response by the Government, and one it was not prepared to make, whether for political or other reasons (eg, statements about providing safe repatriation and care to any injured HCWs). That the Government was forced to move from an initial position of only providing funds to international humanitarian organisations, to engaging a private medical provider (Aspen Medical) to deliver an 'Australian response', suggests that these external actors had some success in securitizing the outbreak. Meanwhile, federal public servants rationalised state government deviation from national strategies for returning HCWs as 'political policy' and a consequence of the federal division of responsibilities in health and democratic governance.

The Australia-US security alliance: the unspoken referent object

A key finding from this study is the extent to which the Alliance operated as a referent object in debates over the DTC Bill and securitization of research. Chapter 4 and 5 reported how *not* enacting the DTC Bill was even positioned as a threat to the alliance. Addressing this threat dictated both the scope of the regulatory regime and even the timing of its passage so as to not embarrass visiting Presidents and Secretaries of State. Securitization theory often positions the securitizing actor as a figure of power, with 'sedimented authority', who, if not

⁷⁹⁷ Roe, 'Is Securitization a "negative" Concept?', above n 53, 260 discussing McDonald, above n 119, 580.

exactly acting with the ‘decisionist’-decisiveness of Schmitt’s ‘sovereign’,⁷⁹⁸ at least is engaging freely in its securitizing moves. In a similar vein, national security or defence is an area cited by Braithwaite, Drahos and other regulation scholars as a domain where States traditionally prioritise direct control over the design of regulatory options, advancing a regulatory principle of ‘national sovereignty’.⁷⁹⁹ However, the DTC Bill suggests that *domestic* securitization can occur while the relevant sovereign is attempting to achieve a regulatory outcome that, rather than furthering a principle of ‘national sovereignty’, is looking to bring their rules up to standards set by a foreign power, in this case the US Senate. In this case, Australia was prepared to impose additional (and unequal) restrictions on its own researchers and defence community to gain additional access to US Defence technologies.

While the DTC Bill represents the Alliance in its strongest form as referent object, Chapter 6 identified its limits. Notably, the Alliance was unsuccessfully deployed by the ALP in their attempts to prompt a more dramatic, humanitarian response to the Ebola outbreak. This was likely due to the call to action being grounded in humanitarianism rather than a classically securitized domain such as arms sales and controls. Moreover, while the US directly lobbied various Australian officials during the debate over the DTC Bill, this degree of external pressure was not reported during the Ebola outbreak.

The case of the DTC Bill shows how threat identification and securitization can be achieved with the use of silences and suggestions. Silences are critical to security discourse, whether as a rhetorical tool to strengthen a perlocutionary act – a dramatic pause; or a consequence – eg, a silencing;⁸⁰⁰ or a ‘thing’ created or alluded to. As examined in Chapter 4, the SRS to the DTC Bill positioned a failure to comply with US demands for Australia to tighten controls of dual-use research was implicitly presented as a threat to ‘our most important defence relationship and the foundation stone of our foreign policy and national security arrangements.’ This threat framing – muted though it was – worked on the audiences it needed to: namely, the Government Ministers advancing the Bill and senior members of the Opposition. It was unnecessary for other legislators to accept, or even fully understand the nature of, the threat or referent object.

⁷⁹⁸ Williams, ‘Words, Images, Enemies’, above n 64.

⁷⁹⁹ See, for example, the case of telecommunications in: Braithwaite and Drahos, above n 36, 349; Stephen Bell and Andrew Hindmoor, *Rethinking Governance* (Cambridge University Press, 2009) 10.

⁸⁰⁰ McDonald, ‘Securitization and the Construction of Security’, above n 119; Nik Brown, Brian Rappert and Andrew Webster (eds), *Contested Futures: A Sociology Perspective Techno-Science* (Ashgate Publishing, 2000).

Two lessons emerge from this finding. First, that when engaging discourse analysis, security analysts need to consider the possibility that only a narrow slice of a given ‘audience’ (eg, Parliament or the Cabinet) is the true audience to whom a security utterance is directed, and that this utterance may be coded. The second lesson, for those seeking to challenge securitization, is that naming and giving form to these silent threats (and the assumptions that underpin them) is, arguably, a critical step in desecuritizing a problem or challenging its initial securitization. Whether the academic sector could have overcome the deep bipartisanship between the ALP and Liberal Parties on the Alliance is questionable, but they may have been more successful had their arguments been based on nationalistic appeals to ‘standing up to America’ than more esoteric arguments centred on academic freedom. Past examples of resistance to other efforts to globalise US regulation – for example intellectual property rights under the Australia-US Free Trade Agreement and Trans-Pacific Partnership Agreement – highlight the possibilities for success.⁸⁰¹

The public service as hidden securitizing actors

This study adopted a critical view of the focus of much securitization literature on public statements by Ministers, Presidents, or highly public figures, such as Ambassadors.⁸⁰² Informed by their career as a public servant, the researcher’s initial view was that Parliamentarians were often the public performers of rhetoric prepared elsewhere. Would this be the case for security rhetoric? Chapter 5’s analysis of the departmental drafts of SRS with the versions delivered by Ministers in Parliament found almost no meaningful changes made by Ministers to speeches prepared by apolitical public servants. Initial assumptions based on professional experience notwithstanding, the extent to which SRS went unchanged surprised the author. This finding provided a useful insight: that public securitizing moves can be scripted by hidden securitizing actors, with the public speakers (eg, Ministers) acting more as performers.

⁸⁰¹ Thomas Faunce et al, ‘Assessing the Impact of the Australia-United States Free Trade Agreement on Australian and Global Medicines Policy’ (2005) 1(1) *Globalization and Health* 15; Thomas Faunce, ‘Australia’s Embrace of Investor State Dispute Settlement: A Challenge to the Social Contract Ideal?’ (2015) 69(5) *Australian Journal of International Affairs* 595; Deborah H Gleeson, Kyla S Tienhaara and Thomas A Faunce, ‘Challenges to Australia’s National Health Policy from Trade and Investment Agreements’ (2012) 196(5) *Medical Journal of Australia* 354; Deborah Gleeson and David Legge, ‘Strengthening Public Health Engagement in Trade Policy: PHAA’s Policy on Trade Agreements and Health’ (2012) 36(1) *Australian and New Zealand Journal of Public Health* 7, 9.

⁸⁰² But cf, Salter and Piché, above n 147.

While such a finding may not be surprising to public administration scholars,⁸⁰³ it raises important theoretical and empirical questions for security analysts. As a minimum, it points to the need for analysts to examine securitization outside public forums such as Parliament and critically reflect on the field's primary research method of retrospective discourse analysis, which can over-privilege specific moments and particular actors.⁸⁰⁴ In the case of this thesis, it provides an empirical justification for the wider use of documentary analysis and interviews with public servants to explore how issues came to be seen as biosecurity threats.

Because the SRS often constituted the main parliamentary debate on a biosecurity law it also raises theoretical questions about the application of speech-theory in Securitization Theory that fuse the illocutionary and perlocutionary functions of speech acts. Consider, for instance, the 'felicity conditions' held to be important in the theoretical underpinnings of securitization as an inter-subjective process. In the 'grammar of security', an illocutionary speech act will fail if it does not satisfy, among other conditions, a 'sincerity condition that posits that participants in this "conventional procedure" must have certain thoughts or feelings, and "must intend so to conduct themselves"'.⁸⁰⁵ In relation to an SRS, whose 'thoughts or feelings' matter as a condition of the speech-act? The drafter's or the speaker's? Does the adoption of a Department's SRS by a Minister validate the speech act or does it represent a *de novo* speech act?⁸⁰⁶ Does the Minister accept the Department's speech as audience to a Departmental speech-act or is the relationship between the two truly more akin to that between a speechwriter and speaker (contrary to the apolitical nature of the Australian public service)? While some of these questions can be addressed theoretically, answering others demands the use of a wider palette of analytical techniques, such as elite interviews, content analysis or participant observation.⁸⁰⁷

It is recognised that SRS are intentionally dry and technical in nature. This may explain why Ministers did not amend them (although this may also be an Australian idiosyncrasy). Future research may wish to compare the findings from this study with other parliamentary speeches, such as 'Ministerial Statements', where a department would also be expected to play

⁸⁰³ Or Salter and Piché, above n 147, 935–936, 'illocutionary acts do not spring fully formed from the head of Zeus, President Bush, Governor Ridge or any other actor'.

⁸⁰⁴ See similar criticisms in Floyd, 'Extraordinary or Ordinary Emergency Measures', above n 134.

⁸⁰⁵ Buzan, Wæver and De Wilde, above n 42, 32–33; Balzacq, 'The Three Faces of Securitization', above n 139, 175–176 citing Austin, above n 42.

⁸⁰⁶ This process may be similar to that of the 'duplex approach' to legal interpretation where the legislature (or, in the case, Minister) 'validates' the text of the drafter through their delivery in Parliament: discussed in McLeod, above n 273.

⁸⁰⁷ See similar calls in: Karyotis, above n 52; Salter, above n 45; Salter and Piché, above n 147.

some role in their preparation. However, the special status afforded to SRS as an enduring interpretative aid by the judiciary and public service is unique, and means they provide – per Balzacq and Roe – ‘moral’ support as well as ‘formal’ support for active forms of securitization.⁸⁰⁸ Further, studies in similar parliamentary systems (and correspondence from Australian FoI officers) have identified the degree of ownership public servants feel in relation to such extrinsic materials, suggesting they – if not their political masters – understand the power of an SRS.⁸⁰⁹ These speeches, therefore, represent a way in which hidden security actors can construct threats and referent objects that persist across different Governments, and vindicate post-enactment decision-making by the same department who crafted the speech.

This study also found that, to the extent securitization featured in biosecurity policymaking, public servants and not Ministers were the central security actors. For instance, Chapter 5 outlined how public servants developed and set the frameworks for the SSBA review and chose the legislative vehicle through which to deliver the policy (the NHS Bill). Likewise, pandemic planning in the mid-2000s, and the responses to pandemic H1N1 influenza in 2009, and Ebola in 2013–2016, were largely driven by public servants. The truly exceptional decision of the Prime Minister to pause humanitarian visas serves more to confirm the rule of public service leadership than to undermine it. As discussed above, securitizing actors outside DFAT, Health and the Government emerged during the Ebola outbreak.

One retort to this finding is that officials might merely have been acting as good agents of the Government-of-the-day, giving effect to the (security) ambitions of the Government, despite personal misgivings. In the case of SRS, could the seemingly strong role of public servants as security actors simply be the result of a gradual alignment of principles between staff involved in drafting SRSs, the leadership of the Department and the Minister? Public servants with different principles to senior officials or the Minister might have left a department, only to be replaced with staff who accepted (or were attracted to) the dominant principles. This would represent a model of security institutionalization via attrition and, indeed, evidence of such value alignment has been identified in speechwriters in the UN.⁸¹⁰

Such an alignment was not evident in this study. Rather, senior public servants who led the SSBA review reflected proudly on their work and specific interview questions on whether

⁸⁰⁸ Balzacq cited in Roe, ‘Actor, Audience(s) and Emergency Measures’, above n 139, 616.

⁸⁰⁹ Page, above n 278.

⁸¹⁰ Moniza Waheed et al, ‘Values in UN Speeches: Understanding the Speechwriters’ Perspectives’ (2013) 75(7) *International Communication Gazette* 597. Interviews were primarily with staff employed at the Executive Level 2 and Senior Executive Service Band 1 and Band 2 level: *Public Service Classification Rules 2000* (Cth).

Ministers played a direct role in setting the direction of the SSBA review were answered in the negative. A similar distance between the public service and the ministerial arm of the Executive also featured in interviews on disease response. As a former Minister (P1) reflected, her interest was in knowing *something* was in place to respond to a threat not in framing the nature of that threat and the range of acceptable responses. This statement was consistent with reflections from Health employees and their relationships with Ministers during the 2009 pandemic of H1N1 influenza and the Ebola outbreak, and the nature of most correspondence between the Prime Minister and Ministers for Health obtained via FoI.

Consequently, the surprising decision by Prime Minister Abbott (implemented by his Minister for Immigration and Border Protection) to suspend Australia's humanitarian visa program in West Africa during the Ebola outbreak (Chapter 6) represents such a break of standard practice as to constitute its own securitizing move. As Chapter 6 discussed, this move and other moments of 'political policy' by state and territory leaders were 'accepted' by public servants through a process of rationalisation. This rationalisation was expressed in terms of a deference to democratic principles rather than an acceptance (per Securitization Theory) that a securitizing actor was justified in breaking rules due to the nature of a threat. Taken together, these findings support the approach adopted by Davies and others of analysing the role of officials as 'norm entrepreneurs' – even if those entrepreneurs may yield to rare instances of 'political policy'.⁸¹¹

Another challenge to the finding that public servants are the leading securitizing actors, may come from the 'Paris school' of international relations. Could it be that public servants were, themselves, co-opted or enrolled in a wider securitizing process by 'security professionals' engaged in the 'politics of unease'?⁸¹² Or did they, themselves, transform into such security professionals? Such an argument might suggest that securitization has become institutionalised, not through the persistence or recurrence of a 'threat',⁸¹³ but through repeated citational security speech-acts by outsiders to public servants, then from public servants to their Ministers and finally, from Ministers to Parliament.⁸¹⁴ The use of common language across the SRS associated with the NHS Bill and amending laws in 2009, 2010 and 2012, shows such a pattern. Likewise, the enrolment of officials in relevant epistemic communities (see discussion above) might also support this process. If so, this opens counter-hegemonic strategies to

⁸¹¹ Davies, Kamradt-Scott and Rushton, above n 26.

⁸¹² Bigo, above n 119.

⁸¹³ Buzan, Wæver and De Wilde, above n 42, 28.

⁸¹⁴ Ibid, 40–41.

challenge institutionalisation of exceptional measures: a long march through the [securitized] institutions.

Ultimately though, what emerged from the interviews in Chapters 5 and 6 was a messier process than that suggested by the Paris School model of ‘security professionals’ ‘deliberately position[ing] themselves to advantage via various institutional and governance mechanisms and transnational networks to control security agendas.’⁸¹⁵ Part of this messiness arose from the degree to which chance decisions played significant roles in the direction of policy work or disease response. For example, in the SSBA review (Chapter 5), staffing decisions played a central role in the framework to be applied in the review and design of regulatory measures. Contrary to a view that security professionals might seek out such opportunities ‘to control security agendas’, the individuals seconded into DPMC were from the Office of the Gene Technology Regulator (OGTR) – an institution whose dominant organisation logic is risk-management.⁸¹⁶ It was perhaps by chance that officials with similar, scientific qualifications and training, were tasked with this policy – rather than those with a history in the ‘pointy end’ of security. The engagement of key external advisers in the review was similarly described by one official as ‘crappy and informal’ and ‘serendipitous’. In disease response, staffing was also identified as a factor in assessments (by officials and others) of Health’s performance during pandemic H1N1 in 2009 (good) and Ebola in 2013–2016 (less good). These initial conditions are difficult to predict in advance but play a significant role in the extent to which security framings and rhetoric are applied.

In contrast, the close relationship between senior officials within Defence and ‘strategic studies’ think-tanks is a possible example of Bigo’s professionals of unease. Michael Shoebridge, the leading Defence official in the development of the DTC Bill, later moved to a leadership role within the Australian Strategic Policy Institute (ASPI), where he continued calling for tighter controls on academic research. This advocacy included online pieces and a personal submission to the legislated review of the DTCA, which was consistent with this position.⁸¹⁷ Despite calling itself ‘an independent, non-partisan think tank’, ASPI is also ‘a

⁸¹⁵ Thomas, above n 52, 99, citing Didier Bigo, ‘Globalized (in)security: The field and the ban-opticon’ in Didier Bigo and Anastassia Tsoukala (eds), *Terror, Insecurity and Liberty: Illiberal Practices of Liberal Regimes after 9/11* (Routledge, 2008), Chapter 2.

⁸¹⁶ As per its enabling legislation: eg, *Gene Technology Act 2000* (Cth) s 3.

⁸¹⁷ Vivian Thom, *Independent Review of the Defence Trade Controls Act 2012* (Commonwealth of Australia, 2018) 30. See also: Michael Shoebridge, ‘China’s military has one aim in sending its scientists to study in the West’ on ASPI, *The Strategist* (31 October 2018) <<https://www.aspistrategist.org.au/chinas-military-has-one-aim-in-sending-its-scientists-to-study-in-the-west/>> opening line: ‘Research by Chinese scientists in Australian

wholly-owned Commonwealth Company’, with more than a third of its income coming from the Department of Defence.⁸¹⁸ Running security-focused ‘masterclasses’ for senior public servants, it may play an understudied role as part of the Australia’s ‘politics of unease’.

