Epidemics and pandemics in Victoria: Historical perspectives

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Cover image:
Hospital Beds in Great Hall During Influenza Pandemic, Melbourne Exhibition Building, Carlton, Victoria, circa 1919, unknown photographer; Source: Museums Victoria.

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Executive summary

This paper examines the history of epidemics and pandemics in Victoria over the past 200 years. Focusing on the political, social and cultural impacts and legacies of these health crises, it considers what lessons they may—or may not—offer in helping comprehend the current challenges presented by COVID-19.

Victoria has a long history with epidemics and pandemics. Smallpox outbreaks that decimated Indigenous populations during early settlement were followed by frequent epidemics in nineteenth-century Melbourne, the 1891 'Russian flu', 1919 'Spanish flu' and 1957 'Asian flu' pandemics, the 1937 polio and 1980s-90s HIV/AIDS crises, and 'Swine flu' in 2009. Particular attention is paid in this paper to the 1919 Spanish flu, the episode with which COVID-19 is most frequently being compared.

Several clear themes run through all these episodes, including the ways certain groups in the population tend to be impacted by specific epidemics; recurring political issues of quarantine and federalism; instances of racism and stigmatisation of impacted groups; and community resilience, cooperation and activism. Yet each epidemic is also very much a product of the times, shaped not only by medical knowledge and resources, but political choices and cultural norms, changing economic structures and global interconnectedness, and existing social tensions and inequalities.

Searching for historical parallels is an important way to make sense of the scale, cost and severity of the present crisis. There are both limitations and advantages in drawing such analogies to understand the present crisis in a Victorian context. While experts can draw policy lessons from past experiences, as well as identify general patterns in how communities react to the stresses of health crises, historians also stress the crucial differences in the contexts in which each crisis—including the present one—occurs, with unique problems requiring unique solutions. Finally, historians also warn that despite their impact on society, epidemics also tend not to be remembered or memorialised like other disasters and tragedies.

Introduction

In Victoria, as around the world, COVID-19—the disease caused by the novel coronavirus, SARS-CoV-2—has caused the most remarkable interruption to daily life in living memory, if not modern history. The impulse in such circumstances is to search for historical analogies to help comprehend the scale, costs and challenges of the present crisis: the Spanish flu, the Great Depression, the Second World War?[1] As was remarked more than once during the Victorian Parliament's emergency sitting on 23 April 2020, 'right now we are living through history'.[2]

What, if anything, can we learn from history as we live 'through history'? Victoria has a long past with epidemics and pandemics, from epidemics of smallpox and other diseases through the nineteenth century, the 'Russian flu' (1890), 'Spanish flu' (1919) and 'Asian flu' (1957) pandemics, polio (1937–38) and HIV/AIDS (1980s to today) crises, and the 2009 'Swine flu' pandemic. Each episode has had an important impact on Victoria. They were not only public health crises. These events reshaped political and social life, the relationship of the Commonwealth to the states, exacerbated existing social tensions and also created new kinds of community strength and cooperation.

This paper examines the history of epidemics and pandemics in Victoria over the past 200 years. It seeks to draw out the parallels between these events, discussing what lessons may be drawn from the past in making sense of the current crisis. At the same time, it emphasises the limits of drawing lessons from the past and the importance of appreciating the novel circumstances and problems of each crisis.

When comparing past epidemics, the most obvious point of contrast is mortality rates. As the table below summarises, Victoria has had a chequered and, at times, devastating history with epidemics. But numbers only tell part of the story. While epidemics are determined by the nature of a virus and medical knowledge, they are also political cultural events. Epidemics force governments and societies to make choices about how to respond that are shaped by pre-existing social tensions, global interconnectedness and economic structures.

Table 1: Past pandemics and mortality rates—Victoria, Australia, Global

Virus	Year	Victoria		Australia		Global	
		Cases	Deaths	Cases	Deaths	Cases	Deaths
Smallpox	1790s–1830s	n/a	45,000 (75% of Indigenous population)	n/a	>50% of Indigenous population	n/a	n/a
'Russian flu'	1891	n/a	<1,000	n/a	n/a	Up to 40% world pop.	n/a
'Spanish flu'	1918–20	n/a	3,561	Up to 40% population	12,000–20,000	500 million (30% world)	20–50 million
Polio	1937–38	2,096	118	4,555	274	n/a	n/a
'Asian flu'	1957	n/a	40	n/a	Approx. 70	n/a	1–4 million
HIV/AIDs and related illness	1981–2016	n/a	n/a	35,000	10,000	75 million (HIV)	32 million
'Swine flu'	2009	3,089	26	6,725	84	n/a	up to 570,000
COVID-19[3]	2020	1,507	18	6,964	97	4.25 million	291,334

[1] See: N. Burnside (2020) 'Coronavirus lessons we can learn from other dark times in history', *ABC News*, 10 April; A. Clark (2020) 'Australia is looking to lessons from the Spanish flu', *Australian Financial Review*, 14 March.
[2] S. Ratnam (2020) 'COVID-19 Omnibus (Emergency Measures) Bill 2020', *Debates*, Victorian Legislative Council, 23 April, p. 72.
[3] As at 12 May 2020; Commonwealth Department of Health (2020) 'Coronavirus (COVID-19) current situation and case numbers', Department of Health website; Johns Hopkins University & Medicine (2020) 'Coronavirus Resource Center', Johns Hopkins website.

There are nonetheless clear parallels between these events that can help us understand how communities may respond to major health crises. In Victoria, this includes patterns in how certain groups may be impacted by epidemics, recurring political issues of quarantine and federalism, instances of racism and the stigmatisation of impacted groups, but also patterns of community resilience, cooperation and activism. History also reminds us that pandemic outbreaks are often forgotten, despite the impacts they inflict on societies.

This paper traces these themes through Victoria's long history with epidemics. The main part of the paper provides a chronological overview of major epidemic events in Victoria's past. Particular attention is paid to the 1919 Spanish flu, the episode with which COVID-19 is most frequently compared.

The final section considers what might be learned from this history from a range of perspectives, including: direct policy lessons; general patterns in how communities and governments respond to health crises; lessons about how pandemics transform societies; the tendency to forget pandemics; and the possibility that history offers few 'lessons' at all for comprehending the present crisis.

A note on terminology: outbreaks, epidemics, pandemics

Today, 'outbreak', 'epidemic' and 'pandemic' are terms all associated with a widespread health crisis. Epidemiologists and health authorities use them to categorise a disease scenario at different scales. Outbreaks are a noticeable, often small increase over the expected number of cases for a given illness in a specified location. An epidemic is an outbreak over a larger geographic area. A pandemic is global in scale, and typically out of control. Classical definitions identified pandemics as an epidemic that had spread to multiple countries, however some epidemiologists now classify pandemics if the disease is sustained in a newly affected region through local transmission. [4]

The World Health Organisation (WHO) declared COVID-19 a pandemic on 11 March 2020, by which time the disease had spread to 114 countries, with 118,000 cases and 4,921 deaths.[5] At the time of publication, there were over 4 million cases and more than 291,000 deaths.[6] In Australia, there had been just under 7,000 confirmed cases and 97 deaths, with 1,507 cases and 18 deaths in Victoria.[7]

The WHO have retrospectively identified four other influenza pandemics: the so-called 'Spanish flu' (1918–19), which is estimated to have caused 20–50 million deaths, the 1957–58 'Asian flu' and the 1968 'Hong Kong flu', estimated to have caused 1 to 4 million deaths each, and the 2009–10 'Swine flu', which is estimated to have caused up to 575,000 deaths.[8]

[4] R. Fischer (2020) What's the difference between pandemic, epidemic and outbreak? *The Conversation*, 12 March.
[5] World Health Organisation (2020) WHO Director-General's opening remarks at the media briefing on COVID-19 (Online), 11 March.
[6] Johns Hopkins University & Medicine (2020) 'Coronavirus Resource Center', Johns Hopkins website.
[7] As at 12 May 2020; Commonwealth Department of Health (2020) op. cit.
[8] World Health Organisation (2020) 'Past pandemics', WHO website.

Smallpox and other nineteenth-century epidemics

Smallpox and Indigenous population decline

Prior to European settlement, the Kulin people of what came to be known as the Port Phillip region suffered little communicable disease. The Kulin lived in low numbers and without domesticated animals, conditions not conducive to the spread of infectious diseases. Paleopathologists have shown that indigenous peoples living in other parts of Victoria, such as the Murray region, did suffer diarrhoeal diseases resulting from their near-sedentary way of life in a food-rich environment.[9]

Smallpox is generally accepted as the earliest-known epidemic episode in settler-Australian history, decimating Indigenous Australian populations in the south-eastern parts of the continent. There are continuing debates among historians as to whether smallpox was brought to Australia by the Europeans who settled at Port Jackson in 1788 or by Macassans (from South Sulawesi) with whom Aboriginal peoples in northern Australia had been trading since the mid-eighteenth century.[10] Most historians accept the former argument, although the conventional account is complicated by the fact that there were no cases of smallpox recorded on the First Fleet or among early settlers. For similar reasons, some historians have argued the disease was in fact chickenpox, which is more infectious than smallpox and severe (even fatal) when contracted by adults, perhaps explaining its easy transmission over less densely populated parts of the continent.[11]

Two major 'pox' epidemics, one in 1789 and another in 1829–31, severely impacted Australia's Indigenous population. The first recorded outbreak, in April 1789, swept through the Sydney area, and may have reached as far south as the Port Phillip region.[12] A second outbreak spread along the Murray-Darling Basin from 1829, into eastern Australia reaching the south coast of what would later become Victoria. Records suggest the outbreak was 'universal' in 1830 and 1831 in the country west of Port Phillip, from the Murray River to the south coast. There is less evidence of the outbreak reaching Gippsland. Historian Judy Campbell estimates that the incidence of disease in the dwellings of closely related clans in semi-settled and well-endowed districts, from Portland across to Westernport, would have been high and would have seen severe mortalities rates.[13]

The two epidemics are estimated to have killed as many as three-quarters of Victoria's pre-colonial population. It is now thought that the Aboriginal population of Victoria was about 60,000 prior to 1788, which the epidemics halved twice, to a population of about 15,000. The Djadja Wurrung people living in the basins of the Loddon and Avoca rivers, for example, was probably halved from 4,000 to less than 2,000 by 1840.[14]

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[9] J. McCalman (2008) Diseases and Epidemics, *E-Melbourne: The City, Past & Present* , The School of Historical and Philosophical Studies, The University of Melbourne.

[10] J. Campbell (2002) *Invisible Invaders: Smallpox and other diseases in Aboriginal Australia 1780-1880*, Melbourne, Melbourne University Press.

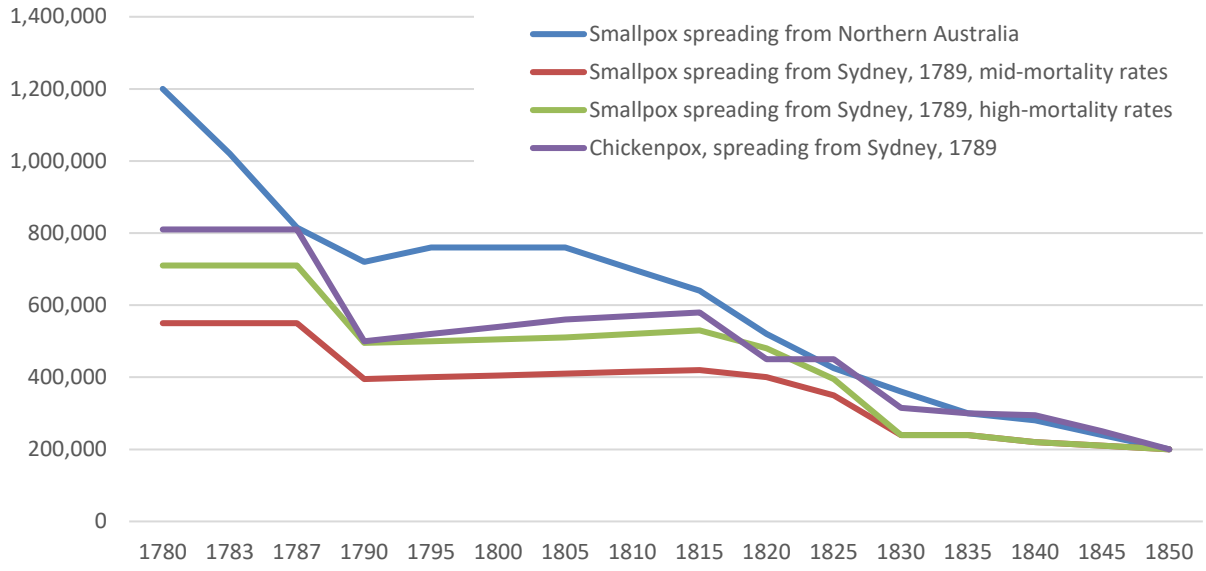
[11] B. Hunter & J. Carmody (2015) 'Estimating the Aboriginal Population in Early Colonial Australia: The Role of Chickenpox Reconsidered', *Australian Economic History Review*, 55(2): pp. 112–138.

