

COVID-19 VACCINE MANDATES: A COERCIVE BUT JUSTIFIED PUBLIC HEALTH NECESSITY

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In response to the COVID-19 pandemic, governments worldwide introduced vaccine mandates and ‘passports’, creating tension between individual liberties and public health. This article provides an overview of the history of vaccine mandates in Australia and the United Kingdom, before examining the COVID-19 period, when Australian states introduced various conditional mandates while the United Kingdom largely avoided doing so. This article considers several medico-legal and human rights arguments for and against the imposition of conditional mandates. Although this article concludes that vaccine coercion is both legally and morally justified, it acknowledges the right to refuse medical treatment, freedom of thought, conscience, and opinion, and the right to bodily integrity as important precepts deserving serious consideration. In many cases, alternatives to coercion are preferable. This article has ongoing relevance, both for COVID-19 (as new variants and treatments emerge) and beyond, including for the use of coercion in childhood vaccination and future pandemics.

I INTRODUCTION

The COVID-19 pandemic has caused enormous global disruption. The World Health Organization (‘WHO’) estimates that global excess mortality associated with COVID-19 between 1 January 2020 and 31 December 2021 was in the order of 15 million persons.¹ Many more deaths are expected to occur into the future, together with illness and disability resulting from ‘long COVID’.² In

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1 ‘Global Excess Deaths Associated with COVID-19, January 2020 – December 2021’, *World Health Organization* (Web Page, May 2022) <<https://www.who.int/data/stories/global-excess-deaths-associated-with-covid-19-january-2020-december-2021>>.

2 Andrew Briggs and Anna Vassall, ‘Count the Cost of Disability Caused by COVID-19’ (2021) 593 *Nature* 502 <<https://doi.org/10.1038/d41586-021-01392-2>>.

response to this extraordinary health crisis, governments worldwide introduced a range of regulatory measures intended to reduce infection, some unprecedented in modern history. Border closures, quarantine directions, lockdowns, curfews, mandatory testing, contact tracing, self-isolation, social distancing, mask wearing, and mandatory diagnosis reporting have been key examples of newly prescribed conduct.³ While the actual economic costs of the pandemic to the global economy are incalculable, analysts have proffered eye-watering estimates of between USD5.8 trillion and USD16 trillion⁴ (or 90% of the gross domestic product of the United States).⁵ Amid the crisis, COVID-19 vaccines became widely accepted as the best ‘way out’ of the pandemic. Rapidly developed and approved through a hitherto unavailable expedited regulatory scheme, these vaccines were distributed around the world in the billions.

For all the logistical and organisational achievements of managing COVID-19, ‘vaccine hesitancy’ was (and continues to be) a stubborn health and economic problem in many countries. While ‘vaccine hesitancy’ is a contested term, in this article we use it broadly to mean generalised uncertainty or indecision about vaccination as well as refusal of vaccination.⁶ We do not use ‘vaccine hesitancy’ to include all instances of under-vaccination caused by external factors, such as lack of vaccine accessibility or convenience, and we acknowledge (and argue in Part V below) that inadequate or poor government information and policy failures also contribute to COVID-19 vaccine hesitancy.⁷

In many Western countries, vaccine hesitancy has hovered between 20% and 30%. In September 2021, research published by Imperial College London indicated that some 25% of the United States population were unwilling to be vaccinated, with more than 6% uncertain. The same study confirmed that, in the United Kingdom, France, Germany and Sweden, around 20–22% were unwilling to be vaccinated, with 5–6% uncertain. In Canada, Australia and Italy, around 17% were unwilling to be vaccinated, with between 4 and 9% uncertain.⁸ That said,

3 Kay Wilson, ‘The COVID-19 Pandemic and the Human Rights of Persons with Mental and Cognitive Impairments Subject to Coercive Powers in Australia’ (2020) 73 *International Journal of Law and Psychiatry* 101605:1–10 <<https://doi.org/10.1016/j.ijlp.2020.101605>> (‘The COVID-19 Pandemic’).

4 See, eg, David M Cutler and Lawrence H Summers, ‘The COVID-19 Pandemic and the \$16 Trillion Virus’ (2020) 324(15) *Journal of the American Medical Association* 1495, 1496 <<https://doi.org/10.1001/jama.2020.19759>>; Munim K Barai and Saikat Dhar, ‘COVID-19 Pandemic: Inflicted Costs and Some Emerging Global Issues’ [2021] *Global Business Review* 1, 5 <<https://doi.org/10.1177/0972150921991499>>, quoting Asian Development Bank, ‘COVID-19 Economic Impact Could Reach \$8.8 Trillion Globally: New ADB Report’ (News Release, 15 May 2020) <<https://www.adb.org/news/covid-19-economic-impact-could-reach-8-8-trillion-globally-new-adb-report>>.

5 Cutler and Summers (n 4) 1496.

6 Helen Bedford et al, ‘Vaccine Hesitancy, Refusal and Access Barriers: The Need for Clarity in Terminology’ (2018) 36(44) *Vaccine* 6556 <<https://doi.org/10.1016/j.vaccine.2017.08.004>>; Katie Attwell, Adam Hannah and Julie Leask, ‘COVID-19: Talk of “Vaccine Hesitancy” Lets Governments off the Hook’ (2022) 602 *Nature* 574 <<https://doi.org/10.1038/d41586-022-00495-8>>.

7 See above n 6.

8 Bobbie Macdonald, ‘Attitudes to COVID-19 Vaccinations’, *Our World in Data* (Web Page, 15 December 2021) <<https://github.com/YouGov-Data/covid-19-tracker>>.

in many countries, vaccine hesitancy has tended to reduce over time.⁹ As at 11 January 2023, some 96% of Australians over 16 have had two COVID-19 vaccine doses (following the introduction of vaccine requirements). A smaller majority of the eligible population (72.4%) has received a third ‘booster shot’, and only 44.3% of those over 30 have received a fourth.¹⁰ Although the percentage of vaccine-hesitant people remains a clear minority, the total number can be a large cohort: 25% of the US population amounts to 80 million people.¹¹

In response to vaccine hesitancy, governments have considered incentives to encourage citizens to undergo vaccination, ranging from direct payments through to prize lotteries.¹² Commonly, as discussed in detail below, governments also resorted to deploying social and legal coercion. Some required people working in certain roles or in specific age groups to undergo vaccination while others ‘rewarded’ vaccinated persons with ‘freedoms’ from restrictions on travel, movement and everyday activities.¹³ Many private businesses, including airlines,¹⁴ also required employees and customers to be vaccinated or risk employment termination or suspension. Administered in a context of legal uncertainty (at least initially), these government and private actions led to multiple legal challenges that continue today (some of which are discussed below).¹⁵

In principle, the use of coercion to compel vaccination stands in tension with the values of individual liberty, personal autonomy and bodily integrity – values that distinguish liberal democracies from totalitarian regimes.¹⁶ But the imposition of coercion also raises more than just questions of principle. In many countries, like the United States, vaccination has become a contentious political issue, sowing

9 See *ibid.*

10 ‘Vaccination Numbers and Statistics’, *Department of Health and Aged Care (Cth)* (Web Page, 11 January 2023) <<https://web.archive.org/web/2023011120218/https://www.health.gov.au/our-work/covid-19-vaccines/vaccination-numbers-and-statistics>>.

11 Joe Biden, ‘Remarks by President Biden on Fighting the COVID-19 Pandemic’ (Speech, The White House, 9 September 2021) <<https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/09/09/remarks-by-president-biden-on-fighting-the-covid-19-pandemic-3/>> (‘Remarks by President Biden’).

12 Allan J Walkey, Anica Law and Nicholas A Bosch, ‘Lottery-based Incentive in Ohio and COVID-19 Vaccination Rates’ (2021) 326(8) *Journal of the American Medical Association* 766 <<https://doi.org/10.1001/jama.2021.11048>>.

13 European Union (‘EU’) Digital COVID Certificates apply to all EU countries and 51 non-EU countries: see ‘EU Digital COVID Certificate’, *European Commission* (Web Page) <https://ec.europa.eu/info/live-work-travel-eu/coronavirus-response/safe-covid-19-vaccines-europeans/eu-digital-covid-certificate_en> (‘EU Digital COVID Certificate’).

14 Craig Platt, ‘Emirates World’s First Airline to Bring in IATA’s Digital Health Pass for Passengers Worldwide’, *Traveller* (online, 24 September 2021) <<https://www.traveller.com.au/emirates-worlds-first-airline-to-bring-in-iatas-digital-health-pass-for-all-passengers-h1ysh7/>>.

15 Andy Park, ‘COVID-19 Vaccine Mandates a Legal and Ethical Quagmire for Businesses’, *ABC News* (online, 9 September 2021) <<https://www.abc.net.au/news/2021-09-08/vaccination-freedoms-businesses-call-for-government-mandate/100442974>>; *Construction, Forestry, Maritime, Mining and Energy Union v Mt Arthur Coal Pty Ltd* (2021) 310 IR 399 (‘*Mt Arthur*’).

16 The long list of liberal theorists valorising personal autonomy as a fundamental value of liberalism and liberal democracy include John Stuart Mill, John Rawls, Richard Dagger, Joseph Raz, Jeff Spinner-Halev and Lawrence Haworth, among others. For a historical survey of the idea of personal autonomy in Western thought, see Lucas Swaine, *Ethical Autonomy: The Rise of Self-Rule* (Oxford University Press, 2020) ch 2 <<https://doi.org/10.1093/oso/9780190087647.003.0002>>.

division along party lines.¹⁷ While the vaccinated population grew impatient and frustrated with the unvaccinated,¹⁸ some vaccine objectors attacked and harmed medical practitioners, retail workers and others.¹⁹ A minority of unvaccinated people, in countries including Australia, organised in protest against perceived government overreach, some becoming violent.²⁰

This article acknowledges the delicate tension between individual rights and public health control, and analyses arguments both for and against the use of ‘soft’ and ‘hard’ coercion by states to address or overcome vaccine hesitancy. Focusing on the contrasting approaches of Australia and the United Kingdom, Part II defines what we mean by coercion. In Part III, we examine vaccine-related coercion in its sociohistorical context, reviewing governmental responses to anti-vaccination movements in 19th century Britain and Australia. Part III also surveys a range of COVID-19 vaccine-mandating laws and summarises select Australian legal cases. In Part IV, we consider the most forceful arguments *against* vaccine coercion, drawing on concepts from medical and human rights law. In Part V, we review the arguments in *favour* of mandatory vaccination, underlining the sociocultural lessons of history discussed in Part III.

Ultimately, this article argues that most forms of vaccine-related government coercion are justified in view of the overwhelming personal, social, health and economic benefits that come with vaccination (especially during a pandemic). But we also contend that coercion is not to be imposed lightly or as a first resort. Thus, our conclusion identifies other approaches to encourage vaccination that may be preferable to coercion. In its consideration of the scope and limits of liberty in liberal democracies, this article is expected to have relevance not just for the immediate crisis (as novel variants and treatments evolve) but for law and policy in the post-COVID-19 period, including for policy on vaccine hesitancy and the use of coercion for routine childhood vaccination, and for future pandemics.

II DEFINING ‘COERCION’

While it is a complex and contested term, ‘coercion’ usually refers to a process in which a person or organisation imposes pressure on another so that the latter complies with the former’s will.²¹ Coercion can be conceptualised along

17 ‘Remarks by President Biden’ (n 11).

18 Ibid.

19 Ibid.

20 See Nancy Krieger, ‘ENOUGH: COVID-19, Structural Racism, Police Brutality, Plutocracy, Climate Change – and Time for Health Justice, Democratic Governance, and an Equitable, Sustainable Future’ (2020) 110(11) *American Journal of Public Health* 1620 <<https://doi.org/10.2105/AJPH.2020.305886>>; Jeffrey R Bloem and Colette Salemi, ‘COVID-19 and Conflict’ (2021) 140 *World Development* 105294:1–9 <<https://doi.org/10.1016/j.worlddev.2020.105294>>; Brett Bowman, ‘On the Biopolitics of Breathing: Race, Protests, and State Violence under the Global Threat of COVID-19’ (2020) 50(3) *South African Journal of Psychology* 312 <<https://doi.org/10.1177/0081246320947856>>.

21 Charles Allan McCoy, ‘Adapting Coercion: How Three Industrialized Nations Manufacture Vaccination Compliance’ (2019) 44(6) *Journal of Health Politics, Policy and Law* 823 <<https://doi.org/10.1215/03616878-7785775>>.

a continuum of controls and intrusions, starting with punitive instruments or strategies on the ‘hard’ side through to encouragement or ‘nudge’-oriented and educative policies on the ‘soft’ side.²² As British philosopher David Archard and his colleagues write, coercion frameworks may range from “‘quasi-mandatory’ policies that penalise non-compliance’ through to “‘incentivised’ ones that reward compliance’ and still further to ‘those that neither penalise nor reward but provide education and information to facilitate compliance’.²³

In this article, we adopt a broad definition of coercion and describe any legal or quasi-legal rule that requires a person to be vaccinated or else face an adverse consequence (including a fine or an exclusion from employment or other lawful activity) as a ‘vaccine mandate’. We adopt this terminology for the sake of convenience and argument, but also because some legislative instruments have been titled this way (eg, *COVID-19 Mandatory Vaccination (Workers) Directions (No 8) 2021 (Vic)*).²⁴ But we also acknowledge that the expression ‘mandate’ is problematic, not least because some rules have been recognised not to be technical ‘mandates’ at law. That is because they do not require positive action but instead impose a blanket prohibition on all citizens and then exempt vaccinated persons from the prohibition.²⁵ Accordingly, most mandates are *conditional* on COVID-19 vaccination, where restrictions on free movement, employment, and access to goods and services are only conditionally limited. This may be contrasted with *compulsory* mandates that, for example, may force persons to vaccinate against their will or punish unvaccinated people through fines or imprisonment. We also recognise recent jurisprudence that indicates that whether a given rule should be described as a ‘mandate’ might depend on the extent to which it factually limits one’s freedom of movement or ability to work, violates one’s bodily integrity, or involves a violation of one’s privilege against self-incrimination.²⁶

In most countries, employment-related vaccine mandates have only applied in those industries necessitating close physical contact with vulnerable persons: eg, aged care, health care and education. Italy was one of the first nations to mandate vaccination for all workers in all workplaces in October 2021. However, in January 2022, the Italian government mandated vaccination for all residents over 50 years of age.²⁷ Vaccine mandates have sometimes applied only to specific cohorts. However, the cumulative effects of these conditional restrictions have

22 Katie Attwell et al, ‘Recent Vaccine Mandates in the United States, Europe and Australia: A Comparative Study’ (2018) 36(48) *Vaccine* 7377, 7378 <<https://doi.org/10.1016/j.vaccine.2018.10.019>>.

23 David Archard, Joe Brierley and Emma Cave, ‘Compulsory Childhood Vaccination: Human Rights, Solidarity, and Best Interests’ (2021) 29(4) *Medical Law Review* 716, 724 <<https://doi.org/10.1093/medlaw/fwab024>>.

24 A direction made under section 200 of the *Public Health and Wellbeing Act 2008 (Vic)*.

25 Al-Munir Kassam, ‘Submissions of the State Defendants’, Submission in *Kassam v Hazzard*, 2021/249601, 29 September 2021, 15–16 [54] <https://www.supremecourt.justice.nsw.gov.au/Documents/Cases%20of%20Interest/001_2021_KASSAM/003_Kassam_Henry_State_Submissions_29.09.21.pdf>.

26 See *Kassam v Hazzard* (2021) 362 FLR 113, 139 [83] (Beech-Jones CJ at CL) (*‘Kassam Supreme Court’*).

27 See, eg, Chico Harlan and Stefano Pitrelli, ‘Italy Begins Enforcing One of the World’s Strictest Workplace Vaccine Mandates, Risking Blowback’, *The Washington Post* (online, 16 October 2021) <https://www.washingtonpost.com/world/europe/italy-vaccination-mandate-workers/2021/10/15/d1b045e2-2d99-11ec-b17d-985c186de338_story.html>; Angelo Amante, Giuseppe Fonte and Gavin Jones, ‘Italy Extends

tended to ripple outwards so that people experience significant reductions in the ways they can work and participate in society.²⁸ Arguably, the view that individuals may exercise their personal choice or ‘freedom’ to participate in a workplace, or access goods, services and certain venues as a customer, must become untenable as more barriers are deployed. For many people, even temporary losses of income resulting from workplace changes, exclusions or suspensions may amount to significant financial penalties, greater than many fines.²⁹ Furthermore, the effects of the changes may be serious and distressing – they may even be experienced as physically painful for some.³⁰ By contrast, requirements that offer regular testing as an alternative to vaccination may be less coercive than workplace exclusions: for example, the test mandate proposed by President Biden (before it was stayed by the Supreme Court of the United States)³¹ or those facilitated by the European Union (‘EU’) Digital COVID Certificate.³²

While we embrace a broad definition of ‘coercion’, the scope of our analysis is bounded by common sense and experience. For example, we do not include and are not aware of any law or rule that has purported to authorise the ‘forced’ administration of a COVID-19 vaccine to any ordinary citizen against their will. Similarly, we do not consider the provision of information or general attempts by government or other agencies to persuade a person to become vaccinated as coercion – even if a person may subjectively claim to feel ‘pressured’. Of course, whether something is coercive is a different question to whether that coercion might be legally permitted or morally justified.

We also acknowledge that when governments coerce citizens to vaccinate, they may generally have corresponding duties to ensure vaccines are safe, effective, accessible and affordable.³³ In many cases, governments may also provide a no-fault compensation scheme for those who face adverse reactions.³⁴

COVID Vaccine Mandate to Everyone over 50’, *Reuters* (online, 7 January 2022) <<https://www.reuters.com/world/europe/italy-make-covid-jab-mandatory-over-50s-tighten-curbs-draft-2022-01-05/>>.

- 28 See Achraf Ammar et al, ‘COVID-19 Home Confinement Negatively Impacts Social Participation and Life Satisfaction: A Worldwide Multicenter Study’ (2020) 17(17) *International Journal of Environmental Research and Public Health* 6237:1–17 <<https://doi.org/10.3390/ijerph17176237>>.
- 29 See Mathieu Despard, Andrae Banks and Lyneisha Dukes, ‘COVID-19 Job and Income Loss and Mental Health: The Mediating Roles of Financial Assets and Well-Being and the Moderating Role of Race/Ethnicity’ (2023) 21(1) *Social Work in Mental Health* 28 <<https://doi.org/10.1080/15332985.2022.2063042>>.
- 30 Eric D Wesselmann et al, ‘Social Exclusion in Everyday Life’ in Paolo Riva and Jennifer Eck (eds), *Social Exclusion: Psychological Approaches to Understanding and Reducing Its Impact* (Springer, 2016) 3, 3–4 <https://doi.org/10.1007/978-3-319-33033-4_1>.
- 31 *National Federation of Independent Business v Department of Labor, Occupational Safety and Health Administration*, 595 US ____ (2022) (‘*Independent Business*’).
- 32 ‘EU Digital COVID Certificate’ (n 13).
- 33 See, eg, *Therapeutic Goods Act 1989* (Cth) s 4, which states that the object of the Act includes establishing a ‘national system of controls relating to the quality, safety, efficacy and timely availability of therapeutic goods’ used in Australia. See also, eg, Department of Health and Aged Care (Cth), ‘National Medicines Policy 2022’ (Policy, 2nd ed, 2022) 6–7 <<https://www.health.gov.au/sites/default/files/2022-12/national-medicines-policy.pdf>>; Clyde Sloan, *A History of the Pharmaceutical Benefits Scheme 1947–92* (Australian Government Publishing Service, 1995), which details the history and goals of the Pharmaceutical Benefits Scheme, operating under part VII of the *National Health Act 1953* (Cth).
- 34 See, eg, *COVID-19 Vaccine Claims Scheme Policy 2021* (Cth).