The language of proportionality can mask or even support exceptional measures

Both in the SRS, and in the interviews reported in Chapters 5-6, it was common for proposed legislation or response measures to be described as ‘proportionate’. This is quite different from the justificatory language expected of a securitizing move – words such as ‘necessary’, ‘urgent’, ‘critical’ or ‘life-saving’. Security scholars may be tempted to argue that to say an action is proportionate is, by definition, to remove it from the realm of the extraordinary – necessary for something to be a security issue. This would be misguided both theoretically and pragmatically. In *A New framework for Analysis*, Buzan and colleagues refer to three components of successful securitization: ‘existential threat, emergency action, and effects on interunit relations by breaking free of rules.’⁸¹⁹ This criterion does not require that actions are disproportionate to the risk. (However, as Enemark observed in relation to dreaded diseases, measures may appear disproportionate when assessed objectively against a disease’s burden.)⁸²⁰ Absent a theoretical requirement that exceptional security measures rise to the level of a scorched earth (or scorched Constitution) response, justifying a measure as necessary to safeguard a referent object from a security threat could quite logically be couched in terms of proportionately (ie, the ends justify the means). Resistance to a securitizing move could, likewise, challenge claims that measures are proportionate but, as already suggested, this should be coupled with efforts to draw attention to hidden threats and referent objects.

Moving away from a semantic argument, including measures described as ‘proportionate’ in an analysis of securitization gives appropriate weight and respect to the interests of other ‘units’, audiences, or actors. For instance, although the Government sought to position the SSBA regime and the DTCA as proportionate,⁸²¹ the *effect* of both on the

and other Five Eyes nations’ universities increases China’s military capability and is not in our national interest.’

⁸¹⁸ In 2020-2021, an additional 25% came from ‘federal government agencies’, 18% from ‘overseas government agencies’ and 3% from ‘defence industries’: ASPI, *ASPI funding* (1 November 2022) <<https://www.aspi.org.au/about-aspi/funding>>.

⁸¹⁹ Buzan, Wæver and De Wilde, above n 42, 26. The existential threat criterion has been discussed elsewhere in this thesis.

⁸²⁰ Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia* above n 27, 1, 6, 8.

⁸²¹ Chapter 4 and Chapter 5.

relationship between the State and researchers was real and dramatic. As the author argued in an article published as part of this study:

The enactment of the DTCA collapsed the division between [academic research and national security], extending a command and control regulatory regime over science and academia. Prior to the DTCA many ordinary research activities could be considered lawful unless prohibited ... after the DTCA those same activities are now prohibited unless excepted, exempted or otherwise approved. This break [had] been justified on the grounds that certain research...[posed] a risk to national and international security.⁸²²

The adoption of a ‘legitimate purpose’ test (to be applied by a Commonwealth official on advice from national security agencies) in the SSBA regime, represents a similar reconstitution of relations. And, finally, the nearly unlimited powers that could be exercised under the Biosecurity Bills once a ‘human biosecurity emergency’ had been declared, easily answers *A New Framework for Analysis*’ threshold question: ‘how big an impact does the securitizing move have on wider patterns of relations?’

Overall, this study found that the language of proportionality – and its invocation as a principle of regulatory design – was used by either side in the intersubjective process of securitization. As such, it served pragmatic and tactical purposes as well as rhetorical ones. Rather than serving as a true counter-principle (compare to ‘academic freedom’) its main role was to provide legitimacy and cover for other principles. In this sense, proportionality is not so much a principle as a frame, serving as a ‘cognitive baggage handler’ deployed ‘in an attempt to generate or legitimise specific pathways of response....’⁸²³ A consequence of this is that contesting securitization by focusing on questions of proportionality alone is unlikely to succeed. This may be one reason Australia was able to resist initial objections from the WHO over its visa ‘pause’ during the Ebola outbreak – notwithstanding its discriminatory and disproportionate effects (Chapter 6). Proportionality may only be a useful counter-principle when attached to some ‘cost’ for a key operational audience, for example the political cost to a state premier of accepting advice to close state schools during the 2009 pandemic of H1N1 influenza (Chapter 6). Concluding this point, security scholars should ensure that their analysis of discourse includes an examination of terms – such as ‘proportionate’ and ‘efficiency’ –

⁸²² Vines, above n 1, 669–670.

⁸²³ McInnes et al, ‘Framing Global Health: The Governance Challenge’, above n 113, S85 citing Jeremy Youde ‘The development of a counter-epistemic community: AIDS, South Africa and international regimes’ (2005) 19(4) *International Relations*, 421, 423.

which, on appearance, seem part of regular political discourse but which may mask something else.⁸²⁴

The good global citizen principle as a powerful driver of domestic rule breaking and securitization

A difference between threat identification in public speeches and the content of a law reflects that the underlying policy work that led to a Bill usually sought to advance multiple principles, with securitization and security framings helping to advance some principles. As examined in Chapters 4–6, these principles included the procedural (eg, parliamentary oversight and natural justice), normative (eg, deference to medical experts and human rights) and upholding Australia’s international and constitutional obligations. This thesis has described these last two principles as the ‘good global citizen’ principle and a principle of ‘domestic comity’.

A finding of interest was the role of the good global citizen principle in supporting securitization. This combination was most strongly demonstrated in the development and justification of the SSBA regime and the DTC Bill. Chapter 5 showed how senior public servants driving both policies invoked Australia’s obligations under post-2001 UNSC resolutions, the Biological and Chemical Weapons Conventions (BWC and CWC, respectively), membership of the Australia Group and Wassenaar Arrangement and – just as critically – Australia’s self-identification as an ‘exemplar’ of counter-proliferation adherence.⁸²⁵ Accepting the contention in the literature that these international regimes reflect the securitization of those topics at a global level,⁸²⁶ this study shows how the good global citizen principle can ease the entry of new regulatory rules into a domestic setting, all while cloaking a more ambiguous process: securitization.

⁸²⁴ The language of effectiveness has appeared in the context of anti-terrorism lawmaking and – recently – in the granting of extensive police powers during COVID-19 outbreaks. See Victorian Premier Daniel Andrews’s comments in, Michael Fowler, Noel Towell and Sumeyya Ilanbey, ‘Melbourne’s COVID-19 curfew an enforcement aid, Andrews confirms’ *The Age* (online), 9 September 2020 <<https://www.theage.com.au/national/victoria/melbourne-s-covid-19-curfew-an-enforcement-aid-andrews-confirms-20200909-p55u1s.html>> - ‘It just makes the job of police much, much easier’; in the context of anti-lockdown protests and policing see ABC News, ‘Daniel Andrews address anti-lockdown protests’, Live Press Conference, 21 September 2021 (Daniel Andrews).

⁸²⁵ PS8 and Chapter 5 generally; Commonwealth, *Parliamentary Debates*, Senate, 29 October 2012, 8115 (Senate), (Senator David Johnson).

⁸²⁶ Youde, ‘High Politics, Low Politics, and Global Health’, above n 29; Fidler and Gostin, *Biosecurity in the Global Age*, above n 38; Fidler, ‘Biosecurity: Friend or Foe for Public Health Governance?’, above n 38; Enemark and Selgelid, above n 38; Davies, ‘Securitizing Infectious Disease’, above n 25.

In the cases examined, to position oneself as a good global citizen lent additional moral weight to actors seeking to transplant global regulatory rules and norms into a domestic setting. Australia would not have breached international law by not adopting the guidelines and lists of controlled technology developed by the Wassenaar Arrangement and Australia Groups. However, Australia's moral investment in these organisations and the participation of senior Defence and DFAT officials in their epistemic communities, made these groups potent sources of regulatory principles that could be readily adopted by domestic securitizing actors. This use of the good global citizen principle was particularly evident in the testimony of senior Defence officials justifying the DTC Bill to Parliament and in their debates with the academic community (Chapter 5). Being a good global citizen in this context foreclosed almost all alternative regulatory options (eg, self-regulation via codes of conduct). Having said that, the principle accommodated a degree of local latitude, as was evident in disagreements between officials designing the SSBA regime in how closely it ought to model and replicate the select agents regime in the US, the Australia List of agents or those controlled under the DSGL. Nonetheless, in the case of the SSBA, the high-level regulatory design options (ie, a list of agents that would be subject to federal government oversight and control) were fixed early on.

A second role for the good global citizen principle is as an alternate justification for pursuing a desired policy outcome (eg, regulating DURC or Gain of Function (GoF) research), when an audience resists a justification grounded in security rhetoric. This can be particularly effective where – as was the case with pathogen research and DURC – the audience (academics and researchers) are accepting of the normative goal (counter-proliferation and non-use of biological weapons) but opposed to the actors promoting reform (Defence) or the regulatory means (command-and-control regimes). Indeed, the research community conceded that ‘it was never our view that nothing was required’ (R1) but, having made this concession, it was then harder to resist the regulatory model proposed as the *something* required.⁸²⁷

Related to this use, the principle can be used to enlist allies who can support the securitizing actor's move. Chapter 6, for example, identified how this principle has strong attraction to Australian foreign ministers, regardless of political persuasion. Yet, just as securitization is a process of construction, so too is designating oneself a good global citizen. Chapter 6 demonstrated how the Government's claims to be acting as a good global citizen in the early months of the Ebola outbreak were challenged by humanitarian NGOs and the

⁸²⁷ See the author's similar argument in Vines, above n 1, 676.

Opposition – to some effect. It is likely too much to say that shame drove the decision to eventually engage Aspen, but a fear that the Government risked being perceived by the public and media for responding to the crisis badly did emerge from the documentary analysis. This points to some interesting areas for future securitization research. Where, as was the case in the Ebola outbreak, securitizing actors are in a politically or materially weak position compared to the entity (eg, Government) with the power to take the desired exceptional measures, what role does shaming language play in securing acceptance by the reluctant party. Exploring this dynamic may assist in preventing ‘securitizing’ becoming a mere label for discussions about fear and othering.⁸²⁸

What were the consequences of securitization on regulation or responses?

Consequences of positioning the Indo-Pacific as a referent object in Ebola

A significant finding in this study was how, during the Ebola outbreak, Government and non-government actors positioned the Indo-Pacific region as a domain of particular responsibility and security interest for Australia (Chapter 6). This study argues that the Indo-Pacific was seen by the Government as a key referent object and – conversely – the [fragile] health systems of PICs were framed as a security threat to Australia. This framing was a contributing factor to the Government’s reluctance to send an AUSMAT team to West Africa and, when an Australian-funded response *was* provided, to use a private business (Aspen) to deliver those services. The framing of the Indo-Pacific as a referent object affects how governments are likely to respond to humanitarian and health emergencies in the future and the Government’s relationship with State-employed HCWs, such as AUSMAT teams. These teams and HCWs may come to be seen as strategic resources by the Government with their deployment prioritised to further security – rather than humanitarian – objectives. Such an outcome is likely to be perceived as negative by AUSMAT members.

However, if referent objects can obtain a degree of permanence (eg, through repetition, an accretion of [vested] interests, or by becoming co-mingled with the self-interests of an audience), there is an opportunity for health practitioners and humanitarian organisations seeking to elevate public health issues in PICs, and secure additional funding and resources. The benefits of using security framings and rhetoric by public health campaigners has been

⁸²⁸ Which is how the concept is largely positioned in the introduction to Hofman and Au (eds), above n 90.

noted in this thesis and elsewhere.⁸²⁹ For instance, the establishment of an Ambassador for Regional Health Security and Indo-Pacific Centre for Health Security within DFAT discussed in Chapter 6 can be seen as positive steps to elevate these issues. The risks and opportunities arising from this finding are explored further in Recommendations.

The effect of securitization on the field of public health?

Chapter 1 posed the question: if securitization does serve as a mechanism to shape regulatory action, what effect would that have on the field of public health? This study has found that securitization did serve as a mechanism to pursue and justify regulatory change that positioned various threats (including biological agents and research activities) as security problems that demanded a certain type of regulatory response (frequently a licensure regime with command-and-control style rule). Indeed, the SSBA regime and DTCA also represented cases where health *researchers* were constituted as threats and, similarly, Ebola demonstrated how health care practitioners can represent a threat to national health security.

Combined with its effects on disease response measures, securitization can be said to have had some effect on the practice of public health. But were those consequences negative, as the critiques of securitization discussed in Chapter 2 might expect? Did it, for example, lead to disproportionate responses?

From the cases examined, the answer to that appears mixed. Indeed, one finding from this study is that the author's starting assumption relating to 'proportionality' as a meaningful counter-principle to a securitizing outcome appears misplaced. Proportionality served as a rhetorical palliative to be used by a securitizing actor to win over an audience, or by those countering the move. Nonetheless, the routine human biosecurity provisions of the *Biosecurity Act 2015* (Cth), for example, represent a reasonable attempt to embed Gostin's vision for 'power, duty and restraint', and support a 'scientific' approach that values information sharing and responses that centre human-dignity and human rights?⁸³⁰ Key principles of public health are upheld (see Chapter 4).

A material consequence of securitization in the case of the DTC Bill was that the 2012 Act required significant amendment (in 2015) to restore some degree of freedom to academics

⁸²⁹ For example: Elbe, 'Should HIV/AIDS Be Securitized?', above n 53; O'Manique and Fourie, above n 150, 247–249; Hakan Seckinelgin, Joseph Bigirimwami and Jill Morris, 'Securitization of HIV/AIDS in Context: Gendered Vulnerability in Burundi' (2010) 41(5) *Security Dialogue* 515; Elbe, 'Securitizing Epidemics: Three Lessons from History', above n 23.

⁸³⁰ Gostin, *Public Health Law: Power, Duty, Restraint*, above n 55. IHR 2005 art 3(1), 43(2).

and researchers and to wind-back the extent to which ordinary research activities (emails, phone calls, conference presentations and peer-review of publications) were captured. The interviewees in Chapter 5 spoke to the disconnect and lack of understanding between Defence officials, those developing the SSBA regime and the academic community. This disconnect, which included disagreements over the use of security-framings to justify regulatory responses, led to poor engagement and – as revealed by the aborted work of the NHMRC – wasted effort.

As reported in Chapter 5, the DTCA also resulted in challenges for the Australian therapeutic goods regulator to perform certain public health functions related to vaccine development. Given these negative consequences, it is not surprising that the SARS-COV-2 virus has *not* (as of 13 March 2023) been added to the list of SSBA, nor to the DSGL. This particular virus remains within the field of public health and not (yet) defence and security interests. As such, the DTC Bill represents the clearest example of the feared adverse consequences of securitization being used in regulatory design.

In disease response, the Ebola outbreak demonstrated how the human rights of some (Australians) were given greater weight than others (West Africans, refugees and returning HCWs). We have seen this occur again during COVID-19, but with a clearer understanding of the importance of *residence* as opposed to mere citizenship. In Ebola, the Government's decision to pause visa processing was unilateral, considered scientifically unjustified by the WHO (at least initially),⁸³¹ and opaque – with it refusing to release information demanded by the Senate. The Australian Government's response similarly exposed a lack of understanding of the norms that underpin the humanitarian sector and how those norms might be translated into operational arrangement (including whether an organisation would accept government funding). Finally, the regulation of biological agents and the *information* associated with those agents under the SSBA regime and DTCA hinders the sharing of relevant health data, both in terms of better understanding a disease and developing appropriate countermeasures.

What does emerge from the cases examined is a view that regulatory reforms between 2001–2016 did collapse some boundaries that existed between the fields of public health, health research and national security. While national health research funders are still not required to assess applications for national security issues, the attention of researchers is increasingly being

⁸³¹ See further, Chapter 6.

drawn to these issues by funders and universities.⁸³² Security is now a routine part of the field.⁸³³

The role of organisational culture in moderating the impact of securitization

The role of serendipity in policy and lawmaking was examined above as confounding efforts to identify exactly who and how an issue came to be securitised. Adding additional unpredictability to assessing the degree to which securitization features in Australia's biosecurity laws and disease response, is the role of organisational culture and approach to regulation. This study had the benefit of following policy work over several years and can draw some conclusions from how organisational culture presents challenges to Elbe's thesis of the medicalization of insecurity. Concerns over the regulatory culture and technical competence of Defence, for instance, formed one thread of misgiving expressed by the academic community in the development of the DTC Bill (Chapter 5). Researchers sought a regulatory outcome that would be developed and managed by an institution they saw as more aligned with their values: the NHMRC. However, for reasons hinted at in Chapter 5, the NHMRC was unwilling or unable to take up a leading role in relation to DURC. The command-and-control regulatory culture of Defence came to shape the regime.