[12] N. G. Butlin (1993) *Economics of the Dreamtime: A Hypothetical History*, Cambridge, Cambridge University Press, p. 128.

[13] J. Campbell (2002) op. cit.

[14] R. Broome (2005) *Aboriginal Victorians: a history since 1800*, Sydney, Allen & Unwin; B. Attwood (2017) *The Good Country: The Djaja Wurrung, the settlers and the Protectors*, Melbourne, Monash University Press, pp. 6–8; Smith L., J. McCalman, I. Anderson, S. Smith, J. Evans, G. McCarthy, and J. Beer (2008) 'Fractional Identities: The Political Arithmetic of Aboriginal Victorians', *Journal of Interdisciplinary History*,38(3):4, pp. 533–551.

Figure 1: Indigenous Australian population, entire continent, 1780–1850: four epidemic scenarios



Note: estimates only. Pre-colonial populations have been calculated by back-casting from (roughly) known 1850 populations and estimating likely mortality rates of each disease. Estimates include population decline from frontier violence. *Source:* Hunter and Carmody (2015) 'Estimating the Aboriginal Population'.

These losses were compounded by other diseases introduced from Europe. From the early nineteenth century, European whalers and sealers introduced venereal diseases, which not only killed people but rendered Aboriginal women sterile and infected babies, severely diminishing the possibility of an Aboriginal demographic recovery. As Attwood puts it, 'white men's lust killed many more Aboriginal people than did their guns'.[15] As settlement spread, a further fall occurred as Indigenous peoples came into increasing contact with Europeans. Colds, bronchitis, influenza, measles, scarlet fever, dysentery and tuberculosis—which can kill up to 50 per cent of those who become infected with the active bacteria—spread through Indigenous populations that had little if any immunity to these illnesses.[16]

Furthermore, as Hunter and Carmody note, the negative effect of these multiple epidemics is likely to have been compounded by declining nutrition associated with the colonial expansion onto lands that had provided their food source.[17]

Other nineteenth-century diseases

Adult Europeans who arrived in Australia came from disease-rich home environments and were therefore largely immune to these early epidemics. But this also meant they brought Europe's infectious diseases with them. Living conditions in early settler Melbourne were often basic, polluted with human and animal waste that exposed residents to diarrhoeal diseases. As urban and health historian Janet McCalman has written, 'with overflowing cesspits, polluted rivers and creeks, open sewers in the city streets and casual use of pans, 'Smelbourne' had a pervasive odour of human

[15] Attwood (2017) op. cit., p. 122.
[16] ibid, pp. 121-122; J. Boyce (2008) *Van Diemen's Land*, Melbourne, Black Inc.
[17] B. Hunter and J. Carmody (2015) op. cit.

excrement'.[18] Typhoid also festered in these conditions, and by the 1870s it was reported that recorded death rates from the 'colonial fever' were 300 to 400 times higher than the worst British cities.[19]

As was the case elsewhere during the nineteenth century, Victorian children endured their own selection of diseases, including measles, diphtheria, scarlet fever and tuberculosis. All of these reached epidemic proportions on several occasions in the second half of the nineteenth century.[20]

Although Europe's repeated nineteenth century cholera epidemics were much feared, assiduous quarantine ensured that it never reached Australia. Smallpox, however, continued to be a problem, arriving on infected ships from Britain. Melbourne's most significant outbreak was 56 cases in 1885–86. The most feared epidemic disease, bubonic plague, arrived in Sydney in January 1900, prompting a clean-up of Sydney's worst slums around the Rocks and rat-extermination programs throughout the country. Melbourne suffered only ten cases in 1900, but the clean-up of living conditions focused public attention on the practices of boiling water and milk and controlling rodents.[21]

Most of these diseases began to decline by the turn of the century. Improved public sanitation—Melbourne's sewers were built from 1897—acceptance of germ theory, provision of plentiful and clean water and roomier housing all contributed to the decline of epidemic episodes.[22] Smallpox, typhoid and diphtheria were all subjects of government inquiries in this period, the last being the focus of an 1872 royal commission.[23] The opening of the Fairfield Infectious Diseases Hospital in 1904 provided isolation and expert care, in particular for children and adults suffering from diphtheria, poliomyelitis, scarlet fever and all other serious infectious diseases. The hospital's final years of service were in the treatment and palliative care of terminal HIV/AIDS sufferers.[24]

'Russian flu', 1891

As the nineteenth century progressed, faster shipping ensured Australia was no longer safe from Europe's influenza pandemics. Victoria's first serious flu outbreak was in 1860–61; it became more common by the 1880s. By the close of the century, global transport networks ensured Victoria was to share in the world's grief of the nineteenth century's largest epidemic, the 'Russian flu' of 1889–91. The pandemic spread rapidly—carried on new railways and steamships—and took only four months to circumnavigate the world, peaking in the United States 70 days after the original outbreak in St. Petersburg.[25]

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[18] F. B. Smith (2002) 'Disputes about Typhoid Fever in Victoria in the 1870s', *Health and History*, 4(2), pp. 1–18.
[19] McCalman (2008) op. cit.
[20] ibid.; F. B. Smith (1999) 'Comprehending diphtheria', *Health and History* 1(2/3), pp. 139–161.
[21] ibid.
[22] C. Hooker and A. Bashford (2002) 'Diphtheria and Australian Public Health: Bacteriology and Its Complex Applications, c. 1890-1930', *Medical History*, 46(1), pp. 41–64.
[23] Chief Medical Officer (1869) *Small-pox. An Additional Report of the Chief Medical Officer*, Melbourne, Government Printer; W. McCrea, Chairman (1872) *Diphtheria: Report of the Royal Commission, with Minutes of Evidence*, Melbourne, Government Printer; Central Board of Health (1887) *Typhoid Fever. Report by the Central Board of Health*, Melbourne, Government Printer.
[24] J. McCalman (2008) op. cit.; J. H. L. Cumpston (1926) *The History of Plague in Australia*, Melbourne, Government Printer.
[25] A. J. Valleron, A. Cori, S. Valtat, S. Meurisse, F. Carrat, & P. Y. Boëlle(2010) 'Transmissibility and geographic spread of the 1889 influenza pandemic', *PNAS*, 107(19), pp. 8778–8781.

The first cases were reported in Australia towards the end of March 1890, with the outbreak reaching epidemic proportions in Victoria for three or four months, claiming 164 lives.[26] As was the case in Europe, the disease reappeared the following year, this time in far more virulent form. According to the 1892 *Victorian Yearbook*, 1,035 people died from influenza in 1891. In the entire preceding decade, there were only 398 deaths from influenza, and 276 deaths from influenza between 1871 and 1880. In 1891, the deaths per head of 100,000 of mean population were 90.24, compared with just 4.29 deaths the decade prior.[27]

The epidemic had a considerable impact in Victoria. Doctors reported widespread 'dispiritedness' in the Melbourne suburbs.[28] The *Yearbook* reported the disease 'pressed most hardly on the old and the very young', although it was equally fatal in Melbourne as in the country districts. It noted that many more deaths 'were registered as from bronchitis, pneumonia, and other diseases of the respiratory system which originated in attacks of influenza and were complications of that complaint'.[29]

According to the *Commonwealth Yearbook*, the disease persisted for the next decade. Only once did fewer than 150 people die from influenza-related illnesses between 1893 and 1904, including almost 1,000 in 1899.[30]

The politics and culture of nineteenth-century disease

Quarantine

In addition to advances in sanitation and public health, and the decimation of Indigenous populations, several significant political and cultural legacies emerged from Victoria's early history with epidemics.

First, together with all other Australian colonies, was the development and expansion of maritime quarantine as the primary public health strategy against epidemics. Australia's first quarantine legislation was passed by New South Wales in 1832 in response to the threat of a European cholera. A quarantine ground was established at North Head, near Sydney.[31] In Victoria, quarantine powers initially existed under the NSW legislation before being provided for in *Victoria's Public Health Act 1865* and then the *Health Act 1890*. A dedicated quarantine station was built at Port Nepean in 1852.[32] All other colonies followed suit.

Australia's expanding use of quarantine across the nineteenth century contrasted sharply with the rest of the world, which was increasingly reducing its reliance on quarantine as the primary defence against epidemics. In Britain, quarantine was largely abandoned, partly because it was considered 'anti-commercial, anti-social, and anti-Christian',[33] partly because of its failure to stop repeated cholera epidemics across the nineteenth century, and partly because public health strategies increasingly focussed on sanitation. By contrast, Australian colonial governments increasingly employed quarantine methods to combat epidemics because, unlike in Europe, public sanitation was not as

[26] Victorian Government (1892) *Victorian Yearbook 1892*, Melbourne, Government Printer, pp. 416-419.
[27] ibid.
[28] McCalman (2008) op. cit.
[29] Victorian Government (1892) *Victorian Yearbook 1892*. Melbourne, Government Printer, pp. 431-2.
[30] Commonwealth Government (1920) *Commonwealth Yearbook 1901-1919*, Melbourne, Government Printer, p. 1129.
[31] K. Maglen (2005) 'A world apart: geography, Australian quarantine, and the Mother Country', *The Journal of the History of Medicine and Allied Services*, 60(2), pp. 196-217.
[32] J. H. Welch (1969) *Hell to Health: the history of quarantine at Port Phillip Heads, 1852-1966,* Melbourne, Nepean Historical Society.
[33] Maglen (2005) op. cit.

strong, vaccinations were less readily available and disease such as smallpox did not yet have a 'local footing', meaning they tended to be more virulent. Most discussions about quarantine in the early part of the nineteenth century concentrated on protecting against smallpox arriving from England.[34]

Quarantine, disease and race

The increasing severity of Australian quarantine strategies was informed by a second development tied up with Australia's nineteenth-century history of epidemics: the increasing tendency to associate disease with foreign migrants, especially the Chinese. Many white settler Australians blamed Chinese immigrants for an 1881–82 smallpox outbreak and the bubonic plague outbreak of 1900. Confronted by the constant threat of death and disfigurement, people looked for a scapegoat to explain epidemics of infectious disease. These associations reflected white-settler hostility to Chinese migrants, who across popular, liberal and working-class media were increasingly represented as infecting Australia not only with smallpox, but cheap labour, immorality, opium and bribery.[35]

Ideas of 'Asia' as a source of disease began to inform medical theory and policy more generally. A distinct racial focus was applied to existing quarantine systems in Australia that soon became a matter of policy. By the end of the nineteenth century, Australia's quarantine measures were unsurpassed in their length and breadth, as other countries ratified agreements at international sanitation conferences which gradually moved towards the British model. In Britain, it was standard that public health officials would inspect a ship's crew and passengers. Those with symptoms would be taken to the isolation hospital and everyone else on board was free to go. By contrast, in the Australian colonies, it was not only those who arrived displaying signs of disease that were detained but everyone else onboard the ship, the vessel itself and usually the entire cargo. Sometimes quarantine was carried out on board, but in most cases the crew and passengers were landed at quarantine stations.[36] Ships from certain destinations could expect particularly vigilant attention. During the 1882 smallpox epidemic, for example, a ship carrying 450 Chinese immigrants was refused to dock and passengers were left stranded off Sydney's coast without food and water.[37]

Federalism

By the time of the Russian flu in 1890, the intersection of ideas about infectious disease, quarantine and 'foreigners' was becoming central to thinking about nationhood. From the early 1880s, the colonies held a series of sanitation conferences to discuss making quarantine laws uniform across the Australian colonies, with the Victorian Act selected as the model.[38] During the inter-colonial debates that preceded federation, quarantine was constantly debated as the task of a new federal government. As Alison Bashford has argued, quarantine enabled the language of biomedicine—epidemic, contagion, immunity, hygiene—to become tied up with the language of defending the nation—resistance, protection, invasion, immigration. Quarantine and defence from infectious disease helped colonial Australians to imagine themselves as a unified 'island-nation', in which medical and racial 'purity' was central to national imagining and border-talk.[39]

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[34] ibid.