These schemes have emerged historically because governments seeking to make vaccines available to citizens have decided to bear exclusive liability for injuries to incentivise vaccine manufacturers to make vaccines where the latter were unable to obtain insurance coverage.³⁵

III VACCINE COERCION, THE ANTI-VACCINATION MOVEMENT AND COVID-19 VACCINATION LAWS IN THE UNITED KINGDOM AND AUSTRALIA

Vaccination is an incomparably successful public health measure.³⁶ Today, vaccines exist for over 20 diseases.³⁷ The only human disease ever to have been eradicated, smallpox, was eradicated in 1980 through the use of vaccines.³⁸ The WHO estimates that vaccination prevents 3.5–5 million deaths each year from diseases like diphtheria, tetanus, pertussis (whooping cough), influenza and measles. Still, many thousands of people around the world cannot access vaccines due to their socio-economic status, remoteness from health systems or other reasons.³⁹ With vaccine shortages and other challenges to vaccine equity facing many low-income countries during the COVID-19 pandemic, it may seem perverse or paradoxical that those with the most socio-economic advantage have been among the most vaccine hesitant.⁴⁰

Low vaccine uptake has many causes. Some scholars point to a problem with one of the so-called ‘five Cs’.⁴¹ These are problems in confidence (trust in the safety or efficacy of the vaccine), complacency (failure to act with urgency in response to the risk of disease), convenience (the perceived irritation or burden in undergoing vaccination), communication (information about vaccines is inadequate or is combined with misinformation), or context (structural or social problems,

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- 35 On the legal immunity of vaccine manufacturers under some statutes, see Richard Goldberg, ‘Vaccine Damage Schemes in the US and UK Reappraised: Making Them Fit for Purpose in the Light of COVID-19’ (2022) 42(4) *Legal Studies* 576 <<https://doi.org/10.1017/lst.2022.9>>. See also Christian Günther, Lauren Tonti and Irene Domenici, ‘Vaccination as an Equaliser? Evaluating COVID-19 Vaccine Prioritisation and Compensation’ (2022) 30(4) *Medical Law Review* 584, 596–605 <<https://doi.org/10.1093/medlaw/fwac020>>.
- 36 Walter A Orenstein and Rafi Ahmed, ‘Simply Put: Vaccination Saves Lives’ (2017) 114(16) *Proceedings of the National Academy of Sciences of the United States of America* 4031 <<https://doi.org/10.1073/pnas.1704507114>>.
- 37 ‘Vaccines and Immunization’, *World Health Organization* (Web Page) <<https://www.who.int/health-topics/vaccines-and-immunization>> (‘Vaccines and Immunization’).
- 38 Frank Fenner et al, *Smallpox and Its Eradication* (World Health Organization, 1988) ix–x.
- 39 ‘Vaccines and Immunization’ (n 37).
- 40 Gabrielle M Bryden et al, ‘The Privilege Paradox: Geographic Areas with Highest Socio-economic Advantage Have the Lowest Rates of Vaccination’ (2019) 37(32) *Vaccine* 4525 <<https://doi.org/10.1016/j.vaccine.2019.06.060>>; Susan M Reverby, ‘Racism, Disease, and Vaccine Refusal: People of Color Are Dying for Access to COVID-19 Vaccines’ (2021) 19(3) *PLOS Biology* e3001167:1–3 <<https://doi.org/10.1371/journal.pbio.3001167>>.
- 41 Mohammad Razai et al, ‘COVID-19 Vaccine Hesitancy: The Five Cs to Tackle Behavioural and Sociodemographic Factors’ (2021) 114(6) *Journal of the Royal Society of Medicine* 295 <<https://doi.org/10.1177/01410768211018951>>.

including social or race-based inequities, may prevent access).⁴² However, the ‘five Cs’ have also been criticised for conflating personal and external causes of non-vaccination and allowing governments to avoid accountability for access problems of their own making.⁴³

Vaccine hesitancy has also stemmed from mistrust of biomedical innovation.⁴⁴ In recent decades, vaccine approval has taken up to 15 years, with additional time spent studying vaccines through post-marketing surveillance.⁴⁵ It is unsurprising, then, that concerns have been raised about the speed with which the COVID-19 vaccines were provisionally approved.⁴⁶ For some, these misgivings have not been allayed by assurances from government drug regulators that no safety data had been assessed prematurely or favourably.⁴⁷ For others, a fear of needles (affecting some 10% of people) has been a significant factor.⁴⁸ But COVID-19 vaccine hesitancy has also been fuelled by conspiracy theories and disinformation, especially online and in social media, where the notion that vaccines have been developed for profit by major pharmaceutical companies (‘Big Pharma’) has proliferated.⁴⁹

Empirical studies have shown that vaccine hesitancy is also a problem of shared social attitudes.⁵⁰ During the COVID-19 pandemic, some hesitant social influences were unavoidable. For example, in the United Kingdom, anti-vaccine activists issued counterfeit National Health Service (‘NHS’) pamphlets including false claims about the risks of COVID-19 to children.⁵¹ Similarly, in Australia, right-wing politician Craig Kelly sent misleading information to the mobile phones

42 Ibid.

43 See Bedford et al (n 6).

44 Lorenzo Palamenghi et al, ‘Mistrust in Biomedical Research and Vaccine Hesitancy: The Forefront Challenge in the Battle against COVID-19 in Italy’ (2020) 35(8) *European Journal of Epidemiology* 785 <<https://doi.org/10.1007/s10654-020-00675-8>>.

45 James E Hurford, ‘COVID-19 and Compulsory Vaccination: An Acceptable Form of Coercion?’ (2022) 28(1) *New Bioethics* 4, 18 <<https://doi.org/10.1080/20502877.2021.2010441>>.

46 Thomas May, ‘Anti-vaxxers, Politicization of Science, and the Need for Trust in Pandemic Response’ (2020) 25(10) *Journal of Health Communication* 761 <<https://doi.org/10.1080/10810730.2020.1864519>>.

47 See, eg, ‘Is It True? Were COVID-19 Vaccines Developed Too Quickly to Be Safe?’, *Department of Health (Cth)* (Web Page, 11 May 2021) <<https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/is-it-true/is-it-true-were-covid-19-vaccines-developed-too-quickly-to-be-safe>>; ‘Coronavirus Disease (COVID-19): Vaccines Safety’, *World Health Organization* (Web Page, 24 January 2022) <[https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-\(covid-19\)-vaccines-safety](https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-(covid-19)-vaccines-safety)>; ‘Safety of COVID-19 Vaccines’, *Centers for Disease Control and Prevention* (Web Page, 13 February 2023) <<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/safety/safety-of-vaccines.html>>.

48 Daniel Freeman et al, ‘Injection Fears and COVID-19 Vaccine Hesitancy’ (2023) 53(4) *Psychological Medicine* 1185 <<https://doi.org/10.1017/S0033291721002609>>.

49 Daniel Freeman et al, ‘COVID-19 Vaccine Hesitancy in the UK: The Oxford Coronavirus Explanations, Attitudes, and Narratives Survey (Oceans) II’ (2022) 52(14) *Psychological Medicine* 3127 <<https://doi.org/10.1017/S0033291720005188>>.

50 See, eg, Ángel V Jiménez, Joseph M Stubbersfield and Jamshid J Tehrani, ‘An Experimental Investigation into the Transmission of Antivax Attitudes Using a Fictional Health Controversy’ (2018) 215 *Social Science and Medicine* 23 <<https://doi.org/10.1016/j.socscimed.2018.08.032>>.

51 Zoe Tidman and Katherine Denkinson, ‘Anti-vaxxers Mock Up Leaflets Imitating NHS Documents and Cartoon Posters Targeting Children’, *The Independent* (online, 12 September 2021) <<https://www.independent.co.uk/news/uk/home-news/antivaxxers-covid-vaccine-telegram-leaflets-b1917305.html>>.

of many unwitting Australians, highlighting the putative dangers of vaccines.⁵² Elsewhere, far-fetched claims were made, including that COVID-19 vaccines can infect a person with the virus, implant microchips, cause sterilisation,⁵³ create a magnetic field in the body⁵⁴ or cause blindness.⁵⁵

Despite the widely acknowledged achievements of vaccination, vaccines have always engendered some controversy. Indeed, opposition to vaccination, especially compulsory vaccination, is as old as vaccination itself. The WHO has listed vaccine hesitancy in the top 10 global health threats of our time.⁵⁶ Understanding the history of the anti-vaccination movement can partly explain the ways in which different governments have responded to COVID-19. In this Part, we use the term ‘anti-vaccinationist’ to refer to vaccine objectors of the 19th century.⁵⁷ However, acknowledging that the label ‘anti-vaxxer’ is problematic, we describe those opposed to vaccines (for any reason, including external factors) as ‘vaccine objectors’.⁵⁸

A The United Kingdom⁵⁹

1 History of Vaccine Coercion

Inoculation for smallpox had long been practised in Africa and the East before it came to the attention of Lady Mary Wortley Montagu in the Ottoman Empire around 1717.⁶⁰ It was thence brought to England via the physician Charles Maitland.⁶¹ However, inoculation (or variolation) had its drawbacks. When a mild form of the smallpox virus was instilled subcutaneously, patients could develop

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- 52 Christopher Rudge, ‘The Therapeutic Goods Administration Has the Power to Stop Misleading Advertising. So Why Can’t It Stop Craig Kelly’s Texts?’, *The Conversation* (online, 28 September 2021) <<https://theconversation.com/the-therapeutic-goods-administration-has-the-power-to-stop-misleading-advertising-so-why-cant-it-stop-craig-kellys-texts-168083>>.
- 53 Alan Glasper, ‘Dispelling Anti-vaxxer Misinformation about COVID-19 Vaccination’ (2021) 30(6) *British Journal of Nursing* 374, 375 <<https://doi.org/10.12968/bjon.2021.30.6.374>>.
- 54 See, eg, Connie Schultz, ‘The Wrath of the Anti-vaxxers: Are They Magnetic Enough for You?’, *USA Today* (online, 11 June 2021) <<https://www.pressreader.com/usa/usa-today-us-edition/20210611/281646783082017>>.
- 55 Tidman and Denkinson (n 51).
- 56 ‘Ten Threats to Global Health in 2019’, *World Health Organization* (Web Page) <<https://www.who.int/news-room/spotlight/ten-threats-to-global-health-in-2019>>.
- 57 The term seems to capture the language, and denotes the existence, of the English Anti-vaccination League of the time: see, eg, Robert M Wolfe and Lisa K Sharp, ‘Anti-vaccinationists Past and Present’ (2002) 325 *British Medical Journal* 430 <<https://doi.org/10.1136/bmj.325.7361.430>>.
- 58 Jay Court et al, ‘Labels Matter: Use and Non-use of “Anti-vax” Framing in Australian Media Discourse 2008–18’ (2021) 291 *Social Science and Medicine* 114502:1–10 <<https://doi.org/10.1016/j.socscimed.2021.114502>>.
- 59 This section is devoted predominantly to England and Wales and does not detail the history of vaccination in Scotland or Northern Ireland. On these latter countries’ vaccination histories, see Deborah Brunton, *The Politics of Vaccination: Practice and Policy in England, Wales, Ireland, and Scotland, 1800–1874* (University of Rochester Press, 2008) <<https://doi.org/10.1017/UPO9781580467483>>.
- 60 Emine Ö Evered and Kyle T Evered, ‘Mandating Immunity in the Ottoman Empire: A History of Public Health Education and Compulsory Vaccination’ (2020) 6(11) *Heliyon* e05488:1–5, 1 <<https://doi.org/10.1016/j.heliyon.2020.e05488>>.
- 61 Ibid.

serious infections or become infected by other diseases (such as syphilis). Some patients even caused new outbreaks of smallpox by not isolating while infected with the inoculated form.⁶² The discovery of vaccination by Edward Jenner in 1798 transformed the procedure by using the milder cowpox virus to immunise patients. Because of this, vaccination was named after the Latin word for cow, 'vacca'. Vaccination made immunisation considerably less risky, even if it seemed counterintuitive to many.⁶³

For a time, inoculation and vaccination were voluntary; but in 1853, the British Government made smallpox vaccination compulsory for all children in England and Wales over three months old.⁶⁴ With broad consensus among the medical profession that universal childhood vaccination would extinguish smallpox epidemics, the compulsory rule was enacted without much public discussion or debate.⁶⁵ Smallpox was a pernicious disease that killed more than 30% of those infected.⁶⁶ It also often blinded, disabled or deformed those who survived.⁶⁷ Given the horrific effects of this disease, opposition to vaccination may now seem unthinkable. Yet, the advent of compulsory vaccination with smallpox gave rise to a fierce anti-vaccination movement in Britain.⁶⁸ Notably, with the enactment of the compulsory vaccination legislation, some employers threatened to dismiss those adult employees who could not produce proof of smallpox vaccination.⁶⁹

The objections of the 19th century anti-vaccinationists were advanced on two chief grounds, resembling the kinds of objections prevalent among vaccine objectors today. The first related to the safety and efficacy of vaccination. Suspicion had arisen about the transplantation into humans of the lymph glands of a diseased cow (a 'lower species' of God's creatures).⁷⁰ Some outlandish claims were circulated, including that vaccination could transform one into a cow or give one bovine-like characteristics.⁷¹ A popular conspiracy theory postulated that

62 Stefan Riedel, 'Edward Jenner and the History of Smallpox and Vaccination' (2005) 18(1) *Baylor University Medical Center Proceedings* 21, 22 <<https://doi.org/10.1080/08998280.2005.11928028>>.

63 Ibid. See also Patricia Fara, 'The Original Anti-vaxxers', *History Today* (online, 1 January 2021) <<https://www.historytoday.com/archive/history-matters/original-anti-vaxxers>>.

64 *Vaccination Act 1853* (UK). See also Brunton (n 59) 11–19.

65 *Royal Commission Appointed to Inquire into the Subject of Vaccination* (Final Report, 1896) 217–18 [282] <<https://iiif.wellcomecollection.org/pdf/b21361356>>.

66 Michael H Hsieh and Margaret M Mentink-Kane, 'Smallpox and Dracunculiasis: The Scientific Value of Infectious Diseases That Have Been Eradicated or Targeted for Eradication' (2016) 12(1) *PLOS Pathogens* e1005298:1–4, 1 <<https://doi.org/10.1371/journal.ppat.1005298>>.

67 Stanley Williamson, *The Vaccination Controversy: The Rise, Reign and Fall of Compulsory Vaccination for Smallpox* (Liverpool University Press, 2007) 11 <<https://doi.org/10.5949/UPO9781846314216>>.

68 See Nadja Durbach, *Bodily Matters: The Anti-vaccination Movement in England, 1853–1907* (Duke University Press, 2005) 38–68 <<https://doi.org/10.1215/9780822386506>>.

69 Nadja Durbach, "'They Might as Well Brand Us": Working-Class Resistance to Compulsory Vaccination in Victorian England' (2000) 13(1) *Social History of Medicine* 45, 48 <<https://doi.org/10.1093/shm/13.1.45>> ('Working-Class Resistance to Compulsory Vaccination').

70 Fara (n 63).

71 Ibid.

the medical profession's self-interest and desire for profit rendered practitioners incapable of evaluating vaccination objectively.⁷²

The second ground of objection related to the 'liberty of the subject'. Objectors warned against government interference in private matters (parental authority, the body, religion and 'the sanctity of the home') while stoking fear of medical elites who were alleged to hold power over individuals' lives.⁷³ Religious objections included that vaccination was 'un-Christian' as to 'propagate disease [through vaccination] is to fly in the face of God'.⁷⁴ Moral critics alleged compulsory vaccination unfairly targeted the lower classes – a group stigmatised for being dirty and diseased and already subject to coercive state control by the New Poor Laws of the 1830s.⁷⁵ While some vaccine objectors were fined or had their furniture repossessed, 'martyrs' were imprisoned.⁷⁶ In 1865, around 20,000 people protested compulsory vaccination in the streets of Leicester.⁷⁷

Vaccination in the 19th century was less sanitary than today. The crude process led many prominent members of the medical profession to raise concerns about its safety.⁷⁸ A 'public vaccinator' would extract cellular matter ('lymph') from blisters on an infant's arm some eight days after vaccination and then transfer that lymph to another patient's arm.⁷⁹ Many parents worried vaccination would convey other diseases, such as consumption, leprosy or syphilis.⁸⁰ Vaccination also left scars.⁸¹ The working classes objected to receiving cellular tissue from 'paupers' who they viewed as lower on the social stratum and from whom they felt distinguished.⁸² Additionally, the procedure was not always performed competently, with complications leading to adverse events. Unfortunately, anti-vaccinators attributed almost any death or injury following the procedure to vaccination, often erroneously.⁸³

The nascent state of 19th century scientific knowledge made it difficult to determine whether vaccination prevented smallpox infection efficaciously. Statistical data were patchy and some scientists believed reduced smallpox mortality could be attributed to other factors, including improved sanitation and

72 Martin Fichman and Jennifer E Keelan, 'Resister's Logic: The Anti-vaccination Arguments of Alfred Russel Wallace and Their Role in the Debates over Compulsory Vaccination in England, 1870–1907' (2007) 38(3) *Studies in History and Philosophy of Biological and Biomedical Sciences* 585, 588 <<https://doi.org/10.1016/j.shpsc.2007.06.006>>.

73 Williamson (n 67) 182; Karen Walloch, *The Antivaccine Heresy: Jacobson v Massachusetts and the Troubled History of Compulsory Vaccination in the United States* (University of Rochester Press, 2015) 3.

74 Williamson (n 67) 180.

75 Durbach, 'Working-Class Resistance to Compulsory Vaccination' (n 69) 49.

76 Fichman and Keelan (n 72) 585, 592.

77 Daniel A Salmon et al, 'Compulsory Vaccination and Conscientious or Philosophical Exemptions: Past, Present, and Future' (2006) 367(9508) *The Lancet* 436, 436 <[https://doi.org/10.1016/S0140-6736\(06\)68144-0](https://doi.org/10.1016/S0140-6736(06)68144-0)>.

78 Fichman and Keelan (n 72) 589.

79 Williamson (n 67) 123.

80 Ibid 127, 225.

81 Ibid 147.

82 Durbach, 'Working-Class Resistance to Compulsory Vaccination' (n 69) 53.

83 Walloch (n 73) 2, 16.

nutrition.⁸⁴ By the 1820s, it was clear that one vaccination would not guarantee life-long protection and that revaccination was usually required.⁸⁵

While anti-vaccinators regarded themselves as ‘conscientious objectors’, the medical establishment and press, which accepted that the benefits of the procedure outweighed the risks, viewed them with disdain.⁸⁶ This tension between mainstream practitioners and laypeople meant that vaccination continued to be politically contentious. In 1889, a Royal Commission on Vaccination was conducted to scrutinise the treatment’s efficacy.⁸⁷ In its final report, the Commission recommended all vaccinations use calf rather than human lymph to minimise the ‘extremely small’ risk that other diseases could be transmitted.⁸⁸ While the Commission did not endorse abolishing compulsory vaccination, it recognised public distaste for the mandate and recommended a scheme be established through which honest objectors (as opposed to the merely complacent or apathetic) could register an objection and reasonable excuse. By doing so, objectors could avoid liability for not vaccinating their children.⁸⁹

As disputes arose involving unvaccinated children, however, some magistrates refused to grant objector parents the protection of this ‘reasonable excuse’ exemption. This remained a source of disaffection until 1907, when 100 anti-vaccinationists were elected to Parliament and removed all remaining barriers to exemption.⁹⁰ By 1946, half the population of England had obtained exemptions and, accordingly, the compulsory vaccination requirements were repealed altogether. Ironically, the repeal followed a successful voluntary diphtheria vaccination scheme that reduced the case load from 46,000 in 1940 to just 952 in 1950.⁹¹ In ensuing years, vaccination rates plummeted during periods of normalcy (attributed to ‘apathy’) but rose again during outbreaks.⁹²

Whether it be conceptualised as a social movement or as a disparate group of disaffected individuals,⁹³ a collective strain of anti-vaccination sentiment swelled in 1998 when *The Lancet* published an article lead-authored by Andrew Wakefield.⁹⁴ The article, which was fraudulent, was later retracted; and Wakefield, a

84 Alfred Russel Wallace was among the most prominent: see Fichman and Keelan (n 72) 585–6.

85 Walloch (n 73) 16.

86 Ibid 2.

87 *Royal Commission Appointed to Inquire into the Subject of Vaccination* (n 65).