Organisational culture also presents a challenge to Elbe's view that we have seen the medicalisation of insecurity. The second contention of Elbe's thesis is that the medicalization of insecurity:

...enable[s] a range of medical and public health experts to play a much greater role in the formulation and analysis of contemporary security policy, thereby increasing the political influence of these social groups.⁸³⁴

Contrary to this argument, interviews with officials within the Department of Health identified little engagement with security agendas and institutions. This extended to the officers administering the SSBA regime and even those whose functional tasks included 'biosecurity'.

⁸³² NHMRC, *Applicable laws and obligations* (2 November 2022) <<https://www.nhmrc.gov.au/applicable-laws-and-obligations>>; Australian National University, *Defence Export Controls and Your Research* (October 2020) <<https://services.anu.edu.au/research-support/ethics-integrity/defence-export-controls-and-your-research>>.

⁸³³ See also the 2019 establishment of a dedicated 'University Foreign Interference Taskforce' within the Department of Education and subsequent guidelines: Australian Government, Universities Australia and the Group of Eight, *Guidelines to counter foreign interference in the Australian university sector* (Commonwealth of Australia, 2021).

⁸³⁴ Elbe, 'Pandemics on the Radar Screen', above n 123, 849.

To some of these officials, security was a ‘guns, bombs, and police [mindset]’ and Health, when it did participate in forums which considered such matters, saw itself as an outsider.

Certainly, as Elbe suggested, new biosecurity laws created additional roles for the CMO, Directors of Human Biosecurity and health officials in the Office of Health Protection. But, as Chapter 5 reported, interviews did not find that these individuals saw themselves as playing any role in the formulation of ‘security policy.’ Even when presenting to Cabinet’s NSC during the Ebola outbreak, the former CMO (to the extent they were able to say), felt their advice to be medical in nature. Likewise, it is notable that the visa pause decision arose, not during NSC or as part of a process involving health officials, but during an informal Prime Minister’s ‘deep dive’ session, with an *ad hoc* assemblage of Ministers and other officials.

In defence of Elbe’s argument, the period under examination in this study extended beyond a peak period of biosecurity law and policymaking for pandemic influenza (2004–2008) that also saw the development of the SSBA regime (2002–2006). During this earlier period, DPMC – and not Health – was leading policy-work in this area and this work does, indeed, more closely align with the three prongs of the medicalization of insecurity outlined by Elbe. Once this work was ‘handed over’ to Health, though, engagement with security policy altered dramatically – even if the use of securitizing language in SRS continued.⁸³⁵ Equally, interviews with Health officials in 2017 and 2018 suggest that the Department of Agriculture, which had resisted appropriation of its term ‘biosecurity’ during the 2002–2006 CoAG Review, has managed to reassert some control over the term; restoring its meaning closer to its original, agricultural remit. Combined with findings in Chapter 5 about the role of organisational and even national cultures on regulatory approaches (and acceptability to audiences), this suggests that studies of the institutionalisation of security could benefit from the public administration literature on the role of institutional values, examining the use of securitizing language as a gambit to be deployed in bureaucratic politics.⁸³⁶

⁸³⁵ Given the findings from the interviews, the researcher believes repeated use of language in later speeches likely reflects a common tactic in the public service: sticking with what works. The Department of Health (at the officer level) may have been naive as to the constructive effects of its language, even if they might have seen it as a tool to marshal additional resources (compare discussion on institutionalisation in Buzan, Wæver and De Wilde, above n 42, 27-29; Balzacq, ‘The Policy Tools of Securitization’, above n 46; O’Manique and Fourie, above n 150; Elbe, ‘Securitizing Epidemics: Three Lessons from History’, above n 23; Stephenson, ‘The Disappearing Act of Global Health Security’, above n 75; Fidler and Gostin, *Biosecurity in the Global Age*, above n 38).

⁸³⁶ For example: Tom Christensen, et al, ‘Comparing Coordination Structures for Crisis Management in Six Countries’ (2016) 94(2) *Public Administration* 316; ’t Hart and Wille, above n 519; Thurid Hustedt and Thomas Danken, ‘Institutional Logics in Inter-Departmental Coordination: Why Actors Agree on a Joint Policy Output’

A related finding in this study was the narrow role played by the Commonwealth Department of Health, with this narrowness affecting how it projected its influence domestically and internationally. This is despite the deep knowledge and expertise the Department possesses and international networks, including serendipitous networks of former employees, able to provide important health surveillance data (Chapter 6, discussion of the 2009 pandemic of H1N1 influenza). Overall, a picture emerged from interviews and documentary analysis of a Department that sees itself operating only at the geographic and Constitutional boundary between Australia (the country) and the international sphere and the Commonwealth (as a polity) and the states and territories. Some of the consequences of this self-ascribed narrow role are discussed below in Recommendations. However, it is suggested that Health's mismatch between its perceived role and its potential role limits the extent to which it (and its professional staff) seeks to operate as a securitizing actor in the manner envisaged by Elbe.

3. What of COVID-19?

At the close of December 2019, reports emerged from Wuhan province, China, of a cluster of pneumonia with an unknown cause.⁸³⁷ In early January 2020, the causative agent for this outbreak was identified as a novel coronavirus – later designated SARS-CoV-2 and the resultant disease caused by SARS-CoV-2 became known as COVID-19.⁸³⁸ The Director-General of the WHO determined that COVID-19 was a PHEIC on 30 January and described it as a 'pandemic' on 11 March 2020, applying that appellation too late to avoid complaints from some quarters of 'hesitancy' and countries taking unilateral action in advance of the WHO's declaration.⁸³⁹ Australia and New Zealand, for example, moved faster than – and in

(2017) 95(3) *Public Administration* 730; Paul 't Hart, Uriel Rosenthal and Alexander Kouzmin, 'Crisis Decision Making: The Centralization Thesis Revisited' (1993) 25(1) *Administration & Society* 12; Uriel Rosenthal, Paul 't Hart and Alexander Kouzmin, 'The Bureau-Politics of Crisis Management' (1991) 69 *Public Administration* 211.

⁸³⁷ International Society for Infectious Diseases, 'Undiagnosed pneumonia – China (HU): RFI' on *ProMED* (31 December 2021) <<https://promedmail.org/promed-post/?id=6864153>>.

⁸³⁸ WHO, *Naming the coronavirus disease (COVID-19) and the virus that causes it* (23 October 2022) <[https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-\(covid-2019\)-and-the-virus-that-causes-it](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it)>.

⁸³⁹ Manfred S Green, 'Did the hesitancy in declaring COVID-19 a pandemic reflect a need to redefine the term?' (2020) 395 *The Lancet* 1034-1035; Fidler suggested the situation made it look 'like WHO doesn't want to exercise its authority', quoted in Stephen Buranyi, 'The WHO v coronavirus: why it can't handle the pandemic', *The Guardian* (online), 10 April 2020 <<https://www.theguardian.com/news/2020/apr/10/world-health-organization-who-v-coronavirus-why-it-cant-handle-pandemic>>.

contradiction to – WHO-advice in imposing border control measures and activating their own ‘pandemic’ plans.⁸⁴⁰ As of 30 March 2023, over 761 million people worldwide have tested positive to the virus (‘confirmed cases’) and over 6.8 million people have died from the disease (‘reported deaths’), including over 1.1 million deaths in the United States alone.⁸⁴¹

When this project commenced, the potential uses (and thresholds for use) of the human biosecurity emergency powers were only speculative.⁸⁴² Indeed, while the provisions appear to be a modern reformulation of the *Quarantine Act 1908* (Cth) emergency powers (discussed above) the author is unaware of those earlier powers ever being invoked (see Chapter 4).⁸⁴³ However, the Australian Government’s response to COVID-19 has seen significant use of the powers. Assessing the effectiveness or appropriateness of these measures is beyond the scope of this study. It is noted, however, that some public health measures which focused on protecting groups at higher risk from COVID-19, for example remote indigenous communities, seemed intuitively good.⁸⁴⁴ In contrast, measures which criminalised attempts by Australian citizens from certain ‘high risk’ countries (only one though: India)⁸⁴⁵ to return to Australia, and the extraordinary (and unprecedented) ban on Australian residents and citizens *leaving* Australia during the pandemic, are likely to attract criticism in the future.⁸⁴⁶ In any event, the use of previously dormant biosecurity powers in the current pandemic suggests a (new?)

⁸⁴⁰ Australia ‘activated’ its own ‘pandemic plan’ on 25 February 2020, with then Prime Minister Scott Morrison stating that Australia was ‘getting out well ahead of the World Health Organization’ in calling COVID-19 a pandemic: Scott Morrison, ‘Press Conference – Australian Parliament House (Transcript, 42691, 27 February 2020) <<https://pmtranscripts.pmc.gov.au/release/transcript-42691>>; Amy Coopes, ‘Australia activates pandemic plan as COVID-19 outbreak gathers pace’ on *Croakey* (26 February 2020) <<https://www.croakey.org/australia-activates-pandemic-plan-as-covid-19-outbreak-gathers-pace/>>.

⁸⁴¹ WHO, *WHO Coronavirus (COVID-19) Dashboard* (28 February 2023) <<https://covid19.who.int/>>.

⁸⁴² In a touch of dramatic irony, the Regulatory Impact Statement (RIS) to the Biosecurity Bill 2012 (Cth) had stated that ‘[g]iven the similarities to existing powers *and that they may never be invoked*, it is not possible to predict substantive impacts on stakeholders [of the emergency powers] and these have not been analysed.’ Explanatory Memorandum, Biosecurity Bill 2012 (Cth) 35 (emphasis added).

⁸⁴³ Emergency regulations restricting intra-state movement were enacted in during the 1918-1919 pandemic influenza outbreak, but these preceded the inclusion of section 2A and 2B of the *Quarantine Act 1908* (Cth) [repealed]: eg, *Quarantine (Pneumonic Influenza) Regulations 1919* (Cth) [repealed]; *Quarantine (Influenza) Regulations (No. 1) 1919* (Cth) [repealed]. See Explanatory Memorandum, Biosecurity Bill 2012 (Cth) 35.

⁸⁴⁴ *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements for Remote Communities) Determination 2020* (Cth). To the extent the powers sought to reduce the risk of COVID-19 to at-risk indigenous communities at the request of those communities remains unknown and is a key element in assessing their appropriateness.

⁸⁴⁵ *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Emergency Requirements—High Risk Country Travel Pause) Determination 2021* (Cth).

⁸⁴⁶ *Biosecurity (Human Biosecurity Emergency) (Human Coronavirus with Pandemic Potential) (Overseas Travel Ban Emergency Requirements) Determination 2020* (Cth) reg 5. This declaration was re-issued repeatedly throughout the pandemic and upheld by the Federal Court in *LibertyWorks Inc v Commonwealth of Australia* [2021] FCAFC 90. On lockdowns and their appropriateness this trend is already emerging: Peter Shergold et al, *Fault Lines: An Independent Review into Australia’s Response to COVID-19* (Paul Ramsey Foundation, 2022).

willingness to invoke latent federal powers, and there are legitimate legal, academic and public debates to be had over exactly who should hold such powers in a democratic state.⁸⁴⁷

Future research on domestic COVID-19 responses may also provide useful insights on the role of ‘operational audiences’ and what are now more commonly referred to as ‘essential workers’. As Chapter 6 found, working effectively with ‘operational audiences’ (including essential workers and unions) was often a missed step in pandemic responses during the period examined in this study.

As disclosed in Chapter 1, data collection had ended before the first cases of COVID-19 emerged, and COVID-19 falls outside the period under analysis. Moreover, it was not considered useful to attempt to analyse an unfolding pandemic using methods and theories best designed for retrospective analysis. In writing this Chapter, the researcher has also been conscious of the risk of ‘hindsight bias’ – an assumption that decisions made in the past were more logical and predictable than they really were. Indeed, a major finding from this study is how serendipitous biosecurity policymaking can be (Chapter 5). As such it is not a conclusion of this thesis, for instance, that the decisions made (or not made) during the period of analysis led inexorably to our current circumstances – although there are those who have argued this.⁸⁴⁸ At most, certain findings which emerged from data collected prior to COVID-19 – for example the importance placed on ‘single points of truth’ by public health officials in communicating with the public (Chapter 6), or the importance of industrial relations as a sometimes-forgotten element of pandemic response planning – might now be more testable.⁸⁴⁹

Reflecting on the findings of this thesis and the COVID-19 pandemic

Limitations and potential biases notwithstanding, it is not possible to conclude a thesis on pandemics in 2022 without making some reference to an ongoing one. To avoid co-mingling the conclusions of this study with the researcher’s own, emerging views, I have confined my observations on the current pandemic to the following sections:

⁸⁴⁷ See, for example, judicial comments in *Borrowdale v Director-General of Health* [2020] NZHC 2090 [101]-[102]; in Australia see the more critical remarks of Justice Ginnane in *Loiello v Giles* [2020] VSC 722 [13], [150].

⁸⁴⁸ Richard Horton, *The COVID-19 Catastrophe: What’s Gone Wrong and How to Stop It Happening Again* (Polity Press, 2020) 2.

⁸⁴⁹ Alternatively, the ‘uniqueness of this experience’ may mean some researchers treat COVID-19 as a sui generis event and distinguish it from past cases upon which existing theories have been built, see similar comments in Daniel Devine et al, ‘Trust and the Coronavirus Pandemic: What Are the Consequences of and for Trust? An Early Review of the Literature’ [2020] *Political Studies Review* 1, 10.

Findings or themes that emerged from my data that may be seen as more relevant now:

- The view of the CMO (in 2017) that the risks associated with Ebola and haemorrhagic fevers to Australia and Australians were overblown but respiratory viruses, and coronaviruses such as MERS should be seen by politicians as a more significant concern (Chapter 6).
- The view in some of the literature that bioterrorism was a misdirected focus for government prioritisation, and that new or emerging diseases ought to have greater priority within gamut of ‘biosecurity risks.’⁸⁵⁰ However early and ongoing arguments over the origin of SARS-CoV-2 – including allegations that it may have been ‘created’ in a Chinese laboratory and/or released deliberately or accidentally – point to the ongoing relevance of the ‘bio-terror’ and ‘bio-error’ in the biosecurity debate.⁸⁵¹
- The heroism of frontline healthcare workers and the importance of industrial relations systems, and employment laws in pandemic response.
- The risk of ‘othering’ – be it African bodies with Ebola; ‘reckless’ HCWs or – in the initial stages of COVID-19 – Chinese people and people of Asian descent.
- The seemingly weak power of the WHO to use its moral authority to compel adherence to the IHRs and rules governing the imposition of border measures.
- The scramble for PPE (in Ebola) and constrained global supply of key pieces of infrastructure (including medivac-capable planes). These supply chain issues have featured far more prominently with COVID-19.
- That a ‘public health approach’ is not a panacea when it comes to liberty-friendly laws. For example, lockdowns, curfews and mandatory testing have significant human right and societal implications.

⁸⁵⁰ Enemark’s discussion on ‘suicide sneezers’ being one example: Enemark, *Disease and Security: Natural Plagues and Biological Weapons in East Asia*, above n 27, 104–106.

⁸⁵¹ Enemark, *Biosecurity Dilemmas*, above n 27; Fidler and Gostin, *Biosecurity in the Global Age*, above n 38; Marc Lipsitch and Thomas V Inglesby, ‘Moratorium on Research Intended to Create Novel Potential Pandemic Pathogens’ (2014) 5(6) *mBio* 1; Selgelid, ‘Gain-of-Function Research: Ethical Analysis’, above n 561.

Themes or issues not identified in the research for various reasons, including that they occurred post-data collection:

- While this thesis considers the impact of ‘boom and bust’ policy cycles, it did not consider the effects of austerity politics and ideologies on decisions to: disband pandemic groups (US); not conduct pandemic exercises (Australia); make long-term funding cuts for public health (UK, US, Australia, NZ) or run down national medical stockpiles (US and UK).⁸⁵² Such decisions will likely feature in retrospectives on COVID-19.
- Although concepts of ‘legitimation’ were explored early in the project, the theoretical model adopted for this study did not consider the effects of previous ‘anti-[big]government’ rhetoric and corrosion of trust in the ability of governments to implement pandemic control strategies and measures. Related to this is the erosion of trust in the WHO and its moral authority.
- The creation of a ‘National Cabinet’ in Australia to effectively replace the previous Council of Australian Governments is an unexpected and possibly significant shift in the governance of the federation if it continues. While it may have been that the shift to the National Cabinet was planned prior to the pandemic, its emergence appeared sudden and framed as a mechanism to coordinate a unified, national response.
- Although this thesis engages with discourse analysis and recognises the power of language, there remains more to explore over the importance of couching public health measures in metaphors, for example, ‘Bubble’ (NZ), and behavioural invocations: ‘Be kind’, ‘Unite against COVID’ (NZ) and ‘team Australia moment’ (Australia).