[35] W. Anderson (2002) *Cultivation of Whiteness: Science, Health and Racial Identity in Australia*, Melbourne, Melbourne University Press, pp. 90–5; A. Bashford (2004) *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*, New York, Palgrave Macmillan.

[36] Maglen (2005) op. cit.

[37] G. Watters (2002) 'The S.S. Ocean dealing with boat people in the 1880s', *Australian Historical Studies*, 33(120), pp. 331–343

[38] For an overview, see, J. H. L. Cumpston (1913) *Quarantine: Australian Maritime Quarantine and the evolution of international agreements concerning quarantine*, Melbourne, Government Printer.

[39] A. Bashford (1998) 'Quarantine and the imagination of the Australian nation', *Health*, 2(4): pp. 387–402.

Accordingly, quarantine occupied a key role in section 51 of the new Commonwealth Constitution and was expressed in new federal legislation such as the *Immigration Restriction Act 1902* and the *Quarantine Act 1908*. Quarantine powers were conferred from the states to the Commonwealth with the establishment of the Federal Quarantine Service in 1909.[40] While providing a topic of national unity, as would be the case in the Spanish flu some 20 years later (and to a lesser extent, the novel coronavirus today), quarantine also sowed lines of fracture between the states, and between the states and the Commonwealth.

Media and epidemics

Finally, links between quarantine, disease, race and nationhood were facilitated by a third set of developments, which shaped the epidemic experience: an increasingly globalised media. The Russian flu was the first global pandemic to receive intensive world-wide coverage. The same technologies that had carried the Russian flu so quickly around the world were also responsible for helping build hype and anxiety about the disease. This gave the pandemic a double face: the physical reality of the infection and its 'media reality', which, in the case of places like Australia, preceded the arrival of the pandemic and shaped expectations, responses and prejudices by several months.[41] The spread of the Russian flu was first reported in Melbourne in December 1889, as the telegram enabled the papers to report its spread and the infection of notable individuals, especially in Britain.[42] The same medium would become indispensable in the following century in shaping, tempering and inflaming public responses to global pandemics.

Victoria and the 'Spanish' Influenza, 1918–20

The recurrent epidemics of the late nineteenth century were dwarfed by the 1918–19 influenza pandemic—Influenza A(H1N1) or 'Spanish flu'. It was one of the worst natural disasters in history and perhaps the worst pandemic since the fourteenth-century Black Death in terms of mortality and social impacts.[43] Emerging in the final months of World War I, in just over a year the pandemic was transported around the world by returning soldiers. It is not clear where or how the pandemic began, although some experts think it plausible that a milder form of influenza was carried to Europe by American troops in April 1918, transforming into a pandemic which spread westward across the world. It is clear the pandemic didn't begin in Spain but was given the name after the King of Spain became one of its earliest known victims.[44]

An estimated 500 million people—or one third of the world's population—were infected, with somewhere between 20 million and 50 million dying from the disease (some say as high as 100 million), three-fifths occurring in Asia. In terms of single events causing major loss of life, the Spanish flu surpassed the First World War (17 million dead) and the Second World War (60 million dead), and perhaps both combined. The pandemic was notorious for inflicting an unexplained high-mortality rate

[40] A. Bashford (2002) 'At the border: contagion, immigration, nation', *Australian Historical Studies*, 33(120): pp. 344–358.
[41] R. Peckham (2015) 'Panic enabled: epidemics and the telegraphic world', in R. Peckham (ed.) *Empire of Panic: Epidemics and Colonial Anxieties*, Hong Kong, Hong Kong University Press, pp. 131–154.
[42] (1889) Mysterious epidemic in Russia, *The Herald*, 2 December; (1890) Late cables, The Influenza Epidemic, *The Herald*, 10 January.
[43] L. Spinney (2017) *Pale Rider: The Spanish Flu of 1918 and How It Changed the World*, New York, Vintage.
[44] H. McQueen (1976) 'The "Spanish" Influenza Pandemic in Australia, 1912-19', in Jill Roe, ed., *Social Policy in Australia: Some Perspectives 1901-1975*, Sydney, Cassell, pp. 131–147.

on those aged between 20 and 40—a cruel underscore to the millions of young lives lost in four years of war.[45]

The flu strain, H1N1—the parent strain for Swine flu a century later—was highly virulent, with a mortality rate of more than 2.5 per cent, compared to less than 0.1 per cent for other pandemics.[46] While victims initially suffered the typical signs and symptoms of influenza—including aches, fever, coughing and an overwhelming weariness—a high proportion deteriorated rapidly. Patients' lungs filled with fluid (which is why it became known as 'pneumonic influenza') and they struggled to breathe. For nurses and doctors, a tell-tale sign of impending death was a blue, plum or mahogany colour in the victim's cheeks.[47]

Spanish flu in Australia

Australia had the advantage of seeing the epidemic coming, having heard about its progression first in Europe in the northern summer of 1918 and then in the reports of the second wave that emerged in September. Watching it advance through Africa and Asia, Australian authorities introduced quarantine procedures at all Australian ports on 18 October 1918. New Zealand did not follow suit, with devastating outcomes. When news broke of war's armistice in November, the crowds in Sydney's Martin Place and at Melbourne's Town Hall enjoyed the privilege—almost unique in the world—of having nothing to fear from the virus. However, many V-Day celebrations were to be cancelled, as the country came to suffer the epidemic's third wave in early 1919.[48]

In a period of six months from February 1919, it is estimated more than 15,000 Australians died from influenza and possibly as many as two million Australians (two-fifths of the population) were infected. The 1920 *Commonwealth Yearbook* lists just under 12,000 deaths.[49] Experts have since estimated this should be at least 3,000 to 4,000 higher. Consistent with mortality rates elsewhere in the world, almost a third of deaths in Australia were adults aged between 24 and 34. Consequently, more than 5,000 marriages were affected by the loss of a partner and over 5,000 children lost one or both parents.[50] As historian Peter Hobbins notes, the mortality rates from the Spanish flu match the average annual death rate for the Australian Imperial Force throughout 1914–18.[51]

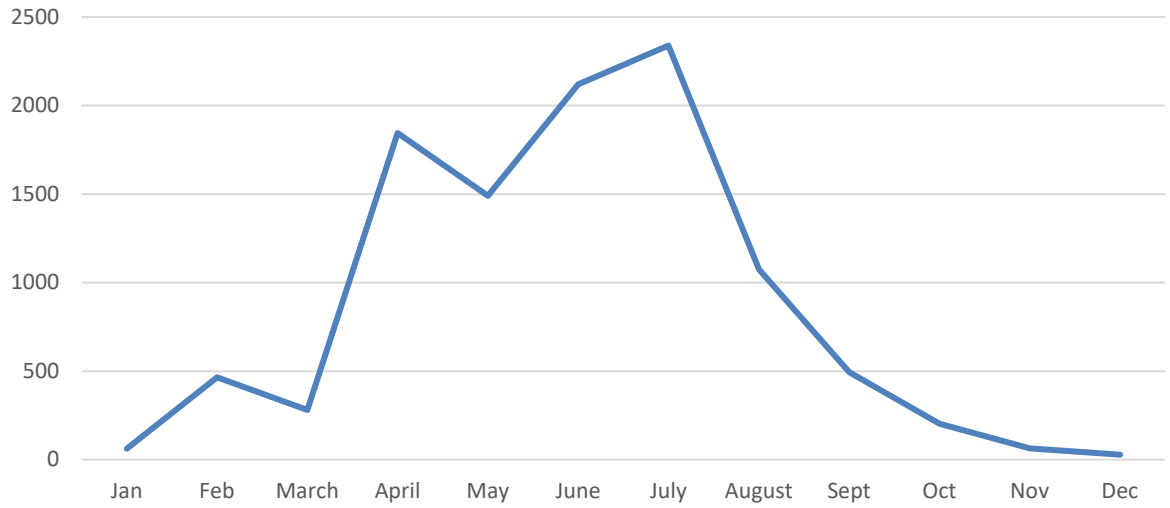
When the Victorian Government declared the epidemic over on 15 September 1919, officials announced 3,224 people had died from the disease: 2,327 in Melbourne and 897 in regional areas.[52] The *Victorian Yearbook* (3,530 deaths) and *Commonwealth Yearbook* (3,561 deaths, 2,413 in Melbourne, 1,148 in regional areas) provide slightly higher estimates, which again, are probably conservative.[53] One of the issues with accurately reporting mortality rates appears to have been confusion over categorising whether influenza or pneumonia was the cause of death, and for many

[45] P. Curson & K. McCracken (2006) 'An Australian perspective of the 1918-1919 influenza pandemic', *New South Wales Public Health Bulletin*, 17(7-8) pp. 103–7.
[46] ibid.
[47] P. Hobbins (2019) 100 years later, why don't we commemorate the victims and heroes of 'Spanish flu'? *The Conversation*, 21 January.
[48] Spinney (2017) op. cit.
[49] Commonwealth Government (1920) *Commonwealth Yearbook 1920*, Melbourne, Government Printer, pp. 1128–1133.
[50] Curson & McCracken (2006) op. cit., pp. 103–4.
[51] Hobbins (2019) op. cit.
[52] (1919) Influenza epidemic ends, *The Argus*, 15 September.
[53] Commonwealth Government (1920) *Commonwealth Yearbook 1920*, Melbourne, Government Printer, p. 1129; Victorian Government (1920) *Victorian Yearbook 1919-20*, Melbourne, Government Printer, p. 180.

years afterward statisticians differentiated between 'influenza' and 'pneumonia influenza' in their annual vital statistics.[54]

Mortality rates in Australia were characterised by two waves: the first in February–April and a second in May–June. Several commentators have drawn lessons from this aspect of the Spanish flu, with the second wave occurring after social restrictions were relaxed when it appeared the disease was abating in autumn, only to strike again in the heart of winter.

Figure 2: Monthly number of deaths from influenza, Australia, 1919



Source: Commonwealth Government (1920) *Commonwealth Yearbook 1920*, Melbourne, Government Printer, p. 1130.

Responses in Australia: a breakdown in federalism?