88 Ibid 113–14 [433], [437].

89 Ibid 137 [525].

90 Salmon et al (n 77) 436, 438.

91 Gareth Millward, *Vaccinating Britain: Mass Vaccination and the Public since the Second World War* (Manchester University Press, 2019) 202.

92 Ibid.

93 See Stuart Blume, ‘Anti-vaccination Movements and Their Interpretations’ (2006) 62(3) *Social Science and Medicine* 628, 638 <<https://doi.org/10.1016/j.socscimed.2005.06.020>>.

94 See Matthew Motta and Dominik Stecula, ‘Quantifying the Effect of Wakefield et al (1998) on Skepticism about MMR Vaccine Safety in the US’ (2021) 16(8) *PLOS ONE* e0256395:1–9 <<https://doi.org/10.1371/journal.pone.0256395>>. For the retracted article, see AJ Wakefield et al, ‘Ileal-Lymphoid-Nodular Hyperplasia, Nonspecific Colitis, and Pervasive Developmental Disorder in Children’ (1998) 351 *The Lancet* 367 <[https://doi.org/10.1016/S0140-6736\(97\)11096-0](https://doi.org/10.1016/S0140-6736(97)11096-0)>.

gastroenterologist, was subsequently deregistered.⁹⁵ The article linked the measles, mumps and rubella (‘MMR’) vaccination to autism and bowel disease.⁹⁶ Even with a strong medical education campaign, MMR vaccination dropped from 92% in 1996 to 80% in 2004.⁹⁷ This decline precipitated various outbreaks of measles (including those in the United States of 2010–12)⁹⁸ and signalled the power of vaccine misinformation.⁹⁹

2 COVID-19 Vaccine Coercion

In the post-war era, Britain has relied on public health education to advance its vaccination programs. After much debate, the British Government decided against both adopting mandates for COVID-19 vaccination and vaccine passports (other than for care home workers for a short period).¹⁰⁰ While the *Public Health (Control of Disease) Act 1984* (UK) (‘PH Act’) prohibits the Secretary of State from making regulations that mandate medical treatments, including vaccination,¹⁰¹ there is no legal or human rights restriction on the power of Parliament to pass primary legislation mandating vaccination.¹⁰² For instance, the legality of a vaccine mandate requiring the vaccination of workers in care homes was upheld on appeal by the High Court in *R (Peters) v Secretary of State for Health and Social Care* (‘Peters’).¹⁰³

In *Peters*, the applicants challenged a regulation¹⁰⁴ that purported to impose a requirement that all care home workers be vaccinated with ‘an authorised vaccine’ unless they held a medical exemption. They challenged the regulation on five grounds, including that it was ultra vires for being inconsistent with section 45E of the *PH Act*.¹⁰⁵ Whipple J rejected all five grounds of the applicants’ challenge and found the regulation to be lawful. Her Honour held that its express purpose was to reduce the spread of COVID-19 in care homes and protect residents vulnerable to the disease.¹⁰⁶ Whipple J also found the Government had not erred in law since

95 Brian Martin, ‘On the Suppression of Vaccination Dissent’ (2015) 21(1) *Science and Engineering Ethics* 143, 149–51 <<https://doi.org/10.1007/s11948-014-9530-3>>.

96 Fiona Godlee, Jane Smith and Harvey Marcovitch, ‘Wakefield’s Article Linking MMR Vaccine and Autism Was Fraudulent’ (2011) 342 *British Medical Journal* 64 <<https://doi.org/10.1136/bmj.c7452>>.

97 Millward (n 91) 202.

98 Similar outbreaks occurred in 2019 and 2022: see ‘Measles (Rubeola): Cases and Outbreaks’, *Centers for Disease Control and Prevention* (Web Page, 6 February 2023) <<https://www.cdc.gov/measles/cases-outbreaks.html>>. There was also a polio outbreak in 2022: see ‘Detection of Circulating Vaccine Derived Polio Virus 2 (cVDPV2) in Environmental Samples: The United Kingdom of Great Britain and Northern Ireland and the United States of America’, *World Health Organization* (Web Page, 14 September 2022) <<https://www.who.int/emergencies/disease-outbreak-news/item/2022-DON408>>.

99 Millward (n 91) 202.

100 From November 2020 to 15 March 2021: see *Health and Social Care Act 2008 (Regulated Activities) (Amendment) (Coronavirus) Regulations 2021* (UK) SI 2021/891 (‘*Health and Social Care Amendment Regulations*’).

101 *Public Health (Control of Disease) Act 1984* (UK) s 45E.

102 Hurford (n 45) 9.

103 [2021] EWHC 3182 (Admin) (‘Peters’).

104 *Health and Social Care Amendment Regulations* (n 100) reg 5(3)(b).

105 *Peters* (n 103) [7]–[11] (Whipple J).

106 Ibid [19]–[20].

there was ‘a discretion afforded to Government – a broad discretion – to determine policy decisions of this nature’.¹⁰⁷ Her Honour rejected the argument that the regulation was a ‘mandate’, as care home workers had a choice as to whether they complied with it and so maintained their employment.¹⁰⁸ Her Honour’s judgment embraced reasoning from a recent decision of the European Court of Human Rights that had upheld mandatory school vaccination: namely, *Vavříčka v Czech Republic* (discussed in Part IV).¹⁰⁹

On 6 January 2022, the United Kingdom Government tabled regulations to extend the vaccine mandate for care home workers to all healthcare workers through to April 2022, thus requiring all staff to receive a first dose of the vaccine by 3 February 2022 or risk dismissal.¹¹⁰ Human resources departments contacted unvaccinated employees and reassured them about vaccine safety, resulting in 130,000 staff undergoing vaccination.¹¹¹ But the extension of the mandate was controversial. On 24 January 2022, the House of Commons debated a petition containing over 200,000 signatures opposing the healthcare worker vaccination mandate.¹¹² Concerns were raised that some 5% of the NHS workforce would miss the deadline, jeopardising already strained health services through additional staff losses.¹¹³ Research into the attitudes of health workers indicated that only 18% supported the mandates, with many more (32%) preferring education.¹¹⁴ On 31 January 2022, the Health Secretary announced a consultation on the mandate.¹¹⁵ Then, when the results of this consultation were published on 1 March 2022, the Government announced it would revoke the mandate, explaining that the Omicron variant meant the risk profile of the pandemic had changed: the virus was less deadly and vaccines less effective.¹¹⁶

B Australia

1 History of Vaccine Coercion

From British conquest until Federation, vaccination through lymph was introduced into the new self-governing colonies on several occasions. From 1804

107 Ibid [21].

108 Ibid [9].

109 *Vavříčka v Czech Republic* (European Court of Human Rights, Grand Chamber, Application Nos 47621/13, 3867/14, 73094/14, 19298/15, 19306/15 and 43883/15, 8 April 2021) (*‘Vavříčka’*).

110 Martin McKee and May C I van Schalkwyk, ‘England’s U Turn on COVID-19 Vaccine Mandate for NHS Staff’ (2022) 376 *British Medical Journal* 323 <<https://doi.org/10.1136/bmj.o353>>.

111 Ibid.

112 United Kingdom, *Parliamentary Debates*, House of Commons, 24 January 2022, vol 707, cols 233–58.

113 Ibid.

114 Katherine Woolf et al, ‘Healthcare Workers’ Views on Mandatory SARS-CoV-2 Vaccination in the UK: A Cross-Sectional, Mixed-Methods Analysis from the UK-REACH Study’ (2022) 46 *The Lancet* 101346:1–15, 1 <<https://doi.org/10.1016/j.eclinm.2022.101346>>.

115 Ibid 2.

116 Department of Health and Social Care (UK), ‘Consultation Outcome: Revoking Vaccination as a Condition of Deployment across All Health and Social Care’ (Consultation Paper, 1 March 2022) <<https://www.gov.uk/government/consultations/revoking-vaccination-as-a-condition-of-deployment-across-all-health-and-social-care/revoking-vaccination-as-a-condition-of-deployment-across-all-health-and-social-care#the-proposed-way-forward>>.

onwards, the colonial populations were protected by such inoculations sporadically.¹¹⁷ Though not always strictly enforced, compulsory quarantine and vaccination legislation was adopted in some parts of the continent in the mid-19th century.¹¹⁸ The colonies of South Australia and Tasmania (which adopted Britain's Act in 1853),¹¹⁹ Victoria (in 1874)¹²⁰ and Western Australia (in 1878) all enacted compulsory vaccine laws.¹²¹ By contrast, New South Wales ('NSW') did not legislate strict compulsion, despite several attempts.¹²² Instead, NSW offered free facilities for those wishing to be vaccinated; a public vaccinator was appointed and they received a payment for each vaccination administered.¹²³ Although several smallpox scares occurred throughout the 19th century (with smallpox 'always present in some part of [Australia]'), the colonies' compulsory quarantine rules and the inspection of ships for ill passengers meant they had considerable success in preventing widespread infection, with some noting that Australia had remained 'remarkably free' of the disease.¹²⁴ Despite this, it is now widely acknowledged that smallpox had a catastrophic impact on the Indigenous peoples around Sydney Cove.¹²⁵

After Federation, several vaccination programs were administered by the states and territories and delivered into Australian schools, including for the diphtheria-tetanus toxoid vaccine (from 1932 to 1936), the Bacille Calmette-Guerin vaccine (from the 1940s to the 1980s) and the polio vaccine (in the 1950s and 1960s).¹²⁶ A rubella vaccine program was implemented for schoolgirls in the early 1970s but was eventually replaced by the combined MMR vaccine program for all school students (boys and girls) in 1993. In the early 1990s, NSW and Victoria introduced legislation to require proof of immunisation when a child enrolled in primary school.¹²⁷

In 1993, the first Australian National Immunisation Strategy was published. It recommended against compulsory vaccination and recognised conscientious

117 See Rebekah McWhirter, "'Lymph or Liberty': Responses to Smallpox Vaccination in the Eastern Australian Colonies" (PhD Thesis, University of Tasmania, 2008) 2 <<https://eprints.utas.edu.au/8077/2/02Whole.pdf>>.

118 See, eg, *Royal Commission Appointed to Inquire into the Subject of Vaccination* (n 65) 128–30 [495]–[498].

119 *Vaccination Act 1853* (SA); 'Eldershaw Lecture: Keeping Tasmanians Safe', *Tasmanian Historical Research Association* (Web Page, 12 April 2022) <<https://thra.org.au/events/eldershaw-lecture-keeping-tasmanians-safe-smallpox-quarantine-and-vaccination-nineteenth>>.

120 *Compulsory Vaccination Act 1874* (Vic).

121 *Vaccination Act 1878* (WA).

122 See JHL Cumpston, *Health and Disease in Australia: A History* (Australian Government Publishing Service, 1989) 188; Peter Curson, *Deadly Encounters: How Infectious Disease Helped Shape Australia* (Arena Books, 2015) 37–43; Frank H Beard, Julie Leask and Peter B McIntyre, 'No Jab, No Pay and Vaccine Refusal in Australia: The Jury Is Out' (2017) 206(9) *Medical Journal of Australia* 381 <<https://doi.org/10.5694/mja16.00944>>.

123 JHL Cumpston and F McCallum, 'The History of Smallpox in Australia, 1909–1923' (1926) 40(33) *Public Health* 63 <[https://doi.org/10.1016/S0033-3506\(26\)80034-4](https://doi.org/10.1016/S0033-3506(26)80034-4)>.

124 See *ibid* 63; *Royal Commission Appointed to Inquire into the Subject of Vaccination* (n 65) 130–1 [500].

125 See, eg, Michael J Bennett, 'Smallpox and Cowpox under the Southern Cross: The Smallpox Epidemic of 1789 and the Advent of Vaccination in Colonial Australia' (2009) 83(1) *Bulletin of the History of Medicine* 37, 59–60 <<https://doi.org/10.1353/bhm.0.0167>>.

126 Kirsten Ward et al, 'A History of Adolescent School-based Vaccination in Australia' (2013) 37(2) *Communicable Diseases Intelligence* E168, E168.

127 See *Health (Amendment) Act 1990* (Vic); *Public Health (Amendment) Act 1992* (NSW).

objection as a legitimate ground for vaccine refusal.¹²⁸ In 1996, a national register of vaccination, the Australian Childhood Immunisation Register ('ACIR'), was established to collect data on vaccinations for children seven years of age and younger, including data about conscientious objections.¹²⁹ Since then, several other registers have been maintained by government at the state and territory level, together with databases maintained by general practitioners.¹³⁰

In 1998, the Immunise Australia Program implemented a more coercive approach to vaccines, linking eligibility for welfare (family assistance) payments to proof of vaccination.¹³¹ School-based vaccination programs were further developed in the late 1990s and early 2000s with the implementation of several 'whole of school' programs.¹³² In the years that followed, coverage for vaccines grew. In 1991, 75% of children aged 12 months had been vaccinated; in 2001, the figure was 94%.¹³³

In the early 2000s, vaccine objections increased from 0.23% (1999) to 1.34% (2015).¹³⁴ To reduce this growing rate of objection, the Australian Government introduced the so-called 'No Jab No Pay' scheme in 2015.¹³⁵ Operative from January 2016, the new framework abolished the conscientious objection exemption and linked several social security payments (with a value of up to \$15,000 per year)¹³⁶ to proof of vaccination.¹³⁷ Around the same time, five state governments (Victoria, NSW, Queensland, South Australia and Western Australia) introduced 'No Jab, No Play' policies, prohibiting or restricting the enrolment of unvaccinated children in early childcare services.¹³⁸ Thus, overall, Australian governments have grown

128 See National Health and Medical Research Council, 'National Immunisation Strategy' (Strategy, April 1993) ix.

129 LK Chin et al, 'Australian Immunisation Registers: Established Foundations and Opportunities for Improvement' (2012) 17(16) *Eurosurveillance* 20148:1–8, 2 <<https://doi.org/10.2807/ese.17.16.20148-en>>.

130 Ibid. See also Wolfgang Maurer et al, 'Standardization and Simplification of Vaccination Records' (2014) 13(4) *Expert Review of Vaccines* 545 <<https://doi.org/10.1586/14760584.2014.892833>>.

131 Kirsten Ward, Brynley P Hull and Julie Leask, 'Financial Incentives for Childhood Immunisation: A Unique but Changing Australian Initiative' (2013) 198(11) *Medical Journal of Australia* 590 <<https://doi.org/10.5694/mja12.10820>>.

132 These included the National Measles Control Campaign in 1998 and the National Meningococcal C Vaccination Program in 2003. See Department of Health and Aged Care (Cth), *Let's Work Together to Beat Measles: A Report on Australia's Measles Control Campaign* (Report, 2000) <<https://vaccinateyourchildren.files.wordpress.com/2010/05/beatmeasles.pdf>>; Natalie J Cohen, 'Introduction of the National Meningococcal C Vaccination Program' (2003) 27(2) *Communicable Diseases Intelligence* 161, 161–162; Ward et al (n 126) E169.

133 Salmon et al (n 77) 438.

134 Department of Health and Aged Care (Cth), *Australian Immunisation Register: National Vaccine Objection (Conscientious Objection) Data, 1999 to 2015* (Report, 23 March 2018) <<https://www.health.gov.au/sites/default/files/national-vaccine-objection-conscientious-objection-data-1999-to-2015.pdf>>.

135 See *Social Services Legislation Amendment (No Jab, No Pay) Act 2015* (Cth).

136 Ang Li and Mathew Toll, 'Removing Conscientious Objection: The Impact of "No Jab No Pay" and "No Jab No Play" Vaccine Policies in Australia' (2021) 145 *Preventive Medicine* 106406:1–16, 2 n 2 <<https://doi.org/10.1016/j.ypmed.2020.106406>>.

137 Ibid.

138 Katie Attwell and Shevaun Drislane, 'Australia's "No Jab No Play" Policies: History, Design and Rationales' (2022) 46(5) *Australian and New Zealand Journal of Public Health* 640 <<https://doi.org/10.1111/1753-6405.13289>>.

increasingly strict in requiring vaccination since the 1990s, primarily in response to parental apathy, vaccine hesitancy, pursuing the goal of ‘herd immunity’ and limited civil society opposition.¹³⁹

Vaccination requirements in Australia apply to both permanent and temporary residents (eg, international students). Section 60 of the *Migration Act 1958* (Cth) provides that medical examinations may be carried out on all visa applicants or anyone seeking entry to Australia.¹⁴⁰ The relevant administrative form characterises the legislative provision as one that authorises the Department of Home Affairs (Cth) to ‘collect personal information’ about an applicant’s health status, including their vaccination history.¹⁴¹ As has been observed, this ‘compulsion’ for medical screening ‘currently engenders very little public or political debate, although it has [done so] in the past’.¹⁴² In practice, ‘vaccine screening’ invariably takes place offshore, with visa applicants required to meet all health requirements (including vaccinations) in their country-of-application and to produce a record of compliance to immigration officials on arrival.

To prove they have been screened, visa applicants may present the International Certificate of Vaccination or Prophylaxis (‘ICVP’), otherwise known as the ‘Yellow Card’ or *carte jaune*.¹⁴³ The ICVP is a ‘medical passport’ issued by the WHO to those vaccinated in accordance with the *International Health Regulations (2005)* (‘IHR’).¹⁴⁴ The IHR was adopted by the WHO Health Assembly in 1969 and initially defined ‘quarantinable diseases’ as ‘cholera, including cholera due to the eltor vibrio, plague, smallpox, including variola minor (alastrim), and yellow fever’.¹⁴⁵ Smallpox was removed in 1981 after it was eradicated. Today, the regulations are more flexible, with some diseases being always notifiable (eg, smallpox and SARS) and others becoming notifiable when Member States declare a public health emergency of international concern (‘PHEIC’).¹⁴⁶ Since 2005, the list of PHEIC notifiable diseases includes Influenza A (H1N1), Poliovirus, Ebola (Western Africa and Democratic Republic of Congo), Zika, COVID-19 and Monkeypox.¹⁴⁷ However, the only disease specifically designated for which proof

139 Ibid 640, 645; McCoy (n 21) 844 ff.

140 *Migration Act 1958* (Cth) s 60.

141 See Department of Home Affairs (Cth), ‘Medical Examination for an Australian Visa’ (Form No 26, August 2021) <<https://immi.homeaffairs.gov.au/form-listing/forms/26.pdf>>.

142 Ian Convery, John Welshman and Alison Bashford, ‘Where Is the Border? Screening for Tuberculosis in the United Kingdom and Australia, 1950–2000’ in Alison Bashford (ed), *Medicine at the Border: Disease, Globalization and Security, 1850 to the Present* (Palgrave Macmillan, 2007) 97, 99 <https://doi.org/10.1057/9780230288904_6>.

143 World Health Organization, *International Health Regulations (2005)* (WHO Press, 3rd ed, 2016) annex 6 <<https://www.who.int/publications/i/item/9789241580496>> (‘IHR’); Department of Health (Cth), ‘National Guidelines for Yellow Fever Vaccination Centres and Providers’ (Guidelines, November 2018) 3.

144 See IHR (n 143) annex 6 item 2.

145 World Health Organization, *International Health Regulations (1969)* (WHO Press, 1st ed, 1969) 8.

146 See Annelies Wilder-Smith and Sarah Osman, ‘Public Health Emergencies of International Concern: A Historic Overview’ (2020) 27(8) *Journal of Travel Medicine* 1, 8 <<https://doi.org/10.1093/jtm/taaa227>>.