One final reflection is on the starting position in this thesis that the 2005 IHR’s criteria for justifying ‘additional health measures’ (eg, travel bans) remain normatively appropriate and exclusive of other principles. However, the researcher’s work with the New Zealand government during COVID-19 suggests ‘solidarity’, ‘responsibility’ and even ‘atonement’ are other ethical principles that could also justify additional health measures or, in the absence of accommodating rules, ‘rule-breaking’. For instance: a key interest identified by New Zealand

⁸⁵² See discussion in John Hopkins Center for Health Security, *Global Health Security Index* (Nuclear Threat Initiative, 2019) 6: ‘Unfortunately, political will for accelerating health security is caught in a perpetual cycle of panic and neglect.’

Government in its early moves to close its own border in contradiction to WHO advice included a desire to protect Māori, who had been severely affected by the 1918 pandemic (its effects exacerbated by racism and colonisation) and PICs, many of whose citizens transit through Auckland airport.⁸⁵³

4. Limitations

The methodological aim of this study is to present a credible explanation for the design and implementation of regulatory measures characterised by the author as ‘pandemic preparedness and response’ measures. As a PhD project, resource limitations meant that data collection, coding and analysis tasks was undertaken by a single individual. This introduces a single point of failure for key data-tasks, including the transcription of interviews and the re-typing of textual documents that were provided as images. For both risks, transparency is the mitigation. In the short term, the retention of audio recordings of the interviews provides accountability for the accuracy of any transcribed quotes (subject to assurances of confidentiality to participants); while the retention of the analysed SRS allows other researchers to identify errors.

Likewise, the absence of a second reviewer may weaken the ‘rigour’ of any findings and raises questions of rater-reliability.⁸⁵⁴ However, while in *theory* (that is, Securitization Theory) – securitization begins simultaneous with the initiating speech or securitizing-act, the *study* of securitization operates post facto.⁸⁵⁵ A study of securitization would, if it were to produce credible findings, be expected to identify multiple instances that together represent a consistent

⁸⁵³ See, eg, the proactively released government papers from the NZ government, for example: Government of New Zealand, *Health Report: Novel Coronavirus – Review of Temporary Border Measures* (14 February 2020) COVIV19.govt.nz <<https://covid19.govt.nz/assets/Proactive-Releases/proactive-release/Novel-Coronavirus-Review-of-Temporary-Border-Measures.pdf>> 10. Paternalism is not entirely absent from these discussions, yet there is also a strong institutional memory of the country’s acknowledged negligence in exporting the Spanish Flu to Pacific Islands, resulting in 5% of Fijians dying of the virus and up to 22% of West Samoans: Nick Wilson et al, ‘A 100 years ago today a Death Ship from NZ Arrived in Samoa: A Reminder of NZ’s Responsibilities to its South Pacific Neighbours’ on *Public Health Expert* (November 7, 2018) <https://blogs.otago.ac.nz/pubhealthexpert/2018/11/07/a-100-years-ago-today-a-death-ship-from-nz-arrived-in-samoa-a-reminder-of-nzs-responsibilities-to-its-south-pacific-neighbours/>; Helen Clarke, ‘Full text: Helen Clark’s apology to Samoa’ NZ Herald (online), 4 June 2002 <<https://www.nzherald.co.nz/nz/full-text-helen-clarks-apology-to-samoa/65TV2LDV6S7HHIYRDCFSC5YOZI/>>.

⁸⁵⁴ Pricilla R Ulin, Elizabeth T Robinson and Elizabeth E Tolley, ‘Collecting Qualitative Data: The Science and the Art’ in Tolley et al (eds), *Qualitative Methods in Public Health: A Field Guide for Applied Research* (Jossey-Bass, 2005) 75.

⁸⁵⁵ Rychnovská, above n 41, 14 quoting Michael C Williams, ‘The Continuing Evolution of Securitization Theory’, in Thierry Balzacq (ed), *Securitization Theory: How Security Problems Emerge and Dissolve* (Routledge, 2011) 212–222.

pattern of securitizing moves, their acceptance by a relevant audience and, potentially, their incorporation into the pragmatic tools of securitization: laws, regulations, new bureaucracies or technologies (such as thermal scanners and entry cards for immigrants). These events might each be discrete but located along a strand in a broader web of intersubjective-processes and outputs. For example, repeated use of securitizing terms over a series of similar laws may be able to be traced back to a key or seminal ‘securitizing move’,⁸⁵⁶ but it is the evidence of the whole that makes the subject worthy of study. As such, even though this study had a single investigator, it involved the examination of several possible instances of securitization across a range of cases. A strength of this study has been the use of multiple methods and data sources to strengthen the findings of a study through the process of ‘triangulation’.⁸⁵⁷ As such, the risk that the misinterpretation of any single source, or misapplication of a code will lead to an erroneous conclusion is diminished. Equally, the ‘confirmability’ of thematic constructions or theory generation has been, if not assured then at least somewhat surefooted, through the appropriate use of the supervisory panel who provided advice in the early stages of the interview coding.⁸⁵⁸

Triangulation plays an important role in addressing the known limitations in semi-structured interviews.⁸⁵⁹ By combining data collected via interviews with an historical record (eg *Hansard*), it has been possible to undertake a more ‘credible’ and ‘authentic’ analysis of the data – with individual statements able to be contextualised appropriately.⁸⁶⁰ Further, speaking to individuals involved in different stages of the lawmaking process (politicians and government officials) afforded an opportunity to cross-reference assertions or understandings. Practical limitations such as memory loss, which given the passage of time from some events is likely, remain a challenge but could be ameliorated by reminding interviewees of what was said (sometimes by them) at the time. In this way, historical records such as *Hansard* and media releases also serve an important use. In a similar manner, the use of FoI requests to compare the SRS prepared by a Department and the speech as delivered is – to the researcher’s knowledge – a novel method for identifying, if not intentionality of meaning, the entity (public service, Minister’s office or Minister) responsible for *making* a particular change and,

⁸⁵⁶ See discussion in Chapter 2 about the importance placed on the National Intelligence Estimates report on the threat of infectious diseases.

⁸⁵⁷ Pierce, above n 264.

⁸⁵⁸ Michael Ungar, “‘Too Ambitious’: What Happens When Funders Misunderstand the Strengths of Qualitative Research Design” (2006) 5(2) *Qualitative Social Work* 261, 264.

⁸⁵⁹ Pierce, above n 264.

⁸⁶⁰ Ungar, above n 858.

subsequently, *inferring* a meaning from the nature and context of the change to the text. This FoI method provided a more robust approach than documentary analysis or interviews alone.

The researcher's own proximity to some of the events (eg, the DTCA) is both a strength and weakness, and those weaknesses have been mitigated through transparency with participants and the reader, and reflective-research practices. For instance, in the design of this study, and the collection and analysis of data, the researcher engaged continuous self-reflection, using 'reporting checklists' designed for qualitative research as prompts.⁸⁶¹

Finally, to the extent the discussion and conclusion point to lessons for individuals and coalitions seeking to challenge a securitizing move (or desecuritize an issue), findings from this study can only rise to the level of informed recommendations.

5. Recommendations and Conclusion

This section begins by setting out four recommendations arising from this study, which are directed to security scholars, public health lawyers, health practitioners and those – such as NGOs and some researchers – with an interest in challenging the securitization of specific issues. It is noted that some of these recommendations are likely to be considered and possibly contested in future academic and parliamentary reviews of Australia's response to the COVID-19 pandemic.⁸⁶² These recommendations are generally consistent with the wider normative and democratic objectives of Securitization Theory and *Global Business Regulation* discussed in preceding chapters.

This section then concludes with a summary of how the thesis has answered the research question outlined in Chapter 1 and points to future research opportunities.

⁸⁶¹ Allison Tong, Peter Sainsbury and Jonathan Craig, 'Consolidated Criteria for Reporting Qualitative Research (COREQ): A 32-Item Checklist for Interviews and Focus Groups' (2007) 19(6) *International Journal for Quality in Health Care* 349.

⁸⁶² Some of these reviews have served partisan ends. See, for example, the use of 'failure' in the chapter headings of the majority report of the Senate Select Committee on COVID-19 ('failure to plan', 'failure to take responsibility', 'failure to get it right'): Senate Select Committee on COVID-19, Parliament of Australia, *Select Committee on COVID-19 – Final Report* (2022). For less partisan and academic reviews see: Peter Shergold et al, above n 846; Nicholas Bromfield and Allan McConnell, 'Two Routes to Precarious Success: Australia, New Zealand, COVID-19 and the Politics of Crisis Governance' (2021) 87(3) *International Review of Administrative Sciences* 518.

Recommendations

Recommendation 1: Security scholars should look beyond Parliament and the Ministerial wing of the Executive for securitizing actors; but practitioners (and Parliamentarians) should strengthen the potential Parliament as a forum for desecuritization

This thesis has shown how the Australian Parliament did not engage in meaningful contestation over important biosecurity legislation and, where public contestation did occur (eg, the DTC Bill), the existence of powerful, hidden referent objects lent it an air of being cynical theatre. This is not to dismiss Parliament's power to desecuritize an issue. But it should not be relied upon to do this through its own routine practices. As the case of the DTCA shows (Chapter 4 and Chapter 5), external advocacy and lobbying is required to activate Parliament's potential to slow down Executive action and shift legislative activities into forums (eg, Senate committees) where competing values can be heard and adopted by sympathetic Parliamentarians.

Forum shifting has been shown to be a powerful tool for those seeking to challenge securitization. As such, a recommendation for practitioners, researchers and groups opposed to securitization of a specific issue, is to engage early in the parliamentary process and to recognise the tactical uses of Parliament's processes. Of course, the reverse is true and a securitizing actor may seek to shift the review of the law to a more sympathetic (ie, pro-security) forum, such as the Parliamentary Joint Committee on Intelligence and Security.

For those seeking to challenge securitization, the case of the DTCA provides two additional lessons. The first is to correctly identify the threat under construction and the referent object(s) that are perceived as under threat. The research communities' focus on the *ethics* of dual-use and GoF research distracted them from challenging the Department of Defence's attempt to frame such research (and researchers) as a counter-proliferation threat. This allowed Defence and others (including representative bodies for the tertiary sector) to dismiss the concerns of academics as not engaging with the 'real' issue. Likewise, the academic sector realised too late that a goal of Defence was to maintain Australia's good standing with international arms controls groups – groups the community and their allies had little knowledge of or influence over.

A second, related lesson, is to recognise that not all threats are explicitly identified by securitizing actors. Rather than explicit, a threat might remain suspended, only crystalised if

some event fails to occur. For instance, in the DTC Bill's SRS, a failure to comply with US demands for Australia to tighten controls of dual-use research was implicitly presented as a threat to 'our most important defence relationship and the foundation stone of our foreign policy and national security arrangements.'⁸⁶³ Naming and giving form to these silent threats (and the assumptions that underpin them) is, arguably, a critical step in desecuritizing a problem or challenging its initial securitization.

Recommendation 2: The effect of positioning the Indo-Pacific as a referent object on how the Government prioritises and responds to health emergencies warrants closer and critical attention by researchers, humanitarian organisations and volunteer health practitioners

The discussion above and Chapter 6 explored the positioning of the Indo-Pacific as a referent object, with fragile PIC health systems also identified as a threat to Australia. Such a framing is consistent with concerns raised in the literature discussed above that the true objectives of the 'global health security' agenda are to protect developed countries. It likewise points to the risks of such framings, including that it distorts priorities and result in inappropriate responses. Other consequences include reducing the incentive/imperative for the Government to deploy resources and personnel further afield, notwithstanding the epidemiological sense of fighting a disease at its source or humanitarian exhortations. It may even result in unwanted intervention by the Australian Government in the affairs of a PIC should the country not seem to be acting in a way that protects (Australia's) interests in the country.⁸⁶⁴

Likewise, for members of AUSMAT, their future deployments are likely to be local, despite their wishes for more distant deployments, and future research could examine how the securitization of the Indo-Pacific transforms healthcare workers into national security resources. To the extent this challenges their professional and personal values (see Chapter 6) they should activate their professional networks to challenge inappropriate securitization of the

⁸⁶³ Commonwealth, *Parliamentary Debates*, House of Representatives, Wednesday 2 November 2011, 12434 (Jason Clare, Minister for Defence Materiel).

⁸⁶⁴ Recently, this has manifested in strategic tussles over the influence of China in the south Pacific: Mary Yang and Jack Detsch, 'Australia's Got a Solomon Islands Headache (Again)', *Foreign Policy* (online), 19 May 2022 <<https://foreignpolicy.com/2022/05/19/solomon-islands-australia-election-pacific-national-security-us-china/>>; Emanuel Stoakes, 'Chinese Police Could Crush Solomon Islands Opposition', *Foreign Policy* (9 August 2022) <<https://foreignpolicy.com/2022/08/09/solomon-islands-china-security-pact-beijing-policing-democracy/>>. This issue quickly became politicised in Australia, with suggestions it could form the basis of a 'khaki election': Phillip Coorey, 'Why Australia is heading to a khaki election' *Australian Financial Review* (online), 11 March 2022 <<https://www.afr.com/politics/federal/economics-and-national-security-the-pathway-to-a-khaki-election-20220310-p5a3gu>>.

region and their roles. In addition, humanitarian principles, such as those espoused by the Red Cross Australia and MSF Australia, are also less likely to find purchase with policymakers and Ministers where a humanitarian crisis is outside the Indo-Pacific region.

While the outsourcing of government-funded humanitarianism action (eg, Aspen) provides one model to meet these goals, such a model deserves close attention: both to ensure contractual arrangements do not unduly impinge on humanitarian principles and that transparency over funding decisions is maintained. To that end, it is recommended that contracts such as the ones between DFAT and Aspen be pro-actively released, rather than depend on the chance disclosure during Senate estimates. Further, to provide assurance that humanitarian principles are respected, legislative protections should be put in place to prohibit contracts that would restrict, for example, the ability of Aspen employees to deliver healthcare to any patient who entered a funded clinic. Such a protection could be easily achieved through an amendment to the existing *Not-for-profit Sector Freedom to Advocate Act 2013* (Cth).⁸⁶⁵

Finally, framing of PIC health systems as a threat – particularly, within the context of *communicable* diseases – encourages responses that prioritise Australia’s interests over the interests of individuals and communities living in PICs. As noted by Niamh and Ruston in other cases, security framings present the fragility of health systems as a threat *to* Australia, rather than a risk of underserving local needs.⁸⁶⁶ And, while communicable diseases do present real risks to these countries, it is non-communicable diseases (NCDs) which constitute the greatest burden of mortality and morbidity in these states.⁸⁶⁷ As NCDs present – at ‘worst’ – an indirect financial risk to Australia,⁸⁶⁸ a security framing may lead to over-prioritising the less important issue.

⁸⁶⁵ Timothy Vines, Angus Donohoo and Thomas Faunce, ‘Government Controls over Health-Related Not-For-Profit Organisations: *Agency for International Development v Alliance for Open Society International*’ (2013) 21 *Journal of Law and Medicine* 278.

⁸⁶⁶ Rushton, ‘Global Health Security: Security for Whom? Security from What?’, above n 152; Stephenson, ‘The Disappearing Act of Global Health Security’, above n 75.

⁸⁶⁷ Roger S Magnusson and David Patterson, ‘How Can We Strengthen Governance of Non-Communicable Diseases in Pacific Island Countries and Territories?’ (2015) 2(2) *Asia & the Pacific Policy Studies* 293; WHO, *Western Pacific Regional Action Plan of Noncommunicable Diseases (2014-2020)* (WHO, 2014). For a discussion of key literature see: Dorottya Patay, *Navigating Conflicting Mandates and Interests in the Governance of the Commercial Determinants of Health: The Case of Tobacco in Fiji and Vanuatu* (PhD Thesis, Australian National University, 2020) 31–34.

⁸⁶⁸ For example, the allocation of domestic healthcare resources within Australia to provide healthcare to residents of PICs who fly to Australia for treatment.