Australia's first line of defence against influenza was quarantine. The new Australian Quarantine Service was alerted to the existence of the new influenza type in July 1918. Monitoring its spread, they implemented maritime quarantine on 17 October 1918 after learning of outbreaks in New Zealand and South Africa. Returning troop ships were often badly affected. Half of the complement of the *Barambah* were infected and 23 deaths occurred during the voyage.[55] The first infected ship entered Australian waters on 18 October 1918 and over the next six months the service intercepted 323 vessels, 174 of which carried the infection. Of the 81,510 people who were checked, 1,102 were infected.[56] Numerous deaths occurred at Sydney quarantine stations in the three months before the infection infiltrated the domestic population.[57]

In late November 1918, state ministers of health, medical authorities and the Commonwealth Government met for a national influenza planning conference. The meeting adopted a 13-point plan for dealing with the spread of the virus, which centred on the federal government taking responsibility

[54] Victorian Department of Public Heath (1922) *Report of the Commission of Public Health*, Melbourne, Government Printer; Commonwealth Government (1921) *Commonwealth Yearbook, 1901-1920* Melbourne, Government Printer, 132.
[55] McQueen (1976) op. cit.
[56] National Museum of Australia (2020) '1919: Influenza pandemic reaches Australia', NMA website.
[57] McQueen (1976) op. cit.

for proclaiming which states were infected and organising maritime and land quarantine. The states would arrange emergency hospitals, vaccination depots, ambulance services, medical staff and public awareness campaigns.[58] Under the agreement, state authorities were required to promptly report any cases to the Commonwealth, which would then close that state's borders to protect its neighbours. Once cases were reported in other states, the Commonwealth would lift the border controls.[59]

The plan was cumbersome and did not work, as Victoria and New South Wales soon came to disagreement. The first diagnosed case within Australia occurred in New South Wales at the end of January. The patient was a returned soldier who had come to Sydney from Melbourne. When NSW reported the case to the Commonwealth, Victoria immediately followed suit, also reporting its first case. However, it was already public knowledge in the newspapers that Victorian doctors had been treating for almost a week what they suspected might be the new influenza, but were not yet prepared to declare it.[60] When they did so, a day after NSW, the NSW government blamed Victoria for failing in its duties under the national agreement and causing interstate transmission. Under the federal agreement, NSW and Victoria were now supposed to be declared a single 'quarantine area', but NSW closed its border nonetheless, walking away from the November agreement.[61]

(1919) *Arrival at quarantine camp Wallangarra*. Pictures Collection.
State Library of Queensland.

The November agreement broke down and each state followed its own course of action. While Victoria imposed no restrictions, New South Wales extended its border closure to South Australia and a few days later Queensland closed its border with NSW. Those wishing to move between states were quarantined in tents for between four and seven days before gaining permission to cross the border. Western Australia closed its borders, while anti-Commonwealth sentiment led to the impounding of the transcontinental train. Tasmania maintained the most rigid measures and clashed with the

[58] National Museum Australia (date unknown) 'Defining moments: Influenza pandemic', NMA website.
[59] F. Bongiorno (2020) 'How Australia's response to the Spanish flu of 1919 sounds warnings on dealing with coronavirus', *The Conversation*, March 22.
[60] (1919) Pneumonic Influenza, *The Age*, 24 January.
[61] McQueen (1976) op. cit.; (1919) Influenza epidemic, *The Age*, 29 January.

Commonwealth over how long steamers should be quarantined in its ports. By the end of the pandemic, Tasmania had one of the lowest mortality rates in the world.[62] The Commonwealth threatened that Queensland, WA and Tasmania would have their trade disrupted if they did not ease the quarantine of shipping; however, a seamen's strike (see below) denied them this option. As the historian Humphrey McQueen has written: 'In 1915 an external menace had driven Australians together; by 1919, an internal danger revealed yet again how easy it was for Australians to stand apart. If national unity involved loyalty to the Commonwealth as an administrative machine, the Pandemic showed how little of it there was.'[63]

The end of the crisis was nevertheless marked by an achievement of unity, when the Commonwealth Government established a new Department of Health in 1922. The Department would be the focal point of future epidemics and quarantine measures. Notably, Prime Minister William Watt had floated the idea of such a Department to the various state Premiers in February 1919. Not until late in 1920 did all the Premiers reply.[64]

Victoria's responses: health and social regulations

States were responsible for managing the disease in their own jurisdiction. In Victoria, this included widespread closure of public venues and schools. Under the *Health Act 1915*, responsibilities were further delegated to the municipal councils, to provide for the treatment of all infectious disease in their ward, with the government to pay half the duties.[65] Hospitals were a municipal rather than state responsibility at this time. The councils were informed by the state government in early October 1918 of their responsibilities, issued with what was then thought might work as a vaccine and instructed to spread posters and leaflets informing residents to seek medical advice if unwell.[66]

Medical authorities scrambled in their response. There was a dearth of doctors, partly due to about five per cent of all registered practitioners still being on overseas service. Those who remained were generally older, possibly unfit or wounded, and invariably over-worked, making them highly susceptible to infection.[67]

Makeshift hospitals and isolation camps sprang up, most prominently at Melbourne's Exhibition Building. The conditions were often basic. In Ballarat, an isolation hospital was erected in the Ballarat Showgrounds. Male and female patients were separated only by a large screen and the hut's earthen floors covered in wattle bark, with the kitchen under the old grandstand and a mortuary under the new grandstand.[68] At Wangaratta, a new infectious diseases ward was built on a wooden frame with an iron roof and hessian walls.[69] At Warrnambool, and likely elsewhere, nurses serving in the makeshift infectious disease ward were required to live at the hospital, sleeping in the cramped dispensary which served as their accommodation.[70]

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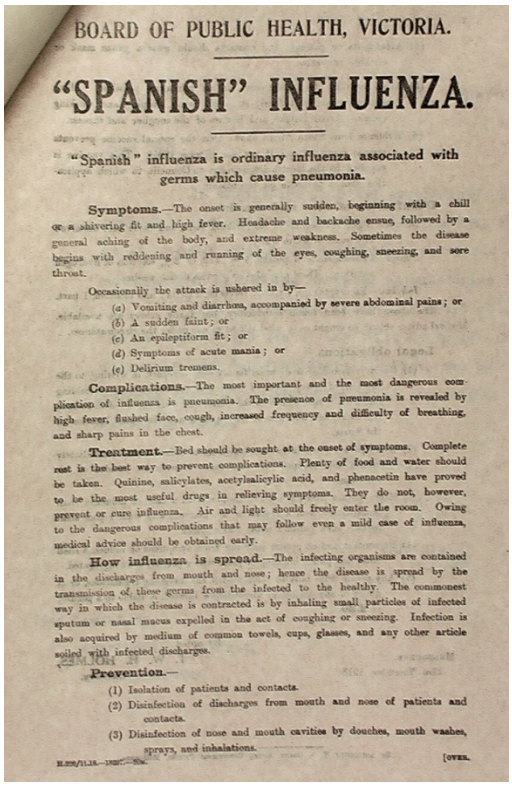
[62] McQueen (1976) op. cit.; M. Sheehan (2020) Were these the good old days? *Living Histories* (Online), 12 March.
[63] McQueen (1976) op. cit.
[64] M. Roe (1976) 'The establishment of the Australian Department of Health: Its background and significance', *Historical Studies*, 17(67), pp. 176–192.
[65] (1919) Cost of influenza epidemic, *The Age*, 3 May.
[66] Mr Bowser, Minister of Public Health (1918) Spanish Influenza*, Debates,* Victoria, Legislative Assembly, 20 November, pp. 2165-6.
[67] McQueen (1976) op. cit.
[68] A. Hsylop (1989) *Sovereign Remedies: A history of Ballarat Base hospital, 1850s to 1980s*, Allen and Unwin p. 229; (1919) An official circular, *The Age*, 30 April.
[69] McQueen (1976) op. cit.
[70] K. Lovell (2020) 'What it was like when the Spanish flu hit Warrnambool in 1919', *The Standard*, 21 March.

Then, as now, social distancing regulations were staggered and improvised. In late 1918, the state government passed the *Health Act 1919*, making amendments to the existing legislation that gave new powers to isolate localities where the disease developed.[71] Regulations were imposed about a week after the first infections were declared, which involved closing down 'all theatres, picture theatres, music or concert halls, and all public buildings where persons assemble for purposes of entertainment of instruction', within a 15-mile radius from the Post Office at the corner of Elizabeth and Bourke Streets.[72] Two days later, these regulations were applied to any 'infected area' across the state, which was to be a 15-mile radius around where someone had been infected.[73]



BOARD OF PUBLIC HEALTH, VICTORIA.

"SPANISH" INFLUENZA.

"Spanish" influenza is ordinary influenza associated with germs which cause pneumonia.

Symptoms.—The onset is generally sudden, beginning with a chill or a shivering fit and high fever. Headache and backache ensue, followed by a general aching of the body, and extreme weakness. Sometimes the disease begins with reddening and running of the eyes, coughing, sneezing, and sore throat.

Occasionally the attack is ushered in by—

(a) Vomiting and diarrhœa, accompanied by severe abdominal pains; or
(b) A sudden faint; or
(c) An epileptiform fit; or
(d) Symptoms of acute mania; or
(e) Delirium tremens.

Complications.—The most important and the most dangerous complication of influenza is pneumonia. The presence of pneumonia is revealed by high fever, flushed face, cough, increased frequency and difficulty of breathing, and sharp pains in the chest.

Treatment.—Bed should be sought at the onset of symptoms. Complete rest is the best way to prevent complications. Plenty of food and water should be taken. Quinine, salicylates, acetylsalicylic acid, and phenacetin have proved to be the most useful drugs in relieving symptoms. They do not, however, prevent or cure influenza. Air and light should freely enter the room. Owing to the dangerous complications that may follow even a mild case of influenza, medical advice should be obtained early.

How influenza is spread.—The infecting organisms are contained in the discharges from mouth and nose; hence the disease is spread by the transmission of these germs from the infected to the healthy. The commonest way in which the disease is contracted is by inhaling small particles of infected sputum or nasal mucus expelled in the act of coughing or sneezing. Infection is also acquired by medium of common towels, cups, glasses, and any other article soiled with infected discharges.

Prevention.—

(1) Isolation of patients and contacts.
(2) Disinfection of discharges from mouth and nose of patients and contacts.
(3) Disinfection of nose and mouth cavities by douches, mouth washes, sprays, and inhalations.

[over.

Board of Health (1918) *Influenza precautions leaflet*, VPRS 3181, Public Records Office Victoria.

On 7 February 1919, all racing events, billiard rooms and saloons in Melbourne and other infected areas were closed, while rules against congregating in 'excessive numbers'—that is, where there was 'less than 25 superficial feet available for each individual present'—were applied to gyms, pools and other exercising places.[74] Five days later, on 12 February, all other bars, registered clubs and bottle shops were closed and on 20 February, group meetings of larger than 20 were prohibited, except in churches (provided facemasks were worn), workplaces or, oddly, given the closure of drinking in hotels, restaurants and dining rooms.[75]

Schools did not return from summer holidays until 18 March.[76] Some closed again later in the year.[77]

Parliament was prorogued for an extended period. When the 1918 session ended in late December, it scheduled to resume on 21 January 1919.[78] This date was pushed back five times until Parliament finally resumed in July 1919.[79]

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[71] Mr. Bowser, Minister for Health (1918) 'Second reading speech: Health Bill (1918)', *Debates*, Victoria, Legislative Assembly, 11 December, p. 2950.
[72] Victorian Government (1919) *Government Gazette*, no. 16, p. 207.
[73] Victorian Government (1919) *Government Gazette,* no. 18, pp. 251–252.
[74] Victorian Government (1919) *Government Gazette,* no. 27, p. 579.
[75] Victorian Government (1919) *Government Gazette*, no. 35, p. 661.
[76] (1919) Reopening schools, *The Argus*, 1 March.
[77] McQueen (1976) op. cit.
[78] Mr. Lawson, Premier (1918) Close of the session, *Debates,* Victoria, Legislative Assembly, 20 December, p. 3511.
[79] Victorian Government (1919) *Government Gazette*, no. 8, p. 77; Victorian Government (1919) *Government Gazette*, no. 30, p. 615; Victorian Government (1919) *Government Gazette*, no. 46, p. 761; Victorian Government (1919) *Government Gazette*, no. 64, p. 991.