147 See Claire Wenham and Mark Ecclestone-Turner, ‘Monkeypox as a PHEIC: Implications for Global Health Governance’ (2022) *The Lancet* 400(10369) 2169, 2169–70 <[https://doi.org/10.1016/S0140-6736\(22\)01437-4](https://doi.org/10.1016/S0140-6736(22)01437-4)>.

of vaccination may be required under the *IHR* by travellers to Member States is yellow fever.¹⁴⁸

Travellers to Australia are required to comply with the *IHR* and must be vaccinated against yellow fever, as well as other diseases from time to time.¹⁴⁹ Where a true vaccine contraindication exists, a traveller may present a signed letter written by a doctor that clearly states the reason for non-vaccination. Such a letter, however, does not oblige a destination country to permit entry to the applicant, as was illustrated in *Djokovic v Minister for Immigration, Citizenship, Migrant Services and Multicultural Affairs* (*'Djokovic FCA'*).¹⁵⁰ In *Djokovic FCA*, the applicant provided a letter purporting to exempt him from COVID-19 vaccination, signed by two medical specialists said to comprise an 'Independent Expert Medical Review Panel' and commissioned by Tennis Australia. That letter, however, was ultimately rejected by the Minister for Home Affairs. Furthermore, in circumstances where the Minister for Immigration was satisfied the applicant was a risk to the health and good order of the Australian community, the Full Court of the Federal Court of Australia found that the doctor's letter was no bar to the Minister's exercise of their personal powers to cancel the applicant's visa.¹⁵¹

There is historical precedent for the mandatory vaccination of healthcare workers in Australia. In early 2007, the NSW Department of Health issued the Occupational Assessment, Screening and Vaccination against Specified Diseases Policy Directive (*'NSW Directive'*).¹⁵² It required all health workers, including students and volunteers, to demonstrate protection from infectious diseases (including measles, mumps, rubella, diphtheria, tetanus, pertussis, hepatitis B, and varicella) and to be screened for tuberculosis.¹⁵³ The most recent version of the policy includes a requirement for influenza vaccination by 1 June each year.¹⁵⁴ While knowledge of the policy directive was poor initially, some 78% of health workers supported it.¹⁵⁵ Two years later, in 2011, support for the policy was higher still at 83% and then 91% (although less support was shown for including

148 World Health Assembly, *Implementation of the International Health Regulations (2005)*, WHA Res WHA67.13, 9th plen mtg, Agenda Item 16.1, UN Doc A67/VR/9 (24 May 2014, adopted 11 July 2016) annex 7 [1], [2](a)(iii)–(iv).

149 *World Health Organization Act 1947* (Cth) s 5.

150 (2022) 289 FCR 21, 31 [52] (The Court) (*'Djokovic FCA'*); *Djokovic v Minister for Immigration, Citizenship, Migrant Services and Multicultural Affairs* (2022) 366 FLR 163, 175 [55] (Kelly J) (*'Djokovic Initial Application'*).

151 See *Djokovic FCA* (n 150) 43 [104]; *Djokovic Initial Application* (n 150) 175 [55].

152 Department of Health (NSW), 'Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases' (Policy Directive No PD2007_006, 1 February 2007) <https://web.archive.org/web/20080921075508/http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_006.pdf>.

153 Holly Seale, Julie Leask and C Raina MacIntyre, 'Do They Accept Compulsory Vaccination? Awareness, Attitudes and Behaviour of Hospital Health Care Workers following a New Vaccination Directive' 27(23) (2009) *Vaccine* 3022, 3022 <<https://doi.org/10.1016/j.vaccine.2009.03.038>> (*'Do They Accept Compulsory Vaccination?'*).

154 Department of Health (NSW), 'Occupational Assessment, Screening and Vaccination against Specified Infectious Diseases' (Policy Directive No PD2022_030, 28 July 2022) 21 <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/PD2022_030.pdf>.

155 Seale, Leask and MacIntyre, 'Do They Accept Compulsory Vaccination?' (n 153) 3024.

influenza).¹⁵⁶ As will be discussed in what follows, reference to the NSW Directive was made in the reasons of the Supreme Court of New South Wales in *Larter v Hazzard [No 2]* (*‘Larter’*), where the Court held that COVID-19 vaccine mandates for health workers were lawful.¹⁵⁷

2 COVID-19 Vaccine Coercion

Though the Australian Government did not introduce COVID-19 vaccination mandates or vaccine passports, it did not prevent state and territory Health Ministers from doing so. Proposed anti-mandate legislation, such as the COVID-19 Vaccination Status (Prevention of Discrimination) Bill 2021, introduced into the Senate by One Nation Leader, Pauline Hanson, failed to pass,¹⁵⁸ as did similar Bills.¹⁵⁹ However, the Government agreed to introduce a limited vaccine injury compensation scheme.¹⁶⁰ Existing arrangements under the 2020–25 National Health Reform Agreement were maintained, so that all residential and community aged care and disability providers were (and still are) required to report numbers of vaccinated employees to the Department of Health (Cth).¹⁶¹

Every Australian state and territory has introduced a COVID-19 vaccine mandate scheme of different strictness for particular groups and lengths of time. In addition, all states introduced mandates for aged care, health and disability workers,¹⁶² some of which remain in place for health and aged care workers in

156 Ibid. Cf Holly Seale, Julie Leask and C Raina MacIntyre, ‘Awareness, Attitudes and Behavior of Hospital Healthcare Workers towards a Mandatory Vaccination Directive: Two Years On’ (2011) 29(21) *Vaccine* 3734 <<https://doi.org/10.1016/j.vaccine.2011.03.050>>.

157 [2021] NSWSC 1451 (*‘Larter’*).

158 COVID-19 Vaccination Status (Prevention of Discrimination) Bill 2021 (Cth). See also Tom Stayner, ‘Jacqui Lambie Slams Pauline Hanson’s Claim Vaccine Mandates Amount to “Discrimination”’, *SBS News* (online, 22 November 2021) <<https://www.sbs.com.au/news/article/jacqui-lambie-slams-pauline-hansons-claim-vaccine-mandates-amount-to-discrimination/vxs1qcey4>>.

159 See, eg, the No Domestic COVID Vaccine Passports Bill 2021 (Cth) introduced into the House of Representatives by Craig Kelly.

160 Department of Health and Aged Care (Cth), ‘No Fault COVID-19 Indemnity Scheme’ (Media Release, 28 August 2021) <<https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/no-fault-covid-19-indemnity-scheme>>; Katie Attwell, Shevaun Drislane and Julie Leask, ‘Mandatory Vaccination and No Fault Vaccine Injury Compensation Schemes: An Identification of Country-Level Policies’ (2019) 37(21) *Vaccine* 2843 <<https://doi.org/10.1016/j.vaccine.2019.03.065>>.

161 See ‘Mandatory COVID-19 Vaccination Reporting’, *Department of Health and Aged Care (Cth)* (Web Page, 17 August 2022) <<https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/information-for-aged-care-providers-workers-and-residents-about-covid-19-vaccines/mandatory-covid-19-vaccination-reporting>>. See also Australian Health Ministers, *National Health Reform Agreement (NHRA): Long-Term Health Reforms Roadmap* (Report, 17 September 2021) <<https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-10/NHRA-longterm-reforms-roadmap.PDF>>.

162 See, eg, *Public Health (Aged Care Workers and Visitors COVID-19 Vaccination) Emergency Direction (No 2) 2021* (ACT); *Public Health (COVID-19 Care Services) Order (No 3) 2022* (NSW); *COVID-19 Directions (No 55) 2021* (NT); *COVID-19 Vaccination Requirements for Workers in Residential Aged Care and Disability Accommodation Services Direction 2022* (Qld); *Emergency Management (Healthcare Setting Workers Vaccination No 7) (COVID-19) Direction 2022* (SA); Tasmania, *Tasmanian Government Gazette*, No 22 138, 12 November 2021; *Pandemic COVID-19 Mandatory Vaccination (Specified Facilities) Order 2022 (No 7)* (Vic); *Disability Support Accommodation Worker (Restrictions on Access) Directions 2022* (WA).

Victoria and health workers in Queensland.¹⁶³ In late 2021, the two states worst affected by COVID-19 community transmission – NSW and Victoria – mandated vaccination and implemented a vaccine passport scheme. These states linked the ‘easing’ of lockdowns and public health restrictions to vaccination targets of, respectively, 70% and 80%, requiring all eligible people to be vaccinated with two doses in accordance with a National Plan.¹⁶⁴

In NSW, the *Public Health (COVID-19 Additional Restrictions for Delta Outbreak) Order (No 2) 2021* (NSW) prevented ‘authorised workers’ in ‘areas of concern’ from leaving their local area without receiving one dose of a vaccine.¹⁶⁵ Conversely, after construction sites were found to have significant COVID-19 transmission, Victoria extended its mandate requirements to construction workers and all ‘approved workers’ (a long list of essential workers able to leave home during the lockdown), sparking days of protests.¹⁶⁶ NSW introduced a vaccine passport system restricting the activities of restaurants, shops and public events between October and December 2021, while in some other states, the ‘vaccinated economy’ continued until as late as April 2022.¹⁶⁷ While NSW withdrew all vaccination mandates in April 2022 (except those relating to working with vulnerable people), Victoria continued to mandate ‘boosters’ for workers in health, aged and disability care, education, and meat and food processing (with exceptions for those who had a recent infection or were exempt on medical grounds).¹⁶⁸

States and territories with no significant COVID-19 community transmission sought to prevent an influx of infection and incentivise vaccination by linking high vaccination rates with state border openings.¹⁶⁹ Among them, Western Australia had the most extensive vaccine mandates. These industry-specific mandates covered around 75% of workers and required mandatory ‘booster’ (additional dosage) shots before the border was reopened.¹⁷⁰ The result was that Western Australia has had the highest level of secondary vaccination in Australia (83.2%), translating to

163 See ‘COVID-19 Vaccination for Workers’, *Queensland Government* (Web Page, 1 February 2023) <<https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/business/vaccination-for-workers>>; ‘Vaccination for Healthcare Workers’, *Department of Health (Vic)* (Web Page, 8 November 2022) <<https://www.health.vic.gov.au/immunisation/vaccination-for-healthcare-workers>>.

164 ‘National Plan to Transition Australia’s National COVID-19 Response’, *Australian Government* (Web Page, 6 August 2021) <<https://www.australia.gov.au/national-plan>>.

165 *Public Health (COVID-19 Additional Restrictions for Delta Outbreak) Order (No 2) 2021* (NSW) cl 4.3, repealed by *Public Health (COVID-19 General) Order 2021* (NSW).

166 *COVID-19 Mandatory Vaccination Directions (No 4)* (Vic) (‘Mandatory Vaccination Directions’).

167 See directions made through the *Public Health and Social Measures Linked to Vaccination Status Direction (No 4)* (Qld), which ended on 14 April 2022. See also Martin Foley, ‘High Vax Rate Means Most Restrictions Can Safely Ease’ (Media Release, 20 April 2022) <<https://www.premier.vic.gov.au/high-vax-rate-means-most-restrictions-can-safely-ease>>.

168 *Pandemic (Workplace) Order 2022 (No 8)* (Vic).

169 Heather McNeill, ‘WA Premier Mark McGowan Delays Border Reopening, Targets Triple Dose Vaccination Rate of 80%’, *The Sydney Morning Herald* (online, 20 January 2022) <<https://www.smh.com.au/national/west-australian-premier-mark-mcgowan-calls-7-30pm-press-conference-20220120-p59q0s.html>>.

170 Jolyon Attwooll, ‘What Impact Are Boosters Having on Illness and Death in Australia?’, *News GP* (online, 1 April 2022) <<https://www1.racgp.org.au/newsgp/clinical/what-impact-are-boosters-having-on-illness-and-dea>>.

‘remarkably’ lower hospital admissions and deaths.¹⁷¹ In addition, many employers, including the University of Melbourne, required staff and students to be vaccinated as a condition of attending their campus.¹⁷² The implementation of vaccine mandates has sparked many legal challenges, all of which have been rejected bar one: namely, *Construction, Forestry, Maritime, Mining and Energy Union v Mt Arthur Coal Pty Ltd* (‘*Mt Arthur*’).¹⁷³ However, that case turned on matters of procedure rather than substance. In *Mt Arthur*, the Fair Work Commission considered that, while a mandate at the site, a coal mine, was reasonable and lawful, the employer had not consulted with unions and employees before introducing the policy, the failure rendering the mandate an unreasonable direction.

There are too many failed challenges to recount here. Several have been heard in the Fair Work Commission and the Queensland Industrial Relations Commission, and some are still making their way through the courts. Nevertheless, in what follows, we provide a summary of some of the key cases, including those that have been considered by the appellate courts.

An early and widely reported case, *Kimber v Sapphire Coast Community Aged Care Ltd*, involved a receptionist at an aged care provider who claimed she was unfairly dismissed before the pandemic after refusing a mandatory influenza vaccination.¹⁷⁴ This claim was dismissed by the Fair Work Commission, a majority of which found that the termination was lawful. The dissent of Deputy President Dean, however, which referred to ‘medical apartheid and segregation’, has been widely reported (and much criticised).¹⁷⁵

A proceeding that has progressed through the appellate courts is *Kassam v Hazzard* (‘*Kassam Supreme Court*’).¹⁷⁶ In this matter, several plaintiffs challenged NSW public health orders (made under section 7 of the *Public Health Act 2010* (NSW)) on several grounds, including on the basis that the Minister lacked jurisdictional power to issue the orders. The plaintiffs’ contentions were dismissed by the Supreme Court of New South Wales and the reasons of the primary judge affirmed by the New South Wales Court of Appeal. The plaintiffs then sought special leave to appear in the High Court of Australia; however, that application was dismissed with costs (discussed below). Similarly in the case of *Larter*, the Supreme Court of New South Wales upheld the legality of public health orders requiring the mandatory vaccination of health workers.¹⁷⁷

171 Ibid; Operation COVID Shield, Australian Government, ‘COVID-19 Vaccine Rollout Update’ (Presentation, 11 June 2022) 3 <<https://www.health.gov.au/sites/default/files/documents/2022/06/covid-19-vaccine-rollout-update-11-june-2022.pdf>>.

172 Email from Vice-Chancellor Professor Duncan Maskell to staff and students of the University of Melbourne, 27 September 2021.

173 *Mt Arthur* (n 15).

174 (2021) 310 IR 21.

175 Ibid 70 [182]; *Kassam Supreme Court* (n 26) 136 [64]–[70] (Beech-Jones CJ at CL); Transcript of Proceedings, *Kassam v Hazzard* [2022] HCATrans 131 (‘*Kassam Transcript*’).

176 *Kassam Supreme Court* (n 26); *Kassam v Hazzard* (2021) 106 NSWLR 520 (‘*Kassam Appeal*’).

177 *Larter* (n 157).

In Victoria, in *Harding v Sutton*,¹⁷⁸ Richards J of the Supreme Court declined to grant an interlocutory injunction to suspend certain vaccine-related directions made by the Chief Health Officer. More than 100 plaintiffs from a range of industries, including health and education, alleged their jobs were under threat if they refused vaccination. Her Honour held that the risk of injustice to third parties who might suffer serious health effects or die of SARS-CoV-2 if the injunction were granted outweighed the risk of injustice to the employee plaintiffs, thus dismissing the application.¹⁷⁹ Further, as discussed below, the Supreme Court of Western Australia recently dismissed two claims brought by a police officer Ben Falconer and others against the Police Commissioner and Chief Health Officer for judicial review of certain orders requiring police officers to be vaccinated.¹⁸⁰

Empirical studies have demonstrated that, immediately before COVID-19, there had been ‘very high’ support for vaccine mandates in Australia from across the political spectrum, with no major attitudinal distinctions between social or economic groups.¹⁸¹ While some political parties and candidates included anti-vaccination messages in their campaigns during the 2022 Federal Election, the issue did not gain traction with most voters, indicating that mainstream support remained high.

IV THE RIGHT TO REFUSE MEDICAL TREATMENT

As Part III sought to illustrate, the United Kingdom and Australia have different histories of social attitudes and health policies with respect to compulsory vaccination. These differing backgrounds shaped the ways these (otherwise similar) liberal democracies adopted dissimilar vaccination policies during COVID-19.¹⁸² In the United Kingdom, the public’s contempt for compulsory smallpox vaccination laws arguably left an unyielding cultural legacy that saw the population largely resist any coercive measure relating to vaccination (perhaps even beyond what was already inimical to the libertarian leanings of a conservative Johnson Government).¹⁸³ In contrast, Australia had established wide public acceptance of vaccine mandates in previous decades (including for childhood vaccination, migration, travel, and in some professions), which in turn laid the legal and social groundwork for the implementation of stricter vaccine rules during COVID-19.

178 [2021] VSC 741 (*Harding*).

179 *Ibid* [200]–[201].

180 *Falconer v Commissioner of Police (WA) [No 4]* [2022] WASC 271 (*Falconer [No 4]*); *Falconer v Chief Health Officer [No 3]* [2022] WASC 270 (*Falconer [No 3]*).

181 See, eg, David T Smith, Katie Attwell and Uwana Evers, ‘Majority Acceptance of Vaccination and Mandates across the Political Spectrum in Australia’ (2020) 40(2) *Politics* 189 <<https://doi.org/10.1177/0263395719859457>>.

182 McCoy (n 21).

183 On Johnson’s libertarianism, see Rachel Sylvester, ‘Boris Johnson Plays to His Voters, Not His Party’, *The Times* (online, 22 March 2021) <<https://www.thetimes.co.uk/article/boris-johnson-plays-to-his-voters-not-his-party-3vj7bbt3h>>.

Systematic analysis of the infection–fatality ratio (‘IFR’), which quantifies the likelihood of an individual dying once infected with a pathogen, indicates that the United Kingdom experienced a higher COVID-19 IFR than Australia before vaccines were made available (including both before and after age standardisation).¹⁸⁴ Other studies indicate that the United Kingdom experienced a higher case fatality rate (‘CFR’) than Australia during the Delta and Omicron periods.¹⁸⁵ It is not possible, however, to determine whether this apparently higher ratio of COVID-19 infections to deaths in the United Kingdom stems from differences in vaccination rates or vaccine coercion. Broadly speaking, such data would likely depend on much more than vaccination (eg, border closures, medical systems and other external factors, such as unrelated health influences).¹⁸⁶ However, as has been widely acknowledged, vaccination rates are closely linked with the death rate.¹⁸⁷ Notably, the United Kingdom is currently holding a public inquiry into its COVID-19 response. Its broad-ranging terms of reference include careful consideration of evidence of the bereaved and ‘reasonable regard to relevant international comparisons’.¹⁸⁸ Presumably, a comparison with Australia will be made.

In Part IV, this article moves beyond the sociohistorical context of vaccine coercion and analyses the three most cogent arguments against vaccine coercion. The first is that vaccines should only be given with free and informed consent; the second is that the law should protect freedom of thought, conscience and political opinion; and the third is that vaccine coercion is a violation of bodily integrity, offending the right not to be subject to torture or medical experimentation. Although other notable objections have been advanced (eg, ‘the right to earn a living’, the general right ‘not to be discriminated against’ or the ‘right to privacy’), this article will not consider them as they tend to be less well defined and, according to recent case law, may be less likely to have material legal force.¹⁸⁹

184 See COVID-19 Forecasting Team, ‘Variation in the COVID-19 Infection–Fatality Ratio by Age, Time, and Geography during the Pre-vaccine Era: A Systematic Analysis’ (2022) 399(10334) *The Lancet* 1469 <[https://doi.org/10.1016/S0140-6736\(21\)02867-1](https://doi.org/10.1016/S0140-6736(21)02867-1)>.

185 See Chao Wang et al, ‘Differences in Incidence and Fatality of COVID-19 by SARS-CoV-2 Omicron Variant versus Delta Variant in Relation to Vaccine Coverage: A World-Wide Review’ (2023) 95(1) *Journal of Medical Virology* e28118:1–12, fig 3 <<https://doi.org/10.1002/jmv.28118>>. See also William Msemburi et al, ‘The WHO Estimates of Excess Mortality Associated with the COVID-19 Pandemic’ (2023) 613(7942) *Nature* 130 <<https://doi.org/10.1038/s41586-022-05522-2>>.