Recommendation 3: A wider and bolder role for the Department of Health

A perception that the Department has a ‘coordinating’, but non-operational role, conforms – at a superficial level – with the constitutional distribution of responsibilities between the Commonwealth and the states and territories. Its use of expert-driven forums (such as AHPPC) has allowed it to effectively coordinate responses with clinicians and the states and territories, until disease responses become politicised (eg, school closures in 2009 and quarantine requirements for returning HCWs – Chapter 6). There may be little the Department can (or should) do to prevent this politicisation, but acceptance of constitutional limits need not require full withdrawal from local action. Interviewees identified how the effectiveness of public health measures depended on the buy-in of ‘operational audiences’ – most of whom work in the community or for the states and territories. Through its financial power and moral and technical leadership, the Commonwealth Department of Health ought to take a stronger and more visible role at the sub-national. This is especially in those areas where the Commonwealth does have unique responsibilities, such as quarantine facility management during a pandemic, or providing additional protection for Aboriginal communities, the delivery of healthcare in external territories or ensuring the timely provision of pharmaceuticals and – as tragically seen in the case of COVID-19 – appropriate standards for aged care. Indeed, this recommendation finds support in similar, recent recommendations from the Royal Commission into Aged Care Quality and Safety, which called on:

...a renamed Department of Health and Aged Care to also *step up* and embrace the role of steward of the aged care system. It can *no longer be a distant and seemingly disengaged player*, providing commentary to Ministers but not driving the aged care system forward.⁸⁶⁹

As inward, so too outward. Although the Department maintains connections with the WHO and international funders and health organisations, the Ebola outbreak showed how willingly it deferred to DFAT leadership in the global-facing elements of the response. This extended to not playing a role reviewing the infection control protocols and performance standards captured in the DFAT-Aspen contract (Chapter 6). Because DFAT and Health have different interests, and can draw on different epistemic communities, both should play a role in global health policy, such as regional contingency planning. Beyond disease response,

⁸⁶⁹ Commonwealth, Royal Commission into Aged Care Quality and Safety, *Final Report: Care, Dignity and Respect* (2021) vol 1, 48, 73 (emphasis added). The Royal Commission also conducted a rapid inquiry into aged care and COVID-19.

Health needs the capacity and mandate to pursue its interests and values at international forum, such as the Australia Group and Wassenaar Arrangement, where de facto binding rules are being determined which affect how health research and innovation can be undertaken.

While the domestic/international division of responsibilities may seem a logical policy choice, it is not an inevitable one. Past Health Ministers and the Department have taken prominent, global roles on the development legislation requiring ‘plain packaging’ of tobacco products and leadership on the WHO Framework Convention on Tobacco Control. As such, it would be a mistake to assume that the Department cannot play a more ‘audacious’ role in global health matters.⁸⁷⁰

Recommendation 4: Support public interest research through improved, ‘open book’ approach to Freedom of Information processes

This study relied heavily on FoI requests, both to obtain key documents for analysis and as part of a novel method of analysing authorship of second reading speeches. While many Departments were willing to provide documents within and outside formal FoI processes (ie, ‘administrative release’) several key documents were refused, or their release fought. In one case, the researcher appealed a refusal decision and – after proceeding through an internal review and then appeal to the independent Office of the Australian Information Commissioner – was successful. After 799 days! That this was a dispute over the release of a draft SRS – something every other agency had released equivalent documents uncontested – points to the arbitrary nature of FoI decision making in Australia and the ability for Departments to run down the clock. Fortunately, in this case, the researcher was completing their PhD part-time. However, the 10 years old *CoAG review of Biological Materials* was subject to a security classification and, as such, the researcher decided against pursuing a likely futile appeal. Other documents related to the Ebola response were likewise withheld on national security grounds (Chapter 6) or were subject to the 20-year protection afforded to Cabinet documents. Researchers examining Australia’s response to the 2013–2016 Ebola outbreak in 2035–2037 will benefit from this additional material.

⁸⁷⁰ Examples of policy ‘audacity’ in tobacco control is examined in Marita Hefler et al, ‘What Facilitates Policy Audacity in Tobacco Control? An Analysis of Approaches and Supportive Factors for Innovation in Seven Countries’ (2022) 31(2) *Tobacco control* 328. Nicola Roxon MP was Health Minister at the time plain packaging was introduced and Attorney-General when the High Court of Australia upheld the legislation following a challenge from the tobacco industry: see Becky Freeman, ‘Thinking outside the box: Tobacco plain packaging and the demise of smoking’ in Joannah Luetjens, Michael Mintrom and Paul ‘t Hart (eds), *Successful Public Policy: Lessons from Australia and New Zealand* (ANU ePress, 2019), 303.

Conclusion

This thesis has sought to make a unique contribution to the academic literature on the securitization of infectious diseases. Through an in-depth, multi-method examination of biosecurity law and policymaking in Australia, this study provides a thick empirical foundation from which to assess the extent to which securitization featured as a mechanism in biosecurity lawmaking and disease response in Australia.

The study has identified multiple instances of securitization featuring in the development of Australia's biosecurity legislation and in the policy work that underpinned those laws. Likewise, in the design on disease response measures. But what emerges from the findings is a more complex process than presented in securitization studies which tend to focus only on a single-forum or point-in-time moment of contestation. Securitization in Australia, this study has found, can take place with a lack of genuine contestation between key audiences – such as major political parties. It can involve the use of hidden or only alluded to threats and referent objects, to achieve the same outcome as explicit invocation of security-rhetoric. Neutral or positive sounding language such as 'proportionality' and 'good global citizen' can mask or even aid efforts to securitize a topic, practice or profession, such as health care workers or researchers. Even where public contestation over securitization was identified, closer examination of documentary evidence and interviews reveals that much of the security language was drafted by hidden authors (eg, public servants) or that the debates were designed to advance an ulterior motive, embarrassing the Government, without any intention to actual resist the securitizing move. Importantly, this thesis has illuminated and clarified the role of public servants as key securitizing actors, and the public service as a key site for analysis. The author's use of FoI laws to examine SRS shows how legal transparency tools can deepen analysis of security language.

Building on these findings, this Chapter has identified challenges and opportunities for the refinement of securitization as a theory and practice. By focusing on three commonly cited biosecurity problems – rapidly spreading infectious diseases (eg, pandemics), bioterrorism, and the risks associated with DURC and GoF research – the project's findings can be usefully compared and contrasted with other studies.

Finally, in drawing on analytical concepts and theories from the regulation and governance literature, this thesis has also staked out new ground and identified new avenues for further research and – importantly – new insights on challenging securitization. This

normative goal was important when the project started. However, as countries seek to move beyond the current pandemic, this goal becomes even more important. It is hoped the findings from this study will contribute to future assessments of what regulatory approaches served us well during COVID-19, what made our response more difficult and how best we should prepare for the next public health emergency.

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Appendices

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18 September 2017

Freedom of Information Coordinator
FOI Unit
Department of Health
GPO Box 9848
CANBERRA ACT 2601

Subject: Request for Certain Department Drafted 2nd Reading Speeches

Dear FOI Coordinator

My name is Tim Vines and I am a PhD candidate at the Australian National University's (ANU) School of Regulation and Global Governance (RegNet).

My research is looking at how Australian law and policy-makers have responded to the threat of infectious diseases such as Ebola, SARS and pandemic influenza. I am studying the values and interests that motivate institutional responses to these diseases and how those responses are explained by law-makers.

As part of my research, I am collecting a range of primary sources relating to the development of a number of Quarantine, Biosecurity and Health Security laws and have identified a number of documents that may be in the Department's possession. In particular, I would like to review the final 2nd reading speeches prepared by the Department (i.e as provided to the relevant Minister) for the following Bills:

- National Health Security Amendment Bill 2009
- National Health Security Amendment (Background Checking) Bill 2009
- National Health Security Amendment Bill 2012

While the Minister would have delivered or tabled a version of the 2nd reading speech in Parliament, it is the differences (if any) between the speeches prepared by the Department and the speech delivered that is of particular interest.

Appendix 1 - Sample FOI Request

I am writing to you in the first instance to discuss whether this information could be provided outside the scope of the *Freedom of Information Act 1982* and, if so, what the most convenient mechanism would be for the Department to make these documents available.

However, if access to these documents can only be provided under the FOI regime, then I would like to proceed on that basis and, as the request is part of a Commonwealth Supported research program and would contribute to an important public policy discussion, request a waiver of fees under section 29 of the *Freedom of Information Act 1982*.

If I can assist in any way to narrow or confine my request please let me know.

Should you require further information on this project, I have set out some key contact details below.

Thank you for your assistance.

Sincerely

Tim Vines

PhD Scholar

School of Regulation and Global Governance (RegNet)

Contact Details

Name:	Tim Vines
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Appendix 2 – Interview Guide (Ebola questionnaire)

Interview Guide

Project: Securitization as a mechanism in the design of pandemic preparedness and response regulation

Investigator: Timothy Vines

Approving Ethics Body: Asia & Pacific Delegated Ethics Review Committee (ANU)

Ethics Approval Number: 2016/701

Ethics Approval Granted: 17 January 2017

Appendix 2 – Interview Guide (Ebola questionnaire)

Project: Securitization as a mechanism in the design of pandemic preparedness and response regulation

Date: ____/____/20____

Time Started: _____ **Time Started:** _____

Location: _____

Interviewer: Tim Vines

Interviewee _____

PICF understood and signed? Y / N

Recorded? Y / N (File name: _____)

Appendix 2 – Interview Guide (Ebola questionnaire)

Question 1: Profiling

Thank you again for agreeing to meet with me. I'd like to start with some general questions about your organisation and role.

Would you mind telling me about your role with _____ [organisation]? In particular, what do you see as the central mission of your organisation and what is your role within it?

Sub-questions:

- Relationships with other individuals/companies/boards
- International presence?
- Area of focus (defence, public health)?

Question 2: Ebola Narrative

Thank you. I'd like to discuss your/institution's role in Australia's response to the 2013-14 West Africa Ebola outbreak.

When and how did you become involved?

What was your role/your organisation's role during the outbreak?

Sub-questions:

- Other organisations you worked with?
- How was the response coordinated? By whom?
- Are there any individual moments, statements or decisions that stood out at the time in your mind? Why?

Question 3: Actors and Mechanisms

Thank you. I'd like to ask a few more questions about your work during the Ebola outbreak. During the outbreak, which individuals or organisations played the greatest role (took the lead) in coordinating Australia's national response?

Do you think they were pursuing a particular goal or interest, for example, helping people or stopping the spread of disease? Protecting Australia? Why do you think that?

Sub-questions:

- How was the response coordinated? By whom?
- What were your/organisation's priorities in responding?
- Other organisations you worked with?
- Are there any individual moments, statements or decisions that stood out at the time in your mind? Why?

Date:

Interviewee:

Qn#:

Page:

Appendix 2 – Interview Guide (Ebola questionnaire)

Question 4: Principles and Acceptance of the Exceptional

Thank you, I'd like to conclude with some questions on your impressions of how the response was handled

What was your impression about the outbreak in relation to the risk (if any) it posed to Australia and Australians? Was that view shared by others?

Sub-questions:

- If a similar situation arose in the future what would you do differently?
- Do you believe Australia's response should have been different? How so?
- Did you feel the work you did – and way it occurred – was consistent with your organisation's mission?

Question 5: Anything else?

Finally, is there anything else you'd like to mention about the Ebola outbreak and/or the interactions of your organisation with other bodies during that time?
Is there anyone else you think I should speak to about this?

Thank you very much for your time.

Closing off:

- Any questions about my research
- How answers will be used
- Confirm attribution/pseudonym/anonymous

→ **Attribution / Pseudonym / Anonymous**

- Planned dissemination

→ *Do you want to know when my research is published?* **YES/NO**

→ *Would you like a copy sent to you? (note ©)* **YES/NO**

Date:

Interviewee:

Qn#:

Page:

Appendix 2A – Interview Questions

Questions starting with a number are the chief questions. Questions beginning with a letter are possible prompts, depending on the interviewee.

For individuals involved in the development of the DTCA

Purpose: Profiling

1. *Would you mind telling me about your role with _____[organisation]? In particular, what do you see as the central mission of your organisation and what is your role within it?*
 - a. Relationships with other individuals/companies/boards
 - b. International presence or membership of international bodies?
 - c. Area of focus (defence, public health, foreign affairs, trade)?

Purpose: Actors (role and who)

2. *I'd like to know more about your involvement in the development of the DTCA/Australia's position on dual use technology. What was your role at the time?*
 - a. Who else (individuals, agencies) did you work with? How were those interactions coordinated? By whom?
 - b. Who do you felt was in control of the process? Why?
 - c. Who did you see as the 'audience' for your work? Who did you see as partners, and who (if any) did you see as impeding your work/interests?

Purpose: Interests (why, what for?)

3. *What was your/your organisation's goal during the development of the DTCA? Who determined that goal and, do you know why it was set? If more than one, what was the priority of those goals?*
 - a. What was the risk/hazard/concern you were trying to address?
 - b. Did you feel you had to convince anyone to change their views to yours in relation to the risk/hazard/concern?
 - c. If so, who and what were their views? What do you think they were trying to achieve?
 - d. In approaching the development of the DTCA did you feel that any particular value or goal was paramount? (public safety? Public health? National security?) Did you/your organisation hold this value in common with the others involved in the project?
 - e. Suggest counter-value as prompt (e.g. public health, freedom of research, national security).

Purpose: Strategies (How)

4. *How did you or your organisation go about achieving its goals in developing /shaping / challenging the DTCA?*
 - a. Did you use any particular mechanisms to pursue your goals? (prompts include: legislation, inquiries, outside opinion, briefing, face to face meetings, informal chats)
 - b. If there was a group identified as impeding the goal - what techniques did you use to get them to accept your view/compromise? (prompts include: media awareness, training sessions, overseas experts)

Appendix 2A – Interview Questions

Purpose: Reflection on Outcomes

5. *Did you feel that the eventual DTCA was consistent with your organisation's mission? If not, why not?*
 - a. Do you think it has managed the risk/concern/hazard it was intended to?
 - b. If you had to ask any individual or group if the result was 'acceptable', who would that be? What do you think they'd say?
 - c. Are there any individual moments, statements or decisions that stood out at the time in your mind? Why?
 - d. Would you have done anything differently?

Purpose: Conclusion and snowballing

Finally, is there anything else you'd like to mention about the development of the DTCA and/or the interactions of your organisation with other bodies during that time?

- a. Is there anyone else you think I should speak to about this?

Appendix 2A – Interview Questions

For individuals involved in the development of general 'biosecurity' legislation

Purpose: Profiling

1. *Would you mind telling me about your role with _____[organisation]? In particular, what do you see as the central mission of your organisation and what is your role within it?*
 - a. Relationships with other individuals/companies/boards
 - b. International presence or membership of international bodies?
 - c. Area of focus (defence, public health, foreign affairs, trade)?

Purpose: Actors (role and who)

2. *I'd like to know more about your involvement in the development of the _____.*
 - a. Who else (individuals, agencies) did you work with? How were those interactions coordinated? By whom?
 - b. Who do you felt was in control of the process? Why?
 - c. Who did you see as the 'audience' for your work? Who did you see as partners, and who (if any) did you see as impeding your work/interests?

Purpose: Interests (why, what for?)

3. *What was your role at the time? What was your/your organisation's goal during the development of the _____? Who determined that goal and, do you know why it was set?*
 - a. What was the risk/hazard/concern you were trying to address?
 - b. Did you feel you had to convince anyone to change their views to yours in relation to the risk/hazard/concern?
 - c. If so, who and what were their views? What do you think they were trying to achieve?
 - d. In approaching the development of _____ did you feel that any particular value or goal was paramount? Did you feel this was a value you/your organisation were pursuing?
 - e. Suggest counter-value as prompt.

Purpose: Strategies (How)

4. *How did you or your organisation go about achieving its goals in developing /shaping /challenging the _____?*
 - a. Did you use any particular mechanisms to pursue your goals? (prompts include: legislation, inquiries, outside opinion, briefing, face to face meetings, informal chats)
 - b. Did you feel you had to convince others to change their views?
 - c. If so, who and what were their views? What do you think they were trying to achieve?
 - d. What techniques did you use to get them to accept your view/compromise? (prompts include: media awareness, training sessions, overseas experts)

Purpose: Reflection on Outcomes

5. *Did you feel that the eventual _____ was consistent with your organisation's mission? If not, why not?*
 - a. Do you think it has managed the risk/concern/hazard it was intended to?

Appendix 2A – Interview Questions

- b. If you had to ask any individual or group if the result was 'acceptable', who would that be? What do you think they'd say?
- c. Would you have done anything differently?

Purpose: Conclusion and snowballing

- 6. *Finally, is there anything else you'd like to mention about the development of the _____ and/or the interactions of your organisation with other bodies during that time?*
 - a. Is there anyone else you think I should speak to about this?

Appendix 2A – Interview Questions

For individuals involved in Australia's response to the Ebola outbreak

Purpose: Profiling

1. *Would you mind telling me about your role with _____[organisation]? In particular, what do you see as the central mission of your organisation and what is your role within it?*
 - a. Relationships with other individuals/companies/boards
 - b. International presence or membership of international bodies?
 - c. Area of focus (defence, public health, foreign affairs, trade)?