Most of these regulations were officially lifted by 8 March, meaning they had only been in place for some weeks.[80]

Within a month, at the beginning of April, a second outbreak had occurred. Restricted times were reimposed on theatres and picture theatres, but the full array of measures was not re-implemented.[81] In fact, the Victoria Board of Public Health also relaxed its policies on notification and isolation and tried to play down the spread. In a circular to all municipalities, the Department of Health stated that the influenza now prevalent was 'similar in character to the disease which has occurred every year for years past', the only difference being that this time it was 'more widespread'.[82] Circumstances seemed to shape this pronouncement, the Board adding that 'owing to the lack of nurses' it was 'not possible to treat every case in hospital'.[83] Instead, a new set of regulations were released targeting individual behaviour rather than public gatherings, requiring infected patients to stay at home or at provided accommodation (and for doctors to police them), or risk a fine totalling up to £25.[84]

Economic impacts: unemployment relief, strikes and coal

Theatrical artists and musicians were hit hardest by the regulations. The *Herald* reported many 'who were touring the country districts when the regulations closing places of entertainment were issued are now stranded in country towns'.[85] The same report estimated 4,000 entertainers, bartenders and wait staff were without work. In Melbourne, workers from various trades organised demonstrations in protest of the regulations that were causing unemployment, while a Labor Party deputation to the Premier requested temporary wage relief for workers.[86] By March, it was reported a £1,300 payment had been afforded to the unemployed by the state government.[87] Later that year, liquor licensees wrote to the government seeking compensation for the closure of their hotels.[88]

The unemployed—including those too sick to go to work—largely relied on trade unions or friendly societies to whom they may have paid contributions, limited municipal relief funds, or private charities and benevolence. While the government appears to have offered some relief, it did not match the £2 18s. paid to unemployed *married* men in New South Wales.[89] Indeed, prior to the Great Depression, there was no state-based relief system, and a Commonwealth welfare system did not materialise until after WWII.[90]

Yet these circumstances also fostered community spirit and cooperation. In Port Melbourne and surrounding suburbs, for example, residents devised a system where the sick would tie a white cloth

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[80] Victorian Government (1919) *Government Gazette*, no. 42, p. 711.
[81] Victorian Government (1919) *Government Gazette*, no. 59, p. 945.
[82] (1919) An official circular, *The Age*, 30 April.
[83] Hsylop (1989) op. cit., p. 229.
[84] Victorian Government (1919) *Government Gazette*, no. 74, p. 1165.
[85] (1919) 'Four thousand Idle', *The Herald*, 14 February. See also (1919) 'Extent of unemployment: Musicians and theatrical employees', *The Age*, 6 February; see also (1919)' Theatrical employees', *The Age*, 11 February.
[86] (1919) 'The economic aspect', *The Age*, 26 February; (1919) Government regulations: meeting in protest, *The Age*, 24 February; (1919) 'Unemployed make protest', *The Herald*, 28 February.
[87] (1919) 'Cost of the epidemic', *The Age*, 13 March.
[88] (1919) 'New of the day', *The Age*, 29 July.
[89] (1919) 'Relief fund closed', *The Herald*, 10 March; (1919) 'Government regulations: meeting in protest', *The Age*, 24 February; (1919) 'In New South Wales', *The Age*, 5 March.
[90] J. Murphy (2006) 'The other welfare state: Non-governmental agencies and the mixed economy of welfare in Australia', *History Australia*, 3(2): 1–15.

from their door, gate or front window to indicate they needed assistance. Volunteers or neighbours would then know to provide food or other help.[91]

Other aspects of the pandemic had unintended but devastating consequences. While maritime quarantine had helped slow the rate of infection, the various regulations adopted by different states damaged an already fragile economy devastated by the war. Coal was the lifeblood of Australia's industrialising economy and was mainly carried by the coastal shipping trade.[92] By the end of May, *The Age* estimated 25,000 tons of coal was sitting unmoved in various ports, depleting Victorian manufacturers' and domestic energy supplies.[93]

These factors were intensified when Australian seamen embarked on one of the longest strikes in Australian history. This dispute, which began in late 1918, arose in a wage dispute between shipowners and sailors. The pandemic exaggerated the issue. In early February, the Seamen's Union complained that the owners of the ship, *Loogana*, docked in Melbourne, expected 24 sailors to sleep in one room, contravening the Victorian Government's 20-person-per-room rule. When a Victorian Board of Health Inspector found the conditions acceptable and dismissed the complaint, strikes began soon after in early May. By the end of that month, the press reported 18 steamers were tied up in Melbourne and some 4,000 workers had been stood down. In New South Wales, stranded coal ships forced the closure of 12 pits, leaving about 3,000 miners out of work.[94]

Quarantine and strikes crippled shipping and magnified the economic consequences of the pandemic. Victorian manufacturing industries, which relied largely on the import of coal by sea from New South Wales, were especially hard hit. Woollen mills, clothing and confectionery factories shut their gates. By the end of June 1919, 32,500 people, including 8,000 women, were estimated to be out of work due to the strike, adding to those already demanding unemployment relief due to the pandemic. The plight of Melbourne's unemployed—whether caused by influenza regulations or the strike—was deepened when restrictions were applied to domestic power use through the middle of the winter. Restrictions on commercial use followed, impacting shops, restaurants and theatres, again curtailing nightlife and yet again putting hospitality, entertainment and artistic workers under strain. As other states accessed coal via rail, they were not as severely impacted as Victoria.[95]

Despite all this, retrospective calculations of GDP indicate the Australian economy in fact grew by 1.7 per cent in 1918–19 and almost four per cent the following year.[96] Economic historian Pierre van der Eng suggests this may not be surprising as Australia was coming out of wartime trade and rationing restrictions that had contributed to negative growth over the preceding years. These restrictions were lifted in November 1918.[97] Victoria's economy appears to have grown at a rate comparable to the rest of the nation.[98]

Of course, estimates of GDP are aggregated numbers that do not reflect local or regional circumstances. It is clear some communities were hit harder than others, with much of the burden

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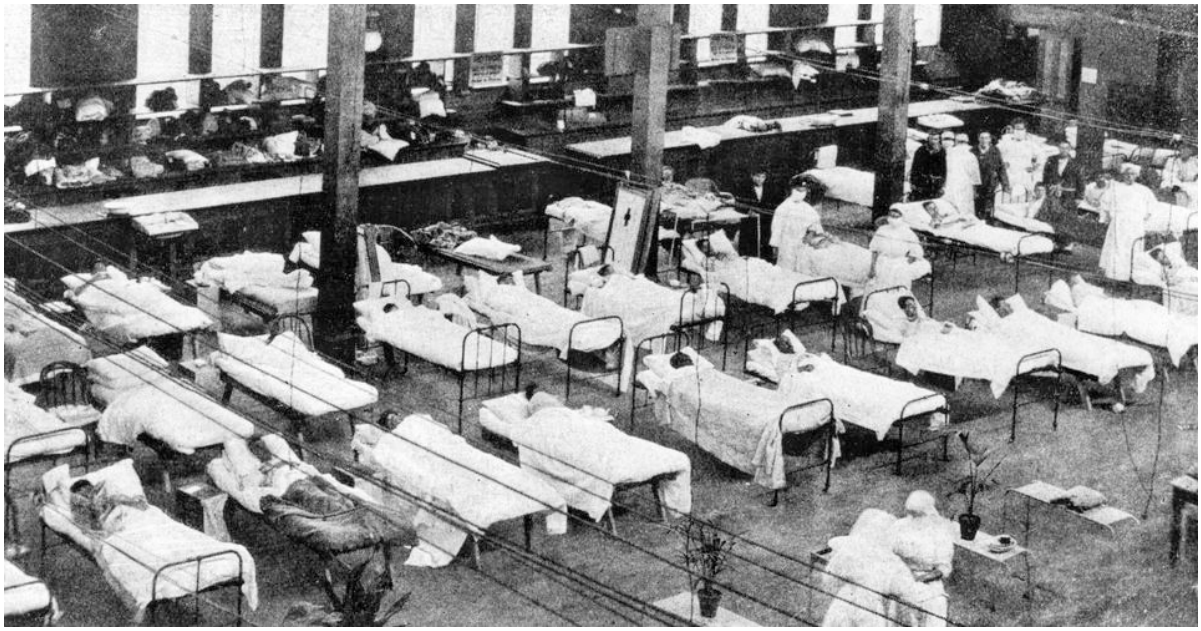
[91] (1919) 'White flag of distress', *The Herald*, 30 April.
[92] (1919) 'Shipping, coal, and quarantine', *Geelong Advertiser*, 16 April.
[93] (1919) 'Quarantine restrictions', *The Age*, 27 March.
[94] R. Morris (1979) 'Mr. Justice Higgins Scuppered: The 1919 Seamen's Strike', *Labour History,* 37(1) p. 52–62.
[95] ibid.
[96] B. Haig (2001) 'New estimates of Australian GDP: 1861-1948/49', *Australian Economic History Review*, 41(1), pp. 1–34.
[97] P. Van der Eng (2002) 'Australian economy: lessons from the Spanish flu', *ANU College of Business and Economics*, 2 April.
[98] For estimates of Victoria's historical GDP, see, W. A. Sinclair (1996) 'Victoria's economy in the long run', *Australian Economic History Review* 36(2), pp. 3–29.

falling on the poor. When Parliament resumed in July 1919, the Labor Member for Albert Park, Joseph Hannan, noted that 'the disease was operating principally in [Melbourne's] industrial centres of … Port Melbourne, South Melbourne, Fitzroy and Collingwood', impacting those that had the least means of supporting themselves or families if they fell sick.[99] Labor Member for Brunswick, James Jewell, observed that children of the unemployed in these areas who died through the pandemic 'would have lived had they had a sufficiency of food'.[100]

Controversies



(1919) *Hospital Beds in Great Hall During Influenza Pandemic, Exhibition Building, Melbourne*, MM103429, Photo Collection, Museums Victoria.

When Parliament resumed in July 1919, the government faced attack from the Opposition over its handling of the crisis. This included the charge that Parliament should have been consulted earlier, as well as comments regarding the shortage of nurses and the inconsistent messages about whether individuals with symptoms should be required to present themselves to hospital.[101] Opposition members from metropolitan seats argued the State Government should reimburse all of the municipalities' expenditure on healthcare during the crisis: 'Anything done by one of those municipalities in treating influenza and preventing its spread', said Mr Hannan, again in reference to the hard-hit industrial suburbs, 'was in the interests, not of that particular district only, but in the interest of the whole state'.[102] However the Government had determined earlier in the crisis that it would 'carry the law'.[103] These same members attacked the ineffectiveness of the regulations that closed bars and hotels and caused unemployment in their constituencies.[104]

[99] Joseph Hannan (1919) Reply to Governors' Speech, *Victorian Hansard*, 16 July, p. 140
[100] James Jewell (1919) Reply to the Governor's Speech, *Victorian Hansard*, 9 July, p. 86.
[101] Allan (1919) Reply to the Governor's Speech, *Victorian Hansard*, 16 July, p. 135; Prendergast (1919) Reply to the Governor's Speech, *Victorian Hansard*, 15 July, p. 98; Bailey (1919) Reply to the Governor's Speech, *Victorian Hansard*, 17 July, p. 169.
[102] Joseph Hannan (1919) 'Reply to Governors' Speech', *Victorian Hansard*, 16 July, p140; Beckett, Reply to the Governor's Speech, *Victorian Hansard*, 17 July, p. 597.
[103] (1919) 'Cost of influenza epidemic, who should pay?', *The Age*, 3 May.
[104] Hannan (1919) 'Reply to Governors' Speech'.