186 See Msemburi et al (n 185) 136.

187 See, eg, Oliver J Watson et al, ‘Global Impact of the First Year of COVID-19 Vaccination: A Mathematical Modelling Study’ (2022) 22(9) *Lancet Infectious Diseases* 1293 <[https://doi.org/10.1016/S1473-3099\(22\)00320-6](https://doi.org/10.1016/S1473-3099(22)00320-6)>.

188 ‘Terms of Reference’, *UK COVID-19 Inquiry* (Web Page) <<https://covid19.public-inquiry.uk/terms-of-reference>>.

189 *Kassam Appeal* (n 176) 544–6 [100]–[113] (Bell P).

A Free and Informed Consent to Medical Treatment

The common law of tort has long recognised that people have ‘sacred’ interests in their physical and psychological integrity, liberty and property.¹⁹⁰ Over several centuries, strict principles have developed to protect these interests from outside interference or trespass.¹⁹¹ A vaccination forced on a person would ordinarily violate the ‘fundamental principle, plain and incontestable, that every person’s body is inviolate, and that any touching of another person, however slight may amount to a battery’.¹⁹² Additionally, Anglo-Australian common law ensures that patients are entitled to refuse treatment or are given an opportunity to consent on a fully informed basis: they must be provided with all the information they would be likely to regard as significant, even for small or low risks.¹⁹³ To be lawful, health or treatment decisions must also be made freely and without duress, undue influence or coercion from external forces, including friends and relatives.¹⁹⁴

In principle, these common law rules – which safeguard patient autonomy, ensure voluntary consent and censure undue influence – are at odds with coercion. They would appear to problematise a legal enactment that has the effect of threatening a person’s employment if they were to refuse a given medical treatment, such as vaccination. As such, the force and amplitude of these principles have formed the basis of several challenges to vaccine coercion in the United Kingdom.¹⁹⁵

But an obstacle to applying these principles has been that free and informed consent to medical treatment is not always paramount in law. Several exceptions operate to permit non-consensual trespasses to persons’ bodies; indeed, these have ancient origins, pre-dating the modern requirement of consent expressed in the *Nuremberg Code* (discussed below).¹⁹⁶ The state’s *parens patriae* jurisdiction to protect the health or lives of its citizens (today exercised in the courts of equity) has its English origins in the wardship laws of the Middle Ages, including in the royal prerogative (*De Praerogativa Regis*).¹⁹⁷ That jurisdiction permits a court

190 Sir William Blackstone, *The Oxford Edition of Commentaries on the Laws of England* (Oxford University Press, 2016) vol 3, 81 [120] <<https://doi.org/10.1093/oseo/instance.00248899>>.

191 See, eg, *Weaver v Ward* (1616) 80 ER 284; *Reynolds v Clarke* (1725) 92 ER 410, 412; *Hutchins v Maughan* [1947] VLR 131.

192 See *Rixon v Star City Pty Ltd* (2001) 53 NSWLR 98, 112–13 [53] (Sheller JA), citing *Collins v Wilcock* [1984] 1 WLR 1172, 1177–8 (Goff LJ). See also *Cole v Turner* (1704) 90 ER 958; Blackstone (n 190) 81 [120].

193 *Rogers v Whitaker* (1992) 175 CLR 479, 489 (Mason CJ, Brennan, Dawson, Toohey and McHugh JJ) (‘*Rogers*’).

194 *Re T (Adult: Refusal of Treatment)* [1993] Fam 95, 113–14 (Lord Donaldson) (‘*Re T*’).

195 See, eg, Hurford (n 45) 8; United Kingdom, *Parliamentary Debates*, House of Commons, 24 January 2022, vol 707, cols 233–6 (Martyn Day).

196 Nuremberg Military Tribunals, *Trials of War Criminals before the Nuremberg Military Tribunals under Control Council Law No 10, October 1946 – April 1949* (1949) vol 2, 181–2 (‘*Nuremberg Code*’).

197 The statute *De Praerogativa Regis* is the earliest known enactment relating to the property of those who lacked mental capacity (either from birth or as a result of a change during their life). It is generally thought that the statute originated in the reign of Edward I; however, it also appeared in two Acts reprinted by Ruffhead in 1339. The effect of the statutes was to require the King to provide for a person who lacked capacity out of the person’s own estate and to ensure that the King take no property from the incapacitated person for his own use. See JH McClemens and JM Bennett, ‘Historical Notes on the Law of Mental Illness in New South Wales’ (1962) 4(1) *Sydney Law Review* 49; Paul LG Brereton, ‘The

to authorise health interventions in the absence of consent where the person is incapacitated or incapable.¹⁹⁸ During the 17th century, this protective jurisdiction developed the ‘best interests’ principle; today, it is the touchstone of decision-making in this area.¹⁹⁹

Moreover, conflicting duties and defences to trespasses may authorise medical batteries, even prospectively or retrospectively. In discharging their duty of care, a health practitioner might lawfully administer a treatment to a patient without their consent, such as where they act out of necessity to save the patient’s life in an emergency.²⁰⁰ In this circumstance, a defence based on a justification referred to as necessity or the ‘emergency principle’ would be available.²⁰¹

In other circumstances, governments may create regulatory frameworks and enact laws to modify individual rights. Power-imbalanced situations may prompt a person to knowingly or unknowingly consent to treatments or conditions that would place them in harm’s way. Thus, the imposition of statutory duties under occupational health and safety legislation protects employees from workplace harms where they might not otherwise protect themselves.²⁰² Similarly, the regulation of voluntary assisted dying protects those who might be coerced or compelled by others to end their life while they are vulnerable and suggestible.²⁰³ Moreover, where an individual’s decision-making capacity may be compromised (such as where mental health or cognitive impairments, undue influence by a third party, or many other temporary factors may apply), guardianship laws may require that a guardian be appointed as substitute decision-maker for the incapacitated person.²⁰⁴ Governments may also enact laws to minimise harm where one person makes a decision that, while lawful, may yet cause injury to that person or others.²⁰⁵ For instance, smoking in public places may be regulated because it may affect others’ health,²⁰⁶ the sale of alcohol and drugs may be regulated to protect both the

Origins and Evolution of the *Parens Patriae* Jurisdiction’ (Lecture, Sydney Law School, 5 May 2017) <https://www.supremecourt.justice.nsw.gov.au/Documents/Publications/Speeches/2017%20Speeches/Brereton_050517.pdf>.

198 Brereton (n 197).

199 *Secretary, Department of Health and Community Services v JWB* (1991) 175 CLR 218, 259 (Mason CJ, Dawson, Toohey and Gaudron JJ) (*‘Marion’s Case’*). See also Lindy Willmott, Ben White and Malcolm K Smith, “‘Best Interests’ and Withholding and Withdrawing Life-Sustaining Treatment from an Adult Who Lacks Capacity in the *Parens Patriae* Jurisdiction” (2014) 21(4) *Journal of Law and Medicine* 920, 923.

200 See, eg, *Marion’s Case* (n 199) 310 (McHugh J); *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, 52 (Lord Bridge), 56 (Lord Brandon), 72–4, 76–7 (Lord Goff) (*‘Re F’*); *Mulloy v Hop Sang* [1935] 1 WWR 714, [4] (Jackson DCJ) (Alberta Supreme Court); *K v Minister for Youth and Community Services* [1982] 1 NSWLR 311, 318, 321, 327 (Helsham CJ in Eq). Cf *Malette v Shulman* (1990) 67 DLR (4th) 321 (Ontario Court of Appeal).

201 *Re F* [1990] 2 AC 1, (n 200) 72 (Lord Goff); *Hunter and New England Area Health Service v A* (2009) 74 NSWLR 88 [31] (McDougall J); *Rogers* (n 193) 489 (Mason CJ, Brennan, Dawson, Toohey JJ).

202 See, eg, *Work Health and Safety Act 2011* (Cth) s 17.

203 See, eg, *Voluntary Assisted Dying Act 2017* (Vic) s 5.

204 *Re T* (n 194) 112 (Lord Donaldson).

205 See Lawrence O Gostin and Lindsay F Wiley, *Public Health Law: Power, Duty, Restraint* (University of California Press, 3rd ed, 2016) 10.

206 See Howard M Leichter, *Free to Be Foolish: Politics and Health Promotion in the United States and Great Britain* (Princeton University Press, 1991) ch 4 <<https://doi.org/10.1515/9781400861996>>.

consumer and others;²⁰⁷ and abortion is generally regulated (although not banned) because it may affect both the decision-maker and the unborn child.²⁰⁸

In this connection, the ‘classic’ example of the requirement to wear a seatbelt illustrates how rules or regulations may curtail the rights of individuals (eg, the right to be free of the bodily restriction imposed by a seatbelt) in recognition of a broader framework of competing rights.²⁰⁹ The so-called ‘seatbelt analogy’ argues that vaccine coercion is justified where the benefits afforded to the affected individual and society are high; the risks, burdens or curtailment of rights imposed on the affected individual are low; and where rational decisions about the risks are difficult or impossible to make (due to poor evidence or other reasons).²¹⁰

Laws regulating the risk of infectious diseases to individuals and the community have frequently displaced individuals’ rights to govern their personal healthcare. In the 1905 decision of *Jacobson v Massachusetts* (‘*Jacobson*’), Harlan J opined that, by virtue of ‘the principle of self-defense [and] of paramount necessity, a community has the right to protect itself against an epidemic of disease which threatens the safety of its members’.²¹¹ Recently, when the Supreme Court of the United States stayed President Biden’s vaccine mandate (for businesses employing over 100 workers), it did not overturn *Jacobson* (a case often considered foundational in US public health law). Instead, the Court adopted a narrow construction of the powers of the executive, which allowed the mandate to continue to apply to health workers.²¹²

Further, it can be argued that the restrictions on movement and liberty already imposed by COVID-19 public health orders, including lockdowns outlined above, were just as or more draconian than the restrictions entailed by the vaccine mandates. Insofar as they required persons to submit to the control of state authority, they could be identified as a species of false imprisonment,²¹³ albeit subject to the operation of the same exceptions identified above for non-consensual battery.

In most jurisdictions, mental health laws authorise involuntary detention and psychiatric treatment for those diagnosed with serious mental health conditions at risk of harming themselves or others.²¹⁴ These laws share a conceptual public health basis with infectious disease laws.²¹⁵ However, mental health laws are usually far more coercive and invasive than those associated with the vaccine mandates; while

207 Ibid ch 5.

208 See Gostin and Wiley (n 205) 10, 27, 31, 90–3.

209 Alberto Giubilini and Julian Savulescu, ‘Vaccination, Risks, and Freedom: The Seat Belt Analogy’ (2019) 12(3) *Public Health Ethics* 237 <<https://doi.org/10.1093/phe/phz014>>.

210 Ibid.

211 197 US 11, 27 (1905) (‘*Jacobson*’).

212 *Independent Business* (n 31); *Biden v Missouri*, 595 US ___ (2022); Lawrence O Gostin, Wendy E Parmet and Sara Rosenbaum, ‘The US Supreme Court’s Rulings on Large Business and Health Care Worker Vaccine Mandates: Ramifications for the COVID-19 Response and the Future of Federal Public Health Protection’ (2022) 327(8) *Journal of the American Medical Association* 713 <<https://doi.org/10.1001/jama.2022.0852>>.

213 See, eg, *Symes v Mahon* [1922] SASR 447, 453 (Murray CJ); *South Australia v Lampard-Trevorrow* (2010) 106 SASR 331, 394 [298] (The Court).

214 See, eg, *Mental Health Act 1983* (UK) ss 2–5; *Mental Health Act 2014* (Vic) pt 4.

215 Wilson, ‘The COVID-19 Pandemic’ (n 3).

the latter may impose financial penalties or limit labour or social participation, the former may authorise non-consensual treatment, detention in hospital, restraint and seclusion.²¹⁶

As with mental health laws, vaccine mandates offer benefits to both the person treated and others. For the former, they reduce the risk of COVID-19 infection, while for the latter, they reduce community transmission, protect the immunocompromised, disburden the health system and, as discussed below, may reinforce herd immunity.²¹⁷ As scholar and hospital psychiatrist Christopher Ryan notes, the risks posed by infectious diseases are often higher and more predictable than the risks of harm posed by persons with mental impairment.²¹⁸ While mental health laws raise complex issues beyond the scope of this article,²¹⁹ their operation demonstrates another lawful exception to the right of free and informed consent. Notably, mental health laws have not, in the United Kingdom or Australia, been subject to forms of public protest or resistance comparable to that directed towards vaccination mandates.

B Human Rights Arguments

While vaccine-hesitant persons often claim that vaccine mandates violate their ‘human rights’, no plaintiff has substantiated these claims in a domestic or regional human rights court. One problem facing such litigants is that international human rights treaties are not self-executing and are not legally enforceable in domestic courts if not specifically adopted into legislation.

In Australia, only Victoria,²²⁰ the Australian Capital Territory (‘ACT’),²²¹ Queensland,²²² and the Commonwealth²²³ have enacted domestic human rights legislation, drawing on Australia’s international treaty obligations, particularly under the *International Covenant on Civil and Political Rights* (‘ICCPR’).²²⁴ Further, these regimes are very limited, with the Commonwealth Act permitting

216 For example, see *Mental Health Act 2015* (ACT) ss 65, 73, 80–3, 107, 144A, 263–4, 266; *Mental Health Act 2007* (NSW) ss 3, 68, 190; *Mental Health and Related Services Act 1998* (NT) ss 3, 61; *Mental Health Act 2016* (Qld) ss 5, 242–53, 268–70; *Mental Health Act 2009* (SA) ss 7, 34A; *Mental Health Act 2013* (Tas) ss 12, 57; *Mental Health Act 2014* (Vic) ss 10, 105–9, 113–16; *Mental Health Act 2014* (WA) ss 10, 226–40. Notably, mental health laws in Canada and the United States permit detention in hospital, but not involuntary psychiatric treatment for persons with mental capacity: see Mary Donnelly, ‘From Autonomy to Dignity: Treatment for Mental Disorders and the Focus for Patient Rights’ (2008) 26(2) *Law in Context* 37, 45.

217 See below Part V.

218 Christopher James Ryan, ‘One Flu over the Cuckoo’s Nest: Comparing Legislated Coercive Treatment for Mental Illness with That for Other Illness’ (2011) 8(1) *Journal of Bioethical Inquiry* 87, 89 <<https://doi.org/10.1007/s11673-010-9270-2>>.

219 See Kay Wilson, *Mental Health Law: Abolish or Reform?* (Oxford University Press, 2021) <<https://doi.org/10.1093/oso/9780192843258.001.0001>> (‘*Mental Health Law*’).

220 *Charter of Human Rights and Responsibilities Act 2006* (Vic) (‘*Victorian Charter*’).

221 *Human Rights Act 2004* (ACT).

222 *Human Rights Act 2019* (Qld).

223 *Human Rights (Parliamentary Scrutiny) Act 2011* (Cth) (‘*HRPS Act*’).

224 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) (‘*ICCPR*’).

parliamentary review of federal legislation only.²²⁵ None creates substantive human rights directly enforceable without an existing cause of action;²²⁶ nor does any afford an independent right to damages.²²⁷ The recognised rights are also capable of being limited, or expressly overridden, by Parliament.²²⁸ Consequently, the human rights-based interests established by these instruments are simply matters that Parliament must consider when making legislation and that government officials must consider when making administrative decisions.²²⁹ Courts cannot invalidate legislation inconsistent with human rights, but may issue a declaration of ‘inconsistent interpretation’ or ‘incompatibility’ to the relevant state Attorney-General for their response and action.²³⁰

Regional human rights treaties, as well as the European Court of Human Rights (on which Australian human rights jurisprudence often relies),²³¹ have also given States a ‘wide margin of appreciation’ in such matters.²³² Another difficulty is that the rights themselves, in Australia, internationally and regionally, are not absolute, containing ambiguities and limitations. For instance, Australian domestic human rights legislation may be subject under law to certain reasonable limitations demonstrably justifiable in a free and democratic society, and the statutes must generally be construed in consideration of the nature of the right and the purpose and extent of any relevant limitation.²³³ On this basis, the lawful exceptions to trespass outlined previously are likely to be regarded as valid limitations in any proceedings against vaccine mandates brought on a human rights-based footing.

C Freedom of Thought, Conscience and Opinion, and the Freedom to Choose

Strictly speaking, vaccine mandates do not prevent people having thoughts or opinions that are against, or sceptical about, vaccination. Nor do they prevent the dissemination of vaccine misinformation or the organisation of peaceful protests against vaccination.²³⁴ However, as Frederick Schauer observes, the freedom of thought, conscience and opinion (‘FoTOC’) is effectively meaningless if one is

225 *HRPS Act* (n 223) s 7(a); George Williams and Daniel Reynolds, ‘The Operation and Impact of Australia’s Parliamentary Scrutiny Regime for Human Rights’ (2015) 41(2) *Monash University Law Review* 469.

226 See, eg, *Victorian Charter* (n 220) s 39(1); *Loiello v Giles* (2020) 63 VR 1, 56 [203]–[206] (Ginnane J); *Human Rights Act 2004* (ACT) s 40C; *Human Rights Act 2019* (Qld) s 59(1).

227 See, eg, *Victorian Charter* (n 220) s 39(3); *Human Rights Act 2004* (ACT) s 40C; *Human Rights Act 2019* (Qld) pt 4 div 2 sub-divs 4–5.

228 See, eg, *Victorian Charter* (n 220) ss 7(2), 31; *Human Rights Act 2004* (ACT) s 28; *Human Rights Act 2019* (Qld) ss 13, 43.

229 Kent Blore and Brenna Booth-Marxson, ‘Breathing Life into the *Human Rights Act 2019* (Qld): The Ethical Duties of Public Servants and Lawyers Acting for Government’ (2022) 41(1) *University of Queensland Law Journal* 1, 3 <<https://doi.org/10.38127/uqlj.v41i1.6351>>.

230 *Victorian Charter* (n 220) s 36; *Human Rights Act 2004* (ACT) s 32; *Human Rights Act 2019* (Qld) s 53.

231 See, eg, *Roach v Electoral Commissioner* (2007) 233 CLR 162, 178 [16] (Gleeson CJ), 203 [100] (Gummow, Kirby and Crennan JJ).

232 *Vavrička* (n 109).

233 *Victorian Charter* (n 220) s 7(2); *Human Rights Act 2004* (ACT) s 28; *Human Rights Act 2019* (Qld) s 13.

234 These freedoms are subject to other laws or legal duties. For instance, protests involving social gatherings in violation of public health orders will inevitably constitute offences: see, eg, ‘Explainer: Protests during

unable to lawfully act on that opinion.²³⁵ On the basis of this principle, vaccine mandates may be said to interfere with FoTOC in four ways:

- First, vaccine mandates may restrict the ability of vaccine-hesitant persons to reject the pro-vaccination opinions of medical experts or the avowed position of governments. As Lucas Swaine contends, freedom of thought is a discrete personal interest associated with liberty; and in history, certain thoughts have been targeted or impugned by the state, even where freedom of expression remains unencumbered.²³⁶ In this argument, the interference with the right to think differently, and even with the ‘right’ to be wrong (associated with patient autonomy),²³⁷ is enforced indirectly through vaccine mandates.
- Second, vaccine hesitant persons are not distinguishable from those who have historically self-identified as ‘conscientious objectors’²³⁸ and claimed an entitlement to reject the burden of complying with a civic duty inconsistent with their conscience.²³⁹ While many object to vaccination because of safety and efficacy concerns (rather than because vaccination is incompatible with their belief system),²⁴⁰ others use ‘knowledge to decide upon the right course of action’ in ways consistent with conscientious objectors.²⁴¹ That knowledge may derive from many sources, ranging from the rejection of Western medicine through to a difference of expert opinion.²⁴²
- Third, the origin of some vaccines has created legitimate questions of conscience for some.²⁴³ While most recognised religions (including Roman

COVID-19’, *Victorian Equal Opportunity and Human Rights Commission* (Web Page, September 2021) <<https://www.humanrights.vic.gov.au/resources/explainer-protests-during-covid-19>>.