Purpose: Actors (role and who)

2. *I'd like to discuss your/institution's role in Australia's response to the 2014-16 West Africa Ebola outbreak. When and how did your organisation become involved? What was your role/your organisation's role during the outbreak?*
 - a. Who else (individuals, agencies) did you work with? How were those interactions coordinated? By whom?
 - b. Who do you felt was in control of the process? Why?
 - c. Who did you see as the 'audience' for your work? Who did you see as partners, and who (if any) did you see as impeding your work/interests?

Purpose: Interests (why, what for?)

1. *What was your impression about the outbreak in relation to the risk (if any) it posed to Australia and Australians? Was that view shared by others?*
2. *During the outbreak, do you think your organisation was pursuing a particular goal or interest, for example, helping people or stopping the spread of disease? Protecting Australia? (prompt: Why do you think that?)*
 - a. Did other individuals/organisations have different priorities?
 - b. If so, who and what were their views? What do you think they were trying to achieve?
 - c. Did you feel that any particular value or goal was paramount in Australia's response? Did you feel this was a value you/your organisation were pursuing? (Suggest counter-value as prompt.)

Purpose: Strategies (How)

3. *Did you need to resolve conflicts between these priorities? Did you use any particular mechanisms to pursue your priorities? (prompts include: legislation, inquiries, outside opinion, briefing, face to face meetings, informal chats)*
 - a. What techniques did you use to get them to accept your view/compromise? Did they work?
 - b. If you had to convince a single individual, group or organisation that Australia's response to the Ebola outbreak was 'acceptable', who would that be? What do you think they'd say?
 - c. Was the Ebola response any different from other infectious diseases you've been asked to respond to?

Appendix 2A – Interview Questions

Purpose: Reflection on outcomes/Snowballing

4. *Finally, is there anything else you'd like to mention about the Ebola outbreak and/or the interactions of your organisation with other bodies during that time?*
 - a. If a similar situation arose in the future what would you do differently?
 - b. Did your international counterparts do anything differently? Did it work?
 - c. Is there anyone else you think I should speak to about this?

Participant Information Sheet

Hello. My name is Tim Vines and I am a part-time PhD candidate at the Australian National University's (ANU) School of Regulation and Global Governance (RegNet), part of the College of Asia & the Pacific.

In addition to my studies, I also work for the National Health and Medical Research Council (NHMRC); however, this research is solely for my PhD and is not funded by, or being carried out for, NHMRC.

Project Title

An investigation of the influence and consequences of 'securitization' on pandemic prevention and response law-making in Australia.

General Outline of the Project

My research is looking at how policy and lawmakers have responded to the threat of infectious diseases such as Ebola, SARS and pandemic influenza. I am looking at what values and interests motivate institutional responses to these diseases, how those responses are explained by policy and law-makers, and whether (and why) those responses are accepted by specific communities of individuals – such as researchers and public health practitioners.

I am hoping to answer these questions through a series of semi-structured interviews and documentary analysis.

Participants

In the course of my research, I will be talking with policy officers within the Australian Public Service, former and current ministers and parliamentarians involved in the creation and implementation of legal and regulatory responses to the threat of infectious diseases. I will also be talking to researchers (and their peak-body representatives) who make up one 'audience' for these laws. If the opportunity arises, I will also speak to international policy and law-makers involved in similar work, and non-governmental organisations engaged by governments to respond to pandemics.

Use of Data and Feedback

Data collected through interviews and documentary analysis will be used in a series of publications that, together, constitute my PhD thesis. I intend for these articles to be published in domestic and international peer-reviewed academic journals. Your data may also be used to inform other publications, such as short pieces for *The Conversation* or formal submissions to parliamentary and governmental inquiries, or in presentations.

If you have provided me with an email address, I will be able to send you a link to a summary of my research at the conclusion of my PhD.

Participant Involvement

My research involves finding out why, and how, certain events and law-making activities took place. Interviews are a critical means to gain this information. As such, I am asking for some of your time to assist me with my research. Details about what is involved are set out below.

Voluntary Participation & Withdrawal

First, your participation in this project is voluntary. That means you have the option to not take part at all, to take part but not answer all interview questions, or to withdraw from the research project without needing to



provide an explanation. There will be no negative consequences if you chose to withdraw or decline to answer a question.

Importantly, you may withdraw at any time *until* the work is prepared for publication. After the work is prepared for publication, it may not be possible to retract your answers. By default, your responses will be confidential (i.e. not attributed). If you agree to have your responses attributed you may, at any time before the work is prepared for publication, request for your responses to be de-identified: that is, used without your name and position, or used with a pseudonym. If you withdraw from the research, your data (for example, audio-recordings or written answers) will be destroyed.

What does participation in the research entail?

For this project, I am asking you to participate in a semi-structured interview, with me as the interviewer.

A semi-structured interview is one where I have identified some particular questions prior to starting, but where the conversation can move away from those questions to cover other relevant areas of interest.

Depending on your role (policy officer or lawmaker, researcher, advocate or other) my questions will focus on your role in the development of regulatory measures designed to prevent or respond to pandemics, or in your involvement in Australia's response to certain outbreaks. Legislation of interest includes: post-2001 amendments to the *Quarantine Act 1908*; the *National Health Security Act 2007* and the *Biosecurity Act 2015* and the *Defence Trade Controls Act 2012*. I will be asking about what you understood to be the main motivation behind the creation of these laws, who the chief actors were and on what basis the lawmaking activities were justified.

If relevant, I will also ask you about your role during Australia's response to the 2002-2003 SARS outbreak and the 2014-16 West Africa Ebola outbreak. These questions will, again, look to explore who the main actors were in designing and implementing Australia's response, how and why they took the actions they did and how certain community or professional groups (e.g. doctors) responded to those measures.

I will take interview notes by hand, but – with your permission – will audio-record the interview to confirm the accuracy of my notes at a later stage. I do not intend to transcribe the audio-recordings into formal transcripts.

Location and Duration

Interviews will take place in a mutually convenient location. A quiet office or room within your workplace would be preferable; however, interviews can also take place in public venues such as a café or restaurant near your workplace. If you are unable to be interviewed in-person, the interview can also take place via telephone or using an online service.

Interviews are expected to last no more than one hour.

Risks

I do not foresee any material risks to you from your participation in my research. As discussed above, your answers will be confidential and not-identifiable (i.e. without your name associated with them). You can also not take part in the research, withdraw from the research prior to the submission of a draft publication to a journal or third party or to not answer a particular question. As a semi-structured interview, you will also have the opportunity to move the conversation away from topics you find upsetting or do not wish to answer.



The main risk to you is ‘third-party identification’ – the risk that someone else may identify you from your response and take adverse action against you. Providing confidential answers and the use of broad role descriptions, (e.g. ‘a current public servant’ as opposed to ‘the branch manager of x team’) will reduce this risk. So too will the use of multiple sources. However, for some roles – such as former or current ministers or very senior public servants – it may not be possible to prevent third parties from correctly guessing who you are given the possibility of using publicly available records to cross-reference who held a particular role at a particular time.

If you are concerned about the potential for third parties to identify and take adverse action against you, then you should discuss this with me prior to commencing the interview.

Public servants and others who may be bound by the Australian Public Service *Code of Conduct* and *Public Service Act 1999* should be aware of the requirements of regulation 2.1 of the Public Service Regulations 1999 and section 70 of the *Crimes Act 1914* regarding confidential information. Likewise, an ‘entrusted’ person may have secrecy obligations under the *Australian Border Force Act 2015* and commissioned officers may have obligations under the *Defence Force Discipline Act 1903*. Where necessary, you may need to seek approval from a third party (e.g. your supervisor) before taking part in the interview or providing any official documents.

Benefits

It is unlikely that you will personally benefit from participating in this research, but I hope that my research will further develop our knowledge of how and why policy and lawmakers respond in the way they do to the threat of infectious diseases with pandemic potential. If you are a policy officer or lawmaker, this information may be generally useful in the development of future policy or regulatory measures. If you are a public health advocate, it may be useful to you in the design and implementation of relevant campaigns.

Confidentiality

During the collection of data, only I will have access to the material you provide. By default, your responses will be confidential. However, before the interview begins, you will have the opportunity to say if you would like responses to be recorded and published under a pseudonym or attributed to your real name and position. This choice will be recorded on the consent form. If you wish your information to be kept confidential then your confidentiality will be protected as far as the law allows.

As I prepare an article or publication, I may seek feedback from my supervisor and PhD panel. Unless you requested confidentiality or the use of a pseudonym when you provided your data, then my supervisor and PhD panel members may know your identity. My supervisor is Professor Sharon Friel and my two panel members are Professor Thomas Faunce and Dr Jeremy Youde, all of the Australian National University.

Once an article is published, or my thesis submitted, it will no longer be possible to de-identify your responses, if you were previously happy for them to be attributed.

Privacy Notice

In collecting your personal information within this research, the ANU must comply with the Privacy Act 1988. The ANU Privacy Policy is available at https://policies.anu.edu.au/ppl/document/ANUP_010007 and it contains information about how a person can:

- Access or seek correction to their personal information;
- Complain about a breach of an Australian Privacy Principle by ANU, and how ANU will handle the complaint.



Data Storage

Where?

During the collection and analysis stage of the research, data relating to you, including typed notes, transcripts and audio recordings, will be stored on a password protected, encrypted volume of my computer. Access to the computer account is limited to me and the hard-drive is encrypted under the FireVault (2.0) Protocol. Data will be backed up to ANU's servers (OneDrive) and stored in a password protected, encrypted volume.

Physical data, such as written notes, will be stored in a locked container/cabinet at the ANU School of Regulation and Global Governance (RegNet).

How long?

I will need to store your data for the duration of my PhD, and then for at least five years from the date of any publication arising from the research.

After finishing my PhD, your electronic data will be securely stored on ANU's servers. Physical records will be stored in a locked container/cabinet at the ANU School of Regulation and Global Governance (RegNet).

Handling of Data following the required storage period?

At the end of the storage period, data will be deleted.

Contact Details for More Information

If you need to contact me during the research, you can reach me by post at

Tim Vines
School of Regulation and Global Governance (RegNet)
Coombs Extension Building 8
The Australian National University
Canberra ACT 2601

or by email at [redacted] or by phone on [Redacted].

You may also contact my supervisor, Professor Sharon Friel, at [redacted] or [Redacted].

Ethics Committee Clearance

The ethical aspects of this research have been approved by the ANU Human Research Ethics Committee (Protocol 2016/701). If you have any concerns or complaints about how this research has been conducted, please contact:

Ethics Manager
The ANU Human Research Ethics Committee
The Australian National University
Telephone: +61 2 6125 3427
Email: Human.Ethics.Officer@anu.edu.au

APPENDIX 4 – Table comparing diseases and biological agents listed under the National Notifiable Disease List, Security Sensitive Biological Agents (SSBA) List, *Defence and Strategic Goods List 2021* (Cth) (DSGL) and ‘listed human diseases’ under the *Biosecurity Act 2015* (Cth) (as of 16 March 2023)

[Note: Disease names copied verbatim from sources, with diseases matched across lists. For example, Ebolavirus in the SSBA list is placed next to ‘Viral haemorrhagic fever’ in the National Notifiable Disease List. Causative agents (eg, bacillus anthracis) are placed next to the resultant disease (eg, anthrax)]

National Notifiable Disease List (2023) ³	Security Sensitive Biological Agent ⁴ Agent (Tier)	Biological agents controlled under the DSGL ⁵	Diseases that would trigger a ‘public health event of national significance’ under the <i>National Health Security Agreement</i> ⁶	<i>Biosecurity Act (Listed Human Diseases) Determination 2016</i> (Cth) ⁷
	Abrin (5 mg) (Tier 1)	Abrin		
		Aflatoxins		
	African swine fever virus (Tier 2)			
		Andes virus		
Anthrax	Bacillus anthracis (Anthrax – virulent strains) (Tier 1)	Bacillus anthracis		
Australian bat lyssavirus infection				
Barmah Forest virus infection				
Botulism	Botulinum toxin (0.5 mg) (Tier 1) Clostridium botulinum (Botulism toxin-producing strains) (Tier 2)	Clostridium botulinum; Clostridium argentinense, botulinum neurotoxin producing strains (‘BNPS’); Clostridium baratii, BNPS; Clostridium butyricum, BNPS		

³ *National Health Security (National Notifiable Disease List) Instrument 2018* (Cth).

⁴ Department of Health, *SSBA – Fact Sheet 5 – List of Security Sensitive Biological Agents* (Commonwealth of Australia, March 2016).

⁵ *The Defence and Strategic Goods List 2021* (Cth). Virus and Bacteria listed. To reduce repetition, and because many listed bacteria produce toxins that are separately listed on the DSGL not all toxins are listed in this table.

⁶ Australian Government, *National Health Security Agreement between the Commonwealth of Australia and the State of New South Wales, the State of Victoria, the State of Queensland, the State of Western Australia, the State of South Australia, the State of Tasmania, the Australian Capital Territory and the Northern Territory* (Commonwealth of Australia, 2011) <<https://www.health.gov.au/resources/publications/national-health-security-agreement?language=en>> (hereafter ‘the Agreement’).

⁷ *Biosecurity (Listed Human Diseases) Determination 2016* (Cth).

Brucellosis		Brucella abortus; Brucella melitensis; Brucella suis		
		Burkholderia mallei; Burkholderia pseudomallei		
Campylobacteriosis				
	Capripoxvirus (Sheep pox virus and Goat pox virus) (Tier 2)			
		Chapare virus		
Chikungunya virus infection		Chikungunya virus		
Chlamydial infection (excluding eye infections)				
		Choclo virus		
Cholera		Vibrio cholerae	Cholera	
	Classical swine fever virus (Tier 2)			
		Clostridium perfringens, epsilon toxin producing types ⁸		
		Conotoxins		
			COVID-19 ⁹	Human coronavirus with pandemic potential (added 21 January 2020)
Creutzfeldt-Jakob disease (CJD)—classical				
Creutzfeldt-Jakob disease—variant (vCJD)				

⁸ A note to this item in the DSGL reflects the intention to distinguish between security and safety: ‘Limiting this control to epsilon toxin-producing strains of Clostridium perfringens therefore exempts from control the transfer of other Clostridium perfringens strains to be used as positive control cultures for food testing and quality control’ *Defence and Strategic Goods List 2021* (Cth) item 1C351(c)(17).

⁹ Although COVID-19 is not listed in the Agreement, other ‘events’ – including, but not limited to diseases – may trigger a Public Health Event of National Significance. Reference would be made to Annex 2 of the IHR for event-thresholds and to decisions of the WHO, eg the declaration of a Public Health Emergency of International Concern (PHEIC). For example, ‘COVID-19’ is not explicitly included in the agreement but, because it was declared a PHEIC and otherwise met the criteria in paragraph (b) of the Definitions section of the Agreement, it was declared a ‘Public Health Event of National Significance’ on 25 February 2020 and confirmed by CoAG on 13 March 2020: Kelsey Campbell and Emma Vines, ‘COVID-19: a chronology of Australian Government announcements (up until 30 June 2020)’ (Research Paper Series 2020-2021, Parliamentary Library, Parliament of Australia, 23 June 2021) 10-11; Council of Australian Governments, *Communique* (13 March 2020) <<https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22media%2Fpressrel%2F7236692%22>>; Australian Government, *Emergency Response Plan for Communicable Disease Incidents of National Significance: National Arrangements (National CD Plan)* (Commonwealth of Australia, 2018).

Cryptosporidiosis				
Dengue virus infection				
		Diacetoxyscirpenol toxin T-2 toxin HT-2 toxin		
		Dobrava-Belgrade virus		
Diphtheria				
Donovanosis				
		Eastern equine encephalitis virus		
Flavivirus infection (unspecified)—including Zika virus		[Some overlap with viral haemorrhagic fevers]		
	Foot-and-mouth disease virus (Tier 1)			
Gonococcal infection				
Group A streptococcal disease—invasive (iGAS)		Staphylococcus aureus enterotoxins, hemolysin alpha toxin, and toxic shock syndrome toxin		
		Guanarito virus		
Haemolytic uraemic syndrome (HUS)				
Haemophilus influenzae type b infection—invasive only				
		Hantaan virus		
		Hendra virus (Equine morbillivirus)		
Hepatitis (NEC)				
Hepatitis A				
Hepatitis B				
Hepatitis C				
Hepatitis D				
Hepatitis E				
Human coronavirus with pandemic potential				
Human immunodeficiency virus (HIV)				

Influenza—avian influenza in humans	Highly pathogenic influenza virus, infecting humans ¹⁰ (Tier 1)		Human influenza caused by a new subtype	Human influenza with pandemic potential
Influenza—laboratory confirmed				
		Reconstructed 1918 influenza virus		
Japanese encephalitis virus infection		Japanese encephalitis virus		
		Junin virus		
		Kyasanur Forest disease virus		
West Nile virus infection—including Kunjin virus				
		Laguna Negra virus		
		Lassa fever virus		
Legionellosis				
Leprosy				
Leptospirosis				
Listeriosis				
		Louping ill virus		
	Lumpy skin disease virus (Tier 2)			
		Lymphocytic choriomeningitis virus		
Lyssavirus infection (NEC)				
		Machupo virus		
Malaria				
Measles				
Meningococcal disease—invasive				
		Microcystins		
Middle East respiratory syndrome coronavirus (MERS-CoV) infection				Middle East respiratory syndrome

¹⁰ A note to the List provides that ‘Highly pathogenic influenza virus infecting humans’ includes influenza viral strains that fulfil all the criteria listed below: considered highly pathogenic in usual host animal; proven infection of humans; and involved in an outbreak of human disease. Examples of such viral strains include the 1918 pandemic Influenza virus A and Influenza virus A H5N1.’ Department of Health, *SSBA – Fact Sheet 5 – List of Security Sensitive Biological Agents* (Commonwealth of Australia, March 2016) 2 (formatting removed).