One of the biggest controversies in Victoria at the time was not political or medical, but religious. When the state government established a make-shift hospital in the Exhibition Building, Melbourne Catholic Archbishop Daniel Mannix offered to send Sisters of Charity from St Vincent's Hospital. The Health Minister, John Bowser, accepted the offer, only to be attacked at the popular Pleasant Sunday Afternoon forum at Melbourne's Wesley Church: 'The garb worn by the Nuns and Brothers, the ceremonies they observed, the customs they follow, were things that should not be introduced into a State hospital,' complained the Rev. Worral. 'When people were ill it was in the highest degree objectionable that they should have forced upon them views and customs that were irritating to them.'[105] Worrall convinced Bowser to refuse Mannix's offer, prompting Mannix to criticise the minister in the press.[106] 'German diplomatists who tried to justify the invasion of Belgium had an easy task compared with that of Victoria's Ministers', Mannix wrote of Bowser's failure to explain publicly why his offer was being refused at the time when nurses were in short supply.[107]

Doctors and the public also bickered over the most effective methods to combat the pandemic, especially the wearing of masks and inoculation. The demand for masks was so extensive that the Commonwealth Government fixed the price of butter muslin and gauze to prevent profiteering.[108] Opposition came from those who saw them as breeding grounds or unfashionable. Bogus methods and quackery flourished in this context. One doctor claimed masks were 'like using barbed wire fences to shut out flies', and instead recommended Bovril beef stock to 'fortify the system against attacks.'[109] Others were concerned the masks made one conspicuous. Similarly, while municipal councils attempted mass and free inoculations, there were pockets of resistance to inoculation for any purpose as impure batches of serum still caused occasional mass fatalities.[110]

Finally, as in early epidemics, 'foreigners'—even those who'd been in Australia for generations—were treated with utmost suspicion. In Australia and throughout allied Europe and the US, the supposed genesis of the Spanish flu had its foundations firmly in fear and blame of the other, not least the old enemy: 'This modern plague … has commonly been called Spanish influenza,' the *Australasian* of 29 March 1919 reported, 'Yet it did not originate in Spain, nor was it exactly the grippe or influenza of other days. It appears that the Germans, in anticipation that the malady might be justly named German plague … broadcast a misleading name which they had craftily devised before the infection spread from Germany to other countries.'[111]

[105] D. Mannix (1920) *No-Popery and the Spanish Influenza*, Melbourne, A.C.T., p. 10.
[106] B. Niall (2016) *Mannix*, Melbourne, Text Publishing.
[107] (1919) Archbishop Mannix and the Victorian Government, *The Advocate*, 12 April.
[108] McQueen (1976) op. cit.
[109] (1919) 'Resistance to influenza', *Weekly Times*, 7 June.
[110] McQueen (1976) op. cit.
[111] (1919) '"Spanish" influenza', *The Australasian*, 29 March.

Twentieth-century epidemics: polio, influenza, AIDS

Polio epidemic, 1937–38

Lyle Fowler (1936) *Frankston Children's Hospital, Jackson's Road, Mt. Eliza*, H92.20/52, Pictures Collection, State Library of Victoria.

For much of the twentieth century, the most-feared type of epidemic in Australia was not influenza but poliomyelitis, or polio. Polio is a condition mostly affecting children, especially those aged under ten, often causing varying degrees of paralysis and even death. Unlike influenza, it was most marked in the industrialised first world, with major epidemics occurring during the early twentieth century in Scandinavia, the United States, Canada, Australia and New Zealand. It had become endemic in Australia in the early twentieth century, subject to periodic outbursts or virulence.[112]

Between the 1930s and 1960s, it is estimated some 2,000 people were killed by successive polio epidemics, and more than 40,000 were paralysed. Polio Australia estimate there are 400,000 survivors of polio living in Australia today.[113] In Victoria, the most severe outbreak was in 1937–38, killing 113 children in less than 12 months from June 1937. It was the final significant epidemic episode before the arrival of HIV/AIDS, in 1982.

Historian Kerry Highley has described the nature of the virus: 'Epidemics arrived silently, often with symptoms that could easily be mistaken for a common cold, and dreadful suddenness. Those who were

[112] McCalman (2008) op. cit.
[113] Polio Australia (2020) Polio epidemics, Polio Australia website.

fortunate enough to survive infection often faced an unfriendly and unhelpful world. Appropriate treatments for polio survivors were fiercely debated.'[114]

In Australia, polio was first recognised as a notifiable disease by Tasmania in 1911. Victoria followed in 1916, when the first incidences of polio were officially recorded. By 1922, all Australian states recognised the disease. The events of 1937 (77 deaths) and 1938 (41 deaths) greatly exceeded the next-worst year in 1929 (17 deaths).[115]

The Victorian Government responded to the outbreak of 1937–38 with the widespread closures of schools and bans on children using public transport, especially in the south-eastern parts of Melbourne where the outbreak began. As McCalman notes, the higher susceptibility of 'respectable' families was particularly alarming to a society accustomed to associating disease with poverty. By contrast, the early exposure of poor children to the virus protected them from more damaging attacks later in life.[116]

The government response echoed aspects of 1919. From July 1937, 37 Victoria state schools (over 20,000 pupils) in the 'central danger area' in south-eastern Melbourne were closed indefinitely by the Department of Education, along with around 30 Catholic schools comprising 8,000 students. Students at public schools were banned from attending school elsewhere.[117] In August 1937, police were stationed on the NSW and South Australian borders, denying children without signed certificates permission to leave Victoria, while the British Medical Association urged doctors in Victoria not to sign such certificates as immunity couldn't yet be verified.[118]

The experience for sufferers was debilitating. Those who survived could end up with some form of paralysis, forcing them to use crutches, wheelchairs or to be put into an iron lung—a large tank respirator that would pull air in and out of the lungs, allowing them to breathe. Some children remained in hospital up to a year and could only be periodically visited by their parents.[119] Those discharged from hospital were required to spend a further three weeks in isolation.[120]

As with COVID-19, governments strongly advised avoiding contact with others and frequent hand washing. People were told to stop shaking hands or touching each other.[121] One survivor has recently recalled how 'people would cross the streets to get away from someone because they were scared to go near them'.[122] Highley has reflected that, prior to COVID-19, she had been 'hard pressed to think of another time in history when Australians have felt that level of fear'. [123]

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[114] K. Highley (2015) *Dancing in my Dreams: Confronting the Spectre of Polio*, Melbourne, Monash University Publishing.
[115] Victorian Government (1940) *Victorian Yearbook 1937-38*, Melbourne, Government Printer, pp. 119–20; Victorian Government (1941) *Victorian Yearbook 1939-40*, Melbourne, Government Printer, pp. 117.
[116] McCalman (2008) op. cit.
[117] (1937) Schools closed to 28,000 – Infantile Paralysis Counter, *The Herald*, 24 July.
[118] (1937) Board patrol starts today, *Argus*, 28 August.
[119] A. Hooton (2020) 'Reflect on the greater collective good': what Australia can learn from its past polio epidemics, *Sydney Morning Herald*, April 10.
[120] (1937) Isolation period, *The Herald*, 6 December.
[121] A. Hooton (2020) op. cit.
[122] L. Romensky (2020) Polio survivors see in coronavirus era levels of fear not seen since poliomyelitis epidemics, *ABC News*, 4 April.
[123] ibid.

With the introduction of the Salk vaccine in 1956–57, polio was eradicated in two years.[124] The world's first intensive care units (ICUs) and ventilators, now essential in COVID-19 treatment, were invented to ventilate polio patients in the 1950s.[125]

1957 'Asian flu' and 1968 'Hong Kong flu'

Following the 1919 'Spanish' flu, influenza remained relatively stable around the world from 1918 until 1957. That year, a new strain, Influenza A(H2N2), emerged. The new flu strain probably appeared in Guizhou and Yunnan provinces, southern China, in February 1957. It was first identified in Beijing in March and the first notification reached the WHO from Singapore on 4 May. It spread around the world in two directions: westwards via the Trans-Siberian railway into Russia and Europe, and by sea from Hong Kong, to Singapore, Taiwan and Japan. It reached Australia, probably by plane, in May 1957, and had penetrated the Americas, Europe and Africa by September, with infection rates ranging from 20 to 80 per cent.[126]

The first Australian fatality was recorded in early June, when a Melbourne woman died after she contracted the flu and developed complications. Following her death, authorities admitted they had known that the virus had been in Australia for six weeks but had wanted to avoid a public scare. By late July, the outbreak had already passed its peak on the eastern seaboard, flaring up somewhat later in Western Australia. A subsequent Commonwealth Health Department report concluded 40 people in Victoria died from the virus, and 18 in Western Australia. Although, the report noted that 'except for Victoria, the influence of the Asian virus on mortality was no greater than some other outbreaks of influenza in recent years'.[127]

Quarantine was again the focal point of resistance, and again a topic of widespread debate—with some commentators concluding it was an ineffective measure against disease spread in an internationalised world. Ships were quarantined off the Western Australian coast, while Australian authorities and airlines introduced the spraying of aircraft cabins. This measure would have been of limited medical value at the time, but it did partly assuage the public need for assurance that something was being done.[128]

In the only major study of the pandemic in Australia, historian Lachlan Strahan has argued Australia's experience of the health crisis was largely characterised by alarmist and sometimes racist media coverage. As Strahan has written, despite being relatively mild in Australia, the global spread of the pandemic was the source of considerable public angst. 'Jittery media coverage and the government's bungled public relations', Strahan writes, 'reflected a pre-existing and widespread fear of Asia and its "appalling" diseases'.[129] Spread of the disease through neighbouring countries in May and June was sensationalised, providing the impression that it was island hopping towards Australia. Echoing the late nineteenth-century linking of Chinese migrants with smallpox, newspaper-printed maps with gigantic arrows depicted the disease sweeping down towards Australia like the armies of Imperial Japan or the Red Menace.

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[124] Victorian Government (1961) *Victorian Yearbook 1960*, Melbourne, Government Printer, pp. 142, 224.
[125] H. Wunsch (2020) 'The outbreak that invented intensive care', *Nature*, 3 April.
[126] L. Strahan (1994) 'An oriental scourge: Australia and the Asian Flu Epidemic of 1957', *Australian Historical Studies*, 26(103), pp. 182–101.
[127] ibid.
[128] ibid., p. 190.
[129] ibid., p. 192.

The episode also helped to reinforce recriminations of non-white migrants. The identification of the flu with 'outsiders' was further augmented by new reports that the disease had appeared at an early stage in the Bonegilla migrant centre in northern Victoria, a fact authorities concealed for two months.[130] The link only added to difficulties for Italians, Maltese and other 'eastern' European migrants. By the mid-twentieth century, Australian colloquialisms reinforced associations between 'foreigners' and 'disease'. For example, since the 1940s the term 'wog' had been used interchangeably to refer to foreigners, insects, germs and influenza.[131] In May 1957, the Melbourne *Sun* claimed a scientist had tracked down the 'flu wog'.[132]

A decade later, the Influenza A(H2N2) strain evolved via an antigenic shift into H3N2, causing a milder pandemic in 1968 and 1969.

HIV/AIDS epidemic, 1980s–90s

Issues of representation and stigmatisation were also significant during the human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) epidemic. The first case of HIV/AIDS was reported in the Western world in 1981. Since then, around 75 million people have become infected with HIV and about 32 million people have died.[133]

The first Australian case appeared in Sydney in 1982 and was reported publicly in May 1983. At its peak during the mid-1990s, there were close to 1,000 new diagnoses of AIDS each year, the majority among men in their 20s and 30s. In 2017, Australian health authorities declared that AIDS was no longer a public health issue.[134] By then, more than 35,000 Australians had been diagnosed with HIV and there were around 10,000 deaths from AIDS-related illnesses.[135] HIV continues to be prevalent in the Australian community; however, through consistent use of antiretroviral treatment (ART) most HIV cases (around 75 per cent) no longer develop into AIDS.[136]

When it first emerged, AIDS was a new, unidentifiable, infectious and lethal disease. There were no medical explanations, little understanding of the communities affected and no overseas policy models to guide action. Occurring overwhelmingly in gay men, HIV/AIDS was initially depicted as a disease of immorality and deviance, sometimes referred to as the 'gay plague'.[137] Some public figures, with media backing, depicted gay men as irresponsible and dangerous, guilty not only of their misdirected sexual predilections but of their potential to infect and kill 'normal' Australians.[138] For a time, such representations threatened to give license to a formal crackdown on gay civil liberties. While Victoria had decriminalised homosexuality in 1980 (following the 1978 Commonwealth Royal Commission on

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[130] ibid., p. 195.
[131] W. S. Ramson (1988) *The Australian National Dictionary: A Dictionary of Australianises on Historical Principles*, Melbourne, Oxford University Press, p. 741.
[132] Strahan (1993), 'An Oriental Scourge', p. 196.
[133] UNAIDS (2019) Global HIV & AIDS statistics – 2019 fact sheet. UNAIDS (online).
[134] S. Dalzell (2017) 'AIDS epidemic no longer a public health issue in Australia, scientists say', *ABC News*, 10 July; The Kirby Institute (2018) *HIV, viral hepatitis and sexually transmissible infections in Australia: Annual surveillance report 2018*, Sydney, Kirby Institute-UNSW.
[135] For latest statistics, ibid.
[136] J. Power (2016) 'AIDS epidemic no longer a public health issue, but HIV still is', *The Conversation*, 12 July.
[137] G. Dowsett (2009) *The "gay plague" revisited: AIDS and its enduring moral panic*, New York University Press, New York.
[138] J. Power (2011) *Movement, Knowledge, Emotion Gay activism and HIV/AIDS in Australia*, Canberra, ANUPress, pp. 7–8.