- 235 Frederick Schauer, ‘Freedom of Thought?’ (2020) 37(2) *Social Philosophy and Policy* 72, 89 <<https://doi.org/10.1017/S0265052521000054>>.
- 236 Lucas Swaine, ‘Freedom of Thought as a Basic Liberty’ (2018) 46(3) *Political Theory* 405, 418 <<https://doi.org/10.1177/0090591716676293>>.
- 237 James Adams, ‘Respecting the Right to Be Wrong’ (1998) 5(8) *Academic Emergency Medicine* 753 <<https://doi.org/10.1111/j.1553-2712.1998.tb02499.x>>; Joan M Henriksen Hellyer and Leah R Eisenberg, ‘The Right to Be Wrong? Is There a Responsibility to Ensure That Patients Act on Accurate Information?’ (2014) 14(7) *American Journal of Bioethics* 48 <<https://doi.org/10.1080/15265161.2014.922371>>.
- 238 Other conscientious objectors would include pacifists and those with certain religious beliefs who object to military conscription on the basis that it is against their conscience to kill another human being. See Mark R Wicclair, *Conscientious Objection in Healthcare: An Ethical Analysis* (Cambridge University Press, 2011) 14 <<https://doi.org/10.1017/CBO9780511973727>>; Kerry O’Halloran, *Conscientious Objection: Dissent and Democracy in a Common Law Context* (Springer, 2022) 26–7 [1.4.1.3] <<https://doi.org/10.1007/978-3-030-97648-4>>.
- 239 Anti-vaccinators may have been the first to use the term ‘conscientious objector’: Anders Schinkel, *Conscience and Conscientious Objections* (Amsterdam University Press, 2007) 486.
- 240 Wicclair (n 238) 14.
- 241 Stuart Chalmers, *Conscience in Context: Historical and Existential Perspectives* (Peter Lang, 2013) 137–8, cited in Michal Pruski, ‘Conscience and Vaccines: Lessons from *Babylon 5* and COVID-19’ (2021) 27(3) *New Bioethics* 266, 271 <<https://doi.org/10.1080/20502877.2021.1959789>>.
- 242 See, eg, Marcus Dahlquist and Henrik D Kugelberg, ‘Public Justification and Expert Disagreement over Non-pharmaceutical Interventions for the COVID-19 Pandemic’ (2023) 49(1) *Journal of Medical Ethics* 9 <<https://doi.org/10.1136/medethics-2021-107671>>.
- 243 See, eg, Javier Martínez-Torrón, ‘COVID-19 and Religious Freedom: Some Comparative Perspectives’ (2021) 10(2) *Laws* 39:1–16, 12–13 <<https://doi.org/10.3390/laws10020039>>.

Catholicism)²⁴⁴ raise no objections to COVID-19 vaccination,²⁴⁵ some people hold that specific vaccines are not compatible with their moral principles because they incorporate fetal cells obtained from fetuses after elective abortions in the early 1970s.²⁴⁶

- Fourth, opposition to vaccination, even where it is not a political-partisan issue, may constitute a ‘political opinion’ or, alternatively, given the decline of traditional religions and growth in unconventional belief systems, a ‘religious belief’ broadly defined.²⁴⁷ As such, these beliefs should not be censored by law, including by virtue of the implied freedom of political communication in Australia.²⁴⁸

There is a vast literature on the freedom of thought, opinion, religion and conscience, which is too large to reproduce here.²⁴⁹ However, John Stuart Mill’s *On Liberty* is axiomatic, and worth summarising briefly.²⁵⁰ Mill argues that FoTOC is inherently valuable, as it is necessary for individual wellbeing and character development and because a diversity of opinion is a wider social good.²⁵¹ He also argues that FoTOC should be protected on epistemological grounds: given all knowledge is fallible and incomplete, it is important to allow dissenting views.²⁵² Regarding COVID-19 vaccines, much scientific knowledge has been imperfect, uncertain and evolving,²⁵³ and some vaccine-hesitant persons may reasonably expect their concerns to be vindicated.

Freedom of thought, opinion, religion and conscience is also recognised in international human rights law, including in article 18 of the *Universal Declaration*

244 Holy See Press Office, ‘Note of the Congregation for the Doctrine of the Faith on the Morality of Using Some Anti-COVID-19 Vaccines’ (Press Release, 21 December 2020) <<https://press.vatican.va/content/salastampa/en/bollettino/pubblico/2020/12/21/201221c.html>>.

245 See Emma Tomsick, ‘The Public Health Demand for Revoking Non-medical Exemptions to Compulsory Vaccination Statutes’ (2020) 34(1) *Journal of Law and Health* 129, 137–40.

246 These include those replicated from the HEK-293 (kidney) and PER.C6 (retinal) cell lines. See Alberto Giubilini, Julian Savulescu and Dominic Wilkinson, ‘Which Vaccine? The Cost of Religious Freedom in Vaccination Policy’ (2021) 18(4) *Journal of Bioethical Inquiry* 609 <<https://doi.org/10.1007/s11673-021-10148-6>>. See also Meredith Wadman, ‘Abortion Opponents Protest COVID-19 Vaccines’ Use of Fetal Cells’, *Science* (online, 5 June 2020) <<https://www.science.org/content/article/abortion-opponents-protest-covid-19-vaccines-use-fetal-cells>>.

247 Katherine Eichelbaum, ‘Is Mandatory Vaccination an Unjustified Limit on Human Rights?’ (2019) 25 *Auckland University Law Review* 105, 116.

248 *Australian Capital Television Pty Ltd v Commonwealth* (1992) 177 CLR 106; *Nationwide News Pty Ltd v Wills* (1992) 177 CLR 1.

249 Notably, most of this literature does not directly address vaccine hesitancy and coercion. But see, eg, Marc Jonathan Blitz and Jan Christoph Bublitz (eds), *The Law and Ethics of Freedom of Thought* (Palgrave Macmillan, 2021) vol 1; John Rawls, *Political Liberalism* (Columbia University Press, 2005); JB Bury, *A History of the Freedom of Thought* (Henry Holt, 1913).

250 Christopher Clausen, ‘John Stuart Mill’s “Very Simple Principle”’, *Wilson Quarterly* (online, 2009) <<https://www.wilsonquarterly.com/quarterly/spring-2009-decline-or-renewal/john-stuart-mills-very-simple-principle>>.

251 John Stuart Mill, *On Liberty and the Subjection of Women* (Henry Holt, 1879) ch III.

252 Ibid 88.

253 Lawrence O Gostin and Sarah Wetter, ‘Risk Trade-Offs and Equitable Decision-Making in the COVID-19 Pandemic’ (2022) 52(1) *Hastings Center Report* 15 <<https://doi.org/10.1002/hast.1328>>.

of *Human Rights* ('UDHR'), article 18 of the *ICCPR*²⁵⁴ and article 9 of the *European Convention of Human Rights* ('ECHR').²⁵⁵ However, these rights are limited by 'respect for the rights and freedoms of others',²⁵⁶ 'health'²⁵⁷ and the 'general welfare in a democratic society'.²⁵⁸ Arguably, these limits would permit vaccine mandates and passports where necessary and proportionate.²⁵⁹

Several other exceptions canvassed above would also apply to FoTOC-type objections. The well-recognised 'harm principle' (namely, that individual liberty may be limited where it harms others)²⁶⁰ has been an oft-cited justification for vaccine mandates and other health-based restrictions during COVID-19.²⁶¹ Similarly, conscientious objection should arguably exempt an objector. Of course, such objection may also shift the burden of compliance onto others and, if widespread, could have cumulative effects whereby the community's detriment exceeds that of the objector's loss of FoTOC.²⁶² Moreover, being excused from a social obligation as a conscientious objector often comes with a price for the objector (eg, a requirement to provide community service in exchange for being excused).²⁶³ This is analogous to the 'price' paid by an unvaccinated person, who is restricted in their employment and social participation because they might become a virus victim or vector.

Finally, Millian arguments about the free 'marketplace of ideas' are perhaps less compelling today than in Mill's time. The online informational context now features an intractable volume of resources and includes self-reinforcing echo chambers.²⁶⁴ Furthermore, the complexity and scale of modern science, the growth and weaponisation of misinformation, and an unprecedented distrust of scientific and social institutions prevail.²⁶⁵ Mill's study also seems to have overrated the public's commitment to truth-seeking and the value of universal education, which

254 *ICCPR* (n 224) art 18.

255 *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) art 9 ('ECHR').

256 *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) art 29 ('UDHR').

257 *ECHR* (n 255) art 9(2).

258 *UDHR* (n 256) art 29.

259 Jeff King, Octávio Luiz Motta Ferraz and Andrew Jones, 'Mandatory COVID-19 Vaccination and Human Rights' (2022) 399(10321) *The Lancet* 220 <[https://doi.org/10.1016/S0140-6736\(21\)02873-7](https://doi.org/10.1016/S0140-6736(21)02873-7)>.

260 Mill (n 251) 23, 28.

261 See, eg, Frank A Chervenak, Jonathan D Moreno and Amos Grünebaum, 'John Stuart Mill Is Relevant to COVID-19 Vaccination in Pregnancy Today' (2022) 50(5) *Journal of Perinatal Medicine* 528 <<https://doi.org/10.1515/jpm-2022-0055>>; Franklin G Miller, 'Liberty and Protection of Society during a Pandemic: Revisiting John Stuart Mill' (2021) 64(2) *Perspectives in Biology and Medicine* 200 <<https://doi.org/10.1353/pbm.2021.0016>>.

262 O'Halloran (n 238) 11; Lóránt Csink, 'Freedom of Conscience and COVID-19 Vaccination: Reconciling Contradictory Forces' (2021) 1(1) *Law, Identity and Values* 41, 47 <<https://doi.org/10.55073/2021.1.41-53>>.

263 O'Halloran (n 237) 25.

264 Rachael L Jones, 'Can You Have Too Much of a Good Thing? The Modern Marketplace of Ideas' (2018) 83(4) *Missouri Law Review* 971, 972; Douglas S Diekema, 'Rhetoric, Persuasion, Compulsion, and the Stubborn Problem of Vaccine Hesitancy' (2022) 65(1) *Perspectives in Biology and Medicine* 106, 115 <<https://doi.org/10.1353/pbm.2022.0006>>.

265 See Diekema (n 264) 114–15.

are today often criticised as aiding neoliberal economic goals rather than advancing liberal democracy.²⁶⁶

D The Right to Bodily Integrity and the Right Not to Be Tortured or Subjected to Non-consensual Medical Experimentation

As already addressed in Part IV(A), administering COVID-19 vaccines involves piercing the skin and injecting medicines into the body (eg, recombinant adenoviral-vectors or lipid nanoparticles containing messenger RNA). Vaccine mandates therefore raise sensible concerns about the right to bodily integrity. Despite a ‘jealously guarded’ protection for this right in Australian civil law,²⁶⁷ a unanimous New South Wales Court of Appeal decision recently upheld the holding of the primary judge in *Kassam Supreme Court* that a vaccine mandate (under a public health order) did not violate the right to bodily integrity.²⁶⁸ While the relevant order imposed restrictions on an unvaccinated person’s movement, and might have even had an encouraging or coercive effect on them, it did not authorise a forced injection.²⁶⁹

By contrast, in *Falconer v Commissioner of Police (WA) [No 4]* (*Falconer [No 4]*),²⁷⁰ the Supreme Court of Western Australia held that an employer direction²⁷¹ could be assumed to infringe the right to bodily integrity.²⁷² However, Allanson J found that this right was lawfully curtailed by ‘necessary implication’ in circumstances where a police officer was part of an ‘obedient’ force whose duties already exposed officers to harm.²⁷³ In this case, the seriousness of the emergency was also at issue; however, Allanson J rejected submissions that COVID-19 was ‘a maelstrom in a petri dish’ rather than an extraordinary emergency.²⁷⁴

If, as the reasoning in *Falconer [No 4]* implies, some vaccine mandates could be understood to infringe the right to bodily integrity, other claims about that right’s scope, meaning and content might present difficulties both for tort and human rights law jurisprudence. For instance, Johnathan Herring and Jesse Wall argue that the right to bodily integrity is broader than that of bodily autonomy: ‘The right gives a person exclusive use of, and control over, their body on the basis that the body is the site, location, or focal point of their subjectivity (however understood and constituted).’²⁷⁵

266 See, eg, Guoping Zhao, ‘STEM Education in the Age of “Fake News”: A John Stuart Mill Perspective’ (2020) *Philosophy of Education Yearbook* 393, 394–5 <<https://doi.org/10.47925/75.2019.393>>.

267 *Kassam Appeal* (n 176) 555 [166] (Leeming JA).

268 *Kassam Supreme Court* (n 26) 122 [8]–[9], 134 [59] (Beech-Jones CJ at CL).

269 *Ibid*; *Kassam Appeal* (n 176) 543–4 [95]–[99] (Bell P), 555 [166], 557 [174] (Leeming JA). See also *Kassam Transcript* (n 175).

270 *Falconer [No 4]* (n 180).

271 The direction was made under section 5 of the *Police Act 1892* (WA) and the *Police Force Regulations 1979* (WA).

272 *Falconer [No 4]* (n 180) [32] (Allanson J).

273 *Ibid* [38] (Allanson J).

274 *Ibid* [111] (Allanson J).

275 Jonathan Herring and Jesse Wall, ‘The Nature and Significance of the Right to Bodily Integrity’ (2017) 76(3) *Cambridge Law Journal* 566, 580 <<https://doi.org/10.1017/S0008197317000605>>.

Similarly, AM Viens describes the right not as a singular idea, but as a complex ‘bundle of rights’ that has not yet been fully elucidated in human rights law jurisprudence.²⁷⁶

Although the ‘right to bodily integrity’ is a discrete and well-recognised right in international human rights law, it is also commonly inferred from other rights.²⁷⁷ While recognised in some regional charters,²⁷⁸ only the *Convention on the Rights of Persons with Disabilities* (‘CRPD’) refers to the right specifically at the international level: ‘Every person with disabilities has a right to respect for his or her physical and mental integrity on an equal basis with others.’²⁷⁹

The text of article 17 is sparse because there was strenuous disagreement about its scope during the CRPD negotiations, particularly over whether its language could or should abolish all involuntary detention and medical treatment of persons with disabilities.²⁸⁰ But according to Bernadette McSherry, the article should be read narrowly, and as prohibiting only non-beneficial or intrusive involuntary treatments.²⁸¹ Of course, the CRPD only applies to persons with disabilities (broadly defined)²⁸² and so it will have limited application where vaccine mandates apply to persons without disabilities or to the community in general.

The right to bodily integrity has also been inferred from the prohibition against torture contained in article 17 of the ICCPR: ‘No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation.’²⁸³

The two limbs of article 7 prohibit (1) torture and cruel, inhuman and degrading treatment; and (2) involuntary medical or scientific experimentation. Cruel, inhuman, or degrading treatment or punishment is generally understood as treatment that falls short of torture in terms of the degree of suffering and severity but may create the conditions for torture.²⁸⁴ As the prohibition on torture in article

276 AM Viens, ‘The Right to Bodily Integrity: Cutting Away Rhetoric in Favour of Substance’ in Andreas von Arnald, Kerstin von der Decken and Mart Susi (eds), *The Cambridge Handbook of New Human Rights: Recognition, Novelty, Rhetoric* (Cambridge University Press, 2020) 363, 374–5 <<https://doi.org/10.1017/9781108676106.029>>.

277 Ibid.

278 The right also exists at the regional level in article 4 of the *African Charter on Human and Peoples’ Rights*, opened for signature 27 June 1981, 1520 UNTS 217 (entered into force 21 October 1986); article 3 of the *Charter of Fundamental Rights of the European Union* [2000] OJ C 364/1; and article 5 of the *American Convention on Human Rights*, opened for signature 22 November 1969, 1144 UNTS 123 (entered into force 18 July 1978). However, none of these instruments defines ‘bodily or physical integrity’ or fully prescribes the contours of that right.

279 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 17 (‘CRPD’).

280 Bernadette McSherry, ‘Protecting the Integrity of the Person: Developing Limitations on Involuntary Treatment’ (2008) 26(2) *Law in Context* 111, 112–13.

281 Ibid 122.

282 CRPD (n 279) art 1.

283 ICCPR (n 224) art 7.

284 See United Nations Commission on Human Rights, *Civil and Political Rights, Including Questions of: Torture and Detention*, 58th sess, Agenda Item 11(a), UN Doc E/CN.4/2002/76 (27 December 2001) annex III.

7 is a peremptory norm that binds States regardless of their treaty obligations, breaching the article constitutes one of the most serious human rights violations.²⁸⁵

While some scholars have claimed that all medical treatments without informed consent would breach article 7,²⁸⁶ such arguments are problematic where the level of pain and suffering is typically low (eg, mild-to-moderate side effects that resolve within a few days) and the purpose of the treatment is not ‘punishment’ but to protect the patient, on a non-discriminatory basis, from a life-threatening virus. Indeed, it is arguable that intentionally withholding access to a COVID-19 vaccine during a global pandemic would constitute a form of cruel, inhuman and degrading treatment or punishment and violate the right to health,²⁸⁷ especially given the risk posed to the unvaccinated (illness, disability and death).²⁸⁸

The second limb of article 7, which requires no one to be subjected to medical or scientific experimentation without free and informed consent, reflects the findings of the Nuremberg Trials.²⁸⁹ These revealed the horrors of the experiments under the Nazi Government in concentration camps in the 1940s, including the ‘aviation atrocities’ and the truth-serum (mescaline) experiments at Dachau.²⁹⁰ Widely recognised as the ‘most important document in the history of the ethics of medical research’,²⁹¹ the *Nuremberg Code* constituted a blueprint for the rights of persons subject to medical research and practice, including the right to withhold consent.²⁹²

While some vaccine objectors have expressed concerns that COVID-19 vaccines are ‘experimental’ and that populations have been compelled to participate in a ‘human experiment’,²⁹³ rarely do these accounts comport with the legal and substantive nature of the detailed and highly regulated clinical trial process, the nature of the different approvals or licensures issued by state therapeutic goods regulators, the differences between vaccines and their histories of use (ie, the

285 Wilson, *Mental Health Law* (n 219) 76.

286 See, eg, Tina Minkowitz, ‘The United Nations *Convention on the Rights of Persons with Disabilities* and the Right to Be Free from Nonconsensual Psychiatric Interventions’ (2007) 34(2) *Syracuse Journal of International Law and Commerce* 405.

287 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12 (‘ICESCR’).

288 See, eg, *D v United Kingdom* (1997) 24 EHRR 423.

289 See *Nuremberg Code* (n 196).

290 See Paul Julian Weindling, *Nazi Medicine and the Nuremberg Trials: From Medical War Crimes to Informed Consent* (Palgrave Macmillan, 2004) 65–94 <<https://doi.org/10.1057/9780230506053>>; Alfred W McCoy, ‘Science in Dachau’s Shadow: Hebb, Beecher, and the Development of CIA Psychological Torture and Modern Medical Ethics’ (2007) 43(4) *Journal of the History of the Behavioral Sciences* 401, 410 <<https://doi.org/10.1002/jhbs.20271>>.

291 Evelyn Shuster, ‘Fifty Years Later: The Significance of the *Nuremberg Code*’ (1997) 337(20) *New England Journal of Medicine* 1436, 1436 <<https://doi.org/10.1056/NEJM199711133372006>>; George J Annas and Michael A Grodin (eds), *The Nazi Doctors and the Nuremberg Code: Human Rights in Human Experimentation* (Oxford University Press, 1992).

292 *Nuremberg Code* (n 196). See, further, Paul Weindling, ‘The Origins of Informed Consent: The International Scientific Commission on Medical War Crimes, and the *Nuremberg Code*’ (2001) 75(1) *Bulletin of the History of Medicine* 37 <<https://doi.org/10.1353/bhm.2001.0049>>.