		Modeccin		
Monkeypox virus infection ¹¹		Monkeypox virus		
Mumps				
Murray Valley encephalitis virus infection		Murray Valley encephalitis virus		
		Nipah virus		
		Oropouche virus		
Psittacosis (ornithosis)		Chlamydophila psittaci		
Paratyphoid fever				
Pertussis				
	Peste-des-petits-ruminants virus (Tier 2)			
Plague	Yersinia pestis (Plague) (Tier 1)	Yersinia pestis	Pneumonic plague	Plague
Pneumococcal disease— invasive				
Poliovirus infection			Poliomyelitis due to wild-type poliovirus	
		Powassan virus		
Q fever		Coxiella burnetii		
Rabies			Rabies	
Respiratory syncytial virus (RSV) infection				
	Ricin (5 mg) (Tier 1)	Ricin		
		Rift Valley fever virus		
	Rinderpest virus (Tier 1)			
		Rocio virus		
Ross River virus infection				
Rotavirus infection				
Rubella—including congenital and non-congenital				
		Sabia virus		
Salmonellosis				
		Saxitoxin		

¹¹ In 2022, Monkeypox (*sic*) virus was added to the National Notifiable Disease List under the *National Health Security Act 2007* (Cth)'s emergency disease listing procedures via the *National Health Security (National Notifiable Disease List) Amendment Instrument 2022* (Cth). Mpox's listing was made permanent following consultation with the states and territories via the *National Health Security (National Notifiable Disease List) Amendment (Monkeypox) Instrument 2022* (Cth).

		Seoul virus		
Severe acute respiratory syndrome (SARS)	SARS coronavirus (Tier 1)	Severe acute respiratory syndrome-related coronavirus (SARS-related coronavirus)	Severe Acute Respiratory Syndrome (SARS)	Severe acute respiratory syndrome (SARS)
Shiga toxin-producing Escherichia coli (STEC) infection		Shiga toxin producing Escherichia coli (STEC) of serogroups O26, O45, O103, O104, O111, O121, O145, O157, and other shiga toxin producing serogroups		
Shigellosis		Shigella dysenteriae Verotoxin		
		Sin Nombre virus		
Smallpox	Variola virus (Smallpox) (Tier 1)	Variola virus	Smallpox	Smallpox
		St Louis encephalitis virus		
		Suid herpesvirus 1		
Syphilis—including congenital and non-congenital				
Tetanus				
		Tetrodotoxin		
		Tick-borne encephalitis virus (Far Eastern subtype)		
Tuberculosis				
Tularaemia	Francisella tularensis (Tularaemia) (Tier 2)	Francisella tularensis		
Typhoid fever		Salmonella typhi		
		Rickettsia prowazekii		
Varicella zoster infection—chickenpox, shingles and unspecified				
		Venezuelan equine encephalitis virus		
		Viscumin		
		Volkensin		
Viral haemorrhagic fever	Ebolavirus (Tier 1) Marburgvirus (Tier 1)	Crimean-Congo haemorrhagic fever virus ('HFV') Ebola virus (all members of the Ebolavirus genus)		Viral haemorrhagic fevers

		Lassa fever virus Lujo virus Marburgvirus (all members of the Marburgvirus genus) Omsk HFV		
		Western equine encephalitis virus		
Yellow fever	Yellow fever virus (non-vaccine strains) (Tier 2)	Yellow fever virus	Yellow fever	Yellow fever

APPENDIX 5 – Key events and outputs from two different policy programs occurring up to the passage of the *Defence Trade Controls Act 2012* (Cth)

[Note: the events in bold are discussed in more detail in **Chapter 5**]

Program one: Defence market access events	Stream two: arms controls and dual-use goods events	Select policy outputs or associated events
Australia defence firms subject to International Traffic in Arms Regulations (ITAR) rules for access to US defence articles and services. ¹	Pre-existing control regimes (year entered into force), including the Non-Proliferation Treaty (1973) ² and Biological Weapons Convention (BWC) (1975)	<i>Weapons of Mass Destruction Act 1995</i> (Cth)
	Use of chemical weapons by Iraq in Iran-Iraq war (1980-1988)	Establishment of the Australia Group ³ Customs (Prohibited Exports) Regulations 1958 (Cth) amended – progenitor of the Defence and Strategic Goods List (DSGL) established (1987) ⁴
	Collapse of the USSR (1991)	Dissolution of the Coordinating Committee on Multilateral Export Controls (1994) and replacement with the Wassenaar Arrangement (1996) ⁵

¹ For a US perspective on the implications of these rules, see then Senator Joseph Biden's remarks in US Senate Committee on Foreign Relations, *Treaties Hearing*, May 21 2008, 2-5 (110th Congress 2nd sess, S. HRG 110-651): 'The Arms Export Control Act has never been a very popular piece of legislation. Our allies and friends have found it difficult, and there have been many attempts over the years, a 40-year history of the existence of this to amend it to accommodate changes.'

² *Treaty on the Non-Proliferation of Nuclear Weapons*, opened for signature 1 July 1968, 1973 ATS 3 (entered into force for Australia: 23 January 1973).

³ This event is highlighted on The Australia Group, *The Origins of the Australia Group* (2007 [archived 4 June 2022]) Department of Foreign Affairs and Trade <<https://webarchive.nla.gov.au/awa/20220604073813/https://www.dfat.gov.au/publications/minisite/theaustraliagroupnet/site/en/origins.html>>.

⁴ Customs (Prohibited Exports) Regulations (Amendment) 1987 (Cth) introduced regulation 13E, the empowering provision for the *Defence and Strategic Goods List* (DSGL).

⁵ The Wassenaar Arrangement, *About us* (1 December 2022) <<https://www.wassenaar.org/about-us/>>.

	Chemical Weapons Convention (CWC) (1997)	
Reviews of Australia's defence capabilities and defence industry sectors (1998-2000)		<i>Defence 2000</i> , including a 'Defence Capability Plan' ⁶
September 11, 2001		ANZUS Treaty invoked for first time Australia joins the US in its invasion of Afghanistan <i>PATRIOT Act</i> (US)
Anthrax attacks in Washington D.C.		<i>Public Health Security and Bioterrorism Preparedness and Response Act 2002</i> (US) and 'Select Agents Regulations' (2003) 'White powder' law passed in Australia: <i>Criminal Code Amendment (Anti-hoax and other measures) Act 2002</i> (Cth) Council of Australian Governments (CoAG) Review of Hazardous Biological Materials commences (2002)
Regional terror attacks on Australians by Jemaah Islamiyah ⁷ : Bali bombings (October 2002) ; Marriott Hotel Bombing (2003); bombing of the Australian Embassy in Jakarta (September 2004).		Establishment of the 'National Critical Care and Trauma Response Centre' (2004) and the Australian Medical

⁶ Department of Defence, *Defence 2000: Our future defence force* (Commonwealth of Australia, 2000).

⁷ It is acknowledged that many (if not most) of the victims in these attacks were Indonesians.

Terror attacks in Madrid (2004) and London (2005) also cited in second reading speeches implementing outputs from the CoAG reviews (see Chapter 4).		Assistance Team (AUSMAT) program ⁸
US invasion of Iraq (2003), ostensibly on weapons of mass destruction concerns and alleged transfers of materiel between Iraq and terrorist groups		Australia joins the ‘Coalition of the willing’
Early, ultimately unsuccessful, bilateral efforts to allow licence-free export of ‘low-sensitivity, unclassified, [US] defense items’ to Australia and the UK (2003). ⁹	Work by Australia Group and Wassenaar Arrangement on non-state actor proliferation concerns UN Security Council unanimously adopts Resolution 1540, which extends CBRN non-proliferation obligations to transfers between States and non-state actors	Wassenaar Arrangements creates rules on arms brokering (2003) Establishment of the 1540 Committee ¹⁰
US and UK announce a Defence Trade Cooperation Treaty providing UK firms with greater access to US arms technology (2005)	Wassenaar Arrangement develops new rules on intangible technology controls (2006)	Defence acknowledges work underway to develop similar Treaty between Australia and the US (2006) ¹¹
Prime Minister John Howard and President George Bush sign the Australia-US Defense Trade Cooperation Treaty (2007)	CoAG agrees to recommendations of review of hazardous materials (see Chapter 5)	National Health Security Bill (Cth) introduced to Parliament (2007)

⁸ National Critical Care and Trauma Response Centre, *About Us* (2023) Department of Health and Aged Care <<https://nationaltraumacentre.gov.au/about-us/>>. PS(H)1 dated the formation of AUSMAT to the ‘tsunami in Banda Aceh and parts of the Pacific and Indian Ocean back in 2004.’

⁹ Secretary of State Colin Powell cited in US Senate Committee on Foreign Relations, *Treaties Hearing*, May 21 2008, 2 (110th Congress 2nd sess, S. HRG 110-651) (Senator Richard G Lugar).

¹⁰ SC Res 1540, UN SCOR, 4956th mtg, UN Doc S/RES/1540 (2004).

¹¹ Joint Standing Committee on Foreign Affairs, Defence and Trade, Parliament of Australia, *Australia’s Defence Relations with the United States [Inquiry Report]* (2006), [7.21].

	Security sensitive biological agents (SSBA) provisions in the NHS Act commence (2009)	
US Congress imposes ratification requirements for Cooperation Treaty, including that Australia have in place appropriate laws governing intangible transfers of dual-use goods ¹² (2010)		Defence Trade Controls Bill undergoing development after decision taken that amending the <i>Weapons of Mass Destruction Act 1985</i> (Cth) not an appropriate legislative vehicle to implement the Treaty (date unknown – 2011) ¹³ Review into the <i>Weapons of Mass Destruction Act 1985</i> (Cth) commences (2011) ¹⁴
Visit by US President Barak Obama and meeting with then Prime Minister Julia Gilliard to coincide with 60th anniversary of ANZUS Treaty ; joint announcement of new military cooperation agreement; President Obama addresses the Australian Parliament (17 November 2011)		Defence Trade Controls Bill (DTC) introduced (2011) DTC Bill referred to the Joint Standing Committee on Foreign Affairs, Defence and Trade (3 November 2011) DTC Bill passed by House of Representatives 21 November 2011
Visit to Australia by US Secretary of State Hilary Clinton to discuss deepening defence links between Australia and the US (12 November 2012)		Parliament passes the Defence Trade Controls Bill (29 October 2012)

¹² See 'Condition 2', Committee on Foreign Relations, US Congress (Senate), *Defense Trade Cooperation Treaties with the United Kingdom and Australia (Executive Report 111-5)* (2010) 24.

¹³ See progress of thinking in US Senate Committee on Foreign Relations, *Treaties Hearing*, May 21 2008 (110th Congress 2nd sess, S. HRG 110-651) (Senator Richard G Lugar).

¹³ Evidence to Senate Standing Committee on Foreign Affairs, Defence and Trade Legislation, Parliament of Australia, 2 March 2012 (Michael Shoebridge)

¹⁴ The outcomes of this review could not be located by the researcher and may have not been published.

APPENDIX 6 – Methodology for assessing biological agents for inclusion or removal from the list of SSBA

Source: Based on the methodology developed for the *COAG Review of Hazardous Materials, Regulation and Control of Biological Agents: Methodology of agent assessment scheme and final list of agents to be regulated* (2006) [final document classified – not publicly available or released to the researcher]. The summary in this Appendix was published in: Department of Health, *Review of Biological Agents of Security Concern – Final Report* (Commonwealth of Australia, 2016), pages 5-6, 11 and Appendix A).

All text is from the original except for **bold, underlined text** added for the reader's aid. Formatting has been recreated by the author to closely match the original.

Producing the initial SSBA

The COAG Biological Working Group identified all the potential agents which warranted assessment for consideration in the list of biological agents to be regulated. The following sources were used to identify the initial list of candidate agents:

- Australia Group list of biological agents, animal pathogens and plant pathogens for export control;
- the Australian Defence and Strategic Goods list;
- the biological agent control lists from the United States, United Kingdom and Canada;
- other publicly accessible information - broad internet searches were conducted to identify any organisms that could be potentially used as a terrorist agent and that were of relevance to the Australian context; and
- expertise, know-how and personal knowledge of the COAG Biological Working Group.

From this initial list of candidates, 200 agents were chosen for individual risk assessments consisting of an assessment of the health impact, feasibility and interest in use, with 22 biological agents or toxins recommended for regulation. These agents were split into two tiers, with Tier 1 agents being of the highest security concern and Tier 2 agents being of a high security concern.

2015 Review of the SSBA List

In order to ensure that the appropriate agents were captured in this review, the top 80 agents from the COAG Biological Report Working Group List, which includes the 22 agents designated as SSBA, were considered for review and the remaining agents on the COAG Working Group Assessment List briefly re-assessed to ensure that they had not increased in

threat. In addition to the COAG agents, henipaviruses (Hendra and Nipah viruses) were added to the assessment list following renewed media interest within Australia in these agents as a potential bioterrorism threat. All agents, including any that were not reviewed in this current process, may be revisited at a later date if significant information relating to changes to the health impact, threat, or feasibility of use is received. A horizon scan for any emerging agents of interest, such as the Middle East Respiratory Syndrome coronavirus (MERS CoV) or new strains of influenza A was also conducted to determine security risk. These horizon scans are ongoing. **[As of August 2021, nothing further on these ‘scans’ has been published on the Department of Health’s SSBA website.]**

Health Impact Assessment

For each biological agent an analysis of the health impact was undertaken using an end-to-end Matrix Assisted Risk Assessment (MARA) methodology. The MARA used discrete scenarios to calculate the likelihood or consequence of the impact criteria. Each assessment looked at the potential magnitude of impact on humans and on agriculture for those agents affecting plants or animals of economic significance.

For agents affecting human hosts, the impact of the agent was assessed on the health aspects including the flow on affect to the health system. For agricultural agents, the economic impact of use was included. For zoonotic agents affecting both human and non-human hosts, the impact score used was the higher of the health impact or economic impact score.

Morbidity and Mortality

For agents affecting humans, the health impact assessment looked at the morbidity and mortality rates within the Australian health context, including overall population health and vaccination levels. The final assessment for mortality was based on the Case Fatality Rate (CFR) which was defined as *the proportion of individuals contracting an illness caused by an agent and who die because of that illness*.

Morbidity considerations included the impact on an individual as well as the impact on the health system in terms of the costs of the care required to manage the illness or injury resulting from the agent. The final Mortality/Morbidity score was taken as the higher score of either mortality or morbidity.

Transmissibility

The Transmissibility criterion assessed the ability of the agent to spread from an infected person to other people including the efficiency of transmission from person to person via specified routes of transmission, (for example casual contact, casual contact in a small area/confined space, or requirements for vectors) as well as those agents not easily transmitted, difficult to transmit, or with no person-to-person transmission.

Difficulty to Treat

This criterion assessed the ability to treat a disease outbreak, toxin poisoning, illness or disease caused by an agent. Assessment included pre- and post-exposure treatments, such as vaccines, medication and supportive care; the availability of the treatments in Australia and the impact on the clinical outcome.

Economic Impact

For agents affecting agriculture, the economic impact was also assessed. The consequence aligned with the dollar value ascribed to the severity of the economic impact measured in the period of one year. The criteria considered included the control/eradication costs as well as domestic and export economic impacts (for example, loss of market, recovery times and reputational damage).

As there are many variables that could influence the impact on the Australian economy, it was considered important to evaluate factors such as how long an outbreak would last, if the agent could be eradicated or controlled and how the export market would react in excluding affected exported products. The Department of Agriculture was extensively consulted for these assessments.