Human Relationships), the media now debated the merits of compulsory HIV testing for gay men, banning lesbian and gay events and quarantining people with AIDS.[139]

Among gay men, fear and grief were widespread, as eventually thousands were diagnosed with the disease. Men watched as HIV attacked sufferers, making them susceptible to infections that usually took their lives. But gay men also organised against the virus, fought efforts to ostracise sufferers, told their stories in a manner that gave the virus a human face—and aligned their experience with the language of trauma increasingly prominent in public discourse.[140]

The Victorian AIDS Action Committee (VAAC) was established in 1984, with Victorian Government funding provided from 1985.[141] AIDS activists formed partnerships with both policymakers and journalists, providing the latter with regular and consistent information about scientific and medical aspects of HIV/AIDS. Governments extended the 'safe sex' message to the whole community, breaking down the stigma of the disease by treating it as something every sexually active person should worry about.[142]

Scholars now regularly stress that Australia's success in responding to HIV/AIDS should not only be measured epidemiologically, but for its policy and cultural achievements.[143] These achievements included: empowerment of affected communities; increased awareness of the human rights of marginalised groups; radical changes in community behaviour, including a revolution in safe sex and drug-using practices; and changes to policy process including policy partnerships between politicians, community groups, clinicians and researchers, innovative public health programs and healthcare services.[144]

Twenty-first century

2009 'Swine flu'

The early twenty-first century has been marked by several major epidemics, including Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome (MERS), Ebola and Zika virus. Prior to COVID-19, the most significant outbreak was the 2009 H1N1 'Swine flu' pandemic, reaching most parts of the world including Victoria.[145]

What began as a report of an influenza-like illness in Mexico on 24 April 2009 was declared a pandemic by the WHO on 11 June 2009.[146] The pandemic lasted nearly 16 months, spreading to more than 200 countries.[147] Accurate mortality rates are difficult to assess. The Centers for Disease Control and

[139] ibid., pp. 12, 32–34.
[140] F. Bongiorno (2015) *The Eighties*, Melbourne, Black Inc., p. 204.
[141] J. Power (2011) op. cit., p. 46.
[142] Bongiorno (2018) op. cit., p. 204.
[143] Power (2011) op. cit. p. 22.
[144] L. Fitzgerald, A. Mutch and L. Heron (2019) 'Responding to HIV/AIDS: Mobilisation through partnerships in a public health crisis', J. Luetjens, M. Mintrom and P. Hart, *Successful Public Policy*, Canberra, ANU Press, pp. 29–58.
[145] World Health Organisation (2020) 'How the 4 biggest outbreaks since the start of this century shattered some long-standing myths', WHO website.
[146] ibid. See also, Weeramanthri et al. (2015) 'Response to pandemic (H1N1) 2009 influenza in Australia – lessons from a State health department perspective', *Australian Health Review,* 34(4), p. 478.
[147] Centers for Disease Control and Prevention (2019) '2009 H1N1 Pandemic', CRC website.

Prevention in the United States estimated global mortality rates from the pandemic to be between 151,700 and 575,400.[148] The WHO declared the end of the H1N1 pandemic on 10 August 2010.[149]

The first case of H1N1 in Victoria occurred on 20 May 2009. According to the Victorian Infectious Disease Laboratory, there were 3,089 cases and 26 deaths reported in Victoria from H1N1.[150] This accounted for almost one third of the 84 deaths and half the 6,725 cases confirmed in Australia.[151]

Like COVID-19, Swine flu causes symptoms such as fever, chills, a cough and headaches. It is generally considered mild at the community level; however, it is contagious and spreads easily, causing respiratory illness.[152] Both viruses are worse for people with underlying respiratory or chronic illness, who are more susceptible to infection, including infants, those in aged care, and Indigenous peoples.[153] Unlike the novel coronavirus, Swine flu is more likely to impact children, young and middle-aged people, whereas COVID-19 has caused the highest percentage of deaths in people over 65.[154] Of the first 1,000 cases of H1N1 notified in Victoria, two-thirds were school-aged (5 to 17 year-olds).[155]

Responses: Australia and Victoria

Initial responses in Australia included border-control measures, which required travellers entering Australia to declare symptoms of influenza or contact with someone with severe respiratory illness, and contact tracing of persons identified with influenza.[156] Then, as now, there were issues with the management of cruise ships. In New South Wales, around 2,000 passengers disembarked the ship, *Pacific Dawn*, despite dozens of people showing flu-like symptoms. The incident was a major source of disseminating the infection into the other states and territories, including Victoria.[157]

Victoria's response was characterised by school closures. Health authorities closed Clifton Hill Primary School, Thornbury High School and Mill Park Secondary College in May after reporting multiple cases, while nine other schools remained open after reporting only one case.[158] Primary and secondary schools across Melbourne were closed for days at a time in the first half of the year.[159] In June, Victoria changed its policy from automatically closing schools if there were confirmed cases across several

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[148] ibid. See also, National Public Radio (2013) '2009 Flu Pandemic Was 10 Times More Deadly Than Previously Thought' NPR website; L. Simonsen (2013) 'Global Mortality Estimates for the 2009 Influenza Pandemic from the GLaMOR Project: A modelling Study' *PLOS Medicine,* p. 1.

[149] Centers for Disease Control and Prevention (2019) '2009 H1N1 Pandemic', CRC website.

[150] C. Looker et al. (2010) 'Influenza A (H1N1) in Victoria, Australia: A Community Case Series and Analysis of House Transmission' *PLOS ONE,* 5(10), p. 1.

[151] (2020) 'Australia coronavirus cases', Worldometer website.

[152] Department of Health (2020) 'What you need to know about coronavirus (COVID-19)', Department of Health website; 'Centers for Disease Control and Prevention (2010) '2009 H1N1 Flu ("Swine Flu") and You' CDC website.

[153] K. Overton (2016) 'The Australian public health response to the H1N1 pandemic', *Australian Journal of Emergency Management,* 31(3), p. 21; Centers for Disease Control and Prevention (2020) 'Coronavirus Disease 2019 (COVID-19)', CDC website.

[154] K. Overton (2016) op. cit., p. 21.

[155] J. Fielding et al. (2013) 'The Spread of Influenza A(H1N1) in Victorian School Children in 2009: Implications for Revised Pandemic Planning', *PLOS ONE,* 8(2), p. 1.

[156] Commonwealth Department of Health and Aging (2011) '*Review of Australia's Health Sector Response to Pandemic (H1N1) 2009: Lessons Identified,* Canberra, Department of Health and Aging, chapter 4.

[157] B. Clare (2009) 'Swine flu hits Mackay', Daily Mercury, 30 May.

[158] B. Smith (2009) 'Swine flu spreads: Victorian schools named', *The Age*, 27 May.

[159] ABC News (2009) 'More schools close as swine flu cases grow', *ABC News*, 2 June.

classes, to placing affected students with flu-like illness in home quarantine for several days (see below).[160]

Managing Swine flu in Australia

By the early twenty-first century, planning for public health crises had developed significantly since Australia's last experience of a global pandemic, with global coordination now provided by the WHO. However, in practice, as in 1919 it was still characterised by the sharing of responsibilities between Commonwealth and state. The Swine flu pandemic again reflected the tensions in public health crises between national plans and state-specific circumstances.

The key national planning instruments in operation during the 2009 pandemic were the Australian Health Management Plan for Pandemic Influenza (AHMPPI) and the National Action Plan for Human Influenza. These plans centred around six pandemic phases: *Alert, Delay, Contain, Sustain, Control* and *Recover.* Importantly, these categories were drawn from the WHO's prescribed pandemic phases.[161] In total, Australian governments issued 18 primary plans, 28 sub-plans, appendices and annexes and 11 guidelines for responding to the 2009 crisis.[162] Victoria had five of its own pandemic plans.[163]

The epidemic demonstrated the limits of a universal model to public health crisis management. When it was realised the virus was milder than first expected, yet with especially high prevalence in Victoria, state and federal authorities scrambled to modify their classification systems.[164] In early June, Victoria proposed a modified pandemic phase, 'Modified Sustain', to better reflect its circumstances. The Australian Government later adopted this proposal as part of the national plan, calling it the 'Protect' phase. This phase fell between 'Contain', which represented a 'pandemic virus that has arrived in Australia and is causing a small number of cases', and 'Sustain', which represented a 'pandemic virus that is established in Australia and spreading in the community'.[165] These changes enabled Australia to adjust its focus to treating and caring for people who were considered 'high risk', lessening the strain on resources. For example, while there were cases recorded at 203 Victorian schools, the new approach dictated a more targeted management of schools and individual students, as opposed to the mass shutdown of all schools.[166]

Critiques

While Victoria's flexibility and willingness to modify its plans and responses were praised as one of the success stories of Australia's response to Swine flu, medical practitioners and health experts made several important critiques of the country's overall response.[167] First, it was reported that too wide a case definition was provided for Swine flu when Victoria shifted from *Contain* to the *Modified Sustain* phase of pandemic control. Widening the classification of the virus meant that antiviral drugs were provided for all people who presented with influenza-like illness within 48 hours of symptoms. It has

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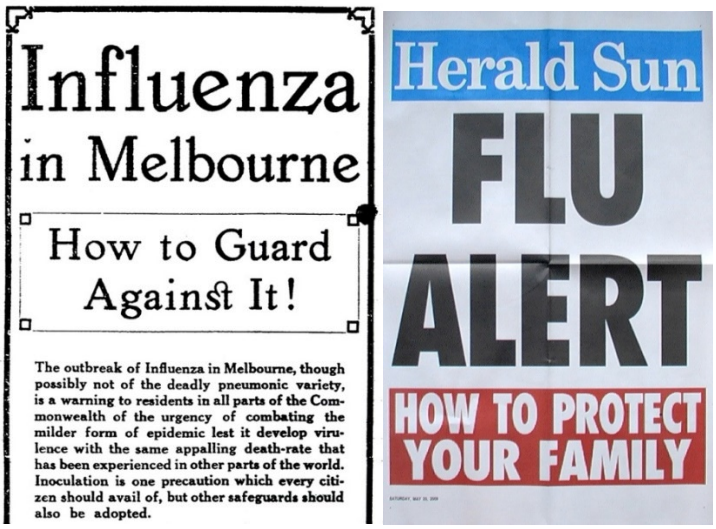
[160] D. Prestipino (2009) 'Schools close as swine flu tally increases', *Sydney Morning Herald*, 8 June.
[161] Commonwealth Department of Health (2009) 'The World Health Organization (WHO) and the Australian Pandemic Phases', Department of Health website.
[162] For the full list of publicly available pandemic plans in 2009, see T. Carney et al. (2012) 'Pandemic planning as risk management: How fared the Australian Federation?' *Journal of Law and Medicine,* 19(1) p. 567.
[163] ibid.
[164] A. Hamilton et al. (2010) 'Australia's response to Swine Flu in 2009 – Has it been appropriate?', *Journal of Rural and Tropical Health*, 9, pp. 14–18.
[165] ibid.
[166] Commonwealth Department of Health and Aging (2011) *Review of Australia's Health Sector Response to Pandemic (H1N1) 2009: Lessons Identified,* Canberra, Department of Health and Aging
[167] Commonwealth Department of Health and Aging (2011) op. cit.

been speculated some 10,000–15,000 individuals were treated with antiviral drugs who did not have influenza.[168]

Medical experts also criticised delays on flu sampling tests, as well as a month-long wait on deployment of personal protective equipment for front-line healthcare workers. The synergies between jurisdictional and other health organisation websites were also reported to be an issue, with complaints of government websites being behind media reporting.[169]

At the national level, a review by the Department of Health and Ageing criticised the confusion among health professionals about laboratory testing criteria, and the broader difficulties associated with evolving policies, phase categories and a constant stream of changing public information.[170]

What do we learn from history?