293 See, eg, Martin Pengelly, ‘Fox News Host Tucker Carlson Compares Vaccine Mandates to “Nazi Experiments”’, *The Guardian* (online, 23 January 2022) <<https://www.theguardian.com/media/2022/jan/22/tucker-carlson-compares-us-vaccine-mandates-nazi-medical-experiments>>.

recombinant adenoviral-vectored vaccines as compared to messenger RNA vaccines), and the stringent requirements, at least in Western jurisdictions, for ongoing data collection and product surveillance.²⁹⁴

However, some distrust and caution was perhaps inevitable in view of the rapid processes through which the vaccines were developed and approved.²⁹⁵ The clinical trial process entailed overlapping and staggered phases, with only interim analysis of Phase I and II data completed before Phase III commenced.²⁹⁶ Moreover, the manufacturers had commenced large-scale production of the vaccines even before any Phase III trial data had been finalised.²⁹⁷ Nevertheless, these new trial designs were not simply a product of recent advances in epidemiological and statistical analysis; they also inaugurated unprecedented levels of collaboration between manufacturers, medical practitioners, and regulatory agencies and government. In the end result, these new trial designs were precisely what enabled the ‘triumph of science’ to occur.²⁹⁸

To compare this complex reconfiguration of drug development and approval to a human experiment – or worse, to identify it with the criminal experiments that led to the *Nuremberg Code*²⁹⁹ – is untenable. While there have been some data transparency issues³⁰⁰ and the use of placebo controls has been criticised,³⁰¹ the empirical and clinical evidence for the vaccines’ safety and efficacy was sound, and regulators reached consensus on the design requirements for Phase III COVID-19 vaccine clinical trials.³⁰²

The reported efficacy of the vaccines manufactured by Pfizer/BioNTech, AstraZeneca, Moderna, and Johnson & Johnson were, for the COVID-19 virus

294 For overviews of these requirements, see, eg, ‘COVID-19 Vaccine Safety Surveillance’, *Food and Drug Administration (US)* (Web Page, 7 December 2021) <<https://www.fda.gov/vaccines-blood-biologics/safety-availability-biologics/covid-19-vaccine-safety-surveillance>>; ‘COVID-19 Vaccine Safety Monitoring and Reporting’, *Therapeutic Goods Administration* (Web Page, 9 February 2021) <<https://www.tga.gov.au/covid-19-vaccine-safety-monitoring-and-reporting>>.

295 For two responses to such distrust and concern, see Mia Harrison, Kari Lancaster and Tim Rhodes, ‘“A Matter of Time”: Evidence-Making Temporalities of Vaccine Development in the COVID-19 Media Landscape’ (2021) 31(1) *Time and Society* 132, 135 <<https://doi.org/10.1177/0961463X211032201>>. See also Mark Toshner, ‘Less Than a Year to Develop a COVID Vaccine: Here’s Why You Shouldn’t Be Alarmed’, *The Conversation* (online, 25 November 2020) <<https://theconversation.com/less-than-a-year-to-develop-a-covid-vaccine-heres-why-you-shouldnt-be-alarmed-150414>>.

296 Florian Kramer, ‘SARS-CoV-2 Vaccines in Development’ (2020) 586(7830) *Nature* 516, 517 <<https://doi.org/10.1038/s41586-020-2798-3>>.

297 Dominique Deplanque and Odile Launay, ‘Efficacy of COVID-19 Vaccines: From Clinical Trials to Real Life’ (2021) 76(4) *Therapies* 277, 278 <<https://doi.org/10.1016/j.therap.2021.05.004>>.

298 See Margie Danchin and Jim Buttery, ‘COVID-19 Vaccine Hesitancy: A Unique Set of Challenges’ (2021) 51(12) *Internal Medicine Journal* 1987 <<https://doi.org/10.1111/imj.15599>>.

299 Beverley Chalmers, ‘The Medical Manipulation of Reproduction to Implement the Nazi Genocide of Jews’ (2019) 4(2) *Conatus* 127 <<https://doi.org/10.12681/cjp.20993>>.

300 See Sarah Tanveer et al, ‘Transparency of COVID-19 Vaccine Trials: Decisions without Data’ (2022) 27(4) *BMJ Evidence-based Medicine* 199 <<https://doi.org/10.1136/bmjebm-2021-111735>>.

301 See Jerome Amir Singh et al, ‘WHO Guidance on COVID-19 Vaccine Trial Designs in the Context of Authorized COVID-19 Vaccines and Expanding Global Access: Ethical Considerations’ (2022) 40(14) *Vaccine* 2140, 2142 <<https://doi.org/10.1016/j.vaccine.2022.02.038>>.

302 Ibid 2141.

strains of the time, 95%,³⁰³ 70%,³⁰⁴ 94%³⁰⁵ and 66%³⁰⁶ respectively.³⁰⁷ Further, the rollout of these medicines has meant that COVID-19 vaccines have been administered over 13 billion times globally at the time of writing,³⁰⁸ which has allowed even exceedingly rare side effects to be detected.³⁰⁹ Despite this evidence, it is notable that some objectors have promoted or expressed a preference for unapproved interventions for COVID-19, including vitamins,³¹⁰ or drugs restricted by regulators due to clinical inadequacy (eg, ivermectin and hydroxychloroquine).³¹¹

It also remains commonplace among objectors to question the long-term effects of COVID-19 vaccines.³¹² However, studies attempting to identify long-term adverse events ('LTAEs') have found they are rare.³¹³ Conversely, there is strong evidence that the long-term effects of infection are common, with more than 90% of COVID-19 survivors developing sequelae.³¹⁴ On this basis, the rollout of the vaccines is not rationally described as a human experiment within the meaning of article 7 of the *ICCPR*.

Still, the prohibition on scientific experimentation without free and informed consent extends to medical treatments in Victorian, ACT and Queensland human rights legislation.³¹⁵ No substantive judicial interpretation has considered whether

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- 303 Fernando P Polack et al, 'Safety and Efficacy of the BNT162b2 mRNA COVID-19 Vaccine' (2020) 383(27) *New England Journal of Medicine* 2603 <<https://doi.org/10.1056/NEJMoa2034577>>.
- 304 Merryn Voysey et al, 'Safety and Efficacy of the ChAdOx1 nCoV-19 Vaccine (AZD1222) against SARS-CoV-2: An Interim Analysis of Four Randomised Controlled Trials in Brazil, South Africa, and the UK' (2021) 397(10269) *The Lancet* 99 <[https://doi.org/10.1016/S0140-6736\(20\)32661-1](https://doi.org/10.1016/S0140-6736(20)32661-1)>.
- 305 Lisa A Jackson et al, 'An mRNA Vaccine against SARS-CoV-2: Preliminary Report' (2020) 383(20) *New England Journal of Medicine* 1920 <<https://doi.org/10.1056/NEJMoa2022483>>.
- 306 Jerald Sadoff et al, 'Interim Results of a Phase 1–2a Trial of Ad26.COV2.S COVID-19 Vaccine' (2021) 384(19) *New England Journal of Medicine* 1824 <<https://doi.org/10.1056/NEJMoa2034201>>.
- 307 Rikin Patel et al, 'A Comprehensive Review of SARS-CoV-2 Vaccines: Pfizer, Moderna and Johnson & Johnson' (2022) 18(1) *Human Vaccines and Immunotherapeutics* e2002083:1–12 <<https://doi.org/10.1080/21645515.2021.2002083>>.
- 308 Edouard Mathieu et al, 'Coronavirus (COVID-19) Vaccinations', *Our World in Data* (Web Page, 27 January 2023) <https://web.archive.org/web/20230127192611/https://ourworldindata.org/covid-vaccinations?country=OWID_WRL>.
- 309 Jake Ellison, 'Clinical Trials Brought Us COVID Vaccines, but We're in Largescale Population "Trials" Now and Will Learn More', *University of Washington News* (online, 7 May 2021) <<https://www.washington.edu/news/2021/05/07/clinical-trials-brought-us-covid-vaccines-but-were-in-largescale-population-trials-now-and-will-learn-more>>.
- 310 'No Evidence to Support Intravenous High-Dose Vitamin C in the Management of COVID-19', *Therapeutic Goods Administration* (Web Page, 27 March 2020) <<https://www.tga.gov.au/alert/no-evidence-support-intravenous-high-dose-vitamin-c-management-covid-19>>.
- 311 Therapeutic Goods Administration, 'NSW Individual Fined \$7,992 for Alleged Unlawful Advertising of Ivermectin and Zinc for COVID-19' (Media Release, 30 November 2021) <<https://www.tga.gov.au/media-release/nsw-individual-fined-7992-alleged-unlawful-advertising-ivermectin-and-zinc-covid-19>>.
- 312 Rachel Schraer, 'Vaccines: What We Know about Long-Term Safety Now', *BBC News* (online, 25 February 2022) <<https://www.bbc.com/news/health-60468900>>.
- 313 Najla Dar-Odeh et al, 'Long-Term Adverse Events of Three COVID-19 Vaccines as Reported by Vaccinated Physicians and Dentists: A Study from Jordan and Saudi Arabia' (2022) 18(1) *Human Vaccines and Immunotherapeutics* 2039017:1–7 <<https://doi.org/10.1080/21645515.2022.2039017>>.
- 314 Marwa Kamal et al, 'Assessment and Characterisation of Post-COVID-19 Manifestations' (2021) 75(3) *International Journal of Clinical Practice* e13746:1–5, 3–4 <<https://doi.org/10.1111/ijcp.13746>>.
- 315 *Victorian Charter* (n 220) s 10(c); *Human Rights Act 2004* (ACT) s 10(2); *Human Rights Act 2019* (Qld) s 17(c).

the right to not be subjected to medical treatment without ‘full, free and informed consent’ applies to COVID-19 vaccination. However, in *Harding v Sutton*, Richards J considered there was at least an ‘arguable case’ that certain vaccine mandates – directions made under section 200(1) of the *Public Health and Wellbeing Act 2008* (Vic) – limited this right.³¹⁶ In distinguishing this finding from that of Beech-Jones CJ at CL in *Kassam Supreme Court*, where it was held that the NSW vaccination directions did not constitute a trespass to the person,³¹⁷ her Honour noted that the common law concept of consent was arguably ‘narrower than the “full, free and informed consent” to medical treatment that is contemplated by s[ection] 10(c) of the *Charter*’.³¹⁸ Her Honour made this finding that an ‘arguable’ case existed on the basis that the plaintiffs felt coerced to consent in order to ‘keep their jobs’ in circumstances where ‘they would not otherwise consent to the treatment’.³¹⁹

As previously noted, however, Australian human rights legislation permits the reasonable limitation of such rights. Thus, the exigencies of the circumstances – such as the potential loss of life and health, and the preservation of the health system – would likely carry considerable weight in any determination of the validity of a vaccine mandate. Additionally, Victoria, ACT and Queensland permit more coercive treatments without consent in several other situations, including in emergencies, mental health treatment, guardianship and blood transfusions involving children.³²⁰

The right to bodily integrity is further expressed in the *ECHR*, especially article 3 (anti-torture provision) and article 8 (the right to private life). In *Vavříčka v Czech Republic*,³²¹ the European Court of Human Rights upheld a vaccine mandate on the basis that Member States had a wide ‘margin of appreciation’ in health care matters.³²² The mandate required parents to vaccinate their children before attending preschool or pay a one-off administrative fine.³²³ The majority of the Court held that the Czech vaccine mandate did not violate article 8 because it responded to a ‘pressing social need’ to protect life and health, was supported by ‘relevant and sufficient reasons’, was proportionate (as it guarded against nine recognised diseases and conferred no absolute duty) and, finally, did not impose an ‘excessive’ penalty.³²⁴

The majority of the Court also considered that a vaccination duty arose from a principle of ‘social solidarity’ whereby those accepting a ‘minimum risk’ did so to protect the health of society and the ‘children attending preschool establishments’.³²⁵ However, in a dissenting opinion, Judge Wojtyczek criticised the majority for

316 *Harding* (n 178) 50 [161].

317 *Kassam Supreme Court* (n 26) 128–9 [36].

318 *Ibid.*

319 *Ibid.*

320 See Alistair Pound and Kylie Evans, *Annotated Victorian Charter of Rights* (Thompson Reuters, 2nd ed, 2018) 97–8, 101.

321 *Vavříčka* (n 109).

322 *Ibid* 46 [203], 48 [212], 50 [221] (The Court).

323 *Ibid* 66 [293].

324 *Ibid* 63 [281], 65 [289]–[290], 66 [293], 70 [304].

325 *Ibid* 12 [62], 70 [306].

promoting the best interests of children as a group rather than examining the best interests of individual children.³²⁶ Similarly, the philosopher David Archard has criticised ‘social solidarity’ as inadequately defined and conflicting with the rights of individuals.³²⁷

While the majority of the Court was careful to find that the case applied only to well-established childhood vaccinations,³²⁸ legal scholars have underlined the unignorable relevance of the case for COVID-19 vaccination.³²⁹ In this regard, it is notable that in the English High Court case of *Peters*, Whipple J relied on *Vavříčka* to find that vaccine mandates with respect to care home workers were not in breach of the same article:

[I]f children can be barred from school because they are not vaccinated, ... it must follow, by analogy, that there is no breach of Article 8 to legislate so that workers, who are not vaccinated, can be prevented from working in care homes.³³⁰

V ARGUMENTS IN FAVOUR OF VACCINE COERCION

While Part IV analysed several arguments against vaccine coercion, Part V will explore the arguments for mandatory vaccination. This Part will support our contention that, despite being coercive, vaccine mandates may be legally and morally justified. However, as already foreshadowed, it remains necessary to examine when and how vaccine mandates should be introduced and whether their status as justified might change under different conditions.

A The Effectiveness of Vaccines

By far the most persuasive argument in favour of vaccine mandates is that the COVID-19 vaccines have been the most effective public health countermeasure during the pandemic.³³¹ As the eminent American public health law scholars Lawrence O Gostin and Sarah Wetter observe: ‘If there were a single observation that could be garnered from the world’s collective experiences with Covid-19, it is that virtually every country struggled mightily in curbing hospitalizations and deaths using nonpharmaceutical interventions.’³³² As they continue, if it were not for the emergence of the vaccines, then ‘nations would eventually have had devastating hospitalization and death rates’.³³³ On the basis of the devastating consequences of not mandating vaccination, a legal instrument requiring citizens

326 Ibid 92–3 [12]–[13].

327 Archard, Brierley and Cave (n 23) 721.

328 *Vavříčka* (n 109) 38 [158].

329 Anna Nilsson, ‘Is Compulsory Childhood Vaccination Compatible with the Right to Respect for Private Life? A Comment on *Vavříčka and Others v the Czech Republic*’ (2021) 28(3) *European Journal of Health Law* 323, 337 <<https://doi.org/10.1163/15718093-bja10048>>.

330 *Peters* (n 103) [26].

331 See Gostin and Wetter (n 253) 19.

332 Ibid 17.

333 Ibid.

to vaccinate or face limits on their rights may be justified in the interests of preserving public health.

B Protecting the Rights to Life and Health

The modern democratic state has an important role to play in protecting the lives and health of its citizens in observance of its human rights obligations³³⁴ and being accountable for the economic, political and moral conditions of the population.³³⁵ On this basis, vaccine coercion may be justified on the ground that it is an effective means of increasing population vaccination rates and thus promoting the rights to life and health, including the rights of those who cannot be vaccinated for medical reasons.³³⁶

At the individual level, it is often said that those who are medically eligible hold an ethical ‘obligation to vaccinate’ (‘OTV’) so as to protect those who are medically ineligible or otherwise at risk.³³⁷ However, aspects of the OTV argument have been criticised by those contending that the obligation to protect the health of the medically vulnerable should not override the freedoms of others (recalling the reasoning of Judge Wojtyczek in *Vavříčka*).³³⁸ According to Michael Kowalik, ‘individual freedoms cannot be overridden just to prevent disaster’ and ‘[r]estrictions on freedoms can be justified only if they are reasonably necessary to preserve what makes human life worth living, because freedom is a necessary condition of a life worth living and, therefore, worth preserving’.³³⁹ This criticism, however, conceives neither of life nor health as individual rights that may or must be protected in the same way as ‘freedom.’ Nor, does it consider the avoidance of death or ill-health as central to the concept of a ‘life worth living’.

Even the broad conception of liberty espoused by Harlon J in *Jacobson* recognises that liberty is subject to restraint, and that the liberty rights of a minority should not ‘dominate’ the majority:

[L]iberty ... does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. ... We are unwilling to hold it to be an element [of] ... liberty ... that one person, or a minority of persons, residing

334 See, eg, *ICCPR* (n 224) art 6 (right to life); *ICESCR* (n 287) art 12 (right to health); *International Convention on the Elimination of All Forms of Racial Discrimination*, opened for signature 21 December 1965, 660 UNTS 195 (entered into force 4 January 1969) art 5(e)(iv) (right to health); *CRPD* (n 279) arts 10 (right to life), 25 (right to health).

335 See, eg, Ellen Rock, *Measuring Accountability in Public Governance Regimes* (Cambridge University Press, 2020) 12, 13, 19 <<https://doi.org/10.1017/9781108886154.004>>.

336 For instance, young children, for whom vaccines were only approved in mid-2022, were at risk: see Centers for Disease Control and Prevention, ‘CDC Recommends COVID-19 Vaccines for Young Children’ (Media Statement, 18 June 2022) <<https://www.cdc.gov/media/releases/2022/s0618-children-vaccine.html>>. See also, eg, Attwell et al (n 22); Bridget Williams, ‘Vaccine Mandates Need a Clear Rationale to Identify Which Exemptions Are Appropriate’ (2022) 48(6) *Journal of Medical Ethics* 384 <<https://doi.org/10.1136/medethics-2022-108353>>.

337 See Michael Kowalik, ‘Ethics of Vaccine Refusal’ (2022) 48(4) *Journal of Medical Ethics* 240 <<https://doi.org/10.1136/medethics-2020-107026>>. For a representative argument, see Jason Brennan, ‘A Libertarian Case for Mandatory Vaccination’ (2018) 44(1) *Journal of Medical Ethics* 37 <<https://doi.org/10.1136/medethics-2016-103486>>.

338 *Vavříčka* (n 109) 91–3 [10]–[13] (Judge Wojtyczek).

339 Kowalik (n 337) 240.

in any community and enjoying the benefits of its local government, should have power to dominate the majority.³⁴⁰

Accordingly, a temporary suppression of individual liberty may well be justified to secure the prospect of liberty for a wider population, especially if, in the case of mandatory COVID-19 vaccination, the majority may then enjoy the benefits of virus suppression, the potential achievement of herd immunity, and the significant reduction or elimination of risk. Indeed, it may be that the emphasis on individual rights is a weakness of liberalism as a social theory. As it turns out, liberalism may not be well equipped to respond to contemporary global challenges like the COVID-19 pandemic and climate change where there is a need for high levels of cooperation, altruism, trust and consensus.³⁴¹

C Achievement of Herd Immunity (or the Next Best Thing)

The protection of others through the achievement and maintenance of ‘herd immunity’ has been a powerful argument in favour of a measure of vaccine coercion, especially with respect to routine childhood vaccination.³⁴² From this perspective, ‘herd immunity’ is a public good that transcends individual interests. By contrast, ‘free-riding’ (benefiting from widespread vaccination but failing to receive a vaccination) is thought to be unethical because, like tax evasion, it violates fairness in the collective distribution of risks, burdens and benefits.³⁴³

Yet, the virulence of the COVID-19 pandemic – where even efficacious vaccines cannot prevent breakthrough infections or stop immunity waning over time, and where novel variants and reinfections have occurred often – has meant that ‘herd immunity’ is not likely to be achieved.³⁴⁴ Still, widespread vaccination and boosters remain critical (especially for immunocompromised and older people)³⁴⁵ to slow or reduce the risk of transmission, as well as to preserve healthcare resources to ensure that new and emergency treatments may be available to those who need them. Although high levels of vaccination may not lead to elimination, it may achieve a form of ‘practical herd immunity’, in which infections may be managed in a way that leads to low hospitalisation and fewer deaths than any alternative.³⁴⁶ Several factors support the goal of practical herd immunity. Epidemiological

340 Jacobson (n 211) 26, 38.

341 See, eg, Jean-François Caron, *Irresponsible Citizenship: The Cultural Roots of the Crisis of Authority in Times of Pandemic* (Peter Lang, 2021) 19, 71–2.