Assumptions

When undertaking the Health Impact Assessments a number of assumptions were made:

- Not all biological agents and their symptoms will be familiar to health care professionals. For exotic diseases, this may lead to a delay in diagnosis. Where this delay may occur, discussions on the transmissibility gained a higher importance.
- Sporadic cases at the beginning of an event may not be diagnosed correctly for uncommon diseases or disease events may not be connected.
- A robust syndromic surveillance system is in place within Australia with large scale (>20 events in a localised area, >200 events Australia wide) detected by such a system. This system may not be likely to detect a wide spread vector borne disease but such an event may be detected by clinicians.
- For the Difficulty to Treat scores:
 - If there is no vaccine or treatment for the disease caused by the agent, then supportive care will be scored to show the full impact of the agent.
 - Unless otherwise stated, it is assumed that the efficacy of any drug registered in Australia has been fully tested.
 - The presence of emerging antibiotic resistance in a specific organism was taken into account where such a resistance is considered to currently have a significant impact on treatment options.

- When undertaking assessment of toxins:¹
 - It was acknowledged that there can be some difficulty in extrapolating toxic effects from animal studies to humans for some biological agents and uncertainty factors, consistent with international best practice, were used to account for intra- and inter-species differences.
 - Assessments used acute Lethal Dose 50 (LD₅₀)² to provide an estimate of the relative toxicity of a substance for a specific exposure route.
 - LD₅₀ was used as an endpoint to approximate the potential mortality to humans where case fatality rate data was unavailable.

Security Threat Assessments

The AIC was requested to undertake a review of the current threat of the use of these agents as bioweapons. This review was facilitated by the AFP in consultation with ASIO and DIO.

The overall threat of an agent was determined through an assessment of the interest in the use of the agents and a determination of the feasibility of use.

Interest

The interest assessment measured the level of interest in the agent for use by terrorist, criminal or issue motivated groups of concern to Australia. These assessments hold a national security classification and are not available for public release.

Feasibility

This criterion assessed the availability, the ease of production and the ease of dissemination to determine the overall feasibility of use.

- *Availability*: assessed the ease of access to the agent within Australia, including if the agent was readily available in Australia, the ease of importation, and the availability of information relating to the use of the agent, including background information and methodologies.
- *Ease of production*: assessed the ease in which the agent could be produced in a form that could be used as a bioweapon, including the ease in isolating or producing the agent and the requirement for specialised equipment or knowledge/skills.
- *Ease of dissemination*: was determined by an assessment of the ability to spread the agent to a large number of targets including the ease of preparing the agent for dissemination, possible methods for dissemination and the level of preparation required (e.g. use of a crude or sophisticated dissemination method or production for a large or a small scale release).

¹ Toxin Health Impact Assessments were led by the Office of Chemical Safety in the Department of Health.

² In toxicology, LD₅₀ is the median lethal dose required to kill half (50%) of the test population after a specified time period. A lower LD₅₀ is indicative of increased toxicity.

Calculation of overall risk score

The final risk score was calculated by first determining the overall threat score and the overall health impact score. These scores were then used to determine the risk score for each biological agent. The formulas used to calculate each score are listed below.

Health Impact score

The mean for the health impact for agents affecting human hosts was calculated using the following:

$$\text{Impact Mean} = \frac{1}{3} (\text{Mortality/Morbidity} + \text{Transmissibility} + \text{Difficulty to Treat})$$

For agents affecting non-human hosts (animals and plants), the 'Impact' criterion was assessed on the economic impact. It should be noted that human pathogens and toxins were not assessed for potential economic impact.

Threat score

The threat score was based on the following:

- Interest in the agent; and
- Feasibility ($\text{Feasibility} = \frac{1}{3} (\text{Availability} + \text{Production} + \text{Dissemination})$)

Threat was then determined using the following formula:

$$\text{Threat} = \frac{1}{2} (\text{Interest} + \text{Feasibility})$$

Overall risk score

The final risk score for each biological agent was determined by using the formula:

$$\text{Risk} = \text{Threat} \times \text{Impact}$$

This score was then used to rank the biological agents to assist in determining if a change to regulatory status was warranted.

Weighting of security risk

The SSBA Regulatory Scheme is based on management of the security risk of biological agents not the public health risk. In order to ensure that any agents fit this risk criteria, a second ranking was undertaken using just the overall threat score to determine if any agents had a high enough threat score to indicate further discussions with the intelligence community were required in regards to regulation for security purposes.

Appendix 7A - Timeline of Australia's response to 2009 pandemic influenza

Source: Australian Government, *Pandemic (H1N1) Influenza 2009* (2 June 2011 [archived])

<<https://web.archive.org/web/20110601172726/http://www.flupandemic.gov.au/internet/panflu/publishing.nsf/Content/H1N1%202009-1>>.

Date	Activity [key events highlighted by author]
24 April 09	WHO announces detection of novel human influenza in Mexico
25 April 09	WHO declares the outbreak of swine influenza A/H1N1 a Public Health Emergency of international concern
27 April 09	WHO moves to pandemic phase 4 – sustained human to human transmission of a pandemic potential virus
28 April 09	Australia moves to pandemic phase DELAY – novel virus has emerged overseas but has not arrived in Australia
29 April 09	WHO moves to pandemic phase 5 – sustained community transmission in two or more countries in one WHO region
30 April 09	National press advertising campaign - Public information on the national freecall pandemic (H1N1) influenza 2009 hotline number (180 2007) and the health emergency website
27 May 09	Television Commercials commence – to alert the public to cough and cold etiquette and advise the public on the sorts of symptoms associated with pandemic (H1N1) influenza 2009 that people should be aware of
03 June 09	Victoria moves to MODIFIED SUSTAIN – modified version of SUSTAIN which is realistic about extent of outbreak in community; mindful of disruption caused by some of public health measures and recognition of mild nature of illness in most people
05 June 09	Effective date of the contract between CSL and Commonwealth Department of Health and Ageing
11 June 09	WHO moves to pandemic Phase 6 – start of new pandemic. Sustained community transmission in two or more WHO regions
17 June 09	Australia moves to pandemic phase PROTECT – recognition that pandemic virus is mild in most but severe in some and moderate overall. Focus on treating and caring for those more vulnerable to severe outcomes
22 Jul 09	First dose administered in CSL Australian <i>adult</i> clinical trial
03 Aug 09	First dose administered in CSL Australian <i>children</i> clinical trial
12 Aug 09	Second dose administered in CSL Australian <i>adult</i> clinical trial.
31 Aug 09	Pre-positioning of vaccine to CSL jurisdictional warehouses commenced
03 Sep 09	First dose adult clinical trial report delivered by CSL
10 Sep 09	Preliminary results from the clinical trial of the vaccine in adults, published in the New England Journal of Medicine, provided clarification that only one dose was required for adults and children over 10
18 Sep 09	Therapeutic Goods Administration (TGA) approval to register vaccine for use in children 10 years and older and adults
18 Sep 09	Minister announced the vaccination program would commence on 30 September 2009
18 Sep 09	The Prime Minister announced that Australia would commit up 10 per cent (21 million) of its vaccine to the World Health Organization (WHO) for use in developing countries in our region
18 Sep 09	ATAGI Statement Guideline for the administration of pandemic (H1N1) influenza 2009 vaccine from multi-dose vials (MDV)
18 Sep 09	CMO advice to General Practitioners regarding the best use of MDV's for the vaccination program

24 Sep 09	Delivery of vaccine, consent forms, information sheets, VacPacs to vaccination providers commenced.
24 Sep 09	ATAGI Statement Use of multi-dose vials in vaccination programs
29 Sep 09	ATAGI Statement Advice regarding the use of influenza vaccines containing thiomersal (including pregnancy)
30 Sep 09	Pandemic (H1N1) influenza 2009 Vaccination Program commences
30 Sep 09	Mass media communication campaign commences (radio, TV, newspaper) – Free pandemic (H1N1) influenza 2009 vaccine available for adults and children 10 years and over to protect both the vulnerable groups and the general population against future waves of this virus.
Oct 09	The U.S. Government launched its national pandemic (H1N1) influenza 2009 vaccination campaign
08 Oct 09	ATAGI Statement Advice regarding influenza, influenza vaccines and Guillian-Barre Syndrome
09 Oct 09	ATAGI Statement Guidance on the use of latex-containing 1mL syringes from pandemic vaccination packs
12 Oct 09	CMO advice to General Practitioners regarding the latex in syringes leading to hypersensitivity reactions
09 Nov 09	First dose children clinical trial report delivered by CSL.
19 Nov 09	ATAGI Statement Advice: on the use of seasonal vaccine as second dose in children
03 Dec 09	(TGA) approval to register vaccine for use in children aged 6 months to 9 years
04 Dec 09	Vaccination of children aged 6 months to 9 years commences
09 Dec 09	CSL commences distribution of Panvax® Junior Pre filled syringes to immunisation providers (for use in children aged 6 months to 3 years)
17 Dec 09	ATAGI Statement Use of pandemic and seasonal influenza vaccines in children <10 years of age
22 Dec 09	ATAGI Statement Recommended clinical protocol for the administration of pandemic (H1N1) influenza 2009 vaccine from MDVs for children aged >6 months to <3 years and for all people aged >3 years
23 Dec 09	Second dose children clinical trial report delivered by CSL
2010	
21 Mar 10	“Facts about Swine Flu” Campaign commences to help people understand the risks swine flu poses to the community, and the need for all people to get vaccinated
10 Aug 10	WHO declares the move from phase 6 of the influenza pandemic alert to post pandemic period
26 Aug 10	The shelf life of Panvax® Junior pre-filled syringes reduced from 12 months to 6 months
Oct 10	Australia donates a further 1.7 million doses of vaccine to the WHO, bringing Australia’s total donation to 3.8 million doses
01 Dec 10	Australia decreases pandemic phase from PROTECT to ALERT, signifying the end of pandemic (H1N1) influenza 2009 in Australia
31 Dec 10	Vaccine Expires - Last date possible to receive Panvax® H1N1 vaccine in Australia

Appendix 7B – Timeline of Department of Health’s response to Ebola outbreak

Adapted from Table 1 in: Apis, ‘Review of the Department’s Response to the Ebola Virus’ in Department of Health, *FoI Request [063-1516]* (16 October 2015) 13-15. Key events highlighted by author. Additional events added by author. See further, **Chapter 6**.

Date	Context	Activity by Department of Health
December 2013	Index case in Guinea	
March 2014	23 March – Ebola outbreak reported in Guinea	
April 2014	7 April – Ebola cases reported in Liberia	1 April – Regular reporting commenced to Department Executive about the Ebolavirus disease (EVD) situation 9 April – Commenced ad-hoc reporting to the CMO/AHPPC on testing and monitoring through the National High Security Quarantine Laboratory (VIDRL), and State/Territory health authorities 15 April – Responses to enquires from members of the public commenced 28 April – Created EVD Question Time Brief (QTB) ongoing updates in line with events Advice for laboratories, GPs, clinicians and the public developed in consultation with CDNA and PHLN Department requested data from Department of Immigration on the volume of incoming passengers from Guinea and Liberia to inform risk assessment
May 2014	Ebola cases reported in Sierra Leone	
June 2014		4 June – Department briefed DFAT on Ebola response 5 June – CMO provided an update on Ebola to the Presidents of the Medical Colleges and the AMA
July 2014	Transmission outside three countries to Nigeria and Senegal	7 July – email from David Learmouth (Acting Secretary of Health) to CMO linking to a <i>news.com.au</i> article on Ebola outbreak in Nigeria, asking ‘Chris [CMO], What is the deal here? Risks to Aus? Action required? People in a Nigerian airport could go anywhere...’¹ 14 July – Department briefed DFAT on Ebola response 22 July – Ebola webpage set up and published with Information Sheets for travellers, patients and consumers, GPs, clinicians and laboratories – on the Department website

¹ Department of Health, *FoI Request [114-1415]* (5 March 2015) <<https://webarchive.nla.gov.au/awa/20171113055637/http://www.health.gov.au/internet/main/publishing.nsf/Content/foi-146-1415>>.

		24 July – Department participated in WHO meeting with donor countries to discuss resource mobilisation 29 July – Rapid Assessment Teams meetings commenced about risk assessment – continued until the ERTF commenced in October 2014 31 July – Interim EVD SoNG developed
August 2014	6 August 2014 – First whole-of-Government IDC on the Ebola outbreak 8 August – WHO declared a PHEIC 9 August – Australia introduced initial border screening measures: • In flight announcements • Incoming passenger cards to identify passengers from Africa in the past 6 days • At risk passengers further assessed by Human Quarantine Officers • Assessed travellers provided with written information on Ebola symptoms and management • Call centre script provided 24 August – Australian Government commits \$1 million to WHO outbreak response fund²	7 August – CMO briefed National Security Committee of Cabinet 8 August – Script provided to Public Health Information Line 14 August – The National High Security Quarantine Laboratory Guideline for Management of Quarantinable Viral Haemorrhagic Fevers was updated on the Department website 15 August – The EVD SoNGs (agreed to by States and Territories) were uploaded onto the Department's website 26 August – CMO briefed National Security Committee
September 2014		2 September – Weekly Prime Minister's EVD update commenced

² Julie Bishop MP, 'Australian assistance to control the Ebola outbreak in West Africa' (Media Release, 24 August 2014).

	17 September – Australian Government announces commitment of addition \$7 million to support international response to Ebola outbreak: • \$2.5 million to WHO • \$2.5 million to MSF • \$2 million to support UK response³ 30 September – US CDC confirms first case of Ebola [in the US]	14 September – CMO briefed National Security Committee 18 September – An Ebola Agency Planning meeting chaired by the Department is held weekly – officer level 19 September – CMO briefed Australian Health Ministers' Advisory Council on the Ebola situation in West Africa and Australia's preparedness. (A Memo to the Acting Secretary of Health prior to this meeting noted that 'The EVD outbreak has attracted significant media attention, and although the risk of transmission to Australia is currently considered to be very low, the matter is potentially contentious and politically sensitive.') ⁴ 19 September – OHP daily updates on rumour surveillance and epidemiology 22- September – CMO member of the IHR Emergency Committee that issued statement regarding Ebola 25 September – CMO meets with US CDC
October 2014	2 October – Australian Government commits additional \$10 million to international response⁵ 6 October – Health Care Worker (HCW) diagnosed with Ebola in Spain 9 Oct – HCW diagnosed with Ebola in US 12 October – HCW diagnosed with Ebola in US 16 October – ALP writes to Prime Minister requiring 'immediate arrangements' be made to deploy AUSMAT to West Africa	10 October – OHP commenced circulating weekly Biosecurity Referral data to Chief Health Officers Mid Oct – Staff changes at SRS level within Health (also in mid-Sep) 20 October – Dedicated Ebola Response Taskforce (ERTF) commenced in OHP
November 2014	4 November – Australian Government agrees to fund	

³ Julie Bishop MP and Peter Dutton MP, 'Further assistance to control the Ebola outbreak in West Africa' (Media Release, 17 September 2014).

⁴ Department of Health, *FoI Request [114-1415]* (5 March 2015) Document 6.

⁵ Julie Bishop MP, 'Australia provides further assistance to fight Ebola' (Media Release, 2 October 2014)

	Aspen Medical to establish and run an Ebola Treatment Centre (ETC) in Sierra Leone 14 November – Enhanced border screening measures introduced: temperature checks and additional health questions 21 November – Australia chairs UN Security Council meeting on Ebola	7 November – EVD Information for clinicians and GPs was updated
December 2014	14 December – Aspen ETC commences operations	19 December AHPPC telecon to review preparedness measures in relation to EVD outbreak in West Africa
January 2015	16 January – Australian nurse medevac'd to UK for observation after possible exposure to Ebola	27 January – Department participates in DFAT's Ebola Response Workshop regarding regional (i.e., Indo-Pacific) preparedness
February 2015	21 February – second Australian nurse medevac'd to UK for observation after possible exposure to Ebola	
March 2015		1 March – Department participated in DFAT's Ebola Response Workshop regarding regional (i.e., Indo-Pacific) preparedness
April 2015	30 April – Australia closes the Aspen run ETC in Sierra Leone	2 April – the IDC co-chaired by DFAT and Department will meet on an as-needed basis
May 2015		4 May 2015 – Terms of Reference finalised for Departmental internal review of response to Ebola outbreak (review undertaken between May – August 2015)
June 2015		1 June – ERTF transitioned to EM Branch of OHP
November 2015	7 November – WHO declares Sierra Leone Ebola Free 11 November – Australian Government starts to downscale incoming passenger screening measures	
December 2015	Guinea declared Ebola free by WHO	

January 2016	Liberia declared Ebola free by WHO (for 3 rd time).	
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