(1919) 'Influenza in Melbourne: how to guard against it', *Argus*, 25 January 1919; (2009) Headline poster, *Herald Sun*, 23 May. Photos courtesy: e-Melbourne: the city past and present (online)

What can we learn from two centuries of pandemics in Victoria? Policy experts, commentators and historians have argued there are both advantages and limitations to drawing historical analogies with the episodes discussed above. This concluding section briefly outlines some of these arguments, focusing on five areas: policy lessons; general patterns in Victoria's experience of epidemics; big picture lessons about how pandemics transform society; lessons about the tendency to 'forget' epidemics; and the possibility that history offers no lessons for the current crisis.

Policy lessons

The most obvious use of history is to draw lessons that will help in the management of future crises. In relation to COVID-19, there have been no shortage of policy experts and commentators drawing

[168] P. Eizenberg (2009) 'The general practice experience of the swine flu epidemic in Victoria – lessons from the front line' *Medical Journal of Australia,* 191(3).
[169] ibid.
[170] Commonwealth Department of Health and Aging (2011) op. cit.

analogies with the apparent mistakes of the 1919 Spanish flu. Soon after social restrictions were put in place in March 2020, historian Frank Bongiorno commented that Victorian authorities' early relaxing of social restrictions when the crisis appeared under control in autumn 1919 allowed for the disease to strike again through the middle of the year at a much higher mortality rate.[171] In the current crisis, many other commentators have drawn on this analogy to warn against complacency in withdrawing social distancing measures too early.[172]

More directly, the experience of Swine flu has shaped technical and policy responses to the epidemic diseases.[173] Many analysts argued responses to the 2009 pandemic had demonstrated a one-size-fits-all approach to public health emergencies is unlikely to work for all communities. The 2009 epidemic led to the drafting of the 2014 *Victorian health management pandemic plan for pandemic influenza*, which now provides the basis for Victoria's health response to COVID-19. No longer using the operationally-focused WHO phases, a key principle underpinning the pandemic response plans is flexibility. The new plan characterises the virus by its level of severity (mild, moderate, severe), which is linked to a set of actions that are available to be applied based on the evidence.[174] Presently, there are eight publicly available national response plans for the current coronavirus situation.[175]

General lessons

Historical perspectives also help to do more than draw like-for-like lessons; they can identify certain patterns in how people and governments respond to health crises.[176] Writing in relation to the Spanish flu, public health experts Peter Curson and Kevin McKrasken have identified four such patterns relating to (a) how people and communities react to severe diseases; (b) the role of the media in shaping or inflaming public reactions; (c) the potential impact of such crises on public health facilities and logistical difficulties in delivering vaccines; and (d) that cooperation between levels of government in Australia cannot be taken for granted.[177]

Each one of these aspects is borne out in the preceding discussion of Victoria's epidemic history. First, most of the epidemics discussed here were characterised by cultures of anxiety, fear and apprehension—whether the erratic behaviours of people fleeing cities in 1919, or the targeting and ostracization of certain groups such as the Chinese and 'Asians' in the 1880s and 1857, Germans in 1919, affected families in the 1930s polio pandemic, or the stigmatisation of gay men during the HIV/AIDS epidemic. Throughout COVID-19, survivors of polio have likened the current public fear and ostracization to what they experienced during polio epidemics.[178] However, these epidemics also

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[171] Bongiorno (2020) op. cit.

[172] S. Hamilton, et al. (2020) 'Open letter from 265 Australian economists: don't sacrifice health for "the economy"', *The Conversation*, 20 April.

[173] For example, Royal Australian College of General Practitioners (2014) *Managing pandemic influenza in general practice: A guide for preparation, response and recovery*, Melbourne, RACGP, p. 8.

[174] Department of Health (2014) *'Victorian health management plan for pandemic influenza'*, Victoria, Department of Health, p. 1.

[175] See: Australian pandemic response planning: a quick guide; National emergency and disaster response arrangements in Australia: a quick guide; Australian COVID-19 response management arrangements: a quick guide; Australian COVID-19 response management arrangements: a quick guide; Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19); Australian Health Management Plan for Pandemic Influenza, official short form of the COVID-19 Plan; Management Plan for Aboriginal and Torres Strait Islander Populations; Management and Operational Plan for COVID-19 for People with Disability.

[176] D. S. Jones (2020) 'Perspective: History in a Crisis – Lessons for COVID-19', *The New England Journal of Medicine*, 30 April.

[177] P. Curson & K. McCracken (2006) op. cit.

[178] M. Adler (2020) Coronavirus revives memories of polio outbreak, *Canberra Times*, 24 March.

provide for moments of extraordinary community cooperation, as demonstrated in the white cloth system during the Spanish flu or the alliance built between community groups and governments during the HIV/AIDS epidemic. Second, cultures of recrimination have often been inflamed in media representations, although, again, as in the 1980s, the media has played a crucial role in public education campaigns, setting new public standards and improving the visibility of marginalised groups. The pressure on public health facilities was a key feature during all the episodes discussed above, especially through the twentieth century. So, too, the recurring stress that quarantine has placed on Australia's federation. This is often because disease has impacted Victoria differently to other states—whether in the closing of borders (in 1937) or schools (2009), but also, as demonstrated in 1919, because of disputes between states in how best to manage a national crisis.

The bigger picture

At a more general level, other experts have been looking to the past to gain some sense of what may follow in the wake of COVID-19. For example, some have reached to Europe's fourteenth century Black Death—which killed perhaps half that continent's population and transformed labour relations and social hierarchies—to highlight the lasting impact of mass pandemics.[179] As we have seen, Australia—and Victoria—have more proximate examples of how epidemics can change the big picture. Responses to epidemics in the nineteenth century were in part responsible for the move towards Australian Federation; the 1919 Spanish flu resulted in the establishment of the Commonwealth Department of Health; while the community cooperation of the 1980s HIV/AIDS epidemic helped to greatly curb discrimination against the gay community.

Remembering and forgetting epidemics

If epidemics are considered socially transformative by some historians, this has raised a different kind of question: why don't we remember them? The Spanish flu is again a clear case in point. As was noted by several commentators in the lead up to Anzac Day in 2020, there is a clear gulf between how we remember the tragedy and heroism seen during the Spanish flu compared to the Great War, despite the pandemic being more deadly globally and just as deadly for Australians.[180] Historian Peter Hobbins writes: 'Compared with the Anzac memorials that peppered our towns and suburbs in the decades after the Great War, few monuments mark the impact of pneumonic influenza'. Hobbins adds: 'Nevertheless, its stories of suffering and sacrifice have been perpetuated in other ways, especially within family and community memories. A century later, these stories deserve to be researched and commemorated'.[181]

Compared to the 62,000 monuments to Anzacs, there are fewer than a dozen public Australian monuments to the dead of that pandemic. Spanish flu historian Mary Sheehan believes this is because of the 'invisible nature of the disease in comparison to other natural disasters like floods and bushfires.' The pandemic, Sheehan adds, 'was not a sudden dramatic event like these disasters, no traditional

[179] D. Griffin & J. Denholm (2020) 'This isn't the first global pandemic, and it won't be the last. Here's what we've learned from 4 others throughout history', *The Conversation*, April 17; Rachel Clamp (2020) 'Coronavirus and the Black Death: spread of misinformation and xenophobia shows we haven't learned from our past', *The Conversation*, 6 March.
[180] For example, P. Daley (2020) 'Politicians, take note this Anzac Day: coronavirus is a pandemic. Not a war'. *Guardian* (Online), 25 April.
[181] P. Hobbins (2020) op. cit.

heroes emerged, and it did not leave a visible legacy of destruction—except, of course death, and rises in the number of single parents and orphans'.[182]

History has no lessons

Finally, historians and other experts also recognise that the history of health crises often warns us of the limits in drawing historical analogies: sometimes there are few or no parallel lessons. As leading science journal, *The Lancet*, noted at the beginning of the current crisis: 'When the present is viewed through the lens of former disease outbreaks, we typically focus on similitudes and overlook important differences. In other words, analogies create blind spots.'[183] Changing geopolitical contexts in east Asia in the early twenty-first century, the journal argued, shaped similar and chronologically close diseases—SARS and COVID-19—with significantly different outcomes.

Similarly, while the Spanish flu is often seen as a natural analogy for COVID-19, Mary Sheehan reminds us different political and social contexts in 1919—the end of a world war, no central health agency, no international bodies, as well as mass strikes and returning soldiers—will mean that the kinds of imaginable and expected responses and outcomes are very different between now and then.[184] Likewise, medical historian Michael Bresalier argues that pandemics do not tend to create foreseeable *new* social divisions and inequalities, but exacerbate existing social, economic and geopolitical inequalities and divisions. To this extent, every pandemic is a step into the unknown.[185]

Some historians have taken COVID-19 as an opportunity to reinforce the dubiousness of a pandemic's inherent 'stages'.[186] This is because history does not—and should not—necessarily provide a clear sense of an ending. For example, many of the 400,000 Australian polio survivors still suffer a range of symptoms, known as post-polio syndrome (PPS).[187] Similarly, despite AIDS no longer being a public health issue, HIV remains so.[188] As medical historian Dora Vargha writes: 'Endings are often messier than any international, national or local governing body would care to admit, and most diseases do not map onto neat narratives'.[189]

Bresalier offers a fitting conclusion:

> We need to bear in mind crucial differences in the context in which influenza and COVID-19 emerged, in the state of medical and scientific know-how, in health care infrastructures, and in the world's ability to respond. We are in a better position than ever before to tackle this pandemic. We have the science, medical technology, and systems to mitigate its impact. But they will not be effective without political will, cooperation, and the sharing of vital medical and scientific resources … Putting COVID-19 in historical perspective reminds us that each pandemic brings with it unique problems that require unique solutions. It can teach us how we got to where we are now. And provide us with a measure of hope.[190]

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[182] Quoted in P. Daley (2020) op cit.
[183] R. Peckham (2020) 'Comment: COVID-19 and the anti-lessons of history', *The Lancet*, 395(10227), 14 March.
[184] M. Sheehan (2020) Were these the good old days? *Living Histories*, 12 March.
[185] M. Bresalier (2020) 'COVID-19 and the 1918 'Spanish 'flu': differences give us a measure of hope', *History & Policy* (online blog), 2 April.
[186] G. Lachenal and G. Thomas (2020) 'COVID-19: When history has no lessons', *History Workshop*, 30 March.
[187] L. Romensky (2020) op. cit.
[188] N. Medland (2019) 'Australia will never be HIV-free if access to prevention requires a medicare card', *The Conversation*, 23 January.
[189] D. Vargha (2016) 'After the End of Disease: rethinking the epidemic narrative', *Somatosphere*, 17 May.
[190] M. Bresalier (2020) 'COVID-19 and the 1918 'Spanish 'flu'.

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