342 Tomsick (n 245) 141–2, 150.

343 Alberto Giubilini, ‘An Argument for Compulsory Vaccination: The Taxation Analogy’ (2020) 37(3) *Journal of Applied Philosophy* 446, 451–2 <<https://doi.org/10.1111/japp.12400>>; Alberto Giubilini, ‘Vaccination Ethics’ (2021) 137(1) *British Medical Bulletin* 4, 6–7 <<https://doi.org/10.1093/bmb/ldaa036>>; Justin Bernstein, ‘Anti-vaxxers, Anti-anti-vaxxers, Fairness, and Anger’ (2021) 31(1) *Kennedy Institute of Ethics Journal* 17, 19–26 <<https://doi.org/10.1353/ken.2021.0003>>.

344 Rebecca SY Wong, ‘COVID-19 Vaccines and Herd Immunity: Perspectives, Challenges and Prospects’ (2021) 43(2) *Malaysian Journal of Pathology* 203, 213.

345 Nikolaos P Rachaniotis et al, ‘Is Mandatory Vaccination in Population over 60 Adequate to Control the COVID-19 Pandemic in EU?’ (2022) 10(2) *Vaccines* 329:1–11 <<https://doi.org/10.3390/vaccines10020329>>; Marcello Candelli, ‘COVID-19 Vaccine: What Are We Doing and What Should We Do?’ (2022) 22(5) *Lancet Infectious Diseases* 569 <[https://doi.org/10.1016/S1473-3099\(22\)00003-2](https://doi.org/10.1016/S1473-3099(22)00003-2)>.

346 Wong (n 344) 213.

evidence indicates that, as the prevalence of SARS-CoV-2 increases, the likelihood of more novel mutations emerging also increases.³⁴⁷ Additionally, recent research has suggested that multiple COVID-19 reinfections can be more dangerous than one infection due to cumulative organ damage.³⁴⁸ Finally, just as mandatory routine childhood vaccination can prevent possible outbreaks of diseases long forgotten,³⁴⁹ COVID-19 vaccination and ‘booster’ revaccination can ensure that SARS-CoV-2 (and mutations) are kept at bay.

D Reducing Death and Protecting the Health System

Vaccines have been very effective in preventing hospitalisation and death, despite the ‘waning of vaccine protection’ over time.³⁵⁰ However, there is also an indirect social and public health interest in high community vaccine coverage: namely, it ensures that public and private hospitals and health workers are not overwhelmed.³⁵¹ This in turn ensures that those requiring medical assistance for COVID-19 and other illnesses can access services, especially since recovery from the infection can be protracted and resource intensive, leading to medication shortages and requiring staff to take additional precautions, such as wearing personal protective equipment.³⁵²

E Protecting the Economy

Vaccine mandates may bring economic and socio-economic benefits, as infection control can allow businesses and markets to maintain operations and foster high sentiment.³⁵³ High vaccination also inspires feelings of safety and protection, enabling better psychological wellbeing and societal functioning, contributing to sustained economic productivity, including for employees seeking to continue in their work uninterrupted and in promoting tourism.³⁵⁴

347 Daniel Kim et al, ‘The Balancing Role of Distribution Speed against Varying Efficacy Levels of COVID-19 Vaccines under Variants’ (2022) 12(1) *Scientific Reports* 7493:1–8, 1 <<https://doi.org/10.1038/s41598-022-11060-8>>.

348 Brendan Crabb and Mike Toole, ‘Don’t Pump Brakes: Our COVID Strategy Must Change to Reflect Reality’, *The Age* (online, 23 June 2022) <<https://www.theage.com.au/national/victoria/don-t-pump-brakes-our-covid-strategy-must-change-to-reflect-reality-20220622-p5avqb.html>>.

349 See, eg, Arindam Nandi and Anita Shet, ‘Why Vaccines Matter: Understanding the Broader Health, Economic, and Child Development Benefits of Routine Vaccination’ (2020) 16(8) *Human Vaccines and Immunotherapeutics* 1900, 1900 <<https://doi.org/10.1080/21645515.2019.1708669>>.

350 Peter Nordström, Marcel Ballin and Anna Nordström, ‘Risk of Infection, Hospitalisation, and Death up to 9 Months after a Second Dose of COVID-19 Vaccine: A Retrospective, Total Population Cohort Study in Sweden’ (2022) 399(10327) *The Lancet* 814, 822 <[https://doi.org/10.1016/S0140-6736\(22\)00089-7](https://doi.org/10.1016/S0140-6736(22)00089-7)>.

351 See, eg, André Calero Valdez et al, ‘Europe Must Come Together to Confront Omicron’ (2022) 376 *British Medical Journal* o90:1–2 <<https://doi.org/10.1136/bmj.o90>>.

352 See Jason Phua et al, ‘Intensive Care Management of Coronavirus Disease 2019 (COVID-19): Challenges and Recommendations’ (2020) 8(5) *Lancet Respiratory Medicine* 506 <[https://doi.org/10.1016/S2213-2600\(20\)30161-2](https://doi.org/10.1016/S2213-2600(20)30161-2)>.

353 See Athina Zervoyianni, Sophia Dimelis and Alexandra Livada, ‘Economic Sentiment and the COVID-19 Crisis: Evidence from European Countries’ (2023) 55(1) *Applied Economics* 113 <<https://doi.org/10.1080/00036846.2022.2061903>>.

354 See generally Pragyan Deb et al, ‘The Effects of COVID-19 Vaccines on Economic Activity’ (2022) 158(1) *Swiss Journal of Economics and Statistics* 3:1–25 <<https://doi.org/10.1186/s41937-021-00082-0>>;

F Counterbalancing the Power of Anti-vaccination Movement

Vaccine mandates can be useful in counterbalancing the power of the anti-vaccination movement. For instance, a mandate may allow vaccine objectors to change their minds without reputational damage. Vaccination can instead be attributed to the legal rule, together with the need for continuing employment and the desire to maintain social freedoms, rather than an endorsement of vaccination.³⁵⁵

G Ethical Frameworks: Limitations on Coercion and Public Support

Of course, although coercive measures to achieve the vaccination of as many people as possible as quickly as possible can be morally and legally justified, a vaccine mandate will generally represent a considerable restriction on a person's rights and should not be adopted lightly. The thorny question, then, is not whether mandates can ever be morally and legally justified but rather: In what circumstances and for what duration will a vaccine mandate remain justified? The WHO's criticism of the Chinese Government's vaccine policy as 'extreme' (China continued to restrict individual rights as it pursued a 'COVID-zero' target) indicates that some vaccine mandates will be unjustifiable, even during a global pandemic.³⁵⁶

While scholars have called for more fine-grained and contextual analyses of vaccine coercion,³⁵⁷ several useful ethical frameworks have been advanced. Ethicist Julian Savulescu has proposed an 'algorithm' for justified mandatory vaccination based on an assessment of several questions, including whether the public health risk is grave, whether confidence in the vaccines' safety and efficacy is high, whether the utility of mandatory vaccination is high, and whether the penalties or costs for non-compliance are proportionate.³⁵⁸ Lawrence Gostin and Sarah Wetter have developed a similar 'question-based' model. They ask whether an intervention will achieve its goal, whether less restrictive methods can be imposed, whether

Youpei Yan et al, 'Risk Compensation and Face Mask Mandates during the COVID-19 Pandemic' (2021) 11(1) *Scientific Reports* 3174:1–11 <<https://doi.org/10.1038/s41598-021-82574-w>>. See also Vanessa Rémy et al, 'The Economic Value of Vaccination: Why Prevention Is Wealth' (2015) 3(1) *Journal of Market Access and Health Policy* 29414:1–3 <<https://doi.org/10.3402/jmahp.v3.29284>>; Sibilia Quilici, Richard Smith and Carlo Signorelli, 'Role of Vaccination in Economic Growth' (2015) 3(1) *Journal of Market Access and Health Policy* 27044:1–8 <<https://doi.org/10.3402/jmahp.v3.27044>>.

355 Amy Kaler, 'Opinion: Vaccine Mandates Help Anti-vaxxers Get the Shot while Saving Face', *Edmonton Journal* (online, 21 October 2021) <<https://edmontonjournal.com/opinion/columnists/opinion-vaccine-mandates-help-anti-vaxxers-get-the-shot-while-saving-face>>.

356 The situation in China, however, may be explained by the limited efficacy of the Sinopharm vaccine vis-à-vis the Omicron variant, together with low vaccination rates among the elderly: see 'WHO: Omicron Makes China's 'Zero-COVID' Policy Unsustainable', *AP News* (online, 18 May 2022) <<https://apnews.com/article/covid-health-china-pandemics-united-nations-c2b99ca8ce5f99f0d2b60aa66dcb8c2d5>>.

357 Mark C Navin and Katie Attwell, 'Vaccine Mandates, Value Pluralism, and Policy Diversity' (2019) 33(9) *Bioethics* 1042, 1042 <<https://doi.org/10.1111/bioe.12645>> ('Vaccine Mandates').

358 Julian Savulescu, 'Good Reasons to Vaccinate: Mandatory or Payment for Risk?' (2021) 47(2) *Journal of Medical Ethics* 78 <<https://doi.org/10.1136/medethics-2020-106821>> ('Good Reasons to Vaccinate'). See also Jonathan Pugh et al, 'The Unnaturalistic Fallacy: COVID-19 Vaccine Mandates Should Not Discriminate against Natural Immunity' (2022) 48(6) *Journal of Medical Ethics* 371 <<https://doi.org/10.1136/medethics-2021-107956>>.

predictable or unintended harms are accounted for and whether the benefits and burdens are distributed fairly.³⁵⁹ In contrast, Katie Attwell and Mark Navin have developed a conceptual framework for analysing mandatory vaccination policies for children. In this framework, policies are categorised according to their scope, sanctions, severity, selectivity and salience.³⁶⁰

There is general consensus among scholars and policymakers that vaccine mandates for healthcare workers in close contact with vulnerable people (ie, those working in aged care, health and disability) are justifiable, especially in view of these workers' duty of care toward their patients.³⁶¹ However, such a limited mandate means that non-healthcare workers and their families will remain at risk.³⁶² Vulnerability arguments may also justify vaccine mandates for people over 60, as the risks of COVID-19 contributing to mortality in this group is clear.³⁶³

However, justifications for vaccine coercion, especially relating to 'vulnerability', may change during a pandemic, especially as a virus mutates, as new knowledge about vaccine efficacy emerges, and as immunity rates change – rising from widespread infection, or waning as the vaccines wear off.³⁶⁴ Vaccine coercion is also harder to justify as new treatments emerge, such as those that may reduce the strain on hospitals and other resources.

Given the complexity of these variables, the decision to implement a vaccine mandate may inevitably constitute a value judgment based on subjective views about rights and values (such as that of life, liberty and health). And on these questions, there is great scope for disagreement. Some governments will inexorably impose coercion when they should not, while others will inexorably fail to coerce its citizens when they ought to do so.³⁶⁵

The history of vaccine coercion in the United Kingdom and Australia, chronicled above in Part III, illustrates why public support for vaccination coercion is fundamental. Concerns that COVID-19 vaccine coercion may backfire, entrench vaccine hesitancy, or cause people to abandon other vaccines, are not unreasonable.³⁶⁶ Yet, the vaccine mandates themselves, when combined with education and access to compensation schemes, can, as in the case of seatbelts, 'manufacture' public

359 Gostin and Wetter (n 253) 16.

360 Katie Attwell and Mark C Navin, 'Childhood Vaccination Mandates: Scope, Sanctions, Severity, Selectivity, and Salience' (2019) 97(4) *Milbank Quarterly* 978 <<https://doi.org/10.1111/1468-0009.12417>>. See also Navin and Attwell, 'Vaccine Mandates' (n 357).

361 Rachel Gur-Arie, Euzebiusz Jamrozik and Patricia Kingori, 'No Jab, No Job? Ethical Issues in Mandatory COVID-19 Vaccination of Healthcare Personnel' (2021) 6(2) *BMJ Global Health* e004877:1–5 <<https://doi.org/10.1136/bmjgh-2020-004877>>; Chris Stokel-Walker, 'COVID-19: The Countries That Have Mandatory Vaccination for Health Workers' (2021) 373 *British Medical Journal* n1645:1–2 <<https://doi.org/10.1136/bmj.n1645>>.

362 Gostin, Parmet and Rosenbaum (n 212) 713.

363 Rachaniotis et al (n 345).

364 Julian Savulescu, 'Provide Vaccines, Not Require Immunity or Vaccination Passports ... For Now' (2021) 49(2) *Journal of Law, Medicine and Ethics* 303 <<https://doi.org/10.1017/jme.2021.43>>.

365 Miller (n 261) 206–7.

366 Giuseppe Vetrugno et al, 'Compulsory Vaccination Would Exacerbate Resistance' (2019) 366 *British Medical Journal* l4464 <<https://doi.org/10.1136/bmj.l4464>>; Moises Velasquez-Manoff, 'The Anti-vaccine Movement's New Frontier', *The New York Times* (online, 31 May 2022) <<https://www.nytimes.com/2022/05/25/magazine/anti-vaccine-movement.html>>.

support and establish vaccination as an accepted social norm.³⁶⁷ While anecdotal reports highlight examples of vaccine-hesitant people who regret their choice once infected,³⁶⁸ it is possible that some vaccine-hesitant people will later feel grateful for being compelled to vaccinate when they were otherwise disinclined to do so (as is the case with many mental health patients).³⁶⁹

H Alternatives to Vaccine Coercion Are Preferable

Ideally, governments should achieve high levels of vaccination without resort to legal coercion at all; or, if legal coercion is required, it should be a matter of late or even last resort. In this regard, Australian state governments might reasonably be criticised for implementing vaccine mandates at an early stage,³⁷⁰ especially in circumstances where no effective public education campaign was delivered and no less coercive measures (such as incentives) were attempted.³⁷¹ A burgeoning field of research now focuses on non-coercive vaccine policy, exploring the causes of vaccine hesitancy,³⁷² the overlap between vaccine hesitancy and psychological processes,³⁷³ different means of persuading vaccine-hesitant people,³⁷⁴ and the degree of scientific trust among vaccine objectors. One finding that seems to have been clearly identified is that enabling citizens to choose among different vaccines, especially where different categories of vaccine are offered, is a powerful way of ensuring both that informed consent is more readily obtained and vaccination is

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- 367 Katie Attwell, Jeremy K Ward and Sian Tomkinson, 'Manufacturing Consent for Vaccine Mandates: A Comparative Case Study of Communication Campaigns in France and Australia' (2021) 6 *Frontiers in Communication* 598602:1–17 <<https://doi.org/10.3389/fcomm.2021.598602>>; Giubilini and Savulescu (n 209) 243.
- 368 Jack Healy, 'They Spurned the Vaccine. Now They Want You to Know They Regret It', *The New York Times* (online, 4 August 2021) <<https://www.nytimes.com/2021/07/30/us/covid-vaccine-hesitancy-regret.html>>.
- 369 Wilson, *Mental Health Law* (n 219) 6.
- 370 Gyan Moorthy, 'Compulsory COVID-19 Vaccination? Only as a Policy of Last Resort' (2020) 6 *Voices in Bioethics* 1 <<https://doi.org/10.7916/15fy-b922>>.
- 371 See, eg, Savulescu, 'Good Reasons to Vaccinate' (n 358).
- 372 Stephane Hess et al, 'The Path towards Herd Immunity: Predicting COVID-19 Vaccination Uptake through Results from a Stated Choice Study across Six Continents' (2022) 298 *Social Science and Medicine* 114800:1–18 <<https://doi.org/10.1016/j.socscimed.2022.114800>>; Jessica Fishman et al, 'Comparative Effectiveness of Mandates and Financial Policies Targeting COVID-19 Vaccine Hesitancy: A Randomized, Controlled Experiment' (2022) 40(51) *Vaccine* 7451 <<https://doi.org/10.2139/ssrn.3964293>>; Shupeí Yuan and Haoran Chu, 'Vaccine for Yourself, Your Community, or Your Country? Examining Audiences' Response to Distance Framing of COVID-19 Vaccine Messages' (2022) 105(2) *Patient Education and Counseling* 284 <<https://doi.org/10.1016/j.pec.2021.08.019>>; Yilang Peng, 'Politics of COVID-19 Vaccine Mandates: Left/Right-Wing Authoritarianism, Social Dominance Orientation and Libertarianism' (2022) 194 *Personality and Individual Differences* 111661:1–7 <<https://doi.org/10.1016/j.paid.2022.111661>>.
- 373 Renana Danenberg et al, 'Attitudes of Patients with Severe Mental Illness towards COVID-19 Vaccinations: A Preliminary Report from a Public Psychiatric Hospital' (2021) 143 *Journal of Psychiatric Research* 16 <<https://doi.org/10.1016/j.jpsychires.2021.08.020>>; Luca Simone et al, 'Mistrust and Beliefs in Conspiracy Theories Differently Mediate the Effects of Psychological Factors on Propensity for COVID-19 Vaccine' (2021) 12 *Frontiers in Psychology* 683684:1–15 <<https://doi.org/10.3389/fpsyg.2021.683684>>; Şerif Bora Nazlı et al, 'Psychological Factors Affecting COVID-19 Vaccine Hesitancy' (2022) 191(1) *Irish Journal of Medical Science* 71 <<https://doi.org/10.1007/s11845-021-02640-0>>.
- 374 Diekema (n 264).

more widely adopted.³⁷⁵ Further, in 2023 the Australian Government is planning to legislate to reduce the spread of misinformation and disinformation on global technology platforms.³⁷⁶

VI CONCLUSION

This article began by defining coercion, adopting a broad characterisation. It then compared the history of vaccine coercion in the United Kingdom and Australia – two relatively similar jurisdictions that have implemented divergent vaccine frameworks, both in history and during the COVID-19 pandemic. While the United Kingdom has arguably deferred to individual liberty at the expense of public health, Australia, through its individual states and territories, opted to maximise public health at the expense of individual liberty. Part IV of this analysis methodically explored the right to refuse medical treatment; however, in Part V, the article presented arguments for mandatory vaccination, finding that, in the pandemic context, laws mandating COVID-19 vaccines were both legally and morally justifiable.

Perhaps regrettably, the need for high levels of vaccination to protect the vulnerable leaves little room for uncertainty, much less dissent, about whether vaccination should be mandatory or coercive. At the same time, the high social, political and economic benefits of vaccination have also hastened the turn towards coercion and stoked suspicion and scepticism among a minority of people. Improvements in vaccine education, and more constructive dialogues and engagement between vaccine objectors and governments, may enable a reduction in vaccine hesitancy, and in turn reduce governments' dependence on coercive legal mandates.³⁷⁷

Even so, history indicates that vaccine hesitancy may always exist and that some populations may never achieve high vaccination rates without a degree of coercion. Though many lessons will be taken from the COVID-19 pandemic into the future, it remains uncertain whether the same kinds of vaccine mandates as were adopted in Australian states during this pandemic would, or will, be imposed again and what long-term effects the pandemic experience will have on vaccine hesitancy in relation to the ongoing debates about coercion, including with respect to childhood vaccination.

375 Mark T Hughes et al, 'The Importance of Offering Vaccine Choice in the Fight against COVID-19' (2021) 118(43) *Proceedings of the National Academy of Sciences* e2117185118:1–4 <<https://doi.org/10.1073/pnas.2117185118>>; Philipp Sprengholz et al, 'The Power of Choice: Experimental Evidence That Freedom to Choose a Vaccine against COVID-19 Improves Willingness to Be Vaccinated' (2021) 87 *European Journal of Internal Medicine* 106 <<https://doi.org/10.1016/j.ejim.2021.03.015>>.

376 Zoe Samios, 'Government Introduces Laws to Protect Australians from Online Misinformation', *The Sydney Morning Herald* (online, 20 January 2023) <<https://www.smh.com.au/business/companies/government-introduces-laws-to-protect-australians-from-online-misinformation-20230119-p5cdqg.html>>.

377 See King, Ferraz and Jones (n 259) 222.